

The Philosophy and Practice of Japanese Acupuncture

Benjamin Christopher Ward Chant

BHSc (Acupuncture), Endeavour College of Natural Health

AdvDip (Acupuncture), Endeavour College of Natural Health

A dissertation submitted for the degree of

Doctor of Philosophy

UNIVERSITY OF NEW ENGLAND

July 2017

Acknowledgments

極意とは己が睫毛のごとくにて近くあれども見えざりにけり。

Mastering the secret is like looking at your eyelashes; so close, yet so difficult to see.

- Hiroshi Yamamoto (My friend and Sensei)

Special thanks go to my fantastic supervision team (Dr Gudrun Dieberg, Adjunct Professor Jeanne Madison and Dr Paul Coop) for their tireless assistance, patience and wonderful support throughout my entire long period of candidature. Their combination of sharp attention to detail, encouraging perspective of the bigger picture and decades of technical expertise bore this thesis into existence. They persevered with this project over several years and across several thousand kilometres. It is through their dedicated mentorship that this research has been successful, and I am truly fortunate and very grateful to have had their influence in both my personal and professional development.

I would also like to acknowledge the support provided by the Australian Postgraduate Scholarship in the final year and a half of my candidature, which contributed to the success of this research.

I am greatly indebted to the practitioners who assisted my expatriation from Australia to Japan, and all who accepted me into their clinics; they were so generous with their time and knowledge. All of them are fantastic people and inspirational practitioners. Without their help and willingness to make a contribution, this research would never have been possible.

I must also thank my friends and family for their continued companionship despite my long absence from home. Chris, Cheryl and Rachel were always forgiving and accepting of my pressures while in Japan; they never failed to inspire me through the many challenges I faced and welcomed me with open arms and unconditional love when I returned. Their help and advice in preparing this manuscript is also very much appreciated.

Finally, to those I was closest to while on location. The isolation and loneliness in a foreign land were remedied by you: times shared together, conversations had, and the certain death we cheated on occasion. This thesis is more than a product of intellect and academia; it has been, a sometimes unwilling adventure, written with the blood we spilled, tears of agonies suffered and quiet moments of happiness that have stained my life and these pages equally.

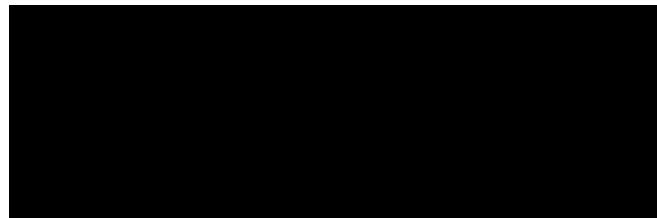
本当にありがとうございました

毎度おおきに

Hamish Love, thanks for all the ice-cream. See you in the lounge room!

Certification of Dissertation

I certify that the substance of this dissertation has not already been submitted for any degree and is not currently being submitted for any other degree or qualification. The work contained within this dissertation is an original product and contains no material previously published or written by another person except where due acknowledgment and reference is made.



Signature

13/07/2017

Date

Abstract

Traditional Japanese Medicine (TJM) acupuncture is gaining recognition as an alternative to Traditional Chinese Medicine acupuncture in Western countries. However, previous research has failed to comprehensively describe the characteristics of TJM acupuncture by not investigating it within the social and cultural context of Japan.

The purpose of this ethnographic study was to describe the philosophy and practice of TJM acupuncture practitioners in Japan and to explain philosophical concepts, diagnostic methods and treatment principles; additionally to determine if TJM acupuncture is a distinct style. In Japan, participants were recruited by chain referral and emergent sampling. Over four and a half years, data was collected through participant observation, interviews and by gathering documents. Thematic analysis was used to evaluate data.

Findings indicate that TJM acupuncture knowledge is strongly based in biomedical science. Regarding Traditional East Asian Medicine knowledge, Ki, meridians and the eight principles are emphasised. The instantaneous effects of treatment, effect through technique and patient comfort are important beliefs and values influencing clinic operations. Inquiry is one of the most significant diagnostic methods. Perception and sensitivity are also valued attributes, often applied to pulse palpation or in searching for body tissue abnormalities on the skin or abdomen. Furthermore, esoteric, biomedical and orthopaedic diagnostic methods are utilised. Diagnostic methods often result in simple patterns of disharmony or the location of abnormal body tissue. Slightly long, thin filiform needles inserted with guide tubes are common. Additionally, small amounts of higher grade moxa floss, non-inserted contact tools, machines and manual methods are applied in treatment. Using the pressing hand to prepare the skin for tool application, monitor the patient's and maintain intervention accuracy is important. That tool manipulation and stimulation is performed in small amounts over many treatment locations is distinctive of TJM acupuncture. Many needle and moxibustion methods are minimally intrusive and dependent on immediate feedback to gauge treatment success on micro, meso and macro levels of confirmation. TJM acupuncture emphasises practical skills and tangible phenomena by relying on the palpated qualities of treatment locations and techniques used at them.

This study described TJM acupuncture in terms of routines and analysed how practitioner beliefs and behaviours connected with the cultural context of Japan. TJM acupuncture is a unique style with defining features; this study suggests that an enhanced understanding of TJM acupuncture could benefit acupuncture at government, research, education and clinical levels, with the ultimate goal of providing better care for individual patients.

Publications, Presentations and Posters

Publications

Chant, B., Madison, J., Coop, P. and Dieberg, G. (2017). Contact tools in Japanese acupuncture: An ethnography of acupuncture practitioners in Japan. *Journal of Acupuncture and Meridian Studies*, 10(5), 331-339.

Chant, B., Madison, J., Coop, P. and Dieberg, G. (2017). Beliefs and values in Japanese acupuncture: An ethnography of Japanese trained acupuncture practitioners in Japan. *Integrative Medicine Research*, 6(3), 260-268.

Chant, B., Madison, J. and Dieberg, G. (2016). Cross-cultural differences in acupuncture: A review. *Australian Journal of Acupuncture and Moxibustion*, 10(2), 12-18.

Conference Presentations

Chant, B. (April, 2016). An Australian acupuncturist's perspective of moxibustion practice in East Asian countries. In Chant, B. (Chair) & Yamashita, H. (Chair), *Acupuncture Symposium*. Symposium conducted at The 18th International Congress of Oriental Medicine, Okinawa, Japan.

Conference Posters

Chant, B., Coop, P., Madison, J. and Dieberg, G. (November, 2016). Confirmation of treatment effects in Japanese acupuncture. Poster session presented at the World Federation of Acupuncture-Moxibustion Societies, Tsukuba/Tokyo, Japan.

Nishimura, R., Furuta, T., Chant, B. and Yano, T. (November, 2016). Comparison of acupuncture and moxibustion for improving blood flow to the face: A recommendation for Japanese moxibustion. Poster session presented at the World Federation of Acupuncture-Moxibustion Societies, Tsukuba/Tokyo, Japan.

Table of Contents

Acknowledgments	i
Certification of Dissertation.....	ii
Abstract.....	iii
Publications, Presentations, Posters and Positions	iv
Table of Contents.....	v
List of Figures	viii
List of Tables	xi
Glossary of Terms	xiii
Chapter 1: Introduction	1
1.1 Background	1
1.2 Analytical Framework.....	2
1.3 Dissertation Outline.....	3
Chapter 2: Literature Review	6
2.1 Traditional Medicine	7
2.1.1 Traditional medicine in Asia	8
2.1.2 Traditional East Asian Medicine (TEAM)	8
2.2 Acupuncture	10
2.3 Style Diversity in Acupuncture.....	15
2.3.1 History and progression of acupuncture	15
2.3.2 Philosophical concepts	20
2.3.3 Overview of TCM, TKM and TJM acupuncture	27
2.4 Contemporary Japanese Acupuncture, Culture and Context	37
2.4.1 Historical development of acupuncture in Japan.....	38
2.4.2 Current understanding of TJM acupuncture.....	40
2.4.3 Philosophical concepts	42
2.4.4 Diagnostic methods	44
2.4.5 Treatment principles	46
2.5 Chapter Summary	51
Chapter 3: Methodology and Methods	53
3.1 Research Aim and Research Questions	54
3.2 Positioning of the Researcher	54
3.3 Research Paradigm	55
3.4 Methodological Framework	58
3.5 Methodology.....	60
3.5.1 Sampling.....	61
3.5.2 Data collection	62
3.5.3 Data management and analysis.....	66
3.5.4 Researcher roles.....	73
3.6 Research Design.....	74
3.7 Methods	78
3.7.1 Development of guidelines and questionnaires.....	78

3.7.2 Ethical implications	79
3.7.3 Setting and recruitment.....	79
3.7.4 Data collection	80
3.7.5 Data analysis	82
3.8 Limitations.....	86
3.9 Chapter Summary	87
Chapter 4: Setting and Practitioners	91
4.1 Research Setting	91
4.2 Recruitment and Sampling	94
4.3 Education and Career	103
4.4 Chapter Summary	106
Chapter 5: Philosophical Concepts	109
5.1 Overview of Philosophical Concepts.....	109
5.2 Knowledge	110
5.2.1 Structure and function of the body	114
5.2.2 Order, balance, movement and cycles	118
5.2.3 Identification and location of disease	121
5.3 Beliefs and Values	123
5.4 Styles	126
5.5 Chapter Summary	129
Chapter 6: Diagnostic Methods	133
6.1 Overview of Diagnostic Methods.....	134
6.2 Diagnostic Methods: A Timeline of Processes	137
6.3 Diagnostic Methods and Procedures	142
6.3.1 Inquiry	143
6.3.2 Observation	146
6.3.3 Palpation.....	150
6.3.4 Listening/Smelling.....	167
6.3.5 Esoteric.....	168
6.3.6 Section summary	171
6.4 Diagnostic Methods and Outcomes	171
6.4.1 Patterns of disharmony as a diagnostic outcome	173
6.4.2 Body tissue abnormalities as diagnostic outcomes.....	179
6.4.3 Diagnosis and physical discomfort.....	183
6.4.4 Section summary	184
6.5 Chapter Summary	184
Chapter 7: Treatment Principles	190
7.1 Treatment Tools	191
7.1.1 Overview.....	192
7.1.2 Needles.....	193
7.1.3 Moxibustion.....	200
7.1.4 Other tools	208
7.1.5 Section summary	219
7.2 Pre-Intervention Preparation	220
7.2.1 Point selection	221
7.2.2 Sterilisation	224

7.2.3 Point location procedures	228
7.2.4 Pre-needling and contact	232
7.2.5 Pre-moxibustion	235
7.2.6 Section summary	236
7.3 Needling	238
7.3.1 Insertion and placement.....	239
7.3.2 Manipulation	245
7.3.3 Needle retention.....	264
7.3.4 Withdrawal	271
7.3.5 Section summary	276
7.4 Moxibustion	278
7.4.1 Categories of moxibustion	279
7.4.2 Indirect moxibustion	282
7.4.3 Direct moxibustion	291
7.4.4 Section summary	302
7.5 Confirmation of Effects	304
7.5.1 Timing of confirmation.....	305
7.5.2 Markers of confirmation	307
7.5.3 Consultation time	309
7.5.4 Section summary	314
7.6 Chapter Summary	315
Chapter 8: Discussion and Conclusion.....	318
8.1 Conclusions and Contextualisation	319
8.1.1 Philosophical concepts	321
8.1.2 Diagnostic methods	333
8.1.3 Treatment principles	343
8.1.4 Section summary	358
8.2 Implications and Future Direction	360
8.2.1 Implications for education and professional development.....	360
8.2.2 Implications for research and practice	363
8.3 Conclusion	367
References.....	373
Appendix A	398
Appendix B	402

List of Figures

Figure 2.1 Contextualisation of Traditional East Asian Medicine.....	9
Figure 3.1 Research paradigm.....	56
Figure 3.2 Research design flowchart	76
Figure 4.1 Base of operations	92
Figure 4.2 Prefectures and recruited practitioners.....	93
Figure 4.3 Number and type of clinic sites visited	94
Figure 4.4 Practitioner occupations.....	105
Figure 5.1 Categories of philosophical concepts.....	110
Figure 5.2 Basic interplay of explanatory models of medicine.....	111
Figure 5.3 Practitioner explanatory model of medicine affiliation	113
Figure 5.4 Mubun style abdominal microsystem map	118
Figure 5.5 Taiji symbol with trigrams	119
Figure 5.6 Stem and branch correspondences between channels/organs	120
Figure 6.1 Timeline of diagnostic events	138
Figure 6.2 Zones of correspondence in tongue diagnosis.....	149
Figure 6.3 Translated pulse palpation diagram	152
Figure 6.4 Alternate viscera, bowels or channels at pulse positions	154
Figure 6.5 Simultaneous pulse palpation with Yae.....	156
Figure 6.6 Pulse palpation positions.....	156
Figure 6.7 Hip flexibility correspondences	158
Figure 6.8 Body tissue abnormalities as individual patterns of disharmony	162
Figure 6.9 Abdominal palpation with the entire hand.....	163
Figure 6.10 Abdominal palpation with the fingers.....	164
Figure 6.11 Summary of body tissue palpation	166
Figure 6.12 Abdominal tapping with Ginnosuke	168
Figure 6.13 Denkuro performing esoteric diagnostic methods	170
Figure 6.14 Patterns of disharmony and relationships to philosophical concepts	174
Figure 6.15 Five element acupoint wall chart	176
Figure 7.1 Treatment tool tray at Genrokuro's clinic.....	194
Figure 7.2 J-Type 0.14 mm by 40 mm needle.....	194
Figure 7.3 Pyonex intradermal needle.....	196
Figure 7.4 Hinaishin	196
Figure 7.5 Diamond decorated press stud	197
Figure 7.6 Fire needle with Ginnosuke.....	198
Figure 7.7 Plum blossom needles	198

Figure 7.8 A variety of guide tubes	199
Figure 7.9 Various grades of moxa floss	201
Figure 7.10 Liquid adhesive stick-on moxa	203
Figure 7.11 Sticker adhesive stick-on moxa	203
Figure 7.12 Stick moxa	204
Figure 7.13 Stick moxa with extinguisher	205
Figure 7.14 Incense stick for lighting moxa	206
Figure 7.15 Charcoal marker	207
Figure 7.16 Insulation sticker	207
Figure 7.17 Insulation moulds and receptacles	208
Figure 7.18 Dermal roller friction tool	209
Figure 7.19 Paediatric contact tools	210
Figure 7.20 Brass, wooden and silver teishin	210
Figure 7.21 Disposable plastic paediatric friction tool	211
Figure 7.22 Non-medical objects used as contact tools	212
Figure 7.23 Large silver teishin (dashin) and hammer	212
Figure 7.24 Sterilisation chambers	214
Figure 7.25 TENS machine in Genrokurou's clinic	214
Figure 7.26 Cupping over an inserted needle at Takizou's clinic	215
Figure 7.27 Treatment tools for sale at drug stores	216
Figure 7.28 Ceramic plate and moxa	218
Figure 7.29 Houroku kyu ceremony	218
Figure 7.30 Ginnosuke's sterilisation tools	225
Figure 7.31 Skin sterilisation	226
Figure 7.32 Point location information sheet for students	230
Figure 7.33 Point location prior to the application of interventions	232
Figure 7.34 Initial contact when needling	233
Figure 7.35 Use of the pressing hand with a teishin	233
Figure 7.36 Palpating and preparing the treatment location	234
Figure 7.37 Treatment sites marked with charcoal pencil	236
Figure 7.38 Summary of pre-intervention processes	237
Figure 7.39 Insertion and placement procedures	240
Figure 7.40 Tube placement	241
Figure 7.41 Tube support	241
Figure 7.42 Needle tapping	242
Figure 7.43 Tube is withdrawn and pressing hand maintains needle position	242
Figure 7.44 Tapping insertion	243
Figure 7.45 Twirling	247
Figure 7.46 Sparrow Pecking	248
Figure 7.47 Holding	249
Figure 7.48 Tapping	250
Figure 7.49 Needling depth goals	252
Figure 7.50 Relationship between manipulation speed and depth	253
Figure 7.51 Tapping the contact tool	256

Figure 7.52 Tapping the tool against the skin.....	257
Figure 7.53 Abdominal tapping footprint.....	258
Figure 7.54 Finger positions for tapping against a treatment location	259
Figure 7.55 Holding the contact tool.....	261
Figure 7.56 Pushing/pressing.....	261
Figure 7.57 Finger position for stroking across a treatment area	263
Figure 7.58 Stroke length and direction.....	263
Figure 7.59 Needle retention procedures	265
Figure 7.60 Purposes of needle retention	266
Figure 7.61 Undoushin	268
Figure 7.62 Summary of actions performed during retention or waiting	270
Figure 7.63 Needle withdrawal	273
Figure 7.64 Tanshi needling method	274
Figure 7.65 Single handed reloading.....	276
Figure 7.66 Techniques and procedures for needles and contact tools	276
Figure 7.67 Categories of moxibustion.....	280
Figure 7.68 Smouldering water adhesive stick-on Kamaya Mini moxa	282
Figure 7.69 Stick moxa at Heisuke's clinic	284
Figure 7.70 Insulated moxibustion on a medicated paste at Kiemon's clinic.....	286
Figure 7.71 Moxa insulation mould.....	286
Figure 7.72 Ginger insulated moxibustion at Yae's clinic	287
Figure 7.73 Moxa burner and warm needling	288
Figure 7.74 Moxa burner	289
Figure 7.75 Warm needling with moxa floss.....	290
Figure 7.76 Stick moxa prepared for warm needling	290
Figure 7.77 Rice grain (left) and half rice grain (right) sized moxa cones.....	292
Figure 7.78 Various sized moxa cones	294
Figure 7.79 Moxa cone size range and methods	294
Figure 7.80 Rolling moxa cones	295
Figure 7.81 Direct moxibustion placement practice metal surface	296
Figure 7.82 Direct moxibustion placement practice wooden surface	297
Figure 7.83 Demonstrating the wooden moxa practice surface	297
Figure 7.84 Moxa cone temperature gauge for practice.....	298
Figure 7.85 Stages of incomplete moxibustion.....	299
Figure 7.86 Lighting and regulating heat from direct moxibustion	300
Figure 7.87 Controlling the oxygen and heat sensation with a glass test tube	301
Figure 7.88 Timing and levels of confirmation	305
Figure 8.1 Correct pulse palpation method in TCM acupuncture	338
Figure 8.2 Incorrect pulse palpation method in TCM acupuncture	338
Figure 8.3 Simultaneous wrist pulse palpation method in TJM acupuncture	339

List of Tables

Table 2.1 Timeline of Japanese Historical Periods.....	37
Table 2.2 Acupuncture Styles Identified in Japan.....	41
Table 3.1 Stages of Thematic Analysis	70
Table 3.2 Coding Template for Thematic Analysis	84
Table 4.1 Practitioner Demographic Information	96
Table 4.2 Practitioner Data Contribution.....	101
Table 5.1 Themes Related to Knowledge in Philosophical Concepts.....	111
Table 5.2 Summary of Significant TEAM Knowledge	114
Table 5.3 Concepts Related to Structure and Function.....	115
Table 5.4 Eight Extra Channel Pairs and Connected Points	116
Table 5.5 Concepts Related to Order, Balance and Movement	119
Table 5.6 Important Beliefs and Values.....	123
Table 5.7 Acupuncture Styles Practiced by Practitioners	128
Table 6.1 List of Diagnostic Methods	134
Table 6.2 Practitioners, Explanatory Models and Diagnostic Methods	135
Table 6.3 General Use of Inquiry.....	145
Table 6.4 Explanatory Model and Diagnostic Terminology.....	146
Table 6.5 General Use of Observation	147
Table 6.6 Observation Markers	148
Table 6.7 Use of Pulse Palpation	151
Table 6.8 General Use of Three and Six Position Pulse Palpation.....	155
Table 6.9 Use of Body Tissue Palpation.....	157
Table 6.10 Allocation of Diagnostically Significant Body Tissues	159
Table 6.11 Skin Condition Markers	164
Table 6.12 General Use of Listening/Smelling	167
Table 6.13 Use of Esoteric Diagnostic Methods	169
Table 6.14 Diagnostic Outcomes	172
Table 6.15 Diagnosing Patterns of Disharmony	173
Table 6.16 Diagnosing Body Tissue Abnormalities	180
Table 7.1 Direct Application Tools	193
Table 7.2 Seirin's Best Selling Filiform Needles as of 2015	195
Table 7.3 Types of Moxa	200
Table 7.4 Effects of Manufacture Materials on Ki	211
Table 7.5 Electronic Equipment.....	213
Table 7.6 Philosophical Concepts of Point Selection	222

Table 7.7 Tapping Insertion Effects on Ki.....	244
Table 7.8 Effects of Manipulation Speed.....	253
Table 7.9 Contact Tool Manipulation Variables and Effect.....	255
Table 7.10 Elements and Effects of Pressure When Tapping	259
Table 7.11 Effects of Pressing/Pushing.....	262
Table 7.12 Needle Retention Times	266
Table 7.13 Use of Moxa Methods.....	281
Table 7.14 Summary of Moxibustion.....	303
Table 7.15 Markers of Confirmation	308
Table 7.16 Qualifications, Patients & Treatment Time	311
Table 8.1 Acupuncture, Moxibustion and Judo Therapy Examinees.....	324
Table 8.2 Summary of Preferences: Knowledge in TCM and TJM Acupuncture..	326
Table 8.3 Summary of Differences: Beliefs and Values in TCM and TJM Acupuncture	328
Table 8.4 Styles Reported by Practitioners in 1994, 2004 and 2011.....	332
Table 8.5 Example of Diagnosis and Treatment Principles in TCM Acupuncture	333
Table 8.6 Summary of Preferences: Diagnosis in TCM and TJM Acupuncture....	343
Table 8.7 Summary of Preferences: Tools in TCM and TJM Acupuncture.....	346
Table 8.8 Summary of Preferences: Pre-intervention Preparation in TCM and TJM Acupuncture	349
Table 8.9 Summary of Preferences: Needling in TCM and TJM Acupuncture	353
Table 8.10 Summary of Preferences: Moxibustion in TCM and TJM Acupuncture	355
Table 8.11 Summary of Prefernces: Effect Confirmation in TCM and TJM Acupuncture	357
Table 8.12 Emphasised and Unique Elements of TJM Acupuncture.....	359
Table 8.13 Rubric for TJM Acupuncture	361
Table A1 Original Observation Guidelines	398
Table A2 Original Interview Schedule	399
Table A3 Additional Important Questions	400

Glossary of Terms

10 questions	A set of questions often asked initially in Traditional Chinese Medicine that form the basis of interrogation
12 Primary Channels	The main organ pathways used in acupuncture
28 pulse qualities	The pulse can be felt on the radial pulse of both wrists. There are 28 generally accepted pulse types, which indicate health conditions
Actions and indications	The effects that will occur in the body when an acupuncture point is stimulated and the conditions for which an acupuncture point is indicated
Acupuncture points	Locations on the skin, often in depressions, which affect the body condition and function when stimulated
Arrival of Ki	Awareness of the stimulation of Ki felt by practitioners
Biomedical model	Theories of disease causation and nosology, based on the application of the principles of modern science and modern medicine to clinical medicine
Biomedical tests	Diagnostic tests based on modern biomedicine and biomedical science
Branch treatment	Treatment of the ancillary aspects of an illness
Channels and collaterals	The system of conduits through which the body is connected and which substances are transported
Contact needling	Rather than being inserted, the needle only touches the skin surface
Contact tools	Tools used to stimulate the surface of the skin
Deficiency	A pathological state describing an insufficiency of traditional physiology that would normally sustain and nourish life
Differentiation of syndromes and pattern identification	Diagnosis of patterns/syndromes through analysis of symptoms and signs, which have implications for determining the cause, nature and location of the illness and the patient's physical condition, and their treatment
Direct moxibustion	Moxibustion in which moxa cones are applied and lit directly on the skin surface

Dispersion	Treatment that redistributes pathological excesses
Eight extra channels	Reservoir channels/meridians not directly associated with the organs
Eight principles	Guiding principles of diagnosis and treatment: Yin-Yang, exterior-interior, Cold-Heat, deficiency-excess
Excess	A typically pathogenic state describing traditional physiology which exceeds the normal amount
Explanatory models of medicine	Medical classification bound to specific systems of knowledge, beliefs and values positioned in different socio-cultural and health care sectors with unique theories of disease causation and nosology which is described in abstract, technical and often impersonal idioms
Five phases	Representation of all phenomena in the body and the systemic correspondences between them embodied by Wood, Fire, Earth, Metal and Water. These serve as the guiding ideology and methodology of physiology, pathology, clinical diagnosis and treatment. Also known as the five elements
Four examinations	A collective term for inspection, listening/smelling, inquiry and palpation. Also known as the four diagnoses
Fundamental substances	Three vital substances of the human body: Ki, Blood and fluid
Incomplete moxibustion	Direct moxibustion where the cone is removed before embers reach the skin
Indirect moxibustion	Moxibustion performed not directly on the skin
Internal organs	Divisions of physiological functions which typically relate to the Liver, Heart, Spleen, Lung and Kidneys in TEAM
Judo Therapy	Japanese manual treatment of musculoskeletal disorders
Kansai	An area of Japan focussed around Osaka, Kobe and Kyoto
Ki	The essential constituent of the body which maintains the activities of life, visceral functions and metabolism
Manipulation	Movement of needles or contact tools after insertion or placement to produce an effect
Meridians	Same meaning as 'channels and collaterals'
Microsystem	Areas within one localised part of the body, which correspond to other parts of the body

Moxa burner	A receptacle designed to hold burning moxa floss
Moxa cone	Cone-shaped mass made of moxa floss for moxibustion
Moxa floss	A cotton-like material for moxibustion made from <i>Artemisia</i>
Needling hand	The practitioner's hand that holds and inserts the needle
Needle retention	Maintaining needle insertion in the body for a period of time
Non-inserted needles	Filiform needles not used for insertion
Non-scarring moxibustion	Moxibustion where a burn is prevented and no scar is left
Orthopaedic model	Theories of disease causation and nosology, based on the application of the principles of modern science and modern medicine to the diagnosis and treatment of the musculoskeletal system
Orthopaedic tests	Diagnostic tests based on orthopaedic medicine
Obtain Ki	Causing a feeling of soreness, numbness, distension, heaviness, electric sensation, or tenseness around the treatment location during acupuncture
Pathogenic factors	A collective term for the pathogenic elements: Wind, Cold, Summer Heat, Dampness, Dryness and Fire
Pattern/ Pattern of disharmony	Diagnostic conclusion of the pathological changes at a certain stage of a disease, including the location, cause, and nature of the disease as well as the trend of development
Penetrating heat moxibustion	Moxibustion where small moxa cones are placed directly on the skin and burnt completely or almost completely
Point	See 'acupuncture point'
Point location	Method of determining treatment locations
Point selection	The general principle for determining the locations to be used in acupuncture
Pressing hand	The practitioner's hand which is not performing needle insertion
Qi	Chinese language equivalent of the Japanese term 'Ki'

Reduction	See 'Dispersion'
Root treatment	To treat the primary aspect of illness or the general constitution
Scarring moxibustion	Moxibustion which causes a scar
Sensei	An honorific term used to address a range of professionals. Acupuncture practitioners are called Sensei in Japan
Shonishin/ Shonibari	Contact needles or their methods used on children
Six excesses	Similar term to 'Pathogenic factors'
Six meridians /Six levels/Six divisions	Categorisation of channels and patterns/syndromes applied to the diagnosis of acute febrile diseases at different stages, but also used in the pattern identification/syndrome differentiation of other diseases
Six position pulse diagnosis	Examination by feeling six different positions along the radial pulse
Sparrow pecking	A type of manipulation performed by moving the treatment tool up and down like a bird's pecking
Stems and branches	An acupuncture theory relating to traditional cosmological correspondences
Stimulation	A physiological stimuli usually applied to treatment locations in order to cause a reaction
TCM	The traditional medicine that originated in China
TCM acupuncture	Acupuncture in Traditional Chinese Medicine
TEAM	Traditional East Asian Medicine. The sum total of knowledge, skills and practice of holistic care for maintenance of health and treatment of disease based on indigenous theories, beliefs and experiences as practiced in East Asian countries
TEAM acupuncture	Acupuncture in Traditional East Asian Medicine
TEAM model	Theories of disease causation and nosology, based on Traditional East Asian Medicine
Teishin	Instruments with a thick shaft and a blunt tip used for non-inserted techniques. Also called spoon needles

Three position pulse diagnosis	Examination by feeling three different positions along the radial pulse
TJM	Traditional Japanese Medicine. The medicine traditionally practiced in Japan, based on ancient Chinese medicine
TJM acupuncture	Acupuncture in Traditional Japanese Medicine
TKM	Traditional Korean Medicine. The medicine traditionally practiced in Korea, based on ancient Chinese medicine
TKM acupuncture	Acupuncture in Traditional Korean Medicine
Tonification	A therapeutic treatment that nourishes and replenishes deficient physiology
Traditional cosmology	The science of the origin and development of the universe according to traditional East Asian thought
Treatment location	A place where interventions are applied to the body which may or may not be acupuncture points
Trigger point	Localised area of hyper sensitivity or pain in body tissue
Triple energiser/ Triple burner/ Triple heater	A physical and immaterial subdivision of the body which is sometimes considered to have physiological functions
TSAM	Traditional South Asian Medicine
Viscera and bowels	A collective term for the internal organs relating to TEAM theory
Vital substances	See 'Fundamental substances'
Warm diseases	A general term for acute externally contracted diseases caused by warm pathogens, with fever as the chief manifestation
Warm needling	A practice performed by placing moxa on the handle of the needle after insertion. Also called needle stick moxibustion
Yin-Yang	A theory which proposes unity and opposition in all phenomena and that the interplay between these forces exhibit certain qualities
Zen Buddhism	A Japanese school of Buddhism which emphasises meditation and attempting to understand the meaning of life directly, without being misled by logical thought or language

Chapter 1: Introduction

From tropical islands to sub-arctic tundra landscapes, the ecology, geography, natural resources and climate of the Japanese archipelago is a unique combination of environmental features. The diverse landscape is inhabited by a distinct group of people, who have a long history, an imperial and democratic government, bustling economic system and language with regional dialects; all of which have become the base of an evolving Japanese culture. The beliefs, actions and lifestyles of those who belong to this culture are not only a product of it, but also contribute to the development of traditions and the modern Japanese way of life. Politics, technology, education and affluence change ways of living, thinking and being: each member of society plays an individual role in the development of national identity as they themselves grow and live. But life is at times fragile, and always finite. Sickness, disease and death are constant companions to the human condition, which humankind has long endeavoured to understand, remedy and oppose. In Japan, as elsewhere, this opposition is in part known as medicine, and continues to develop as an artefact of culture that represents generations of tradition, knowledge, experience and innovation both domestically and from abroad. This research illustrates traditional medicine; in particular, acupuncture and the evolution of it in relation to the people who adapted, practiced and developed it in Japan.

The focus of this research is exclusively on describing and exploring the philosophical concepts, diagnostic methods and treatment principles of acupuncture in Japan through clinical observation of, and interviews with, practitioners in Japan. This introductory chapter provides an orientation for the background of the investigation including the analytical framework from which this research draws, and the structure of the dissertation.

1.1 Background

Traditional medicine from China spread into neighbouring countries of Asia during the middle of the 1st century CE (Common Era), and while maintaining similarities with medicine from China, adapted independently in those countries within local

contexts. Over time, the re-interpretation of medicine from China resulted in divergences that represent cultural adaptation of health practices, approaches, knowledge and beliefs of traditional medicine unique to regions of East Asia. Traditional medicine from China (Traditional Chinese Medicine), Korea (Traditional Korean Medicine) and Japan (Traditional Japanese Medicine) stand apart as the most significant traditional medical systems of East Asia in modern times.

The health care practices of Traditional Chinese Medicine (TCM), Traditional Korean Medicine (TKM) and Traditional Japanese Medicine (TJM) each incorporate a different and diverse arrangement of therapeutic models and methods. However, one of the most globally significant and important of these is acupuncture. The awareness of acupuncture in medical, research, education and business settings has been increasing internationally and currently makes a significant social and fiscal impact upon global economies.

In many Western countries, the study, practice and research of acupuncture is dominated by the approach based on TCM. By comparison, acupuncture from TKM and TJM remain largely overlooked by academics and practitioners. TJM acupuncture is gradually gaining popularity in Western countries; however, the absence of in-depth investigation describing TJM acupuncture, an overreliance on low levels of documentation and informal discussions, remains an obstacle in fully understanding the philosophical concepts, diagnostic methods and treatment principles of the practice. It also limits the integration of the methods and knowledge of TJM acupuncture into current medical, educational, research and business settings globally.

1.2 Analytical Framework

The intention of this research was firstly to identify the unique and routine procedural elements of clinical acupuncture practice in Japan and secondly, examine how these elements relate to theory. Finally, it was hoped that a structure for using the findings could be developed to make comparisons between acupuncture styles and inform education programmes and research agendas by

providing accurate descriptions of alternative approaches to acupuncture practice; specifically, methods from Japan.

On this basis, a research goal was formulated: to understand the philosophical concepts, diagnostic methods and treatment principles of TJM acupuncture. In order to achieve this goal, it was necessary to explore TJM acupuncture through sustained immersion in Japan, the environment in which it is historically, socially and culturally bound. Ethnography was chosen as the preferred research methodology and data was collected by observing and interviewing acupuncture practitioners in Japan. Patient records and other relevant documents were also collected and together with recordings from observations and interviews, were critically evaluated with thematic analysis. The research goal was connected directly to the major categories of thematic analysis: philosophical concepts, diagnostic methods and treatment principles. These predetermined themes were used to classify and categorise phenomena which were interpreted from the data.

1.3 Dissertation Outline

This section provides an overview of the topics and structure of the thesis, which is organised into eight major chapters.

Chapter 2: Literature Review clarifies definitions and the terminology used throughout the dissertation. It also contextualises the study in the relevant literature by looking at the recorded history and prevalence of TJM acupuncture in the English language. The topics covered include:

- Traditional medicine in East Asia
- Discourse of professional practice as it relates to acupuncture
- Literature concerning style diversity in acupuncture
- Details about contemporary Japanese acupuncture, culture and context

The literature review places particular importance upon findings from discussions in the literature concerning acupuncture styles. This is because there are few sources which use descriptive, explanatory or theory building research designs detailing acupuncture styles.

Chapter 3: Methodology and Methods is an account of the research method chosen for this study, which includes justification of the research design. The research aim and questions are presented with an outline of the positioning and roles of the researcher. The research paradigm is discussed, and the use of philosophical concepts, diagnostic methods and treatment principles as criteria for understanding is explained. The ethnographic methodology and how it was applied in this study, as well as the procedures directing participant recruitment, data collection and data analysis are specified. This section also provides reflection on methodological and design limitations encountered during the study.

Chapter 4: Setting and Practitioners describes where the research took place in terms of the geographical areas of Japan and the different kinds of clinical settings where data was obtained. How sampling methods resulted in the recruitment of different kinds of TJM acupuncture practitioners and how each practitioner uniquely contributed data is described. Finally, details about practitioners' professional lives are provided.

Chapter 5: Philosophical Concepts presents the themes related to philosophical concepts upon which the practice of TJM acupuncture is founded. The emphasised knowledge of TJM acupuncture in relation to: (i) structure and function of the body (ii) order, balance, movement and cycles (iii) identification and location of disease, are presented and explained in terms of significant themes. Culturally specific beliefs and values relating to knowledge are also described, and analysis of their meaning is explained. The chapter concludes by detailing sub-styles of acupuncture found in TJM acupuncture.

Chapter 6: Diagnostic Methods identifies the different ways TJM acupuncture practitioners determined diagnosis. The themes interpreted from the data are analysed in terms of their relationship to knowledge, beliefs and values as well as treatment principles. Categories of diagnosis are defined as a timeline of processes, in terms of methods and in relation to diagnostic outcomes.

Chapter 7: Treatment Principles is the final results chapter. Themes related to treatment principles are examined: treatment tools, pre-treatment intervention preparation, needling, moxibustion and the confirmation of treatment effects. This

section explains what tools were used and why. It also provides specific details about how tools were used. In addition, procedures following the application of therapeutic interventions are presented and analysed.

Chapter 8: Discussion and Conclusion is divided into two sections. The first section contextualises the findings in comparison and in contrast with published English language literature concerning both TJM and TCM acupuncture. The second section discusses the implications of the findings for education, professional development, professional practice and research. Additionally, the second section proposes some future research directions in light of the findings and uncertainties raised throughout the research process.

Chapter 2: Literature Review

This review examines the literature related to Traditional East Asian Medicine (TEAM) concerned with acupuncture as typically practiced in Japan. Within the context of this study, four areas of discussion are explored:

- Traditional medicine
- Acupuncture
- Style diversity in acupuncture
- Contemporary Japanese acupuncture, culture and context

The initial broad scope of this review was considered a necessary step in situating the study in the domain of TEAM, while highlighting Traditional Japanese Medicine (TJM) within that domain. Published English language literature has been reviewed based on content that includes the history, descriptions and practices related to acupuncture in East Asia and specifically Japan.

The first section describes traditional medicine, especially as it relates to the cultural and geographical region of East Asia by exploring the modalities and practices that constitute the discipline in that region. Traditional medicine is contextualised globally with particular reference to East Asia. This provides representation of the interrelationships of traditional medical culture with the heterogeneity of TEAM and the modalities comprised therein.

The second section defines and clarifies acupuncture. The related tools and methods of acupuncture are also introduced. It is shown that the concept of acupuncture is more than needle insertion alone and incorporates a variety of tools and methods. The varying ontological bases from which acupuncture is practiced are also discussed. Ambiguity of the term acupuncture in the literature is established and a basic definition for the use of the term in this study, proposed.

The third section provides an overview of the history of acupuncture and its progression throughout East Asia. It is demonstrated how traditional medicine spread from China throughout East Asia, was adapted and adopted to become separate and established practices in China, then Korea and finally Japan. The

specialist terms concerning the philosophical concepts, diagnostic methods and treatment principles present in the literature concerning acupuncture are explained and defined. The variability of acupuncture is discussed and an overview of the literature related to acupuncture in China, Korea and Japan is explored in order to compare and contrast what is currently known of the practices in those countries.

The final section describes the history and progression of traditional medicine in Japan as it relates to acupuncture. As a prelude to the primary focus of this research, the literature relating specifically to acupuncture from Japan is examined. This section demonstrates that the current prevailing concept of acupuncture from Japan is closely affiliated with a certain sub-style of practice. It also describes a variety of other styles, philosophical concepts, diagnostic methods and treatment principles which are present in the published English language literature concerning acupuncture from Japan. That there is much uncertainty and contrast in understanding about acupuncture from Japan will also be established.

This review describes gaps and inconsistencies in the current published English language literature and in doing so, demonstrates how the research questions were developed for this thesis.

2.1 Traditional Medicine

Traditional medicine is “the sum total of knowledge, skills and practice of holistic care for maintenance of health and treatment of disease based on indigenous theories, beliefs and experiences handed down from generation to generation” (World Health Organization [WHO], 2007, p. 9).

Traditional medicine in Asia is generally dominated by the indigenous theories, beliefs and experiences originating in India and China. Although there has always been interplay of medical systems between both countries, Indian and Chinese traditional medicines continue to retain their distinctiveness and stand alone as the foundations of traditional medicine throughout the majority of Asia.

2.1.1 Traditional medicine in Asia

Geographically, the influence of Indian and Chinese medicine have affected surrounding countries in different ways; Ayurvedic medicine (traditional Indian medicine) is prevalent in Nepal, Sri Lanka, Mauritius, Bangladesh, Pakistan, Indonesia, Malaysia, Singapore and the Maldives while additionally, the traditional systems of medicine in Myanmar, Bhutan and Thailand bear a very close resemblance to Ayurvedic medicine (Kurup, 2001, p. 3). Conversely, medicine from China has played a stronger role in Japanese, Korean, Mongolian and Vietnamese environments (Motoo, Seki & Tsutani, 2011; Welden, 2010).

Motoo et al. (2011) categorise the traditional medicine of Asia into two general classifications; South and East Asian traditional medicine. Traditional South Asian Medicine (TSAM) and Traditional East Asian Medicine (TEAM) are generally representative of the medical systems originating from Indian and Chinese traditional medicine, respectively. This study is concerned with the branch of Asian medicine originating from and prevalent in East Asia which mainly includes Traditional Chinese Medicine (TCM), Traditional Japanese Medicine (TJM), Traditional Korean Medicine (TKM), Traditional Mongolian Medicine (TMM) and Traditional Vietnamese Medicine (TVM) (Motoo et al., 2011).

2.1.2 Traditional East Asian Medicine (TEAM)

TEAM can be summarised as the traditional medicine from China which has been spread, adapted and established in the countries comprising East Asia including China, Japan, Korea, Mongolia and Vietnam (Figure 2.1). These individual traditional East Asian medical systems (TCM, TJM, TKM, TMM and TVM) may all be distinct in subtle and individual ways, but fall under the aegis of Traditional East Asian Medicine (TEAM).

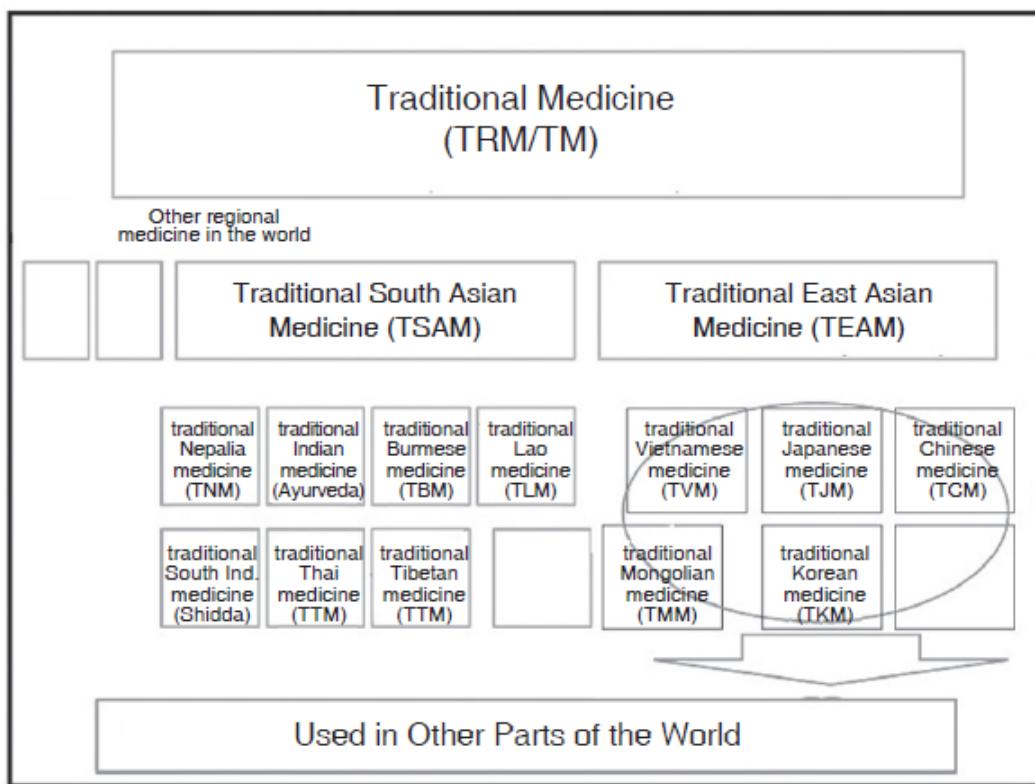


Figure 2.1 Contextualisation of Traditional East Asian Medicine (Motoo et al., 2011)

Note - Although the focus of this research is TEAM, it should be recognised that TSAM is also used globally.

TEAM incorporates "...a diversity of health practices, approaches, knowledge and beliefs and incorporates plant, animal and/or mineral-based medicines, spiritual therapies, manual techniques and exercises, which are applied singly or in combination to maintain well-being and to treat or prevent illness" (Yu et al., 2006). Notwithstanding modern methods available to contemporary practitioners of TEAM, the main traditional modes of treatment are: herbal medicine, acupuncture (needling and moxibustion), dietetics, exercise therapy, bloodletting and physical therapies (massage/manipulation, scraping/gua sha and cupping) (Ahn, Bennani, Freeman, Hamdy & Kaptchuk, 2007; Dong & Zhang, 2001, p. 18; Fruehauf, 1999; Lao, 1996; Sherman et al., 2005).

The use, awareness and prevalence of these traditional medicine modalities in business, medicine, research and education have, in recent times, been increasing internationally and make a significant social and fiscal impact upon global economies (Cramer et al., 2015; Cooper, Harris, Relton & Thomas, 2013; Lee, LaRicca & Newberg, 2004; Schnabel, Binting, Witt & Teut, 2014; Shim, 2015;

Patwardhan, Warude, Pushpangadan & Bhatt, 2005; Sherman et al., 2005; White, Golianu, Zaslawski & Seung-Hoon, 2006; Xue, Wu, Zhou, Yang & Story, 2006; Xue et al., 2008). The most internationally prevalent of the TEAM modalities are herbal medicine and acupuncture (Adusumilli, Ben-Porat, Pereira, Roesler & Leitman, 2004; Ahn et al., 2007; Brinkhaus et al., 2004). Although this study proposes that all TEAM modalities require continual and thorough research agendas, the primary focus of this investigation is acupuncture.

Peer reviewed research literature concerning acupuncture has been published out of at least sixty five different countries, of which some of the most prolific producers are the USA, China, South Korea, UK, Germany, Japan, Taiwan, Sweden, Canada, Australia and Austria (Fu et al., 2012; Han & Ho, 2011; Moré, Tesser, da Silva, & Min, 2016). The number of countries where the actual practice of acupuncture by TEAM practitioners occurs probably exceeds the 65 which were found to produce peer reviewed literature, and acupuncture is now a commonly practiced treatment modality used by medical doctors and physiotherapists internationally (Han & Ho, 2011; White, 2009). Acupuncture is a major medical intervention worldwide. It is also a government registered and nationally insured method of health care in several countries including Australia (Janz & Adams, 2011; Xue et al., 2015; Zheng, 2014) and although it is a significant and growing modality, it continues to be a misunderstood discipline among consumers, health professionals and academics, especially in relation to acupuncture from Japan as is demonstrated in this chapter.

2.2 Acupuncture

The *WHO International Standard Terminologies on Traditional Medicine in the Western Pacific Region* describes acupuncture as “the insertion of needles into humans or animals for remedial purposes or its methods” (WHO, 2007, p. 233). However, confusion exists about the propriety of ontological frameworks for understanding remedial purposes and exactly what acupuncture methods include.

Moxibustion, cupping (Lao, 1996), heat, electricity, sound waves (Lee, LaRiccia & Newberg, 2004), massage and exercise therapy (Dale, 1997) are

reported as methods of acupuncture. Issues with nomenclature also exist when discussing whether acupuncture is a method which can be divorced from TEAM philosophy, or if it is acceptable to use the term acupuncture when referring to a treatment with any ontological background if a needle is inserted into a body for remedial purposes (Deadman, MacPherson, Maxwell, Moir & Scheid, 2009; Fruehauf, 1999). In order to define what acupuncture means, two areas of clarification need to be addressed: the tools and the theoretical model used to apply them.

By necessity, the concept of “acupuncture” is a translation from East Asian languages. The modern English meaning seems to be misaligned with what it originally represented in the languages native to where TEAM was first developed. In China, Japan and Korea, the term acupuncture does not tend to exist in isolation, it is a single term which literally means “needle and moxibustion” (Lu, Needham & Lo, 2002, p. 175; Mizutani, 1994; Wilcox, 2009, p. 1).

When considering the characteristics of the needle in acupuncture, it is important to understand that its use is not limited to simple insertion into the body. TEAM literature lists nine kinds of acupuncture needles (WHO, 2007, p. 233), some of which are sharp and intended for insertion, other blunt varieties are not inserted, while others are designed for cutting the skin. Consequently, acupuncture includes practices where a needle (dull or sharp), is used for various remedial purposes including the stimulation of the body surface, without any insertion (Katai, 2010b; Kuwahara & Nakano, 2015; Yasui, 2010b), cutting the skin, as in the case of bloodletting (Ota, 2011; Shimada, 2006) and standard insertion into the body. Although the needle has a major role in acupuncture, the practice is not defined by the use of the needle alone. Moxibustion is the other integral element comprising acupuncture.

Artemisiae argyi/Mugwort is also known as Moxa and is the main material used in moxibustion therapy. Mugwort is a plant that grows prolifically in many parts of East Asia, and when the leaves are dried, aged and ground until only fine fibres remain, it becomes viable for remedial purposes (Wilcox, 2009, p. 2). The downy tinder produced from the plant is known as moxa punk, floss, wool or simply: moxa (Wilcox, 2009, p. 2). The definition which applies to the majority of moxibustion

practice (Wilcox, 2009, p. 2) is the “. . . therapeutic procedure involving ignited material (usually moxa) to apply heat to certain points or areas of the body surface for curing disease. . .” (WHO, 2007, p. 251). Because the historic and current East Asian language meanings of acupuncture inherently assume a treatment which incorporates the use of both needles and moxibustion, a definition of acupuncture can incorporate all of the methods and related tools of both needling and moxibustion.

The WHO (2007, pp. 233-251) reconciles the separation of the terms acupuncture and moxibustion in English by defining “acupuncture” as specific to needles and “moxibustion” as specific for therapy involving ignited moxa. In this definition, acupuncture or moxibustion do not have any relationship to TEAM philosophy. However, the WHO proposes the term “acupuncture and moxibustion” which is described as:

. . . a branch of traditional Chinese medicine which mainly involves the theory of meridians, location, usage, indications and combinations of acupoints, needling manipulations and application of ignited moxa in the treatment of disease through regulation of Qi, Blood and visceral functions.

(WHO, 2007, p. 233)

This definition, ties acupuncture and moxibustion to traditional theories by the use of TEAM medical terminology. According to the WHO, “acupuncture” refers to needling the body, “moxibustion” refers to burning moxa at certain points of the body and “acupuncture and moxibustion” is the term given to the use of needles and moxa according to TEAM principles.

Clinical trials related to acupuncture often refer to acupuncture (as the WHO suggests) simply as the insertion of needles, without regard to the variety of needle-like tools and their uses, or as a TEAM modality (Deadman et al., 2009). This move away from some traditional aspects of acupuncture practice is perhaps due in part to a Westernisation of TEAM, where acupuncture has been adapted from its original TEAM roots to suit a modern health science paradigm (Scheid & MacPherson, 2012, p. 2; White, 2009). It is also possible that acupuncture has been separated from parts of the original and traditional uses and philosophies by

virtue of a legitimising process: adopting modern scientific terms and methods may have contributed to the recognition of acupuncture by modern medicine (Deadman et al., 2009; Fruehauf, 1999; Kaptchuk, 1985). Nevertheless, in contemporary educational degree programs, acupuncture students in the West are expected to understand the traditional Chinese view of anatomy, physiology, pathology and pathogenesis, in order to apply the knowledge correctly in clinical practice (Ryan, 2003). Thus the successful study of Chinese medicine in the West is generally “predicated on understanding the philosophies, values and cultural perspectives that have informed Chinese medical theory and practice over the centuries” (Ryan, 2003). The propriety of a certain philosophical standpoint when using acupuncture, whether based in TEAM, modern health science or any other framework, is difficult to establish.

This study places less concern on justifying any single ontological perspective and treatment method than it does on recognising that acupuncture is understood by cultures and societies differently, with each perspective including differing methods and ontological perceptions. It is perhaps for this reason that the Standards for Reporting Interventions in Clinical Trials of Acupuncture (STRICTA) (MacPherson et al., 2010) advises the approach or definition of acupuncture as used in a study be explained and justified as part of the clinical methodology of the study. Even with the general acceptance of international standardisation of acupuncture terminology among academics and clinicians, some aspects remain unclear. Well defined explanations of acupuncture practices, as understood by those applying it, is a necessary step in facilitating transparent academic and clinical discourse.

Definitions for acupuncture vary in the literature: it can mean a variety of needling and moxibustion methods and devices or refer only to the insertion of needles into the body. It can also assume a variety of theoretical standpoints, according to the philosophical concepts of TEAM or of modern health science. When acupuncture is discussed in published literature, there is difficulty in knowing an author’s intended meaning unless it is stated specifically. However, authors rarely provide such details and it is generally only through contextual speculation that an understanding may be reached.

Divergences in understanding are not only evident when comparing different ontological perspectives, but are also present within the domain of TEAM itself. Unschuld (2010, p. 116) asserts that the practice of acupuncture is based on a diversity of heterogeneous ideologies that include a complex array of humanistic, holistic and scientific settings. It is in this context that it can be understood how acupuncture in different societies emphasises certain ideological frameworks over others. This creates unique and locally contextualised approaches to acupuncture based on differences in culture and environment while still retaining the essence and basic principles of TEAM. For instance, acupuncture in TCM, TJM and TKM may all present contrasting perspectives of what acupuncture is by divergences in philosophical concepts, diagnostic methods and treatment principles. However, in the reporting of acupuncture, many scholars do not acknowledge that the realities, practices, beliefs and knowledge of acupuncture are culturally embedded in complex social and historical interactions (Scheid & MacPherson, 2012, p. 3). This study acknowledges that philosophical concepts, diagnostic methods and treatment principles in the practice of acupuncture are not stable entities which have universal validity with delineated rules, but accepts the reality that this is how they are described in the majority of published English language literature.

To represent current practice, the definition of acupuncture in this study refers to all uses of traditional and non-traditional needling, contact and moxibustion tools, methods and philosophies. TEAM acupuncture is defined as the styles of acupuncture based on the traditional medical systems native to the countries of East Asia which are currently being practiced either in those countries or worldwide. This concept includes both traditional and contemporary perspectives of acupuncture practice which reflects the evolving and continually adapting progress of medical ideas. This study differentiates the three major TEAM systems of acupuncture by referring to TCM acupuncture (acupuncture in TCM), TJM acupuncture (acupuncture in TJM) and TKM acupuncture (acupuncture in TKM).

Providers of TEAM acupuncture cover a range of vocational positions. The providers of TEAM acupuncture are also probably trained in the use of a range of treatment modalities including non-TEAM acupuncture practices which they provide to patients. This means there are probably a variety of treatment principles and tools associated with TEAM acupuncture treatments. In this study, recognition is

given to the reality that treatments provided by practitioners of acupuncture probably include an array of interventions which are combined in order to produce a range of therapeutic effects. Even though the major focus of investigation in this study is acupuncture, the relationship between the range of treatment tools and procedures performed in treatments which include acupuncture is acknowledged as important.

2.3 Style Diversity in Acupuncture

Traditional medicine from China spread into neighbouring countries of Asia during the middle of the 1st century CE (Common Era) and, while maintaining continuity with medicine from China, adapted independently in those countries within local contexts (Lu et al., 2002, p. 264). The theories, beliefs and practices of traditional medicine from China were integrated with local indigenous medical practices across parts of Asia. The traditional Chinese medical literature was also developed and re-interpreted resulting in divergences that represented cultural adaptation and stylistic differences in the practice of traditional medicine across East Asia (MacPherson et al., 2010; Smith et al., 2011). The acculturation and re-interpretation of traditional medicine from China throughout other East Asian countries resulted in unique adaptations to acupuncture practice which is constantly evolving.

2.3.1 History and progression of acupuncture

The progression and institutionalisation of the traditional medicine from China around East Asia signifies the establishment of TEAM as a distinct medical system. The process of migration, acculturation and saturation throughout East Asia of the traditional medicine from China took place over several centuries and continues to be adapted in modern times (Scheid & MacPherson, 2012, p. 2; White, 2009; Xue et al., 2015). However, the extant literary history of Chinese medicine begins in the pre Han period with the *Ma Wang Dui* Medical manuscripts which emerged from excavated tombs believed to be sealed around 198 BCE (Before Common Era) (White & Ernst, 2004). These manuscripts contain a loose collection of physiological ideologies, treatment strategies and healthy living advice from the pre Han Chinese, but it was not until the appearance of the canonical text, the *Internal*

Classic that a comprehensive and systematic collection of philosophical medical concepts, diagnostic methods and treatment principles were found. The *Internal Classic* is made up of two separate texts; *Plain Questions* and *Miraculous Pivot* are believed to have been collated over several centuries by various authors, and it is the appearance of these texts between around 300 and 100 BCE that mark the founding of Chinese medicine, now called Traditional Chinese Medicine (TCM) (Hurtak, 2002; Jingfeng, 1998; White & Ernst, 2004). From that time on, the progression of Chinese literature and culture steadily developed and was spread across parts of Asia and the world.

The medicine of China travelled throughout mainland Asia as a result of martial occupation, most notably in parts of Vietnam and Korea during the Han dynasty, and later through trade and religion (Baker, 2003, p. 135; Welden, 2010). Similar trends are seen in the expansion of culture and medicine to the West through military endeavour, trade and religion (Klein-Franke, Ming & Qi, 2001), but the greatest influence of Chinese medical culture was felt in East Asia, particularly Korea and Japan.

Around 313 CE, Chinese medicine was integrated into Korean culture, although exactly which aspects of Chinese medicine were assimilated is difficult to tell (Baker, 2003, p. 134). Later, around 692 CE the Silla Kingdom (Korea) established medical offices which based their practice on the *Internal Classic*, the *Classic of Herbal Medicine*, *A-B Classic of Acupuncture and Moxibustion*, *Pulse Classic*, *Mingtang Jing* and the *Classic of Difficult Issues*, all of which are medical texts originating from China (Baker, 2003, p. 135; White & Ernst, 2004).

Chinese medical ideas spread from north-west Korea into the southern Korean peninsula which is geographically close to the westernmost point of Japan, only a few hundred kilometres across the Korean Straight. It was from there that Chinese medical concepts reached Japan first from Korea around the 6th century CE (Baker, 2003, p. 135; Kobayashi, Uefuji & Yasumo, 2008; Motoo et al., 2011). At that time, medicine in Korea was still under the strong influence of China and the transmission of medical ideas to Japan through Korea essentially retained their Chinese cultural heritage. It was not until later that direct contact between China

and Japan was developed and medical influence began to enter Japan directly from China.

Medical texts from China continued to be the main influences in Korean and Japanese medical thinking for many years, and the Korean kingdoms retained close relations with China for centuries. China absorbed medical knowledge from both Japan and Korea and there was close collaboration politically, economically and culturally between those empires (Yeonseok, 2011). There were little differences between the medicine of China and Korea up to the 16th century due to their close relationship. However, while continuing medical exchanges with neighbouring countries, medicine in Korea began to develop away from its Chinese roots after the publication of an important medical text, *Donguibogam* in the 17th century (Yeonseok, 2011). A unique Korean medicine emerged. This is now known as Traditional Korean Medicine (TKM). Like Korea, medicine in Japan developed under the strong influence of China for many centuries, and it was around the same time that medicine in Korea began to become an independent paradigm, that a distinct Japanese medicine also appeared.

Prolific cultural exchange occurred between China, Korea and Japan during the 16th to 18th centuries. This period saw great intellectual agitation among the people of those nations and resulted in the flourishing of unique Asian cultural advancement (Kobayashi et al., 2008; Yasui, 2010a). However, it was not to last forever. The cultural advancement of the previous centuries went into decline around the 19th century with the arrival of medicine from Europe and war between Korea, Japan and China, and later the world wars of the early 20th century. This brought stronger influences from the West (Europe, Britain and America) and started a rapid decline of traditional medicine and other cultural practices in Asia (Kobayashi et al., 2008; Matsumoto, 1995; Pershouse, 1998).

In modern times, three leaders in the advancement of acupuncture and its integration with biomedical practice have emerged: China, Korea and Japan. In China there is strong support for TCM from the government with national policy encouraging the development of both traditional and modern medicine with full legal registration of practitioners, comprehensive education systems, research programs and the practice of traditional and modern medicine side by side at every level of

the national health care system (Dong & Zhang, 2001, p. 17; Liangyue, 2001, p. 75; Lim, Huang, Zhao, & Ha, 2015; Roh, 2005, pp. 184-185; Scheid & MacPherson, 2012, p. 1). As the progenitor of TEAM, it is perhaps not surprising that traditional medicine from China is the most integrated and globally recognised system of TEAM and possibly traditional medicine in the world.

When it comes to the spread throughout the world of traditional medicine, especially herbal medicine and acupuncture, one has to admit that Chinese medicine domination is overwhelming and already ranks at the top, leaving far behind Japanese, Korean, or Vietnamese medicine. (Vigouroux, 2008b)

Traditional Korean Medicine (TKM) in South Korea also has an extensive education program with doctors training for six or seven years at national universities (Lee, Khang, Lee & Kang, 2002; Park et al., 2012; Sop, 2001, p. 71), practicing in hospitals and with major government initiatives promoting the research and advancement of traditional medicine (Kim, 2007; Roh, 2005, p. 184; Sop, 2001, p. 71; Yeonseok, 2011). Although the value of TEAM and modern medicine integration is disputed (Scheid & MacPherson, 2012, p. 6), it appears that China and South Korea are the principal instigators in the research, education and integration of the two medical practices.

Japan may not have as strong traditional and modern medicine integration policies as China or Korea, but the TEAM situation in Japan is perhaps one of the strongest in the world due to the long history and current standing of TEAM practice in the country (N. Suzuki, 2004). Japan integrates traditional medicine in mainstream health services most notably with the controlled coverage of acupuncture, herbal medicine and judo therapy (unique orthopaedic techniques developed by judo practitioners) (N. Suzuki, 2004) by the national health insurance system and with some groups of medical physicians supplementing their practice with acupuncture and herbal medicine (Nishikitani, Inoue & Yano, 2008; Roh, 2005, p. 184; N. Suzuki, 2004). Practitioners of TJM acupuncture in Japan must graduate from a nationally recognised degree program and also pass a national qualifying examination to practice (Yamada, 2005, p. 195) with many of the universities teaching traditional medicine having extensive research priorities. The research pursuits of the universities are supplemented by the academic acupuncture

associations that contribute to the research endeavours in the country (Katai, 2010a).

Japan also makes a major contribution to the WHO in establishing standards for TEAM and acupuncture alongside China and Korea (Katai, 2005; Lim, 2009). The *WHO International Standard Terminologies on Traditional Medicine in the Western Pacific Region* (2007) and *WHO Standard Acupuncture Point Locations in The Western Pacific Region* (2008) theoretically represent a consensus on TEAM acupuncture between China, Korea and Japan. These three nations stand above all others because their history of development and integration of TEAM acupuncture in the respective national health care systems is the longest and arguably most advanced in the world.

Medical history in Asia as it relates to current acupuncture practice spans over two millennia. This study emphasises the spread, evolution and advancement of Chinese medical ideas across East Asia. Acupuncture practice from China, dominates the published English language literature and is the most influential force in acupuncture globally in modern times.

The Chinese treatment and needling approaches that developed out of the 1950s (TCM and TCM-like offshoots) spread prolifically in the West like wildfire in the early 1970s and took hold of the curricula of training programs in the 1980s and 1990s, achieving increased recognition through “scientific” studies and accredited training programs. Chinese-influenced approaches have become a kind of *de facto* standard of entry into the field in most Western countries. In those countries where accredited programs exist, acupuncture and “Chinese medicine” appear to have become part of the accepted norm. (Birch, 2010)

Although acupuncture from China seems representative of acupuncture in general, TKM and TJM acupuncture have characteristics of their own, with similarities and differences to each other and TCM acupuncture.

2.3.2 Philosophical concepts

Part of the premise of this study is that some of the most important differences between acupuncture styles emerge as a result of the different emphasis of unique combinations of philosophical concepts used to inform diagnosis and treatment. This section explains the basic philosophical concepts reported in the literature relating to TCM, TKM and TJM acupuncture.

A review of the published English language literature reveals that there is a variable degree of consistency addressing characteristics of acupuncture from China, Korea and Japan. However, a common pool of philosophical concepts, seemingly Chinese in origin, forms the foundation of acupuncture in Korea and Japan and influences the diagnostic methods and treatment principles of the respective styles. Although most of the philosophical concepts described here appear to be Chinese in origin, they also seem to have become the accepted standard of acupuncture knowledge in Korea and Japan. These philosophies form the foundational knowledge of TEAM acupuncture in general and are referred to as TEAM acupuncture philosophical concepts in this research.

Structure and function of the body

One of the most consistent philosophical concepts across acupuncture traditions is the knowledge of anatomy and physiology, and the idea of the fundamental substances. Among the fundamental substances, Qi is perhaps of greatest significance. All potential and extant phenomena as a product of Qi, is a central tenet in traditional Chinese thought. The philosophy holds that all aspects of the universe arise from the transformation and movement of Qi, encompassing both matter and movement as a fundamental quality of being and becoming (Ho, 2006; Liu & Liu, 2009a, p. 10; WHO, 2007, p. 18). Qi is at times described as “energy”, and although energy is Qi, Qi is not only energy, and thus does not represent the full meaning of the concept (Ho, 2006). Qi is an essential force of movement and transformation, similar to the notion of energy, but it also forms the substratum of matter (Ryan, 2003) and is a difficult to describe and complex concept. However, in medical terms, Qi is an essential constituent of the body which maintains the activities of life, visceral functions and metabolism (WHO, 2007, p. 13). Although Qi

is one of the most essential elements of life, the body includes other substances which assist in maintaining physiological processes. All the basic substances and various types of Qi which constitute the body are known as fundamental (vital) substances (Maciocia, 2006, p. 10; WHO, 2007, pp. 17-21). The fundamental substances are essential to life and exist as various types of Qi and fluids. Transportation of these substances around the body occurs by a variety of methods. Some of the fundamental substances gather and flow through currents or conduits which reach the internal organs and other tissues by way of channels (meridians) and collaterals (Wang & Robertson, 2008, p. 15 -17).

The anatomical theory of TEAM acupuncture postulates that there is a central network of channels and a more superficial system of collateral conduits which serve to connect the body, transport Qi (and other fundamental substances), protect the body from dysfunction and respond to disease (Deadman, Al-Khafaji & Baker, 2001, p. 11; WHO, 2007, p. 28). Along the channels lie small apertures within the connective tissue matrix of the body and it is in these spaces where there is significant physiological movement and activity (Wang & Robertson, 2008, p. 421). These areas of movement are where the channels run close to the surface of the body and can be found as distinct locations called acupuncture points, acupoints or points (Liu & Liu, 2009b, p. 11).

Points are an important part of channel and collateral theory in TEAM acupuncture. Modern textbooks describe a system of primary channels, each having a prescribed number of points, with a variety of unique functions or indications (Deadman et al., 2001, p. 29; Liu & Liu, 2009b, p. 12). Although points are generally found on the channels, the theory accepts that they can be found almost anywhere that has a desired effect on the body. Though there is general agreement on the location and functioning of points, there is also considerable variability in the description of points across publications (Langevin & Yandow, 2002; WHO, 2008, p. 1). Despite the variability of the location, functions and indications of specific points, it is generally accepted that the points are gateways from where it is possible to influence the working of the body by manipulating the channel system. Channels and collaterals link the body into an integrated whole and while doing so, network the viscera and bowels with each other as well as the rest of the body. Throughout this thesis, the word “point” refers to known

acupuncture points as listed in *WHO Standard Acupuncture Point Locations in The Western Pacific Region* (2008). The word “treatment location” represents a place where interventions may be applied to the body, which may not necessarily be acupuncture points, but may be located on a channel.

The viscera and bowels are the internal organs where fundamental substances are formed and stored while the bowels specifically attend to the transportation and transformation of food (WHO, 2007, p. 22). The theory of the viscera and bowels includes the physiological functions, pathological processes and channel interrelationships and correspondences (Liu & Liu, 2009a, p. 50; WHO, 2007, p. 22). The human body in TEAM acupuncture is generally comprised of viscera and bowels, fundamental substances, channels and collaterals and other structures (non-organ structures, sense organs and orifices). The medical theory of the structure and function of the human body in TEAM acupuncture is strongly grounded on philosophical concepts which advocate a system of order, interdependence, balance and movement. One of the most universally accepted concepts of interdependence and balance in TEAM acupuncture is the theory of Yin-Yang.

Order, independence, balance and movement

Yin-Yang theory proposes unity and opposition in all phenomena and that the interplay between the forces of Yin and Yang result in balance and change (Liu & Liu, 2009a, p. 11; Ryan, 2003; WHO, 2007, p. 13). Yin-Yang philosophy is a theoretical framework for observing and analysing phenomena in relation to the qualities of Yin and Yang. In traditional Chinese phraseology, the characters representing Yin and Yang signify the orientation of a hill away from or toward sunlight (Liu & Liu, 2009a, p. 11; Ryan, 2003; WHO, 2007, p. 13). In the theory of Yin and Yang, the terms no longer retain distinct meaning themselves, but act as classifying avatars used to characterise lines of correspondence between phenomena. Viewed from the theory of Yin-Yang, all phenomena exist in continually interchanging complementary opposite pairs, whose Yin aspects are characterised by (for example) interior, cold, deep and deficiency and Yang aspects as (for example) exterior, hot, superficial and excess (Liu & Liu, 2009a, p. 11; WHO, 2007, p. 13).

The theory of Yin-Yang proposes an idea of health that is based in balance and continual movement. The decline and increase of Yin and Yang is mutually responsive, and disease is defined as a state of imbalance caused by the relative surplus or absence of Yin or Yang. It is seen as the physicians job to increase or reduce Yin or Yang in order to return the body to health. For example, if there is a deficiency of Yin or Yang in the body this should be nourished or replenished (tonified), and conversely, if there is an excess of Yin or Yang then this should be dispersed or reduced. In medicine, Yin-Yang theory is important in understanding anatomy, physiology, pathology and in guiding diagnosis and treatment. Yin-Yang theory is very versatile, any phenomena that have a relation to each other, or related aspects within the same phenomena can be classified and analysed according to their Yin-Yang qualities (Zhu & Wang, 2010, p. 23). Although a versatile concept, Yin-Yang was not always seen as appropriate, and a derivative system based on Yin-Yang was devised which allowed a more subtle differentiation between phenomena (Unschuld, 1985, p. 58). This Yin-Yang derivative is known as the six meridians (six levels or six divisions).

In TEAM acupuncture, six meridian theory is conceptually applied to anatomy, physiology, pathophysiology, diagnosis and treatment. It is a classification and categorisation system which describes systematic characteristics of anatomy and physiology according to six divisions of Yin-Yang, and provides an understanding of pathological progression based on the classifications of Yin-Yang divisions (Liu & Liu, 2009a, p. 169; Maciocia, 2006, pp. 737-742; WHO, 2007, p. 153). The six meridian theory is not the only derivative of Yin-Yang used in TEAM acupuncture. One of the other medically important Yin-Yang based concepts is that of the eight principles. In eight principle theory, phenomena are classified into four pairs of opposites which are used to describe the nature and location of disease (Liu & Liu, 2009a, p. 194; Maciocia, 2006, p. 428; WHO, 2007, p. 80). The eight principle theory relies upon systematic correspondences between the qualities of exterior-interior, deficiency-excess, Cold-Heat and Yin-Yang which can be used to categorise symptoms and devise a treatment strategy. The versatility and adaptability of the Yin-Yang doctrine reflects the importance of balance, movement and harmony in traditional Chinese thought. Such versatility has made the

philosophy compatible with other more specialised and often contrasting conceptual frameworks, such as Confucianism and Taoism (Low, 2011).

Natural order and cycles

The interrelated and interdependent nature of phenomenon espoused by the belief systems of Confucianism and Taoism has had a profound influence on Chinese medicine. Although there are differences in ontological perspectives, both philosophies propose a worldview of interrelated and interdependent phenomenon. Confucianism founded an ethical system of family values and social hierarchy based on order. The Confucian ideals of social organisation, common sense and practical knowledge provided Chinese society with a system of education and social etiquette which still persists in modern times (Yao, 2000, pp. 21-35). Confucianism views phenomena as having clearly defined cycles and principles. In medicine, this results in a physician's role which recognises the patient's condition in relation to a predicated natural order and remedies any disorder by the application of prescribed principles and techniques (Ryan, 2003). One of the most physiologically important systems of order in the body is related to the operating procedures of the viscera and bowels.

The functional understanding of the viscera and bowels in early Chinese medical literature is an adaptation of Confucian feudal principles. In the theory of the viscera and bowels, organs are prescribed roles analogous to governmental officials, such as the Heart as Emperor or Lungs as Prime Minister, and when each perform their function according to an orderly hierarchy of responsibility, good health ensues (Maciocia, 2006, p. 129). For both Confucians and Taoists, peace and harmony are valued as integral to good health (Low, 2011). In particular, Confucian ideals assert that a healthy state is attained by compliance to a determined order where the functions and relationships between the viscera, bowels and other body structures must be regulated and maintained.

In TEAM acupuncture, health is predicated not only on order and harmony but also on the premise that phenomena exist in patterns of relationships called systematic correspondence. These interrelationships are linked to each other in identifiable patterns and associated correspondences which combine sets of

concepts whose conceptual relation justifies a common designation (Unschuld, 1985, p. 52). Systematic correspondence is present within Yin-Yang theory, but is exemplified with the concepts of order and interdependence explicitly in five phase theory.

The Yin-Yang doctrine and five phase theory were conceived around the same time (about 1000 – 770 BCE) and together form the basis of TEAM acupuncture philosophy (Maciocia, 2006, p. 20). In medicine, five phase theory is related to the composition and movement of physiology and pathology and is a guiding ideology and methodology for clinical diagnosis and treatment (WHO, 2007, p. 15). The five phases represent all phenomena in the body and the relationships between them can be used to interpret and describe functional processes (Liu & Liu, 2009a, p. 21). Five phase theory is based on the premise of systematic correspondence of the inherent qualities of the individual phases. Certain aspects of anatomy, physiology, pathophysiology, diagnosis and treatment are explained by means of five phase correspondences. However, the analogies are not limited to body processes alone: they also link the somatic with the psychological and to the environment. The correspondences of the five phases are seen to interact in cohesive and predictable developmental cycles which govern health, disease and treatment (Maciocia, 2006, p. 24; Liu & Liu, 2009a, p. 25). All phases have a direct relationship with all the other phases and when these are all in balance, order and harmony, health can be maintained. By understanding the relational order and correspondences of the five phases, it is asserted that a physician can diagnose imbalance and select appropriate treatment strategies to return harmony to the relationships and regulate health.

In TEAM acupuncture philosophy, disruption to the orderly flow of physiological processes in the body results in disease. The scope of aetiological theory in TEAM acupuncture covers the classification of pathogenic factors and their properties, characteristics and processes (WHO, 2007, p.39) which are generally categorised as arising externally from the body, internally or from miscellaneous factors (Maciocia, 2006, p. 241). Internal or miscellaneous diseases tend to result from hereditary factors, imbalance of emotional states and nutrition, overwork or injuries. These internal imbalances can cause endogenous pathogenic

factors which cause disease (Liu & Liu, 2009a, p. 158). However, external disease is seen to be caused by the six excesses.

Under normal circumstances, the climate does not have a pathophysiological effect, but when the balance between the environment and body is disrupted by climatic excesses or physiological weakness, any number of the six excesses may invade the body. These pathological climatic excesses invade the body and cause a variety of disease states depending on the severity and location of the obstruction (Maciocia, 2006, p. 255; Liu & Liu, 2009a, p. 132). The way in which disease is seen to progress and is classified, is an important step in rectifying the disharmony.

Identification and location of disease

Identifying the pathological progression of disease states can be done according to Yin-Yang theory and its derivatives, and the five phases as outlined above. However, identification of disease states according to the theories of the triple energiser (triple burner or *san jiao*) and warm diseases (four levels) are also possible. The triple energiser is seen as both an internal organ and a collective term for three divisions of the body: upper, middle and lower (Maciocia, 2006, p. 209; WHO, 2007, p. 23). The triple energiser theory of disease identification is often used as a system to locate the six excesses within the upper, middle and lower divisions of the body according to associated symptomology (Maciocia, 2006, p. 743). This concept has many similarities with warm disease theory. Warm disease theory in TEAM acupuncture is the theory of febrile and acute infectious diseases based on interaction with the fundamental substances and six excesses (Liu & Liu, 2009a, p. 315; Maciocia, 2006, p. 722, WHO, 2007, p. 42). Warm disease theory determines the severity of disease based on damage to the fundamental substances caused by an invasion of an external pathological excess. As described above, identifying the current condition and progression of pathological disease states can be performed according to a variety of philosophical concepts in TEAM acupuncture.

The essential system of disease identification for the majority of TEAM acupuncture practice is predicated on the philosophy of the differentiation of syndromes and pattern identification. This relies upon collecting all the symptoms

and signs from a patient to identify a pattern of disharmony according to the collective knowledge of TEAM acupuncture philosophical concepts (Maciocia, 2006, p. 417; WHO, 2007, p. 80). A pattern is a representation of the clinical manifestations of the patient that identify the nature, location and pathology of the condition (Maciocia, 2006, p. 418). Patterns can be identified any number of ways, but the essential method is one of searching for relationships between signs and symptoms. The process blends diagnosis, pathology and treatment principles based on TEAM acupuncture philosophies (Maciocia, 2006, p. 421). Differentiation of syndromes and pattern identification is based on an understanding of patterns of relationships designated by specific signs and symptoms which can be rectified by restoring balance to the patterns of disharmony (Ryan, 2003). This philosophy represents the syncretism of TEAM acupuncture concepts. Even contrasting philosophical paradigms are reconciled to some extent to permit practitioners to justify and employ any related diagnostic method or treatment principle.

TEAM acupuncture philosophy should not be considered a systematised homogenous system, but a collection of ideas derived from different philosophical interpretations from different periods of time (Unschuld, 1985, p. 58). This syncretistic diversity of philosophy is a unique element of TEAM acupuncture and a practitioner's ability to utilise the different concepts appropriately is seen as a defining feature of the discipline (Deadman et al., 2009). However, for various socio-environmental reasons, the practice of acupuncture in the various East Asian countries (and possible elsewhere in the world), has gravitated towards some preferred ideologies which is emphasised in their practice of acupuncture (Cha et al., 2007; Katai, 2010b; Ryan, 2003; Smith et al., 2011; Scheid, Ward, Cha, Watanabe & Liao, 2010; Unschuld, 2010, p. xxxii; Yasui, 2010b). It seems that these ideologies are applied to individual scenarios only when needed or deemed appropriate and each philosophical doctrine remains a possible but not necessary facet of the complex heterogeneous system of TEAM acupuncture.

2.3.3 Overview of TCM, TKM and TJM acupuncture

There are contrasts of opinion about the legitimacy of practice styles within TCM, TKM and TJM acupuncture. Most apparent, is a conflict in mainstream TCM acupuncture. The dichotomy between pre and post Chinese Cultural Revolution

traditional medicine has opened debate about the suitability of the current Chinese system, which is the general standard of acupuncture worldwide (Deadman et al., 2009; Flaws, 1992; Fruehauf, 1999; Kaptchuk, 1985). Some criticise it as a herbalisation or Westernisation of acupuncture (Deadman et al., 2009; Flaws, 1992; Fruehauf, 1999; Kaptchuk, 1985) while others seem comfortable with its application as best acupuncture practice.

Heterogeneity of acupuncture styles also exist in TKM acupuncture, including *Saam* and *Taegeuk* acupuncture (Kawakita et al., 2015; Kim et al., 2005; Yin et al., 2007) and in TJM acupuncture with examples including the Meridian Therapy and Taikyoku Therapy styles (Lao, 1996; Yasui, 2010b). However, these styles appear to subsist without much contention in comparison to the apparent conflict of the Chinese styles, especially when described by authors from the West. It is unknown whether this dichotomy is a construct of observers from outside of China, or a true representation of the phenomena within the country itself. It is probable that the apparent lack of contention between styles in Korea and Japan is indicative of a relative scarcity of published scholarly comparative research or discussion in the literature. As future research develops the understanding of TKM and TJM acupuncture, disagreement similar to that found in the discussion of TCM acupuncture is likely to be revealed.

This section provides a brief overview and comparison of the philosophical concepts, diagnostic methods and treatment principles of TCM, TKM and TJM acupuncture. This is presented to discuss the differences and similarities which exist between the styles and as a precursor to the comprehensive discussion regarding TJM acupuncture which concludes this review.

Preferences in philosophical concepts

Differentiation of syndromes and pattern identification is the fundamental philosophical concept of TCM acupuncture (Dale, 1997; Dong & Zhang, 2001, p. 18; Flaws, 1992; Fruehauf, 1999; Kaptchuk, 1985; Kim, Pham & Ko, 2011; MacPherson et al., 2010; Scheid, 2014; WHO, 2007, p. 9; Yu et al., 2006). Other ideologies such as Yin-Yang, viscera and bowels, six excesses, five phase theory, six meridian theory, warm disease theory, triple energiser theory, channels and

collaterals and the fundamental substances, supplement or comprise a core pool of philosophical concepts (Barnes, 1998; Dale 1997; Dong & Zhang, 2001, p. 18; Flaws, 1992; Fruehauf, 1999; Ikeda, 2002; Ishida, 2004; Kaptchuk, 1985; Kim et al., 2011; Lao, 1996; Liangyue, 2001, p. 81; Low & Ang, 2010; MacPherson et al., 2010; WHO, 2007, p. 9; Yu et al., 2006). Almost all literature discussing TCM acupuncture report pattern identification and syndrome differentiation as the prevailing conceptual framework in TCM acupuncture.

Several styles are reported to exist within TKM acupuncture, most of which are a kind of “constitutional acupuncture”. Constitutional acupuncture provides a prescribed treatment based on determining the archetype of the patient (Cha et al., 2007; Chae et al., 2007; Lao, 1996; WHO, 2007, p. 9; Yin et al., 2007). Some sources (Kaptchuk, 1985; Sop, 2001, p. 281; Yeonseok, 2011) acknowledge the existence of an independent TKM acupuncture style while others (Flaws, 1992) have identified it as the same as TJM acupuncture. Additionally, some do not recognise TKM acupuncture at all when considering acupuncture styles in East Asia (Faircloth, 2015). Outside of constitutional acupuncture, the other major tradition reported in TKM acupuncture is primarily symptom based (Kim et al., 2005; Kim, 2010; Park, Kim, Min & Kim, 2004; Yin et al., 2007). This includes microsystem acupuncture such as hand acupuncture. Microsystem acupuncture theory asserts that areas within one localised part of the body, such as the ear or hand, correspond to all other parts of the body (Wang, 2008, p. 1; WHO, 2007, p. 235). By treating the localised area, disorders in the corresponding areas of the body can be affected.

According to the literature, TKM and TJM acupuncture are each based on the same fundamental pool of TCM acupuncture philosophical concepts (Anryu, 2002; Baker, 2003, p. 152; Cha et al., 2007; Kim et al., 2005; Kim et al., 2011; Kim, 2010; Kobayashi et al., 2008; WHO, 2007, p. 9; Yin et al., 2007). Of these concepts, the literature suggests that both TKM and TJM acupuncture emphasise the channels and collaterals, five phase theory and six meridian theory. However, while resembling TCM acupuncture, TKM and TJM acupuncture have their own unique variations. In addition to TCM acupuncture philosophies, TJM acupuncture is reported to combine philosophy from Japanese indigenous cultural practices (Oura, 2007; Matsuda, Brown & Dann, 2009) as well a range of Western medical

theories (Katai, 2010b; Shudo, 2000; Yasui, 2010b) to create an eclectic and contrasting array of philosophies not seen in TCM or TKM acupuncture. The philosophical concepts from the Meridian Therapy or *Toyohari* styles, based on the doctrine of the *Classic of Difficult Issues* (Ohue, 2011; van Huffelen, 2007; Williams, 2007; Wolf, 2009), are the most prevalent in the literature describing TJM acupuncture philosophies.

Although TKM acupuncture in general is similar to TCM acupuncture, the *Sasang* style of TKM acupuncture bears more resemblance in philosophical concepts to Ayurvedic medicine than Chinese medicine due to the shared emphasis of constitutional differences among individuals (Kim et al., 2011). Five phase theory and six meridian theory is part of the knowledge matrix of pattern identification and syndrome differentiation emphasised in TCM acupuncture (Maciocia, 2006, p. 422). However, TKM acupuncture has emphasised five phase theory and six meridian theory in a contrasting approach compared to TCM and TJM acupuncture. The contrast is found in giving attention to the body type and personality traits of an individual patient. This does not appear to be emphasised in TCM or TJM acupuncture. This approach to diagnosis and treatment is based on psycho-somatic constitutional frameworks similar to archetypes (Baker, 2003, p. 149; Cha et al., 2007; Chae et al., 2007; Kawakita et al., 2015; Kim et al., 2005; WHO, 2007, p. 9; Yin et al., 2007). These frameworks rely primarily on the theory of the channels and collaterals, six meridian theory and five phase theory (Baker, 2003, p. 151; Cha et al., 2007; Kim et al., 2011; Yin et al., 2007). Similar to China, modern medicine is well integrated with TKM acupuncture in Korea (Kim, 2007; Lee, Chae, Lim & Kwon, 2015; Yeonseok, 2011). Although modern medical concepts are conventionally integrated with TKM acupuncture, they have merged uniquely with the knowledge of biologic effects of injected substances at acupuncture points (Kim et al., 2005; Yin et al., 2007). Modern medicine does not appear as fully integrated with TJM acupuncture as it is in TCM and TKM acupuncture. However, the philosophical concepts from modern Western medicine form part of the standard knowledge included in the education of TJM acupuncture in Japan (Katai, 2010b; K. Matsumoto, 2000; Yasui, 2010b).

Although acupuncture from China, Korea and Japan share a common base of philosophical concepts, TCM acupuncture uniquely emphasises the

differentiation of syndromes and pattern identification. TKM and TJM acupuncture accentuates five phase theory, six meridian theory and the channels and collaterals. The psycho-somatic systematic correspondences of five phase theory, six meridian theory and microsystem acupuncture exemplify TKM acupuncture while the teachings of the *Classic of Difficult Issues* appear more prominent in TJM acupuncture.

Preferences in diagnostic methods

Standard modern medical lab reports and imaging tests are commonly used by TCM acupuncture practitioners (Zhan, 2001). To a lesser degree, these reports and tests appear to be used in TKM and TJM acupuncture as well. However, the most important diagnostic examinations of TEAM acupuncture are known as “the four examinations”. The “four examinations” include palpation, observation, olfaction/listening and inquiry (WHO, 2007, p. 80). It should be noted that the same Chinese character, *wen*, means both to hear and to smell and are considered one diagnostic method (Maciocia, 2006, p. 377). Diagnosis in TCM acupuncture is generally reported to utilise all of the four examinations in a clinical encounter (Dong & Zhang, 2001, p. 18; Flaws, 1992; Kaptchuk, 1985; Kim et al., 2011; Yu et al., 2006), with an emphasis on observation of the tongue and palpation of the pulse (Ahn et al., 2007; MacPherson et al., 2010). Palpation of the pulse (pulse diagnosis) involves examination of the pulsation of the blood vessels with the fingertips, usually at the radial artery on the wrist (WHO, 2007, p. 101). Inquiry is often based on the “10 questions” (or variants) which are a traditional strategy of inquiry thought to assist in formulating a pattern of disharmony (Maciocia, 2006, p. 320).

Pulse palpation can be applied according to a variety of philosophical frameworks within TEAM. For instance, pulse diagnosis may be conducted according to five phase theory, which sometimes allocates six positions on the radial pulse that are analysed according to the systematic correspondences of five phase theory (Dreu, 1995; Fratkin, 1996; Okabe, 1998; Oura, 2007). This kind of pulse palpation is commonly found in literature describing TJM acupuncture. Conversely, practitioners may also choose to perform pulse diagnosis which

corresponds with the viscera, bowels and six excesses or any other philosophical concepts (Dreu, 1995; Fratkin, 1996; Okabe, 1998; Oura, 2007).

While palpation in general is rarely seen as an important aspect of diagnosis in TCM or TKM acupuncture, it is reported as the single most identifiable diagnostic feature of TJM acupuncture (Dann, 2007; Katai, 2010b; Miyakawa, 2015b; Oura, 2007; Tokuyama, 2013). Literature describing TJM acupuncture emphasises pulse, channel and abdominal palpation as important diagnostic methods in contrast to TCM and TKM acupuncture (Ahn et al., 2007; Katai, 2006; Kobayashi et al., 2008; Yasui, 2010b).

In general, diagnosis in TKM acupuncture is said to rely on the four examinations and can result in the formation of a pattern of disharmony as in TCM acupuncture (Kim, 2010). However, one diagnostic feature of TKM acupuncture which does not appear so common in TCM or TJM acupuncture is the determination of the individual constitution (Baker, 2003, p. 148; Cha et al., 2007; Kim et al., 2005; Lao, 1996; WHO, 2007, p. 9; Yin et al., 2007). Establishing an individual patient's constitution is based on how they meet the criteria of corresponding relationships of personality and physical traits which label them as a certain constitutional type. There are several different ways that the relationship between personality and physical traits can be grouped for the purposes of diagnosis and these are represented in different TKM acupuncture styles. These styles include Saam (Chae et al., 2007; Kim et al., 2005; Yin et al., 2007), Sasang (Cha et al., 2007; Chae et al., 2007; Kim et al., 2011; Yin et al., 2007), Taegeuk (Yin et al., 2007) and the Eight Constitution style (Chae et al., 2007; Kim et al., 2005; Yin et al., 2007). In contrast to TCM and TJM acupuncture, all the reported styles of TKM acupuncture employ an assessment of the patient's constitution for diagnostic purposes.

Inquiry, tongue observation and pulse palpation diagnosis seem to be emphasised in TCM acupuncture (Ahn et al., 2007; Yu et al., 2006). In order to ascertain which constitutional category a patient falls into, TKM acupuncture practitioners are reported to make greater use of observation and inquiry than practitioners from TCM or TJM acupuncture (Kawakita et al., 2015; Kim et al., 2005, Yin et al., 2007). Channel palpation as a form of diagnosis seems to be rarely

employed in TCM acupuncture diagnosis (Dann, 2007; Liangyue, 2001, p. 77), although it appears to be gaining more popularity as a method especially in the West. However, the literature suggests channel palpation to be a hallmark of TJM acupuncture diagnostics (Ahn et al., 2007; Dale, 1997; Flaws, 1992; Katai, 2010b; Kobayashi et al., 2008; Yasui, 2010b).

The syncretistic and heterogenic model of TEAM acupuncture result in contrasts and uncertainties when attempting to categorically describe TCM, TKM and TJM acupuncture diagnostics from the published English language literature. Philosophical variance is rarely acknowledged in the literature and conceptual understanding is often assumed when discussing diagnostic methods. Although it is possible to identify some preferred methods of diagnosis, the philosophical perspective upon which each diagnostic method is based remains generally unknown in the literature describing TCM, TKM and TJM acupuncture.

Preferences in treatment principles

In TEAM acupuncture, treatment principles refer to the general rules that should be followed in treating a patient's condition (WHO, 2007, p. 204). In this study, treatment principles also include the methods that are derived from the principle of treatment and any tools used to administer it. For instance, the pattern of "Spleen Qi deficiency" may be diagnosed in a patient. A possible treatment principle or rule to remedy the condition could be to increase (tonify) Spleen Qi. The method of increasing the Spleen Qi could be to insert needles and apply moxa at certain points which are said to increase Spleen Qi. A treatment may involve a three step process of selecting a suitable treatment principle based on the diagnostic outcome, determining an appropriate method and applying the method with certain tools.

Differences in treatment frequency, treatment methods and treatment tools are found in the literature describing treatment principles in TCM, TKM and TJM acupuncture. Acupuncture patients in China are reported to attend treatment sessions around "every other day" (Flaws, 1992) or a possible seven treatments in 10 days for acute conditions (Kaptchuk, 1985). This could be more frequent than patients in other countries and could be somewhat accounted for by the position

acupuncture has in the health system of China, which is similar to that in Korea (Lee et al., 2002; Yeonseok, 2011). More specific evidence of differences between the treatment principles of TCM, TKM and TJM acupuncture are found in the differences between tools used.

Needles, moxibustion and a range of other treatment tools & methods are associated with TCM, TKM and TJM acupuncture (Ahn et al., 2007; Dale, 1997; Dong & Zhang, 2001, p. 18; Fruehauf, 1999; Kobayashi et al., 2008; Lao, 1996; Liu, 2010; Mitsuhashi, 2010; Park & Shim, 2011). The most obvious difference between TCM, TKM and TJM acupuncture treatment principles is reported in regards to acupuncture needles and their insertion. However, these are reported variably in the literature. For instance, needle diameter (millimetres) in TCM acupuncture is described from 0.20 to 0.28 (Lao, 1996), 0.28 to 0.32 (Dann, 2007) and from 0.32 to 0.38 (Katai, 2010b). In TKM acupuncture, practitioners typically use 40 mm length needles with a diameter of 0.25 mm (Kim, 2010). The description of acupuncture needles used in TCM acupuncture as reported in the published English language literature is inconsistent, contrasting and possibly an inaccurate reflection of clinical reality. Alternatively, all reports may be accurate to some degree due to the variability of practice. Similar inaccuracies or inconsistencies are probably present in the literature discussing TKM and TJM acupuncture.

TCM acupuncture needle insertion is reported as deeper than TKM or TJM acupuncture (Ahn et al., 2007; Birch, 1994; Dale, 1997; Dann, 2007; Katai, 2010b; Kawakita et al., 2015; Kobayashi et al., 2008; MacPherson et al., 2010; Manaka, 2009; Okabe, 1998; Romano, 1994; Yasui, 2010b). Deep needle insertion and strong needle sensation seems to be a characteristic of TCM acupuncture (Deadman et al., 2009; Dong & Zhang, 2001, p. 18; Flaws, 1992; Kaptchuk, 1985; Lao, 1996; MacPherson et al., 2010). This kind of strong needle sensation described by Deadman et al. (2009) as “nasty, brutish and painful” is suggested as being more traditional as opposed to the more gentle styles of acupuncture. This sentiment alludes to parochialism evident among experts in TEAM acupuncture. It serves as an indication that the treatment principles of TEAM acupuncture are misunderstood by many and highlights the importance of in-depth research exploring and describing TEAM acupuncture from a variety of cultural perspectives. This situation is clearly expressed by Michel (2011):

. . . while China attracted much attention as the cradle of acupuncture and moxibustion, traditional medicine in neighbouring countries used to be described in terms of transfer and imitation. Even experts did not recognize significant differences between Japanese and Chinese medicines when tracing the "influences" of Chinese medicine "on other cultures". Such views are not rare even today. Since they distort our understanding of historical developments as well as the present-day situation, researchers need to pay more attention to the independence, creativity, and historical contributions of the "periphery".

Comparison of moxibustion tools and methods between TCM, TKM and TJM acupuncture styles is much less developed in the published English language literature than that with needle and needle-like tools. However, it seems TCM acupuncture methods utilise large amounts of lower grade moxa (especially raw floss moxa sticks) compared to TJM acupuncture methods which reportedly use small amounts of higher grade moxa floss (Chant, 2016; Matsumoto, Katai & Namiki, 2016; Wheeler, Coppock & Chen, 2009). Moxibustion in TKM acupuncture may include methods similar to both TCM and TJM acupuncture and may also involve a much greater variety of moxibustion tools and methods practiced in those styles (Nam, 2016). However, information regarding moxibustion in TKM acupuncture is relatively unavailable in published English language literature.

In regards to needling, TKM acupuncture treatment principles seem to combine and contrast with those from TCM and TJM acupuncture to create a unique approach to treatment. In some styles of TKM acupuncture, once the constitution is determined, treatments are described as systematic and performed in accordance with five phase theory or six meridian theory (Yin et al., 2007). This appears similar to descriptions of TJM acupuncture. Other treatment principles of TKM acupuncture are reported as including superficial and quick needle insertion, where a needling sensation is desired to be elicited, such as in the Eight Constitution method (Yin et al., 2007). This kind of treatment seems to combine elements of both TCM and TJM acupuncture treatment principles. In TKM acupuncture, electricity and laser may be used to stimulate points (Baker, 2003, p. 151) and herbs and bee venom may be injected into treatment locations (Baker, 2003, p. 151; Kim et al., 2005; Yin et al., 2007). The attachment of herbal plasters

to acupuncture loci is also used in TKM acupuncture treatments (Park et al., 2004). Microsystem hand acupuncture is a systematic treatment based on the presenting symptoms and is an important treatment principle in TKM acupuncture (Baker, 2003, p. 152; Kim et al., 2005; Park et al., 2004; WHO, 2007, p. 263; Yin et al., 2007).

TCM acupuncture treatment principles seem to be defined by thicker needles and strong needle sensations. TKM acupuncture seems to have parallels with both TCM and TJM acupuncture. TKM acupuncture practitioners place importance on obtaining Qi when needling and have patients come for treatments two to five times a week (Kim, 2010). However, similar to TJM acupuncture, needle retention may only be for 15 to 20 minutes (Kim, 2010). The injection of substances into the body at specific acupuncture sites and microsystem hand therapy appear to be defining characteristics of TKM acupuncture treatment principles while TCM acupuncture treatments are based on pattern identification and syndrome differentiation.

TJM acupuncture is seen to be comparatively milder than the Chinese and Korean styles (Ahn et al., 2007; Dale, 1997; Deadman et al., 2009; Katai, 2010b; Kobayashi et al., 2008) and uses thinner needles (Katai, 2010b; Kobayashi et al., 2008; MacPherson et al., 2010; Yasui, 2010b) which are inserted superficially (Ahn et al., 2007; Dale, 1997; Katai, 2010b; Kobayashi et al., 2008; Mitsuhata, 2010; Yasui, 2010b). TJM acupuncture treatment principles in the published English language literature highlight a variety of methods with a focus on light stimulation according to the *Classic of Difficult Issues*. However, whether this is an accurate representation or complete description of TJM acupuncture remains unclear.

The next section focusses specifically on presenting a detailed account of TJM acupuncture, firstly by explaining the historical development and current status of acupuncture in Japan. Additionally, a thorough review and critical summary of published English language literature relating to philosophical concepts, diagnostic methods and treatment principles is provided to describe the contemporary understanding of TJM acupuncture.

2.4 Contemporary Japanese Acupuncture, Culture and Context

The major successive periods of Japanese history include the *Jomon*, *Yayoi*, *Kofun*, *Asuka*, *Nara*, *Heian*, *Kamakura*, *Muromachi*, *Azuchi Momoyama*, *Edo*, *Meiji*, *Taisho*, *Showa* and *Heisei* periods (Davies & Ikeno, 2002, p. vii; Sasayama, Satou, Gomi & Takano, 2013, pp. 418 - 425). Japanese historical periods are named according to different criteria. *Jomon* to *Kofun* periods are named after different kinds of archaeological evidence describing objects found in those time periods. *Asuka* to *Edo* periods are named after places where the head of government resided. The *Meiji* to *Heisei* periods are named after Japanese emperors. These successive periods are shown in Table 2.1 adapted from Davies and Ikeno (2002, p. vii) and Sasayama et al. (2013, pp. 418 – 425).

Table 2.1 Timeline of Japanese Historical Periods

Period	Year
Jomon	8000 – 300 BCE
Yayoi	300 BCE – 285 CE
Kofun	285 – 574
Asuka	574 – 710
Nara	710 – 794
Heian	794 – 1185
Kamakura	1185 – 1334
Muromachi	1334 – 1392
	1334 – 1573
	1467 – 1573
Azuchi Momoyama	1573 – 1603
Edo	1603 - 1867
Meiji	1867 – 1912
Taisho	1912 – 1926
Showa	1926 – 1989
Heisei	1989 – Present day

The Jomon to Kofun period is marked from around 8,000 BCE through to the end of the 6th century and spans over the Jomon, Yayoi and Kofun eras. Little information is available about the establishment of Japan and it is appropriate to consider that it was an extension of the Korean peninsula in ancient times (Kanazawa, 1998; Kobayashi et al., 2008). The discussion of medicine in ancient Japan is most relevant from around the Asuka period (574 CE) when Japan was established as a territory and official historical records are preserved.

2.4.1 Historical development of acupuncture in Japan

It seems that the first foreign medicine was imported to Japan from the Korean Silla Kingdom around 414 CE (Kobayashi et al., 2008; Matsumoto, 1994). However, despite the close connection with Korea, the oldest record of formal medical literature arrived from China in 562 CE and from this time onwards, there was an active period of cultural exchange between Japan and China (Kobayashi et al., 2008; Matsumoto, 1994; Yano, 2010).

During the Heian to Muromachi periods (794 - 1573 CE) the Japanese government engaged in a prosperous exchange with China and many books were imported to Japan (Kobayashi et al., 2008). Japan also mimicked the legal codes of the Tang dynasty and established a formal medical system. This period of history saw the formalisation of medicine in Japan and the beginning of original Japanese academia and literature (Kanazawa, 1998). However, the education and publications of this time still closely resembled that of China with seemingly little innovation.

During the Azuchi-Momoyama period (1573 - 1603) the Japanese government formally opened trade with Ming China, which encouraged the free flow of communication and interaction between the countries (Yasui, 2007; Yasui, 2010a). The influx of new ideas and technology inspired and catalysed the establishment and proliferation of various *ryu ha* (styles) in Japan which were influenced by the newly imported knowledge and ideas of the Ming dynasty (Kobayashi et al., 2008; Yasui, 2007). This period of intellectual ferment fostered an environment which saw the rise of important and lasting influences in TJM acupuncture:

During the Kamakura and Muromachi periods, acupuncture and moxibustion experienced almost no development and was in a state of decline. However, in the Azuchi-Momoyama period (1573-1603) and with the influence of Western civilization, many changes occurred. In the field of acupuncture and moxibustion, a new direction was stimulated by the appearance of famous acupuncture practitioners. This was the beginning of a Japanese acupuncture and original techniques non-existent in China. (Vigouroux, 2008a)

Some practitioners became well known and due to their popularity, their techniques and approach to treatment were followed by many practitioners. Their methods developed into recognised and independent styles. From the Azuchi-Momoyama period (1573 - 1603), Japanese medicine was a collection of separate methods or "styles" based on the teachings of prominent individuals.

The Edo period (1603 - 1867) is described as a peaceful and lawful period which lasted for over 250 years. During this time, many medical styles were established and became highly developed as separate methodological systems (Kobayashi et al., 2008). In earlier times, medicine was reserved for lords and nobles but from the Edo period, more people started practicing medicine as an occupation and private practice increased (Shirota, 2001). This period saw the development and solidification of medicine which was unique to Japan, such as distinctive moxibustion techniques, the guide tube (used to assist needle insertion) and related techniques, diagnosis by abdominal palpation and the speciality of non-needle insertion paediatric acupuncture (using a variety of needle-like tools to stimulate the skin without insertion) (Vigouroux, 2008a; Yasui, 2010a).

The Meiji Restoration from 1868 saw the abandonment of the Japanese feudal system and an adoption of European ideology, leaving many of the traditional systems behind in favour of a government more capable of mobilising the people quickly to dominate trade and military power in Asia (Kanazawa, 1998; Matsumoto, 1995; Ogawa, 1998; Okabe, 1998; Pershouse, 1998; Yanagishita, 1998). The medical field in Japan also aligned itself with "modern medicine" from the West, the institution of the hospital was established and a public medical system managed by the government was created (Shirota, 2001). The period of

history from the Meiji restoration to the present era (Heisei, from 1989) saw radical changes and medicine reform in Japan. Most significantly, acupuncture became a separate and complementary treatment modality to modern medicine.

In 2016 there were a total of 99 institutions (11 universities and 88 technical colleges) which offered courses in Traditional Japanese Medicine (TJM) including needling and moxibustion (Tsuchiya, 2016). Students of acupuncture must graduate from a recognised institution and then pass the national examination to become a licensed practitioner in their chosen field of TJM (Goto, 2010; Taniguchi, 2008).

At present, it seems that TJM acupuncture is a regulated and government monitored industry, including a variety of approaches to diagnosis and treatment. The practice of acupuncture in Japan appears to be evolving in response to a multiplicity of change pressures in which the struggle for legitimacy of indigenous Japanese approaches, TCM acupuncture and modern medicine has probably resulted in a unique cultural adaptation of acupuncture.

2.4.2 Current understanding of TJM acupuncture

TJM acupuncture is described in a variety of ways in the published English language literature. There are even some sources which although acknowledging TCM and TKM acupuncture, disregard TJM acupuncture as a distinct style, including WHO publications (Chaudhury & Rafei, 2001; Yu et al., 2006; WHO, 2007, p. 9). There are sources which acknowledge herbal medicine from Japan but describe TJM acupuncture as a “second class pseudo medicine” and state that TJM acupuncture has been divorced from the entirety of Traditional East Asian Medicine (Shim, 2015). TJM acupuncture appears to be an internationally misunderstood and under recognised discipline.

Many authors from outside Japan report TJM acupuncture as a kind of Meridian Therapy or Toyohari; especially in the United States and Europe where Meridian Therapy is described as being representative of TJM acupuncture (Birch, 1994; Birch, 1997; Birch, 1999; Birch, 2012; Bishop, 1999; Dann, 2000; Dreu, 1995; Drue, 1994; Fratkin, 1995; Hayden, 1998; Hayden, 2001; Jansson, 2001; Kenner, 1994; Loew, 2000; Pershouse, 1997; Petruzzi, 2014; Romano, 1994; Seem, 1995;

Williams, 2007; Wolf, 2009; Yackel, 2008). Meridian Therapy and Toyohari are styles of acupuncture based on five phase theory and in particular, on chapter 69 of the *Classic of Difficult Issues* (Ohue, 2011). However, TJM acupuncture does incorporate philosophical concepts, diagnostic methods and treatment principles from a broad variety of styles outside of Meridian Therapy and Toyohari. In the published English language literature, there is some limited evidence of a variety of TJM acupuncture styles which have their own unique philosophical concepts, diagnostic methods and treatment principles. Although discussion relating to these styles is underdeveloped and comprehensive descriptions are unavailable, they serve as an indication that TJM acupuncture includes more than the widely publicised Meridian Therapy or Toyohari styles. These styles are listed in Table 2.2.

Table 2.2 Acupuncture Styles Identified in Japan

Style	Author
Mubun	Takahashi, 1998; H. Matsumoto, 2000; Takahashi, 2005
Buddhist	Fratkin, 1997; Takahashi, 2012
Fukaya	Mizutani, 1998; Fukushima, 2008; Fukushima, 2015; Shinma, 2009
Tanioka or Taishihari	Hayden, 1997; Takahashi, 1997, Tanioka, 1998
Ishizaka	Kubota, 1997; K. Suzuki, 2004; Goto, 2005
Sawada or Taikyoku Therapy	Mizutani, 1994; Mizutani, 2015; Obaidey, 1996; Shirota, 1998; Yamada, 2015
Ryodoraku	Scanlon, 1996; Katai, 2010b; Wong, 2014
Manaka	Birch, 1994; Rubinstein, 2007
Kuwahara paediatric	Fratkin, 1998
Kurumadani	Ichihashi, 2001;
Shakuju	Kobayashi, 2001; Hara, 2005; Katoh, 2008; Takahashi, 2015
Shudo	Murata, 2001; Murata, 2006; Murata, 2013; Shudo, 1997
Ikeda	Ikeda, 1997; Ikeda, 2002
Seitai Shinpo	Sorimachi, 1997; Sorimachi, 2003
Western medicine based	Matsumoto, 1997; Matsumoto, 2003
Edagawa injection Therapy	Orhel, 2003

Style	Author
Kubota Zone acupuncture	Kubota, 2003
Akabane	Shimizu, 2004
Kototama Life Medicine	Duckworth, 2005
M – Test	Mukaino, 2008; Yuki, 2010
Kiko Matsumoto style	Nager, Kobylecka, Pham, Johnson & Gold; 2015; Rollins, 2010
Sakamoto Moxibustion	Sakamoto, 2012
Nagano style	Ogawa, 1999

Despite the variety of styles made mention in the literature, the Meridian Therapy style seems representative of TJM acupuncture in general, even among many Japanese authors (Ikeda, 1999; Kaneko, 1998; Maeda, 1998; Murata, 2001; Murata, 2006; Takahashi, 1995; Ogawa, 1996; Ogawa, 2013; Ohue, 2010; Okabe, 1998; Okada, 2004; Ota, 2011; Yanagishita, 2001a). Whether the prevalence of literature related to Meridian Therapy or Toyohari is representative of the reality of TJM acupuncture practice is currently unknown, and a comprehensive description and analysis of what is actually practiced by TJM acupuncture practitioners in clinics remains absent in the published English language literature.

2.4.3 Philosophical concepts

The philosophical concepts of TJM acupuncture appear to come from three separate sources: TCM acupuncture, indigenous philosophies arising in the Azuchi-Momoyama and Edo periods (1573 - 1867) and the insights of modern anatomy and physiology.

Most significantly, the majority of TJM acupuncture practice is reported to be based on the philosophies of TCM acupuncture (Anryu, 2002; Kanazawa, 1996; Kobayashi et al., 2008; Nishijima, 2003; Okabe, 1998; WHO, 2007, p. 9; Yasui, 2010a). A review of the literature reveals that the most important philosophical concepts include: channels and collaterals, viscera and bowels, eight principles, fundamental substances, six excesses, five phase theory, Yin-Yang and pattern identification and syndrome differentiation (Anryu, 2003; Birch, 1994; Chikurin, 2003; Furue, 2013; Ikeda, 1997; Ikeda, 2001; Iwashita, 2010; Kanazawa, 1996;

Kobayashi, 2001; Manaka, 2006b; Nishijima, 2003; Okabe, 1998; Scanlon, 1996; Shimada, 2006; Yamada, 2015; Yanagishita, 2001a). Nevertheless, five phase theory and the channels and collaterals seem to be the most emphasised philosophical concepts in TJM acupuncture. Whether this is an accurate understanding of the reality of TJM acupuncture practice is currently unknown.

An overview of the literature suggests that TJM acupuncture could be seen not only as a derivative of TCM acupuncture but also as a mix of TCM and Western medical theories. The curricula of most TJM acupuncture educational institutions provide a foundation in health science (K. Matsumoto, 2000) and modern anatomy; biomedical physiology and pathological concepts are an important philosophical system in TJM acupuncture (Katai, 2010b; Murata, 1999; Nagato, 2000; Shudo, 2000; Yasui, 2010b). This is probably similar to acupuncture education and practice globally, but at present it is unknown what role or how significant biomedical philosophies are in clinical TJM acupuncture practice.

The period between the Azuchi-Momoyama and Edo eras (1573 - 1867) in Japan saw the development of practices which were unique to the country at the time, and these have remained present in the philosophical concepts of modern TJM acupuncture practice. These concepts are neither totally TCM acupuncture original ideologies nor are they based exclusively on Western medical knowledge, but are a unique combination of both. Some of the styles utilising these philosophies ignore five phase theory, channels and collaterals and even the concept of Qi which are foundations of the majority of TJM acupuncture practice (Mizutani, 2009; Tanioka, 1998). Other TJM acupuncture styles are reported to restrict the concept of pathology and treatment to the abdominal condition, as in Mubun style (Takahashi, 1998) or the skin, as in the Tanioka or Taishihari style (Takahashi, 1997; Tanioka, 1998). The impact of these philosophies on the clinical practice of TJM acupuncture in Japan and how they are used or combined with other philosophies is not currently clear from the published English language literature.

2.4.4 Diagnostic methods

The standard diagnostic methods in TEAM acupuncture are listening/smelling, palpation, observation and inquiry. In the published English language TJM acupuncture related literature, these four diagnostic methods are reported to be used as a matter of course, but the differentiating feature between practices seems to be what is given more diagnostic significance by each individual style or practitioner (Katai, 2010b). The standard TEAM acupuncture diagnostic methods appear to be supplemented by esoteric techniques, as well as modern health science diagnostic tests in TJM acupuncture.

Of the diagnostic methods described in TJM acupuncture literature, palpation seems to be the most important (Matsumoto, 2013b; Miyakawa, 2015a; Oura, 2007). This includes feeling the various tissues and areas of the body for abnormalities, as well as pulse diagnosis. Pulse diagnosis is very important for some practitioners, especially those of Meridian Therapy (Feldman, 1995; Kuwahara, 1995; Shibata, 1995; Sorimachi, 2003). It is important to note that there are various types of pulse taking philosophies in TJM acupuncture diagnostics. Of these, five phase theory pulse diagnosis seems to be the most prevalent, which is consistent with the Meridian Therapy style (Fukumoto, 2006; Hayden, 1997; Nagato, 2000). However there are also practitioners who do not use pulse diagnosis exclusively or at all.

A review of the literature reveals that some practitioners do not place as much emphasis on pulse diagnosis as others. These tend to be either the more original TJM acupuncture styles or the more modern health science based practitioners. This is exemplified in the Mubun style where only abdominal palpation is used in diagnosis (H. Matsumoto, 2000; Takahashi, 2003). Practitioners of Tanioka, Ishizaka, Taikyoku and some other styles also tend to favour other diagnostic procedures over the pulse such as observation, inquiry and body palpation (Fujimoto, Inoue, Nakajima & Itoi, 2011; Kubota, 2007; Obaidey, 1996; Shirota, 1998; Tanioka, 1997). It is evident that although pulse palpation is not given equal importance by all TJM acupuncture practitioners, some kind of body palpation is significant (Kawakita et al., 2015; Nager et al., 2015). Why this is so remains unclear from the current published literature.

For the purpose of diagnosis and point location, body palpation is reported to hold an important position in TJM acupuncture. Channel, point and abdominal palpation all feature as significant diagnostic methods by many TJM acupuncture experts (Ahn et al., 2007; Anryu, 2002; Fukumoto, 2006; Goto, 2005; Katai, 2006; Katai, 2010b; Kobayashi, 2001; Kobayashi et al., 2008; H. Matsumoto, 2000; Mizutani, 2012; Nagato, 2000; Oura, 2015; Shudo, 2000; Takashima, 2014; Yasui, 2010b).

Even though palpation is an emphasised diagnostic method in TJM acupuncture, observation, especially of the skin can also be utilised (Birch, 1997; Goto, 2005; Kobayashi, 2001; Nagato, 2000; Ogawa, 1996). Although tongue observation is associated with TCM acupuncture and not TJM acupuncture by some authors (Ogawa, 1996; Ota, 2011; Oura, 2007), it is reportedly used by some TJM acupuncture practitioners (Murata, 1999; Nagato, 2000; Scanlon, 1996; Seki, 2008; Shudo, 2000; Toda, 2005). The current published English language literature presents contrasting perspectives on TJM acupuncture diagnostic methods. These contrasts need to be investigated in order to fully comprehend TJM acupuncture diagnostic methods.

Inquiry is also an important aspect of making a final diagnosis for practitioners of TJM acupuncture, although it seems to be less important than palpation and observation (Goto, 2005; Kobayashi, 2001; Mizutani, 2012). To a much lesser degree than other diagnostic methods, auscultation is also utilised in diagnosis when performing abdominal percussion (Ingegno, 2006; Tanioka, 2000), listening to the voice (Nagato, 2000) and listening to body sounds (Shibata, 2001). Outside of the standard four diagnoses in TEAM acupuncture, TJM acupuncture diagnostics is also reported to include modern medical examinations and esoteric practices.

The modern medical and anatomical testing methods used in TJM acupuncture are popular among a variety of practitioners (Kobayashi, 2001; Matsumoto, 2002; Murata, 1999; Nagato, 1999; Scanlon, 1996; Shudo, 2000). These tests include various imaging techniques, blood and blood pressure tests and range of movement testing. A detailed account of the variety and integration of

these methods in TJM acupuncture is currently unavailable in the published English language literature.

Some esoteric diagnostic approaches are also used, such as *tekazashi* which is the process of placing ones hand over the abdomen to feel *Jyaki* (evil Qi) (Takahashi, 2003; Yamada, 2015). Other less defined processes are also reported such as the reliance on “insight” or “intuition” (Ishihara, 2005). These kind of esoteric practices are complemented by Manaka’s (2006a) “O-Ring test”, a kind of kinesiology and other diagnostic processes which use magnets to make a diagnosis.

According to the literature, the diagnostic methods of TJM acupuncture include a variety of practices ranging from the standard TEAM acupuncture diagnostics, modern health science tests and esoteric practices. Palpation is seemingly more important in TJM acupuncture than it is in China or Korea. In particular, the prevalence of body palpation in the literature appears to mark it as a defining feature of TJM acupuncture diagnostics. Five phase theory pulse diagnosis, channel and abdominal palpation may be characteristic of TJM acupuncture diagnostics. Although a general description of what diagnostic methods are predominantly reported in the TJM acupuncture related literature is available, details of what and how the methods are actually used and how these methods are combined in practice remains unclear.

2.4.5 Treatment principles

Similar to philosophical concepts and diagnostic methods, the descriptions of treatment principles in TJM acupuncture related literature are diverse and at times contrasting. TJM acupuncture treatment has been described as systematic and empirical (Flaws, 1992; Kobayashi et al., 2008) and adhering to the same principles of TCM acupuncture (Flaws, 1992; Yasui, 2010b). Overall, the literature supports the idea that TJM acupuncture treatment is based on five phase theory, consistent with the Meridian Therapy system (Ikeda, 1997; Nagato, 1999; Okabe 1998; Okada, 2000; Seki, 2008). In TJM acupuncture, five phase theory based treatments are complemented with the theory of channels and collaterals (Anryu, 2003; Nishijima, 2004) which are sometimes used in conjunction with or omitted entirely in

favour of a more modern health perspective treatment style (Matsumoto, 1997; Yamada, 2007). This includes needling areas of muscular pain and tenderness (e.g. myofascial trigger points) or certain nerves without regard to whether the location is considered a prescribed acupuncture point or not. Such techniques are sometimes known as dry needling (Baldry, 2005; Kawakita, et al., 2015).

Descriptions of treatments focussing on the patient's overall constitution with the purpose of balancing the pulse according to five phase theory, and symptomatic treatment based solely on palpation and informed with health science knowledge (Nagato, 1999) exemplify diversity in TJM acupuncture treatment principles. However, the commonly prevailing treatment principle reported in the literature is that of tonifying (nourishing) deficiency and reducing excess in the tradition of Yin-Yang theory (Anryu, 2002; Ikeda, 2001; Ikeda, 2002; Kajima, Sai, Inoue & Susuki, 2008; Katoh, 2008; Kawase, 2012; Kudo, 2005; Matsumoto, 2013a; Mizutani, 2012; Menjyo, 2012; Ota, 2011; K. Suzuki, 2004; Yanagiya, 2002). This seems consistent with the treatment principles of Meridian Therapy, but the discussion of how congruent these principles are with other approaches in TJM acupuncture is not clearly understood.

Thin needles with tube assisted insertion, short needle retention time, minimal needle stimulation and shallow needle insertion are the emphasised treatment principles and tools in the literature concerning TJM acupuncture treatments (Dann, 2007; Katai, 2010b; Katai, 2013a; Kawakita et al., 2015; Kobayashi et al., 2008; Manaka, 2009; Oura, 2007). This is consistent with the Meridian Therapy or Toyohari styles. However, reports of needle thickness varies from a very thin 0.14 mm (Murata, 1999) through to quite thick 0.50 mm (Shimizu, 2004) with needle insertion depth anywhere from 1 mm (Takahashi, 1999) up to four and 5 cm (Katai, 2013b; Matsumoto, 1998; Murata, 2000) with no retaining of the needle (insertion and withdrawal) (Murata, 2001) or up to 30 minutes needles retention (Fratkin, 1996). Some contrasting descriptions of TJM acupuncture treatment principles illustrate it as almost identical to TCM acupuncture.

Stimulation strength in TJM acupuncture is generally described as light or painless (Ikeda, 2012; Feldman, 1997; Fratkin, 1998; Maeda, 1998; Nagato, 1997; Shirota, 2001; Shirota, 2003; Takahashi, 1997; Takahashi, 1998). According to the

literature, painless and subtle needle sensation is standard in TJM acupuncture. In order to perform techniques painlessly and provide subtle stimulation, hand skill is seen as an important element in the use of the TJM acupuncture tools.

One of the unique features of TJM acupuncture which is not reported in literature pertaining to TCM or TKM acupuncture, is the priority and attention given to the use of the pressing hand (the hand not holding the needle), rather than the hand which inserts the needle (needling hand) (Katai, 2010b; Katai, 2014). The purpose of the pressing hand is to feel the condition of the tissues surrounding the needle and adjust needle technique and stimulation accordingly (Honda, 2006; Ikeda, 2001; Kawase, 2012; Kudo, 2005; Murata, 2001; Takahashi, 2000; Yanagishita, 2001b). The pressing hand is also important in order to feel the arrival of Qi which signifies that a treatment has been successful (Ikeda, 2001; Miyakawa, 2015a; Shudo, 2000; Walton & Shudo, 2006).

Similar to needling, moxibustion is applied according to a range of different treatment principles. These are reported to be based on abnormal findings of body tissue, on channel theory or according to Yin-Yang and five phase theory (Fukushima, 2008; Fukushima, 2015; Mizutani, 2015; Yamada, 2015). During application, moxa is often rolled into small pieces resembling cones which are then placed onto the treatment site and ignited (Fukushima, 2008; Fukushima, 2015; Mizutani, 2015; Yamada, 2015).

The amount of stimulation produced by moxibustion is important in achieving the treatment outcomes. Moxibustion in TJM acupuncture is generally divided into indirect and direct moxibustion (Menjyo, 2014; Menjyo, 2015). Indirect techniques are where there is some kind of barrier between the moxa floss and the patient's skin, such as in box moxibustion (Seki, 2012), boat moxibustion (Kamiya, 2003), or by using an insulating material such as ginger or *shiunko* (Shimada, 2007; Yasushi, 2008) and needle stick moxibustion (Ikeda, 1997; Kamiya, 2003; Ota, 2011). Direct moxibustion is where moxibustion is performed directly on the skin. The use of direct moxibustion commonly appears in the literature and it seems to be a feature of TJM acupuncture which differentiates it from other TEAM acupuncture practices (Manaka, 2009; Okabe, 1998).

Moxibustion in TJM acupuncture is reported to involve practices where the moxa floss is shaped into several different sized cones for application: string (Matsumoto, 1997; Mizutani, 1994), sesame (Honda, 2003; Mizutani, 1994; Kobayashi, 2002), half rice grain (Matsumoto, 1997; Mizutani 1994; Murata, 1999; Seki, 2011), rice grain (Fukushima, 2008; Menjyo, 2011; Murata, 1999; Ohara, 2011; Ota, 2011), soybean (Kokubo, 2003) and horse eye sized used to scar and produce a blister (Fratkin, 1997; Manaka, 2002; Mizutani, 1996). The use of scarring moxibustion in TJM acupuncture contrasts with the “painless” needling approach promoted in the literature. Further research is necessary to understand why such contrasts exist. The cone sizes are reported to provide a different amount of stimulation to produce a certain effect, especially when a therapist is using the tonifying or reducing methods (Mizutani, 2012; Menjyo, 2012; K. Suzuki, 2004). However, the literature does not seem to report any comprehensive guiding principles on the application and use of moxibustion. Details based on empirical research pertaining to the use of moxa in a range of real TJM acupuncture clinic settings remain absent from the literature and require further investigation.

The number of applied moxa cones seems to be important in TJM acupuncture; some therapists use odd numbers which appears to be the standard practice based on Chinese numerology (Mizutani, 1994). The literature suggests that most practitioners use three or five cones (Menjyo, 2011; Ohara, 2011; Kobayashi, 2002; Seki, 2011; Shudo, 1996; Suzuki, 2003) while up to 1000 can be applied (Shimada, 2007).

In TJM acupuncture, there are various schools of thought on moxibustion treatment principles. The literature generally reports that most treatment principles related to moxibustion include point location based on palpation and that stimulation is applied directly on the skin using rice grain sized moxa cones. Direct stimulation provided by rice grain moxibustion seems to be applied with the intention of having an effect on the underlying abnormal body tissues or according to the TEAM principles of tonification or dispersion. Some moxibustion styles only burn the moxa down to about 80% of the way to the skin (Endo, 2000), while others may burn moxa directly on sensitive areas such as the gums (Sakamoto, 2011). Diversity and inconsistency in the reporting of TJM acupuncture treatment principles result in uncertainties which need to be addressed by continuing research.

TJM acupuncture treatments are described as including a range of different principles and tools. In treatment, needling and moxibustion can be complemented by: cupping (Shibata, 2002), embedded needles (Furuya et al., 2009; Noda et al, 2015; Shimizu, 2004; Suzuki, 2003), bloodletting and three edge needles (Anryu, 2002; Ota, 2011; Shimada, 2005; Takahashi, 2002), blunt needles (*teishin*) (Hayden, 1997; Kawase, 2012; Kudo, 2005; Kuwahara & Nakano, 2015; Nishijima, 2003; Manaka, 2002; Yanagishita, 2001b), hand held magnets (Anryu, 2003; Hayden, 1997), press pellets (small metal pellets attached to an adhesive tape which is pressed onto the skin) (Hayden, 1997; Ota, 2011; Manaka, 2002), ion pumping cords (insulated copper wires with gator clips at both ends) (Feldman, 1997), electrical stimulation machines (Suzuki, 2002), point injection therapy (Orhel, 2003; Terayama et al., 2015) wooden mallets (Takahashi, 1998) and electrical resistance measuring machines (Ota, 2011). What other, how, why and when these tools are used in the clinic is difficult to understand clearly from the current published English language literature and further research is required.

In general, TJM acupuncture is reported as being comparatively milder than the Chinese and Korean styles (Ahn et al., 2007; Dale, 1997; Deadman et al., 2009; Katai, 2010b; Kobayashi et al., 2008) and uses thinner needles (Katai, 2010b; Kobayashi et al., 2008; MacPherson et al., 2010; Yasui, 2010b) which are inserted superficially (Ahn et al., 2007; Dale, 1997; Katai, 2010b; Kobayashi et al., 2008; Mitsuhata, 2010; Yasui, 2010b). TJM acupuncture treatment principles in the published English language literature highlight a variety of methods with a focus on light stimulation and five phase theory with a purpose to balance excess or deficiency in the body. There are however, diverse and contrasting reports in the literature. Greater in depth investigation exploring and describing TJM acupuncture is necessary to reconcile contrasts in the published English language literature, advance the understanding of TJM acupuncture within the sociocultural context of Japan and to clarify the philosophical concepts, diagnostic methods and treatment principles of current clinical TJM acupuncture practice.

This section demonstrates that even though there is a great diversity of styles, philosophical concepts, diagnostic methods and treatment principles in TJM acupuncture, it is generally recognised as being very similar to Meridian Therapy. Due to the variety and greatly contrasting elements of TJM acupuncture reported in

the literature, it is probable that TJM acupuncture includes a much greater depth of knowledge and range of techniques than what is commonly believed. A complete understanding of the philosophical concepts, diagnostic methods and treatment principles of TJM acupuncture as they directly relate to clinical reality in Japan, remains unknown. Without comprehensive knowledge of TJM acupuncture, a cross cultural understanding of TEAM acupuncture will remain underdeveloped.

2.5 Chapter Summary

This chapter explores the literature concerning traditional medicine in East Asia and specifically, acupuncture in Japan. It is organised into four major sections: traditional medicine, acupuncture, style diversity in acupuncture and contemporary Japanese acupuncture, culture and context.

The first section defines and contextualises traditional medicine in Asia with specific attention to Traditional East Asian Medicine (TEAM). The traditional medicine of China, Korea, Japan, Mongolia and Vietnam are recognised as the major acupuncture styles prevalent in East Asia. The prevalence and importance of TEAM acupuncture globally is highlighted and shown that in Asia, China, South Korea and Japan are the biggest publishers of academic literature related to acupuncture.

The second section explores definitions of acupuncture and clarifies use of the term in this study. The concept that acupuncture includes moxibustion and is more than a treatment where needles are inserted into the body is also developed. This emphasises the inseparability of needles and moxibustion and proposes that a definition of acupuncture is incomplete without the inclusion of moxibustion and other non-insertion methods.

In the third section it is demonstrated that there is style diversity in TEAM acupuncture. This is shown by explaining the history and progress of acupuncture through East Asia. In describing the variability of practice, preferences in philosophical concepts, diagnostic methods and treatment principles are outlined from TCM, TKM and TJM acupuncture.

Finally, the medical history and the current status of acupuncture in Japan are described. The important events and influences during the history of TJM acupuncture in Japan are strongly linked to the modern practice of acupuncture, and it is described how TJM acupuncture exists as an eclectic mix of styles. These styles are described inconsistently in published English language literature, and it is demonstrated that Meridian Therapy and Toyohari styles are representative of TJM acupuncture according to the literature. Additionally, the review identifies five phase theory, channels and collaterals, subtle stimulation techniques and palpation as widely reported elements of TJM acupuncture.

This literature review highlights gaps in the understanding of TJM acupuncture. It underlines the contrasts and ambiguities in the current published English language literature, and provides evidence that TJM acupuncture encompasses a greater depth of complexity and variety than it is commonly credited with. The actual status of philosophical concepts, diagnostic methods and treatment principles in TJM acupuncture remain unconfirmed in published English language literature. In depth investigation based on first-hand, eyewitness accounts of TJM acupuncture in Japan describing and exploring the practice are also missing in published English language literature.

It was the purpose of this study to explore and describe the current practice of TJM acupuncture in Japan by understanding philosophical concepts, diagnostic methods and treatment principles. To fulfil the aims of the study, it was necessary to select a qualitative methodology that allowed observation of the clinical reality of acupuncture practice in Japan. The next chapter shows how and why ethnography was chosen as the preferred methodology for this study. It is also demonstrated that as a consequence, complete cultural immersion in the TJM acupuncture environment was necessary. A description and justification of the methods used in fieldwork to observe TJM acupuncture directly in clinics, interview experts and analyse documents relating to TJM acupuncture practice is presented.

Chapter 3: Methodology and Methods

This study aims to explore Traditional Japanese Medicine (TJM) acupuncture and describe the philosophical concepts, diagnostic methods and treatment principles of the practice. The design of this study was determined in relation to the research aim and questions, and the interpretivist orientation of the research. Because this study sought to explore TJM acupuncture as a cultural phenomenon in its natural setting, ethnography was chosen as the preferred research method. This chapter describes the research design, methodology and methods used in the study.

This chapter contains eight major sections:

- **Research Aim and Research Questions:** Reviews the research aims and research questions.
- **Positioning of the Researcher:** Outlines the positioning and role of the researcher.
- **Research Paradigm:** Discusses the research paradigm by outlining the use of philosophical concepts, diagnostic methods and treatment principles as relevant criteria for understanding TJM acupuncture.
- **Methodological Framework:** Situates the study within the ethnographic model of understanding.
- **Methodology:** Deals with the methodological foundations of the study as it relates to the assumptions of the ethnographic approach concerning the methods used.
- **Research Design:** Describes the structure of the study and details the development of the strategies employed in data collection.
- **Methods:** Details all the processes and procedures used in conducting the study.
- **Limitations:** Recognises some of the limitations regarding the methodology and methods, discusses the impact of these limitations on the project and explains how these were addressed.

3.1 Research Aim and Research Questions

The motivation for this research was to better understand different acupuncture practices, with a particular focus on Traditional Japanese Medicine (TJM) acupuncture. Improved knowledge of cultural influences and specific methods will inform future research and educational curricula relating to TJM acupuncture and promote the most effective acupuncture treatments.

This study aims to examine the ideas, experiences, and practices of TJM acupuncture practitioners in Japan to understand TJM acupuncture through philosophical concepts, diagnostic methods and treatment principles.

Achieving this aim involved answering the following research questions:

- 1) How do practitioners of TJM acupuncture describe or exhibit the philosophical concepts, diagnostic methods and treatment principles of their acupuncture practice and TJM acupuncture in Japan in general?
- 2) How do clinic procedures, environment and clinic artefacts reflect the philosophical concepts, diagnostic methods and treatment principles of TJM acupuncture?
- 3) How do the patient records, clinic documents and other locally sourced literature reflect the philosophical concepts, diagnostic methods and treatment principles of TJM acupuncture?
- 4) What, if anything, makes TJM acupuncture identifiable as a distinct style of acupuncture?

3.2 Positioning of the Researcher

The researcher's role in this study was shaped not only by their position as a Traditional East Asian Medicine (TEAM) practitioner who specialised in acupuncture and other TEAM body work therapies, but also as an itinerant scholar with a number of years of expatriation in Japan. This research was prompted after TEAM education and practice in Australia, followed by visits to Japan.

During the course of education and apprenticeship, the researcher discovered a disparity between philosophy, diagnosis and treatment in TJM acupuncture clinics in Australia, and what was being taught at educational institutions. This raised curiosity about why the practices seen in TJM acupuncture clinics in Australia were not being taught in undergraduate courses. This curiosity fostered an interest in TJM acupuncture which led to consequent acupuncture study in Japan. During the course of study and apprenticeship in Japan, the researcher discovered another disparity between the TJM acupuncture clinics in Japan and the self-titled TJM acupuncture clinics in Australia. Practitioners of TJM acupuncture in Japan were using a variety of different methods to each other and to those which had been observed in TJM acupuncture clinics in Australia.

The positioning of the researcher in this study was one of an Australian trained practitioner of TEAM acupuncture with a cultural understanding of acupuncture in Japan and Australia, as well as clinical and educational experiences of acupuncture in Japan and Australia.

3.3 Research Paradigm

The tripartite typology of health, illness and health care has long been used in the discussion and comparison of medical systems (Ferdous & Harreveld, 2011; Kleinman, 1978; O'Mahoney & Donnelly, 2007; O'Mahoney, Donnelly, Bouchal & Este, 2013). In this typology, health care refers to the technical or practical aspects of providing care to someone who is unable to do so themselves (Kleinman, 1978; Kleinman & van der Geest, 2009). The beliefs and behaviours of health care are profoundly affected by the interaction of culture, society and individual experiences (Kleinman, 1978; Matsumoto & Juang, 2012, p. 29). It is therefore important to investigate these elements collectively to create contextually appropriate explanations of health care practices, such as acupuncture (Scheid & MacPherson, 2012, p. 3). This study focussed on professional healthcare as it relates to the beliefs and behaviours of TJM acupuncture within the cultural and social context of Japan. In order to describe TJM acupuncture in Japan, this study investigated the relationship between culture, society and individual experiences, and philosophical concepts, diagnostic methods and treatment principles (Figure 3.1).

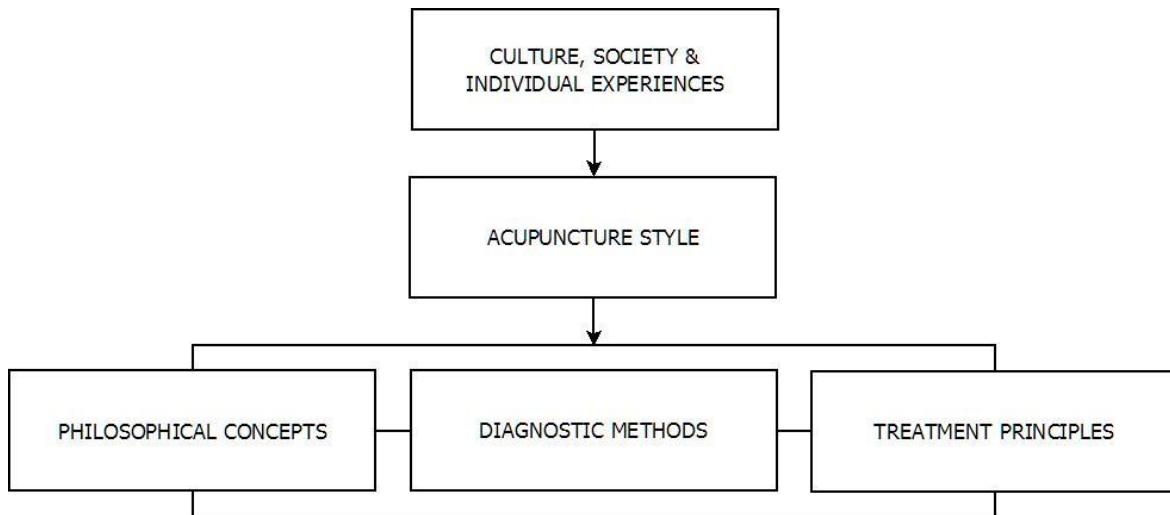


Figure 3.1 Research paradigm

The *International Standard Terminologies on Traditional Medicine in the Western Pacific Region* (WHO, 2007) provides a comprehensive, but not complete explanation of the philosophical concepts in TEAM acupuncture. According to The World Health Organisation (WHO), philosophical concepts relate to the branch of TEAM dealing with the basic concepts, theories, rules, and principles (WHO, 2007, p. 9).

The WHO (2007, p. 9) suggests that different acupuncture styles are based on certain theories or philosophical concepts which identify them as distinct from other TEAM acupuncture approaches. O'Brien and Birch (2009) also state that each TEAM acupuncture style is made up of variations and combinations of traditional concepts, theories and conceptual models which mark them as unique. Patwardhan et al. (2005) use the category of basic theory to compare Ayurvedic medicine and Chinese medicine in a comparative review, while basic theories have been compared in discussions and reviews of TCM, TKM and TJM acupuncture (Chant, Madison & Dieberg, 2016; Dann, 2007; Manaka, 2009). The use of philosophical concepts as a category to describe TJM acupuncture is an appropriate and necessary step in clarification and classification. Therefore it was selected as a category to be used in this study.

Diagnostic methods are the branch of TEAM dealing with the procedure and practice of collecting data to determine the condition of the patient (WHO, 2007, p. 79). Diagnostic methods in TEAM are based on the skills of inspection,

listening/smelling, examination, inquiry and palpation (Maciocia, 2006, pp. 285-380; WHO, 2007, pp. 79-160). In this study, the various terminologies for diagnostic methods were informed by the *International Standard Terminologies on Traditional Medicine in the Western Pacific Region* (WHO, 2007, p. 79).

In a study by Xue et al. (2008), technical capabilities were regarded as the most important category of skills needed for a clinician of TEAM to be competent. Within this category of technical capabilities, Australian acupuncture practitioners regarded the diagnostic methods employed by a therapist to be very important in the clinical setting (Xue et al., 2008). The way in which information is collected from a patient and organised in order to proceed with treatment is an important reflection of TEAM acupuncture philosophical concepts (O'Brien & Birch, 2009; Welden, 2011). Diagnostic methods are an important link which connect basic health models with treatments, and can vary significantly between TEAM acupuncture styles (Chant et al., 2016; Dann, 2007; Manaka, 2009). The Standards for Reporting Interventions in Clinical Trials of Acupuncture (STRICTA) guidelines (MacPherson et al., 2010) insist that the inclusion of the rationale for diagnosis is essential in reporting acupuncture clinical trials. Other authors (Katai, 2010b; Yasui, 2010b) have supported diagnostic methods as a key category of differentiation when comparing TJM acupuncture practices. TEAM acupuncture practitioners often favour certain diagnostic skills or apply diagnostic techniques differently (Katai, 2006; Sop, 2001, p.70; Yin et al., 2007). Documenting and analysing the variety of diagnostic methods in TJM acupuncture was determined as an essential element in this study.

A treatment principle is the general rule that should be followed in the treatment of a patient's condition (WHO, 2007, p. 204.). In this study it also includes the methods that are derived from the principle of treatment and any tools used to administer it. TEAM acupuncture includes a variety of practices where a needle or needle-like tool and moxibustion is used for a range of remedial purposes (Katai, 2010b; Ota, 2011; Shimada, 2006; Yasui, 2010b; WHO, 2007, pp. 233-235). In order to document the heterogeneity of TEAM acupuncture practice, this study considered all TJM acupuncture treatment principles, methods and tools as important inclusions for investigation.

Treatment principles are directly linked to philosophical concepts and diagnostic methods, and are a necessary part of reporting in acupuncture clinical studies (MacPherson et al., 2010; O'Brien & Birch, 2009). Treatment principles have been identified as an important and diverse aspect of the TEAM acupuncture clinical encounter, and are used to compare TEAM acupuncture practices (Sherman et al., 2005; Xue et al., 2008). Treatment principles vary broadly across differing styles of acupuncture (Chant et al., 2016; Dann, 2007; Deadman et al., 2009; Dong & Zhang, 2001, p. 18; Flaws, 1992; Kaptchuk, 1985; Lao, 1996; MacPherson et al., 2010; Manaka, 2009) and it was determined that the inclusion of this category was necessary for comparing, contrasting and describing acupuncture in Japan.

3.4 Methodological Framework

Research into TEAM has predominantly been concerned with quantifying the therapeutic significance of clinical interventions (Han & Ho, 2011). This study is not set within the quantitative constructs of justifying the clinical effectiveness of TJM acupuncture or providing evidence for its authority over any other medicine. Rather, this study attempts to contribute to the understanding of TEAM acupuncture by exploring and describing TJM acupuncture in Japan.

Humans live in groups which exist in differing environments, and require different needs to navigate and thrive in those environments. These groups adapt their behaviours to meet the needs of the surrounding ecology, and the accumulated behaviours eventually become distinctive ways of living, thinking and being (Matsumoto & Juang, 2012, p.13). This study asserts that the practice of TJM acupuncture in Japan is unique, and that the ideas and behaviours related to TJM acupuncture in Japan can only be understood by direct interaction within a cultural context.

Documenting the culture, perspectives and practices that transpire within certain communities in the pursuit of holistic insights into a people's views, actions and environment, is the commitment of ethnographic research (Goodson & Vassar, 2011; Reeves, Kuper & Hodges, 2008). Ethnographic research is the rational

learning of others' ways of life. It places importance on history, development, culture, beliefs, values and actions in order to understand a way of life from the liver's point of view (Engebretson, 2011). It involves sustained and direct contact with social actors, and the deliberate recording of human events (Willis & Trondman, 2000). This study sought to describe, interpret and understand the characteristics of TJM acupuncture in Japan, by investigating it in the diverse social and cultural constructs in which it is found. Therefore ethnography was selected as the essential methodology to address the descriptive and explorative aims of this study.

Ethnography is commonly applied as a methodology and method in medical settings (Atkinson & Pugsley, 2005; Chapman, Hadfield & Chapman, 2015; Engebretson, 2011; Pope, 2005; Popovici et al., 2015; Simmons, 2007; Simmonds et al., 2015) and has also been used extensively in TEAM research (Adams, 2002; Emad, 1997; Ho, 2006; Hsu, 1999; Kim, 2007; Kim, 2009; Kim, Sich, Park & Kang, 1980; Lieber, 2012; Lock, 1980; Ohnuki-Tierney, 1984, Sagli, 2010; Scheid, 2002). The long history of medical ethnography exploring a variety of contexts including TEAM, and the ethnographic commitment to cultural immersion, establishes it as an appropriate method of investigation for this study.

As a methodology, ethnography is based on a set of guiding values which include (Hammersley & Atkinson, 2007, p.3; Lotfali, 2006; Scott-Jones, 2010, p. 23 – 26; Walford, 2009; Willis & Trondman, 2000):

- Emphasis on historical and cultural contextualisation through long term immersion within a community.
- A desire to accurately provide a thick description of a social world through multiple methods of fieldwork.
- The stress on ethics, representation, power and inclusion.
- The importance of reflexivity as awareness of subjectivity.

These values align completely with the aims of this study that embraces the fundamental beliefs of ethnography in methodology and method, as reflected in the design of the research project.

As a research method, ethnography generally refers to fieldwork conducted by a single investigator who lives with, and lives like those who are under study for an extended period of time (van Maanen, 1996, p. 263). This allows the researcher to obtain a deep understanding of the people, community and broader context in which those under study are situated (Lotfali, 2006). Ethnography includes flexible and unobtrusive field methods which are designed for use in real life environments, and enables the fieldworker to recognise patterns of behaviour and thought, and examine the relationship between them (Forsythe, 1999). Fieldwork methods in ethnography commonly include:

- The recruitment of relatively few study participants (Reeves et al., 2008).
- Flexible researcher roles and multiple methods of data collection (Hammersley & Atkinson, 2007, p.3; Simmons, 2007).
- Iterative and descriptive data analysis (Simmons, 2007; Willis & Trondman, 2000).
- Reflexivity in establishing validity (Amira de la Garza, 2013, p. 166; DeWalt & DeWalt, 2011, p. 123; Pope, 2005).

This study employed a variety of ethnographic fieldwork methods as they are all appropriate for investigating TJM acupuncture. Understanding the participants' experience and perspective is considered an important element of ethnography (Engebretson, 2011; Holloway & Todres, 2003; Scott-Jones, 2010, p. 26). The ethnographic methods used in this study were designed to capture real life experiences of participants, and to provide a living and current account of TJM acupuncture.

3.5 Methodology

This study includes data from multiple perspectives and different contexts within Japan. The specific culture under investigation in this study is that of TJM acupuncture practitioners and educators in Japan. How members of this culture perceive the phenomena of TJM acupuncture and how their values, beliefs and actions might differ in time and space from each other both in Japan and in other parts of the world, was important to the design of this study.

3.5.1 Sampling

Sampling procedures can be generally divided into three broad categories; probability, purposive and opportunistic methods (Teddlie & Yu, 2007). Purposive sampling involves deliberately selecting certain members of a population based on a specific purpose (Maxwell, 1997, p. 87; Tashakkori & Teddlie, 2003, p. 713). Sampling in ethnographic research typically relies on purposive sampling methods to ensure participants with specific knowledge, and relevance to the research aims are included in the study (Ho, 2006; Holloway & Todres, 2003; Klien, 2011; Reeves et al., 2008; Simmons, 2007; Walford, 2009). This study employed purposive sampling methods to recruit practitioners relative to the research aims.

Gaining access to a largely unknown and foreign population situated in a sensitive setting often depends on cooperating with those who have the authority to grant access, or act as intermediaries between research sites and the researcher (Morrill, Buller, Buller & Larkey, 1999; Pope, 2005; Reeves et al., 2008; Simmons, 2007). Individuals who control access to potential research sites or populations and help create relationships between the target population and researcher, are known as gatekeepers (Murchison, 2010, p. 30; Penrod, Preston, Cain & Starks, 2003). Gatekeepers are commonly employed in ethnographic research to initiate access to communities of difficult to reach populations (Ho, 2006; Klien, 2011; Reeves, 2010; Sanghera & Thapar-Bjorkert, 2008; Simmons, 2007). This study sought the co-operation of gatekeepers during participant recruitment.

Gatekeepers often provide access to established personal and professional networks of potential participants. These networks are important and commonly used resources in ethnographical studies when recruiting (Browne, 2007; Ferrigno, 2007; Klien, 2011). Introductions through multiple participants' personal and professional networks simultaneously, are known as "Chain Referral Sampling" (Biernacki & Waldorf, 1981; Penrod et al., 2003). The target sample in this study included members of a very specialised and difficult to reach population, so chain referral sampling was an essential strategy to recruit TJM acupuncture practitioners for investigation.

Ethnography often combines purposive and opportunistic sampling methods to include willing and easily accessible participants into the study (Kusenbach, 2003; Mahoney, 2001; Reeves et al., 2008). This study implemented purposive and opportunistic sampling strategies to recruit TJM acupuncture practitioners who were both geographically accessible, and relevant to the specific research aims of this study. Emergent sampling is a method of opportunistic sampling which “. . . involves drawing samples that are both easily accessible and willing to participate in a study” (Teddlie & Yu, 2007). Emergent sampling in this study capitalised on new opportunities as they arose in the field, which maximised recruitment by including willing TJM acupuncture practitioners as they were identified during fieldwork.

3.5.2 Data collection

Ethnography is synonymous with the data collection strategies which exemplify it as a method: participant observation, interviews and document analysis (Bowen, 2009; Engebretson, 2011; Pope, 2005; Reeves, 2010; Reeves et al., 2008; Simmons, 2007; Walford, 2009). Participant observation, interviews and document analysis are commonly used together or alone in medical settings (Atkinson & Pugsley, 2005; Engebretson, 2011; Pope, 2005; Simmons, 2007) and also in TEAM research (Adams, 2002; Emad, 1997; Ho, 2006; Kim, 2009; Kim et al., 1980; Lieber, 2012; Sagli, 2010). This ethnographic study complimented participant observation with interviews and document analysis where possible.

Participant observation

As a research method, ethnography commits to the first-hand experience of the setting on the basis of intensive fieldwork and participant observation (Holloway & Todres, 2003). Participant observation is a strategy designed to “. . . observe people in their natural surroundings, their everyday behaviour, interactions, routines and rituals, along with the artefacts and symbols that bring meaning to their lives, while of course, conversing and listening to their narratives” (Watt & Scott-Jones, 2010, p. 109). Ethnographic observations often focus on the seemingly trivial aspects of everyday life (Walford, 2009). However, by considering both the mundane and unique aspects of participants’ lives, participant observation can begin to illuminate “. . . details and seemingly trivial aspects within experience that

may be taken for granted... with an aim of creating meaning and achieving a sense of understanding" (Wilson & Hutchinson, 1991). This study adopted these accepted tenets of participant observation in both methodology and method.

Participant observation refers to the serial process of deliberately and systematically observing participants and their environments while capturing these observations in combinations of written notes, photographs and audio recordings (Bowen, 2009; Forsey, 2010; Kusenbach, 2003; Reeves et al., 2008). Likewise, this study used written notes, photographs and audio recordings to document observations in the field. This study also adhered to the recommended strategies for conducting ethnographic note taking (Gobo, 2008, pp. 208 – 213; Palmer, 2010, pp. 148-149):

- What is observed should be immediately (appropriate timing is sometimes necessary; directly during participant observation is not always possible due to the interaction of the researcher with participants) put to paper, committed to audio recording or photographed.
- The notes should be completed once out of the field site. A write up process of filling in details with reflections is part of the data enrichment process.
- Notes should then be organised into operational notes, theoretical notes, methodological notes and emotional notes to assist data analysis.

Participant observation can provide empirical data about culture and society in action, and gives the opportunity to access experiential data and information about behaviour, conversations and perspectives that are not directly solicited (Pope, 2005; Reeves et al., 2008). Unsolicited, naturally occurring oral accounts are often relied on as important data sources in ethnographical studies (Holloway & Todres, 2003). They are "... a useful source of both direct information about the setting and of evidence about the perspectives, concerns and discursive practices of the people who produce them" (Hammersley & Atkinson, 2007, p. 99). This study considered that not only are the physical objects and actions important, but also the unsolicited thoughts and feelings of TJM acupuncture practitioners as well. These informal interviews were recorded when conducting participant observation in this study.

Writing full and detailed field note entries during ethnographic fieldwork can be culturally inappropriate and time consuming (Hammersley & Atkinson, 2007, p. 142). When transcribing written text and visual data collected as field notes, ethnographic researchers often transform the raw data with further writing to provide the detailed reconstruction necessary for ethnographic analysis (Hammersley & Atkinson, 2007, p. 150; Murchison, 2010, p. 75). Researcher reflections were added as an essential part of the data enrichment process during transcription in this study.

Interviews

Ethnography as a research methodology typically “. . . insists on the importance of coming to understand the perspectives of the people being studied. . . .” (Hammersley, 2006). One of the most established methods for understanding people’s perspectives and the meaning behind their actions, is by conducting interviews (DiCicco-Bloom & Crabtree, 2006; Dilley, 2004; Seidman, 2013, p. 7). Interviews in qualitative research can be generally classified into either unstructured or semi structured interviews (Baumbusch, 2010; Curry, Nembhard & Bradley, 2009; DiCicco-Bloom & Crabtree, 2006; Whiting, 2008). Semi structured interviews are generally (DiCicco-Bloom & Crabtree, 2006; Silva & Fraga, 2012; Whiting, 2008):

- Scheduled in advance at a designated time and location outside of everyday events.
- Organised around a set of predetermined open-ended questions and probes which can contribute to the interview.
- Capable of involving multiple participants.

Health related ethnographic studies commonly employ formal semi structured interviews and informal impromptu interviews (recorded fieldwork conversations) to complement participant observation and document analysis (Bowen, 2009; Hopkins, 2002; Malhotra, Jordan, Shortliffe, Patel, 2007; Neergaard, Olesen, Anderson & Sondergaard, 2009; Simmonds et al., 2015). This study employed formal semi structured and informal impromptu interviews to complement participant observation and document analysis. The combination of formal

focussed, and informal conversational ethnographic interviews, provided the depth and flexibility required for this research project over long term field work.

Document analysis

Document analysis is a systematic procedure for reviewing or evaluating printed or electronic material which has been recorded without researcher intervention (Bowen, 2009). It involves sourcing, selecting, reviewing and synthesising documents which members of the culture under investigation have produced (Bowen, 2009; Hammersley, 2006; Hammersley & Atkinson, 2007, p. 142; Holloway & Todres, 2003; Pope, 2005). Documents serve a range of purposes which are useful in ethnographic research (Bowen, 2009):

- Provide background information, historical insight and context.
- Suggest areas of further inquiry to be followed up in interviews or participant observation.
- Provide supplementary research data.
- Provide means of tracking change and development.

Rather than consider documents as concrete evidence about TJM acupuncture, documents used in this study were included as valuable supplementary sources of data. Documents that may be used for analysis take a variety of forms. These include:

. . . advertisements; agendas, attendance registers, and minutes of meetings; manuals; background papers; books and brochures; diaries and journals; event programs (i.e., printed outlines); letters and memoranda; maps and charts; newspapers (clippings/articles); press releases; program proposals, application forms, and summaries; radio and television program scripts; organisational or institutional reports; survey data; and various public records. (Bowen, 2009)

Patient records are also commonly analysed documents in scientific research (Brandner, Van der Haak, Hartmann, Haux & Schmucher, 2002; Eccher et al., 2006; Iliffe et al., 2002; Schulz, van Ackere, Hartung & Dunkel, 2012). The researcher collected documents which were deemed relevant to the research aims

and questions of this investigation, including patient records. These were considered important documents which could demonstrate how clinical information was organised by practitioners of TJM acupuncture.

Document analysis often involves the thematic analysis of documents by conducting an initial superficial examination of a document, followed by a thorough examination and interpretation (Bowen, 2009; Al-Hajri, 2014; Mitchell, Rubin & Macleod, 2013). When using this approach, the researcher should establish the meaning of the document and the relevance it has to the research aims (Bowen, 2009; Hammersley & Atkinson, 2007, p. 142). This is accomplished by critically reviewing each document considering the following points (Al-Hajri, 2014; Bowen, 2009; Flick, 2009, p. 296; Hammersley & Atkinson, 2007, p. 142-143):

- How are the documents written and read?
- Who writes and reads the documents?
- For what purpose and when?
- With what outcomes?
- What is recorded or omitted?
- What is taken for granted?
- What do readers need to know in order to make sense of them?

A comprehensive process of critical evaluation and thematic analysis was conducted and contributed to the data by developing understanding and insight relevant to TJM acupuncture that could not be observed or directly solicited from TJM acupuncture practitioners.

3.5.3 Data management and analysis

The management of data in this study required attention to the processes of translation, transcription, data analysis, validity and credibility, triangulation, and bracketing and reflexivity.

Translation

Data in this study was collected in both English and Japanese, and hence sometimes required translation. Translation in cross-language research can be

accomplished by researchers working with translators, or by the researcher translating between languages themselves (Temple & Young, 2004). There is a long tradition of researcher translation in ethnographic studies from the 1920's and 30's (Malinowski, 2013; Radcliffe-Brown, 2013) and in present times, ethnographic researchers still commonly translate between languages themselves (Black, 2012; Bryant, 2010; McHugh, 2011; Silva, 2011). The long term nature of this study allowed the researcher to become thoroughly familiar with the language and culture of the TJM acupuncture practitioners. This enabled the researcher to perform translation for the majority of the research project. However, there were times when translators were required.

When working with translators, researchers may decide to hire and train bilingual research assistants (Lopez, Figueroa, Connor & Maliski, 2008; Williamson et al., 2011). With the help of bilingual research assistants, the translation procedure can produce verbatim translations (lexical equivalence) in the participants' language, followed by transcription and translation into the researcher's language (Ishii-Kuntz & Maryanski, 2003; Perreira, Chapman & Stein, 2006). Alternatively, researchers may utilise bilingual interpreters as intermediaries between the researcher and participants (Neufeld, Harrison, Stewart, Hughes & Spitzer, 2002; Riessman, 2000; Temple, 2002; Williamson et al., 2011). Rather than lexical equivalence, bilingual interpreters provide equally acceptable interpretations consistent with the central meanings of researcher and participant dialogue (conceptual equivalence) (Crang & Cook, 2007, p. 24; McLellan-Lemal, 2007, p. 114; Temple & Young, 2004; Williamson et al., 2011). In order to manage the complex nature of the long term cross-language fieldwork in this study, the researcher employed both methods of translation at various stages of the research process.

Transcription

As described above, data in this study consisted of written text (field notes and documents), visual data (photographs and sketches) and audio data (digitally recorded interviews). In order for qualitative data to be reviewed in detail, coded and analysed, it must first be transcribed digitally (Bailey, 2008; Bird, 2005; McLellan, MacQueen & Neidig, 2003).

Researchers have a choice about the transcription strategy for a study. It can either be performed by the researcher themselves or outsourced to others (Bailey 2008; Halcomb & Davidson, 2006; McLellan-Lemal, 2007, p. 107; Tilley & Powick, 2002). Conducting transcription themselves allows the researcher to become comprehensively involved with the data, and is an important step in data analysis (Bailey, 2008; Mansell, Bennett, Northway, Mead & Moseley, 2004; McLellan-Lemal, 2007, p. 108). Studies entailing research across different languages commonly involve bilingual research assistants or interpreters to transcribe audio data (Lopez et al., 2008; Hyman, Guruge & Mason, 2008). All of the written and visual data in this study was transcribed by the researcher, while some of the audio data was transcribed by bilingual interpreters.

The degree of detail that is needed for the transcription of audio data varies according to the analytic purposes of a study (Bailey, 2008; Atkinson & Pugsley, 2005; Hammersley, 2006, p. 150; Murchison, 2010, p. 74). It is generally accepted that audio data from interviews should be transcribed verbatim (Halcomb & Davidson, 2006; MacLean, Meyer & Estable, 2004; Oliver, Serovich & Mason, 2005). However, in addition to spoken words, the importance of including non-verbal cues and paralanguage in a transcript is dependent on the research aims of a study (MacLean et al., 2004; Halcomb & Davidson, 2006). As this study was primarily content focussed, the non-lexical components of speech were not included in transcripts.

Data analysis

Data analysis in ethnographic research takes place throughout the project, and constantly informs data collection during subsequent participant observation, interviews and document analysis (Lotfali, 2006; Simmons, 2007; Willis & Trondman, 2000). Data analysis in this study began from the first day in the field and continued until a satisfactory level of comprehension, saturation (Small, 2009) and accounting of the phenomenon was reached.

The flexible nature of ethnographic research permits a number of analytical methods to be applied successfully to ethnographic data (Hammersley & Atkinson, 2007, p.159). Thematic analysis is one of the most widely accepted and important

qualitative analysis methods, both within and beyond ethnography (Braun & Clark, 2006; Gobo, 2008, p. 24; Mahoney, 2001; Murchison, 2010, p. 175; Scott-Jones & Watt, 2010, p. 162; Simmonds et al., 2015; Ventres et al., 2006). It is a procedure for recognising patterns that are important to the description of the phenomenon under study (Braun & Clark, 2006). The process involves the identification of recurring themes through repeated reading, where identified themes become categories of analysis (Fereday & Muir-Cochrane, 2006; Ramani & Mann, 2015). In this study, thematic analysis was selected as an appropriate method to consistently analyse data collected across participant observation, interviews and documents.

In thematic analysis, themes may be interpreted from the data inductively or developed theoretically, *a priori* (Braun & Clark, 2006; Fereday & Muir-Cochrane, 2006). Inductive interpretation is a process where data is coded without a pre-existing coding frame, whereas theoretic interpretation codes data according to a pre-developed coding template (Braun & Clark, 2006; Fereday & Muir-Cochrane, 2006). A coding template is a set of predefined rules for analysing and organising data and is required for theoretically driven thematic analysis (Brooks, McCluskey, King & Burton, 2013; Crabtree & Miller, 1999, p. 165; Fereday & Muir-Cochrane, 2006; Money, Barnett, Kuljis & Lucas, 2013). Inductive and theoretic approaches are commonly combined to address specific research aims while allowing themes to be interpreted directly from the data (Fereday & Muir-Cochrane, 2006; Hurtado & Sinha, 2008; Marbach & Griffie, 2011).

This study combined inductive and theoretical analytical approaches. A coding template which represented the themes considered to be important for this study was developed before analysis. In addition to the coding template, Braun and Clark's (2006) six stage plan guided analysis in this study (see Table 3.1). The six stages and similar variants are commonly employed by researchers using thematic analysis (Chapman et al., 2015; Drew, Duncan & Sawyer, 2010; Hawkins et al., 2009; Wilson, Gosling & Graham, 2012) and were considered appropriate for this study.

Table 3.1 Stages of Thematic Analysis (Braun & Clark, 2006)

Stage	Description of process
1) Familiarisation with data:	Transcribing, reading and re-reading data, noting down initial ideas.
2) Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3) Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4) Reviewing themes:	Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic map of the analysis.
5) Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6) Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Validity and credibility

The concept of validity in ethnographic research is often reframed to incorporate a sense of authenticity from which the trustworthiness of data can be examined and not only the “truth” of it (Ferrigno, 2007; Ho, 2006; Klien, 2011; Ramani & Mann, 2015). In ethnographic research, this is accomplished by establishing the reliability of the data collection methods, accuracy of collected data and thoroughness of subsequent analysis (Gobo, 2008, p. 266). This study was designed to adhere to ethnography in both methodology and methods so that a reliable, trustworthy and transparent research processes could be achieved. Long term and repetitive fieldwork, data source and method triangulation over different temporal cycles, data

from a variety of participants differentially located, and respondent verification are important methods for ethnographers to demonstrate the authenticity and trustworthiness of data (Gobo, 2008, pp. 261-264; Hammersley & Atkinson, 2007, p. 249; Murchison, 2010, p. 33). This study incorporated all these elements into the design of the study.

Triangulation

Triangulation in ethnography commonly includes data, environmental and method triangulation (Guion, Diehl & McDonald, 2011; Reeves et al., 2008). Data triangulation refers to a range of data sources used to examine a phenomenon (Guion et al., 2011; Reeves et al., 2008) and previous studies have commonly included combinations of doctors, teachers and students (Becker, Geer, Hughes & Strauss, 1961; Bloom, 1965; Ventres et al., 2006). Contrasting beliefs and approaches to TJM acupuncture may exist between practitioners and academics. This study included TJM acupuncture practitioners who may also have been educators or post-graduate students/researchers as separate sources of data.

Environmental triangulation involves identifying potential environmental factors which may influence data collection (Guion et al., 2011). Such influences may include research settings, locations and times, days or seasons (Gobo, 2008, pp. 261-264; Guion et al., 2011; Hammersley & Atkinson, 2007, p. 249; Murchison, 2010, p. 33). Multisite ethnographical studies offer more data validation opportunities than those which do not include environmental triangulation (Kim, 2009; Marcus, 2002; Simmonds et al., 2015). This study identified the potential that different research settings, locations and times, days or seasons may produce different data. Environmental triangulation was included as part of the research design in this study by conducting long term field work across a range of locations in Japan.

Method triangulation incorporates multiple methods of data collection (Guion et al., 2011; Reeves et al., 2008). The comparison of data from participant observation, interviews and document analysis is a common strategy to establish validity in ethnography (Gobo, 2008, p. 278; Hammersley & Atkinson, 2008, p. 250; Ho, 2006; Klien, 2011). By comparing and contrasting data collected through

multiple methods, the researcher can verify results interpreted across data sets, thus reducing the impact of potential biases (Bowen 2009; Guion et al., 2011). Method triangulation in this study was recognised as a strategy to uncover unique variance which may otherwise have been neglected by single methods. Triangulation of methods in this study was employed to capture a complete, holistic and contextual representation of the recruited TJM acupuncture practitioners. Method triangulation also contributed to the design of the project in ways as reported by Goldstein and Reiboldt (2004, p. 246): “interview data helped focus specific participant observation activities, document analysis helped generate new interview questions, and participant observation . . . provided opportunities to collect documents.”

Bracketing and reflexivity

Ethnographic research often acknowledges researcher bias and the steps taken to mitigate it through bracketing (Ganiel & Mitchell, 2006; Gearing, 2004; Kusenbach, 2003; Rolls & Relf, 2006). Bracketing refers to the suspension of researcher presumptions so that an accurate and unclouded interpretation of data can be attempted (Gearing, 2004).

Researchers can use a range of bracketing approaches including ideal, descriptive, existential, analytic, reflexive and pragmatic (Gearing, 2004). The position of the researcher in this study warranted a method which accounted for biases throughout the course of long term ethnographical fieldwork. This can be achieved by analytical bracketing. This is a method used to:

... concentrate on the what's and how's of social life of the phenomenon by examining the tensions between reality and representation. Suppositions are recognized as part of reality and can become incorporated in the investigation of the phenomenon. This form of bracketing is more advantageous to ethnographic and grounded theory methods that allow for a more iterative approach. . . (Gearing, 2004)

Analytical bracketing is commonly used in studies examining aspects of everyday life of a phenomenon (Åkerström, 2006; Gearing, 2004; Holstein & Gubrium, 2011, p. 347). It is a process employed throughout analysis where the researcher

intermittently orients bracketing parenthesis to hold certain biases in abeyance (Holstein & Gubrium, 2011, p. 347). Analytic bracketing was used to continually bracket and unbracket biases in order to reintegrate data into the larger research agenda, while allowing for a gradual unbiased understanding of TJM acupuncture to develop.

The researcher as a detached observer is often an unrealistic stance in long term ethnographic studies:

In order to learn about the complex dimensions of society and culture in action, the ethnographer almost necessarily has to become involved on a personal level to one degree or another. Some ethnographers have found that their most important insights have emerged when they have chosen or circumstances have forced them to abandon their practiced, objective stances. (Murchison, 2010, p. 85)

Bias can be incorporated into ethnographic research when it is honestly assessed by the researcher in reflexive writing (Amira de la Garza, 2013, p. 166; DeWalt & DeWalt, 2011, p. 123; Gobo, 2008, p.264; Hammersley & Atkinson, 2007, p. 104; Scott-Jones, 2010, p. 26). Reflexivity refers to the relationship the researcher shares with the environment under investigation and is presented to the reader in the form of thick (detailed) descriptions and researcher reflections which can be used to judge the impact of bias on a study (Reeves et al., 2008). When writing reflexively in ethnographic studies, the researcher places constant awareness on their own experience and discloses the ways which their position and experience relate to the data and analysis (Gearing, 2004; Holloway & Todres, 2003; Kusenbach, 2003; Laverty, 2003; Reeves et al., 2008; Walford, 2009). Therefore reflexive writing was used to contribute to the bracketing strategy in this study.

3.5.4 Researcher roles

The researcher's role in ethnography can be described according to the typologies of complete observer, the observer-as-participant, the participant-as-observer, or the complete participant (Hammersley & Atkinson, 2007, p. 118; Pope, 2005; Watt & Scott-Jones, 2010, p. 111). Researcher participation may also be described as: complete, active, moderate, passive and non-participant (Gobo, 2008, p. 123).

In TEAM settings, the role of the researcher may take on the role of an apprentice (Ho, 2006). The apprentice is a common and natural role found in TJM acupuncture clinics (Ikeda, 2011; Murata, 2011; Vigouroux, 2011; Yates, 2011) and was selected as an appropriate role in this study. The researcher as apprentice role can be seen as one of peripheral membership, where observations and interactions with participants are maintained under an outsider's identity (DeWalt & DeWalt, 2011, p. 26; Watt & Scott-Jones, 2010, p. 112). However, during long term field work, it is common for ethnographers to change roles and levels of participation as relationships with participants change (Gobo, 2008, p. 107; Hammersley & Atkinson, 2007, p. 122; Pope, 2005; Watt & Scott-Jones, 2010, p. 110). The researcher adapted roles when necessary to maintain culturally appropriate relationships with TJM acupuncture practitioners.

3.6 Research Design

This study was founded on the principal motivation of understanding different acupuncture practices, with a focus on TJM acupuncture. Improved knowledge of cultural influences and specific methods will inform future research and educational curricula relating to TJM acupuncture, and promote the most effective acupuncture treatments. Based on this motivation, the design of the study began with the development of research aims and questions. Each step of the design process was informed by prior steps. This created a cohesive design consistent with the research aims and methodology. The research design process is presented in Figure 3.2.

The research aim of the study was:

To examine the ideas, experiences, and practices of TJM acupuncture practitioners in Japan to understand TJM acupuncture through philosophical concepts, diagnostic methods and treatment principles.

Achieving this aim involved answering the following research questions:

- 1) How do practitioners of TJM acupuncture describe or exhibit the philosophical concepts, diagnostic methods and treatment principles of their acupuncture practice and TJM acupuncture in Japan in general?
- 2) How do clinic procedures, environment and clinic artefacts reflect the philosophical concepts, diagnostic methods and treatment principles of TJM acupuncture?
- 3) How do the patient records, clinic documents and other locally sourced literature reflect the philosophical concepts, diagnostic methods and treatment principles of TJM acupuncture?
- 4) What, if anything, makes TJM acupuncture identifiable as a distinct style of acupuncture?

In regards to research question 4, the criteria for being a distinct style of acupuncture included that TJM acupuncture exhibit recognisably different emphases of certain philosophical concepts, diagnostic methods and treatment principles to other acupuncture styles.

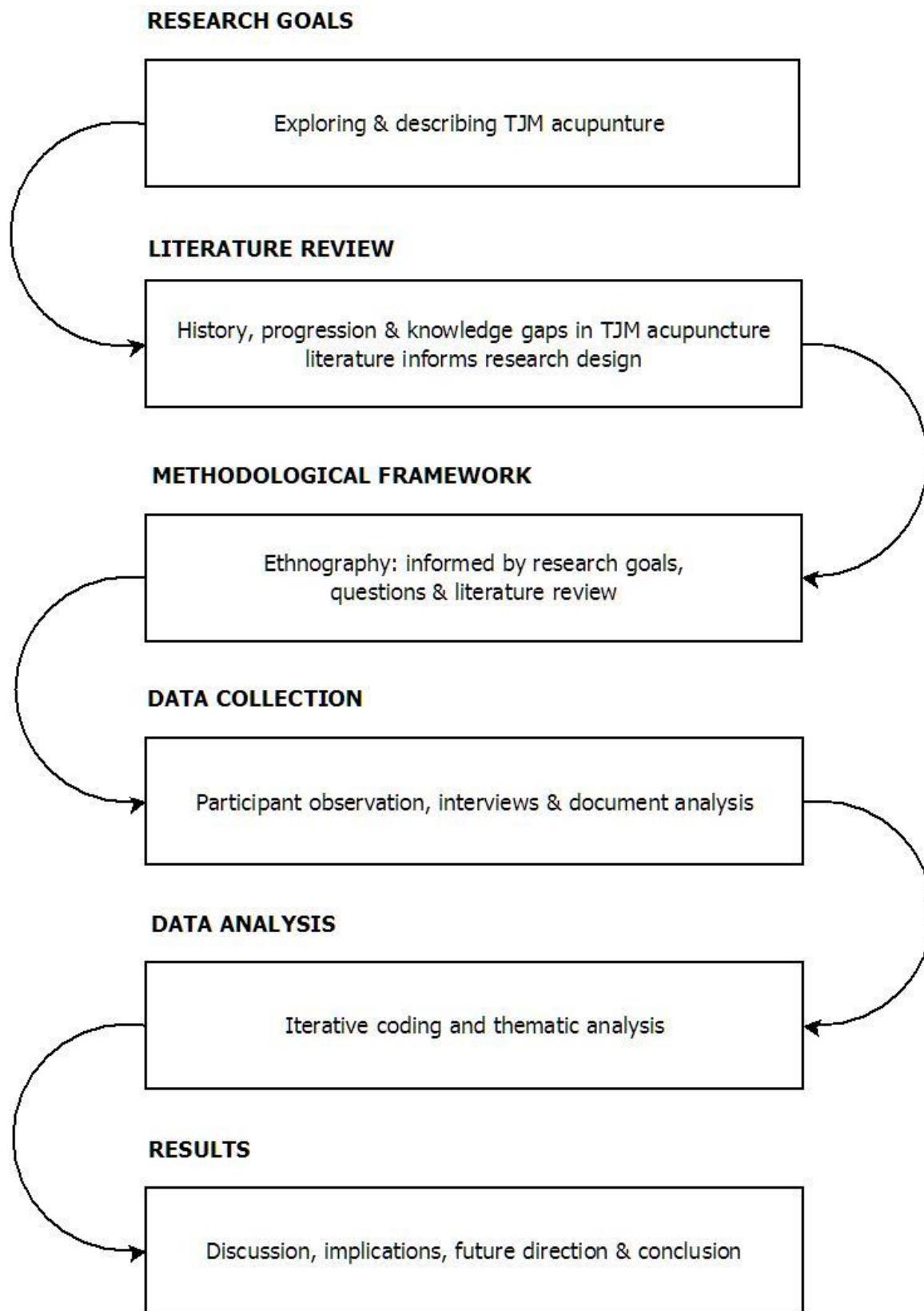


Figure 3.2 Research design flowchart

The research aims and questions were informed by the personal experience of the researcher and the conclusions drawn from the literature review. The literature review tracked the progress of TEAM acupuncture through East Asian history and revealed differences in the approach to TEAM acupuncture across China, Korea and Japan. It also exposed ambiguity in the academic discussion of TJM acupuncture, and validated the necessity of investigation into TJM acupuncture. The literature review established that in order to understand TJM acupuncture, it would be essential to directly observe processes in TJM acupuncture clinics and explore the ideas and practices of Japanese trained TJM acupuncture experts.

The conclusions drawn from the literature review in combination with the research aims and questions resulted in the selection of a research methodology. This was determined on the explorative and descriptive purposes of the study, coupled with the need to base an investigation from where TJM acupuncture experts could be observed and interviewed in their natural setting. Ethnography qualified as the most appropriate methodology for conducting research in a foreign setting.

Ethnography is exemplified by the data collection methods of participant observation, interviews and document analysis. As this study embraced the fundamental beliefs of ethnography in both methodology and methods, participant observation, interviews and document analysis were included as essential data collection methods. The long term and iterative nature of ethnography requires a continually evolving and flexible approach to analysis, and it was decided that the data should be coded and analysed thematically according to the research aims throughout the investigation.

In adherence to ethnographic principles and values, the results of data analysis were designed to be represented by thick descriptions of the beliefs, actions and practices of TJM acupuncture experts. The conclusions drawn from the results were designed to contribute to, and improve the academic understanding of TJM acupuncture and guide future educational, clinical and research initiatives.

3.7 Methods

Although the methods of recruitment, data collection and analysis are presented here sequentially for cohesive reading, it should be understood that they were closely intertwined processes with continual cyclical integration, overlaps and interaction throughout the research period.

3.7.1 Development of guidelines and questionnaires

The observation guidelines and interview questionnaire were developed by the researcher. These guides were informed by the researcher's clinical and academic experience, the literature review and the principles of ethnography.

Participant observation guidelines

Based on the position of the researcher as an observer in Australian acupuncture clinics, a student, TEAM practitioner and business owner, an *a priori* list of themes to guide observation was developed. The observation guidelines (see Appendix A, Table A1) directed the researcher to several key areas of investigation including: the clinic environment and its surroundings, clinic rituals, treatments and practitioner/patient interactions. Observation was guided by, but not limited to the guidelines which were adapted during the study to account for developments in understanding.

Interview questionnaire

Based on researcher experience, the literature review and ethnographic methodology, a semi structured interview schedule was developed (see Appendix A, Table A2). The interviews were aimed to act as a primary source of first-hand accounts of the social, clinical and educational environment of TJM acupuncture. Interviews intended to provide insight into TJM acupuncture practitioners' actions, perspectives and attitudes to TJM acupuncture.

The schedule included general questions regarding TJM acupuncture practitioners' personal and clinic details. It also provided probing suggestions to assist in developing responses. The semi structured interview was guided by, but

not limited to, the interview schedule, which was adapted during the course of investigation to account for developments in understanding. Appendix A, Table A3 shows some additional important interview questions developed during the study.

3.7.2 Ethical implications

The research project was approved by the University of New England Research Ethics Committee (approval number: HE-12-142). All information sheets and consent forms were translated into Japanese. Copies of the information sheets and consent form are attached in Appendix B. Ethics approval was given to the observation guidelines, interview schedule and to conduct document analysis. Prior to any data collection, the TJM acupuncture practitioners were given or sent an information sheet and consent form, which when signed and returned, indicated their informed consent to participate in the study.

TJM acupuncture practitioners were asked to contribute to the study in several ways. Permission for the researcher to enter the workplace and observe treatments was requested. Practitioners were also asked to participate in an interview which was recorded by an audio device and to provide access to clinical case notes from consenting patients. After concluding the observation or interview, practitioners were asked for their permission to be available for follow up interviews and observations. No treatments with patients under the age of 18 were observed. All names, including those of education institutions and other organisations, have been replaced with pseudonyms.

3.7.3 Setting and recruitment

Before the commencement of fieldwork in Japan, a gatekeeper was used to establish contact with potential participants (TJM acupuncture practitioners). TJM acupuncture practitioners were included in the study based on their training and current clinical practice:

- TJM acupuncture practitioners must have conducted their acupuncture training in Japan and be a practicing clinician or educator in Japan.
- Expatriates living in Japan who did their acupuncture training in Japan were included.

- Both men and women above 18 were acceptable for the study.
- TJM acupuncture practitioners may have been practicing or teaching in any area of Japan and could be working out of any location such as from home, dedicated health clinics, hospitals, aged care facilities or educational institutions.
- TJM acupuncture practitioners with no formal qualifications but who were practicing acupuncture were included if they were trained in Japan.
- Those who conducted their training outside of Japan and had immigrated or were working for a short period of time in Japan were excluded from the study.
- Practitioners affiliated with any sub-styles of TJM acupuncture were included.

In the field, additional TJM acupuncture practitioners were recruited by chain referral and emergent sampling methods. Chain referral sampling involved the recruited TJM acupuncture practitioners inviting their associates into the study. Information sheets, informed consent forms and researcher contact details were made available to TJM acupuncture practitioners. They were asked to distribute these among their professional network with instructions to contact the researcher directly to indicate their willingness to participate. Emergent sampling was conducted by making personal contact with practitioners and educators from private enterprises and educational institutions in geographically convenient areas. Geographically convenient areas were places within close proximity to the researcher's local area or locations which were immediately accessible by the researcher.

3.7.4 Data collection

Data was collected from August 2012 to December 2016 according to the principles of ethnographic fieldwork. Collection involved participant observation, interviews and document analysis. TJM acupuncture practitioners who could potentially be recruited, were contacted to arrange meeting times and locations. During initial meetings, the terms of involvement were discussed. The negotiation of involvement was conducted continually on a case by case basis with each TJM acupuncture practitioner. Negotiations included which data collection methods TJM acupuncture

practitioners would be involved in. All data collection methods were used when appropriate. However, there were instances where only a single method could be employed.

Participant observation

Throughout the entirety of this study, the majority of the data collected by participant observation was recorded by the researcher alone. When translators or interpreters were used, their observation notes were also collected for analysis. Although a variety of methods were used to record data during participant observation including photographs and audio recordings, note taking was the most extensively implemented as it was unobtrusive and appropriate for the clinical and educational setting in Japan.

Participant observation involved the researcher shadowing the TJM acupuncture practitioner, watching what they were doing, asking questions when appropriate and recording what was seen, heard, or thought about the particular situation. Recordings in participant observation were informed by the observation guidelines which were revised in an iterative process concurrently with data analysis.

Interviews

All formal interviews were digitally recorded and complemented by the researcher's written notes. Informal interviews were recorded by written notes. Both formal and informal interviews were conducted by the same interviewer according to the interview schedule. In general, the same schedule was used for every TJM acupuncture practitioner. However, each interview was different depending on the narrative solicited from the interviewee or the fieldwork situation (especially for informal interviews). As with the observation guidelines, the interview schedule was revised in an iterative process concurrently with data analysis.

Document analysis

Relevant documents including patient records were acquired, photocopied, photographed, or summarised in field notes so that they could be subjected to

analysis. The observation guidelines and interviews were informed by any additional information gained through analysing collected documents.

3.7.5 Data analysis

Analysis was conducted after every data collection opportunity and involved a combination of processes including translation, transcription, thematic analysis and validation. Analysis began with the translation, transcription and reading of the data. Study of the recorded data, combined with complete immersion in the Japanese cultural environment from August 2012 until July 2017, facilitated a thorough familiarisation with the depth and breadth of the material obtained in the field. Collected data was read and transcribed interpretively, with a constant focus on investigating any patterns, meanings, links or gaps in the material.

Translation and transcription

Data from fieldwork was collected and recorded in both Japanese and English. Cross language communication was facilitated either by the researcher, bilingual interpreters or research assistants working with the researcher.

When the researcher did not perform translation or transcription, Japanese language from participant observations, interviews or document analysis was translated or transcribed by bilingual research assistants or interpreters. Bilingual research assistants were trained to translate documents required for the study. Such documents included information sheets, consent forms and letters of introduction. They were also trained and employed to transcribe audio recordings of interviews conducted in Japanese.

Bilingual interpreters were sometimes used to translate communication contemporaneously between the researcher and TJM acupuncture practitioners during participant observation and interviews. They were also used to translate digitally recorded or transcribed interviews. Due to the long term nature of this study, different bilingual interpreters were employed at different stages of the fieldwork. All interpreters were thoroughly prepared for translation and transcription. Their training included discussions about ethnographic research methods, the aims and background of this study, the conduct and structure of ethnographic

observation and interviews, ethical procedures and translation/transcription expectations of the study. When bilingual interpreters were used, they always worked with the researcher, acting as an intermediary between the TJM acupuncture practitioners and researcher.

English language data was transcribed by the researcher into word processing software as soon as possible following data collection. Thick descriptions of events, as well as researcher reflections on the content and context of collected data, were added to the transcribed recordings. The transcription of field notes from participant observation involved the inclusion and description of sketches, diagrams, audio notes and photos. Transcription also included copying and expanding handwritten field notes into word processing software, while organising the data into analytical categories.

A strategic decision about the kind of data to be collected and the degree of detail to be preserved in transcription was informed by the nature of the research aims for this study. This meant that the interview transcripts needed to be primarily content focussed: an analytical tool to record evidence of TJM acupuncture practitioners' perspectives and experiences. All interviews were transcribed in full to ensure all elements of the conversations could be analysed. Interview transcripts included questions and answers from the interviewer, interviewee and any other parties who were present at the interview. The forum of the talk was relatively unimportant in the interview, and paralanguage was not included in the transcripts. Any relevant information relating to the context, setting and nature of the interview was captured by observational notes which were transcribed at the same time as the interview.

Thematic analysis

Theoretic and inductive thematic analysis was used to critically evaluate data. All coding was conducted by the researcher alone, without the assistance of analytical software.

In order to perform theoretic thematic analysis, a coding template informed by the research aims of this study and the literature review was developed. The coding template provided a guide for assessing elements of data and assigning

data to the key categories of philosophical concepts, diagnostic methods and treatment principles. It was continually appraised to remain appropriate to the data throughout analysis. The original coding template is shown in Table 3.2.

All collected data was transcribed, translated and read repeatedly. Initially suspected patterns and any similarities or differences in the data were summarised in analytical notes. These summaries represented the initial processing and interpretation of themes from the data.

Table 3.2 Coding Template for Thematic Analysis

Code label	Description	Examples
Philosophical concepts	Elements which relate to the branch of TEAM acupuncture concerned with the basic concepts, theories, rules and principles.	Yin/Yang, five phases, channels & collaterals
Diagnostic methods	Elements which inform the procedure and practice of collecting data to determine the condition of the patient.	Pulse palpation, clinical interview, tongue inspection
Treatment principles	Elements which describe the general rule that should be followed in treatment of the patient's condition, which may include treatment interventions that use a needle or needle-like tool and moxibustion to stimulate the body.	Acupuncture needles of varying sizes, moxa

The coding template was applied to the data with the purpose of identifying meaningful units of information. Data was allocated to themes according to the definitions in the coding template, and by considering the relationship between different elements of data and how these related to the research aims.

Analysis was guided by, but not confined to the themes originally developed for the coding template; additional themes were added as they were found during analysis. These additional themes were different to, or expanded, themes from the template. Additional themes were identified as they emerged through reappearing

stories, phrases, ideas, actions and objects, and when they represented some level of patterned response or meaning significant to the research aims.

Once lists of themes were devised, data extracts for each theme were evaluated to see if they formed coherent patterns. When there were inconsistencies, the theme and data were scrutinised for integrity and the data extracts were reassessed to ensure they were representative of the themes.

The themes from the data were described in detail and exemplified with anecdotes, stories, and descriptions from observations, interviews and documents. Once key themes and symbols of the themes were identified, they were interpreted and organised into an explanatory framework consistent with the data.

Validity and credibility

True to the ethnographic methodology, the concept of validity in this study was reframed to represent a sense of authenticity from which the trustworthiness of data can be examined. Analysis was conducted iteratively over an extensive period which allowed any inconsistencies in the data to be examined. It also incorporated participant validation. TJM acupuncture practitioners in the study were called on to verify and clarify researcher recorded data at various stages of the research period.

Analytic bracketing was used to address bias in this study. The temporal structure of the bracketing strategy in this study was designed to evolve in the field and become more clearly defined as the study developed. This was based on the understanding that internal researcher conditions such as suppositions of personal knowledge, history, culture, experiences, values, and professional orientation would become more ostensive as a greater understanding of TJM acupuncture was gained. As contrasts between the phenomenon and researcher bias became apparent, the bracketing parenthesis moved and evolved.

The analysis involved recognising how different data from multiple collection methods, data sources and environments supported or opposed each other. Triangulation was used as a method to compare, contrast, corroborate or contradict this variety of data.

3.8 Limitations

Ethnography as a method and methodology contains inherent philosophical assumptions and limitations which are common to qualitative investigations in general. These limitations have been discussed extensively in other academic literature (Goodson & Vassar, 2011; Hammersley, 2006; Lillis, 2008; Reeves et al., 2008). This study was primarily conducted through observations and interviews with a limited number of practitioners by a single researcher. As a direct consequence of this methodology, the study encountered a number of limitations, which need to be considered.

That this study relied on the available practitioners who were able to be recruited into the study warrants limited generalisation. Many factors influenced who was able to be recruited into the study and how they could contribute. Under different circumstances, a completely different sample may have been obtained and different combinations of contributions negotiated. The personal lives of the potentially recruited practitioners at the particular time of invitations into the study, the ability of the researcher to establish and maintain relationships with certain practitioners and not others, and the luck of who was the initial contact at a potential field site all contributed to the collection of a very unique group of recruited practitioners. The extensive time involved in participant observations and conducting in-depth interviews limited the sample size in this study.

The consequence of Osaka as the primary research site, as well as the length of time spent in the field, resources available to perform fieldwork and visit off-site locations, as well as who the patients were and with what conditions they presented, are factors to consider when contextualising this project in relation to TJM acupuncture at large and the future of research into TJM acupuncture in Japan.

Data collection generally involved the triangulation of three methods: participant observation, interviews, and document analysis. However, there were instances where data collection relied entirely on a single method. The probability that the single method produced a valid account of the actions, experiences, values and beliefs of a participant is unlikely. Therefore, these single instances were

triangulated across the entirety of the data to add to the depth of interpretation. The analysis of data collected in this study may vary between different researchers. The entire research project is subject to the processes and interpretations developed by the individual researcher. Reflexive accounts of the processes involved in this study have been included to provide transparency of the methods.

The circumstances under which fieldwork was performed are unique to this study. However, all the choices made in relation to recruiting practitioners were done so based on valid reasons, and the availability for field sites and practitioners to provide the greatest opportunity to learn about TJM acupuncture. The limited number of practitioners and deep exploration of their personal and professional stories provided focus for this project. It was also the ability to spend time with practitioners which strengthened the empirical results relating to individuals.

3.9 Chapter Summary

The aim of this study was to understand the philosophical concepts, diagnostic methods and treatment principles of TJM acupuncture. This research was grounded in ethnographic values with a desire to describe and explore TJM acupuncture through sustained immersion in the environment in which it is historically, socially and culturally bound.

This chapter begins by outlining the research aims and questions. Focus then moves to explaining the position of the researcher, which is followed by an explanation of the research paradigm. This section describes and justifies the inclusion of the key analytical categories of philosophical concepts, diagnostic methods and treatment principles as a descriptive model in this study. The methodological framework addresses ethnography as the guiding orientation for this research, and the methodological issues relating to the key decisions made in strategising for the research process are explained.

While ethnography has a pedigree in social anthropology, it also has a long and sustained history in medicine and health care. This chapter discusses the appropriateness of the ethnographic approach in describing and exploring TJM acupuncture practice in contemporary Japan. It is shown that the ethnographic

approach accords with the aims and questions of this study, and the appropriateness of the methods employed in this research are justified.

The next chapter outlines the research outcomes relating to the research setting, sampling and recruited practitioners. Fieldwork locations across Japan are identified and the clinical settings in those locations are described. How many, and by what means practitioners were recruited is detailed. In addition, what geographical locations and clinical settings practitioners were sourced from is explained, and specifics about their personal and professional lives are provided.

Fieldwork Diary: “Say hello”

“Good morning! Come in, here are your slippers. Did you bring your white coat?”

The Sensei and I met for the first time. I said hello and nodded.

“OK, here you are. Please get changed.” Tsuru sensei directed me to a small laundry/bathroom and disappeared back into the treatment room through a sliding paper screen door. I quickly pulled out my white coat – it looked a little scruffy after being stuffed into my bag for the 90 minute train ride here.

After getting changed, I took a seat in the reception room with my pen and notebook. A muted TV was showing baseball highlights from the night before, and a J-pop CD played in the background. The clinic smelt like moxa and incense, which was slightly comforting; a familiar smell in an unfamiliar place. It was hot outside at 30 degrees and the air conditioner only set to an economical 27, which is kind of normal in Japan. It was late August, mid-summer and terribly humid. Sweat trickled down my back while I waited for the Sensei to call me into the treatment space.

Today was not only the first time for me to meet Tsuru sensei, but also the first time to meet any practitioner who participated in the study. Now that I was finally here in Japan, I started to feel very uncertain and stared at my notebook suspiciously. . . “Benjamin san,” called out Tsuru sensei as she whipped open the curtain over the counter separating the reception and treatment rooms, “Please come in.”

There were three beds in the treatment room, all with patients, smoke rising from the smouldering stick-on moxa stuck to their legs. Separated only by curtains, Sensei chatted to them, and they spoke without reservation about their problems, without mind that everybody else could hear. I was instantly in the way and tried to find a corner where I could see what was going on while not being an obstacle, which wasn’t easy in such a small space. Opening up to the first blank page in my notebook, I pulled out my pen and started to write – three beds, separated by curtains...

Ding Dong! The door chime rang as the next patient arrived. “Say hello” Sensei instructed me, “Maybe they will be surprised.” I hesitated, opened the sliding paper

screen door and offered my good morning welcome in Japanese: “Ohayou gozaimasu.”

The elderly lady who had just arrived looked up at me slightly confused; I imagine that the last thing she was expecting when she turned up for treatment was to be greeted by a blonde haired, pale skinned foreigner in a crinkled white lab coat. I slid the door closed and turned back to Tsuru sensei who had a mischievous grin on her face.

Chapter 4: Setting and Practitioners

I just hope you will not return home with the impression that your trip to Japan was a waste of time and money. . . Apart from the fact that the vast majority of current politicians and business owners are apparently a bunch of blind jerks that are about to drive Japan into the ruin. . . the culture that has flourished here for a significantly longer period than the entire length of American history has a lot to offer. Unfortunately, the Japanese themselves are not very eager to share this spiritual / intellectual heritage with "outsiders" = you . . . and everybody (who is not Japanese). (Koremitsu: acupuncture practitioner)

This chapter introduces the research setting, sampling and details about the practitioners themselves. The location of the study in Japan and any changes over the research period is explained. Location not only refers to the geographic setting, but also includes the social setting; both the physical and cultural environment where Traditional Japanese Medicine (TJM) acupuncture happens. Although the majority of fieldwork was conducted in the *Kansai* area in Japan, a variety of geographical locations across the country were visited.

Details on practitioner recruitment are discussed, including the triangulation of chain referral and emergent sampling. The contributions of practitioners are also outlined. Finally, demographic information and facts relating to the practitioners' education and professional experience is provided, and how this and other aspects of practitioners' background contributed to interpretation of the data is explained.

4.1 Research Setting

Japan includes 6852 islands divided into 47 prefectures with a population estimated just under 127 million people. The *Kansai* area is the second most populated area in Japan and includes the main urban regions of Osaka, Kobe and Kyoto. The research project was based in *Kansai*, specifically in Yodogawa ward, Osaka city, Osaka prefecture, as shown in Figure 4.1. Data collection began in August 2012 and concluded in December 2016. Data analysis and write-up continued in Japan to July 2017. Although the base of operations for the study was in Osaka, fieldwork

was conducted at, and practitioners (n=38) recruited from, a diversity of prefectures (n=7) in Japan (Figure 4.2).

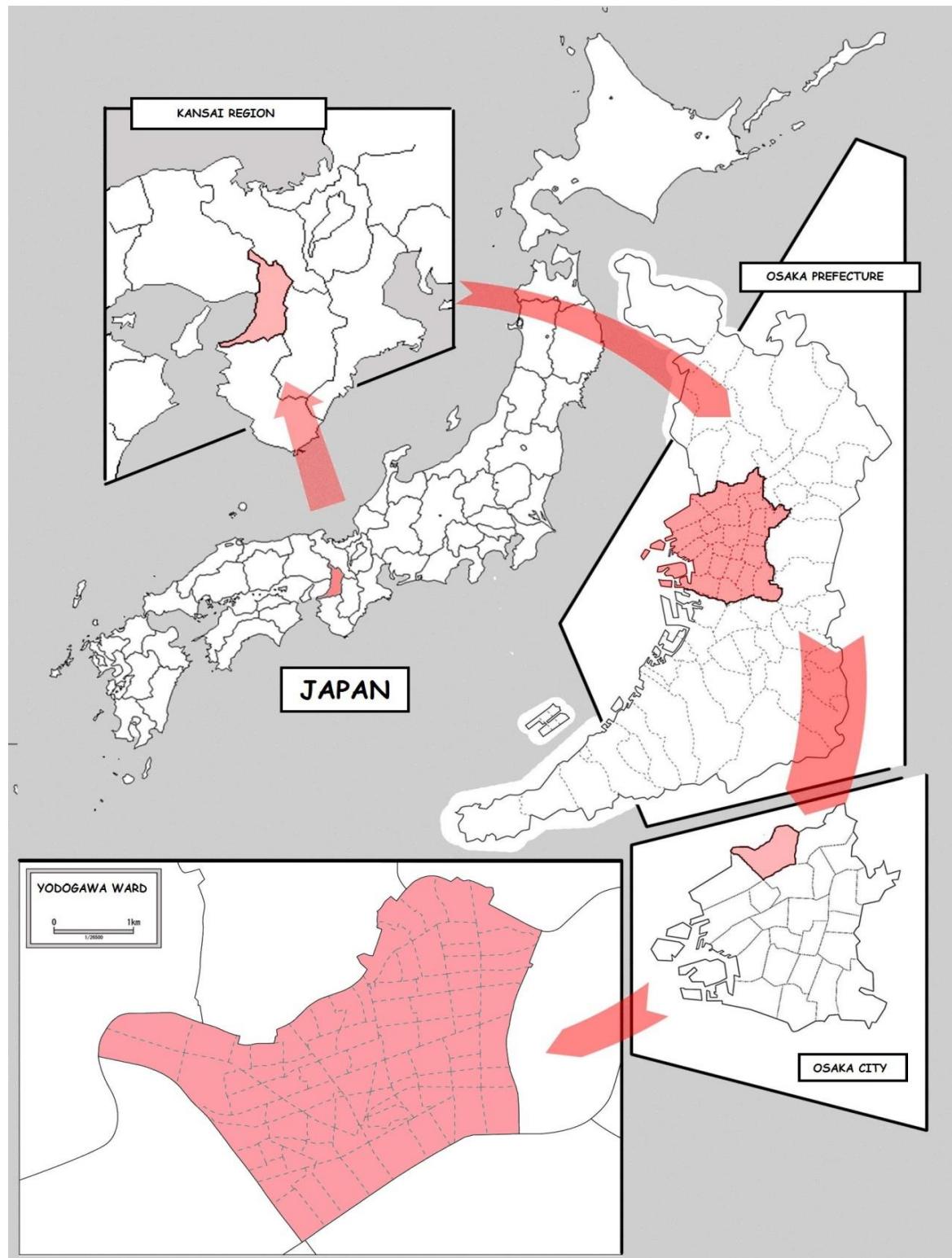


Figure 4.1 Base of operations

This map 'zooms in' to the base of operations located at Yodogawa ward. Red highlights indicate the next section of zoom shown by an arrow connecting the panels.

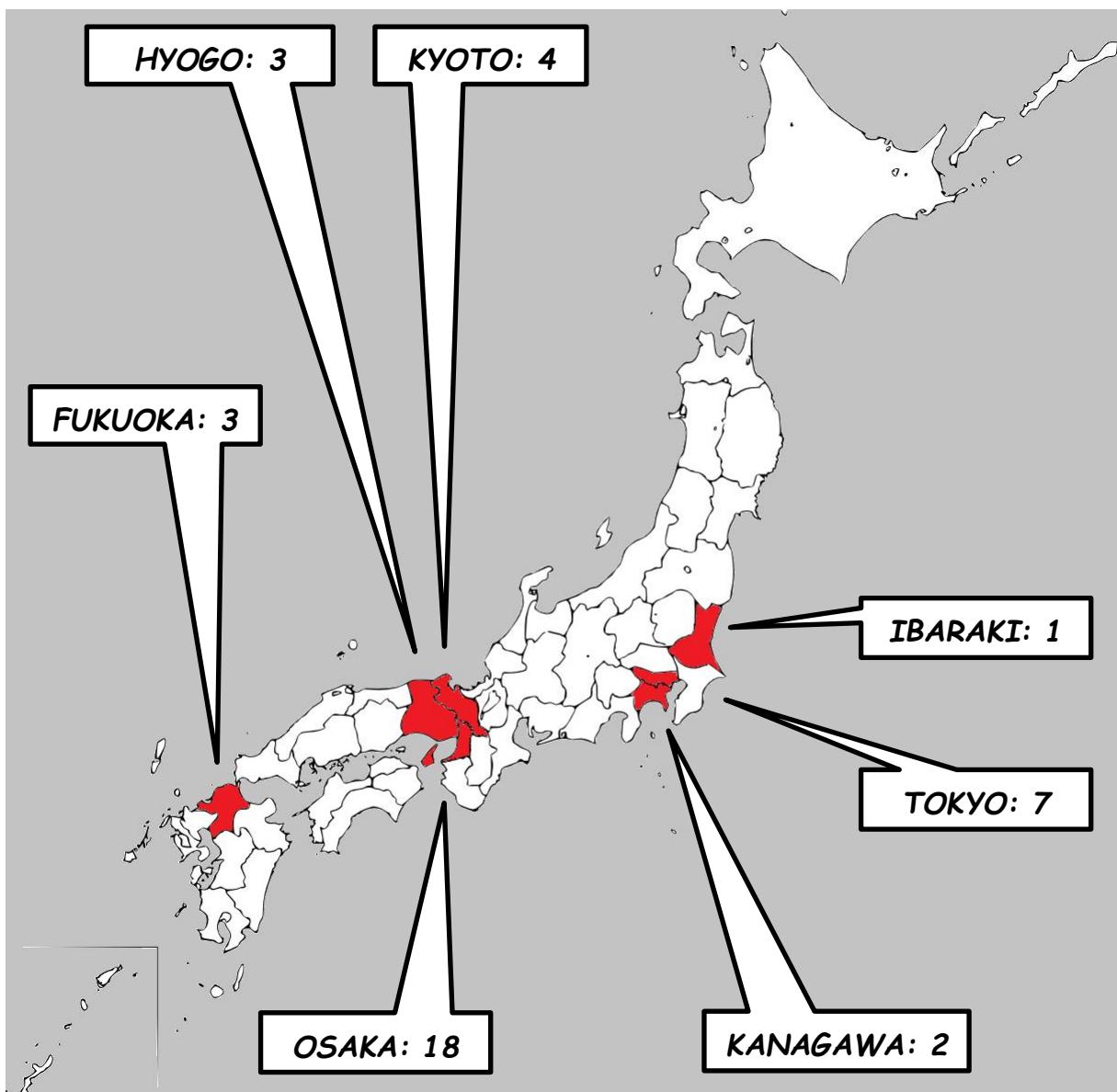


Figure 4.2 Prefectures and recruited practitioners

In addition to conducting fieldwork at a variety of geographical locations across the country, a range of different clinic sites were visited during the research period ($n=19$). These included clinics at educational institutions ($n=6$), multi-modality clinics which included reception staff or practitioners qualified in different allied health disciplines ($n=6$), sole trader clinics ($n=4$) and multi-staffed clinics which included reception staff or practitioners with acupuncture/moxibustion only qualifications ($n=3$). Figure 4.3 shows the number and type of clinic sites visited.

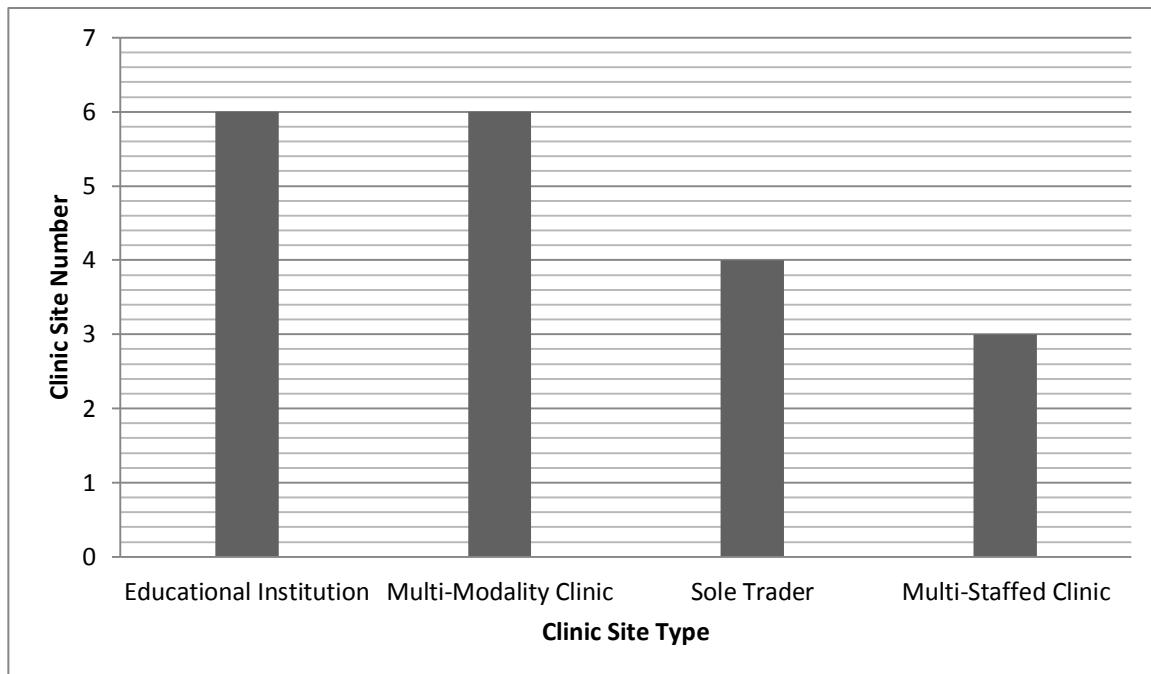


Figure 4.3 Number and type of clinic sites visited

4.2 Recruitment and Sampling

More recently it's been harder for me to organise foreigners to observe at clinics here. Some of them have caused a kind of trouble, not because they are bad people, but because they don't understand the sensitivities of the Japanese and have offended the teacher in some way. I sometimes worry about the foreigners I introduce to my colleagues, they may inadvertently ruin things for everyone. (Koremitsu: acupuncture practitioner)

By extensive personal communication seven practitioners initially agreed to participate in the study. Over time, these practitioners contributed to the recruitment of additional practitioners through chain referral sampling which resulted in the recruitment of more practitioners. By combining chain referral and emergent sampling, 38 practitioners were recruited into the study.

Table 4.1 shows demographic data about practitioners at the time of recruitment, including their pseudonym, gender, age, qualifications, years of professional experience, prefectoral location and their occupation. The study included (n=24) males and (n=14) females with an age range of young adults (≤ 35) to seniors (≤ 60). Where it was not possible to gain information about age due to

cultural reasons, age was established according to age groups; practitioners were described based on appearing either middle aged or as a young adult. Practitioners ranged from having little professional clinical experience through to over 20 years of practice. Practitioners had a range of occupations including clinician, teacher and researcher. Being a researcher involved conducting post graduate research at a university.

Table 4.1 Practitioner Demographic Information

Practitioner Pseudonym	Gender	Age	Qualifications	Years of Professional Experience	Prefecture	Occupation
Tsuru	Female	Middle Aged	Acupuncture Moxibustion	15	Hyogo	Clinician
Ginnosuke	Male	36	Acupuncture Moxibustion	4	Hyogo	Clinician
Asajiro	Male	Middle Aged	Acupuncture Moxibustion	9	Osaka	Clinician
Takizou	Male	36	Acupuncture Moxibustion	14	Fukuoka	Clinician
Bunzaemon	Male	39	Acupuncture Moxibustion Judo Therapy	18	Fukuoka	Clinician
Ume	Female	35	Acupuncture Moxibustion Massage	3	Osaka	Clinician
Zenkichi	Male	67	Acupuncture Moxibustion Chiropractic	Not Available	Kanagawa	Clinician
Koremitsu	Male	Middle Aged	Acupuncture Moxibustion	Not Available	Kanagawa	Clinician
Genrokuro	Male	36	Acupuncture Moxibustion Judo Therapy	Not Available	Osaka	Clinician

Practitioner Pseudonym	Gender	Age	Qualifications	Years of Professional Experience	Prefecture	Occupation
Kojiro	Male	45	Acupuncture Moxibustion Massage	13	Osaka	Clinician
Iwamatsu	Male	48	Acupuncture Moxibustion Massage	Not Available	Kyoto	Teacher
Kame	Female	35	Acupuncture Moxibustion	14	Osaka	Clinician
Shinokichi	Male	46	Acupuncture Moxibustion Massage Judo Therapy	22	Osaka	Clinician Teacher
Tarobi	Male	Middle Aged	Acupuncture Moxibustion	26	Tokyo	Clinician Teacher
Denkuro	Male	36	Acupuncture Moxibustion	Not Available	Fukuoka	Clinician
Bunshichi	Male	Middle Aged	Acupuncture Moxibustion Massage	Not Available	Ibaraki	Teacher
Kiemon	Male	72	Acupuncture Moxibustion	40	Hyogo	Clinician
Toko	Female	40	Acupuncture Moxibustion	2	Tokyo	Clinician
Yae	Female	Middle Aged	Acupuncture Moxibustion	Not Available	Tokyo	Clinician

Practitioner Pseudonym	Gender	Age	Qualifications	Years of Professional Experience	Prefecture	Occupation
Benio	Male	Middle Aged	Acupuncture Moxibustion Judo Therapy	Not Available	Osaka	Clinician Teacher
Sayo	Female	Middle Aged	Acupuncture Moxibustion	20	Osaka	Teacher
Rin	Female	41	Acupuncture Moxibustion	1	Osaka	Researcher
Zenpachi	Male	Middle Aged	Acupuncture Moxibustion	27	Osaka	Teacher
Miyo	Female	Middle Aged	Acupuncture Moxibustion	Not Available	Osaka	Teacher
Nobuhide	Male	Young Adult	Acupuncture Moxibustion	1	Osaka	Researcher
Chusuke	Male	38	Acupuncture Moxibustion	Not Available	Osaka	Teacher
Sasuke	Male	52	Acupuncture Moxibustion	29	Osaka	Teacher
Heijiro	Male	40	Acupuncture Moxibustion Chiropractic	Not Available	Osaka	Teacher
Kinu	Female	40	Acupuncture Moxibustion	Not Available	Osaka	Teacher Researcher
Otoemon	Male	28	Acupuncture Moxibustion	1	Kyoto	Researcher

Practitioner Pseudonym	Gender	Age	Qualifications	Years of Professional Experience	Prefecture	Occupation
Sukegoro	Male	48	Acupuncture Moxibustion	Not Available	Kyoto	Teacher
Hikoemon	Male	31	Acupuncture Moxibustion	1	Kyoto	Researcher
Heisuke	Male	57	Acupuncture Moxibustion	Not Available	Osaka	Clinician
Mitsu	Female	Young Adult	Acupuncture Moxibustion	1	Osaka	Clinician
Kiyo	Female	Middle Aged	Acupuncture Moxibustion	2	Tokyo	Clinician
Iwa	Female	Middle Aged	Acupuncture Moxibustion	2	Tokyo	Clinician
Atsu	Female	Middle Aged	Acupuncture Moxibustion	2	Tokyo	Clinician
Hana	Female	Middle Aged	Acupuncture Moxibustion	2	Tokyo	Clinician

Practitioner contributions were individually negotiated at recruitment. Some practitioners agreed to be formally interviewed and recorded (n=18). Other practitioners agreed to engage in informal interviews (n=28), sometimes in addition to a formal interview. Almost half of the interviewed practitioners (n=18) participated in follow up interviews. Additionally, some practitioners consented to allow observations of treatments (n=22). Some of the practitioners were observed on multiple occasions (n=5).

Table 4.2 shows practitioners and what data was obtained from them. “Ticks” indicate which data could be collected, while “crosses” indicate which data could not be obtained. “Patient number” indicates how many patients were observed. “Observed Occasions” refers to the separate instances a practitioner was visited at a clinic; sometimes the same patient was observed multiple times as a returning patient.

Table 4.2 Practitioner Data Contribution

Practitioner	Formal Interview	Informal Interview	Follow up Interview	Observation	Patient Number	Observed Occasions	Total Observed Treatments
Tsuru	X	√	√	√	45	12	77
Ginnosuke	√	√	√	√	11	14	21
Asajiro	√	X	X	X	X	X	X
Takizou	√	√	√	√	1	1	1
Bunzaemon	√	X	X	√	1	1	1
Ume	√	√	√	X	X	X	X
Zenkichi	X	√	√	√	78	2	78
Koremitsu	X	√	√	X	X	X	X
Genrokurou	√	X	X	X	X	X	X
Kojiro	√	√	X	√	2	1	2
Iwamatsu	√	√	X	√	1	1	1
Kame	√	X	√	X	X	X	X
Shinokichi	√	X	X	X	X	X	X
Tarobi	X	√	√	√	4	1	4
Denkuro	X	√	X	√	1	1	1
Bunshichi	√	√	X	√	2	1	2
Kiemon	X	X	X	√	1	1	1
Toko	√	√	√	X	X	X	X
Yae	X	√	X	√	1	1	1
Benio	X	√	X	√	11	1	11
Sayo	√	√	√	√	1	8	8

Practitioner	Formal Interview	Informal Interview	Follow up Interview	Observation	Patient Number	Observed Occasions	Total Observed Treatments
Rin	√	√	√	√	1	1	1
Zenpachi	X	√	√	√	1	1	1
Miyo	X	√	√	√	2	1	2
Nobuhide	X	√	X	√	1	1	1
Chusuke	√	X	√	X	X	X	X
Sasuke	√	X	X	X	X	X	X
Heijiro	√	X	X	X	X	X	X
Kinu	X	√	√	√	1	1	1
Otoemon	X	√	√	√	4	2	5
Sukegoro	√	X	X	X	X	X	X
Hikoemon	X	√	√	X	X	X	X
Heisuke	X	√	X	√	4	1	4
Mitsu	X	√	√	√	1	1	1
Kiyo	X	√	X	X	X	X	X
Iwa	X	√	X	X	X	X	X
Atsu	X	√	X	X	X	X	X
Hana	X	√	X	X	X	X	X
Total	18	28	18	22	175	55	225

4.3 Education and Career

The Hikomatsu family started this clinic which was opened around 100 years ago. I am a 5th generation practitioner, but I am not from the Hikomatsu family. I was apprenticed to the 4th generation Sensei, Mitsuko Hikomatsu after I graduated. (Yae: acupuncture practitioner)

The majority of practitioners were qualified in acupuncture and moxibustion only (n=28). In addition to being qualified in acupuncture and moxibustion, a number of the practitioners also held other qualifications related to TJM acupuncture including massage (n=4), judo therapy (n=3), chiropractic (n=2) and massage and judo therapy (n=1).

Throughout the research period, practitioners discussed issues regarding qualifications, language and history related to different aspects of Traditional East Asian Medicine (TEAM) and TJM acupuncture. Their discussions helped clarify how acupuncture and moxibustion is understood in Japan, and how it is closely related to other allied health practices.

In Japanese, the word *shinkyū* is commonly used to refer to the combined practices of acupuncture and moxibustion. The first part of the word, *shin*, relates to needling and the second, *kyū* refers to moxibustion. The distinction between needling and moxibustion is important because the two modalities have been divided into two different qualifications under national licensure laws, and graduates are required to undertake separate examinations for both needling and moxibustion in order to practice them professionally. In TJM acupuncture, needles and moxa are separate and distinct tools with different philosophical concepts, diagnostic methods and treatment principles.

Japan has a long and violent military history. Injury was an inherent part of martial training and the knowledge and skills required to rehabilitate injury grew up alongside martial traditions. The modern name given to the rehabilitative techniques used to treat the kinds of injuries commonly sustained in martial arts, is called *judo seifuku* or *judo therapy* in English. *Judo* is Japanese sport wrestling and in Japanese means “the gentle way”. *Seifuku* is a word comprised of two parts: *sei*, (rearrangement) and *fuku* (restoration). The techniques of *judo therapy* are

sometimes called *seikotsu*: *sei* rearrangement and *kotsu*, bones. This can be translated as bone setting. Practitioners offering judo therapy are often called *seikotsu* practitioners rather than judo therapy practitioners in Japanese.

Judo therapy is a unique system of orthopaedic techniques including aspects of physiotherapy and chiropractic methods. It is used to treat injury, pain and aid in the rehabilitation of musculoskeletal abnormality. Judo therapy is regarded as a traditional form of Japanese medicine, although despite its traditional medical lineage, TEAM philosophies are generally ignored in favour of a modern orthopaedic approach to treatment. Unlike acupuncture and moxibustion, judo therapy treatments for musculoskeletal problems are comprehensively covered by the national medical health insurance, and treatments are commonly provided in private clinics.

Massage is also a separately licenced discipline in Japan. Massage includes *anma*, *massaji* and *shiatsu*. *Anma* means to press (*an*) and rub (*ma*) and is a style of body work similar to Chinese massage: *An Mo Tui Na*. It relies on pressing, rubbing, rolling, pulling and other mobilisation techniques. *Massaji* refers to the massage techniques without a traditional history in Japan, and is similar to Swedish or remedial massage. *Shiatsu* is perhaps the most identifiably Japanese of the traditional bodywork modalities. The Japanese character *shi* means finger and *atsu* is pressure. *Shiatsu* is a finger pressure therapy which has more to do with pressing on areas of the body rather than the grasping and pulling actions in *anma*.

In Japan as a whole, there are only a few practitioners who give treatments with only acupuncture and moxibustion. For instance, we had 40 graduates from this school last year, and less than 10% of them do treatments with only acupuncture and moxibustion. Mostly they do it together with judo therapy. They are acupuncturists, but their treatment includes some different kinds of therapy. There are only four schools in Osaka which are very traditional and have a long history. Many of the students from these four schools do only acupuncture and moxibustion compared to our school, but if you think in total, the percentage of the treatments which only include acupuncture and moxibustion is probably only about 20-30%, so it is very rare. (Heijiyo: acupuncture practitioner/head lecturer)

Practitioners who only held acupuncture and moxibustion qualifications seemed to operate their clinics differently to practitioners who had qualifications in acupuncture, moxibustion and judo therapy. They each seemed to have different preferences for philosophical concepts, diagnostic methods and treatment principles. The different allied health qualifications affect clinical practice in several ways which is detailed in chapters five, six and seven.

Figure 4.4 shows practitioner numbers and what occupations they had in relation to TJM acupuncture. Some practitioners had a single primary occupation; clinician, teacher or researcher. Being a teacher also often involved clinic work at their educational institution. Additionally, researchers also often had to conduct clinic work or tutoring at their educational institution. Some practitioners had two occupations which they did part time, such as working in clinic and teaching at an educational institution.

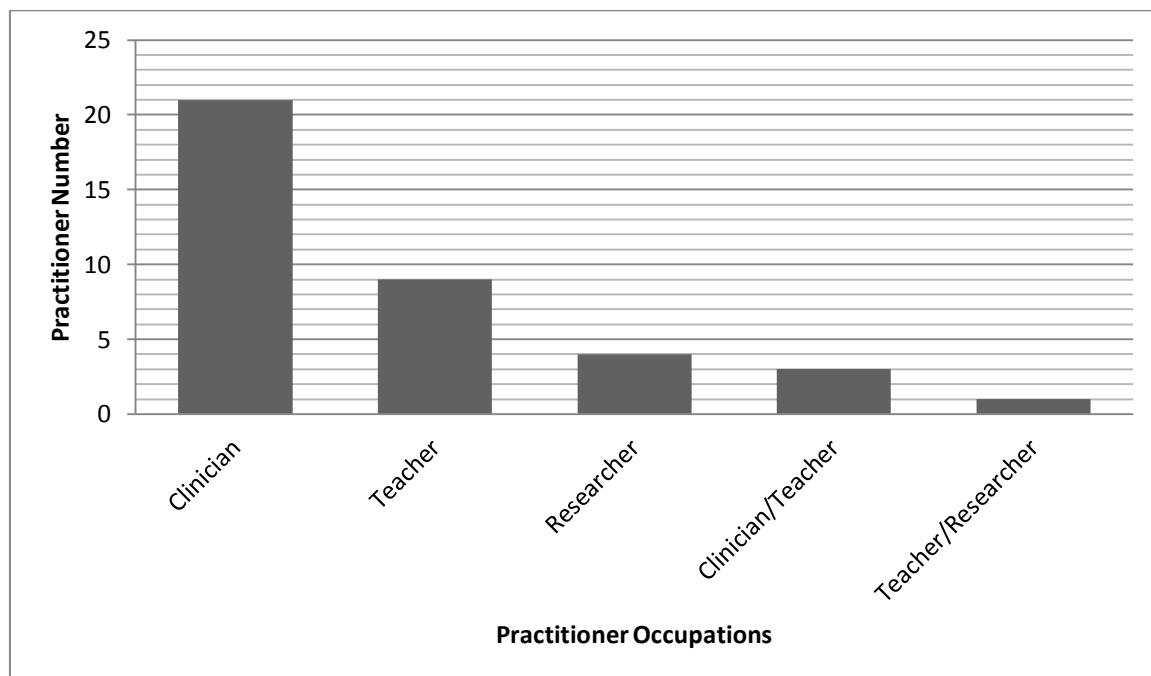


Figure 4.4 Practitioner occupations

Twenty four practitioners worked in private clinics. Fifteen practitioners were owners of their own clinic and nine had employment at other clinics. Of the 24 practitioners who worked in private clinics, three also had part time positions as teachers of TJM acupuncture at technical colleges. Ten practitioners were full time teachers; four at

university and six at technical colleges. Four practitioners were qualified TJM acupuncture practitioners who were postgraduate research students conducting obligatory clinic and/or tutoring work for their educational institution. One of the full time teachers was also undertaking a PhD.

Working environments seemed to affect the way practitioners performed TJM acupuncture. Factors including the balance between times spent on patients and payment for services, health insurance claims and the number of treatment tables available appeared to be somewhat correlated to philosophical concepts, diagnostic methods and treatment principles. The relationship between these factors is detailed throughout chapters five, six and seven.

4.4 Chapter Summary

Japanese acupuncture is so narrow minded. Nobody shows anybody anything or shares knowledge with anyone. Many acupuncturists in Japan are so closed off. Japan is an island country and everybody tends to be a bit like that; closed off and keeping everything to themselves. They don't like to share and there isn't a good connection between many acupuncturists. The medicine and knowledge isn't really growing because they don't collaborate. If we didn't have that closed off mind then treatments would get better and the knowledge would grow and spread. . . That's why I work here as a teacher. I want the students to see everything, I want to show them everything and spread the spirit of collaboration. I want to make a difference and change that closed off mind set. (Sayo: acupuncture practitioner/senior lecturer)

This chapter describes the research setting, sampling methods, practitioner demographics and data contributions for the 38 recruited practitioners. Fieldwork was based primarily in Osaka, but sites from all over the country were visited. Sole trader clinics and educational institutions were the most commonly visited sites.

The findings, in relation to understanding TJM acupuncture through philosophical concepts, diagnostic methods and treatment principles are presented in the three chapters to follow. The next chapter explores philosophical concepts.

Fieldwork Diary: Shabu Shabu

“Shabushabu, you understand?” Ginnosuke sensei held a piece of paper thin beef in his chopsticks and waved it through the simmering water in the pot in front of us. It was also filled with leeks, shitake and enoki mushrooms, tofu, Chinese cabbage and mizuna, but the main event without a doubt was the Kobe beef. He repeated the motion, slowly dipping the marbled beef in and out of the pot. “Sha-bu-sha-bu” he said, emphasising the swish through the bubbling water.

Earlier, all the family had gathered at Ginnosuke sensei’s house before heading out to the restaurant. I was with Sensei in the treatment room cleaning up when his sister walked in through the sliding door to say hello. In recent days I noticed that Sensei had rolled out a foot reflexology mat on the clinic floor, studded with uncomfortable looking pieces of different coloured plastic. At the time I hadn’t paid much attention to it, he was quite often experimenting with something new.

He managed to instantly hijack the situation and had her walking across the reflexology mat, testing it out. It didn’t look enjoyable; his sister grimaced as she trod gingerly across the two metre long mat. As soon as she was done, Sensei had her face up on the treatment table palpating her feet.

His sister Ayane was 38 and married with a seven year old daughter. Slim and assertive, she worked a fairly stressful sales position with no major health problems, but did have recurring stomach issues. She often felt uncomfortable in the abdomen.

Sensei pressed around KI 1 which made her feel very uncomfortable in the area just below the xiphoid process. She described it as “girigiri itai”, which is a kind of grinding, squeezing pain. When he stopped pushing, the pain subsided. Pushed again, and the pain returned. According to the Mubun style of abdominal diagnosis, the area just below the xiphoid process is reflective of the Heart, and can be associated with psycho-emotional stress. Sensei explained that there is a connection between the Heart and the Kidneys: the connection between Fire and Water via the channels and organ function. He said the pathway between the Heart and Kidneys was blocked, and that Ki was stagnating in the upper area of the

abdomen. Pressing on KI 1 activated the channels, but Ki didn't flow. That's why there was discomfort.

He palpated her abdomen and stopped his fingers at CV 6, not exactly on the point, but around the area. It was a little soft there. Sensei explained that below the umbilicus is Water, the area pertaining to the Kidneys. He held the silver dashin (larger, thicker teishin) over the point with his left hand and said that he will concentrate his intention here, willing the Heart Ki down. Sensei held the dashin in place for around 20 seconds, quickly took it away from the point and immediately covered where he was holding the needle with the thumb of the left hand. He then felt Ayane's pulse at her left wrist.

Sensei pushed on KI 1 again. There was no pain this time. He declared that the treatment was over and made her to walk over the mat again. Her feet were still a little sensitive, but not as bad as the first time she walked across it. "Ok, let's go for shabushabu!"

Chapter 5: Philosophical Concepts

I like Yin-Yang and the Five Phases. But actually, the most important thing is just to study. (Shinokichi: acupuncture/massage/judo therapy practitioner/lecturer)

This chapter presents and analyses the philosophical concepts of TJM acupuncture. Philosophical concepts are the ideas which relate to the knowledge and fundamental qualities of phenomenon, existence and reality, which are concerned with health, illness and health care. It is the branch of TJM acupuncture dealing with basic concepts, theories, rules and principles.

This chapter is divided into four sections. The first section is an overview of the findings, while the second addresses knowledge as a sub-theme of philosophical concepts. Section three analyses findings from the data in relation to socio-cultural beliefs and values as a sub-theme of philosophical concepts. In this section, beliefs and values that were interpreted to be significant in shaping clinical reality are discussed, and analysis about how this contributes to the identity of TJM acupuncture as a discipline is provided. The final, fourth section discusses styles of TJM acupuncture from a philosophical perspective.

5.1 Overview of Philosophical Concepts

Data relating to philosophical concepts was obtained from all of the total 38 recruited practitioners. All the data from every practitioner was critically evaluated with thematic analysis and resulted in the interpretation of two major sub-themes concerning philosophical concepts: *knowledge* and, *beliefs and values*. Knowledge refers mainly to academic and clinical knowledge concerned with anatomy, physiology, aetiology, differential diagnosis, pathophysiology, prognosis and treatment. Beliefs and values reflect the socio-cultural aspects of health, illness and health care. Both academic knowledge and socio-cultural beliefs and values were found to have influenced practitioners' clinical reality, specifically diagnostic methods and treatment principles. However, influence was probably not linear; results and developments in diagnosis and treatment, and the effects seen in

treatment, seemed to help shape beliefs and advance knowledge as clinical experience grew (Figure 5.1).

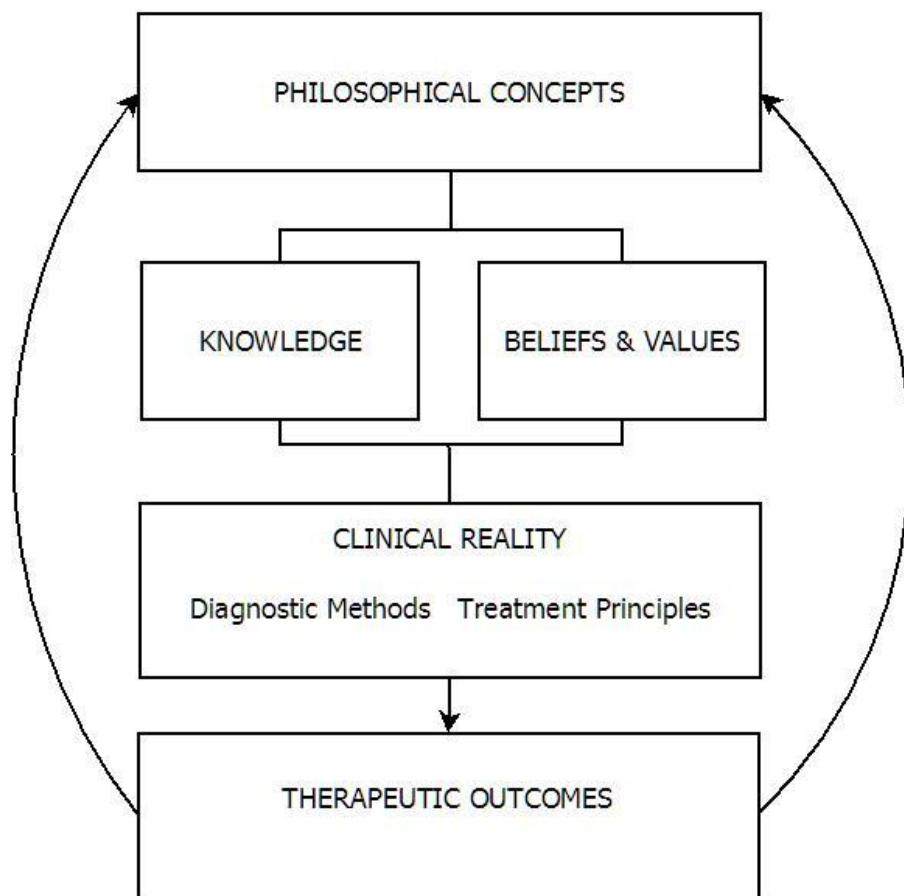


Figure 5.1 Categories of philosophical concepts

5.2 Knowledge

The traditional system of Ki is very important. But just what is written in books or reading about what is written and thinking about it is not enough. You have to try it. You have to feel the body and confirm it all for yourself.
 (Ginnosuke: acupuncture practitioner)

Knowledge included the sub-theme of explanatory models of medicine (see Table 5.1). Explanatory models of medicine (TEAM, biomedicine and orthopaedics) are specific systems of knowledge which are bound to beliefs and values positioned in different socio-cultural and health care sectors. Each model has unique theories of disease causation and nosology which is described in abstract, technical and often impersonal idioms. Different explanatory models of medicine were defined as

instances of related concepts generally tied to specific systems of knowledge and values with unique historical, ontological, social and cultural backgrounds.

Table 5.1 Themes Related to Knowledge in Philosophical Concepts

Main Theme	Sub-theme	Sub-theme 2	Sub-theme 3
Philosophical Concepts	Knowledge	Explanatory Models	TEAM Biomedicine Orthopaedics

TJM acupuncture practitioners were found to diagnose and treat according to three main explanatory models of medicine: TEAM, biomedicine and orthopaedics. These explanatory models of medicine complemented and conflicted with each other and were sometimes integrated to form distinctive clinical realities (Figure 5.2). Although multiple models were found to exist (TEAM, biomedicine and orthopaedics), this study was primarily focussed on the philosophical concepts in the TEAM model. This was in part as a result of the majority of practitioners (acupuncture/moxibustion only qualified practitioners) having a commitment to the TEAM model. However some acupuncture/moxibustion only, and judo therapy practitioners preferred the biomedical or orthopaedic models. Details of the biomedical and orthopaedic model are also reported where appropriate, although in less detail than the TEAM model.

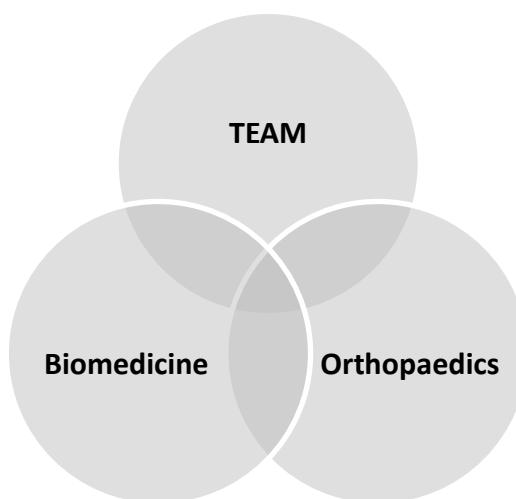


Figure 5.2 Basic interplay of explanatory models of medicine

Biomedical knowledge includes orthodox contemporary biomedical science such as anatomy, physiology and pathophysiology. Furthermore, it incorporates orthodox contemporary medical science which is the knowledge of the interaction of anatomy, physiology, pathophysiology, disease, illness and the process of diagnosing and treating. This was typically known as Western medicine or simply medicine to practitioners. The focus of biomedicine in practitioners' practice typically related to internal medicine. Orthopaedics is a specialised area of biomedicine which is concerned with musculoskeletal medical science. Although orthopaedics is a branch of biomedicine, it was found to be a significant component of practitioners' practice which guided clinical decisions differently to TEAM and biomedicine in general.

In general, practitioners were found to primarily operate from one model, either TEAM, biomedicine or orthopaedics. Practitioners have been categorised as TEAM model (66%, n=25), biomedical model (13%, n=5) or orthopaedic model (13%, n=5) practitioners to clarify their main commitment and allegiances to knowledge and belief systems. TEAM model practitioners included elements of biomedical and orthopaedic knowledge in their practice. However, biomedical or orthopaedic model practitioners were sometimes found to ignore TEAM knowledge in the clinic. Figure 5.3 shows the distribution of practitioners to explanatory models of medicine. Three (8%) practitioners could not be classified into a specific model of medicine due to lack of data.

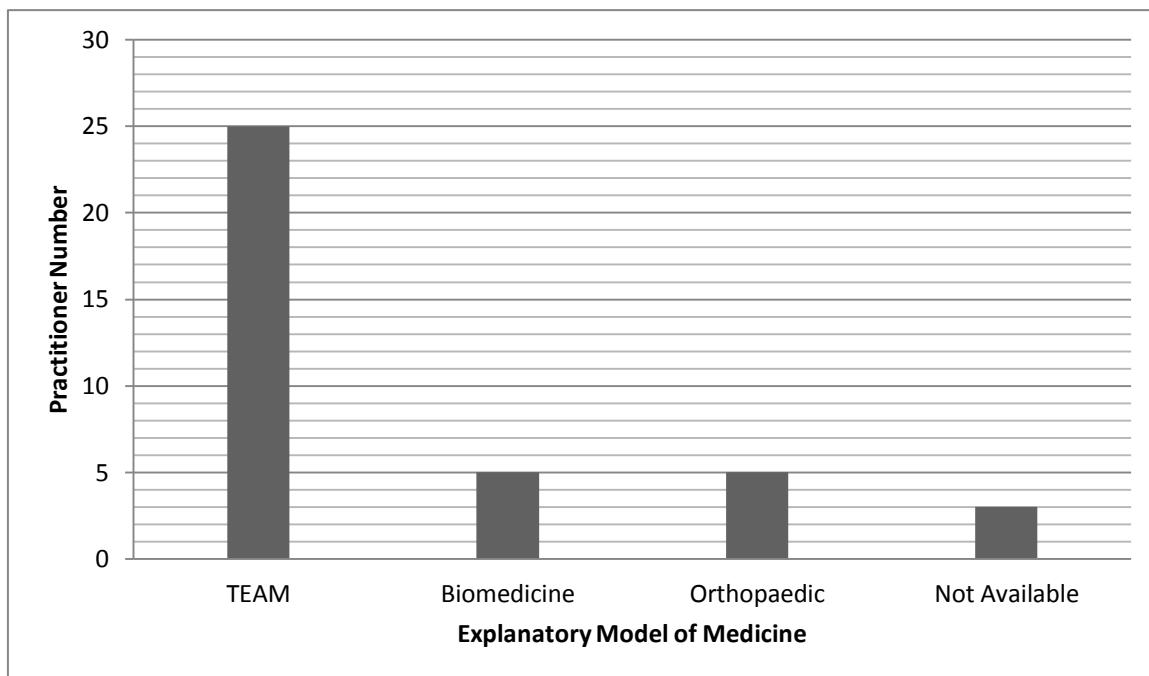


Figure 5.3 Practitioner explanatory model of medicine affiliation

TEAM, biomedical and orthopaedic knowledge was taught in educational institutions to prepare students for the national licensure examination. This examination was a legal requirement for clinical practice for acupuncture and moxibustion and included up to 13 subjects of examination. The subjects in the examination are listed below (items 12 and 13 were dependent on whether the applicant was taking the acupuncture or moxibustion licence examination):

- 1) Overview of healthcare
- 2) Hygiene and public health
- 3) Laws and regulations
- 4) Anatomy
- 5) Physiology
- 6) Pathology
- 7) Overview of clinical medicine
- 8) Advanced clinical medicine
- 9) Rehabilitative medicine
- 10) Overview of TEAM
- 11) Channels, collaterals and points
- 12) Acupuncture theory and TEAM clinical pathology
- 13) Moxibustion theory and TEAM clinical pathology

Biomedicine and orthopaedics were found to be significant elements of TJM acupuncture education and examination. Biomedicine and orthopaedics also appeared to be emphasised more than TEAM knowledge in the assessment of TJM acupuncture.

The remainder of this analysis deals with the knowledge of TEAM in three broad themes:

- Structure and function of the body
- Order, balance and movement
- Identification of illness and location of disease

The TEAM knowledge of TJM acupuncture can be broadly divided into three categories, of which the most important aspects are summarised in Table 5.2.

Table 5.2 Summary of Significant TEAM Knowledge

Structure and Function	Order, Balance and Movement	Identification of Illness and Location of Disease
12 Primary Channels	Yin/Yang	Simple and Multiple Patterns
8 Extra Channels	8 Principles	Evil Ki and Balance of Ki
Yin/Yang Point Connections	5 Phases	Pathogenic Factors: Heat/Cold
5 Phase Point Connections	Stems and Branches	
Ki		

5.2.1 Structure and function of the body

[The important point of TEAM is that] the mind and body are integrated. For instance, the Liver governs emotions. . . This way of thinking attributes different emotions to the viscera and bowels. I think Western medicine doesn't have this way of thinking. It doesn't have anything like the five phases and Yin and Yang either. I like these kinds of ideas. Western medicine is materialistic but in TEAM you have to believe in something you can't actually see. You can't actually see the channels or the functioning of organs like the Heart and its emotions. (Heijiyo: acupuncture practitioner/head Lecturer)

Practitioners incorporated TEAM knowledge of the human body into a functional system. The principal components of this system found in the data are listed in Table 5.3.

Table 5.3 Concepts Related to Structure and Function

Channels and collaterals
Acupuncture points
Viscera and bowels
Vital substances
Microsystems/Holography

Channels, points and organs

TEAM model practitioners generally accepted the theory that a network of channels and collaterals work in systems to connect all aspects of the body. The channels and collaterals are associated with different viscera and bowels which have specific functions integral to health. Practitioners were found to emphasise the 12 primary channels (WHO code 1.4.9) and the eight extra channels (WHO code 1.4.24). Channels and points are believed to be connected through correspondences especially relating to order, balance, movement and cycles. Diagnosing channel pathology and using channel points which connect or link organs and channels, was a theme interpreted from the data.

I often use the eight extra channels, but it depends on the condition of the patient. I also incorporate the eight extra channels when treating the viscera and bowels especially when I want to increase the effect of the treatment. So sometimes I use it alone and other times I use it in combination. It's easy to tell whether the treatment has been effective or not when using the eight extra channels. (Kame: acupuncture practitioner)

Table 5.4 shows the knowledge of how the eight extra channels were linked together and with the primary channels via primary channel points which are categorised as master, coupled, connecting or cleft points. Although this knowledge

seemed to be well known among practitioners, how it was used in actual treatments was reported to vary.

Most people know the channel pairs for the eight extra channels but they don't know how to use them properly. They are effective in more combinations than just their paired points. (Tsuru: acupuncture practitioner)

Table 5.4 Eight Extra Channel Pairs and Connected Points

Channel Pair	Master Point	Coupled Point	Connecting Point	Cleft Point
Conception	LU 7	KI 6	CV 15	
Yin Heel	KI 6	LU 7		KI 8
Governor	SI 3	BL 62	GV 1	
Yang Heel	BL 62	SI 3		BL 59
Belt	GB 41	TE 5		
Yang Linking	TE 5	GB 41		GB 35
Thoroughfare	SP 4	PC 6		
Yin Linking	PC 6	SP 4		KI 9

Team acupuncture theory describes points as access gates which influence the working of the body by linking to and affecting the channel system. Practitioners appeared to rely more on the knowledge of connections and associations between points and channels than they did on the actions and indications of individual acupuncture points.

Although acupuncture points were generally thought to be found on the primary channels, channel and collateral theory accepts that they may be located almost anywhere that has a desired effect on the body. Whether or not a practitioner prescribed to the knowledge of Ki and channels, it was generally accepted that a treatment site could be anywhere on the body which displayed an abnormality. This may be a unique aspect of TJM acupuncture knowledge

My main teacher's style has no channels or points; anywhere there is dysfunction is a location for treatment. If you can understand the body condition, then you can do a treatment. (Otoemon: researcher/acupuncture practitioner)

Vital substances

The channels and collaterals serve as conduits for the vital substances: Ki, Blood and body fluids. Of the three vital substances, Ki was found to be the most important to practitioners. Ki pathology and treatments aiming to affect the balance or amount of Ki appeared to be an important theme within TEAM model practitioners' practice. In addition to the diagnosis and treatment of deficient or excess Ki, the diagnosis and treatment of evil or pernicious Ki was also important. Commitment to the philosophical concept of Ki was interpreted as a defining criterion for situating practitioner allegiances among the explanatory models of medicine.

Throughout Japanese history, more than other theories, Ki and Blood have been the most important concepts. Especially Ki. It is important because it is the basis of our body. If we don't have it, we can't live. Yin-Yang and the five phases actually come second. There are many ways of understanding Yin-Yang and the five phases depending on different people. No one in this industry says Ki is not important in traditional Japanese acupuncture, but there are many opinions about Yin and Yang. (Sukegoro: acupuncture practitioner/professor)

Microsystems

Microsystems resemble anatomical maps projected onto other areas of the body. Sites on the microsystem were said to have a correlation and interrelation with specific anatomical or physiological features elsewhere in the body. The combined areas of the anatomical microsystem maps were considered a functional image of certain parts, and sometimes the whole body. These could be found in defined partial areas such as the face, back, tongue and ears. Microsystems (example shown in Figure 5.4) were found to be a significant part of some practitioners' practice, especially on the abdomen. The abdomen was confirmed by 55% (n=21) of practitioners to be an important microsystem in their practice.



Figure 5.4 Mubun style abdominal microsystem map – Source: Ginnosuke (acupuncture practitioner)

The oval represents the abdomen; the very top indicating the area around the xiphoid process. In general, each bordered area represents one of the viscera or bowels.

5.2.2 Order, balance, movement and cycles

I think utilising the theory of Yin-Yang and the five phases in treatment is one of the most important aspects [of treatment]. (Iwamatsu: acupuncture practitioner/professor)

Many of the TEAM philosophies related to order, balance, movement and cycles are founded on the idea that phenomena exist in patterns of relationships called systematic correspondence. The relationships between phenomena are linked in identifiable patterns with associated correspondences where a theoretical connection justifies a common classification. Philosophies of order, balance, movement and cycles were found to be related to systematic correspondences and conceptually applied to anatomy, physiology, pathophysiology, diagnosis and treatment in a variety of ways. The principal themes related to order, balance, movement and cycles are listed in Table 5.5. These themes seemed especially important in relation to the channels and collaterals.

Table 5.5 Concepts Related to Order, Balance and Movement

Yin and Yang
5 Phases
8 Principles
Stems and Branches

The correspondences between connected Yin and Yang primary channels, connected extra channels and channel correspondences through the 10 stems and 12 branches (WHO code 5.1.152), along with the five phases appeared to be central components in practitioner knowledge of the interaction between points and channels. This is exemplified in the photo in Figure 5.5 which depicts the correspondences between Yin/Yang and Chinese cosmology related to the stems and branches.



Figure 5.5 Taiji symbol with trigrams – Source: Ginnosuke (acupuncture practitioner)

Connections between channels, points and symptomology were also applied in terms of the stems and branches. Although the stems and branches are associated with traditional Chinese cosmology and the measurement of time, this never appeared to be an important factor for practitioners during treatment. In application,

the stems and branches were applied based on channel correspondences and associated channel symptomology in the treatment of symptoms along channel pathways. When arranged according to stems and branches philosophy, the channels interact with one another in two different ways: opposite and adjacent units represent channel correspondences as shown in Figure 5.6.

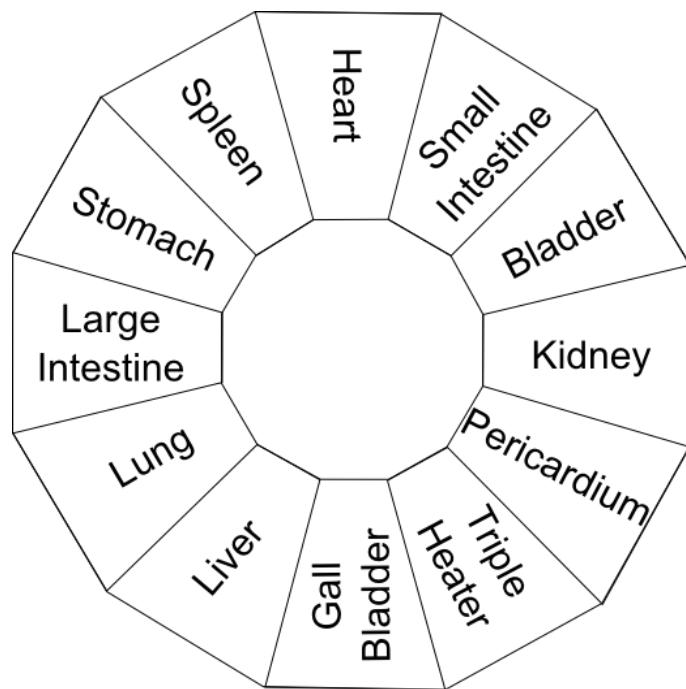


Figure 5.6 Stem and branch correspondences between channels/organs

The conceptual categorisation of philosophical concepts to the human body results in the development of classification systems which describe systematic characteristics of disease states and treatment rules. Among practitioners, one of the most significant of these was the “eight principles”. All but one TEAM model practitioner was found to incorporate elements of the eight principles into their practice. Additionally, use of the eight principles was one of the most consistent applications of knowledge for TEAM model practitioners. This may be a distinct feature of TJM acupuncture.

Eight principle theory classifies phenomena into four pairs of systematic correspondences which are used to categorise symptoms and devise treatment strategies; Yin/Yang, Hot/Cold, excess/deficiency and interior/exterior. In addition to the patterns of relationships of the eight principles, practitioners largely employed

the systematic correspondences of five phase theory. This somewhat extends the relationships found in the eight principles resulting in a more detailed, yet still systematic, theory of medicine.

In regards to the overarching guiding principles of medicine, TEAM model practitioners were primarily committed to the Yin-Yang, the eight principle and five phase theories. These theories are relatively simple due to the defined numerical limitations i.e., *eight principles, five phases*. They are also systematic with simple rules for treating illness. In addition, these are some of the foundational acupuncture theories of TEAM. A preference for the simplest and most foundational aspects of knowledge may be unique to TJM acupuncture.

5.2.3 Identification and location of disease

In relation to Ki, pathology exists when there is excess above and deficiency below. Below should be full and above should be empty. . . Earth is very warm and hard, this is excess. And we say that the sky is very cool and soft, this is to be empty. The body should be like this. (Ginnosuke: acupuncture practitioner)

Disruption to the orderly flow of physiological processes (especially Yin-Yang and the five phases) results in disease. The identification and location of disease was found to largely depend on the knowledge related to pathological factors and pattern differentiation. Disruption was stated to occur due to a number of factors. However, the most significant factor was found to be an excess of evil Ki (WHO code 1.6.60) or an insufficiency of healthy Ki (WHO code 1.2.20). Evil Ki can be differentiated into the six excesses (WHO code 1.6.10), yet TEAM model practitioners were generally found to leave the six excesses undifferentiated, describing them simply as evil or pernicious Ki; the presence of which indicated some abnormality in the patient's condition. Defining the six excesses into the specific categories of Heat, Cold, Wind, Dry, Damp and Fire was not a major aspect of practitioners' practice. Moreover, diagnosing the presence of evil Ki relative to a patient's healthy Ki and removing the evil Ki when it was in excess, or supplementing the patient's beneficial Ki when insufficient, was an important feature of TJM acupuncture.

The most important thing in clinical practice is palpating the abdomen and back because you can easily feel the presence of evil Ki. For example, when you find evil Ki and apply an appropriate treatment, you can feel that the evil Ki is gone instantly. (Sukegoro: acupuncture practitioner/professor)

When a practitioner did identify the six excesses, Heat and Cold were found to be the most important pathogens to diagnose; perhaps because they align with the eight principles easily. The undifferentiating of evil Ki and primacy in the use of polar opposite pathogenic excesses Heat and Cold, reinforce the finding that simplicity is valued in TJM acupuncture. Diagnosis of the amount and location of evil Ki in the body was identified as a more important theme than identifying the specific type of evil Ki. This may also be a distinct feature of TJM acupuncture.

The analysis of clinical data to determine the location, cause and nature of a patient's disease by identifying patterns of disharmony according to the collective knowledge of TEAM is called "differentiation of syndromes and pattern identification". Differentiation of syndromes and pattern identification represents syncretism of TEAM knowledge by drawing on the combined foundations of TEAM philosophical concepts. Practitioners found it acceptable to combine TEAM, biomedical and orthopaedic explanatory models of medicine in order to make conclusions about meaningful indicators of illness when formulating patterns of disharmony.

Pattern differentiation as performed by practitioners was generally comprised of only one or two variables. Practitioners were also found to diagnose several unrelated patterns which were present in a patient at one time. This is analysed completely in Chapter 6 Diagnostic Methods. In summary, the most important themes related to the identification and location of disease in TJM acupuncture are:

- Simple and multiple patterns may be used to describe a patient's condition
- Balance of good and bad Ki
- Pathogenic factors of Heat and Cold

5.3 Beliefs and Values

I think, these days I'm somewhat puzzled about what Japanese acupuncture is, what it means exactly. But I think Japanese acupuncture means finding your own way, like Zen. Like Buddhist philosophy. . . Just practice and just study. Finally you will find your own way. (Takizou: acupuncture practitioner)

Values, although being somewhat personal and individually specific, can be culturally differentiated and shared by communities and organisations. The significance of TEAM, biomedical, orthopaedic or other knowledge appeared to be influenced by the condition of self and world values which informed practitioner treatment behaviour. This section presents the findings on beliefs and values, and how these influence TJM acupuncture. In contrast to knowledge, practitioners (probably like people in general) were less self-aware of their beliefs and values than of knowledge. Beliefs and values were not always articulated clearly in discussions or interviews and were often conveyed as abstract ideas and idioms. Therefore, beliefs and values were also interpreted through behaviours and actions during clinical interactions. These beliefs and values are listed in Table 5.6.

Table 5.6 Important Beliefs and Values

Zen Buddhism
Effect through technique
Instant effects of treatment
Anatomical areas of significance
Resolution of abnormalities
Minimal stimulation
Patient comfort and customer service

Zen Buddhism

As a religion, Zen is a variety of Buddhism that focusses on attaining enlightenment (*satori* in Japanese, which literally translates to 'find out'). Zen enlightenment is a revelation that is said to open a new awareness of the world, previously unperceived in the disorder of the normal mind. It is a sudden achievement,

facilitated by immersion in daily lived experiences, and not by any intellectual understanding or philosophising. This innate practicality both resonated with, and had a profound impact on, the Japanese psyche; while other schools of Buddhism have mostly influenced the spiritual life of Japanese people, Zen Buddhism has been accepted into almost every facet of Japanese culture, identifiable as a unique variety of Japanese pragmatism and simplicity. This means that although Zen Buddhism is a religion, Zen concepts are so embedded in non-religious beliefs and behaviours (including the practice of acupuncture), that they no longer retain religious meaning in those contexts. Simplicity, minimum effort for maximum effect and the respect for practicality above convention are some of the dominant Zen derived values which informed TJM acupuncture practice.

*The most important thing is whether the sickness changes or not. If your method is perfect but nothing changes then you're not practicing medicine.
The important thing is whether the pain goes or not, whether they get better or not. (Ginnosuke: acupuncture practitioner)*

Effect through technique

This is the value of skills above knowledge. This value was represented by the importance of practitioner sensitivity and the significance given to the arrival or obtaining of Ki above the circulation of Ki. This value was also connected to the practice of causing tangible treatment effects and detecting subtle changes in the patient condition. It is also this value which demonstrated the de-emphasis of complex pattern differentiation and the emphasis of location and treatment of body tissue abnormalities.

If you compare it to Chinese acupuncture, our acupuncture methods are gentle. The best way to express Japanese acupuncture is sensitive . . . Chinese acupuncture treats forcefully, but we treat with technique. (Sasuke: acupuncture practitioner/ senior lecturer)

Instant effects of treatment

This represents that acupuncture and moxibustion could have instantly verifiable treatment effects. The process of trial and error throughout treatment and the constant confirmation of treatment effects typify this belief. This also connected to

the concept of overtreatment and the ability to monitor and prevent it. Trying too hard to improve the patient's condition by increasing intervention intensity or volume, or too many attempts to improve the patient's condition during treatment, was believed to be detrimental and result in overtreatment.

In Japanese acupuncture, while we insert needles we are constantly checking the patients' condition at the same time. In Chinese acupuncture, they don't pay much attention to how many needles they insert and they don't check the patients' condition while the needles are inserted. (Chusuke: acupuncture practitioner/senior lecturer)

Anatomical areas of significance

Some areas of the body were valued as more significant to health than others. One major area of significance was the abdomen. The diagnosis and treatment of this area alone could constitute a practitioner's entire clinical procedure. The skin was also observed to be an important area of significance which is typified by the significance of skin palpation, shallow needling and contact needling treatment techniques. Areas such as the spine and sacrum, as well as others were prioritised depending on the commitment to certain knowledge systems.

I only ever use points here at the occiput. I usually use either one or two points depending on what reaction the patient has during the examination.
(Zenkichi: acupuncture/chiropractic practitioner)

Resolution of abnormalities

Physical abnormalities or palpable disturbances of Ki, whether part of the main complaint or not, were often considered sites of dysfunction which should be rectified. The search for and treatment of abnormalities, especially on significant anatomical areas, was an important theme. This resulted in the recognition of abnormalities in relation to a predicated natural order and remedying any disorder by the application of prescribed techniques.

Where tissue feels like it is bunching up and your hand seems to stop there, then that is the place you need to treat. (Sayo: acupuncture practitioner/senior lecturer)

Minimal stimulation

The belief that it was not necessary for needles to be inserted into the body to have a therapeutic effect, and that moxibustion stimulation need not be felt by the patient, represents the value of minimal stimulation. This value is also evidenced by the large range of contact tools and minimally or non-inserted needle techniques which were believed to have an effect on body tissues and Ki.

In my case, I don't insert needles. I just touch the skin surface with them which is called contact needling. When I do tonification, I just touch the skin with the needle. But when I apply draining, I insert needles about 5 mm. I also use teishin to stimulate the treatment site and release muscle tension.

(Chusuke: acupuncture practitioner/ senior lecturer)

Patient comfort and customer service

This value represents the belief that patients should be comfortable and treatment need not cause inadvertent injury to patients. It was common for practitioners to be described as craftsmen, which implies a high level of skill and expertise. It was generally seen as unprofessional to cause discomfort to the patient with needles. This is somewhat demonstrated with the use of thin needles and guide tubes. In addition, mild stimulation of treatment sites and the idea of not overtreating the patient, as previously described, are also practices which are connected to patient comfort.

I don't need to be honoured for curing patients; I just want them to enjoy their lives. I hope all practitioners can understand that. I want all practitioners to think about their patients all the time while they are giving treatments.

(Bunzaemon: acupuncture/ judo therapy practitioner)

5.4 Styles

Combinations of knowledge, beliefs and values have been converged to form distinct styles of practice in TJM acupuncture. After graduation, practitioners had the chance to develop their professional skills and knowledge through various means of study and practice. One common method of professional development

was to attend seminars and join academic or professional study groups and associations. Some practitioners were active members in associations and others attended them casually. These associations provided study groups, seminars and workshops for members to advance their knowledge, adopt different values and develop their clinical skills. Some groups have long and prestigious histories, and attracted members from all over Japan and the world. Many of these groups had unique perspectives on TJM acupuncture, each with complementing and contrasting knowledge and values, diagnostic methods and treatment principles. Some practitioners had dedicated themselves to one certain style, while others developed their skills by joining a variety of groups or associations.

Being a member of one (any) society/association is not really related to practising along certain guidelines (school). Take the JSAM for example. It is supposed to be a society dedicated to the academic pursuit of knowledge about acupuncture. It does not really matter, when a member practices really traditional stuff or follows modern "scientific insights".

Conversely, you are not "destined" for a particular society, simply because you practice a certain style. Also, not everybody is a follower of some form of school. Take me for example. Heretic in nature, I pick up a few things here and there, put them into a big pot, stir the mixture and then pick out the most delicious parts. But that is not any sort of "style" or "school". And I daresay I am not alone. (Koremitsu: acupuncture practitioner)

A large range of associations, groups and styles of TJM acupuncture were found to exist, some which had taken root in the educational system via various political or environmental factors. Others were more secretive and strove to protect professional knowledge in order to maintain exclusivity for some kind of therapeutic/economic advantage. Table 5.7 is a list of styles found to be practiced by practitioners. Some practitioners identified with, and incorporated aspects from multiple styles while others did not refer to themselves as being a subscriber or member to any.

Table 5.7 Acupuncture Styles Practiced by Practitioners

Style
Daoist
Hoku Shin Kai
Ibu dogen
Ichi gen
Ishizaka
Isogai
Kappou Shinkyu Rinshou
Keiraku Chiryou/Meridian Therapy
Kozou Igaku
Mubun
Ritsudou
Shakuju
Shirota
Sugiyama
Sugiyami Shiki
Taikyoku
Tanioka/Taishihari
Traditional Chinese Medicine

Although traditional Chinese medical literature was an important source of knowledge and values for some of the practitioners, many considered Traditional Chinese Medicine (TCM) as a separate style of acupuncture. Some practitioners believed that TCM was the real and classical approach to acupuncture compared to other TJM acupuncture styles.

TCM itself is the foundation of acupuncture practice... I studied the standard Chinese texts. Japanese Meridian Therapy and other styles were created by Japanese people. People studied TCM and changed it a little, I don't like this. I never do Meridian Therapy. . . Now, trigger point therapy is getting more popular than Meridian Therapy. No one really studies so much. . . Especially the ones working in acupuncture/judo therapy clinics. (Asajiro: acupuncture practitioner)

One of the most important points to consider about styles is that there are so many official and unofficial styles of TJM acupuncture. These styles all seem to combine elements of TJM acupuncture in slightly different, although unique ways and are sometimes taught at study sessions by experienced practitioners (some of whom are famous among the TJM acupuncture community). Additionally, many of these styles are associations where practitioners join, pay money to become a member and attend seminars and workshops. The existence of this system is testament to the eclectic culture of TJM acupuncture, the commitment of practitioners to improve their skills and the need to find a niche in an overcrowded market. This is probably a contributing factor to the unique features of TJM acupuncture.

There was insufficient data to categorically define a dominant style within TJM acupuncture. However, the names of three especially important individuals were found to be a reappearing theme when practitioners discussed the foundational philosophical concepts of TJM acupuncture: Isai Misono, Waichi Sugiyama and Bunshi Shirota. Respectively, these individuals have links to Mubun, Sugiyama and Taikyoku styles, and in relation to the TEAM model of TJM acupuncture, it is probable the majority of the unique elements of TJM acupuncture are derived from the philosophical concepts represented within those styles.

5.5 Chapter Summary

Japanese acupuncture came from China, so we have two kinds of styles; Japanese acupuncture which includes Chinese methods and a genuinely Japanese acupuncture. I think it's a characteristic of Japanese people that we try to take the best of what's available and make it our own. You don't need to choose only one way in Japanese acupuncture. For instance, when Japanese people cook spaghetti, we just don't imitate Italian flavours; we arrange the taste to suit our palate. It is the same in the acupuncture world. Most Japanese acupuncturists arrange their treatments their own way, and develop their treatment methods based on what they like. I think that it's a characteristic of Japanese acupuncture that there is no definite convention of practice. To describe Japanese acupuncture in a single term, I'd say that it is flexible. (Heijiro: acupuncture practitioner/ head lecturer)

In this chapter, philosophical concepts are categorised into knowledge, and beliefs and values. Philosophical concepts were found to be derived from three major explanatory models of medicine: TEAM, biomedicine and orthopaedics. This study focused on the analysis of TEAM knowledge in TJM acupuncture.

In addition to knowledge, the thematic category of philosophical concepts was interpreted to include beliefs and values. These are personal and socially conditioned benchmarks which provide professional stability for clinical interactions. Some of the most important beliefs and values of TJM acupuncture are:

- Effect through technique
- Instant effects of treatment
- Minimal stimulation

Although each one of these beliefs and values are distinct themes from the data, many of them stem from Zen Buddhism. The Zen Buddhist maxims of practical experience and deliberate practice appear to have influenced many aspects of Japanese culture including TJM acupuncture.

There seems to be basic homogeneity in practitioner knowledge, which is provided by the education system. There also seems to be homogeneity in beliefs and values, provided by the socio-cultural setting. However, knowledge and values of TJM acupuncture practitioners are synthesised into clinical reality in a variety of different ways due to heterogeneity in practitioner preferences for certain knowledge, the strength of various values, alignment with different explanatory models of medicine and personal/professional experience. Differences between practitioners emerge as a result of the emphasis of unique combinations of philosophical concepts. These are manifested as different styles in TJM acupuncture, either recognised and official, or personal and private.

The next chapter is the second of three results chapters where data related to diagnostic methods is presented and analysed. Themes interpreted from the data are discussed as a timeline of processes, in consideration to methods and finally, treatment objectives.

Fieldwork Diary: Sato San

After over three years of fieldwork in Japan, I had finally become somewhat accustomed to visiting new practitioners for the first time. Google Maps helped a lot. Usually it was quite difficult for foreigners to get phone plans which allowed the purchase of smart phones. However, through various means of begging and grovelling I had managed to get my hands on one. It proved invaluable to navigating the sprawling Osaka residential area and the tangled web of train lines servicing the city. Knowing where I was going took some of the edge off showing up to clinics for the first time.

Although my contact was out on a house call when I arrived, all the staff at the clinic were prepared for me. I was asked to take a seat in the waiting room. The Owner of the clinic proved extremely friendly and got straight down to business by inviting me to follow him from patient to patient. "Did you bring a white coat?" he asked. I should have known that I would have needed one, but I had forgotten to bring it with me. It wasn't a good start. . . The Owner gave me one of his, a pale green treatment smock. I put it on and began to shadow him around the clinic.

Despite being located in the one of largest cities in the prefecture, home to a few million people, my contact described this clinic as being in the countryside. The clinic did have a much more relaxed atmosphere than others I had been to in Tokyo or central Osaka, and the patients chatted among themselves through the curtain dividers between treatment tables. Patients came and went throughout the morning until eventually a young man came through the door who was welcomed in a typical chorus of "good morning" by all the staff at once. He seemed quite surprised to see me there, and one of the other patients jokingly remarked that I would be performing his treatment today. As he was being ushered through to a treatment table, one of the staff took an interest in showing me the electronic water massage bed which I had seen before in other clinics, but never experienced. They asked me if I wanted to try it out and I gladly accepted.

The chatter of the clinic, pleasant aroma of moxa and the warm pressure of the water massage bed working into my knotted muscles had almost sent me off to sleep when one of the staff appeared by my side. "Benjamin san, how is it?" She

asked, and I admitted that I had almost fallen asleep. "Well, Sato san wants a treatment from you. Is it ok?" She paused and looked slightly embarrassed, "He said he wants a treatment from the blue eyed Sensei!" Sato san was the young man who had arrived just as I was being shown the water massage bed; he had actually been a patient of this clinic since he was a high school student. I wasn't comfortable giving anyone a treatment, especially one to a participant's patient in their own clinic! The Owner had obviously allowed me to at least take a look at the patient though, otherwise they wouldn't have asked. . . "Is it ok?" she persisted. Reluctant to say no, I agreed.

After the timer had run down on the water massage bed, I collected myself, washed my hands and went to take a look at my unlikely patient. Gently, I ran my palm over his abdomen to feel his temperature. "I had no idea that foreigners could do acupuncture" admitted Sato san. Everyone had kindly given me plenty of space so as to not make me feel nervous and I began to check over the patient in more detail.

"Sato san, how are you feeling?" The Owner called out from the treatment space next to mine, "Is everything okay?" Sato san very graciously replied that he was relaxed, and then The Owner came in to see what I was up to. He saw that I was preparing needles with plastic guide tubes and suggested that the kind of metal tube that he always uses is much better. "It's much more comfortable" He said as he passed it to me. The Owner must have sensed my confusion. He stepped in beside me to demonstrate the correct insertion technique one or two times. I had never used this kind of guide tube before, especially with needles which were much longer. "Don't worry" he encouraged, "You will get faster at it with more practice."

Chapter 6: Diagnostic Methods

Basically I don't think [the treatment itself] is the most important point of the clinical encounter. I think there are a lot of different practitioners with different ways and methods [for treatment]. The most important thing is to try to figure out the real cause of disease. (Kojiro: acupuncture/massage practitioner)

This chapter presents results and analysis of the data in relation to diagnostic methods: the procedures and practices of collecting data to determine the condition of the patient. Diagnostic methods are presented and analysed in terms of methods, skills, procedures and outcomes. The sequential events performed during diagnosis are a thematic account which links the initial encounter of pathology, to the beginning of treatment by identifying processes and skills.

This chapter is divided into four sections. The first section is an overview of the diagnostic methods used in TJM acupuncture. Findings which were identified as important themes related to diagnostic methods are listed and defined.

The second section is a timeline of processes. This section presents and analyses diagnostic methods as they relate in time and space to each other, and the clinical encounter as a whole. This section presents the routine elements of diagnostic procedures which illustrate each step of the diagnostic timeline.

Section three includes an examination of diagnostic methods used in TJM acupuncture including reading, inquiry, observation, palpation, listening/smelling and esoteric methods. How these methods were performed, what information was sought from the patient and the significance and meaning of that information in relation to philosophical concepts and treatment principles are discussed.

The final section analyses findings from the data in relation to how diagnostic outcomes were constructed from diagnostic methods. It is shown that diagnostic outcomes generally included patterns of disharmony, the location of body tissue abnormalities and the location of physical discomfort. The characteristics of patterns of disharmony are explored, and procedural elements of the identification of body tissue abnormalities and physical discomfort are also described.

6.1 Overview of Diagnostic Methods

A variety of diagnostic methods were identified in the data. These include reading, inquiry, observation, palpation, listening/smelling and esoteric methods (Table 6.1). Inquiry, observation, palpation and listening/smelling were sometimes referred to as the “four examinations” (WHO code 2.0.14). Range of movement, strength, flexibility and neurological tests were also found to be performed as combinations of observation and palpation.

Table 6.1 List of Diagnostic Methods

Method	Definition
Reading	Reading forms, letters or results from diagnostic tests
Inquiry	Asking the patient about their condition and illness history
Observation	Inspecting the patient's physical condition
Palpation	Touching or pressing the body
Listening/Smelling	Listening to the patient's voice and other bodily sounds Recognising body odours
Esoteric	Methods not based on standard TEAM, biomedical or orthopaedic diagnostic procedures

Data relating to diagnostic methods were obtained from 89% (n=34) of the total 38 practitioners who were recruited into the study. Four practitioners did not contribute data to diagnostic methods because interviews with them did not cover any aspects of diagnosis. Of the 34 practitioners who contributed data to diagnostic methods, 22 were observed in clinic. Details relating to the relationship between practitioner numbers and diagnostic methods are provided throughout this chapter where appropriate.

Table 6.2 shows what diagnostic methods were found to be used by each practitioner. The table shows nine categories of data: practitioner, explanatory model, inquiry, observation, pulse palpation, body palpation, listening/smelling and esoteric. “Ticks” indicate whether a practitioner was found to include the diagnostic method in their practice while “crosses” indicate which methods were not found in their practice.

Table 6.2 Practitioners, Explanatory Models and Diagnostic Methods

Practitioner	Explanatory Model	Reading	Inquiry	Observation	Pulse Palpation	Body Palpation	Listening/Smelling	Esoteric
Tsuru	TEAM	✓	✓	✓	✓	✓	X	X
Ginnosuke	TEAM	✓	✓	✓	✓	✓	✓	✓
Asajiro	Orthopaedic	✓	✓	✓	X	✓	X	X
Takizou	TEAM	X	✓	✓	✓	✓	X	X
Bunzaemon	Orthopaedic	X	✓	✓	X	✓	X	X
Ume	TEAM	✓	✓	✓	✓	✓	X	X
Zenkichi	Orthopaedic	X	✓	✓	X	✓	X	✓
Koremitsu	TEAM	✓	✓	✓	✓	✓	X	X
Genrokuro	Biomedical	X	✓	✓	X	✓	X	X
Kojiro	TEAM	X	✓	✓	✓	✓	X	X
Iwamatsu	TEAM	X	✓	✓	✓	✓	X	X
Kame	TEAM	X	✓	✓	X	✓	X	X
Shinokichi	Orthopaedic	✓	✓	✓	✓	✓	X	X
Tarobi	TEAM	✓	✓	✓	✓	✓	✓	X
Denkuro	TEAM	X	✓	✓	✓	✓	✓	✓
Bunshichi	TEAM	✓	✓	✓	✓	✓	X	X
Kiemon	TEAM	X	✓	✓	✓	✓	X	X
Toko	TEAM	✓	✓	✓	✓	✓	X	X

Practitioner	Explanatory Model	Reading	Inquiry	Observation	Pulse Palpation	Body Palpation	Listening/Smelling	Esoteric
Yae	TEAM	√	√	√	√	√	X	X
Benio	TEAM	√	√	√	√	√	X	X
Sayo	TEAM	√	√	√	√	√	X	X
Rin	TEAM	√	√	√	√	√	X	X
Zenpachi	Biomedical	√	√	√	X	√	X	X
Miyo	Biomedical	√	√	√	√	√	X	X
Nobuhide	Biomedical	√	√	√	X	√	X	X
Chusuke	TEAM	X	√	√	X	√	X	X
Sasuke	TEAM	X	√	√	X	√	X	X
Heijiyo	TEAM	√	√	√	√	√	X	X
Kinu	TEAM	Not Available	√	√	√	√	X	X
Otoemon	TEAM	X	√	√	√	√	√	X
Sukegoro	TEAM	Not Available	√	√	√	√	X	X
Hikoemon	Biomedical	Not Available	√	√	X	√	X	X
Heisuke	Orthopaedic	X	√	√	X	√	X	X
Mitsu	TEAM	Not Available	√	√	X	√	X	X
Total	-	17	34	34	22	34	4	3
TEAM		24						
Biomedical		5						
Orthopaedic		5						

6.2 Diagnostic Methods: A Timeline of Processes

[I palpate] the whole body in about one or two minutes. (Genrokurou: acupuncture/ judo therapy practitioner)

Diagnostic events were found to occur simultaneously and were sometimes altered depending on the outcomes of diagnostic processes. However, there appeared to be general routines practitioners followed. Diagnostic methods seemed to conform to a gradient of intimacy. Collecting diagnostic information tended to begin with the least intimate method which was followed by a slightly more intimate method. This section describes the flow of the seven procedural elements of diagnosis up to the commencement of treatment (Figure 6.1).

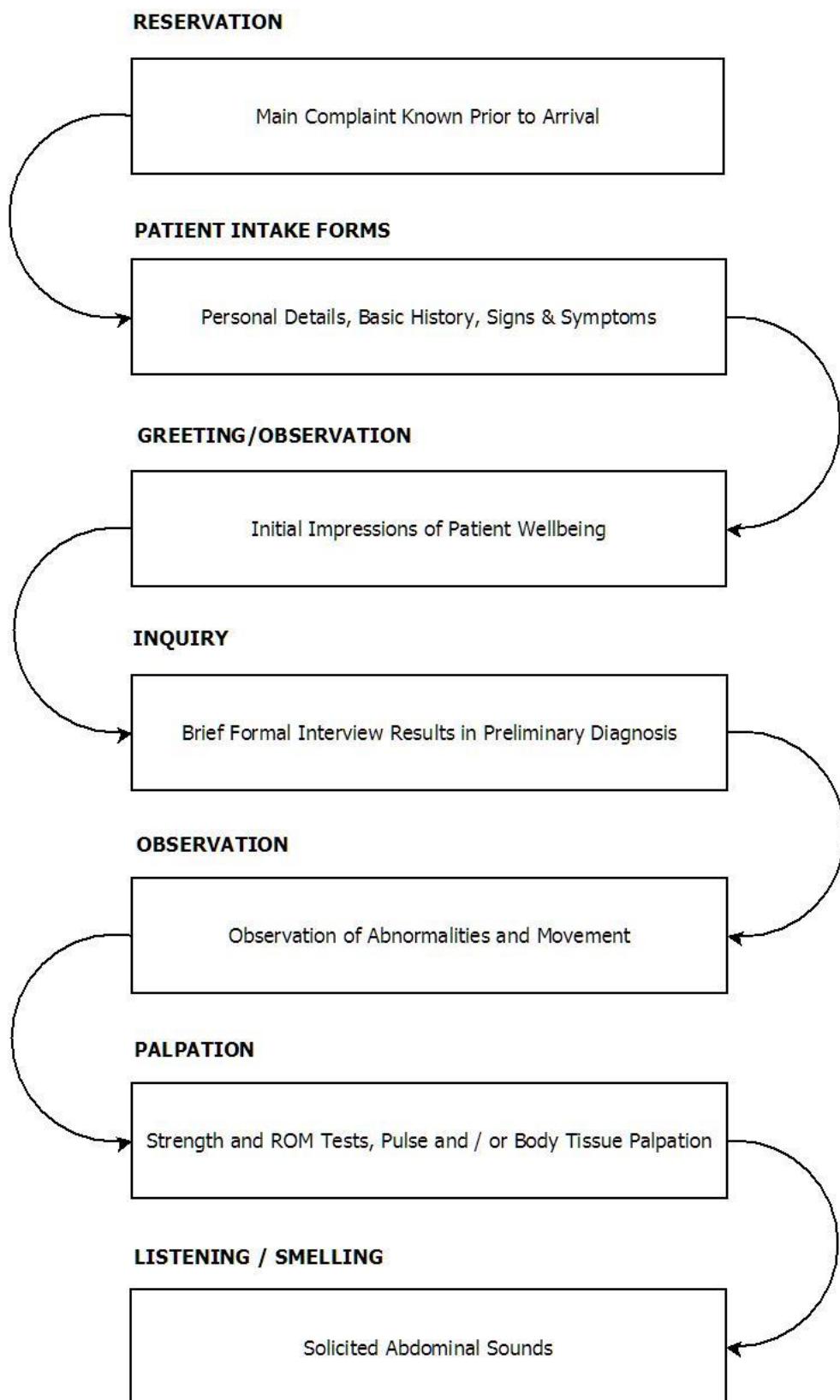


Figure 6.1 Timeline of diagnostic events

Reservation

Inquiry was sometimes found to begin before the practitioner and patient met in person. If a practitioner personally received phone calls (62%, n=21), they were sometimes told the nature of the patient's condition. However, there were also practitioners whose clinic procedures did not allow for reservations (3%, n=1), or there were those who had staff that took reservations for them (35%, n=12). For these practitioners, reservations were not a chance to use inquiry. Although this study only included one practitioner who did not allow reservations, it should be noted that for many medical services (including acupuncture/judo therapy clinics) in Japan, it is normal for clinics to not permit reservations.

Patient intake forms

Exactly half (50%, n=17) of the practitioners were found to have new patients fill out an initial patient intake form which included information pertaining to their condition. This form was filled out before the patient was invited into the treatment space, and handed in at reception. Practitioners could read the form to give them a preliminary diagnosis and some clues about differential diagnosis. For return patients who were treated by a different practitioner at the same clinic, the forms provided diagnostic information helpful for the treating practitioner who otherwise would have had to perform initial diagnosis again. Although the information on the form may have provided some relevant information about the patient's condition, an important purpose of the form was to adhere to the national health rebate laws. Without paperwork which outlined some signs, symptoms, diagnosis and aetiology; patients and practitioners may not have been able to receive rebates for treatments.

Greeting / observation

Reservations and patient intake forms were not used by all practitioners. However, all patients were greeted by practitioners in some manner. Some practitioners used the greeting to observe the patient, assess their range of movement and use polite discourse to gain insight into the patient's condition. Information from polite discourse was diagnostic when something was said which the practitioner felt was pertinent to the case. Sometimes the patient used the greeting as a signal to discuss their health condition and the talk developed into diagnostic inquiry.

Although it was relatively of small significance when compared to more formal diagnostic methods, the greeting was recognised theoretically by practitioners as having potential value in providing diagnostic clues.

Inquiry

The formal interview began once the patient had fully entered the treatment area. Most practitioners conducted inquiry with the patient either sitting or lying on the treatment table. Interviews were found to generally take no longer than around five minutes. For returning patients, the interview was often conducted while the practitioner prepared for the patient, or while performing another kind of diagnosis. On some occasions, even for new patients, the interview was found to be conducted during other diagnostic methods. Interviews were not always private, usually because of the physical environment of the clinic. Almost half (45%, n=10) of practitioners who were observed had clinics in which complete privacy was impossible. This was due to the size of the clinic and that treatment tables were only separated by curtains.

Observation

Observation was an ongoing process throughout the clinical encounter performed in almost constant parallel with other methods; especially inquiry or palpation. Aside from passively looking at the patient, some diagnostic tests relied on observing the patient's range of movement, pupil dilation or testing other reflexes. Range of movement testing sometimes involved inquiry as the practitioner solicited where movement became uncomfortable.

Palpation

Palpation tended to occur on a gradient of intimacy beginning at the radial pulse and progressing through palpation of the limbs, abdomen and finally back. Several aspects of palpation were identified in the data, each apparently requiring separate technical skills to perform. TEAM model practitioners tended to firstly palpate the radial pulse either seated or standing. The pulse taking process typically lasted no longer than around two minutes, with the fastest of the practitioners taking sometimes under one minute to palpate the pulse.

Palpation of the skin and underlying tissues followed a similar gradient of intimacy as diagnostic methods did in general. It tended to begin with light pressure and sometimes progressed to deeper or stronger pressure. The general methods for palpating the skin and underlying tissues was to first use the whole hand to briefly brush over the skin to source any abnormal areas, and then to use the fingertips to carefully locate the exact site and qualities of any abnormality. Initial brushing with the hand took only several seconds over an area of body tissue. Detailed inspection with the finger tips also took several seconds at each area. Palpation speed was probably relative to the skills and experience of the practitioner.

Stronger palpation usually took longer than light palpation. Practitioners spent more time with deeper palpation because it took more time to feel deeply along the course of a muscle, tendon or ligament, around joints and into the abdomen than it did to feel the textual qualities of the skin. More care was also required when palpating deeply not to cause accidental discomfort to the patient. Practitioners also attempted to solicit painful areas and this sometimes took time to identify the exact location.

After palpating the limbs, practitioners sometimes palpated the abdomen. Abdominal palpation often took less than a minute to perform. Palpation of the back usually occurred last. This was probably because most patients were diagnosed from the supine position first. It seemed to be easier to perform all other diagnostic methods with the patient in a supine position than it was for them to be prone. Palpation of the back was most important when the patient's main complaint was located on the back. However, some practitioners palpated muscle tension and bone alignment in the back to assess the general condition of the patient and believed that correcting any abnormalities in the back would be beneficial to the general condition of the patient.

Palpation also included range of movement and strength tests. Range of movement with palpation was particularly evident with passive range of movement tests which were seen to be conducted most often by orthopaedic model practitioners. Palpation was also important in resistance strength tests where

practitioners felt for differences between limbs or judged patient performance against known norms.

Listening/smelling

The procedures surrounding listening/smelling made it one of the most intimate diagnostic methods. It was observed to be performed on the abdomen and was an active process in which the practitioner performed a series of interactions to solicit sounds. This was usually the last diagnostic method performed on patients and generally took less than a minute to complete. It required a unique set of skills to locate diagnostically significant areas on the abdomen by applying the correct tapping technique to generate sounds.

6.3 Diagnostic Methods and Procedures

For new patients, I check the client intake forms first, and then I do an interview to get some more details. I also palpate the problem areas to confirm what's going on. I use tongue [observation], pulse, body palpation and abdominal diagnosis in my general treatments. (Rin: acupuncture practitioner/lecturer)

This section describes the diagnostic methods found to be used by TJM acupuncture practitioners: inquiry, observation, palpation (including pulse and body tissue palpation), listening/smelling and esoteric methods.

Information obtained from diagnostic methods can be categorised into diagnostic evidence used to identify the primary aspect of disease, and diagnostic evidence used to identify any secondary aspects of a disease. Procedures related to collecting diagnostic evidence were sometimes categorised by practitioners as “root diagnosis” and “branch diagnosis”. Diagnostic methods which attempt to solicit information pertaining to a patient’s condition in general can be considered root diagnosis and are holistic in nature.

Root treatment is how the Ki of the whole body can be treated and adjusted into correct balance. (Iwamatsu: acupuncture practitioner/professor)

Diagnostic methods which solicit information relating to a patient's specific problem area/s can be considered branch diagnosis and are local in nature. Practitioners used root/branch and holistic/local diagnosis in complementary and contrasting ways which are described throughout this and later sections.

6.3.1 Inquiry

First of all I talk to the patient and I do all the four examinations of Oriental medicine. . . I ask about their health history and about the health history of their family, as well their social background too. I do Meridian Therapy so I feel the pulse and palpate the abdomen in the beginning. . . These are the most important aspects of diagnosis. . . (Iwamatsu: acupuncture practitioner/professor)

Asking the patient about their condition and the history of the illness (inquiry) was found to be used as a way of gaining diagnostic information. This was comparatively one of the most important diagnostic methods among practitioners. To some extent, 100% of practitioners used inquiry as a diagnostic method. Practitioners used inquiry in differing ways and to different degrees. Most practitioners appeared to significantly weight the findings from inquiry in their consideration of the patient, while some only seemed to use it to gain a general idea about a patient's condition or as a segue into other diagnostic methods.

Inquiry was found to occur at different times throughout the clinical encounter, although it usually began at the beginning in the form of conversation. For initial patients, this conversation could become a formal interview which involved various lines of questioning. For returning patients, inquiry tended to include less comprehensive verbal examination. Inquiry could also be performed throughout the clinical encounter in the form of polite discourse. This method of inquiry was less formal than an interview but still provided clues which could help the practitioner understand the cause or prognosis of the patient's condition, or help provide additional information related to treatment locations.

At first, when patients come in, they fill out the intake form. After that, I examine their symptoms for more details according to what they filled out in the form. While we talk, I also take into account how their lifestyle and

emotional state may be affecting their condition. (Sayo: acupuncture practitioner/senior lecturer)

Inquiry was also used to learn about how the patient was currently feeling or had been feeling. For new patients or patients who had not attended the clinic recently, it was also used to solicit their reason for coming to the clinic and to provide any information about the history, possible causes and duration of their condition. In general it was used by all practitioners to establish the reason why the patient had come to the clinic and to create a goal for the clinical encounter. Inquiry was found to be combined with reading patient intake forms or other medical documents. It was also sometimes used in combination with other diagnostic methods such as pulse and body palpation, range of movement testing or observation. Practitioners used information from the inquiry to form a basic differential diagnosis which they then confirmed and expanded through other diagnostic methods. Conversely, inquiry was also routinely used by practitioners to confirm the findings from other diagnostic methods, or to follow up on diagnostic information found in other methods that were ambiguous.

In Western medicine the diagnosis is very clear, so we can treat the problem directly. But when we are not sure what's going on, or there is some internal disorder, we use Eastern medicine diagnosis. (Zenpachi: acupuncture practitioner/professor)

Diagnostic inquiry was interpreted as being based in combinations of the three explanatory models of medicine outlined in Chapter Five. This included diagnostic inquiry based on the TEAM concept of the '10 questions', biomedicine or orthopaedic principles. Biomedical questioning seemed to be grounded in the modern understanding of internal medicine. Orthopaedic questioning appeared to be founded on the modern understanding of anatomy and structural physiology/pathophysiology. Table 6.3 summarises elements of inquiry.

Table 6.3 General Use of Inquiry

Who	<ul style="list-style-type: none"> • 100% of practitioners
When	<ul style="list-style-type: none"> • More initially, less consecutively (both throughout the clinical encounter and over the course of treatments)
How	<ul style="list-style-type: none"> • TEAM 10 questions • Biomedical questioning • Orthopaedic questioning
Why	<ul style="list-style-type: none"> • Define treatment goals • Establish aetiology • Assess patient condition • Follow up findings from other methods

During diagnosis I might interview the patient and ask them about what is bothering them the most, or use a TEAM based questionnaire for diagnosis. If they have some musculoskeletal disease like a sore lower back for example, I will check to see how far it is comfortable for them to move and I will conduct a Western medicine like interview. I might also do pulse palpation, abdominal diagnosis, examine under the patient's eyes and look at the entire body to determine a diagnosis. I have my own procedure for treatments. I check the pulses, abdomen and heartrate and categorise the patient as a certain type. Depending on that type, I treat them with the corresponding points. (Heijiyo: acupuncture practitioner/head lecturer)

Biomedical and orthopaedic model practitioners, and those committed to TEAM philosophies appeared to differ in relation to what lines of questioning were pursued during diagnostic inquiry. Biomedical and orthopaedic model practitioners were found to rarely base their inquiry on the 10 questions. TEAM model practitioners seemed to base their inquiry more on the 10 questions while sometimes incorporating biomedical or orthopaedic questioning when appropriate.

This patient has a pituitary gland disorder which has affected her growth. The pituitary gland is in the brain, so the best way to treat this is from the Kidneys and the Governing Vessel because the Kidneys are related to the brain. (Tsuru: acupuncture practitioner)

Practitioners who based their inquiry on the 10 questions were also usually found to perform identification of syndromes and pattern differentiation (WHO code 1.1.3). Practitioners using orthopaedic or esoteric methods, or methods which primarily involved locating body tissue abnormalities appeared to give less significance to the findings from inquiry than other practitioners. For such practitioners, inquiry was usually found to be performed after other diagnostic methods had been completed to clarify any ambiguous findings.

Table 6.4 lists the explanatory models of medicine and the emphasised knowledge used in diagnosis by practitioners committed to those models. In regards to the TEAM model of medicine, diagnostic information was not usually categorised using knowledge of the six meridians, four levels or three divisions. Inquiry which served to establish the psychological or emotional state of patients also did not appear significant to any practitioners.

Table 6.4 Explanatory Model and Diagnostic Terminology

TEAM	Biomedical/Orthopaedic
Eight Principles	Anatomy
Five Phases	Physiology
Viscera/Bowels	Pathophysiology
Vital Substances	
Channels and Collaterals	
Pathogenic Factors	

6.3.2 Observation

I observe the patient from as soon as they enter. The condition of their face, how they are walking, the condition of their eyes, nose and anything else we can see. Then I talk to the patient and find out how the organs are operating in the body and which of the five viscera is the cause of the problem. Each one of those organs has its own unique properties and it's the first step of diagnosis to find out which organs are under or over functioning. (Sayo: acupuncture practitioner/senior lecturer)

Observation was used to collect diagnostic information by inspecting the patient's condition; especially physical structure, alignment, movement and body colours. Observatory findings were commonly described as one the first diagnostic methods practitioners utilised when encountering a patient. However, meaningful observation was generally found to be employed after inquiry and sometimes before or together with body palpation, particularly when the patient wanted to show the practitioner an area of concern. Table 6.5 summarises observation.

Table 6.5 General Use of Observation

Who	<ul style="list-style-type: none"> • 100% of practitioners
When	<ul style="list-style-type: none"> • After inquiry • Before or during palpation
Why	<ul style="list-style-type: none"> • Diagnosing lesions • Tongue diagnosis • Diagnosing the meaning of body colours • Diagnosing structural and kinaesthetic abnormalities
Outcomes	<ul style="list-style-type: none"> • Give general indicators about disease states • Reduce possible palpation sites from many to a few • Contribute information to patterns of disharmony

Most importantly, observed findings included structural abnormalities of bones, indurations, joints, movement, muscles and swellings. Generally, observation was found to provide clues about where abnormalities existed in order to confirm the state of any abnormalities by palpation. Diagnostic information from observation was found to be given more significance when palpation could not be used to confirm observatory findings. This included diagnosing lesions, the eyes, the tongue, colours and discolourations, or reflex responses. Information from observation was sometimes found to contribute to the formation of patterns of disharmony or be an indicator for the presence of other pathology in biomedical/orthopaedic terms. Table 6.6 lists observation markers found to be used during diagnosis by observation.

Table 6.6 Observation Markers

Verifiable by Palpation	Unverifiable by Palpation
Bones	Lesions
Indurations	Eyes
Joints	Tongue
Movement	Colours/Discolouration
Muscles, ligaments and tendons	Reflex response
Swellings	

Skin discolouration includes blotches, spots, abnormal complexion or skin colour in general. Mild complexion and general skin colour abnormalities were never found to be significant diagnostic indicators. Although, some practitioners reported that they could be indicators for the presence and severity of a pathological factor in relation to the construction of patterns of disharmony. In such cases, skin discolouration was found to be more important in confirming treatment effects than actual diagnosis; if the complexion seemed improved after treatment, this was a sign of good treatment efficacy. Comparatively, blotches seemed more important diagnostically. The presence of red lesions or blue discolouration was sometimes reported to mark Heat or Ki/Blood deficiency when signs and symptoms were translated into a pattern of disharmony. They were not usually described as viscera/bowel organ pathology. Skin blotches which were not so prominent were found to be used in treatment site location rather than diagnosis.

When it comes to tongue diagnosis, I examine how big or how thin the tongue is. Also, I examine if the tongue is coated, and if it is coated with yellow or white. I also examine if the tongue colour itself is red or pale. So basically I examine the tongue shape, colour, condition of the coating, and the colour of the coating. (Sayo: acupuncture practitioner/senior lecturer)

Tongue diagnosis was used by a minority of practitioners. Although all practitioners studied tongue diagnosis as part of their undergraduate training, it was not found to be commonly used in clinic. Tongue size, shape, colour, fur, geography (cracks, bumps, hollows and textural appearance) and moisture were apparently taken into consideration when observing the tongue.

The tongue was sometimes divided into segments representing the upper, middle and lower portions of the body (Figure 6.2 A). However, zones representing the viscera and bowels were typically not found to be applied to the tongue (Figure 6.2 B). When observing the tongue, practitioners sometimes diagnosed a pattern of disharmony which included a pathological factor in addition to a body segment. The patterns of disharmony included simple descriptions such as 'Heat above', 'Damp' or 'Ki deficiency'.

[When you look at their tongue, what information does that give you?] If they are excess or deficient or have Dampness or Humidity, have Heat or Cold, or if they have a Stomach problem or not. I can also see if they have Blood stagnation. (Toko: acupuncture practitioner).

Practitioners who observed the tongue in initial diagnosis were also usually found to observe the tongue post treatment to confirm any effects of treatment interventions. They considered it typical for the tongue to be able to change in response to treatment. This may be a unique aspect of tongue diagnosis in TJM acupuncture.

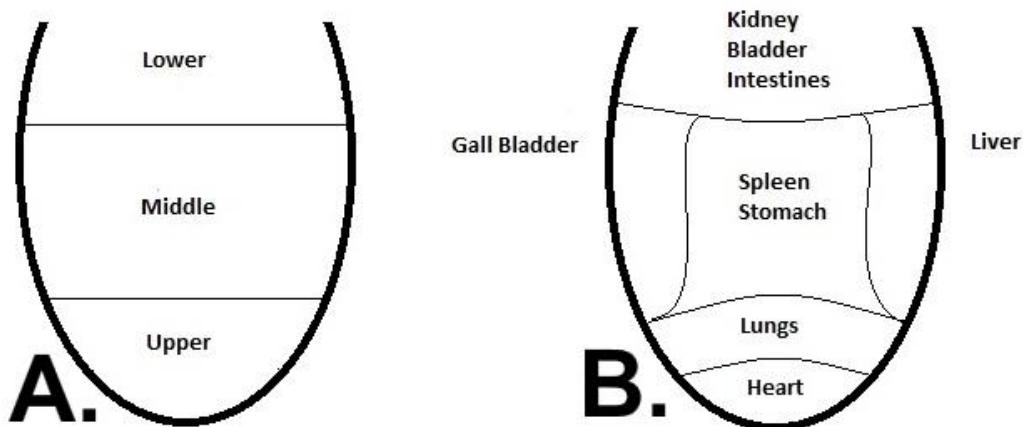


Figure 6.2 Zones of correspondence in tongue diagnosis

In general, the significance of observed findings was found to be weaker than from inquiry or palpation unless a diagnosis was unverifiable by those methods. Observation offered clues about where abnormalities may have existed, and was often seen to be a precursor to confirmation by palpation. It also provided basic information about illness severity and aetiology when observing structural abnormalities and kinaesthetic disorders. Findings from the data indicate that

observation was most significant when diagnosing lesions, the meaning of body colours and structural and kinaesthetic abnormalities. Observation also contributed information to patterns of disharmony especially when inspecting body colours or the tongue.

6.3.3 Palpation

My style isn't to check to see whether the viscera or bowels are in balance. Instead I would examine the firmness/tightness or softness and colour of the body. I also feel the condition of the skin; like if it's too rough. I also learnt how to tell if there's a sympathetic nerve or parasympathetic nerve problem by how the body swells up either on the right or left. (Ume: acupuncture/massage practitioner)

Palpation is the way practitioners gain information for diagnosis by touching or pressing the surface of the body. Palpation appeared to be one of the most complex diagnostic methods due to the necessary skills required and the reliance on sensitivity. Every practitioner was found to perform some kind of palpation which contributed to diagnosis. However, palpation was performed in differing ways according to different philosophical concepts, and what diagnostic markers were considered significant, varied among practitioners.

Pulse palpation

Rarely [do I palpate the pulse]. . . One or two times a day. I don't have the time for that. (Genrokuro: acupuncture/judo therapy practitioner)

Pulse palpation is the examination of the pulsation of the blood vessels with the fingertips. In this study it was typically found to occur at the radial pulse of the wrists. Of practitioners who contributed to data relating to diagnostic methods, 65% (n=22) included pulse palpation in their diagnostic methods. Table 6.7 summarises the main findings related to pulse palpation.

Table 6.7 Use of Pulse Palpation

Who	<ul style="list-style-type: none"> • 65% of practitioners
When	<ul style="list-style-type: none"> • After inquiry • Patient supine • Patient seated
How	<ul style="list-style-type: none"> • Six position pulse diagnosis • Three position pulse diagnosis • Biomedical pulse diagnosis
Why	<ul style="list-style-type: none"> • Assess patient condition • Develop pattern differentiation • Root diagnosis • Follow up findings from other methods

Practitioners not committed to the TEAM model were rarely found to perform pulse palpation, and if they did, it was for different purposes than TEAM model practitioners. For practitioners practicing from the TEAM model, the pulse was sometimes found to provide information useful for diagnosis and treatment, especially when diagnosing a pattern of disharmony. However, even practitioners who were committed to the TEAM model were found to not palpate the pulse, or to not act on any information taken from pulse palpation. This may be a unique feature of TJM acupuncture.

[Do you do pulse diagnosis in your treatments?] Yes! But it's just a kind of performance. I don't know if I understand it. [So it doesn't really have any meaning for you?] No, it does have meaning. It's a performance! (Kinu: acupuncture practitioner/senior lecturer)

Practitioners who palpated the radial pulse applied the three or six position pulse palpation methods. Both methods involved placing three fingers along the radial pulse of either the left, right or both wrists of the patient. When using three position pulse diagnosis, practitioners were interpreted to construct meaning at each finger position in different ways:

- General quality
- Organs and channels
- Upper, middle and lower levels

Three position pulse diagnosis was found to use three fingers to diagnose the general quality of the pulse by palpating either the left or right radial pulse. There were two methods found to use three position pulse diagnosis in contrasting ways. The first involved palpation of three positions along the radial pulse at once, considering each position as one part of a dynamic whole without assigning any organ, channel or level to any one position (Figure 6.3).

In the second, organs and channels were assigned to pulse positions on the left and right wrists. Both methods were practiced according to “the three positions and nine indicators” (WHO code 2.4.6) and relied on knowledge of the basic 28 pulse qualities. However, of the basic 28 pulse qualities described in TEAM, practitioners were found to only use a limited number of them in regular practice. These typically included: floating, sunken, slow, rapid, excess, deficient, slippery and wiry. This is also evidenced in Figure 6.3.

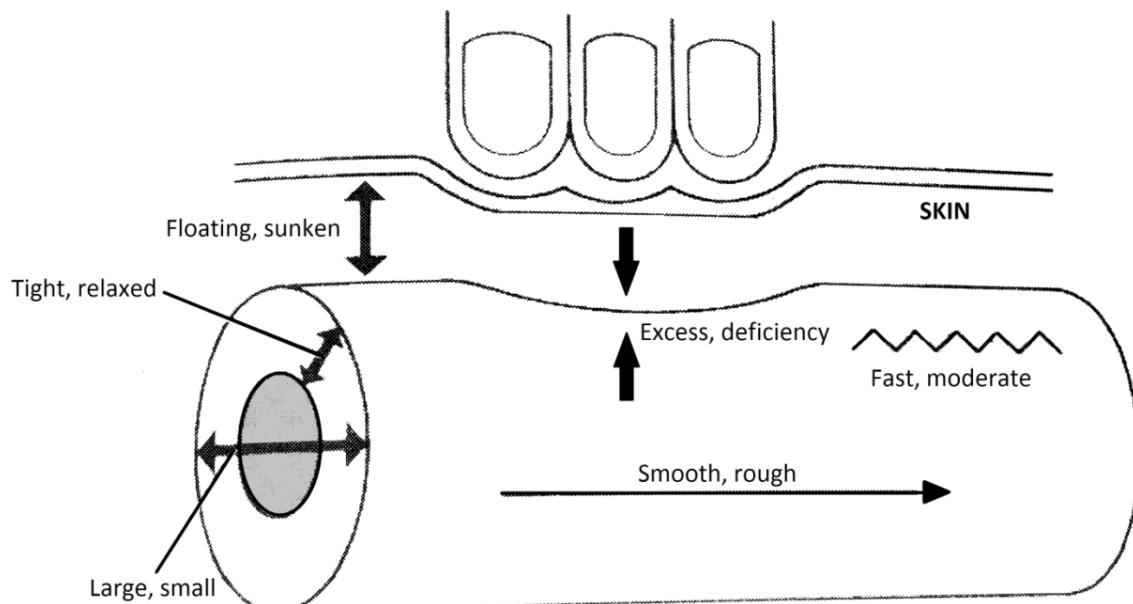


Figure 6.3 Translated pulse palpation diagram – Source: Zenpachi (acupuncture practitioner/professor)

[For the pulse], I simply check if it's fast or slow, deep or superficial. Slippery or wiry. . . I don't [really go into the 28 different pulse qualities]. . .
 (Rin: acupuncture practitioner/lecturer)

Six position pulse diagnosis was found to assess the condition of the pulse according to the separation of six different positions, each representing a viscera, bowel or channel. In general, the qualities of excess or deficiency were found to be used to describe six different paired Yin/Yang organs in terms of the five phases. This system of pulse diagnosis is reportedly derived from *The Classic of Difficult Issues* which is popular with some styles of TJM acupuncture, especially Meridian Therapy. It was interpreted that the clinical significance of the results obtained from six position pulse diagnosis were generally systematic and followed predefined rules and formulas for treatment. These rules were generally based on the *Classic of Difficult Issues*, Chapter 69 and the five phases. For some practitioners, diagnosing and treating the pulse in this manner appeared to be the purpose of the clinical encounter. For such practitioners, the diagnosis and treatment of the pulse was described as "root treatment", and the diagnosis and treatment of other signs and symptoms using other diagnostic methods described as "branch treatment". Practitioners who placed significance on diagnosing the pulse in this manner seemed to believe that by addressing abnormalities in the pulse, all other symptoms could be improved.

My pulse taking system is from Meridian Therapy, I can understand a lot about the patient's condition just by palpating the pulse. . . I can feel the condition of the patient's body at that moment through the pulse and decide what points I should treat. . . The Classic of Difficult Issues, Chapter 69 is the main theory I use for pulse diagnosis. . . Finally, when I check the pulse and I feel that it has balanced, then I can end the treatment. (Takizou: acupuncture practitioner)

There was also diversity in the assignment of organs or channels to the three or six positions of the pulse. Figure 6.4 is a translated diagram of six position pulse diagnosis which was received as a handout from a workshop attended with Tsuru (acupuncture practitioner). Abbreviations in English on the left and right sides of each diagram refer to organ channels. The middle part (inch, bar and cubit) refer to pulse positions. The diagram shows organ/channel correspondences at various

positions within a pulse position segment which refers to the relative depth of palpation where the organ/channel correspondence can be found. On the '12 Meridian Differentiation' diagram at the left cubit pulse position segment, it shows that the Bladder can be felt superficially and the Kidneys at a deeper level of pulse palpation. It shows alternate pulse/channel position correspondences with viscera, bowels or channels at contrasting palpation positions. As this knowledge comes from classical Chinese literature, it is probably not unique to TJM acupuncture. However, it is important to note that practitioners in Japan study and apply unconventional pulse palpation organ/channel correspondences.

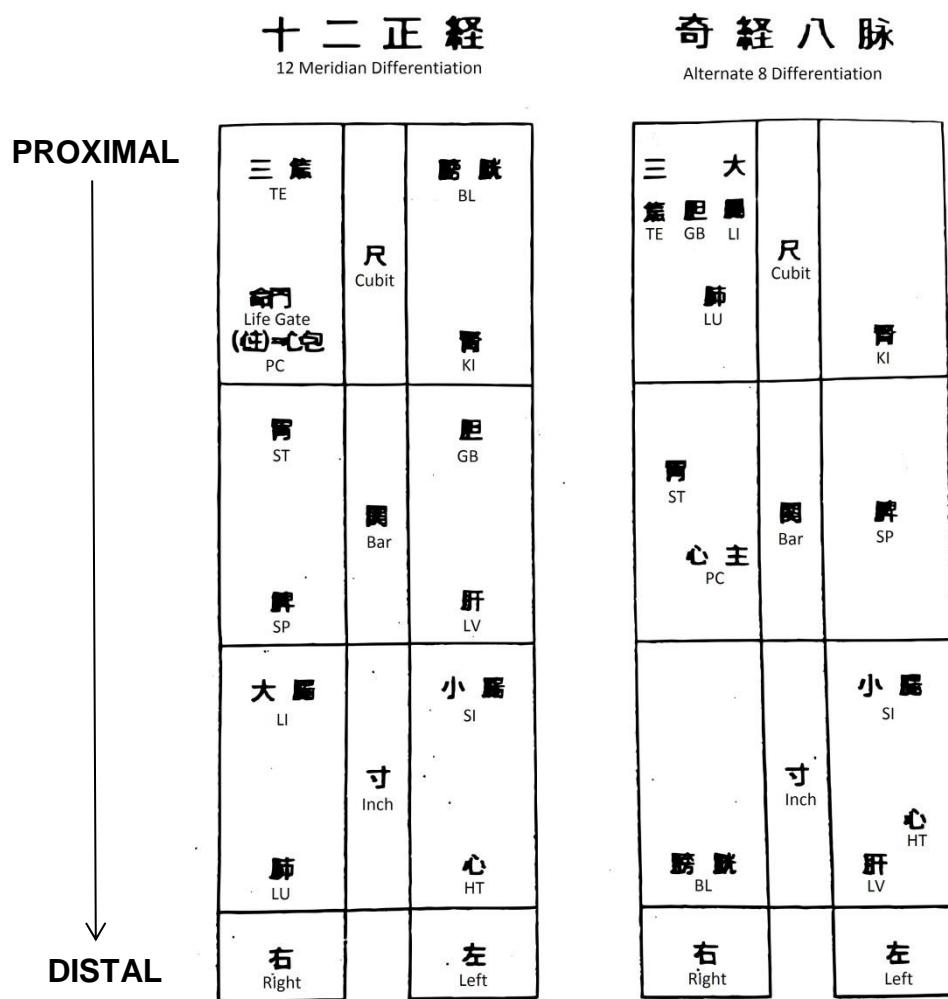


Figure 6.4 Alternate viscera, bowels or channels at pulse positions – Source: Tsuru (acupuncture practitioner)

Pulse palpation was usually found to occur after inquiry. It was performed with patients seated or supine. Pulse palpation was found to be performed at one wrist

only, both wrists consecutively or both wrists simultaneously. Practitioners using six position pulse diagnosis tended to palpate both wrists simultaneously with the patient supine (Figure 6.5). Sometimes practitioners who used only a single radial pulse would remain seated during pulse palpation, consequent diagnosis and treatment. The pulse could be palpated at each of the three positions (represented by black “ovals” on Figure 6.6) on the pulse individually or collectively at various levels of finger pressure. Table 6.8 summarises main elements of three and six position pulse palpation.

Table 6.8 General Use of Three and Six Position Pulse Palpation

	3 Position Pulse Palpation	6 Position Pulse Palpation
Where	<ul style="list-style-type: none"> • One wrist only • Both wrists consecutively • Both wrists simultaneously 	<ul style="list-style-type: none"> • Both wrists consecutively • Both wrists simultaneously
Practitioner	<ul style="list-style-type: none"> • Seated 	<ul style="list-style-type: none"> • Standing
Position	<ul style="list-style-type: none"> • Standing 	
Qualities	<ul style="list-style-type: none"> • Predominantly floating, deep, slow, rapid, excess, deficient, slippery and wiry 	<ul style="list-style-type: none"> • Predominantly excess or deficient
Base	<ul style="list-style-type: none"> • 28 pulse qualities 	<ul style="list-style-type: none"> • Classic of Difficult Issues
Philosophy	<ul style="list-style-type: none"> • Viscera/bowels/channels 	<ul style="list-style-type: none"> • Viscera/bowels/channels



Figure 6.5 Simultaneous pulse palpation with Yae (acupuncture practitioner)

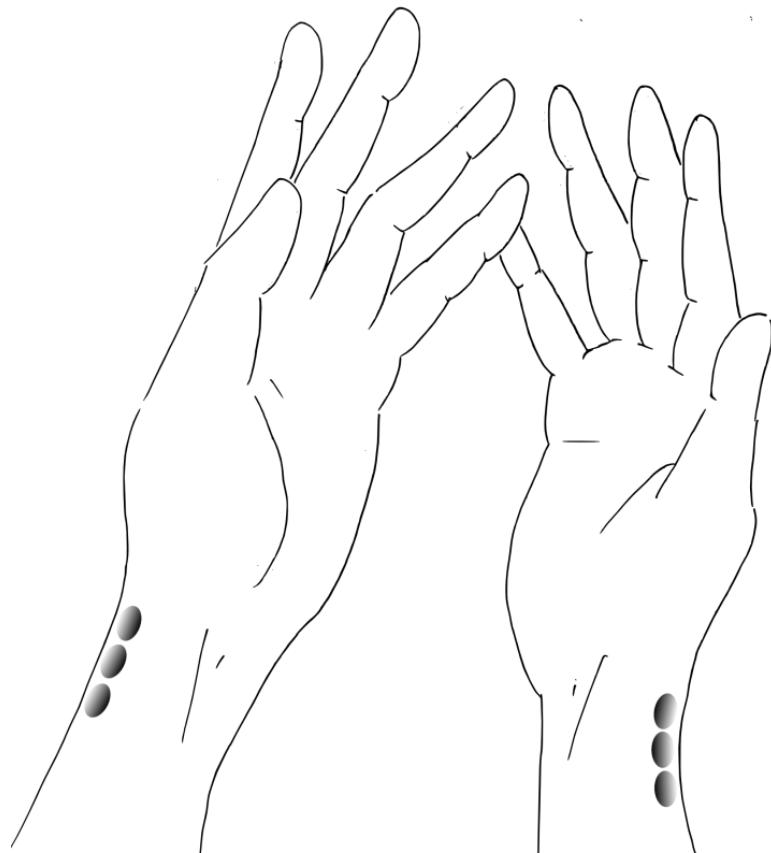


Figure 6.6 Pulse palpation positions

Body tissue palpation

In Ishizaka style we only feel for hard tissue. We feel for hard areas, soft areas, weak areas. Feel for the area and treat it directly with the needle. . . I like to feel the patient, so I study old Japanese acupuncture literature. It's written in a lot of old Japanese books that feeling is more important than thinking. In Ishizaka style there is no thinking. Just where your fingers find the point, stop and treat it. (Ginnosuke: acupuncture practitioner)

Body tissue palpation was found to include feeling the skin and/or any underlying tissues for the purpose of locating and understanding the condition of abnormalities. Table 6.9 summarises the main elements of body tissue palpation. Abnormalities appeared to either represent malfunction in other areas of the body, or existed simply as a malfunction in local tissue. In the former case, areas of body tissues were found to be divided into zones which were seen to represent the condition of other areas of the body, such as the internal organs or anatomical features (refer back to Figure 5.4). Figure 6.7 is a photo of a diagram drawn by Kame (acupuncture practitioner) showing hip flexibility correspondences. Kame explained that the condition of the right hip reflects the lungs, heart and chest while the condition of the left hip mirrors the digestive system.

Table 6.9 Use of Body Tissue Palpation

Who	<ul style="list-style-type: none"> • 100% of practitioners
When	<ul style="list-style-type: none"> • After inquiry, observation and pulse palpation • Throughout clinical encounter
How	<ul style="list-style-type: none"> • Palpating tissue relevant to main complaint • Palpating tissue predetermined to be relevant to any complaint • Both of the above
Why	<ul style="list-style-type: none"> • Diagnose abnormalities • Develop pattern differentiation • Root diagnosis • Branch diagnosis • Follow up findings from other methods

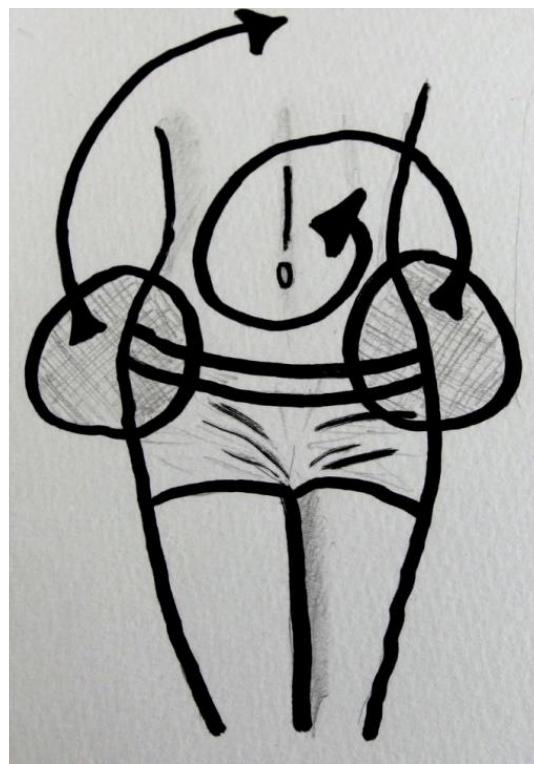


Figure 6.7 Hip flexibility correspondences – Source: Kame (acupuncture practitioner)

The condition of the patient's right hip reflects the lungs, heart and chest. The condition of the patient's left hip mirrors the digestive system.

Practitioners were found to prioritise different body tissues in order of diagnostic significance during palpation. Significance was interpreted to be assigned to palpated body tissues in two ways (Type 1 and Type 2 significance allocation):

- **Type 1:** The most significant tissue is that which is the most abnormal in relation to the patient's main complaint and surrounding body tissues.
- **Type 2:** The most significant tissue is that which is located on predetermined diagnostically and therapeutically significant areas of anatomy.

There was some evidence to suggest that biomedical or orthopaedic model practitioners emphasised Type 1 significance allocation and included structurally important skeletal tissue such as the spine and sacrum when applying Type 2 significance allocation. TEAM model practitioners were also found to use Type 1 but appeared to give more importance to Type 2; especially to body tissues such as the abdomen or back when determining patterns of disharmony and performing a root diagnosis (Table 6.10). Relevant and/or predetermined body tissues were

palpated in order to locate diagnostically significant findings. Main examples of diagnostically significant abnormalities at body tissues in both Type 1 and 2 are shown in (Table 6.10).

I have to think about which points I should apply to the pattern. I also palpate the body to see how bad their condition is. I check how hard the muscles are, if there are any cool areas and what their body shape is like. (Kojiro: acupuncture/massage practitioner)

Table 6.10 Allocation of Diagnostically Significant Body Tissues

Type 1	Type 2	Abnormalities
Bones	Abdomen/Chest	Alignment
Channels	Back	Comfort/Discomfort
Joints	Calcaneal Tendon	Indurations
Ligaments	Channels	Pulsations
Muscles	Face	Range of Movement
Points	Pelvic girdle	Reflex Response
Skin	Points	Shape
Tendons	Skin	Strength
	Spine/Sacrum	Swelling
		Temperature
		Tension
		Texture

Abnormalities at certain locations on significant anatomical areas reflected pathology elsewhere in the body. This zoning is similar to palpating channels for abnormalities which reflect irregularities in the viscera/bowels, and/or channels in general.

A Type 2 significance allocation zone which seemed to be important is the abdomen. Of practitioners who contributed data to diagnostic methods, 62% (n=21) were found to use abdominal palpation in diagnosis. It was performed to diagnose abnormal areas which were zones of association theoretically connected to other

places in the body. The information diagnosed from abdominal palpation was sometimes found to contribute to the formulation of a pattern of disharmony.

I don't really use abdominal diagnosis that much. I look for painful or hard places or anywhere with indurations. . . If I find any hard places then it shows that there is some kind of Blood stagnation there. . . Correspondences with the Heart, Liver or Kidneys can be found on the abdomen but I don't really consider those for my abdominal diagnosis. . .

(Rin: acupuncture/lecturer practitioner)

The data suggests that the abdomen was also palpated to diagnose abnormal areas on the abdomen itself, without relating to any zones of correspondence. In such cases, treatment was found to be applied to the abnormal tissue on the abdomen directly. The diagnosis of abdominal abnormalities could reportedly constitute a root diagnosis.

Practitioners who emphasised root diagnosis by addressing abnormalities in anatomical areas of significance believed that by addressing perceived dysfunction at those areas, all other symptoms may be improved. Practitioners who performed root diagnosis appeared to be doing it as some kind of professional service or duty as a practitioner. Attending to the patient's state of wellbeing holistically in addition to addressing their main complaint seemed to be a valued aspect of how one should practice TJM acupuncture for those practitioners. Root diagnosis in itself is probably not a specific feature of TJM acupuncture. However, root diagnosis at specific areas such as the abdomen or on the skin could be unique to TJM acupuncture.

Other body tissues such as the back, spine and sacrum were also found to be valued as having holistic healing potential. In contrast to TEAM model practitioners, those who primarily operated from the biomedical or orthopaedic model were not found to use abdominal palpation for diagnostic purposes in Type 1 or Type 2 body palpation, unless there was a complaint relating to the abdomen directly.

Observation with Kojiro (acupuncture/massage practitioner)

He continued by lifting up the patient's shirt so that he could see their abdomen. Kojiro remarked that the Liver position was a little deflated: there seemed to be a depression in the abdominal tissue in the bottom left area of the abdomen. This indicated a kind of deficiency. In addition, he said that the Heart position was a little inflated which indicated a kind of excess. Using his open right hand, Kojiro touched and gently pressed over the abdomen. He said that there was indeed a hollow over the Liver position and the Heart area was a little raised. This confirmed his suspicions of a pattern of Liver deficiency with Heart excess.

Palpated abnormalities were sometimes found to be valued as part of a group of symptoms contributing to a pattern of disharmony. In addition, palpated body tissue abnormalities were also found to be diagnosed individually, described in terms of a pattern of disharmony and treated singly. For instance, tight shoulders were found to be diagnosed as Liver excess, or knee stiffness as Kidney Ki deficiency. In this way, simple patterns of disharmony were diagnosed using individual symptoms (Figure 6.8).

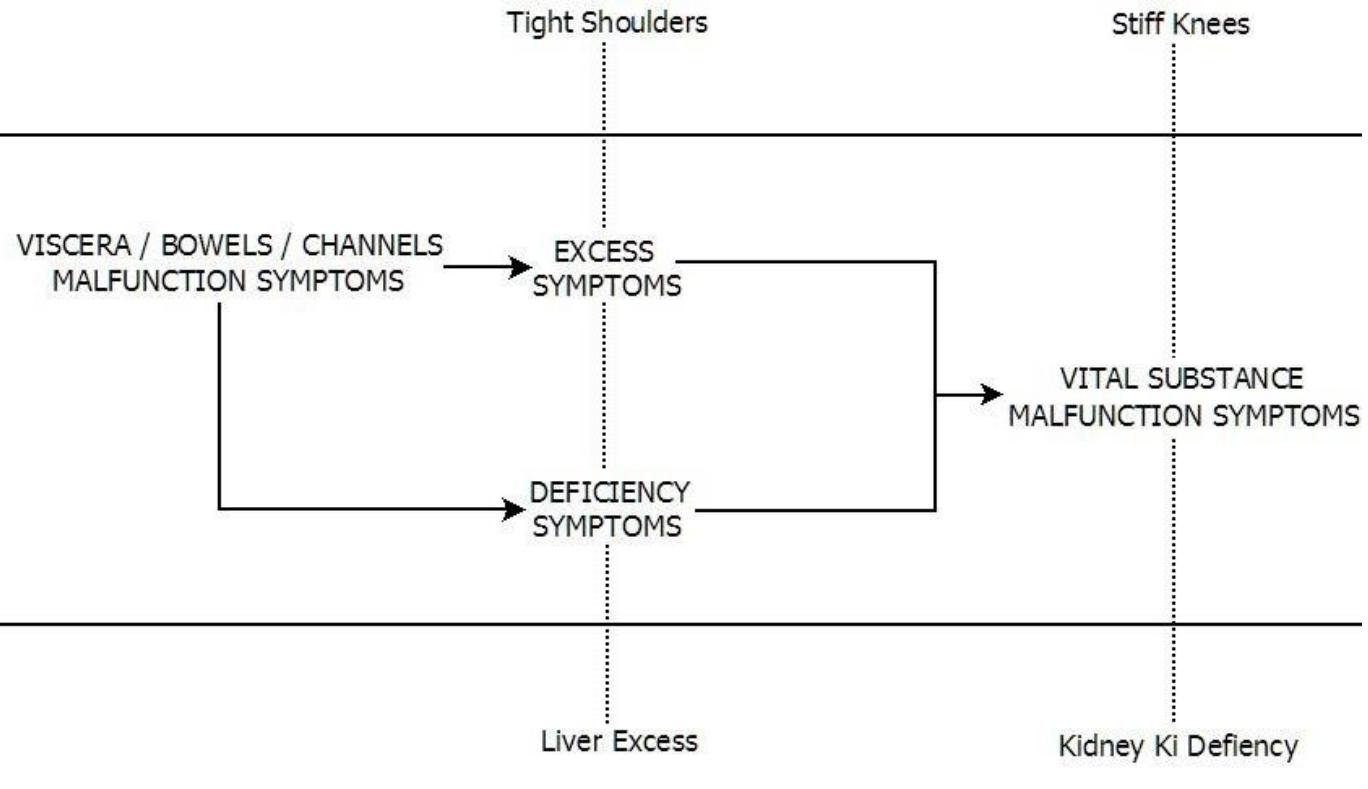
**EXAMPLES OF
PALPATED ABNORMALITIES**

Figure 6.8 Body tissue abnormalities as individual patterns of disharmony

Some palpated abnormalities may relate just to the viscera, bowels and channels, and either excess or deficiency (tight shoulders can be diagnosed as Liver excess). Additionally, palpated abnormalities may also relate to the vital substances (stiff knees can be diagnosed as Kidney Ki deficiency).

Body tissue palpation was usually the final diagnostic method to be conducted before treatment. Body tissue palpation was found to be performed with the pressing hand because the needling hand was typically occupied with a treatment tool. At the start of body palpation, practitioners tended to use the whole palm and the fingers (Figure 6.9). Light pressure was generally applied at first and stronger pressure later. Once palpation had been conducted with the whole palm, palpation with the fingers was used to ascertain the exact location of an abnormality (Figure 6.10). In general, palpation occurred from proximal to distal or from above to below on the torso. This palpation procedure may be unique to TJM acupuncture. Patients were found to be palpated through clothing, blankets/towels or directly on the skin.



Figure 6.9 Abdominal palpation with the entire hand

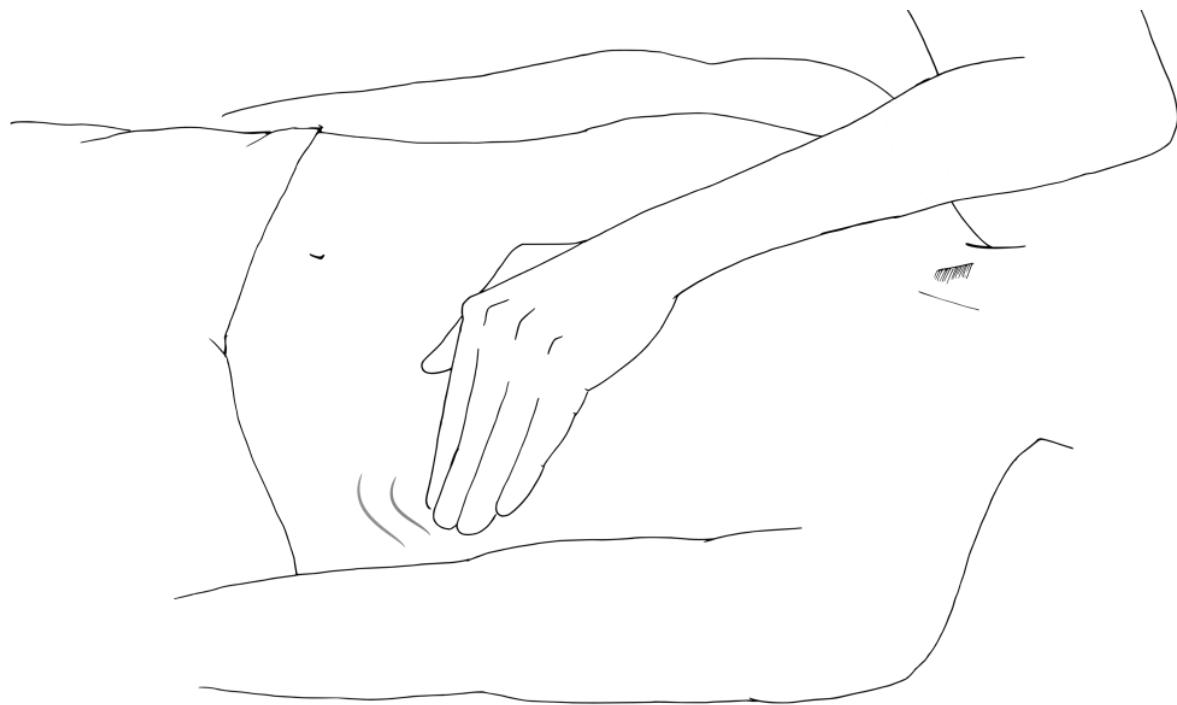


Figure 6.10 Abdominal palpation with the fingers

When palpation occurred directly on the skin, practitioners were reportedly feeling the textural qualities of the skin itself, and/or the condition of body tissues which lay beneath the skin (Table 6.11). Abnormalities on the skin were either found to contribute to a pattern of disharmony or mark a location as a treatment site.

I check the skin texture to see if it is smooth or rough or something like that. . . [If it's rough] it could mean that the defensive Ki is weak. . . Or they have a Lung problem or something. (Toko: acupuncture practitioner)

Table 6.11 Skin Condition Markers

Temperature	
Tension	
Indurations	
Protuberances	
Textural Qualities:	Smooth Rough Dry Wet Soft Hard

Skin palpation was generally found to be performed with light touch. However, in contrast there were times when heavy pressure was used in diagnosis. Such instances occurred when palpating for patient discomfort on tender areas or on tissues deeper than the skin. Deeper palpation seemed to be used to judge the severity of a malfunction, or to diagnose body tissue and organ abnormalities.

In general, all practitioners used body tissue palpation. Quality of shape and alignment, tension, temperature, swelling, indurations, tenderness, comfort, texture, range of movement, strength, reflex response and pulsations were diagnostically significant. Body tissues were palpated to understand the condition of the local tissue and for locating abnormalities which sometimes represented other areas of the body. Information from body tissue palpation was used to determine treatment locations, patterns of disharmony and root treatment. Figure 6.11 summarises body tissue palpation.

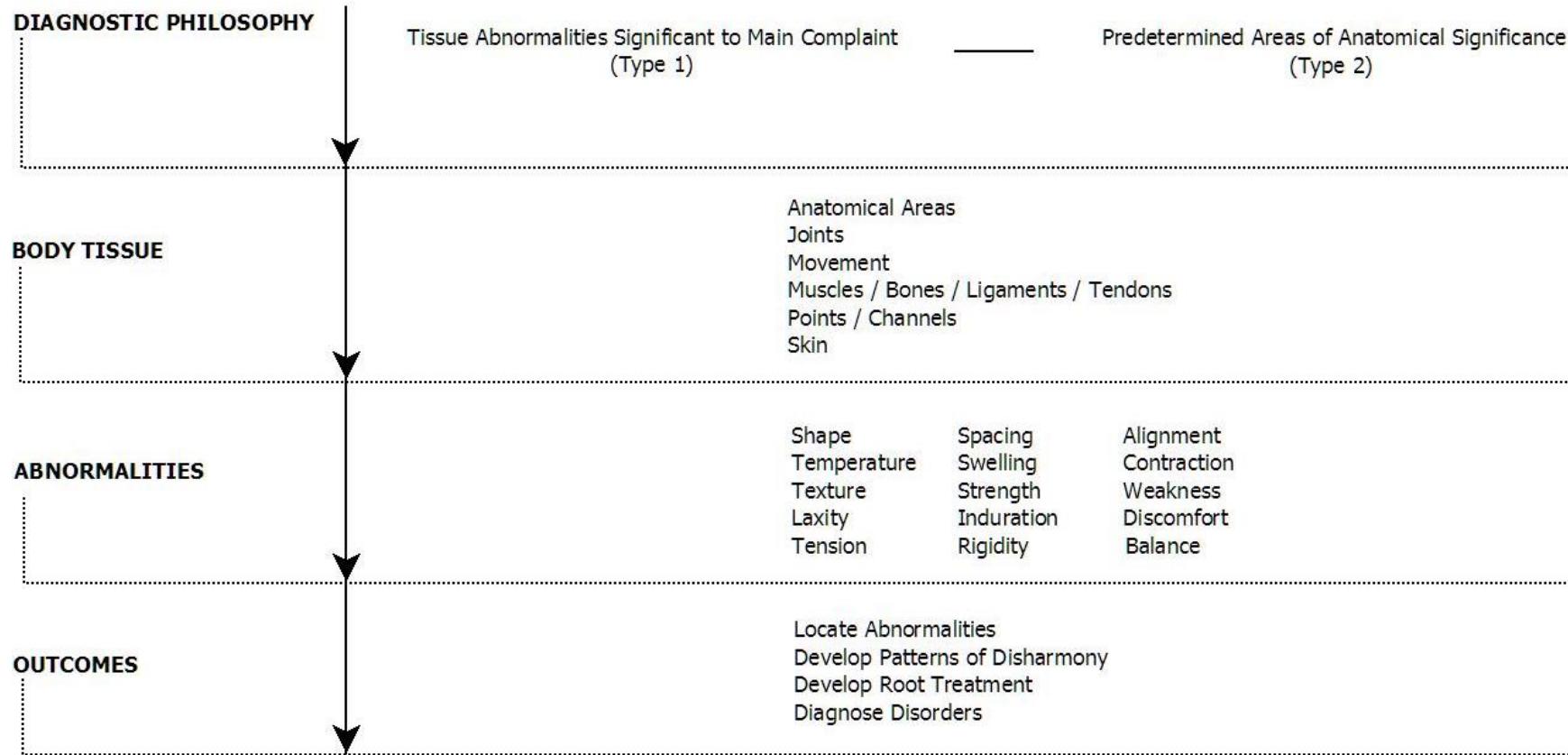


Figure 6.11 Summary of body tissue palpation

The figure shows how philosophy influences clinic routines. Practitioners palpated body tissue according to whether they believed it was significant to the patient's main complaint (Type 1) or whether it was an area they considered of general significance to good health (Type 2). A range of body tissues were found to be palpated in palpation informed by both Type 1 and Type 2 diagnostic philosophies. Practitioners palpated for a number of different abnormalities on the different kinds of body tissue. The diagnostic outcome of locating abnormalities on body tissue was different for different practitioners, and had implications on the treatment principles applied on the patient.

6.3.4 Listening/Smelling

First listen to the sound. Then check the skin colour. Check the tension of the skin. Then start the treatment from the top of the abdomen and move down. (Ginnosuke: acupuncture practitioner)

“Listening” means listening to the quality of the patient’s voice and other bodily sounds. “Smelling” means recognising body odours from the patient. Although listening was observed in clinic, smelling was not, and was also not discussed as significant in any practitioner interviews. Listening/smelling was the least utilised of the four examinations. Of practitioners who contributed data to diagnostic methods, 12% (n=4) used listening for diagnostic purposes. When listening/smelling was used, it was only found to be used by TEAM model practitioners who were especially interested the medical ideas from TJM acupuncture styles which were developed around the 1600’s, such as the Ishizaka or Sugiyama styles (refer back to Table 5.7). General elements of listening/smelling are summarised in Table 6.12.

Table 6.12 General Use of Listening/Smelling

Who	<ul style="list-style-type: none"> Practitioners connected to certain sub-styles
When	<ul style="list-style-type: none"> With abdominal palpation
How	<ul style="list-style-type: none"> On the abdomen Tapping with fingers of both hands
Why	<ul style="list-style-type: none"> Diagnosing percussive abnormalities Diagnosing the meaning of percussive sounds Root diagnosis Not for patterns of disharmony

The most important use of listening/smelling was listening to the sounds of the abdomen. Rather than listening to the organic sounds made by the patient’s body, practitioners listened to sounds made by the patient’s body when they interacted with it in certain ways: practitioners tapped the patient’s abdomen to solicit sounds. Sounds included the tympanic abnormalities of hollow, dull and wet.

Diagnosis of a tympanic abnormality was not found to result in the formation of a pattern of disharmony. It was found to result in the acknowledgement of a problematic area. It was possible that several problematic areas could be diagnosed, each with different abnormal sounds. Remedyng the abnormal sounds was considered a root treatment which did not rely on diagnosing a pattern of disharmony. Only sounds from the abdomen were found to be solicited by practitioners during treatment. No other areas of the body were found to be interacted with in the same manner, although they potentially could be (such as the chest or back). This emphasises the abdomen as a diagnostically significant area for TJM acupuncture practitioners.

Sounds were solicited from the body by using the fingers from both hands to tap on the abdomen. Listening to body sounds required both the knowledge and experience to recognise what sounds were occurring and the technical skills to solicit the body sounds (Figure 6.12).



Figure 6.12 Abdominal tapping with Ginnosuke (acupuncture practitioner)

6.3.5 Esoteric

Don't shoot with your eyes. Don't shoot with your mind. Shoot like the frost forming in the dead of night. (Zenkichi: acupuncture/chiropractic practitioner)

Esoteric methods are those that were not based on standard TEAM, biomedical or orthopaedic diagnostic methods. They were classified as esoteric because they are difficult to comprehend through a conventional understanding of phenomena and were not practiced according to well established or widely accepted diagnostic protocols. Esoteric diagnostic methods were not found to be taught or assessed at

educational institutions. They were found to have been developed and promoted by individual practitioners or organisations which were founded on spiritual practices or the awareness of Ki.

I use the four examinations; looking, listening, smell and palpation. Feeling too. It's important to check the feeling too. Look with your eyes. Get the impression of how the Ki is balanced in their body, but not only in their body. Their presence or atmosphere, the air that surrounds them is also important.

(Ginnosuke: acupuncture practitioner)

Esoteric methods are summarised in Table 6.13. Of practitioners who contributed data to diagnostic methods, 9% (n=3) were found to use esoteric methods. Two of these practitioners used esoteric methods as their main diagnostic tool. These methods appeared to be based on the resistance of body tissues, or a difficult to describe intangible feeling (acute awareness or sensitivity to Ki). It was generally unnecessary for the practitioner to touch the patient; they manipulated their own body tissues to diagnose. However, some interaction with the patient was necessary and how this interaction occurred and how body tissues were manipulated were points of difference between observed esoteric methods. Figure 6.13 shows Denkuro (acupuncture practitioner) performing esoteric diagnostic methods. Esoteric methods found in this study may be specific to TJM acupuncture. However, the use of esoteric methods is probably found in other TEAM acupuncture styles as well.

Table 6.13 Use of Esoteric Diagnostic Methods

Who	<ul style="list-style-type: none"> • 9% of practitioners
When	<ul style="list-style-type: none"> • Replacement for, or in combination with other methods
How	<ul style="list-style-type: none"> • Methods based on spirituality • Methods based on Ki • Using oneself as the diagnostic medium
Why	<ul style="list-style-type: none"> • Diagnosing structural abnormalities • Diagnosing abnormalities of Ki • Diagnosing patterns of disharmony



Figure 6.13 Denkuro (acupuncture practitioner) performing esoteric diagnostic methods

Esoteric methods were found to result in two different kinds of diagnostic outcomes:

- Pattern of disharmony
- Identification of structural abnormality

Patterns of disharmony determined by esoteric methods typically included an organ and either an excess, deficiency, or the presence of some kind of pathogenic Ki. This is similar to the kind of patterns of disharmony diagnosed by practitioners who used standard TEAM diagnostic methods. Structural abnormalities determined by esoteric diagnosis were never found to be based in TEAM philosophical concepts, and consisted of an anatomical description of misalignment of structural components of the body. This is similar to practitioners who favoured biomedical/orthopaedic medical models. Despite the uniqueness of esoteric diagnostic methods, the diagnostic outcome was not so different from standard methods.

6.3.6 Section summary

This section defines the diagnostic methods which were found to be used by practitioners. In presenting these methods, reading, inquiry, observation, palpation (including pulse and body tissue palpation), listening/smelling and esoteric methods are detailed. What information was considered significant to the differing diagnostic methods is outlined, and how these methods were performed in terms of procedures is presented and analysed. Inquiry and palpation were interpreted as the most significant diagnostic methods.

Except for listening and esoteric methods, elements of all other diagnostic methods were found to be practiced by all practitioners no matter what medical model they operated from. These methods generally resulted in the location of abnormalities or contributed to a pattern of disharmony.

6.4 Diagnostic Methods and Outcomes

Diagnostic proficiency is the most important thing. I wish all of us in the industry could do diagnosis properly. Some of us don't. Proficiency in diagnosis is equal to reliability. Once you do proper diagnosis, you can do whatever treatment you want. . . The diagnosis [I do] is mostly Western medicine. (Genrokuro: acupuncture/judo therapy practitioner)

This section examines how knowledge, values and diagnostic methods resulted in the construction of different diagnostic outcomes. How practitioners organised diagnostic information into specific outcomes appeared to influence the general rules they used to perform treatments. In relation to how diagnostic methods resulted in diagnostic outcomes, three main themes were interpreted from the data: patterns of disharmony, body tissue abnormalities and physical discomfort.

In this section, the methods and skills found to be used for collecting the clinical data necessary to achieve the diagnostic outcomes are assessed and a rationale for their use is proposed. Table 6.14 provides an overview of diagnostic outcomes in TJM acupuncture.

Table 6.14 Diagnostic Outcomes

	Pattern of Disharmony	Body Tissue Abnormality	Physical Discomfort
Features	<ul style="list-style-type: none"> Outcomes are simple, involving the eight principles, channels, Ki and viscera and bowels Tend to lack detailed directions Encourages freedom of interpretation and a process of trial and error in addressing pathology throughout the clinical encounter 	<ul style="list-style-type: none"> Outcomes related to the philosophy that health is predicated on established rules of natural order Relies on perception, sensitivity and the correct application of technical skills Prioritises some body tissues over others 	<ul style="list-style-type: none"> Outcomes directly related to the patient's illness experience Allow treatment by any number of methods according to a range of philosophical concepts Allow treatment in a manner of trial and error until a satisfactory objective is achieved
Examples	Liver Ki excess; Spleen deficiency	Moist skin; Tense muscles	Neck pain; Lower back pain

6.4.1 Patterns of disharmony as a diagnostic outcome

I always do pattern differentiation so I can give a name to the disease the patient presents with. . . (Iwamatsu: acupuncture practitioner/professor)

Patterns of disharmony were found to be diagnosed by 62% (n=21) of practitioners who contributed data to diagnostic methods. Table 6.15 summarises diagnostic outcomes related to patterns of disharmony.

Table 6.15 Diagnosing Patterns of Disharmony

Who	<ul style="list-style-type: none"> • 62% (n=21) of practitioners, mostly TEAM model practitioners
When	<ul style="list-style-type: none"> • In conjunction with diagnosing body tissue abnormalities • In conjunction with diagnosing physical discomfort
How	<ul style="list-style-type: none"> • Methods based on the 'four examinations' • Combining philosophical concepts in simple combinations of: <ul style="list-style-type: none"> - Viscera, bowels and channels - Vital substances - Eight principles - Five phases - Pathogenic factors
Why	<ul style="list-style-type: none"> • Diagnosis for root treatment • Return the condition to relative normality

It seemed that the best formula for diagnosed patterns of disharmony included one viscera/bowel organ or vital substance (most likely Ki), a description of excess or deficiency, and sometimes a pathogenic factor. That patterns of disharmony are so simplified in TJM acupuncture may be a unique feature. Figure 6.14 shows which philosophical concepts appeared to be the most important when developing a pattern of disharmony and how those philosophical concepts can be combined to construct simple formulas.

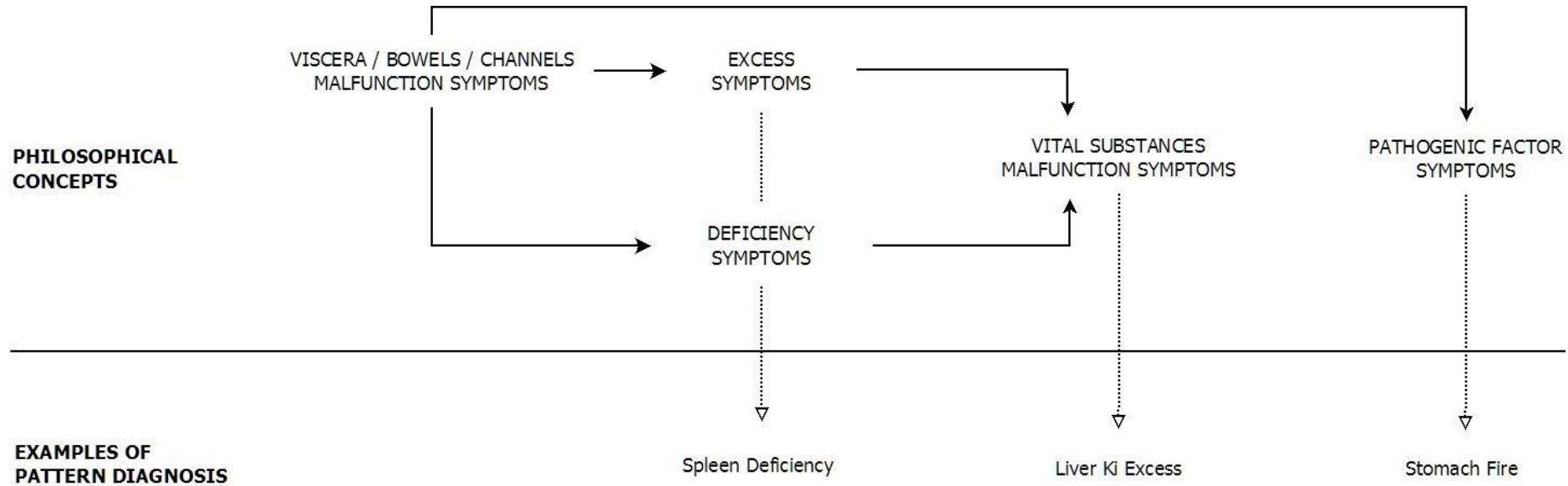


Figure 6.14 Patterns of disharmony and relationships to philosophical concepts

Viscera, bowel and channel malfunction symptoms were often combined with excess, deficiency and vital substance malfunction symptoms to create simple patterns such as, Spleen deficiency or Liver Ki excess. Viscera, bowel and channel malfunction symptoms were also paired with pathogenic factor symptoms; for instance, Stomach Fire.

Observation with Bunzaemon (acupuncture/judo therapy practitioner)

Bunzaemon stepped back from the supine patient. He said, “The problem is actually with your right ankle, not your left. Your Liver is too full of Blood.” Bunzaemon touched the patient’s abdomen above their Liver, “When the Liver is too full of Blood” he said as he ran his hand down the patient’s body to their right foot demonstrating the connection, “the leg becomes heavy and it has to work harder than usual. This is why your ankle has problems.”

The knowledge used to create patterns of disharmony seemed to commonly be based on the “eight principles”: interior/exterior, hot/cold, Yin/Yang and excess/deficiency. Eight principle philosophy is the summarisation of almost every TEAM diagnostic philosophy and can be applied to any disease condition. In general, patterns of disharmony were founded on eight principle theory and combined with internal organ and vital substance knowledge. This resulted in the formation of a minimally detailed diagnosis, which appeared simple because of the few variables involved.

Today the patient is Lung deficient. Usually they are Liver and Spleen deficient, but they said they have a sore throat and runny nose. I also felt the pulse and it was weak in the Lung position. The best point to treat Lung deficiency is KI 7. (Tsuru: acupuncture practitioner)

There are many potential treatment locations on the body. Diagnosed patterns of disharmony can assist in determining at which locations are appropriate to apply interventions. However, patterns which include a limited amount of information do not provide much logical support in deducing appropriate treatment locations. All practitioners who were found to apply patterns of disharmony, diagnosed minimally detailed patterns, and managed treatment point options by placing importance in locating the correct treatment site by observation and palpation. This may be an important feature of TJM acupuncture. Additionally, practitioners utilising pattern differentiation seemed to manage large numbers of treatment point options by relying on predetermined treatment locations.

This treatment strategy was observed in root diagnosis and treatment derived from palpation of the radial pulse, back or abdomen. “Five phase theory” from the *Classic of Difficult Issues*, Chapter 69 uses predetermined treatment locations to treat simple patterns of disharmony (Figure 6.15). This is exemplary of systematic treatments. The minimally described diagnosis and predetermined treatment area are paired in a “zero sum theorem” relationship which allow for a systematic approach to diagnosis and treatment.

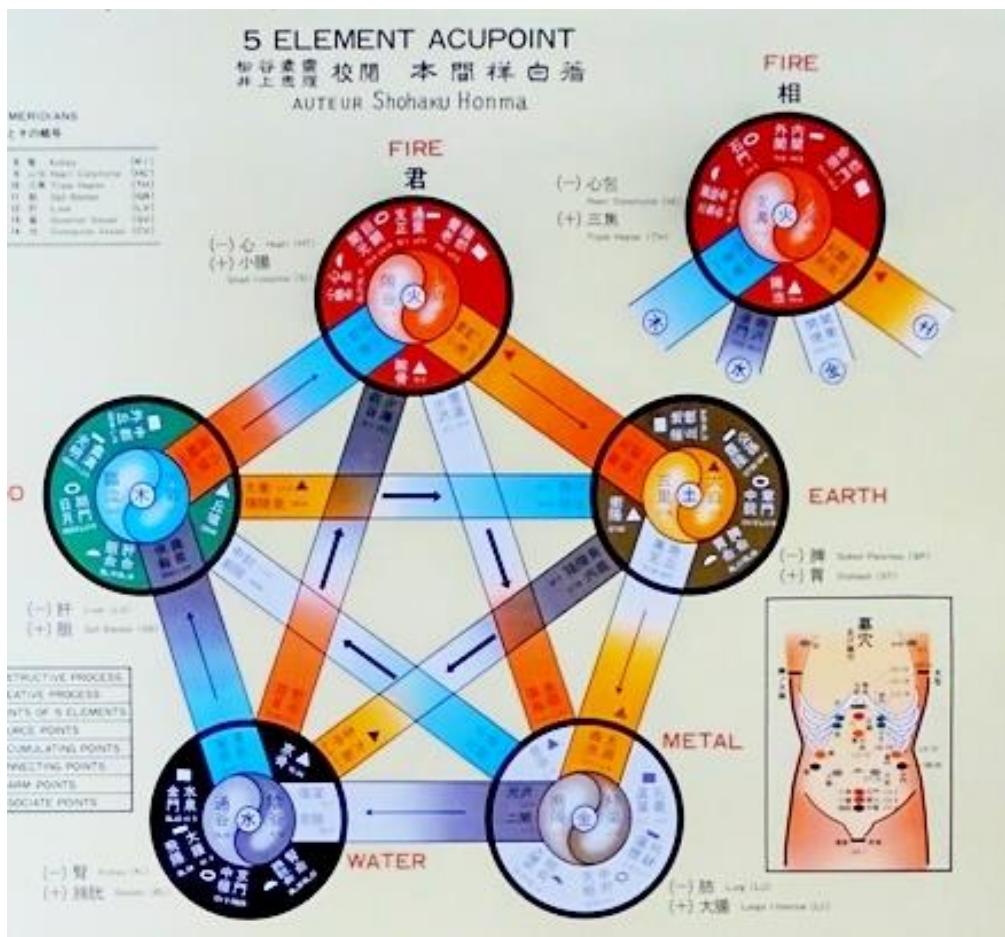


Figure 6.15 Five element acupoint wall chart – Source: Tsuru (acupuncture practitioner)

Using predetermined areas or systematic rules for treatment means that there are potentially fewer options for treatment than when deducing a treatment formula based on the actions and indications of all acupuncture points. However, practitioners were not found to limit diagnosis to one single, all-inclusive pattern. Practitioners commonly included a series of primary and secondary patterns of disharmony depending on diagnostic methods, trial and error and the confirmation

of treatment effects. Practitioners were found to consecutively diagnose a variety of patterns, which were identified and treated in succession. As treatments progressed and diagnosis developed, treatment objectives seemed to become prioritised through the continuous interplay between diagnosis and treatment. However, not all practitioners were found to use patterns of disharmony when diagnosing; even those who practiced from the TEAM model.

Some practitioners believed that it was possible patients could present with contradicting signs and symptoms, making it impossible to categorically restrict diagnosis into a single syndrome. However, they believed that abnormalities in body tissue were finite, more knowable and understandable through observation and palpation. Practitioners who prioritised sensitivity and technical ability in treating body tissue abnormalities appeared to value treating abnormalities as a more individualised approach than diagnosing patterns of disharmony. This could be specific to TJM acupuncture.

There are not enough patterns in Chinese medicine – there is no way these can cover every individual patient. Today's pattern is different to yesterday's pattern which will probably be different to tomorrow's. The patient changes all the time and must be assessed individually on a case by case basis. This means it is difficult to find a pattern to suit each person because of the variety of ways real patients can present in clinic compared to the number of patterns there are. (Benio: acupuncture/judo therapy practitioner/lecturer)

I learnt about the Treatise on Cold Damage Diseases and about pattern identification and syndrome differentiation when I was at university. There was a special Chinese Medicine class for that. But I don't think real life is so straightforward. I think pattern identification and syndrome differentiation is just theory and doesn't actually work. (Takizou: acupuncture practitioner)

When patterns of disharmony were not diagnosed, practitioners were found to use biomedical or orthopaedic terms in describing the disease state or condition of a patient. These included names for the group of symptoms a patient presented, which pointed to the location and nature of the condition.

The patient might tell me that they have sore shoulders or a sore lower back. Although I do look at it, I don't go straight to that area right away to start treatment. I want to find the cause of the problem so I look at the joints of the hips, the sacrum, the mid-back and occiput. I look at these four joints and make a diagnosis. . . I have to look at the vertical plane of the midline of the spine and see if there are any deviations and fix any subluxation using manipulations and mobilisations. (Asajiro: acupuncture practitioner)

Knowledge of anatomy, evidence based medicine and peer experience appeared important when diagnosing using biomedical or orthopaedic methods. In these cases, diagnosis may have also included a scale of severity and a prognosis about how long healing could take.

If I can, I want to be able to give a pattern of disharmony, but it depends on the person. There are times when I use the "Six Classics of Confucius" to create a simple pattern like Liver or Kidney deficiency. But it's not like I always do that, I'm not so consistent. . . I use a lot of different theories. . . There are times when I really think about differentiating a pattern like in Chinese medicine. There are also times when I don't too, like when I see that Ki has risen and the patient can't sleep or they feel kind of faint. I just think I want to try to bring the Ki back down by warming the abdomen or by doing anything I can. I don't stick to any one kind of diagnosis; I use a lot of different ones. (Ume: acupuncture/massage practitioner)

In summary, patterns of disharmony were diagnosed by just over half of the practitioners who contributed to data relating to diagnostic methods. Diagnosed patterns of disharmony were found to be relatively simple in structure, and generally described using the eight principles, viscera/bowels, vital substances and pathogenic factors. Diagnosed patterns were also found to be treated using predetermined treatment areas or systematic rules for treatment. In general, diagnosed patterns of disharmony influenced treatment principles by increasing the significance of treatment site location and the techniques applied to provide stimulation at treatment sites.

6.4.2 Body tissue abnormalities as diagnostic outcomes

I check the tension of the Achilles tendon; the softer the better. So for kids or babies from two months old I just stretch it. At first I twist it and try to make it softer; this is good for blood circulation. From here, the blood flows better and the circulation will improve. (Kame: acupuncture practitioner)

Diagnostic methods which resulted in a pattern of disharmony were found to be complimented with, or ignored, in preference for methods which identified abnormal body tissue. The diagnosis of a body tissue abnormality, as an independent manifestation of disease itself, without any lines of correlation or causation being drawn to any disorder or disease, was found to be a valid diagnostic outcome for every practitioner who contributed data to diagnostic methods. This may be a feature of TJM acupuncture. Diagnosed body tissue abnormalities need not have been explained as part of a pattern of disharmony nor given any qualities associated with possible patterns of disharmony in any language relating to TEAM knowledge such as the eight principles, internal organs, vital substances or pathologic factors. Diagnosed abnormalities also need not have been described in terms of biomedical or orthopaedic language as part of a syndrome, disease condition or any other disorder. The diagnosed areas of abnormality could simply be known by the abnormal qualities which they exhibited, thus making them targets for treatment at the abnormal site itself, or from a location distal to the abnormal area. Table 6.16 summarises diagnostic outcomes related to body tissue abnormalities.

Table 6.16 Diagnosing Body Tissue Abnormalities

Who	<ul style="list-style-type: none"> • All practitioners
When	<ul style="list-style-type: none"> • In conjunction with or as a replacement for pattern differentiation • In conjunction with diagnosing physical discomfort
How	<ul style="list-style-type: none"> • Methods based on practitioner sensitivity and technical ability • Abnormalities as independent manifestations of disease • Body tissues can be prioritised in diagnostic significance • Found at anatomic areas of significance
Why	<ul style="list-style-type: none"> • Diagnosis for root treatment • Return the condition to relative normality

Diagnosing and treating abnormalities was interpreted to rely on established norms of health and disease, and the belief that a return to normality of any tissue displaying abnormality was a step towards improving the health condition. For some practitioners, diagnosing abnormalities seemed to be an important process in returning the body to its natural state, which was believed to result in greater health in general.

First of all, I check how bad [their condition] is. After that, I determine what kind of treatment I need to apply. It depends on the cause as to what I will do. Generally, in the case of the adhesive capsulitis I insert needles not only around the shoulder, (of course there are some who just do that) but we also think about it in regards to the meridians, and treat any misalignment in the spine and spinal column. If we do that, we can help patients use their muscles correctly, prevent injuries and relieve pain. It provides some kind of relief. So it's better not just to treat around the shoulder, but also insert needles at points around other places like the hands, legs and spine.

This is called the branch and root treatment. If a patient has shoulder pain, the cause might not just be in the shoulder, but actually could be somewhere else. For instance, lower back pain might cause the right shoulder not to move properly. You have to find out the actual cause, and not just treat the site of pain, but treat other places besides the shoulder. Because there

might be an imbalance somewhere in the body which results in pain or illness, we need to look for the place that the patient feels pain and the place that is actually the cause of the pain. This is the basic concept of treatment. Branch treatment treats the symptoms. Root treatment treats the cause of the symptoms. This kind of thinking is in both Eastern and Western medicine, but the ways of finding the cause and treating it are different.

(Chusuke: acupuncture practitioner/senior lecturer)

Locating abnormalities was found to be guided by philosophical concepts relating to what body tissues were believed to be the most important to keep in good condition. Areas believed to be of most significance to health were found to be investigated as a primary location and other areas as a secondary priority. The diagnosis of abnormalities was usually found to be performed by observation and palpation. Anatomical areas of diagnostic significance included the spine, sacrum, abdomen, back and skin.

Some practitioners' primary diagnostic method and outcome was locating the appropriate treatment site based on the perception of abnormalities. This contrasts with diagnostic methods and outcomes which result in treatment being performed at predetermined acupuncture points to obtain specific effects. The belief that anywhere on the body can be a treatment location if it presents abnormally, appeared to be a common feature among practitioners. This outcome was interpreted to prioritise two sets of skills:

- Practitioner sensitivity
- Technical ability

The findings suggest that these skills are sometimes prioritised over the knowledge of actions, indications and combinations of treatment locations, and at other times or by other practitioners, used in combination. Practitioners who prioritised sensitivity and technical ability seemed to place importance on the ability to discern subtle abnormalities in a variety of body tissues and on providing the appropriate stimulation to those abnormalities which became treatment sites. Such practitioners also appeared to believe that skilfully applied treatment interventions would result in specific therapeutic effects which aligned with the diagnostic outcome.

Observation with Otoemon (researcher/acupuncture practitioner)

Otoemon brushed his left hand over the patient's left arm from the shoulder to the wrist. He repeated the procedure once more, but moved a little slower when he reached the patient's forearm. "The condition of the muscle is fine, but the skin here is not so good" he said as he indicated the exact area with his index finger. "When the muscles are ok, but the skin is poor, I use a tapping technique either with the teishin or the needle."

Diagnosing abnormalities was sometimes found to take precedence over diagnosing the main complaint. The diagnosis of abnormalities on anatomical areas of significance was an unchanging aspect of the clinical encounter for some practitioners. When the good condition of a certain anatomical area was seen as essential to health and wellbeing, practitioners included the diagnosis of any abnormalities at that location as a standard part of most treatments. This could be considered root diagnosis. Sometimes practitioners exclusively diagnosed abnormalities without attempting differential diagnosis.

In summary, the diagnosis of abnormalities complimented and sometimes replaced pattern differentiation as a primary diagnostic outcome. Abnormalities were often seen to exist as independent manifestations of disease rather than part of the matrix of signs relating to a pattern of disharmony. The philosophical concept that locations anywhere on the body can, and should be diagnosed if exhibiting abnormality, was a feature of some practitioners' diagnostic methods and could be a feature of TJM acupuncture. Abnormalities located at areas of significance tended to have diagnostic meaning over others, and sometimes constituted a root diagnosis. Diagnosing abnormalities prioritised practitioner sensitivity and palpation ability.

6.4.3 Diagnosis and physical discomfort

. . . Sometimes I will add some extra stimulation. For example, there are many cases where patients in Japan want to get some treatment on their painful areas. . . If the patient has lower back pain, they usually want to get some treatment on their lower back. [And so what do you do?] Sometimes I do slight stimulation with the teishin. (Takizou: acupuncture practitioner)

Diagnosing a physical discomfort seemed to rely upon a low amount of diagnostic processing. Relevant diagnostic information was found to be solicited during the interview and sometimes supported with information from palpation or observation. This outcome was generally found to be produced when practitioners focussed on the treatment of musculoskeletal disorders.

Observation with Ginnosuke (acupuncture practitioner)

The patient told Ginnosuke where his pain was and pointed to a place on the right side of his neck. Ginnosuke decided that the pain was on the Small Intestine channel. He treated SI 3 on the patient's left hand with the teishin while feeling the pulse on the patient's left wrist with his other hand.

There was some concern from practitioners about only treating a physical discomfort without paying attention to the body as a whole. This concern was mostly seen by practitioners committed to the TEAM model. As such, there was some contention about the most appropriate way to use TJM acupuncture, especially between acupuncture and acupuncture/judo therapy practitioners. Acupuncture/judo therapy practitioners were found to predominantly treat symptoms of physical discomfort, while acupuncture practitioners sometimes included a root treatment in addition to treating any symptoms of physical discomfort.

Judo therapy clinics: they can (a discrimination, since acupuncture clinics cannot!) use insurance and therefore provide what they call insurance covered treatment. Which means for the patient, that they have to pay mostly only a few hundred yen. But it also means, that one treatment is restricted to ONE site -> like if you have pain in the left knee, then a 10-

minute treatment (usually applying some sort of machine) is applied to the left knee only. Requires 10 minutes. (Koremitsu: acupuncture practitioner)

Identifying body tissue abnormalities sometimes included the diagnostic outcome of identifying physical discomfort. Body tissue abnormalities included a range of different qualities including, but not limited to pain. This is not unique to TJM acupuncture. Other styles of acupuncture treat painful areas on a patient's body with needles. This can be called *ah shi* needling, trigger point needling (WHO code 5.1.226), tender point needling (WHO code 5.1.227) or dry needling. These treatments rely on diagnostic outcomes which locate tender or trigger points on a patient's body, usually by palpating soft muscle tissue. The diagnosis of painful locations anywhere on the body was performed by practitioners from all medical models in this study. However, diagnosing painful points seemed more important to the methods of orthopaedic model practitioners and acupuncture/judo therapy practitioners.

6.4.4 Section summary

This section discusses data in relation to diagnostic methods and diagnostic outcomes. Practitioners used a variety of diagnostic methods to construct one or more diagnostic outcome: patterns of disharmony, body tissue abnormalities and physical discomfort. These outcomes emphasise perception, sensitivity and trial and error.

6.5 Chapter Summary

This chapter describes diagnostic methods in four major sections: overview, timeline of processes, methods and procedures, and diagnostic outcomes.

The first section is an overview of the diagnostic methods found to be used in TJM acupuncture. Data relating to how many practitioners, committed to which medical models, and performed what kinds of diagnostic methods is listed.

Findings from the data are arranged into a timeline of processes and analysed sequentially in the second section. How diagnostic methods relate to each other through timing and routines is described.

The third section describes how the most significant diagnostic methods were inquiry and palpation. Inquiry includes TEAM, biomedical or orthopaedic lines of questioning while palpation focusses on pulse and body tissue palpation.

Finally, three major diagnostic outcomes are detailed: patterns of disharmony, body tissue abnormalities and physical discomfort. Outcomes related to the construction of a pattern of disharmony primarily relied on the knowledge of the eight principles, viscera/bowels and vital substances.

The diagnostic methods employed by practitioners were often based on subjective observations. Signs and symptoms were interpreted differently depending on education, training and experience. Although there were accepted conventions of practice, practitioners also accepted that there were diagnostic methods which deviate from the standardised procedures and that they were also acceptable as long as therapeutic results could be achieved.

The main purposes of diagnosis in TJM acupuncture can be summarised as:

- Diagnosis infers the cause of disease
- Diagnosis describes the current state of disease
- Diagnosis is a protocol informant for treatment
- Diagnosis is constantly performed as a continual process of affirming the efficacy of a treatment

Most of the purposes listed above are probably very similar to other styles of acupuncture. However, that diagnosis is constantly performed as a continual process of affirming the efficacy of a treatment, may be a unique feature of TJM acupuncture. This is examined in greater detail in Chapter 7.

Throughout the description of diagnostic methods in this chapter, analysis gradually progresses to detailing how diagnosis links to elements of treatment. Although this study delineates diagnosis and treatment as separate themes, clinical

reality presented a routine picture of persistent engagement between elements of diagnosis and treatment. The blurry divisions which mark the beginning and end of procedures are interpretations of themes, and it is in the next chapter that the data relating to treatment principles is presented and analysed in detail.

Fieldwork Diary: Hieizan

It tells of winter snow yet to come, these softly falling autumn leaves. Flashes of sunlight highlight the brilliant crimson and gold through the fast moving clouds above the mountain. It's quiet now, except for the forest spring bubbling down through the rocks, full from yesterday's rain, and our feet crunch on the loose pebble pathway up to the temple. There are only a few hikers here now. Perhaps in a week's time the hills around Mount Hiei will be swollen with sightseers sporting expensive cameras, angling for the best shots of the leaves among the temple eaves, but even when the season is at its peak, not many will visit this house of solitude and prayer.

Before the daily ceremony, the head priest receives visitors. Ginnosuke sensei invited me here with his mother and some of her friends who have brought fresh baked bread and coffee to present to the head priest, along with a small monetary donation wrapped in elegant envelopes. The elderly man garbed in white robes sat before us with an amiable smile and light in his eyes. He had a soft presence, but there was no doubt he was iron wrapped in silk. In return for the bread and coffee, he offered us gifts of wooden beads, incense and sweet cakes. One of the house monks guided us to a seat and placed hot cups of barley tea down in front of us.

The temple is of the Tendai sect, run by the Thousand day Marathon Monks of Hieizan. The man congenially sitting here with us is one of only a handful to have completed the gruelling seven year spiritual passage in the last hundred years, for the last time at 60 years of age.

As novices, these men are garbed in temple white robes (representative of death), are given straw sandals and a hat. Carrying a stick, books, candles and a small amount of food, they run; 40km a day for 100 consecutive days, but this is only basic training. In later years this will be extended to 40km a day for 200 days straight, and during the final years of practice, they will run for 100 days covering 60 kilometres and finally 84 kilometres for 100 days without reprieve.

Successive Olympic marathons (sometimes twice a day), day after day, night and day, over uneven and unmarked narrow paths on a diet of meagre vegetarian food,

they run. It snows in those mountains during winter, and it is extremely hot in summer; running the year through is mentally and physically a severely demanding kind of training. As testament to the solemn commitment of those who take this spiritual challenge, nameless graves of men who died during the training are scattered along the mountain trails. Once initiated, there is no turning back from this quest, monks either survive or die. Among the few items given to novices are also a knife and length of rope. Those who are sick or injured, unable or unwilling to continue will take their own life, either by disembowelment or hanging.

The monks must also make visits to temples during the daily run. This means that a single day could take up to 20 hours to complete, not leaving time for full repose or recuperation, but it is all part of their practice. The running itself is a moving meditation, a vehicle for spiritual attainment where the monks align their body in postural efficiency and attempt to enter an altered state of mental awareness.

The running practice, ceremonies, rites and temple duties are not all that is required of the monks during the seven year passage; they must also complete seven days without sleep, rest, food or water. At that time the novice will recite sutras and mantras continuously and will only leave the temple once a day, during the early hours of the morning to collect water from the outdoor well, and return in order to perform a ceremony. Forbidden to drink this water or have any rest, the monk is constantly attended by two others to prevent them from falling asleep during meditation or from temptation to drink the water. This is pure starvation, an ordeal which takes the monk to the brink of death. It is not a kind of initiation or test, it is a spiritual crossing, a step on the continual path to Buddhahood; and once this fasting and praying is over, again they run.

Men, dressed in uniform from a tradition that began hundreds of years ago who run for hundreds of kilometres in straw sandals through the mountains, prepared to take their own life if their body or will falters; sounds like fantasy. It is however, a living tradition in Japan. The timeworn running trail progresses through modern day Kyoto; past karaoke boxes, bars, clubs, department stores, shopping arcades, vending machines selling beer, cigarettes and energy drinks... It is truly a stark contrast of spiritual determination and 21st century materialism, but even today, members of the public line the streets in great numbers to witness the rare times

these monks run the final part of their journey. The monks are believed to have healing powers and many of the spectators hope to be blessed by those dedicated Buddhists who have practiced, prayed and worshipped in an unbroken lineage for hundreds of years.

It's just small talk, but to meet such a man is a unique experience; most head priests do not make the time to meet patrons like this. When he finds out I am from Australia, he starts talking about rugby, "but you are too small for that" he says. He on the other hand is quite large, especially for the Japanese, and despite his age which is indeterminable. He has done the 1000 day marathon twice. Ginnosuke sensei's mother whispered in my ear, "You should ask him something", but I can't think of anything to ask without sounding stupid.

Chapter 7: Treatment Principles

We have a training program for our students to go to China. When we go there and eat the food, we all get food poisoning! In Japan, this hardly ever happens because we have stricter sanitation than China does. The food that people in China eat tends to cause a stomach ache in Japanese people. When it comes to treating Chinese people with acupuncture, the way they feel stimulation seems to be different to us. That's why we changed the treatment methods to suit ourselves. I guess the Japanese body constitution is different to that of Chinese people. Chinese and Japanese people feel acupuncture stimulation differently and we have different levels of sensitivity; basically the range of stimulation which can be accepted by Chinese and Japanese people is different. In saying this some people might get upset, but I think that even if Chinese people eat mud, they would never get a stomach ache! In a good way, Japanese people seem to have a weaker constitution. Maybe we are all sensitive. That's the impression that I have gotten through our college program. (Chusuke: acupuncture practitioner /senior lecturer)

This chapter presents data and provides analyses in relation to treatment principles: the general rules that should be followed in treating a patient's condition. These rules include the methods which are derived from principles of treatment, any tools used to administer treatments, and the technical skills required to use the tools therapeutically. Treatment principles are presented and analysed in terms of procedural routines and are presented through the description of events from the beginning of the therapeutic exchange, to the end. The successive routines of TJM acupuncture are a thematic account which connects diagnostic outcomes with treatment by exploring the processes and skills required to achieve a therapeutic response.

This chapter contains five major sections:

- **Treatment tools:** Describes what tools were found to be used by practitioners. Outlines how filiform needles with guide tubes were the preferred tools for most practitioners.
- **Pre-intervention preparation:** Discusses point selection, sterilisation, point location and pre-needling/pre-moxibustion patient contact.
- **Needling:** Details the techniques associated with needles and contact tools with regards to insertion and placement, manipulation, retention and withdrawal.
- **Moxibustion:** Presents the methods and skills relating to indirect and direct moxibustion.
- **Confirmation of effects:** Describes how confirming the effects of interventions were achieved in relation to timing and markers of confirmation. Data regarding the total consultation time of treatments is also presented and analysed.

Data relating to treatment principles was obtained from 92% (n=35) of the total 38 practitioners who were recruited into the study. Three practitioners did not contribute data to treatment principles because interviews with them did not cover any aspects of treatment. Of the 35 practitioners who contributed data to treatment principles, 63% (n=22) were observed in clinic. Details relating to the relationship between practitioner numbers, tools and methods are provided throughout this chapter where appropriate.

7.1 Treatment Tools

I use needles mostly, 99 percent of the time. But for patients who have just had an operation or have been in hospital for a long time, or been sick for a long time and have really low energy, I use moxa because it's the best treatment for them. There are also people who don't like to be touched right? People who have sensitive skin, or like those who are ticklish on the back. For those people I use shonishin, needles for kids – contact needles, needles which we don't insert: It's like a rubbing massage. . . It spreads the

Ki and makes it easier to treat them. (Sayo: acupuncture practitioner/senior lecturer)

This section presents and analyses findings from the data related to treatment tools. Three categories of tools were identified: direct application tools, assistant tools and miscellaneous fittings, fixtures and items. Direct application tools are the items practitioners used to treat patients; these tools usually came into contact with the patient's body. Assistant tools support the application of directly applied tools. Assistant tools were not generally used on the body, although they were sometimes necessary for the application of direct tools, especially moxibustion. Fixtures, fittings and miscellaneous items are other objects which were found in practitioners' clinics.

Direct application tools are addressed in four themes. The first theme is an overview of the direct application tools which were found to be possessed and used by practitioners. Themes two, three and four present and analyse data relating to needles, moxa and other tools, respectively. Throughout the analysis of direct application tools, assistant tools, fixtures, fittings or miscellaneous items are discussed when relevant to the use of direct application tools.

7.1.1 Overview

Data related to direct application tools was provided by 35 practitioners. The most used direct application tools were found to be filiform needles with guide tubes, higher grade moxa floss and contact tools. Table 7.1 shows the kinds of needles, moxa and other tools which practitioners possessed and indicates how many practitioners possessed and used the tools. 'X' indicates that no practitioners stated that they used a particular tool or were observed doing so.

Although a range of tools were possessed by practitioners, not all of them were used in actual clinical practice. For instance, Tsuru (acupuncture practitioner) was observed performing 77 treatments and was never found to use the electronic needle stimulator she had in the clinic. Possession of a tool does not mean that it was used often or even at all, but it does demonstrate the variety or potential of treatment options in TJM acupuncture.

[You showed me the plum blossom needle in your clinic, how often do you use it?] I never really use it. [Do you think it is popular in Japan?] No, I don't think many people actually use it in Japan. Kinu (acupuncture practitioner /senior lecturer).

Table 7.1 Direct Application Tools

Needles	Possessed	Used
Filiform	33	31
Thumbtack	4	4
Hinaishin	1	1
Press Studs	1	1
Lancing	3	2
Fire	2	1
Plumb blossom	2	X
Moxa		
Floss	20	16
Stick-on	11	11
Stick	5	3
Other tools		
Contact Tools	22	13
Electronic Equipment	22	6
Magnets	2	2
Creams/Pastes/Extracts	4	4
Cupping tools (Cups)	9	3
Heat & Cold Applicators	5	X
Supports for Structural Physiology	4	X

7.1.2 Needles

Needles were found to be made from a variety of different materials, but were most commonly a combination of plastic and steel. Some were found to be manufactured in Japan and others imported from China. In general, the variety of needles found in TJM acupuncture clinics is probably similar to that in other styles of acupuncture. Figure 7.1 shows a range of different sized filiform needles with other tools.



Figure 7.1 Treatment tool tray at Genrokuro's clinic: acupuncture/judo therapy practitioner

Filiform needles

All practitioners who used filiform needles used disposable, stainless steel needles. However, non-disposable filiform needles made of silver and gold were also used on occasion. Although needles with metal handles were found in clinics, the majority of practitioners used needles with plastic handles (example in Figure 7.2).



Figure 7.2 J-Type 0.14 mm by 40 mm needle

Needles can be measured by diameter and length in millimetres. The smallest diameter filiform needles found to be used by practitioners were 0.12 mm, and the largest 0.30 mm. Most practitioners used a variety of needle diameters, with the most common including 0.14 to 0.20 mm. The shortest needle length was found to be 15 mm and the longest 200 mm. Most practitioners were found to use a range of different lengths with the most common including from 30 to 40 mm.

Seirin is one of the largest needle manufacturers in Japan and supplies their products both domestically and internationally. According to Seirin, their most popular needle is the J-type. These needles are disposable, stainless steel, filiform needles including a single needle attached to a plastic guide tube by the plastic needle handle in a single blister pack. These were reportedly the most popular of all their needles. As of 2015, the best-selling needle type, diameter (millimetres) and length both in Japan and internationally reported by Seirin are displayed in Table 7.2.

Table 7.2 Seirin's Best Selling Filiform Needles as of 2015

	Type	Diameter	Length
Domestic sales	J-type	0.16	40 mm
	J-type	0.18	40 mm
International sales	J-type	0.16	30 mm
	J-type	0.20	30 mm
	J-type	0.25	30 mm

Other needles

The most commonly used non-filiform needles were found to be intradermal needles (WHO code 5.1.29). Thumbtack needles (WHO code 5.1.28) are a division of intradermal needles where small needles of varying lengths are attached to a sticky material and are inserted perpendicularly on the skin. Thumbtack needles include the Seirin Pyonex intradermal needle (Figure 7.3). Hinaishin (Figure 7.4) are also a unique Japanese variation of intradermal needles which are small needles (around 5 mm in length) that are inserted parallel under the skin and often covered with an adhesive tape.

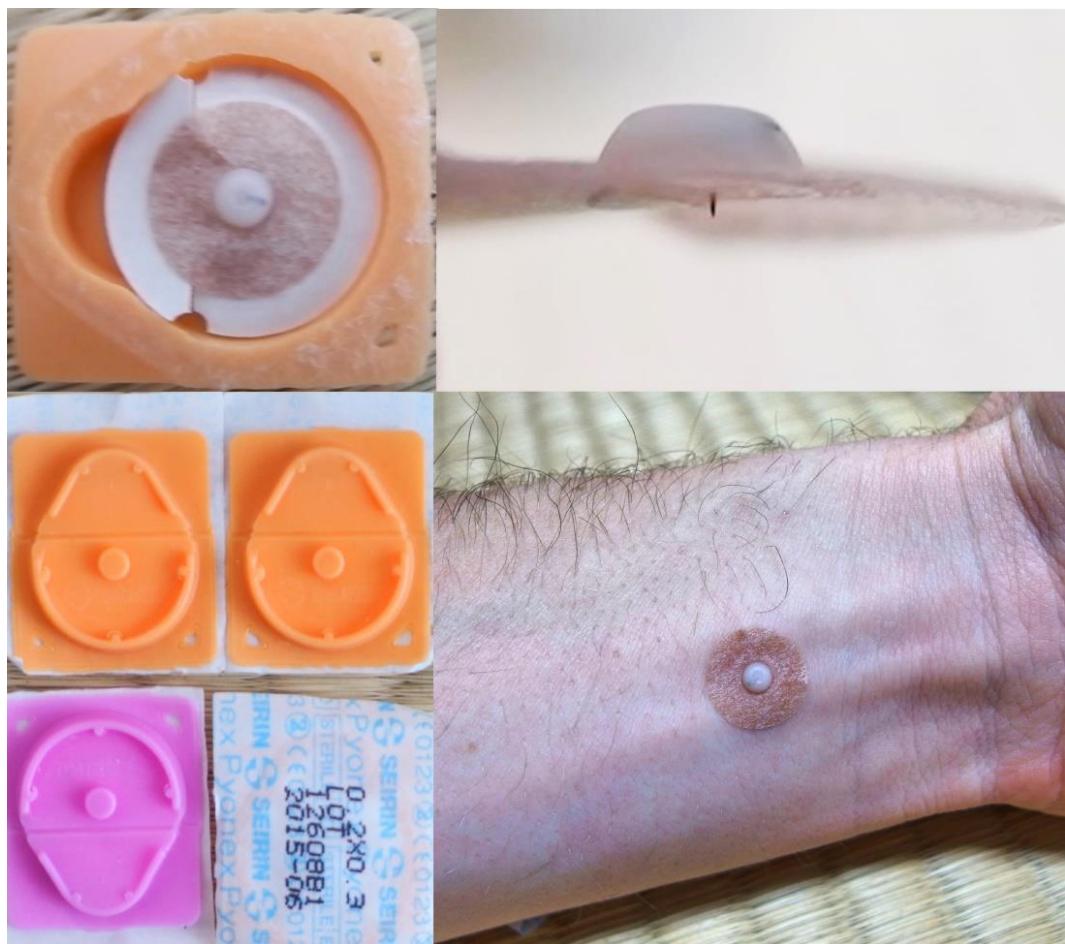


Figure 7.3 Pyonex intradermal needle

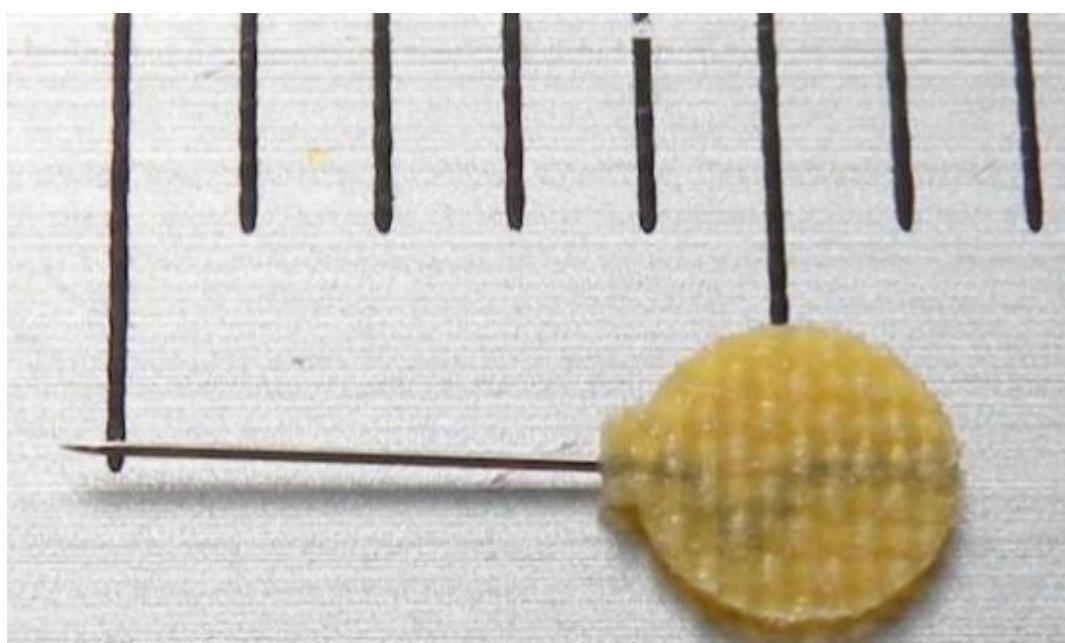


Figure 7.4 Hinaishin (Blasejewicz, 2013, p. 42)

Background gradation shows millimetres. This hinaishin needle is about 5 mm in length.

Press studs, although technically not needles, but capable of breaking the skin, are included in the intradermal needle category of tools. Press studs (Figure 7.5) are small ball bearings attached to an adhesive tape which are stuck to the skin. The ball bearings were found to be magnetised, made from gold, silver or other metals which were believed to achieve different effects.

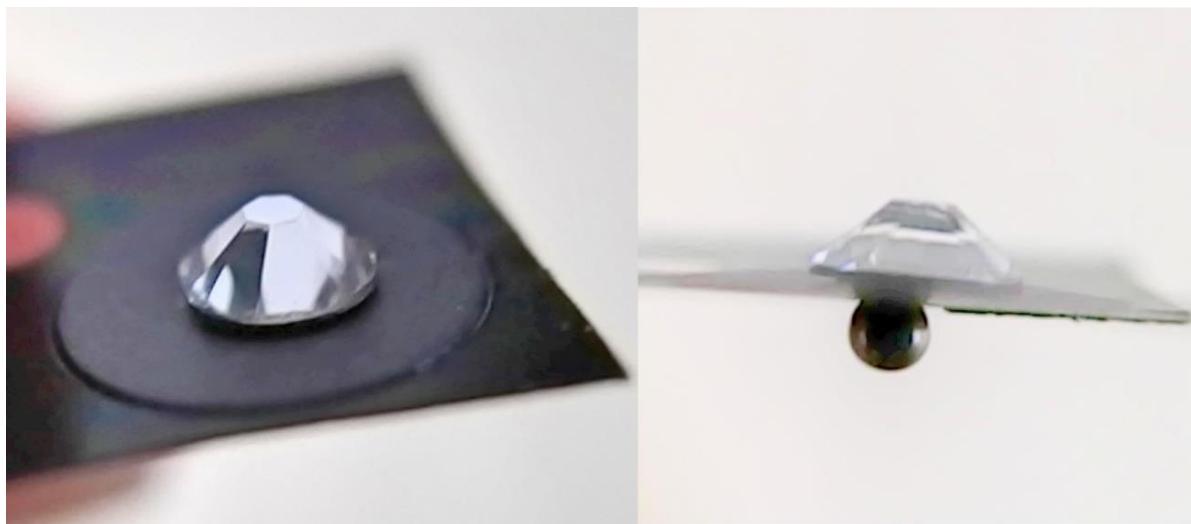


Figure 7.5 Diamond decorated press stud

Intradermal needles were found to be placed anywhere on the body. Typically, treatment locations were chosen because of their actions or indications for certain symptoms or because of the effect they might have on local body tissue. These tools were used with the philosophy that by constantly stimulating a point, a continual effect could be achieved through skin contact or penetration. This contrasts with some aspects of other needling techniques which stimulated treatment locations only briefly. However, the use of such needles reinforces the value of slight stimulation and shallow needling in TJM acupuncture.

Lancing needles, fire needles (Figure 7.6) and plum blossom needles (Figure 7.7) were found to be present in TJM acupuncture clinics. Although fire needles were found to be used, they were being used in scientific experiments on mice ($n=1$), or personal experiments by a practitioner ($n=1$) on themselves. Fire needles are probably not used very often in TJM acupuncture. Plumb blossom needles although found in clinics, were never reported or seen to be used, and are also probably not often used in TJM acupuncture.



Figure 7.6 Fire needle with Ginnosuke (acupuncture practitioner)



Figure 7.7 Plum blossom needles

Needle assistant tools

I use guide tubes made from metal. . . I usually use the ones made from brass which are a little heavier. . . It's much easier to control the tube when it is a little heavier. It's also not just used to help insert the needle, but it is an important treatment tool for a range of techniques in itself. The guide tube has to have a certain weight to use it properly. (Iwamatsu: acupuncture practitioner/professor)

The guide tube is a thin tube through which needles can be inserted (Figure 7.8). Guide tubes were found to come in disposable plastic or reusable metal varieties. When inserting needles, 77% (n=27) of practitioners who contributed data to treatment principles used disposable plastic guide tubes as their preferred tool to assist needle insertion. Reusable metal guide tubes were also found in clinics; 14% (n=5) of practitioners who contributed data to treatment principles were found to prefer to use these kind of guide tubes. Of practitioners who contributed data to treatment principles, 9% (n=3) did not use guide tubes when inserting needles.

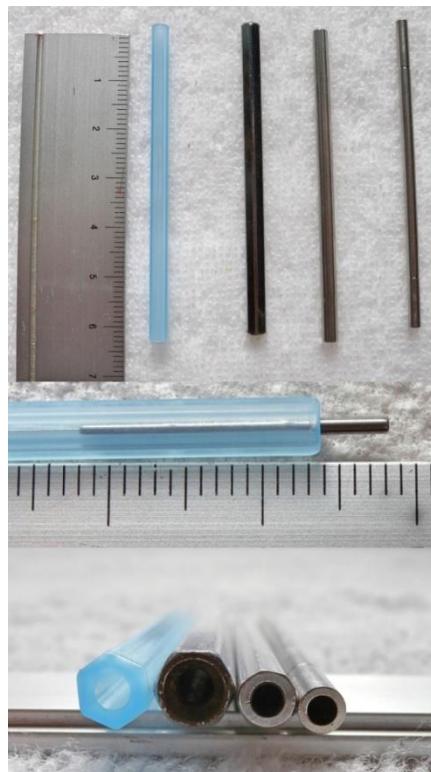


Figure 7.8 A variety of guide tubes (Blasejewicz, 2013, pp. 30-32)
Background gradation shows millimetres and centimetres.

Practitioners from other non-Japanese acupuncture styles probably commonly use disposable plastic guide tubes or insertion techniques which do not rely on the use of tubes. However, the use of reusable metal guide tubes is probably a unique feature of TJM acupuncture.

7.1.3 Moxibustion

[Why do you like moxibustion so much?] I don't know why but. . . When I had migraines, medicine or drugs didn't work at all. But when I went to the acupuncture clinic for the first time and my practitioner applied moxibustion, the pain was relieved. That really surprised me. (Toko: acupuncture practitioner)

Moxibustion involves the application of heat by applying an ignited material (typically moxa floss) on or near the body. Table 7.3 shows the moxa products found to be used by practitioners. Moxa was found to be present in clinics in up to three different forms: moxa floss, stick-on moxa and stick moxa.

Table 7.3 Types of Moxa

Moxa floss	Stick-on moxa	Stick moxa
Higher grade	Liquid adhesive	Raw floss
Lower grade	Sticker adhesive	Charcoal

Moxa floss

You should keep it [moxa floss] in a Japanese paper bag/box or wooden box. Not in a plastic bag or tin because moxa needs to breathe and be kept in a place with some air flow. Don't use any desiccant. That's what I was told. Before, I used desiccant to keep moxa fresh but it was wrong! The most important thing is to let moxa breathe as if it's alive. (Toko: acupuncture practitioner).

Moxa floss (WHO code 5.2.3) is a product made from refined *Artemisia* leaves and has cotton like consistency. There are a variety of grades of moxa floss, which are refined by grinding and sieving *Artemisia* leaves to remove fibrous material. Two

basic distinctions in moxa floss which describe the degree of refinement and how it was used in clinic was interpreted from the data: higher grade and lower grade moxa.

Higher grade moxa is a highly refined product where almost all fibrous materials have been removed from the dried Artemisia leaves, leaving only the softest parts which ignite easily and burn evenly. This requires a process of ageing, repeated grinding, sieving and inspection. Higher grade moxa is usually harvested from prestigious locations, such as Mt. Ibuki in the Kansai area which is believed to produce high quality Artemisia plants. As a result of the more demanding manufacture process, higher grade moxa floss is more expensive than lower grade moxa and in some cases, much more expensive. Figure 7.9 shows a selection of different grades of moxa with the highest grade in the top left. In general, the higher grade floss is a lighter colour and softer looking than the lower grade moxa floss. The dried leaves in their unrefined state are shown in the top right of the figure.



Figure 7.9 Various grades of moxa floss

Lower grade moxa is less refined than higher grade moxa. Lower grade moxa contains more fibrous material, is also aged less and is usually taken from less prestigious locations than higher grade moxa floss. As a consequence, it is cheaper than higher grade moxa, and is more suitable for applications where it does not come into direct contact with the skin, or when the use of higher grade moxa floss is not cost effective.

Moxa floss was found to be able to reproduce the effects of both stick-on and stick moxa when used in specific ways. It also had particular applications of its own which could not be replicated by other forms of moxa. Moxa floss, although the most versatile moxa tool, required the most preparation and technical skills in application. The extensive training and emphasis on the skills required to apply moxa floss in clinic may be a unique feature of TJM acupuncture.

Stick-on moxa

Stick-on moxa is moxa floss which has been placed into a receptacle that can be stuck onto treatment locations on the skin. The size of stick-on moxa cylinders is designed to provide a single dose of heat that lasts a few minutes. A variety of stick-on moxa products produced by different manufacturers were found to be available for professional use.

Stick-on moxa was found in moxa charcoal and raw moxa floss forms. The product was found to be available with either a sticker or liquid adhesive. A very wide variety of stick-on moxa products with different grades of heat, sizes and sometimes including aromatherapy scents were found to be available for purchase from suppliers. However, only raw moxa floss forms of stick-on moxa were found to be used by practitioners. The diverse range of stick-on moxa products may be a unique feature of TJM acupuncture.

Figure 7.10 shows liquid adhesive stick-on smokeless charcoal moxa and Figure 7.11 shows an example of sticker adhesive stick-on raw floss moxa. The moxa in Figure 7.11 is also infused with garlic.



Figure 7.10 Liquid adhesive stick-on moxa



Figure 7.11 Sticker adhesive stick-on moxa

Stick moxa

Stick moxa was found in two different forms: lower grade raw floss rolls or moxa charcoal rolls. These products are similar in size and shape to cigars, and were the least used moxa product among practitioners. Raw floss rolls reportedly produced much smoke and charcoal sticks took a relatively long time to light. As a likely consequence, they were found to be used less than other products. The effects of stick moxa can also be mimicked with other, less inconvenient tools such as heat lamps. Although there are Japanese manufacturers of moxa floss and stick-on moxa, no Japanese moxibustion manufactures were found to produce stick moxa. This does not mean that Japanese stick moxa manufacturers do not exist, but the findings suggest that they are probably rare. This could be representative of the lack of popularity and demand of stick moxa among practitioners in Japan. However, stick moxa was found in the moxa supplies of educational institutions and the use of such tools are taught in undergraduate study.

Figure 7.12 shows an example of raw floss moxa rolls. Figure 7.13 is a photo of stick moxa rolls with an extinguisher.



Figure 7.12 Stick moxa



Figure 7.13 Stick moxa with extinguisher

Moxa assistant tools

A range of moxa assistant tools were found to be used in clinics. Most of these were found to be used with moxa floss. The primary assistant tool when using moxa floss was an incense stick (Figure 7.14). Incense sticks were used by all practitioners who contributed data to treatment principles, when applying raw moxa floss. Moxa floss was rolled into small cones (WHO code 5.2.4) which were used as treatment portions. Incense sticks were used to ignite small moxa cones as a naked flame would increase the risk of burns to both patient and practitioner.

Moisture was found to be used as an adhesive for moxa cones on the skin. A dab of water, charcoal (in the form of a body marker charcoal pencil, Figure 7.15) or vaseline were sometimes found to be used by practitioners who contributed data to treatment principles (14%, n=5), when applying moxa cones. These materials acted as an adhesive so the moxa cone did not fall over and burn the patient.

Small insulated stickers (Figure 7.16) were used by some practitioners who contributed data to treatment principles (11%, n=4) when performing moxibustion. Insulation stickers served three main purposes: to assist in maintaining the upright position of ignited moxa cones, as a marker to indicate treatment location and as an added safety precaution for extra protection against inadvertently burning the patient.

Moulds for shaping moxa insulation and devices which could serve as a receptacle for ignited moxa were also found to be used by practitioners who contributed data to treatment principles (9%, n=3) (Figure 7.17).



Figure 7.14 Incense stick for lighting moxa



Figure 7.15 Charcoal marker



Figure 7.16 Insulation sticker



Figure 7.17 Insulation moulds and receptacles

7.1.4 Other tools

Needles and moxa were the most important tools used by practitioners committed to the TEAM model of medicine. However, there were some practitioners who did not use needles or moxa, or only used them in rare instances, especially practitioners who were committed to the biomedical or orthopaedic models of medicine. Such practitioners were found to use a variety of different treatment tools or none at all by relying on manual methods. This sub-theme examines the other tools found to be used by practitioners by addressing contact tools, electronic equipment, magnets, miscellaneous tools and tools in general society.

Contact tools

Contact tools are instruments that are used on the skin surface and are not designed for skin insertion. Many different kinds of contact tools are found in TJM acupuncture. However, the types that are similar in shape to needles with blunt ends, were the most used by practitioners in this study. These are described in Japanese as teishin. This study uses the Japanese term teishin when specifically discussing needle-like tools not used for skin penetration. Additionally, other tools which were applied to a patient's skin, but were not shaped like a needle are described as friction tools, such as the dermal roller shown in Figure 7.18.



Figure 7.18 Dermal roller friction tool

Teishin and friction tools were reportedly commonly used for children and were sometimes described as *shonishin* or *shonibari* (Figure 7.19). However, they were also used on adult patients. Teishin existed in a variety of shapes, sizes and materials, but the ones found to be used on adults were generally needle-like in shape. They were made from steel, copper, bronze and some plated in silver or gold (Figure 7.20). Some practitioners committed to the concept of Ki, believed that the material of manufacture contributed to the therapeutic efficacy of the treatment, having a tonifying, reducing or neutral effect on Ki (Table 7.4).



Figure 7.19 Paediatric contact tools

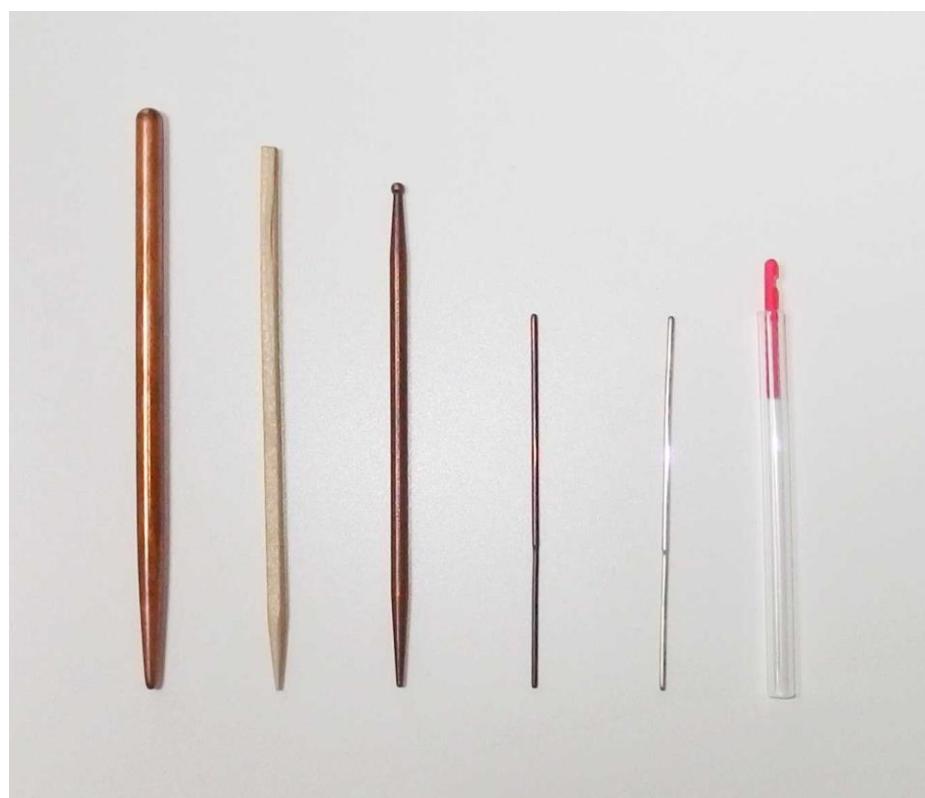


Figure 7.20 Brass, wooden and silver teishin next to a J-Type 0.16 x 40 mm Seirin filiform needle

Table 7.4 Effects of Manufacture Materials on Ki

Material	Effect
Gold	Tonifying
Silver	Reducing
Stainless Steel	Reducing
Bronze	Neutral
Copper	Neutral
Plastic	Neutral
Wood	Neutral

Teishin are manufactured and marketed for use in TJM acupuncture clinics. Many of these products may only be available in Japan and seemed specific to TJM acupuncture, such as disposable plastic friction tools for children (Figure 7.21). Additionally, non-medical objects were found to be used as contact tools in professional practice, such as spoons, leather punches and crystals (Figure 7.22).

**Figure 7.21 Disposable plastic paediatric friction tool**



Figure 7.22 Non-medical objects used as contact tools

Teishin were also found to be used with assistant tools: teishin hammers (Figure 7.23) and teishin metal guide tubes. Teishin hammers could be any solid object, such as a small mallet or block of wood, and provided a solid surface to strike the top of the teishin. This produces a sharper quality to the tap in comparison to a duller tapping quality with softer objects, such as fingers. This sharper quality was believed to be more effective by some practitioners.



Figure 7.23 Large silver teishin (dashin) and hammer

Teishin represent the philosophy that a therapeutic effect can be achieved without needle insertion, and also without skin contact in some cases. The presence of contact tools in TJM acupuncture reinforces the value of superficial stimulation and the immediate effects of treatment.

Electrical equipment

A variety of electrical equipment was found in practitioners' clinics. Some electrical equipment was a standard fixture in all practitioners' clinics which were visited, such as sterilisation chambers (Figure 7.24).

Although practitioners possessed a range of electronic equipment, only a few instances of use in treatment were actually observed. In general, acupuncture only practitioners often had heat lamps in their clinics. Acupuncture/judo therapy practitioners and acupuncture practitioners at educational institutions had many other kinds of equipment (Table 7.5). Only one acupuncture only practitioner was found to use a Transcutaneous Electric Nerve Stimulator (TENS) machine (Figure 7.25). However all acupuncture/judo therapy practitioners had them in their clinics.

Table 7.5 Electronic Equipment

Sterilisation Chambers	Air Compression Pants
Heat Lamp	Electronic Moxibustion Machine
TENS Machine	Hydrotherapy Massage Table
Electronic Needle Stimulator	Ultrasound
Vita Vibration Machine	Laser Stimulator



Figure 7.24 Sterilisation chambers



Figure 7.25 TENS machine in Genrokuro's (acupuncture/judo therapy practitioner) clinic

Magnets

Magnets were found to be applied on treatment locations to stimulate the actions and indications of acupuncture points. Magnet polarity, strength and manufacture materials were believed to have different effects. Magnets were found to be applied in the same manner as embedded needles or hand held contact tools. Magnets which were applied like contact tools were sometimes built into a plastic handle that could be held by a practitioner against a treatment location; these were believed to have an instant effect, which could be confirmed in the radial pulse or by checking changes in body tissue.

Miscellaneous tools

Miscellaneous tools include cups, creams/pastes/extracts, heat and cold applicators and structural supporting tools, such as strapping tape and casts. Cupping (application of suction by placing a vacuumed cup onto the body, WHO code 5.3.2), was only found to be used by 9% (n=3) of practitioners who contributed data to treatment principles. Although present in TJM acupuncture, cupping (Figure 7.26) may not be a popular therapy in Japan. Some of these miscellaneous tools are probably used in very similar ways as in other TEAM acupuncture styles, orthopaedic medicine or physiotherapy. Structural supporting tools were found to be more prevalent in acupuncture/judo therapy clinics than needles and moxa.



Figure 7.26 Cupping over an inserted needle at Takizou's (acupuncture practitioner) clinic

Tools in general society

Although this section has highlighted the tools used by practitioners as TJM acupuncture professionals, it is interesting to note that many TJM acupuncture tools are easily available to non-professionals for purchase and use at home as self-care items. This is especially true for press studs, press tacks and stick-on moxibustion.

The photo in Figure 7.27 was taken at a common Japanese drug store and shows press studs, press tack needles and moxibustion products for sale. The bottom row of products is primarily a combination of sticker adhesive and water adhesive stick-on moxibustion tools. The rows above mostly consist of stick-on intradermal needles and press studs.



Figure 7.27 Treatment tools for sale at drug stores

Many of these products for sale to the general public for use at home are the same which were found to be used by professional practitioners in their clinics. Additionally, all needle and moxibustion tools for sale in this photo were made in Japan. These tools and their availability in common drug stores all over Japan are evidence of the cultural importance of acupuncture and moxibustion as both a professional practice and home remedy for self-care. They are also demonstrative of the variety of products available in the market for laymen and professionals.

In addition to the products for sale in drug stores, some TJM acupuncture modalities are provided by non-professions in the general public. One example of this is *Houroku kyu*. Houroku kyu is a kind of moxibustion that uses ceramic plates and large cones of moxa floss (Figure 7.28). It is part of a Buddhist ceremony which occurs at temples all over Japan, usually at special times of the year. One ceremony was attended with five acupuncture practitioners.

The Houroku kyu ceremony is a paid service performed at Buddhist temples in front of an altar, with priests chanting prayers and hitting drums while attendees hold the smouldering moxa over the acupuncture point GV 20 on top of their heads (Figure 7.29). This ceremony was reported to have become famous in Japan as a result of an incident involving one of the great generals of Japanese history, Takeda Shingen in the Warring States period. It is said that during one of the military campaigns in summer, he suffered heat stroke and fell ill. Fearing an attack, his retainers dared not remove his helmet, so they burnt moxa on top of it, after which he recovered and went on to participate in battle. Apparently after this incident, the use of houroku kyu spread, and in modern times this kind of moxibustion is said to have a holistic effect on health by draining evil Ki from the body. This story is one example of how historical events, folklore and spirituality combine with medicine to create meaningful realities in unique cultural environments. As a result, houroku kyu may be a unique feature of TJM acupuncture and is demonstrative of the popularity and advancement of moxibustion techniques in TJM acupuncture.



Figure 7.28 Ceramic plate and moxa – Source: Kiyo (acupuncture practitioner)



Figure 7.29 Houroku kyu ceremony – Source: Kiyo (acupuncture practitioner)

7.1.5 Section summary

This section begins by firstly discussing what tools were found to be present in practitioners' clinics and how many practitioners used which tools. It is also reported that although a variety of needles can be found in TJM acupuncture clinics, the most commonly used needles by practitioners in this study were stainless steel filiform needles which ranged from 0.14 to 0.20 mm in diameter, and from 30 mm to 40 mm long. Practitioners generally used needles with plastic handles and that came with a plastic guide tube.

The second theme includes descriptions of what moxa products were found to be used by TJM practitioners. These products are divided into three categories: moxa floss, stick-on moxa and stick moxa. Moxa floss is detailed in terms of a higher and lower grade product, and seemed to be more commonly used by practitioners committed to the TEAM model. Stick-on moxa is described in two different forms, liquid adhesive and sticker adhesive, while stick moxa was found to be the least popular moxibustion tool. The assistant tools of moxa are also listed. These generally seemed to be necessary for applying higher grade moxa floss directly to the body.

Finally, it is reported how a miscellaneous selection of tools were also found in addition to needles and moxa. Some of the most important miscellaneous treatment items for TEAM model practitioners were needle-like contact tools such as teishin. The use of teishin and friction tools appeared to be correlated with practitioner commitment to the concept of Ki and belief in the idea that stimulation of the skin surface was enough to cause an instantly verifiable effect either in the local tissue or at an area of anatomical significance. Physically and functionally, many of the tools found to be used by practitioners are demonstrative of the value of superficial stimulation, patient comfort and the perception of treatment effects.

Electrical equipment and machines such as heat lamps and TENS machines were also found to be employed, especially by orthopaedic model practitioners. In contrast to the value of superficial stimulation and patient comfort, some of the machines such as electric needle stimulators, provided a stronger, more sustained stimulus to treatment locations. Such treatment tools were commonly combined

with others to support structural physiology, such as tapes or casts and were founded in orthopaedic philosophical concepts.

The next section reports the pre-intervention preparation practitioners performed in order to apply the tools they selected as interventions.

7.2 Pre-Intervention Preparation

Data relating to pre-intervention preparation procedures are detailed in this section. This is an important theme which represents the findings on the processes of deciding at which treatment locations to apply interventions, and how the skin was prepared for contact before the application of treatment tools. Methods relating to the application of needles, contact tools and moxibustion were found to be the most significant and are the focus of analysis. This section presents the following five steps of pre-intervention preparation:

- **Point selection:** Details the foundations for the cognitive processes which were used to construct strategies about where to apply interventions.
- **Sterilisation:** Outlines how and when sterilisation did and did not occur, and discusses the meaning of sterilisation in terms of knowledge and values.
- **Point location:** Discusses how treatment sites were located and reports how the knowledge of anatomy and known point locations were used together with palpation and observation to find appropriate locations for treatment.
- **Pre-needling and contact:** Reports the importance of the pressing hand and how it was used to preserve the accuracy of selected treatment locations, and maintain patient comfort.
- **Pre-moxibustion:** Briefly explains the role of insulating materials for direct moxibustion.

All of these steps were followed by all practitioners when using needles or moxibustion. Practitioners using contact tools did not always perform sterilisation.

7.2.1 Point selection

... If the patient just has a kind of small muscle injury, I will choose a point around the injury directly. Or if say, the patient has a Stomach problem according to Oriental medicine, I will select a point which will be able to benefit their Stomach... The 69th difficulty of the Classic of Difficult Issues is my main theory. (Takizou: acupuncture practitioner)

Treatment site selection procedures were found to rely on a philosophical decision about how, or by what rules treatment loci were to be chosen, as well as the execution of actual methods for finding the loci. In this study, “point selection” is the term applied to the cognitive analysis that considers differential diagnosis or formulaic philosophies, and creates a strategy for treatment about where to apply interventions. This contrasts somewhat with the term “point location”, which expresses the process of physically locating the treatment site to administer an intervention.

Rules of point selection

I use tonification a lot because I don't like the feeling of reduction. In the Ishizaka style, all needling is tonification. The only method of reduction is bloodletting. If I use the five phases, like Fire or Earth I always use the nourishing cycle. If the Liver is strong – if Wood is strong, the idea is to use Fire to reduce, but I prefer to tonify or control by using Metal or the Lungs. Everything is tonification. If Water is too strong, then by tonifying Earth, the phases can be balanced... To scatter or spread the Ki is like tonification because I am not removing anything. Just moving it... Just softly moving it with a feeling of tonification. Left and right, this way and that way. (Ginnosuke: acupuncture practitioner)

How and why treatment locations were chosen seemed to depend on practitioner preferences in knowledge, values and clinical experience. The philosophical concepts interpreted as primarily governing the rules of point location are listed in Table 7.6.

Table 7.6 Philosophical Concepts of Point Selection

Philosophical Concepts
Actions and indications of points
Anatomy and physiology
Clinical trials (Evidence Based Medicine)
Effective Points
Extraordinary Channels
Five Phases
Proximity to discomfort
Significant areas of anatomy
Stems & Branches

Observation with Zenpachi (acupuncture practitioner/professor)

Zenpachi tested the patient's reflexes at the triceps, biceps and supinator locations with a reflex hammer. He remarked that the reflexes were diminished in the injured arm, especially at the triceps location and that this was due to the nerve impairment at C7. After the reflex test, Zenpachi performed some strength testing by asking the patient to resist against him pushing or pulling her arm in different directions.

The patient lay face down and Zenpachi palpated the spine around C7. He inserted eight 0.16 x 40 mm needles bilaterally about one to 2 cm deep into the paraspinal muscles adjacent to the vertebrae.

Some practitioners (20%, n=7 of those who contributed data related to treatment principles: n=35) seemed to have preferences for point selection methods based on biomedical or orthopaedic knowledge. This included the selection of points based on the location of the main complaint and the knowledge of what body tissues might have been involved in the pathology, as well as how they were related anatomically and physiologically to the patients' condition. Other practitioners (40%, n=14 of those who contributed data related to treatment principles) seemed to favour systematic point selection based on TEAM philosophical concepts. This included

selecting points based on the five phases and correspondences of channels. However, there were also practitioners (40%, n=14 of those who contributed data related to treatment principles) who seemed to use biomedical, orthopaedic and TEAM knowledge interchangeably depending on patients and presenting conditions.

Preferences in point selection philosophy could be due to education, professional allegiances and the health insurance system which required significant documentation about aetiology and treatments in modern medical terms. However, for practitioners who primarily used needles and moxibustion, TEAM model channel based knowledge appeared to be the most significant.

I don't think that each point has some effect like removing Dampness. But if the patient has some Damp then I would choose points on the Spleen or Bladder channel. It doesn't really matter, but this gives me some kind of method for treatment. The body will naturally remove Damp by itself after acupuncture stimulation; it's a kind of placebo effect. If someone is going to use acupuncture then they really should include some Western medical information too. (Hikoemon: researcher/acupuncture practitioner)

For biomedical, orthopaedic and TEAM model based practitioners, formulaic approaches were found to be applied when selecting treatment sites. This involved using the same combination of points, or treating the same area of anatomic significance on every patient no matter what their condition was. Practitioners (34%, n=12 of those who contributed data related to treatment principles) who always incorporated this method of selecting treatment locations believed that treatment at those sites or areas would be therapeutically beneficial for any condition. Sometimes this was called root treatment.

The Spleen and Liver become weak in humid weather. This causes an accumulation of Dampness. I use moxa on Liv 3, St 36 on the left and Sp 4 and St 36 on the right for almost all my patients in summer. (Tsuru: acupuncture practitioner)

In general, practitioners seemed to prefer systematic or formulaic point selection methods. This may reflect practitioners' general tendency towards simplification and may also encourage skill development. When treatments are systematic or

formulaic, practitioners seemed to become very experienced at detecting changes or abnormalities in the patient's condition at their preferred locations for treatment. Additionally, practitioners did not need to invest time analysing where the best treatment locations were; they had already been determined by the formulaic or systematic style of treatment to which practitioners were committed. This means they could proceed quickly to actual treatment.

An apparent preference for predetermined treatment locations at effective points or areas of anatomic significance meant that some practitioners applied less effort in analytical consideration of potential treatment sites. Consequently, they spent more effort utilising practical skills to perceive the correct location at the pre-determined area. This does not suggest that practitioners did not theorise about treatment locations, but that there was a preference for the practical skills of location compared to point selection by theoretical analysis.

Points were also found to be selected for treatment during location. Most of the practitioners observed in clinic (73%, n=16 of practitioners observed in clinic: n=22) considered body tissue abnormalities as treatment site locations and selected points for treatment as they found them during the location process. This may be a feature of TJM acupuncture. However, practitioners were not found to systematically search the entire body for abnormalities; they had a guiding principle about where to search for points. This was based on areas of significant anatomy, theoretical connections of the search area to the signs and symptoms of the patient, or at predetermined and formulaic sites.

7.2.2 Sterilisation

Practitioners' practice seemed to be largely affected, although not completely determined, by the laws surrounding the provision of acupuncture in Japan. The law provides procedures which must be followed when performing skin penetration. Part of the law outlines guidelines for sterilisation which includes the use of sterilisation equipment (Figure 7.30), clean needle techniques and health and safety issues.

Observation with Miyo (acupuncture practitioner/senior lecturer)

In addition to the other tools, the tiered treatment tray contained a stainless steel container occupied with square cotton swabs and a glass vial filled with a clear sterilisation solution. Miyo inserted the finger gloves onto the thumb and index finger of her left hand, took one of the square cotton swabs from the container and removed the cap from the glass vial dispenser. After dabbing the cotton on top of the dispenser a few times, she turned to face the prone patient. "Shodoku shimasu" she said to the patient, an announcement that she was about to begin sterilising their skin. She held the swab in her gloved fingers and stroked over all the skin on the patient's back and legs. Taking a seat on the stool beside the treatment table, she placed the cotton swab on a stainless steel dish, and reached for a needle to begin treatment.

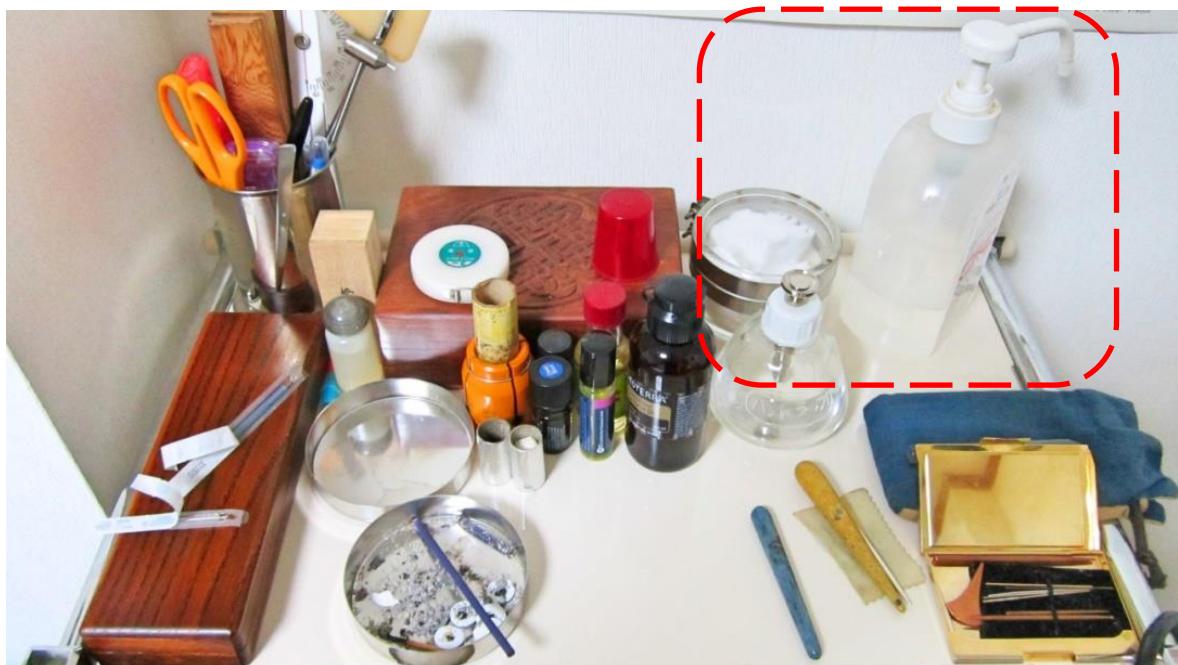


Figure 7.30 Ginosuke's (acupuncture practitioner) sterilisation tools (outlined in dashes)

Every practitioner observed was found to sterilise the patient's skin with a cotton swab and antiseptic solution before needle insertion (Figure 7.31). The antiseptic solution was sometimes found to be non-alcoholic (chlorhexidine gluconate).

Reportedly, it is common for Japanese people to be sensitive to alcohol, and when applied to the skin, alcohol may cause an inflammatory reaction. As a result, non-alcoholic antiseptic solutions were commonly found to be applied in clinic.

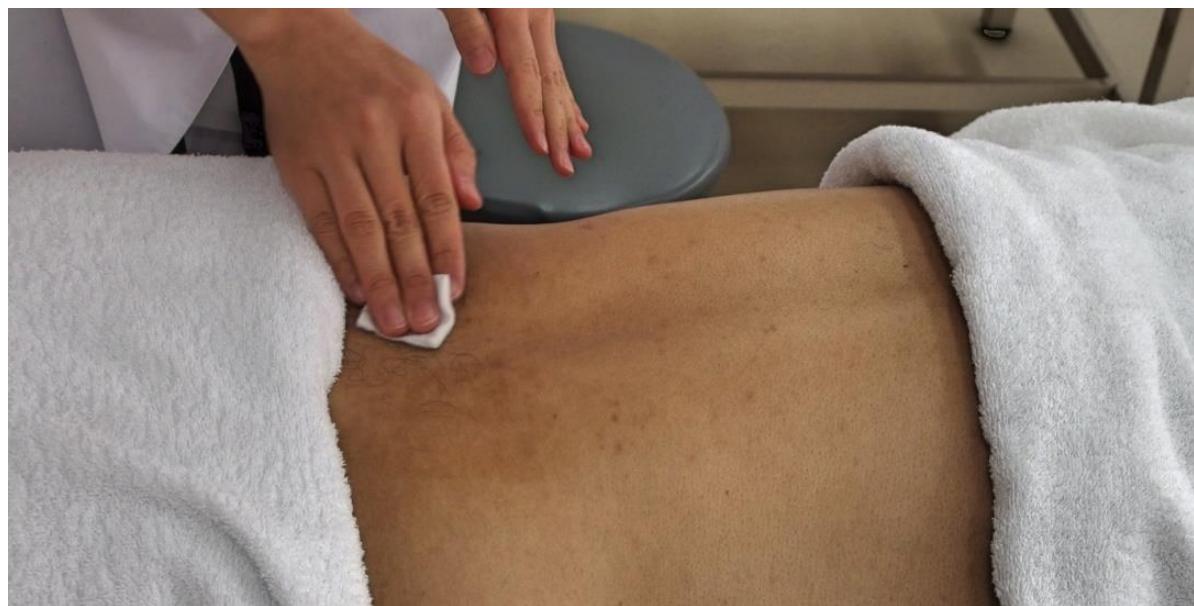


Figure 7.31 Skin sterilisation

Practitioners were found to sterilise entire sections of the body at once. Only 9% (n=2) of practitioners who were observed in clinic were seen to sterilise treatment locations individually. Sterilising the entire area where a needle may be inserted appears to complement needling techniques employed by practitioners. Such instances included when point selection, point location and needle insertion or moxa application occurred consecutively at individual treatment locations. Practitioners applying interventions over anatomical areas by locating abnormalities by palpation did not always know which points they were going to apply interventions at in advance. In addition, such practitioners were found to apply many interventions over an entire area. It was more convenient for such practitioners to sterilise an entire anatomical area in advance so that interventions could be applied smoothly in a consecutive manner, without having to break treatment rhythm by constantly having to sterilise every treatment location individually.

In addition to sterilising the skin, 9% (n=2) of practitioners observed in clinic were also observed to wear finger gloves to prevent their fingers coming in contact

with the needle shaft. The Japanese health laws permit finger contact with the needle shaft, and almost all practitioners allowed their fingers to touch the needle shaft during needle insertion and withdrawal. Almost all practitioners also used the same, already inserted and withdrawn needle at several other treatment sites. This is not permitted by law in some countries. However, reloading a needle into a guide tube is reportedly a historical aspect of TJM acupuncture which remains a significant part of its practice. History, tradition, confidence and faith in the methods passed down through generations of practice, seemed to influence government regulations on some aspects of needle use.

Observation with Otoemon (researcher/acupuncture practitioner)

Otoemon was right handed, so he held the needle in that hand and palpated down the patient's foot with his left. Once an appropriate treatment site was found (near LR 3), he placed his thumb and index finger together over it and positioned the tube in-between his fingers with the needle direction pointing to the end of the Liver channel. Otoemon tapped the needle in slowly and deliberately, gently hitting the top of the handle of the needle three times; once about every two seconds. The needle was tapped in to around 1 mm before the tube was withdrawn, and the thumb and index finger of the left hand remained holding the needle in place. Otoemon held the tube in his right hand and gently manipulated the needle by twisting it with the thumb and index fingers of his right hand, on this occasion, for about 10 seconds. As he removed the needle, he covered the withdrawal point with his left thumb, reloaded the needle into the tube with his right hand and continued palpating for the next treatment site with his left. This process was repeated two more times at different points on each foot.

Although practitioners found it acceptable to touch the needle shaft, they generally observed other regulations surrounding safe practice. Disposable needles were never seen to be shared between patients and they were never inserted through clothes or other materials. In addition to sterilising the skin before needle insertion, practitioners were found to use Ultra Violet sterilisation machines to sterilise other

clinic implements, changed linen between patients, washed hands before and after treatments and kept the premises clean. Every practitioner observed in clinic also wore some kind of protective clothing. This was either a lab coat or variant which included a top and pants for use in clinics. However, almost all practitioners did not wear completely covered footwear.

It is Japanese custom to remove shoes when entering a premise. Once inside and shoes removed, indoor slippers or sandals are commonly worn. Almost all of the observed practitioners wore slippers during treatments while two were observed wearing sandals. One of these practitioners did not wear socks.

7.2.3 Point location procedures

I think compared to Chinese acupuncture, we tend to concentrate on palpation and intuition. One of my friends now works in a clinic belonging to a Chinese acupuncturist. He quizzed her about how she finds acupuncture points: "What is more important, the textbook location of points or what you can feel?" She said that she goes by what she can feel. He said that's wrong! Because the acupuncture points from the textbooks have been decided by the WHO so you have to follow that! (Toko: acupuncture practitioner)

“Point location” is the process of physically locating the treatment site by using location methods. This contrasts with the term “point selection” that expresses the cognitive analysis which considers differential diagnosis or formulaic philosophies and creates a strategy for treatment about where to apply interventions. Three themes relating to point location were found in the data: knowledge, observation and palpation.

Observation with Sayo (acupuncture practitioner/senior lecturer)

Sayo palpated the spinal processes and measured out the appropriate anthropometric measurements to find Bl23 on the left side of the spine. She palpated the area lightly with the fingertips of her left hand while holding the needle in her right, and when she had located the treatment site, she inserted the needle into the point.

Knowledge

I think diagnostic skill is the most important. It is very important to fully understand the patient's condition well. You have to analyse why they feel pain and what caused it. When you actually treat your patients, it is important to analyse and find where to insert the needle. When you want to loosen their muscle, you should know which part of the muscle you should treat. The painful area can change day by day for an individual, so it is important to find the points accurately, as soon as possible when inserting.

(Heijiro: acupuncture practitioner/head lecturer)

In relation to point location, knowledge was found to come from three major sources: textbooks, mentors and clinical experience.

The basic knowledge required for locating points were the standardised point locations found in textbooks. An example of this can be seen in Figure 7.32. All students studied and were required to pass examinations at their college or university and for national licensure on point location.

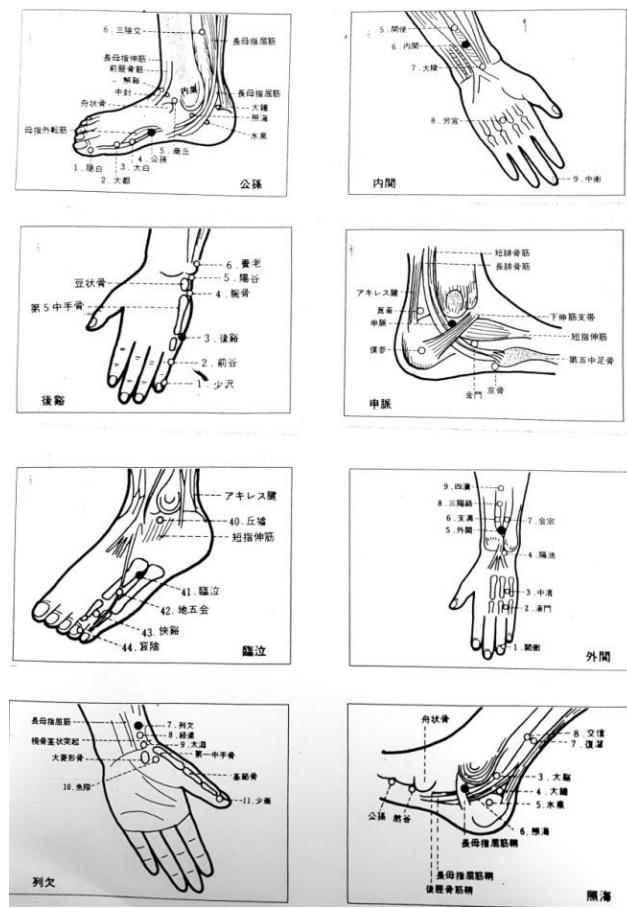


Figure 7.32 Point location information sheet for students – Source: Kinu (acupuncture practitioner/senior lecturer)

The knowledge of point location was applied by observing where a potential location was, and judging the distances of points between anatomical features by measurement and palpation: anthropometric measurement. This is probably a standard method to find appropriate treatment sites among TEAM acupuncture practitioners internationally.

Although on some occasions practitioners found treatment locations by applying textbook locations through anthropometric measurement, more often the standardised channel points were viewed as a concept; an idea attached to a descriptive yet transient location on the body. In general, textbook descriptions of points were not relied on as a map pointing to the treatment location. However, the channel point concept was representative of an impermanent physical location. The physical location was believed to potentially be different every time it was located on the same or different patient, depending on their condition. These impermanent physical locations were sometimes also described as trigger points.

Observation and palpation

Points could be located at sites of observed or palpated abnormality. Observed abnormalities included anatomical irregularities of shape or the colour of the skin. No interventions were found to be performed directly on lesions. However, lesions were markers for treatment sites, which could be found adjacent to, or around any lesions. Palpable abnormalities included what could be felt on the skin or in any underlying tissues. The most important marker for a treatment site was a palpated hollow or an area of increased tension either on the skin or in the muscle.

Observation with Takizou (acupuncture practitioner)

Takizou gently ran the index finger of his left hand proximally over the skin down the course of the Spleen channel, along the medial side of the foot from the head of the first metatarsal bone until it fell into the depression where he felt the point was. After treating this point and checking the patient's radial pulse he moved his attention further up the leg. Takizou palpated the area around the textbook location for ST 40 carefully with the fingertips of his left hand. He gently pressed the skin and underlying tissue until he reported that he had found where the hardest point was; this was the area which had the most amount of skin and muscle tension. He described this point at ST 40 and selected that location for treatment.

Palpation methods for locating treatment sites appeared to be almost the same as during body tissue palpation in diagnosis. The most important difference between palpating in diagnosis and for finding an appropriate treatment site, was that treatment sites were almost always palpated with a finger of the pressing hand and once located, the finger remained at that site so that the skin could be prepared for the intervention to be performed (Figure 7.33).



Figure 7.33 Point location prior to the application of interventions

Practitioners were found to combine different methods of treatment site location during treatment. They tended to locate points based on anatomical features of the body, especially abnormal tissue. For practitioners committed to the TEAM medical model, locations were often found on channels which were palpated to locate abnormalities where interventions were administered. Treatment locations were also found to be over anatomical areas of significance. These included the abdomen, or over areas which exhibited general abnormality, such as coolness on the lower back, and thus need not have been associated with a channel.

7.2.4 Pre-needling and contact

Initial contact with the treatment location prior to interventions with needles and contact tools generally began with the hand not holding the treatment tool. There is a technical term in Japanese to describe the hand not holding the needle, *oshide*: the pressing hand (WHO code 6.1.109). In contrast, the hand holding the tool was called the *sashide*: needling hand (WHO code 6.1.108). Proficiently using both the pressing and needling hands was found to be an important technical aspect of treatment (Figure 7.34), especially for TEAM model practitioners. Reportedly, this

was because it maintained the accuracy of the treatment location, facilitated smooth insertion and manipulation of needles, was used to sense the condition of the body tissues at the site of treatment (thus assisting in confirming treatment effects), and assisted needle withdrawal.



Figure 7.34 Initial contact when needling

The pressing hand typically conducted palpation while the needling hand held the tool. Once the treatment location had been located by the tip of the index finger of the pressing hand, it was rolled to the ulnar edge, and the thumb was brought into contact with the tip of the index finger. This resulted in what looked like an “okay” gesture which rested lightly on the patient’s skin (Figure 7.35). The intended treatment location lay directly under where the thumb and index finger pressed together (Figure 7.36). This was a common hand technique for preparing the treatment site for an intervention with a needle or teishin and was found to be performed by every practitioner who inserted needles with guide tubes.



Figure 7.35 Use of the pressing hand with a teishin

The left photo shows the pressing hand in position, ready for application with the teishin. The middle photo shows teishin application. The right photo shows how the pressing hand can be used after teishin withdrawal.

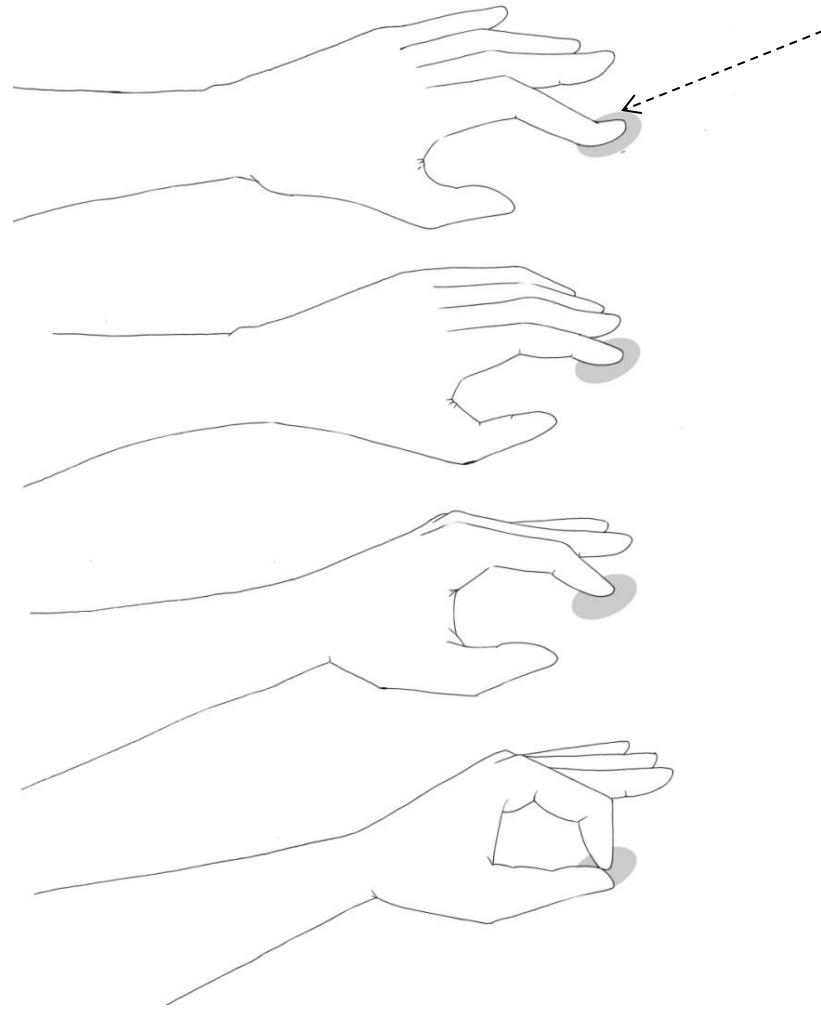


Figure 7.36 Palpating and preparing the treatment location

We treat with the left hand, which is called oshide, but it is actually not so good when it comes to considering sterilisation. However, the oshide is of great significance to us. As I told you earlier, I sometimes do contact needling in my treatments and this can give the patient a needling sensation. I actually know a teacher who can do this just with their oshide! Even if all of us here do the same procedure, we can't replicate what he does. I don't really know how to explain it, but the needling sensation is related to the oshide. Once you have learnt how to place the oshide and how to give appropriate tension to the skin, you can achieve a needling sensation at the point. I believe this is a characteristic of Japanese acupuncture. I guess it's not really good when considering the sanitation. We can treat without the oshide using clean needle technique, but this is very Chinese-ish. I think the oshide is a characteristic of Japanese acupuncture. (Sasuke: acupuncture practitioner/senior lecturer)

Proper use of the pressing hand required that it was applied very lightly on the skin of the patient. Reportedly, the pressing hand must be like a feather touching the skin, but with strong pressure between the fingers holding the tool in place, typically the thumb and index finger. This was said to maintain the accuracy of the treatment location and so that correct needle depth and position could be regulated by the needling hand. It was also essential in holding the guide tube with the enclosed needle in place so that it could be inserted.

After initial contact, during insertion and manipulation, the pressing hand continued to play an important role in sensing the condition of the patient. As the needle or contact tool was manipulated, practitioners used the pressing hand to feel tissue resistance both on the surface of the skin and through the needle.

Initial contact and sustained use of the pressing hand was a feature of all practitioners who inserted needles with the guide tube and may be a unique aspect of TJM acupuncture. The purpose was to maintain precise control over the therapeutic exchange so that the patient remained as comfortable as possible, and so that any discrete changes in the patient's condition could be monitored. This had consequences for deciding when interventions could be ceased at a location and to ensure the patient was not overtreated.

7.2.5 Pre-moxibustion

After sterilisation and point location, it was found that practitioners sometimes applied insulating material, or marked the skin prior to administering moxibustion with cones. Insulation and marks (Figure 7.37) assisted the practitioner in relocating the exact treatment site in the time between locating the site and preparing moxa cones. It also helped maintain the placement of moxa cones once put on the body (because the marker material, usually charcoal, is somewhat sticky), and sometimes assisted in preventing accidental burns (in the case of insulation stickers). The pre-moxibustion routines described here may be a unique feature of TJM acupuncture.



Figure 7.37 Treatment sites marked with charcoal pencil (highlighted in circles)

7.2.6 Section summary

This section gives a procedural account of pre-intervention preparation in five themes: point selection, sterilisation, point location, pre-needling and pre-moxibustion (Figure 7.38).

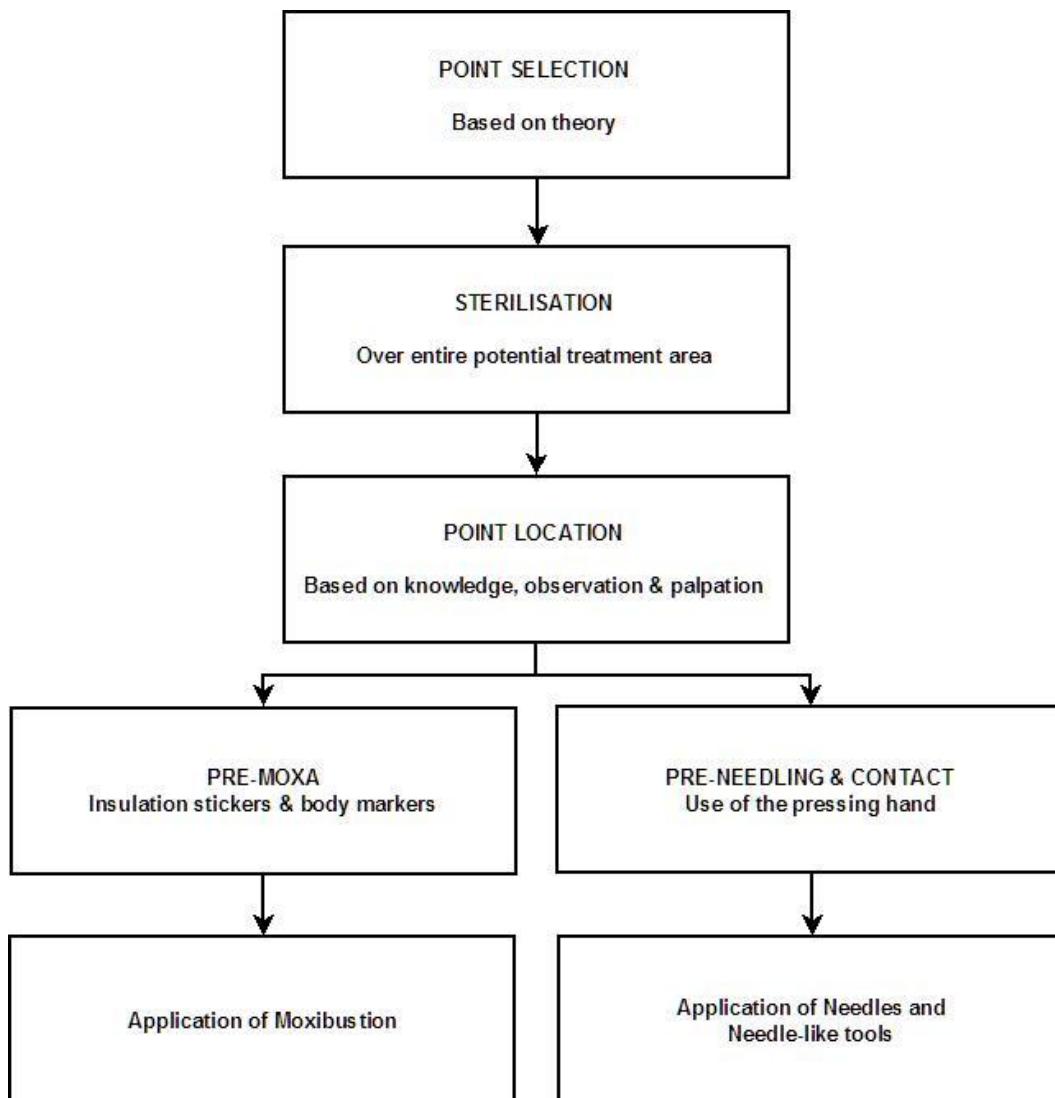


Figure 7.38 Summary of pre-intervention processes

It is shown how point selection was based on knowledge from different explanatory models of medicine and how knowledge from different models was sometimes integrated depending on patients and conditions.

That sterilisation was generally found to occur over the entire possible treatment area before the application of interventions is described, and suggestions about how this connected to needling techniques are made. In particular, that it permitted many treatment locations to be treated in rapid succession is highlighted. This may be a unique feature of TJM acupuncture.

Procedural aspects of point location are presented and analysed in three themes: (i) knowledge, which included recalling known point locations and (ii)

observing or (iii) palpating abnormal body tissue to find them. Finally, it is described how treatment locations were prepared differently depending on whether needles and contact tools, or moxibustion would be applied. Details about how the pressing hand was involved in maintaining the accuracy of point location is provided. It is also shown that for the application of moxa cones, a mark or insulation sticker was sometimes placed at the treatment site. Interpretations about pre-needling and pre-moxibustion resulted in the suggestion that patients were prepared for interventions in a way as to ensure comfort, control the treatment intervention and for the purpose of confirming the effects of treatment.

The next section presents the results and analysis of the techniques related to needles and contact tools.

7.3 Needling

Technique is not so important. Sense is important. Teachers talk too much about it. You need technique if you want to deal with patterns. Better to treat without patterns by using sense. (Benio: acupuncture/judo therapy practitioner/lecturer)

Practitioners were rarely found to discuss tool use during interviews, so much of the data concerning needling procedures were gathered through observation with 22 practitioners. When practitioners did discuss technique, it was often explained in terms of effect rather than procedure. Words used to describe technique effects included tonification, reduction, relax, soften or loosen; these descriptive terms were also interpreted as being treatment objectives. Different techniques were found to be used to achieve similar objectives. This seems to devalue the technical details of procedures while emphasising the achievement of a desired treatment effect via any means possible. This section presents and analyses data relevant to the techniques and procedures of needles and contact tools in four themes:

- **Insertion and placement:** Procedures for needle insertion are described and the perceived differences in the effect of different insertion methods are outlined. How these methods relate to non-inserted needles and contact tools is also explained.

- **Manipulation:** How manipulation is performed with needles and contact tools is detailed. The purposes of manipulation are defined and it is demonstrated how the effects of manipulation were achieved by altering various elements of tool use.
- **Needle retention:** Aspects relating to the duration of retention, other actions performed during the retention of needles and how many needles tend to be retained is reported. Suggestions are made about how this correlates to the techniques of needling, and the ramifications this might have in relation to treatment principles in general are examined.
- **Withdrawal:** Withdrawal methods are reported, and it is demonstrated how the methods for withdrawing needles exemplify attention to patient comfort, safety, and how commitment to the concept of *Ki* might influence these methods. Additionally withdrawal, reloading the needle into the guide tube and reinsertion of the needle is described.

7.3.1 Insertion and placement

*Generally I use both my needling hand and my pressing hand. First you have to relax. If you're tense, then *Ki* doesn't flow. . . In Meridian Therapy, there are a lot of people who just do contact needling at the point, but we actually push and insert the needle. We insert the needle until it stops. Without being tense, relaxed, I push in the needle until I feel it stops, until it hits the spot and it won't go in smoothly any further. This is near where the *Ki* should be moving the most. Once we get to there with the needle, then we can continue. It's got nothing to do with the actual depth of the needle but we have to move through that point. So first we push the needle in and insert as far as it will smoothly go, push it in until it stops. Then, just past that point is the real depth where the *Ki* flows. (Kojiro: acupuncture/massage practitioner)*

The insertion of needles into the body for therapeutic purposes is an important element of acupuncture. However, it was found that needle insertion was not a prerequisite for treatment. Non-inserted needles and contact tools were not inserted into the body; they were placed at the treatment site and then manipulated (Figure 7.39). This may be a unique feature of TJM acupuncture.

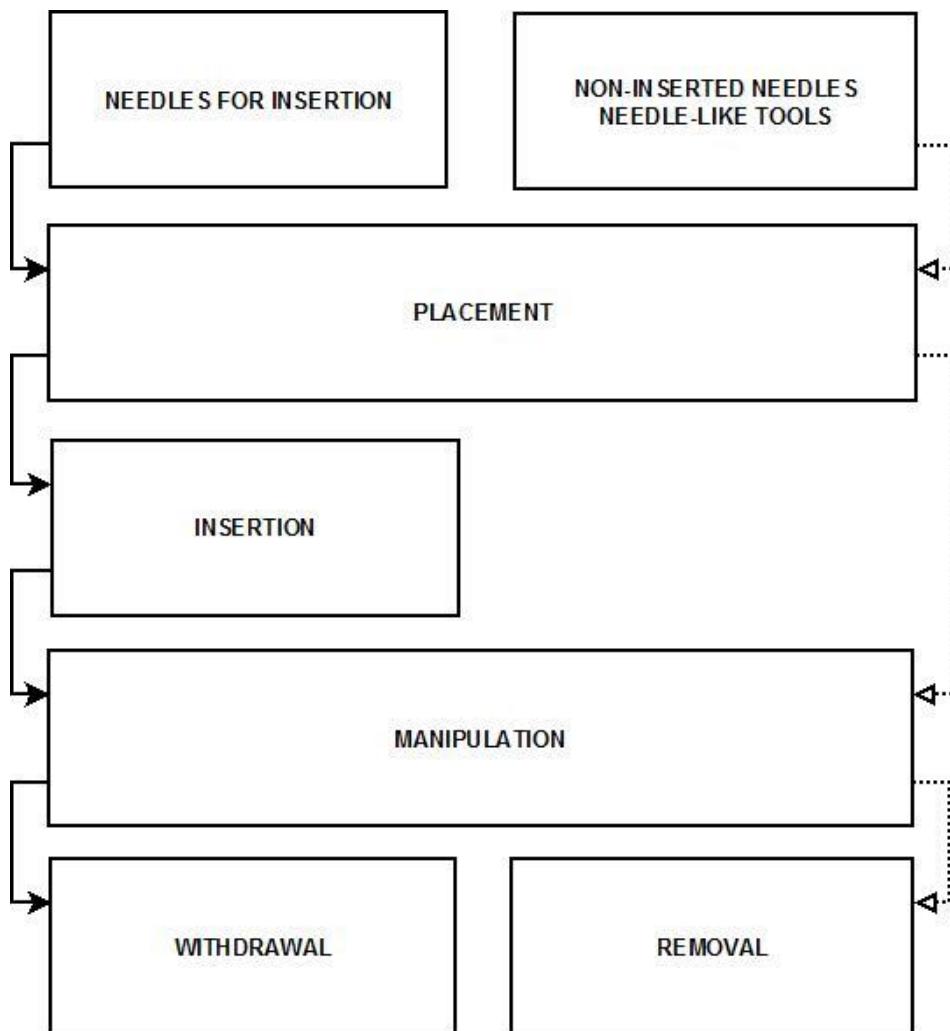


Figure 7.39 Insertion and placement procedures

The left arrow track shows the general routine for how needles for insertion were used, and the right (dotted) arrow track shows the general routine for how non-inserted needles and needle-like tools were used.

Inserted needles, non-inserted needles and contact tools were found to be used with and without guide tubes. The placement procedures for tube assisted insertion of needles were mirrored in the use of non-inserted needles and contact tools without guide tubes.

Tube assisted insertion

When guide tubes were used, all practitioners followed a similar procedure. Figures 7.40 to 7.43 represent the steps in tube assisted placement and insertion diagrammatically.

Observation of tube assisted insertion (Figures 7.40 – 7.43)

1. **Tube placement:** Guide tube is placed between the index finger and thumb of the pressing hand.
2. **Tube support:** Pressing hand holds the guide tube in place.
3. **Needle release:** Needle handle is released by the needling hand.
4. **Needle Tapping:** Needle is tapped in by the needling hand.

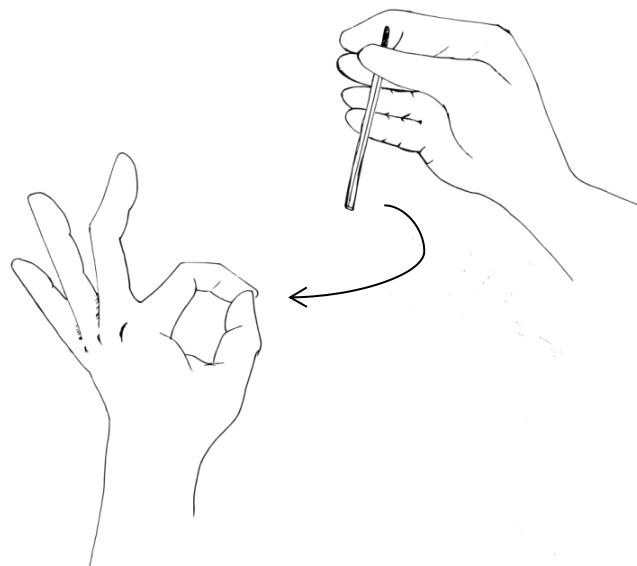


Figure 7.40 Tube placement

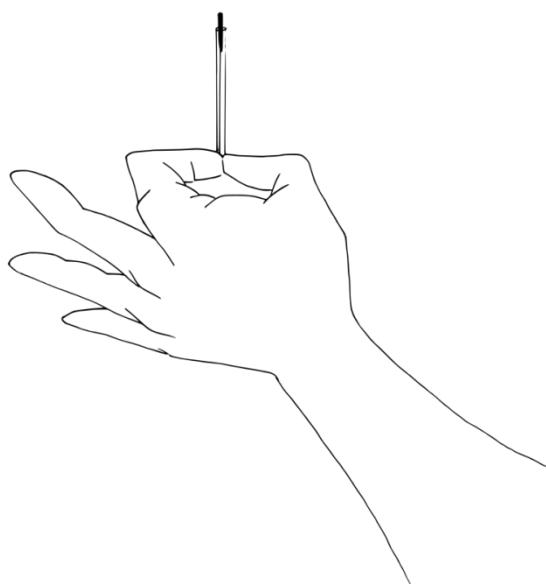


Figure 7.41 Tube support



Figure 7.42 Needle tapping

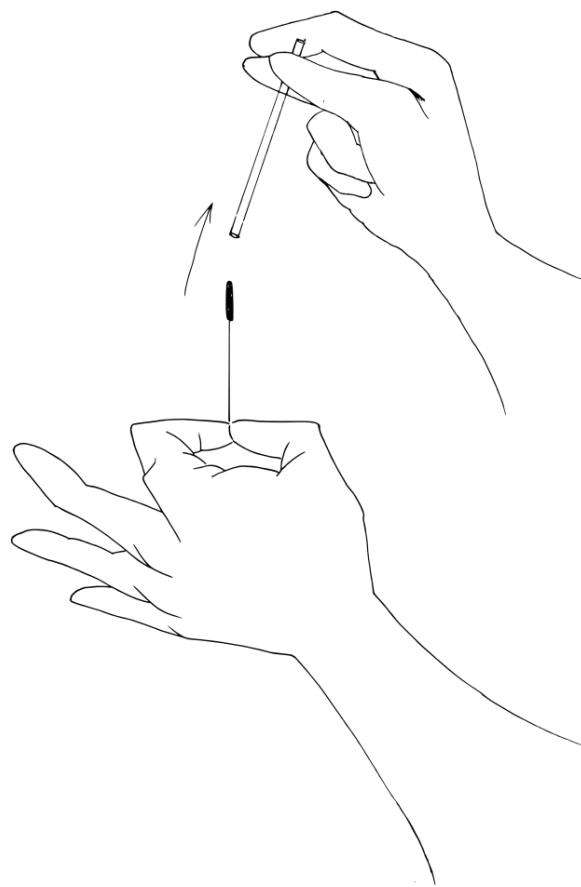


Figure 7.43 Tube is withdrawn and pressing hand maintains needle position

When using a guide tube, practitioners tapped the needle handle until the needle was inserted into the skin. Tapping was generally found to be performed with the index finger (Figure 7.44). Practitioners seemed to have developed their own method of tapping insertion which included attention to four important elements: tapping speed, force, depth and repetition.



Figure 7.44 Tapping insertion

The sequence begins in the top left photo, progresses to the right, and finishes in the second row, bottom right.

Inserting needles by tapping required attention to the force applied to the needle handle as well as the recoil of the tapping finger after the application of force. Even though the needle handle only extended a few millimetres from the top of the guide tube, during observation some practitioners (23%, n=5 of practitioners observed in clinic: n=22) were seen not to tap the needle handle in as far as possible, this was considered too deep. This may be a unique aspect of TJM acupuncture.

Practitioners inserted in particular ways because they believed certain methods provided advantages to the therapeutic encounter for the patient:

- Maintain patient comfort
- Tonify, reduce or move Ki
- Rectify body tissue abnormalities

The reported effects of tapping insertion on reducing or tonifying Ki are shown in Table 7.7. However, practitioners were also found to use the same tapping insertion techniques for any and all conditions; this appeared to be the case especially for speed, which was used both for reduction and tonification. It seemed that depth, pressure and repetition were more significant modifiers than speed when using the tapping insertion method. Practitioners sometimes relied on tapping insertion techniques to facilitate a therapeutic response, but almost always employed insertion tactics to reduce the chances of accidental patient discomfort.

Table 7.7 Tapping Insertion Effects on Ki

Ki Reduction Tapping Insertion	Ki Tonification Tapping Insertion
Deeper	Shallower
Slower/Faster	Slower/Faster
Stronger	Lighter
More Repetitive	Less Repetitive

Some practitioners paid attention to needling insertion advice from classical TEAM acupuncture literature. This included needling in the direction of a channel or inserting as a patient inhaled or exhaled.

I usually tap the needles in using a tube, which is typically Japanese in style, but I change how I use it depending whether patients have a deficiency or excess pattern. If a patient has an excess pattern, firstly I insert needles against the channel flow. Secondly, I use thicker needles. Thirdly, I don't cover the treatment site right after pulling out the needles. I do these steps when it comes to treating excess. (Heijiyo: acupuncture practitioner/head lecturer)

When a practitioner operated from the TEAM model of medicine, the philosophical concepts of Ki and ideas related to tonification or reduction appeared to be of

significance when performing needle insertion. Additionally, the maintenance of patient comfort was also an important value.

7.3.2 Manipulation

I don't think patients can be cured by technique alone. A lot of practitioners have different opinions about technique, but the most important thing is to find the cause of the problem. (Bunzaemon: acupuncture/judo therapy practitioner)

Manipulation means how the tool is adjusted once it has been inserted or placed at the treatment location, and refers to the techniques applied to tools.

Purposes of manipulation

The purpose of manipulation was to stimulate the treatment site to cause a desired reaction that assisted in achieving the treatment objectives. Desired effects of manipulation were somewhat determined by the medical model preferred by the practitioner. Practitioners who primarily operated from the TEAM medical model manipulated tools in an attempt to stimulate Ki or local body tissue. When stimulating body tissue, manipulation was aimed at returning the tissue to a normal state, or achieving a twitch/movement response in the local tissue. When stimulating Ki, manipulation was found to be performed in order to affect Ki in five important ways: move direction, reduce, increase, arrive or be obtained.

The arrival of Ki (WHO code 5.1.116) was described as a sensation felt by the practitioner signifying they had achieved a movement of Ki at the treatment location. Although the practitioner may have been aware of a change in condition at the treatment location, the patient reportedly, did not necessarily feel anything. In contrast, practitioners sometimes wanted to cause a *hibiki* response when manipulating a tool. Hibiki is Japanese for *deQi* (Chinese language term), or the obtaining of Ki (WHO code 5.1.117). This was described as a mild reverberating, vibrating, heavy, electric or dull achy feeling at the treatment site felt by the patient.

The patient's Spleen Ki is weak and is blocking the channel. We need to activate these points strongly until they sweat in order to unblock the channel. (Sayo: acupuncture practitioner/senior lecturer)

Practitioners tended to purposely avoid producing the obtaining of Ki sensation because many believed it caused patient discomfort and was unnecessary to facilitate a therapeutic result. However during observation, there were practitioners (18%, n=4 of practitioners observed in clinic: n=22) found to on occasion make attempts to solicit it deliberately. Nevertheless, in general practitioners valued the arrival of Ki over the obtaining of Ki.

Manipulation of needles for insertion

First of all, I touch the skin and I try to get an image of where the induration is just under the needle tip. I also apply sparrow pecking to get a reaction from the patient. (Chusuke: acupuncture practitioner/senior lecturer)

Data interpretation resulted in the analysis of four essential elements to needle manipulation:

- Form
- Depth
- Speed
- Repetition

Alterations in any of those elements were believed to alter the effects of manipulation. Sometimes, when a desired effect could not be achieved by one manipulation method, changing methods was employed as a tactic to achieve the same effects.

Form

Form is the kind of technique applied to the needle. Although many manipulation forms were found to be part of the knowledge base of practitioners, four basic manipulations forms were observed in actual treatments:

- Twirling
- Sparrow Pecking
- Holding
- Tapping

Twirling (Figure 7.45) was performed superficially to facilitate the arrival of Ki. When performed deeper, it was utilised to cause a twitch response in local nervous or muscle tissue.

Observation of twirling (Figure 7.45)

1. Hold needle handle between thumb and index finger.
2. Spin the needle by rubbing the thumb and index finger together continually in both directions.

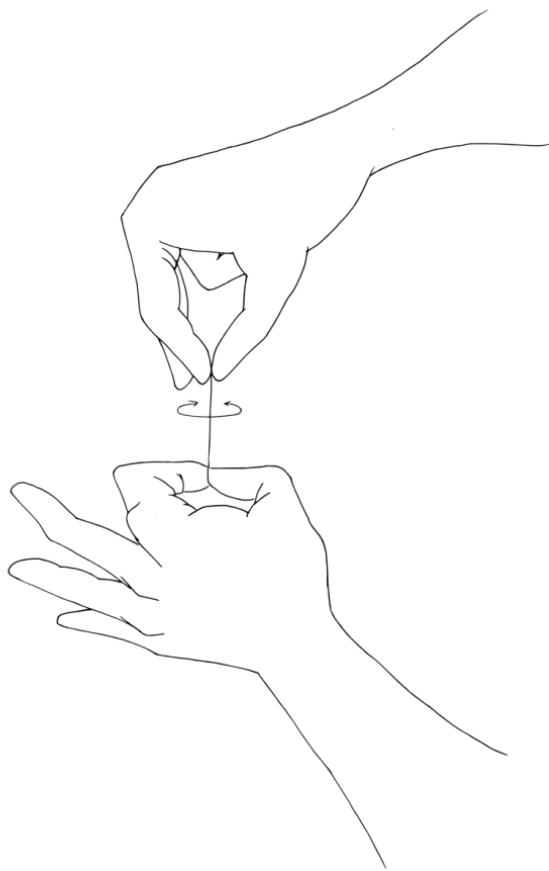


Figure 7.45 Twirling – Rub the index finger and thumb together to twirl the needle

Sparrow pecking (Figure 7.46) is similar to the lifting and thrusting method (WHO code 5.1.127). It was used to dissipate tension in body tissue and to solicit the arrival or obtaining of Ki. It was performed over a short distance, like pushing and releasing tissue under the needle tip, rather than through it. The movement was likened to the moving up and down of a bird's beak, like a sparrow pecking for food.

Observation of sparrow pecking (Figure 7.46)

- 1 Hold needle handle between thumb and index finger.
2. Press the needle tip into the underlying tissue.
3. Withdraw the needle a short distance.

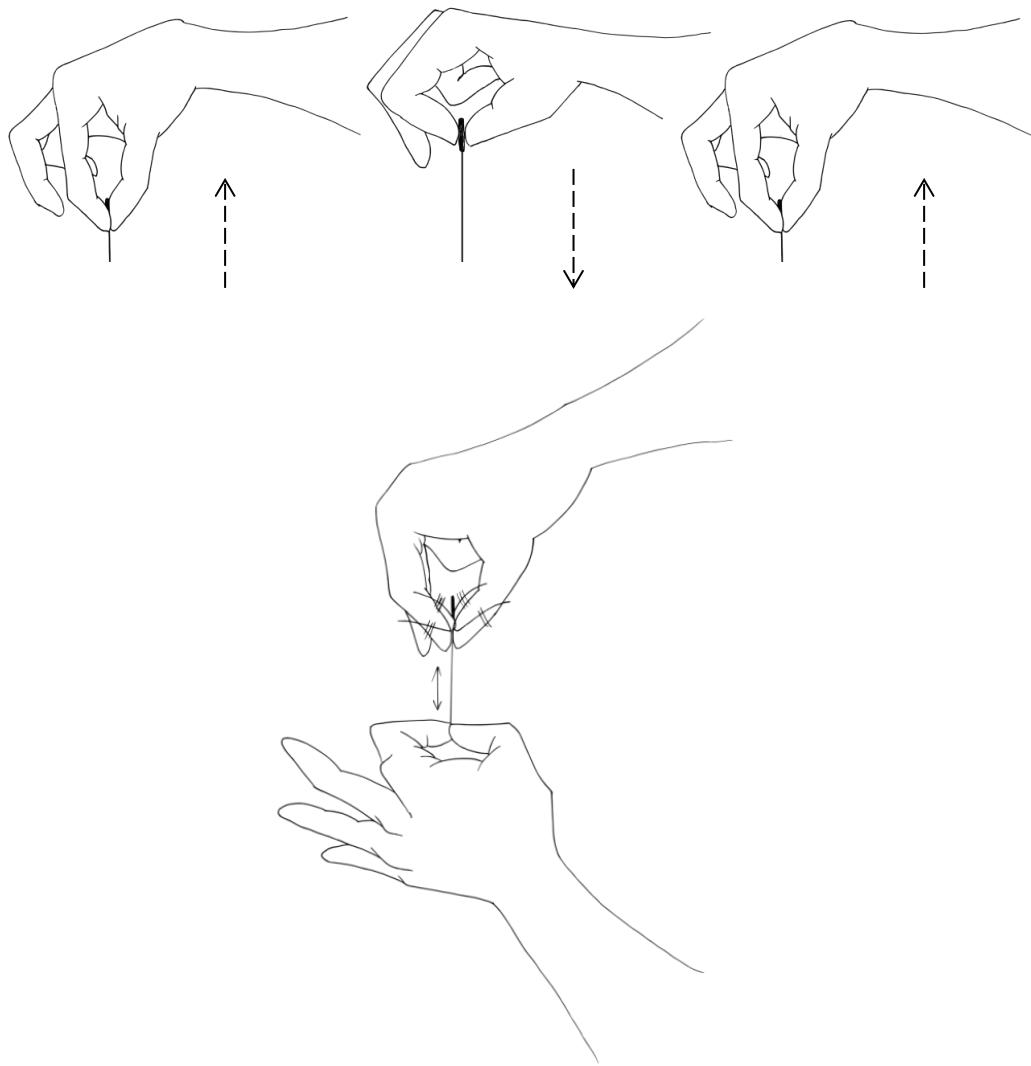


Figure 7.46 Sparrow Pecking – Index finger and thumb move up and down to manipulate needle depth

Performing holding (Figure 7.47), the practitioner waited for Ki to be obtained, for Ki to arrive or for the body tissue at the intervention site or another place to change. The holding manipulation method is similar to needle retention, except that while holding, practitioners are present with the patient and in contact with the needle. Practitioners purposefully waited until deciding a different manipulation was required, or that enough stimulation had been provided at the treatment site.

Observation of holding (Figure 7.47)

1. Hold needle handle between thumb and index finger of the needling hand.
2. Hold the needle shaft between thumb and index finger of the pressing hand.
3. Maintain position

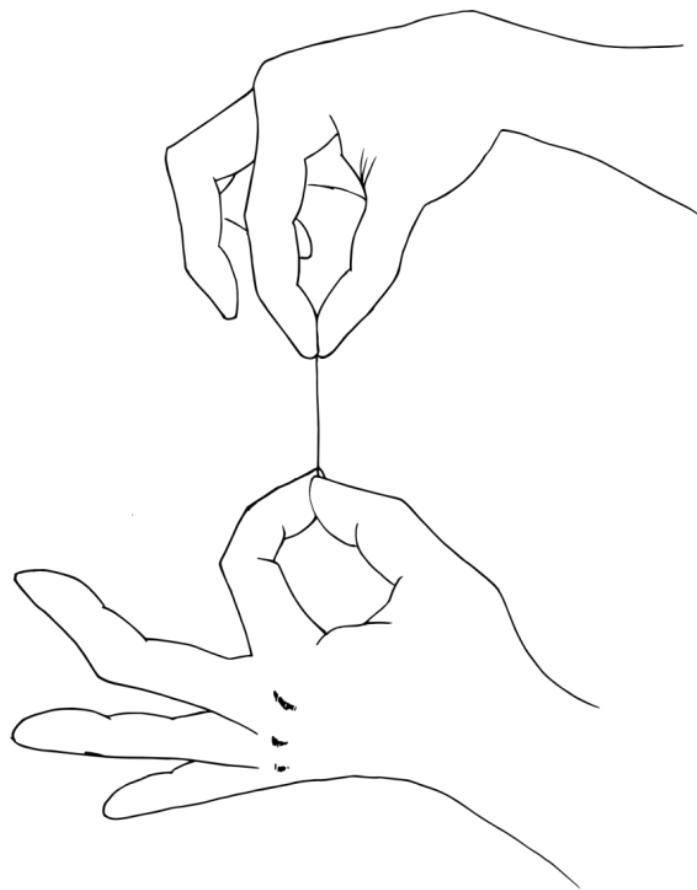


Figure 7.47 Holding – Hold the needle

Tapping (Figure 7.48) was facilitated with the aid of a guide tube when performed on filiform needles. This contrasts with how tapping was applied to teishin and friction tools (described later). Tapping was used to obtain, facilitate the arrival of, move, tonify and reduce Ki. Tapping was also used to alter the condition of local body tissue. In addition to other elements of manipulation, tapping effects could be altered by tapping pressure. Lighter tapping was considered tonifying or a light treatment, while harder tapping was more reducing or a stronger treatment.

Observation of tapping (Figure 7.48)

1. *Do not remove the guide tube after insertion.*
2. *Hold the guide tube lightly against the treatment location with the thumb and index finger of the pressing hand.*
3. *Tap the top or side of the guide tube repetitively.*

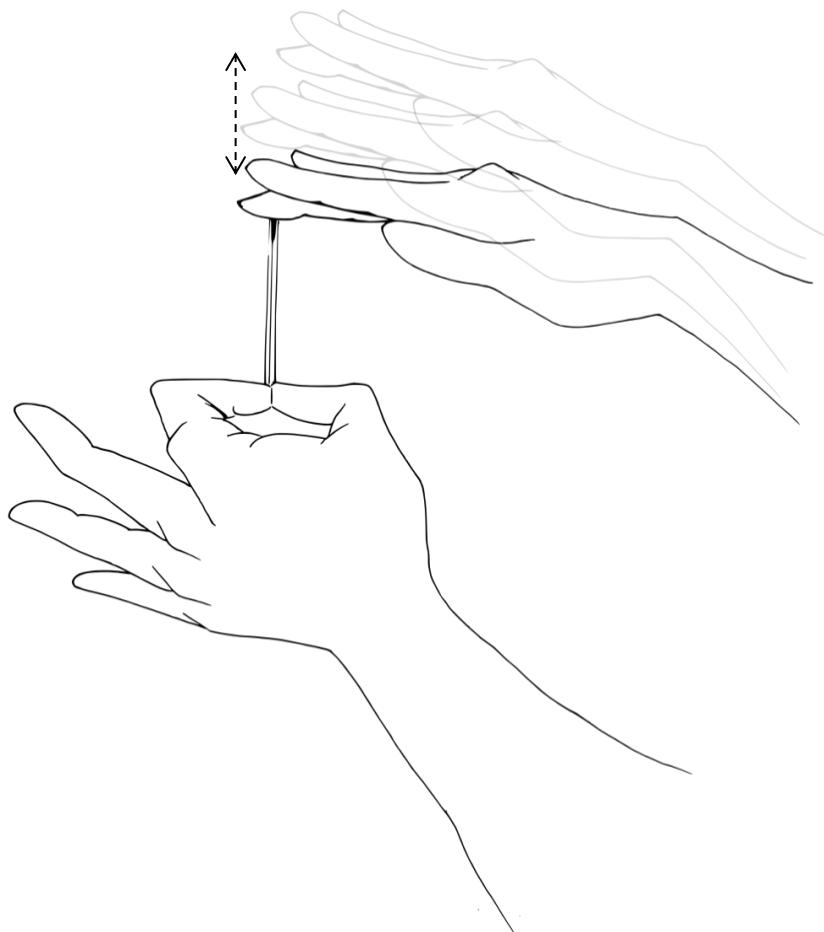


Figure 7.48 Tapping – Tap the top of the needle and tube repetitively

Manipulation forms were sometimes performed in succession or combined with inserting the needle deeper; especially twirling, sparrow pecking and holding. Twirling and sparrow pecking were found to be used in combination to stimulate a treatment site as a stronger method. Holding and sparrow pecking were found to have a softer effect or stimulate a treatment site more gently.

Depth

Depth means how deeply needles are inserted into body tissue, typically in relation to perpendicular insertion. Decisions about how deep to insert needles were made at two stages of needle use: initial skin penetration and subsequent insertion into body tissue (if required). When using guide tubes, needles were almost always consistently inserted to the same depth initially, the distance from the top of the needle handle to top of the guide tube. The tube was then removed and the needle manipulated to the required depth into the body tissue. On occasion, some practitioners (especially those that used metal guide tubes) did not initially insert the needle as deep as the tube would allow because this was considered too deep.

Observation of depth manipulation

1. *Needle contact with, or insertion into the skin.*
2. *Tube removal.*
3. *Needle supported by the pressing hand which holds the needle shaft adjacent to the insertion point on the skin.*
4. *The needle is fed deeper into underlying tissue by the needling hand.*

Use of the pressing hand in the depth manipulation method was necessary when long, thin needles were used. Long and thin needles were reportedly difficult to insert without pressure applied at both ends of the needle because the needle shaft bends under slight resistance. The pressing hand assisted insertion so that the needle could be inserted without bending.

Insertion depth varied from less than one millimetre to around four centimetres. Most practitioners inserted to a consistent depth; those who reliably needled to only a few millimetres were rarely observed to insert deeper, while those who reliably needled up to a few centimetres rarely inserted shallowly.

Treatment goals seemed to influence needle insertion depth (Figure 7.49). In general, needling shallowly was said to have an effect on the skin or Ki (especially a tonifying effect). Needling deeper was performed to affect local body tissue. In

contradiction, some practitioners (23%, n=5 of practitioners observed in clinic: n=22) were found to needle deeper even though they had treatment goals aimed at affecting Ki. These practitioners tended to value the obtaining of Ki and sometimes thought that this had a reducing effect.

NEEDLING DEPTH GOALS



Figure 7.49 Needling depth goals

Needle depth was also found to depend on the anatomical area where needling occurred. Fleshly tissues could be needled deeper, whereas locations close to bones or sensitive tissue were needled more shallowly. This is not a unique feature of TJM acupuncture. However, although treatment locations close to bones could have been needled deeply by threading the needle under the skin, this was not found to occur in any practitioners' practice.

Speed

Speed means the velocity at which a manipulation is performed. In general, speed and depth were seemingly mutually dependent variables. Shallow manipulations were generally performed faster while deeper manipulations were found to be performed slower (Figure 7.50).

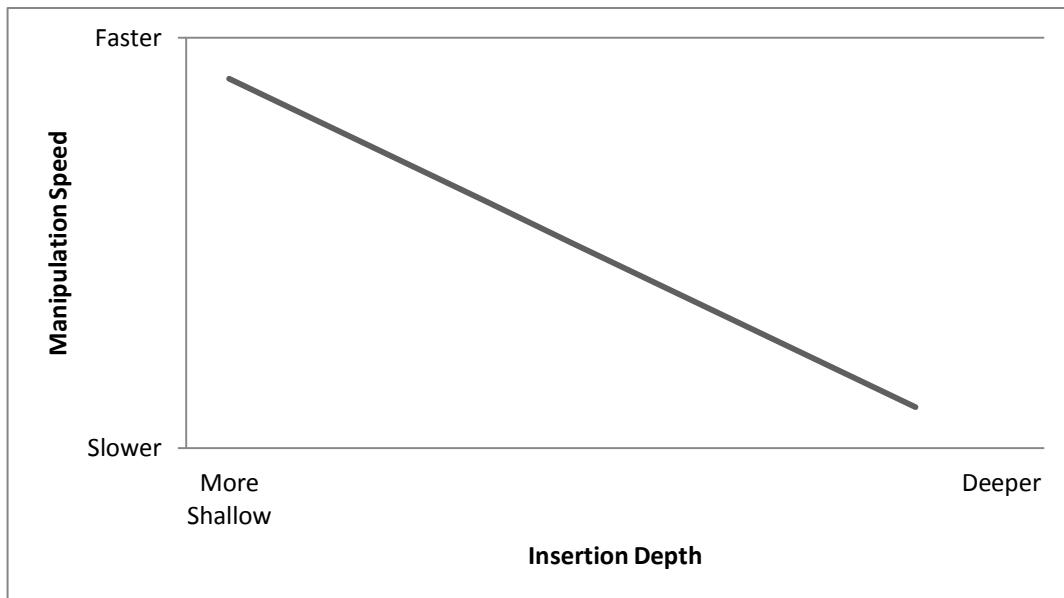


Figure 7.50 Relationship between manipulation speed and depth

Manipulation speed was to some extent determined by the desired outcomes of manipulation and on maintaining patient comfort. Manipulation speed was believed to have different effects depending on the needling form and the depth at which it was performed (Table 7.8).

Table 7.8 Effects of Manipulation Speed

Form	Speed Stimulation Effect	
	Faster	Slower
Twirling	Arrival of Ki Obtaining of Ki Tonifying/Reducing Skin stimulation	Local body tissue stimulation Obtaining of Ki Tonifying/Reducing
Sparrow Pecking	Arrival of Ki Obtaining of Ki Skin stimulation	Local body tissue stimulation Obtaining of Ki
Tapping	Tonifying/Reducing Scattering Ki	Tonifying/Reducing
Insertion	Reducing Local body tissue stimulation	Maintain patient comfort

For many manipulation forms, speed alone did not appear to solely determine the stimulation effects; practitioners were found to perform certain forms faster or slower to produce similar effects. It seemed that depth, repetition and pressure (when performing tapping) were more significant modifiers than speed when manipulating inserted needles.

Repetition

Manipulations were found to be repeated until an effect could be confirmed or until practitioners judged enough stimulation had been provided. In general, more repetition was believed to have a reducing effect and less having a tonifying effect on Ki.

Manipulation of contact tools

Analysis resulted in the interpretation of four important themes in the manipulation of contact tools. Non-inserted needles and contact tools were found to be manipulated similarly to inserted needles:

- Form
- Speed
- Repetition
- Pressure

These elements differed to needles for insertion in relation to aspects of form, speed and pressure. In addition to technique applied with the needling hand, the pressing hand was important in adjusting how much the contact tool protruded through the index finger and thumb of the pressing hand into the skin of a patient. Adjustment of the tool in relation to skin contact with the patient and pressure, contributed to the stimulation strength of manipulation and patient comfort. Regarding speed, manipulation with inserted needles could be performed slower or faster to reduce and tonify. In contrast, the effects of speed on contact tools seemed to be applied to a more regular standard: faster was more reducing and slower was more tonifying. Table 7.9 shows the manipulation variables and their treatment effects.

Table 7.9 Contact Tool Manipulation Variables and Effect

	Pressure	Repetition	Stroke length	Speed
Stronger effect/ Reducing Ki	Harder	More	Longer	Faster
Subtler effect/ Tonifying Ki	Lighter	Less	Shorter	Slower

Form

Form is the kind of technique applied to the contact tool. Although many manipulation forms were found to be part of the knowledge base of practitioners, only four manipulation forms were observed in actual treatments:

- Tapping
- Holding
- Pressing/pushing
- Stroking

Each form was believed to be specific in its effects, and when applied, an appropriate amount of speed, repetition and pressure was required to achieve the desired results. In general, tapping, pressing/pushing, using stronger pressure or greater volume was seen as reducing or moving. Holding, stroking, or using light pressure and decreased volume was seen as tonifying.

Tapping

Tapping could be performed similar to needles for insertion by holding the tip of the tool against the skin with the pressing hand and tapping the top of the tool with the needling hand (or other object) (Figure 7.51). Additionally, contact tools were found to be held in the needling hand and tapped directly against treatment sites (Figure 7.52). The effects of tapping were altered by regulating repetition and pressure. Speed was found to be performed at a consistently rapid rate among practitioners. This method was sometimes described as *san shin* (scatter needling) in Japanese. It was said to scatter Ki and could be used to relieve tension or dissipate Ki.

Tapping repetition involved continual tapping on a single location, or over an area in rapid succession. The treatment site or tool was found to be tapped and then moved to the next location. In this way a large area could be treated, such as the abdomen or back, with the intention of addressing body tissue abnormalities or moving Ki over a wide area. In Figure 7.53, dots represent where tapping has been performed against many treatment locations. Over 100 taps were observed to be performed on some areas.

Observation of tapping the contact tool (Figure 7.51)

1. *Pressing hand holds the contact tool at the tip against the treatment location with the thumb and index finger (or other fingers if appropriate).*
2. *Pressing hand regulates how much of the contact tool protrudes from the fingers to make skin contact. It is not necessary for the tool to make skin contact.*
3. *Needling hand fingers (or other object) are repetitively tapped against the contact tool.*

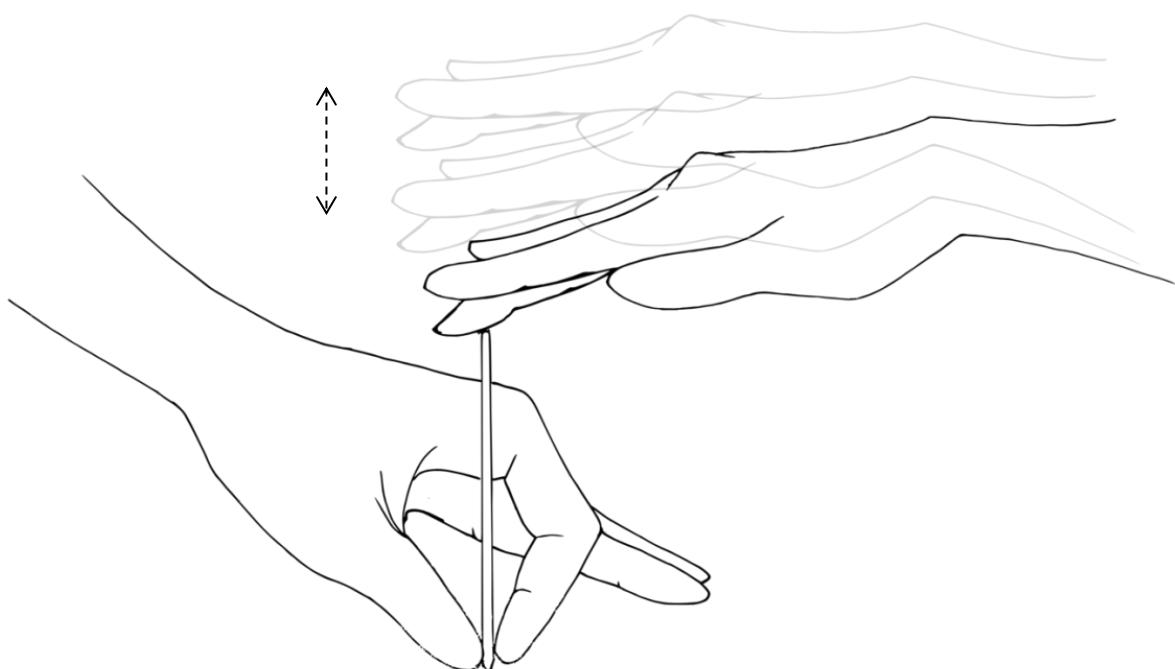


Figure 7.51 Tapping the contact tool

Observation of tapping with the contact tool (Figure 7.52)

1. Needling hand holds tool near the tip with the thumb and index finger.
2. Needling hand regulates how much of the tool protrudes from the fingers to make skin contact. It is not necessary for the tool to make skin contact.
3. Needling hand fingers and/or contact tool are repetitively tapped against the treatment site or area.
4. The pressing hand monitors the patient condition by palpating the skin of the treatment area.

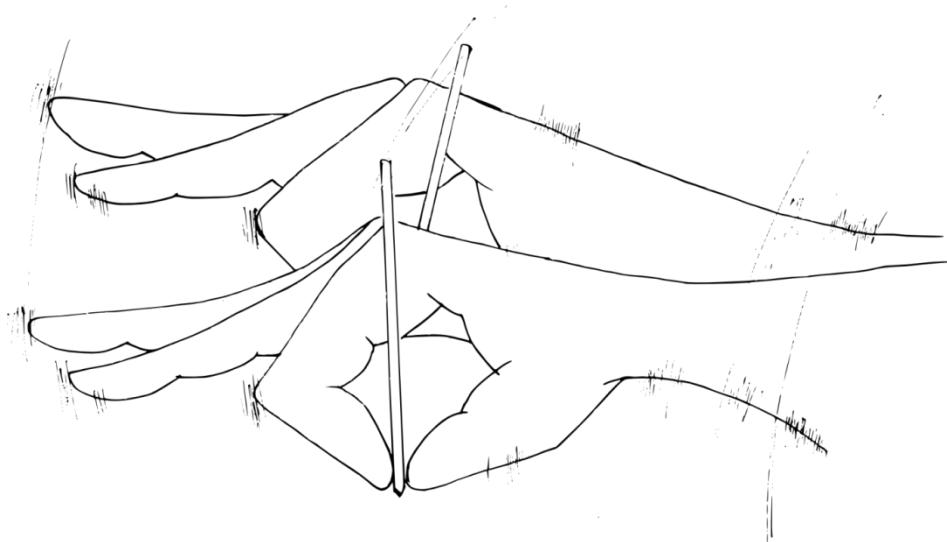


Figure 7.52 Tapping the tool against the skin

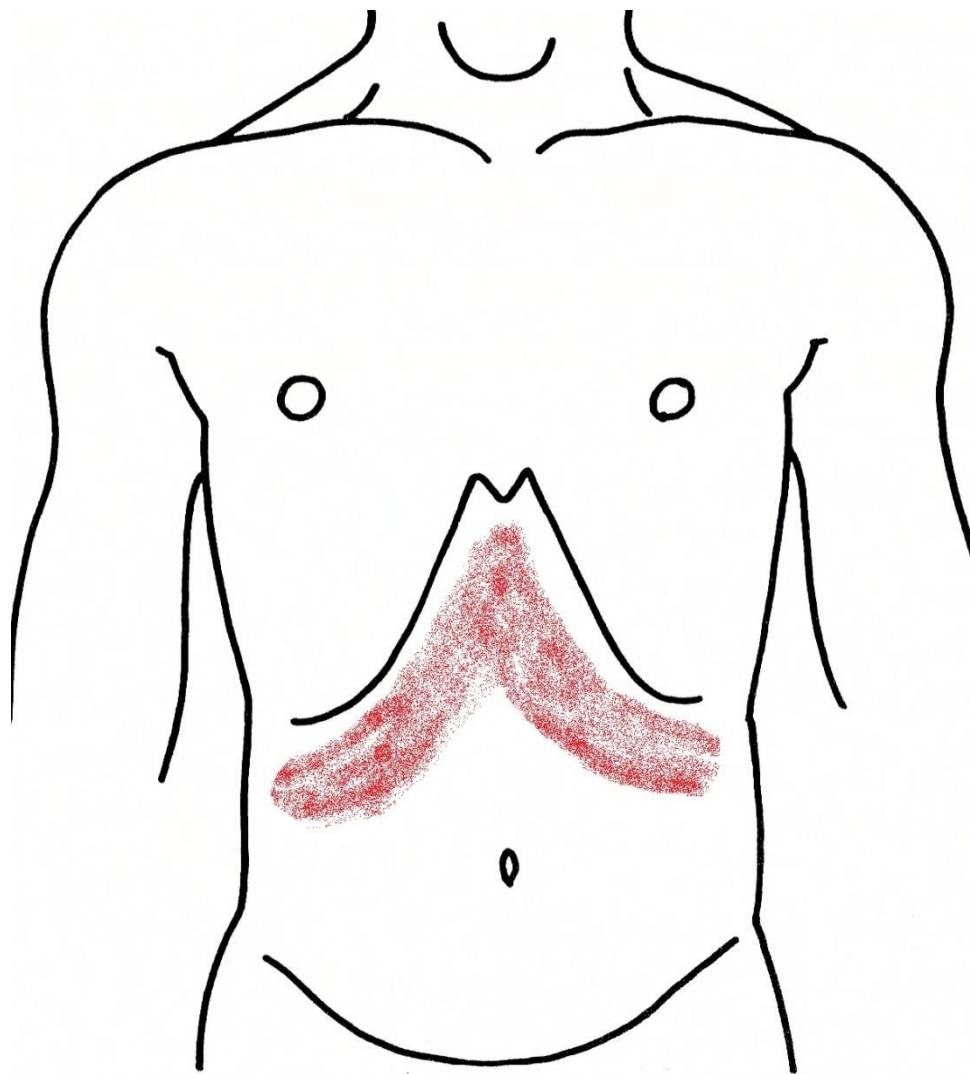


Figure 7.53 Abdominal tapping footprint

Dots represent where tapping has been performed over an area.

Pressure refers to the amount of applied force exerted onto body tissues via the tool and pressing or needling hand. A change in pressure was believed to alter the effects and strength of treatment (Table 7.10). Some contact tools had sharp points which when pressed into the skin caused pain and a pricking sensation. If strong pressure was applied with the tool, the skin could have been damaged and this would have caused discomfort to the patient. Practitioners were careful to regulate how much the tool pressed into the patient's skin by adjusting how a tool was held (Figure 7.54).

Table 7.10 Elements and Effects of Pressure When Tapping

Element of Pressure	More Pressure	Less Pressure
Applied force of tapping implement	Reduce Ki	Tonify Ki
Applied force of pressing/needling hand	Softens body tissues	Gentle Treatment
Tool protrusion from fingers		

More pressure had the effect of reducing Ki or softening body tissues from all “elements of pressure”. Applying less pressure had the effect of tonifying Ki or being a gentle treatment from all “elements of pressure”.

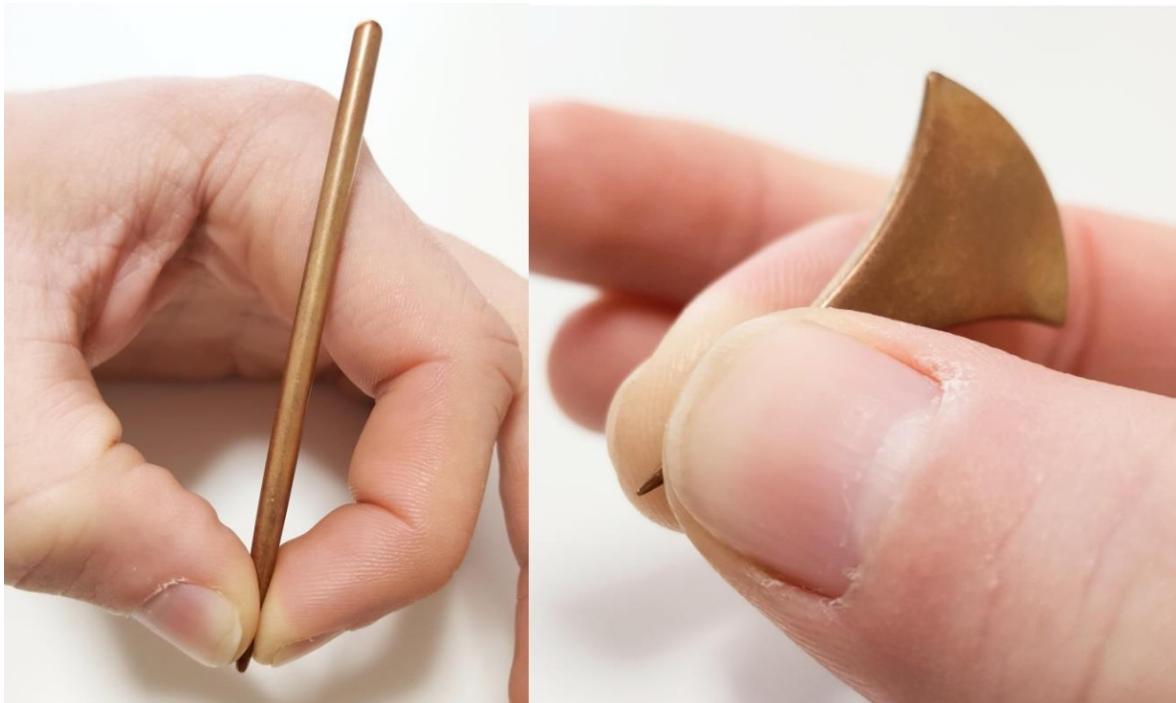


Figure 7.54 Finger positions for tapping against a treatment location

Holding

Holding was performed similarly to needles for insertion and was the precursor to almost all the manipulation forms (Figure 7.55). However, pressure rather than depth was varied with contact tools in comparison to needles for insertion. When performing holding manipulations, pressure was usually found to be applied by the pressing hand rather than the needling hand. The pressing hand served a dual purpose in regulating how much of the tip of the tool was allowed to protrude into the patient's skin while also regulating the force exerted onto the treatment location. The different effects of more or less pressure with the holding manipulation are the same as shown in Table 7.11. Reportedly, a tonifying effect could be achieved with

around three grams of applied force exerted onto a treatment location, while reduction involved around six grams of applied force.

During holding, duration rather than speed and repetition, was altered. Duration of form was generally dependent upon the palpation of a treatment effect or practitioner judgement/intuition.

Pressing/Pushing

Pressing/pushing was performed as shown in Figures 7.55 and 7.56. Pressing/pushing was combined with speed and repetition for the purpose of reducing, tonifying or facilitating the arrival or obtaining of Ki. In addition, it was used to reduce tension in body tissues (Table 7.11).

Observation of holding and pressing/pushing (Figures 7.55 and 7.56)

- 1. Hold the top of the contact tool between the thumb and index finger of the needling hand.*
- 2. Control tool protrusion into the patient's skin with the thumb and index finger of the pressing hand.*
- 3. Press the thumb and index finger of the pressing hand into the treatment site.*
- 4. Release pressure of the pressing hand from the treatment site while maintaining skin contact.*

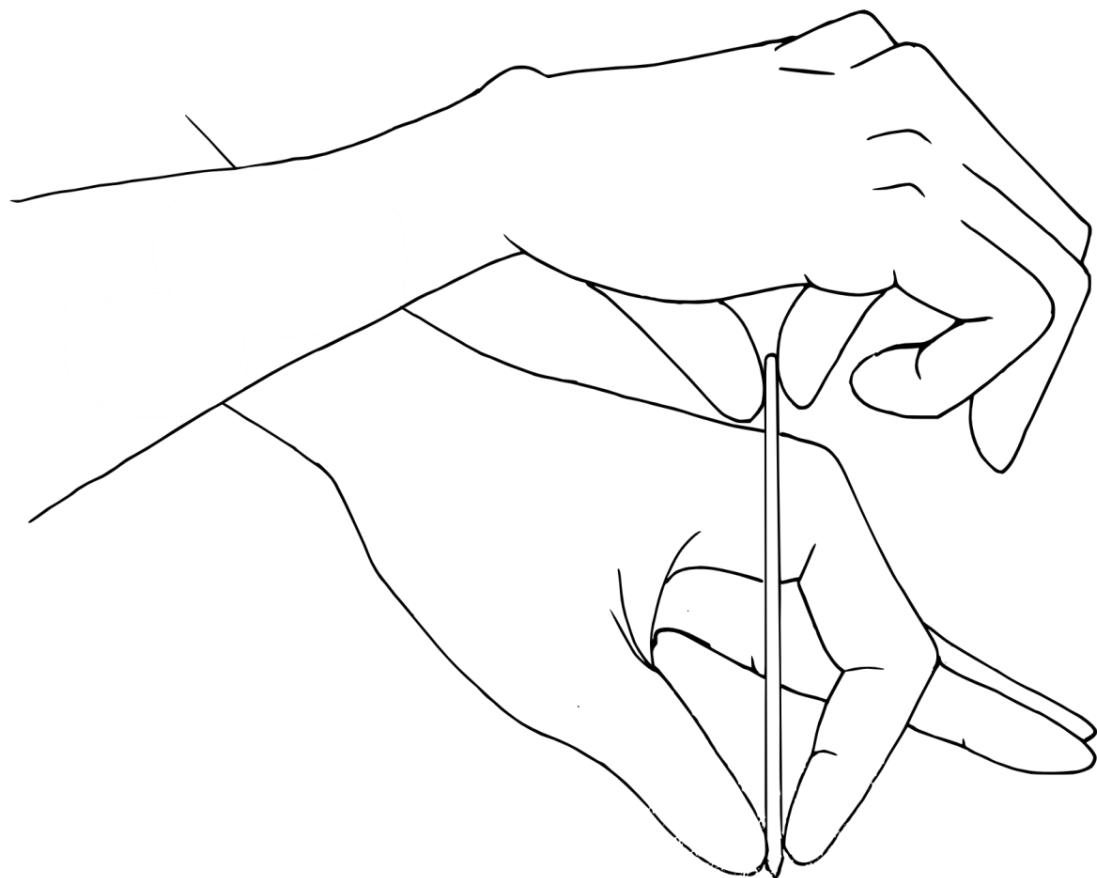


Figure 7.55 Holding the contact tool

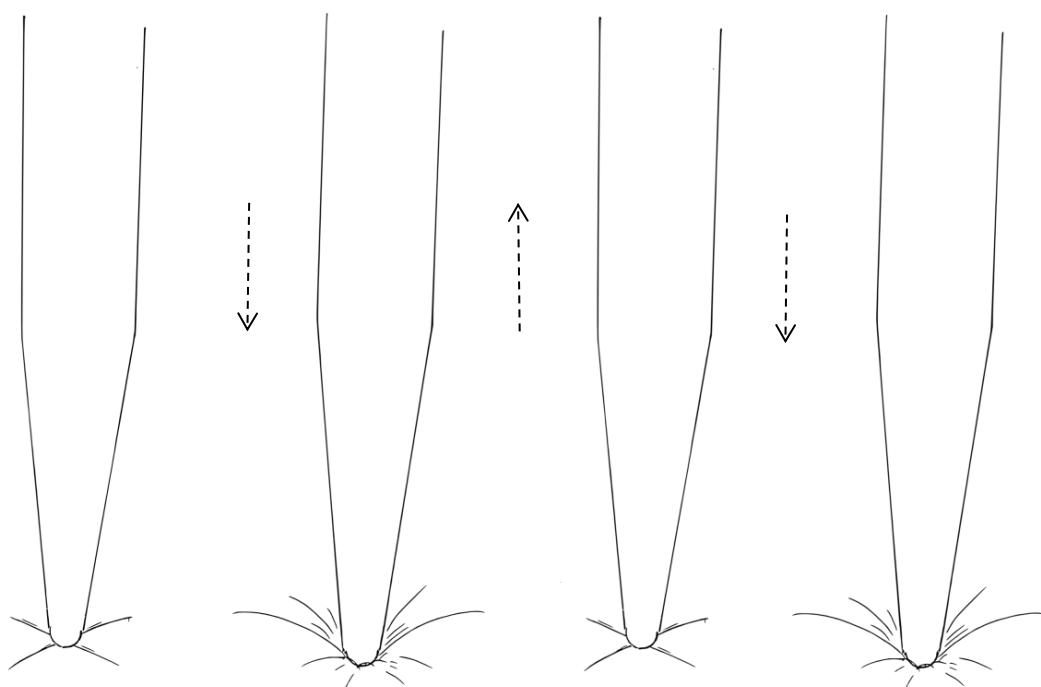


Figure 7.56 Pushing/pressing

Table 7.11 Effects of Pressing/Pushing

Modifier	Pressure	Speed	Repetition
	More	Less	
Effects	Reducing Ki	Tonifying Ki	
	Stronger Treatment	Gentle treatment	
	Softening body tissues		

Although adjusting elements of manipulation was believed to have different effects, changes in pressure, speed or repetitions were not always used to produce any unique outcomes. Adjustments also served to provide alternate stimulation that assisted in encouraging the desired treatment outcome when one method was unsuccessful. Trial and error was an accepted aspect of manipulation for all and any manipulations using needles or contact tools.

Stroking

Stroking was used for the purpose of affecting the texture and tension of the skin, and to move or stimulate Ki. Manipulation by stroking was found to take place over an area rather than a single treatment site. The method involved stroking the skin with the oblique edge of the tool while brushing the patient's skin with fingers of the needling hand.

Observation of stroking (Figures 7.57 and 7.58)

1. *Hold the contact tool between the thumb and index finger of the needling hand.*
2. *Other needling hand fingers may rest on the tool or patient's skin.*
3. *Stroke the treatment site by dragging the tool at an acute angle, obliquely over the skin.*
4. *Pressing hand may follow the needling hand to monitor the patient's condition.*



Figure 7.57 Finger position for stroking across a treatment area

Stroke direction was sometimes considered important in moving Ki a certain direction (Figure 7.58). Speed, repetition, pressure and length of stroking generally depended on the condition of the patient's skin, which often informed treatment objectives (normalise abnormal body tissue, i.e. the skin). Poorer skin condition required more subtle methods, while a better condition could tolerate stronger treatment (refer back to Table 7.9).

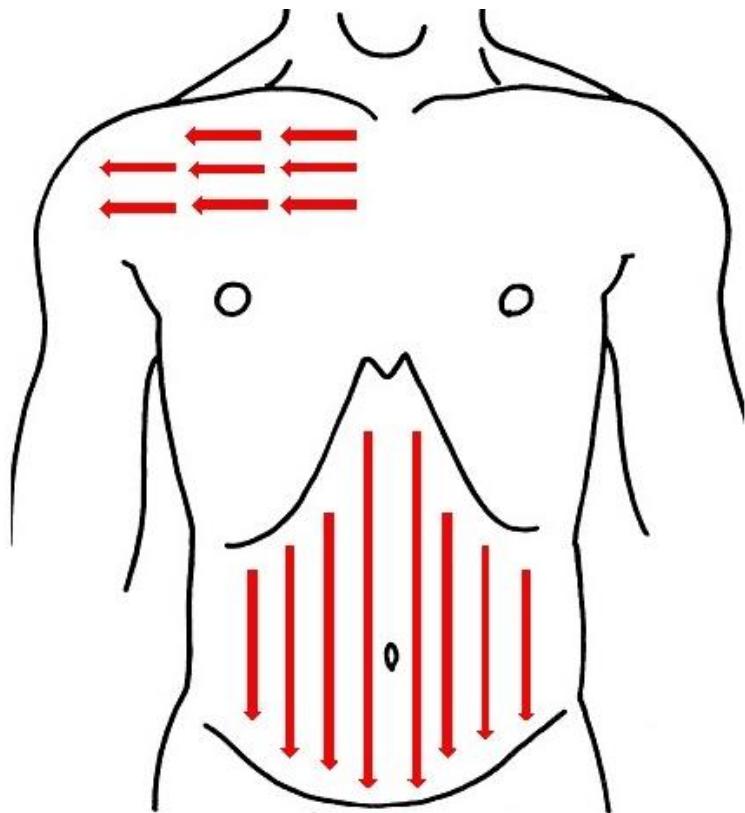


Figure 7.58 Stroke length and direction

Stroking and tapping were performed over areas of the body rather than just at specific treatment locations. Similar to treatment with needles for insertion, contact tools were also applied at many treatment locations with minimal stimulation. Contact tool methods reinforce the value of palpation and the confirmation of treatment effects. It also exemplifies the devaluing of acupuncture point actions and indications, while placing importance on technical abilities, areas of anatomical significance and addressing body tissue abnormalities.

7.3.3 Needle retention

First of all, I insert needles and make sure the patient has some kind of needle sensation. If there isn't one, I don't think the treatment will be so effective. If patients feel a sensation and say "ah..." I will stop manipulation. If patients don't feel anything, I will apply a little more stimulation. While these needles are retained, I treat other points. Once I've inserted the needles into all the points I want to use, I retain them for about 10 minutes. (Heijiro: acupuncture practitioner/head lecturer)

Needle retention is the maintaining of an inserted needle in a treatment location for a period of time. Needles for insertion were considered retained when the practitioner had finished insertion and manipulation and began another activity (Figure 7.59). This section discusses needle retention in three themes:

- Duration of retention
- Actions performed during retention
- Number of needles retained

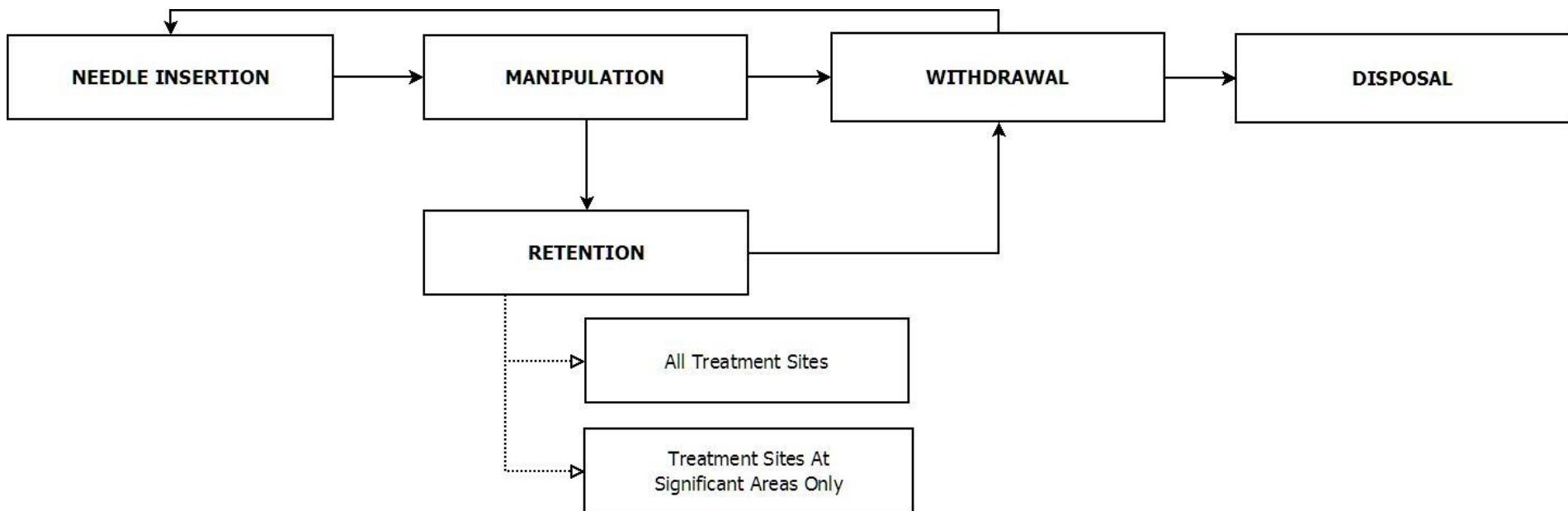


Figure 7.59 Needle retention procedures

Needles were retained in different ways. Some practitioners were found to retain needles at all treatment sites. Alternatively, needles were observed to be retained at treatment sites only on areas a practitioner considered particularly appropriate or significant to the desired therapeutic outcome. In other cases, the needle was not retained at all and was withdrawn directly after manipulation. After withdrawal, the needle was either reinserted at a new treatment site or disposed.

Duration of retention

After manipulation, practitioners were found to either retain or withdraw the needle. It seemed practitioners had personal preferences about whether and where needle retention took place. When needles were found to be retained, the torso (abdomen and back) or head were preferred areas of needle retention.

Needle retention times were commonly around 10 to 15 minutes (Table 7.12). Needle retention times were found to be influenced by either the perceived effects of retention time or clinic operation procedures (Figure 7.60).

Table 7.12 Needle Retention Times

Retention Time (approximate minutes)	
Shortest	3
Longest	30
Median	10-15

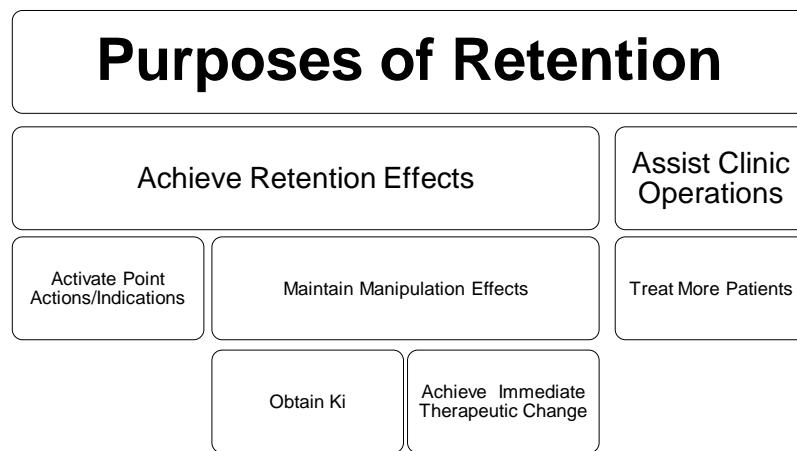


Figure 7.60 Purposes of needle retention

I don't think there is any evidence for retaining needles. Though this is my personal opinion, retention time may be related to business. Acupuncturists can treat two or three patients at the same time if they make patients wait for 15-20 minutes. . . As a clinician, I often see a flare-up around an inserted

needle on the surface of the skin if I retain needles. Some acupuncturists say that is a good sign and time to remove the needle. (Zenpachi: acupuncture practitioner/professor)

Actions performed during needle retention

During retention or waiting time, practitioners were found to attend to the patient in other ways by treating a different location or checking changes in patient condition. Additionally practitioners were also found to treat another patient altogether, or perform other activities such as answer phone calls or perform office tasks.

When attending to the patient, the treatment of a different location typically involved two procedures:

- Site location, needle insertion then needle withdrawal directly following manipulation with subsequent insertion at a different location (tanshi)
- The application of contact tools or other procedures

Checking changes in patient condition tended to occur when practitioners:

- Treated pain
- Attempted to resolve body tissue abnormalities
- Attempted to resolve abnormalities at anatomic areas of significance such as the spine, abdomen or in the pulse

Treatment effect confirmation was generally not performed during needle retention. However, the *undoushin* method for confirming treatment effects during retention was observed with some practitioners (18% n=4 of practitioners observed in clinic: n=22). This was found to be used especially in the treatment of pain.

A needle could be retained in a location and the patient asked to move in a way which would cause the needle to move and aggravate the patient's symptoms. This was called *undoushin*: moving needle (Figure 7.61). This procedure is defined by the use of a single retained needle which is relocated if there is not an instantaneous treatment effect after the needle or affected area is mobilised. *Undoushin* relied on the palpation of the correct treatment location, and it was not

considered that leaving the needle retained for a longer period or more attempted aggravation of symptoms would result in a more beneficial result.

Opportunities for treating other patients or performing other tasks were possible when the patient was left unattended by the practitioner. This was found to happen during:

- Needle retention
- Stick-on moxa application
- Electrical equipment application
- Intervention free waiting time

Observation of Undoushin (Figure 7.61)

- 1. Retain needle.*
- 2. Mobilise patient to aggravate symptoms.*
- 3. Inquire about the patient's condition.*
- 4. Withdraw the needle and retry at a new treatment location if no change.*

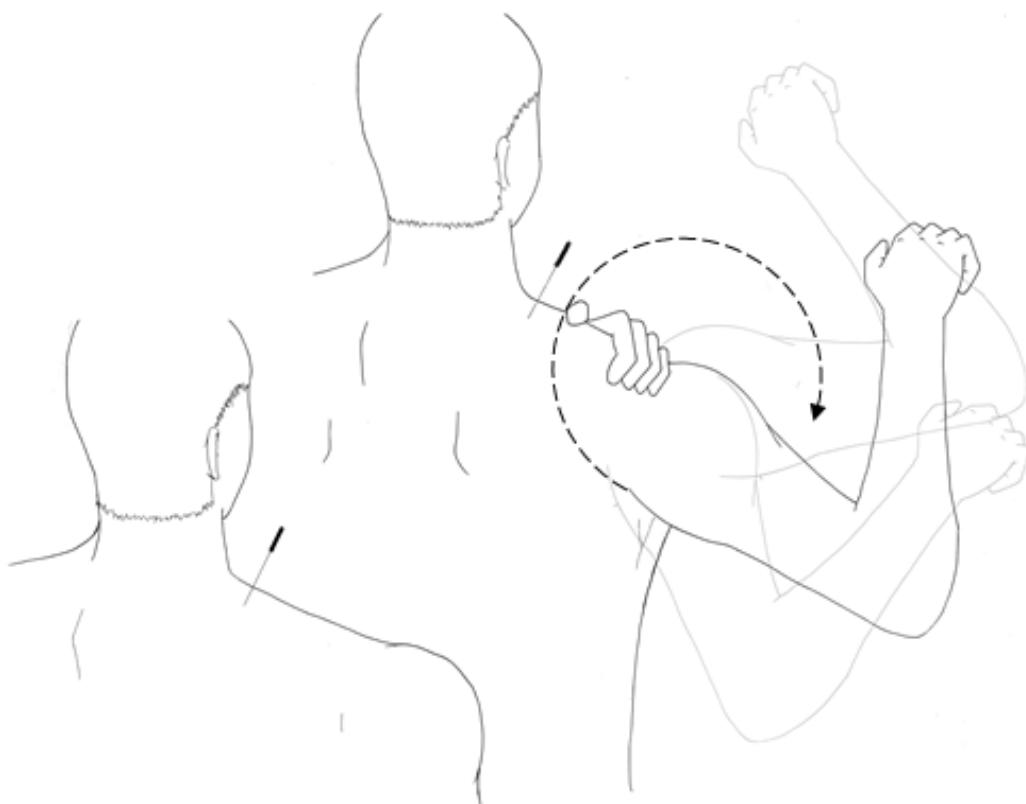


Figure 7.61 Undoushin

Figure 7.62 shows a summary of actions performed by practitioners while patients retained needles or waited on the treatment table. The figure shows that during retention or waiting, practitioners treated an alternative location with either needles or other tools/methods, confirmed the effects of inserted needles or other tools/methods, or treated another patient. In the construction of this figure, the themes were generated from data taken from 35 practitioners who contributed information relating to treatment principles. However, practitioner numbers are taken from the 22 observed performing treatments in clinic. Although some practitioners were not observed to treat an alternate location, confirm effects or treat another patient, they may have done so. The numbers in Figure 7.62 may under represent the actual numbers of practitioners who performed such procedures in their clinics.

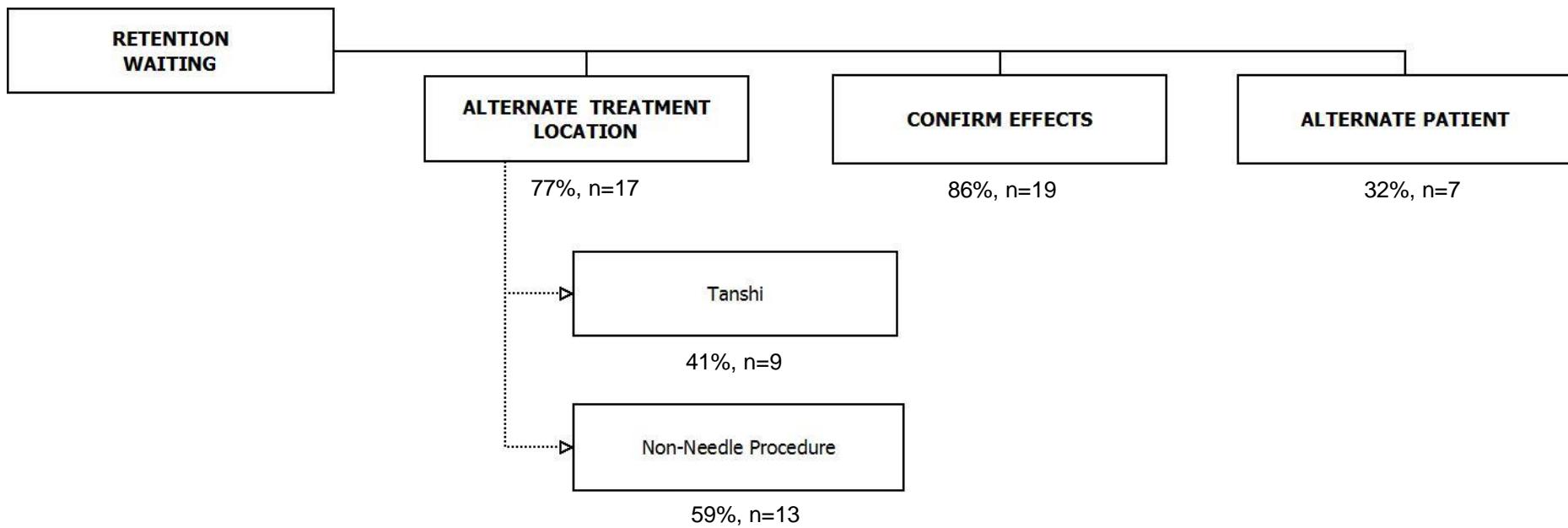


Figure 7.62 Summary of actions performed during retention or waiting

Of the 22 practitioners who were observed in clinic, 17 treated an alternate treatment location, 19 confirmed treatment effects and seven treated an alternate patient while needles were retained or while patients waited on the treatment table. Of the practitioners who treated an alternate treatment location, nine performed the tanshi method and 13 non-needle treatment procedures.

Number of needles retained

The number of needles retained means the number of needles in the patient's body at any particular moment. The number of needles retained is different to the number of treatment locations that had needles inserted in them. Needles were found to be retained both anteriorly and posteriorly. More needles tended to be retained on a prone than a supine patient. The fewest number of needles retained in a patient was found to be one and the most, 11. The median number was six needles at any one time.

7.3.4 Withdrawal

When you insert a needle, Ki gathers around the needle tip. The Ki which gathers around the needle tip is basically Yang in nature and if it builds up, it eventually dissipates. Initially, needle retention is tonification, but then it automatically starts to reduce. This doesn't tend to happen on the abdomen or back, so needles can be retained there without a problem. (Iwamatsu: acupuncture practitioner/professor)

Needle withdrawal is the removal of an inserted needle from the body. Withdrawal occurred at different times during the clinical encounter. It either occurred directly after manipulation or after needle retention time was over. In relation to the withdrawal of inserted needles, two important themes were found in the data:

- Withdrawal methods
- Withdrawal and reinsertion

Withdrawal methods

There were three main purposes of needle withdrawal methods: to extract the needle safely, maintain the integrity of the needle and to maintain patient comfort. Additionally, for practitioners who were committed to the philosophical concept of Ki, withdrawal methods could be used as a way to manipulate Ki. Withdrawal was always found to be performed with two hands; the pressing hand and needling hand were both important when withdrawing needles.

When needles were withdrawn with the purpose of having an effect on Ki, three basic methods were found to be practiced in clinics:

- Quick-slow supplementation and draining (WHO code 5.1.142)
- Open-closed supplementation and draining (WHO code 5.1.144)
- Respiratory supplementation and draining (WHO code 5.1.146)

Not all methods were used by all practitioners. Additionally, withdrawal methods to manipulate Ki were not used with every withdrawal. When used, quick-slow supplementation and draining, and open-closed supplementation and draining were almost always performed together. Respiratory supplementation and draining was rarely found to be used.

Observation of withdrawal (Figure 7.63)

1. *Needling hand index finger and thumb hold the needle handle.*
2. *Needling hand pulls out needle while regulating pulling speed.*
3. *Pressing hand index finger and thumb maintains contact with the treatment location and needle shaft until completely withdrawn.*

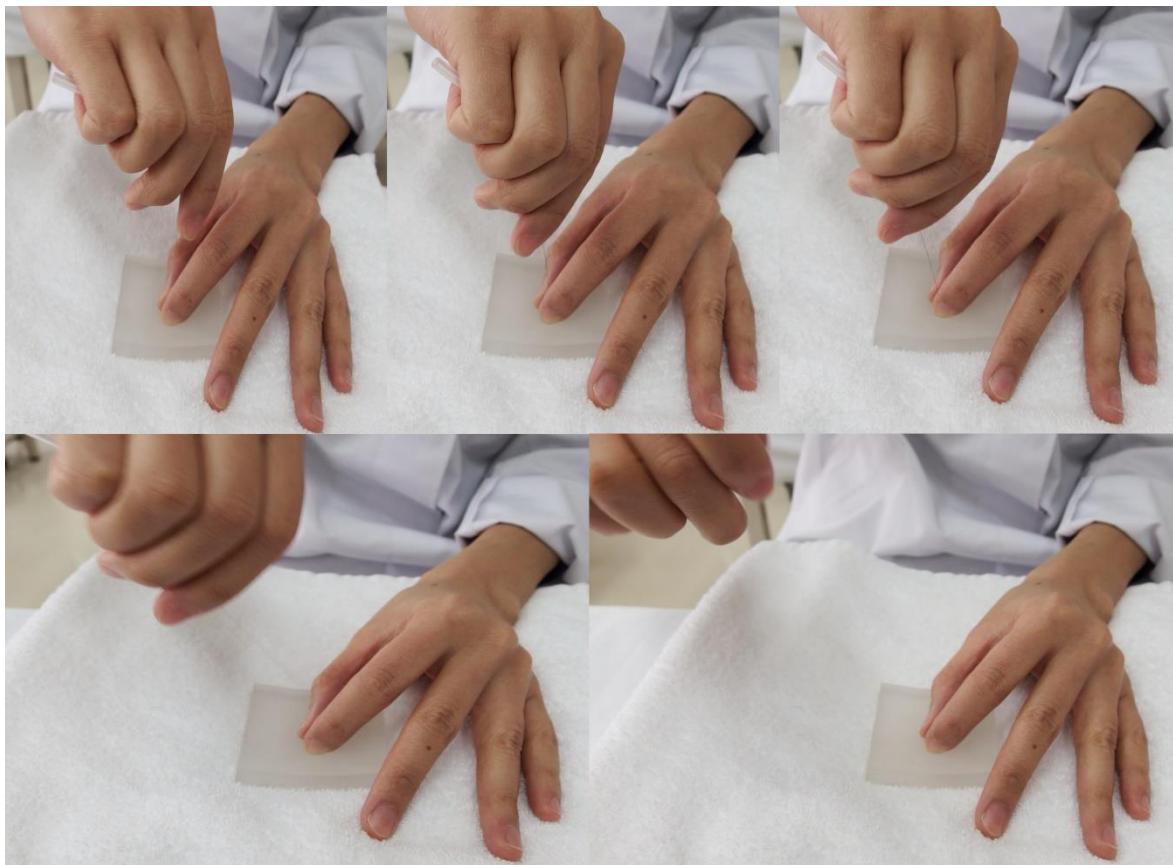


Figure 7.63 Needle withdrawal

The sequence begins in the top left photo, progresses to the right, and finishes in the second row, bottom right. In the photos on the top row, notice how the guide tube is held by the needling hand; this is an important aspect of needle withdrawal.

The same withdrawal methods were used for inserted needles as for contact tools. As nothing was inserted into the skin, withdrawal means removing the contact tool from the skin or from the fingers of the pressing hand. Contact tools were found to be pulled away from the treatment site quickly or slowly for either a Ki tonifying or Ki reducing effect. In addition, even though contact tools had not been inserted, the treatment site was covered (or not) with the fingers of the pressing hand to facilitate either a supplementing or draining effect according to the open-closed supplementation or draining method (refer back to Figure 7.35).

Withdrawal methods aimed at manipulating Ki did not appear to be a significant aspect of needling technique for practitioners, even those practicing from the TEAM model of medicine. This may have been because treatment effects tended to be sought immediately during the application of an intervention at an intervention site rather than after. Once the needle was withdrawn, practitioners did

not tend to attempt to influence the treatment site further because they had already confirmed whether an effect had occurred.

Withdrawal and reinsertion

Needles were found to be reinserted at a different location after withdrawal. Needle withdrawal directly following manipulation with subsequent application of the same needle at a different location is called tanshi (Figure 7.64).

The tanshi method allowed practitioners to apply needles or contact tools over many treatment locations or over a large area in a short amount of time. It was found that a needle could be inserted and withdrawn at around 20 treatment locations in about five minutes. Stimulation applied with tanshi was usually minimal and quick. However, some practitioners were found to spend more time at a treatment location and on occasion attempted to strongly stimulate a Ki obtaining sensation or twitch reaction at the treatment site when performing tanshi.

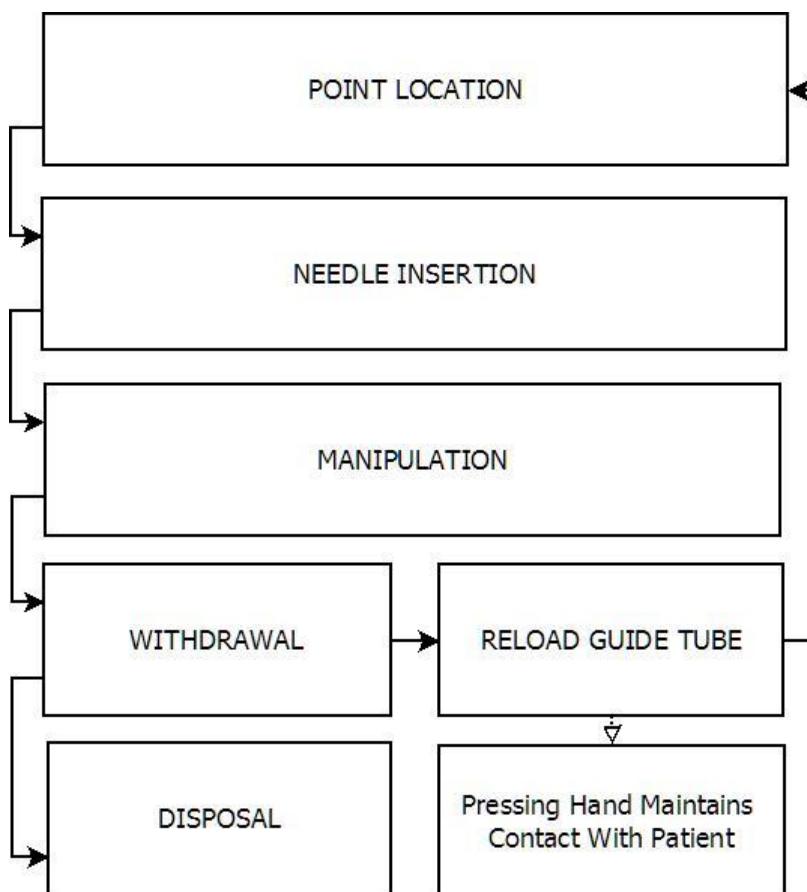


Figure 7.64 Tanshi needling method

The tanshi method involved reusing a needle multiple times after withdrawal. This was usually accomplished by singlehandedly reloading the needle back into the guide tube (Figure 7.65). Reloading the needle into the tube singlehandedly was important because practitioners always tried to maintain patient contact with the pressing hand while needling. Tanshi and singlehandedly reloading the guide tube is probably a unique feature of TJM acupuncture. Tanshi also demonstrates the value of treating many locations with minimal stimulation and reflects the belief in the instantaneous effects of acupuncture. Skilful reloading of the guide tube with a withdrawn needle is exemplary of consideration for economical use of time, resources and use of both the needling and pressing hand.

Observation of single hand guide tube reloading (Figure 7.65)

1. *Needling hand index finger and thumb hold the needle handle which is directed toward the guide tube.*
2. *Lower the needle handle into the opening of the guide tube while grasping the tube with the other fingers.*
3. *Release the needle handing so that it slides down the tube and rests against the hand, thus preventing it from slipping through the tube.*
4. *Turn the guide tube around between the index and middle fingers while stopping the handle with the thumb.*

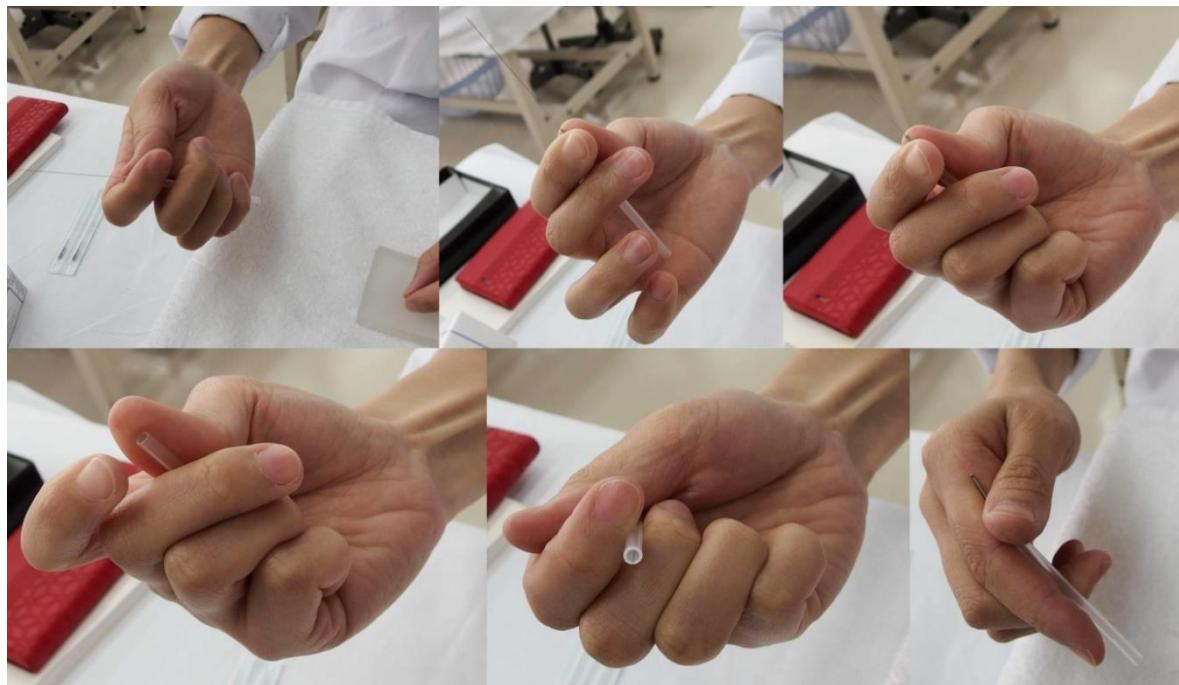


Figure 7.65 Single handed reloading

The sequence begins in the top left photo, progresses to the right, and finishes in the second row, bottom right.

7.3.5 Section summary

Findings and analyses concerning the techniques and procedures related to the use of needles and contact tools are presented in this section in four themes (Figure 7.66).

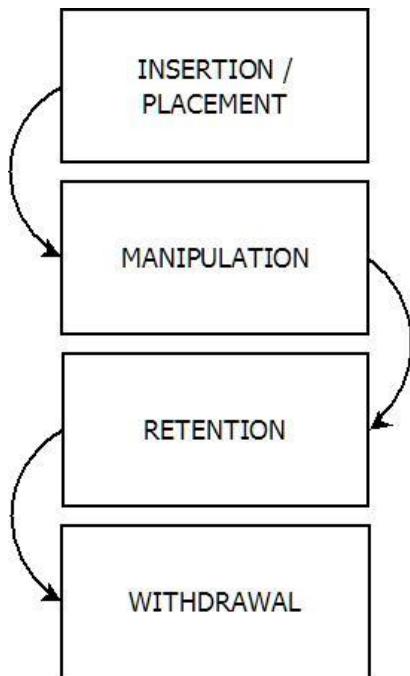


Figure 7.66 Techniques and procedures for needles and contact tools

The first theme describes how needles inserted with the assistance of guide tubes could be inserted by tapping them into the skin. The most important sub-themes in relation to the execution of needle insertion with a guide tube are attention to insertion speed, force, depth and repetition.

How needles and contact tools were manipulated is detailed in the second theme. The manipulation forms of twirling, sparrow pecking, holding, tapping, pressing/pushing and stroking are explained and how these were influenced by speed, repetition, pressure and depth are described. It is shown how manipulations were performed in order to have an effect on Ki or rectify abnormal body tissue.

The third theme includes the presentation of data relating to the retention of needles. It is described how needles tended to be retained for around 15 minutes. This somewhat short retention time may be a unique feature of TJM acupuncture. It was interpreted that needles were retained in order to achieve some therapeutic effect or assist clinic operations. While needles were retained, it is described how practitioners were found to treat a different location on the patient, check for changes in the patient's condition or treat a different patient altogether.

Withdrawal of inserted needles and contact tools are discussed as the final theme. It is described how the pressing hand assisted in the withdrawal of inserted needles and that the methods were designed to assist the safe removal of needles or to manipulate Ki in some way. The procedures of withdrawal and reinsertion as they relate to the tanshi method are also detailed, and how needles were found to be reloaded single handed back into guide tubes is explained.

The technical and procedural aspects of needling are demonstrative of several key values and features of TJM acupuncture:

- Patient comfort
- Effect through techniques
- Use of the pressing hand
- Use of many treatment sites
- Instant needle withdrawal
- Use of contact tools

These features were found to transcend different explanatory models of medical knowledge because they were used by TEAM, biomedical and orthopaedic model practitioners. They were also found in practitioners who were qualified in acupuncture only and also acupuncture and other modalities (judo therapy and massage).

In relation to TEAM acupuncture philosophical concepts, the knowledge concerning Ki and the facilitation of the arrival of Ki were found to be the most important in regards to achieving a therapeutic effect. Additionally, feeling a reaction in local tissue during needling was considered important, especially by practitioners who were not committed to the concept of Ki.

The next section presents the results and provides an analysis of the techniques of moxibustion.

7.4 Moxibustion

[I don't use moxa on all patients] because if I did, my clinic will be foggy and hazy, and it ends up getting dirty. . . If I gave all my patients moxa from the very first time, they would ask for it every time they came to my clinic. So I don't give them moxa on their first treatment. But if they are really suffering and their condition is not treatable without moxa, I will give it to them even it is their first time at the clinic. (Iwamatsu: acupuncture practitioner/professor)

The professional use of moxa in Japan required a nationally accredited licence independent of needling. Laws surrounding the education and practice of moxibustion in Japan reflected the history and traditions of needling and moxibustion as separate disciplines. All practitioners in this study held moxibustion licences. However, moxa was not favoured by everyone. This was probably partly as a result of health insurance laws, availability or perceived substitutability of other tools, potentially adverse by-products and the time intensity involved in applying some types of moxa.

A diversity of moxibustion tools and methods were found in the therapeutic repertoire of practitioners' clinical practice. This diversity is probably partially on

account of the widespread growth of the Artemisia plant across the diverse array of habitats all over Japan, its long time use as a folk remedy among lay people, the encouragement of moxa use by the feudal government and the transmission of how to use it in layman's terms through printed media throughout Japanese history.

Results and analyses in relation to the techniques of moxibustion are presented in three major themes:

- Categories of moxibustion
- Indirect moxibustion
- Direct moxibustion

The first theme describes the most important distinctions between moxibustion methods. The second theme outlines the techniques which were found to be included in the indirect category of moxibustion. These include stick-on, stick, insulated and miscellaneous methods. Who used these methods, for what purposes and according to what procedures are discussed in detail. That indirect moxibustion was performed according to the value of minimal stimulation and patient comfort is also demonstrated.

The final theme addresses the methods of direct moxibustion which were interpreted as being the most important, especially incomplete and penetrating heat moxibustion. In relation to both of these methods, the rules of moxa cone construction and the procedures for lighting cones and managing heat dosage are described. Interpretive insights about how direct moxibustion was principally found to be applied according to the eight principles and at treatment locations which exhibited abnormalities are provided.

7.4.1 Categories of moxibustion

My Sensei's family home is a temple in Kawasaki, Kanagawa prefecture and they still give blistering moxa there today. (Yae: acupuncture practitioner)

Two general distinctions were found to be made when categorising moxibustion methods:

- a) Whether moxibustion methods cause a scar or not
- b) Whether moxa is burned directly or indirectly on the skin

Figure 7.67 shows the different categories of moxibustion. Many of these categories are probably found in other TEAM acupuncture styles. However, incomplete and penetrating heat moxibustion may be unique to TJM acupuncture.

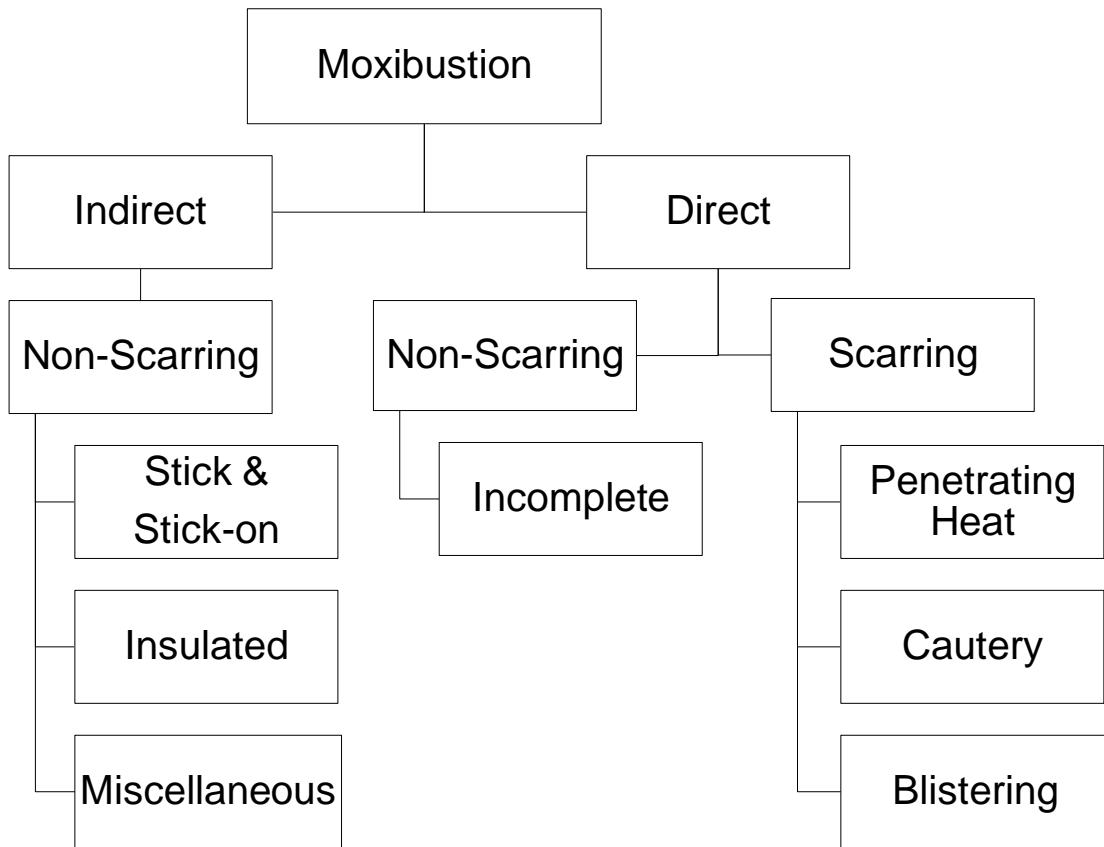


Figure 7.67 Categories of moxibustion

Scarring moxibustion (WHO code 5.2.23) was found to be divided into three categories: (1) *Tounetsu kyu* (penetrating heat moxibustion), (2) *Shoshaku kyu* (cautery moxibustion) and (3) *Dano kyu* (blistering moxibustion). These scarring methods were also included in the category of direct moxibustion (WHO code 5.6.2).

Non-scarring moxibustion (WHO code 5.2.22) was divided into four classifications: *Chinetsu kyu* (incomplete moxibustion), *On kyu* (stick-on or stick moxibustion), *Kakubutsu kyu* (insulated moxibustion) and miscellaneous.

Incomplete moxibustion could also be categorised as direct moxibustion while all others were indirect moxibustion (WHO code 5.2.8). The miscellaneous category included non-scarring, indirect methods which could not be categorised into other divisions (warm needling and moxa burners).

Data related to treatment principles was collected from 35 practitioners, 74% (n=26) of which were found to use some kind of moxibustion. Only 11% (n=4) of practitioners who contributed data related to treatment principles specified that they did not use moxibustion. Not all practitioners were found to use every moxibustion method. Practitioners who used penetrating heat moxibustion almost always included incomplete moxibustion as part of their moxibustion methods too. No acupuncture/judo therapy practitioners were found to use any direct moxibustion methods. However, they were found to use indirect methods such as stick-on moxibustion. This may have been due to the preparation required to perform direct moxibustion and time intensity of the techniques involved. Such practitioners may have believed that the same effect could be gained by using other forms of more conveniently applied moxibustion such as stick-on moxibustion or even heat lamps. Table 7.13 shows how many practitioners used which moxibustion methods.

Table 7.13 Use of Moxa Methods

Moxa Method	Number of Using Practitioners	Percentage
Indirect Moxa		
Stick-on	11	31%
Warm needling	6	17%
Insulated	4	11%
Moxa burner	3	9%
Stick	3	9%
Direct Moxa		
Penetrating heat	11	31%
Incomplete	10	29%
Cautery	X	0%
Blistering	X	0%
Unspecified	3	9%
Unknown	4	11%
Did Not Use	4	11%

7.4.2 Indirect moxibustion

Indirect moxibustion was found to almost always be used with lower grade moxa floss. During indirect moxibustion, a higher amount of moxa floss tended to be used in a single application than during direct moxibustion with higher grade moxa floss. The heat stimulation produced by indirect moxibustion methods using lower grade moxa floss was often sustained longer than that produced by direct higher grade moxa, creating a greater warming effect. Similar warming effects could be gained with other tools including heat lamps, heat packs or manual methods. Indirect moxibustion methods were the most common moxibustion methods among practitioners. Use of these methods was found to be somewhat based on the treatment principles of heating treatment locations for the comfort of the patient, to encourage circulation or relieve tension.

Stick-on moxa

Stick-on moxa acted as a single dose of heat stimulation (Figure 7.68). They were found to be applied in a single dose at a treatment location when activating the actions or indications of a treatment site, or addressing body tissue abnormality. However, more than one dose was found to be applied if treatment goals included warming cool or circulation impaired body tissue. In such instances, stick-on moxa was found to be applied until the desired effects were confirmed by the practitioner.



Figure 7.68 Smouldering water adhesive stick-on Kamaya Mini moxa

Observation with Tsuru (acupuncture practitioner)

On the treatment tray table, there was a rectangular stainless steel tray containing around 20 mild type, stick-on Kamaya mini moxa cones with the plastic applicator. A dampened cotton swab had previously been prepared and placed on another stainless tray next to the one containing the Kamaya minis. Tsuru lit a thin incense stick, took the moxa and cotton over to the patient's treatment table and rested the stainless steel tray on a vacant space next to the patient. One by one she dabbed the bottom edge of the stick-on moxa onto the cotton swab to activate the adhesive and placed them on the treatment locations. Cones were placed at GB 21 bilaterally, GV 12, BL 23 right, LR 5 left, KI 1 left and KI 3 right. She took the incense stick and lit the moxa cone at GV 12 at three different locations on the surface of the cone. She waited. When the cone had stopped smoking she lit the rest of the cones in a similar manner. While the cones were lit, Tsuru attended to one of the other two patients who were either mid treatment or about to begin.

In general, practitioners were confident that a single dose of stick-on moxa at a treatment site was enough to achieve desired treatment effects. Practitioners accepted that for some patients, skin only stimulation could achieve treatment goals and that single dose mild moxibustion was appropriate. The value of minimal stimulation of treatment sites was thus evident in how stick-on moxibustion was applied.

Embedded within practitioners' practice was the contradiction of a preference for highly developed technical and practical skills, and the value of minimum effort for maximum efficiency. Stick-on moxa represents that contrast as an effective yet inexpert tool capable of being applied by untrained lay people. Stick-on moxa was used to stimulate the actions and indications of acupuncture points, rectify abnormal body tissue and for warming cool or circulation impaired body tissue. The successful use of stick-on moxa relied on diagnostic accuracy, knowledge of effective points, and palpation and observational skills to locate correct treatment

sites. Much of the expertise required to use stick-on moxa was knowledge based rather than technical, especially when used to stimulate the actions and indications of treatment sites.

Stick moxa

Stick moxa (Figure 7.69) required lighting and then holding at the treatment site. Because the diameter of moxa sticks was found to be from around 10 mm to 20 mm and the heat produced from the stick radiated out, the amount of body tissue a moxa stick could have an effect on at any one time was larger than stick-on moxa. Additionally, it was possible to stimulate several treatment locations at once. As a result, moxa sticks did not require a high level of accuracy when locating treatment sites. The most important aspect of applying stick moxa was the diagnostic ability to discern if stick moxa was appropriate for the presenting condition and the knowledge of acupuncture point actions or indications. It was also found to be sufficient to simply apply stick moxa around a painful, cold or inflamed area of abnormal body tissue.



Figure 7.69 Stick moxa at Heisuke's (acupuncture practitioner) clinic

The amount of stimulation applied by stick moxa was regulated by the confirmation of treatment effects or practitioner judgement. Treatment was found to be applied until the treatment area became warm or changed colour to pink/red. During application, moxa sticks were found to be used in three ways to control the heat applied to the skin and for patient comfort and safety:

- Held statically
- Constantly moved in a circle
- Moved closer, then away repeatedly

Stick moxa did not appear to be a preferred element of moxibustion among practitioners. There were other methods which were favoured if the purpose was to stimulate the actions or indications of acupuncture points with moxa, and other tools which could provide heat to a treatment site for the purpose of warming cool areas.

Insulated moxibustion

[What's the paste made from?] I am sorry I can't tell you, it's a trade secret.

This recipe belongs to our family. (Kiemon: acupuncture practitioner)

Insulated moxibustion was reportedly performed by placing moxa cones on an insulating material such as salt, miso, garlic, ginger and medicated pastes (Figure 7.70). Medicated pastes were manufactured from materials believed to contribute to the therapeutic effect of moxibustion, help facilitate moxa application and maintain patient comfort. Two practitioners were found to only treat patients with insulated moxibustion; they tended to use no other tools or methods.



Figure 7.70 Insulated moxibustion on a medicated paste at Kiemon's (acupuncture practitioner) clinic

Insulated moxa performed on medicated paste was found to be applied with the assistance of spoons, so that the paste could be taken from a receptacle and placed on the body. Additionally, another assistant tool found to be used in applying insulated moxibustion was a bamboo moxa insulation mould (Figure 7.71). This was found at an educational facility where Kinu (acupuncture practitioner/senior lecturer) stated that all students at the institution learnt how to apply insulated moxibustion with such moulds.



Figure 7.71 Moxa insulation mould

The use of ginger as an insulating material was found to be used in TJM acupuncture (Figure 7.72). The clinic where this photo was taken had a reputation for ginger insulated moxibustion and although the practitioners at the clinic were all qualified acupuncture practitioners, they almost exclusively performed insulated moxibustion on ginger. Ginger as an insulating material may not be unique to TJM acupuncture. However, the use of medicated pastes made from secret family recipes (refer back to Figure 7.70) may be. Additionally, professional moxibustion only clinics may be a distinct feature of TJM acupuncture.



Figure 7.72 Ginger insulated moxibustion at Yae's (acupuncture practitioner) clinic

Miscellaneous

Miscellaneous moxibustion methods include applying low grade moxa floss indirectly with assistant tools. Moxa burners and warm needling were not common among practitioners, but were found to be applied in treatments (Figure 7.73).



Figure 7.73 Moxa burner and warm needling

Ceramic moxa burners feature on the patient's upper back and needle stick moxa on their lower back.

Lower grade moxa floss was found to be placed in moxa burners (WHO code 5.2.31) which were used to stimulate treatment locations indirectly. Moxa burner design and materials affected the degree of heat and area of stimulation. Figure 7.73 shows the use of lidless ceramic moxa burners which were placed on the patient's upper back. In comparison, Figure 7.74 shows a wooden moxa burner. Moxa floss was placed on the wire mesh, lit and the lid put on top of the box. The whole moxa burner was then placed on a treatment location. Moxa burner moxibustion aimed to warm a general area, usually the size of the moxa burner which was sometimes moved around treatment locations. Moxa burner use was somewhat determined by the location which required treatment. They were reportedly better suited to larger, flatter areas such as the back and abdomen. Neither of these tools are likely to be unique to TJM acupuncture.



Figure 7.74 Moxa burner

Warm needling (WHO code 5.1.4) is the placement of moxa on the handle of an inserted needle, which is then ignited. The needle handle acts as a receptacle for the moxa floss, and the distance of insertion and needle length, a spatial barrier between moxa and the patient's skin. Warm needle moxibustion differed to moxa burner moxibustion by adding warmth to a specific treatment location. Warm needling was found to be used with raw moxa floss (Figure 7.75) and small stick moxa rolls specifically manufactured for warm needling (Figure 7.76). All practitioners who used warm needling with moxa floss rolled the floss into balls, placed it on the needle handle and lit it with incense from the bottom of the ball. This may be a unique method of TJM acupuncture warm needling.



Figure 7.75 Warm needling with moxa floss



Figure 7.76 Stick moxa prepared for warm needling

Other tools such as stick moxibustion appeared more convenient for areas which were difficult to use the moxa burner on. However, moxa burners had the benefit of being able to burn moxa over an inserted needle which was considered to provide a similar effect as warm needle moxibustion. The use of moxa burners also allowed practitioners to perform other treatment tasks simultaneously, allowing the burner to rest on the patient. In addition to warming a treatment location, warm needling was also believed to increase stimulation of the actions or indications of acupuncture points, especially when related to tonifying deficiency or moving Ki and Blood.

7.4.3 Direct moxibustion

Non-scarring, direct moxibustion included incomplete moxibustion. Scarring, direct moxibustion methods included heat penetration moxibustion, cautery moxibustion and blistering moxibustion. Of the scarring methods, only penetrating heat moxibustion was found to be used in treatments. Cautery moxibustion was reportedly mainly used for warts and foot corns, and together with blistering moxibustion were not found in any practitioners' practice. Incomplete and penetrating heat moxibustion were the most common direct moxibustion methods. Results regarding direct moxibustion are presented and analysed in three themes:

- Moxa cones
- Incomplete moxibustion
- Penetrating heat moxibustion

Moxa cones

Direct moxibustion used small amounts of higher grade moxa floss directly on the skin of a patient. For application, the moxa floss was rolled into cones. Figure 7.77 shows a rice grain sized cone on the left, and a half rice grain sized cone on the right. Moxa cones were made and used according to specific standards sometimes dependent on applications. The level of stimulation applied at treatment locations was found to be regulated by how practitioners rolled moxa cones, how oxygen was limited to the embers in the cone, and how far it was allowed to burn down to the skin.

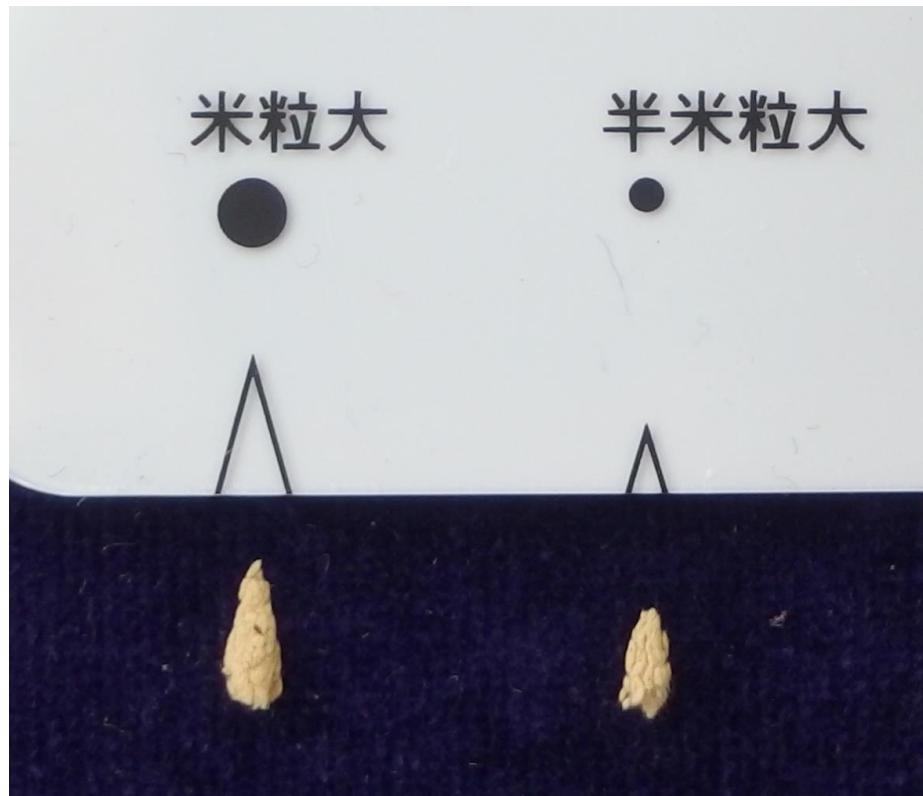


Figure 7.77 Rice grain (left) and half rice grain (right) sized moxa cones

The left cone is rice grain sized and the right cone is half rice grain sized.

Observation with Tarobi (acupuncture/massage practitioner)

Tarobi sat on the left side of the patient, as if at a desk. He gently palpated the patient's abdomen with the fingers of his left hand while his right moved lightly, following his left hand across the abdomen. Tarobi felt the skin of the abdomen for around 30 seconds before reaching for a small bottle containing a black solution: loquat leaf extract. He dabbed one drop of the extract on the skin and placed the bottle back on the tray table.

He pulled a small amount of golden coloured moxa floss from a stainless steel container and lit a thin stick of incense. He held the moxa in his left hand, mostly in between his thumb and index finger, while the incense stick was lightly grasped in the 1st phalanges of the 4th and 5th digits of his right hand, which he held in a loose fist. Tarobi lightly rolled the moxa between his thumb and index finger of his left hand into a thin, string like shape and pinched a rice grain sized piece

off with the thumb and index finger of his right hand. Placing it onto where he had just dabbed the loquat leaf extract, he lit the tip of small moxa cone with the incense and placed three fingers around and over the smouldering cone. Before it burnt completely to the skin, Tarobi extinguished it with the thumb, index finger and middle finger of his right hand by closing off the air off around the cone, and then pinched his fingers together which finally smothered the smouldering moxa. He put the burnt moxa floss into a stainless steel tray and burnt two more cones on the same location in similar fashion. Tarobi put down the incense and returned the unused moxa floss to the stainless steel container.

Six important themes of moxa cone construction and use were interpreted from the data:

- Size
- Consistency
- Shape
- Oxygen
- Timing
- Pressure

[I sometimes use penetrating heat moxa] to take away internal Heat. And it should be very hot. . . I roll [the cone] tighter and I don't extinguish the embers. (Toko: acupuncture practitioner)

Penetrating heat moxibustion utilised the smallest cone size which was around the size of one half to one full grain of rice (Figure 7.78). Rice grain sized moxa cones were reported as being around 4 mm in height, 2 mm in diameter and weighing three grams. However, cone sizes were found to be as thin as cotton thread and varied depending on the condition of the patient and the symptoms being treated. Incomplete moxibustion included cone sizes from around the same sizes used in penetrating heat to cautery moxibustion (Figure 7.79). Cautery moxibustion used bigger sized cones, about the size of a soy bean and blistering moxibustion could reportedly use cones with a base diameter of around 15 mm.



Figure 7.78 Various sized moxa cones

Cones decrease in size from about full rice grain sized on the left, to about half rice grain sized on the right.

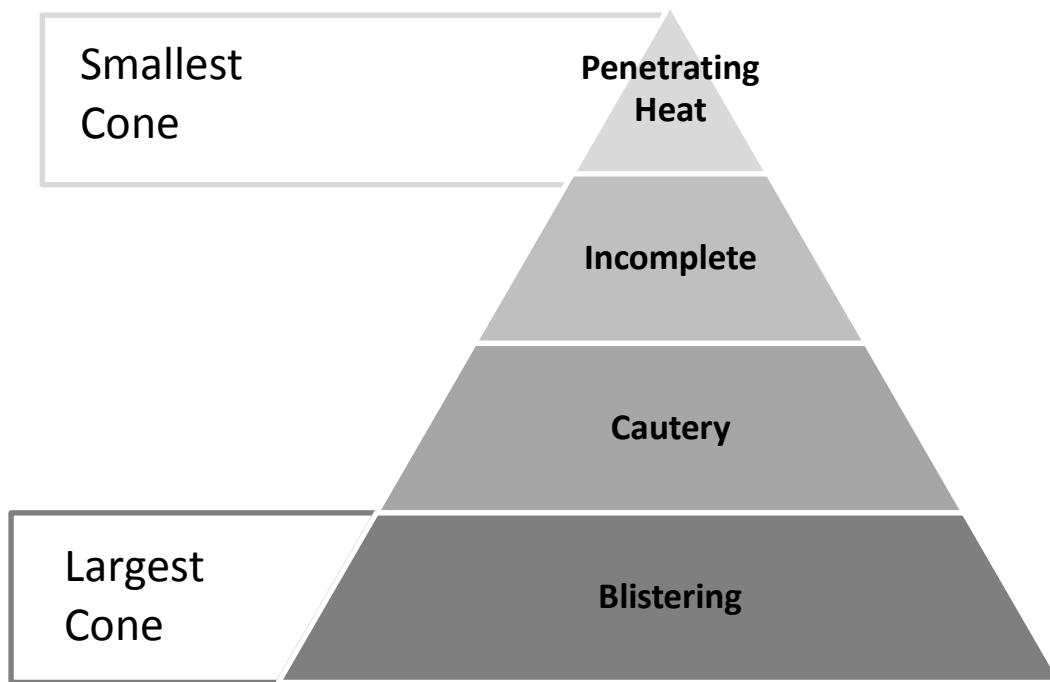


Figure 7.79 Moxa cone size range and methods

Direct moxibustion methods are shown in the pyramid. The label on the left indicates the relative size of moxa cones used in that method. The topmost method (penetrating heat moxibustion) tended to be used with the smallest sized moxa cones. The bottommost method (blistering moxibustion) used the largest sized moxa cones.

Heat was found to be regulated by adjusting the consistency of the moxa cone during construction (Figure 7.80). Reportedly, moxa cones should be rolled softly so that there is space and air between moxa floss fibres to burn quickly at a high temperature. If a moxa cone was rolled too tightly, it burnt slower due to less space for oxygen to fuel the embers. It took longer for moxa floss to be completely consumed by embers of tightly packed moxa cones, which when came into contact

with the skin, were present for longer because they were burning slowly. The lengthened presence of heat on the skin was painful and caused more skin damage than embers which were exhausted faster. Additionally, if the size and shape of the moxa cone was not rolled perfectly, then the base of the cone became too large and caused discomfort or a burn due to an increase in surface area. Ideally the base was just large enough for the cone to remain upright.



Figure 7.80 Rolling moxa cones

The figure shows how moxa cones were rolled. The sequence begins in the top left photo, progresses to the right, down to the second row of photos on the left and finishes in the bottom right.

As a cone burnt down, practitioners prevented the cone from burning all the way to the skin by placing two or three fingers around the burning floss to interrupt air flow. The disturbance of oxygen supply weakened the heat intensity and could exhaust the embers if the practitioner desired. Practitioners regulated oxygen supply to weaken the heat and at the appropriate timing, were seen to extinguish the embers or remove the cone altogether. Pressure could also be applied on the skin around the burning cone to distract the patient from any discomfort and allow the moxa to burn longer.

The application of moxa cones in TJM acupuncture is a highly specialised skill and required much training to use effectively. Applying moxa cones correctly without burning a patient reportedly required many hours of training and a high level

of skill. In order to pass practical moxibustion examinations, some educational institutions required students to apply a minimum of 16 cones in one minute without burning or causing the assessor discomfort. In order to build the necessary skills for moxa cone application, several tools were found in educational institutions and in practitioners' clinics for personal training.

Figures 7.81 and 7.82 show practice surfaces which were used to train moxa cone use. Figure 7.83 shows a wooden practice surface in use, while Figure 7.84 is a photo of a moxa cone thermometer which measures the temperature of burning moxa cones. This thermometer was used so that practitioners could train to consistently achieve the desired heat stimulation from moxa cones and know how not to burn the patient. The use of moxa cones in TJM acupuncture mirrors a commitment to complex practical skills.

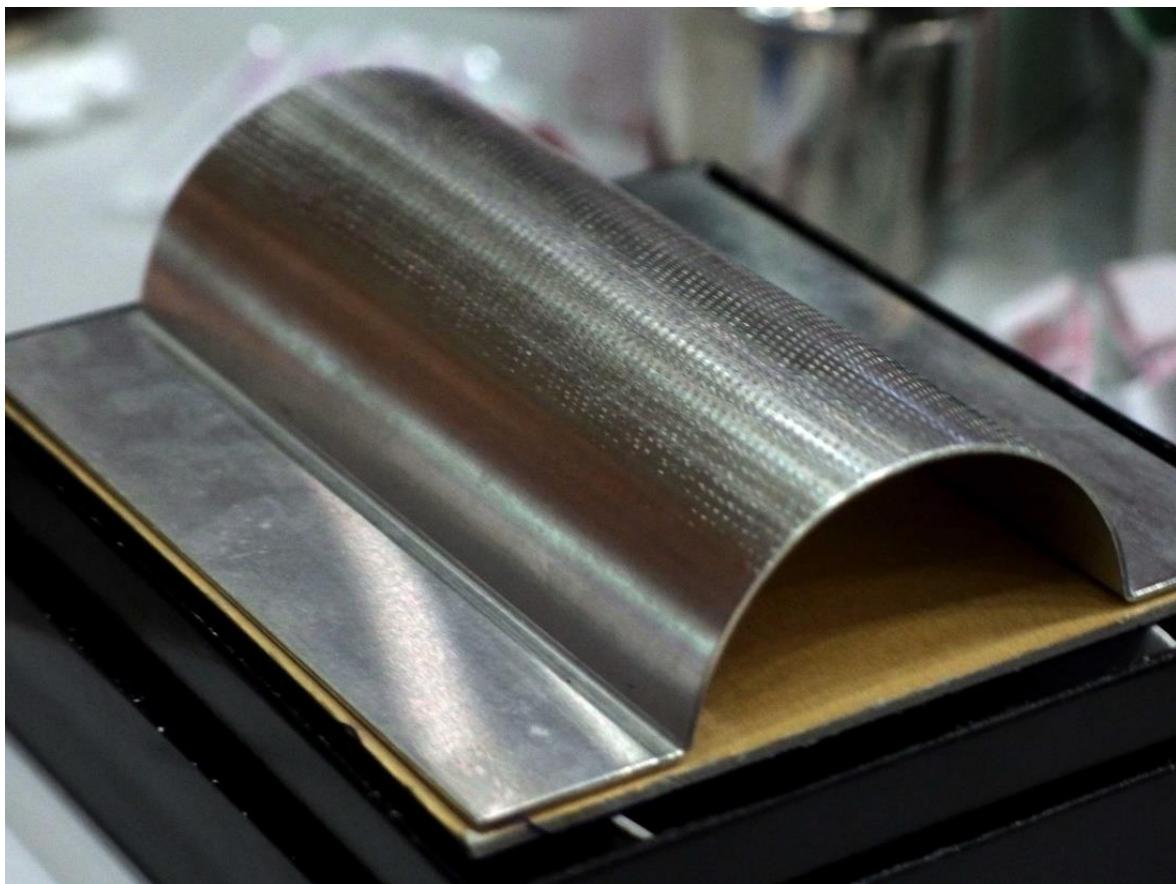


Figure 7.81 Direct moxibustion placement practice metal surface

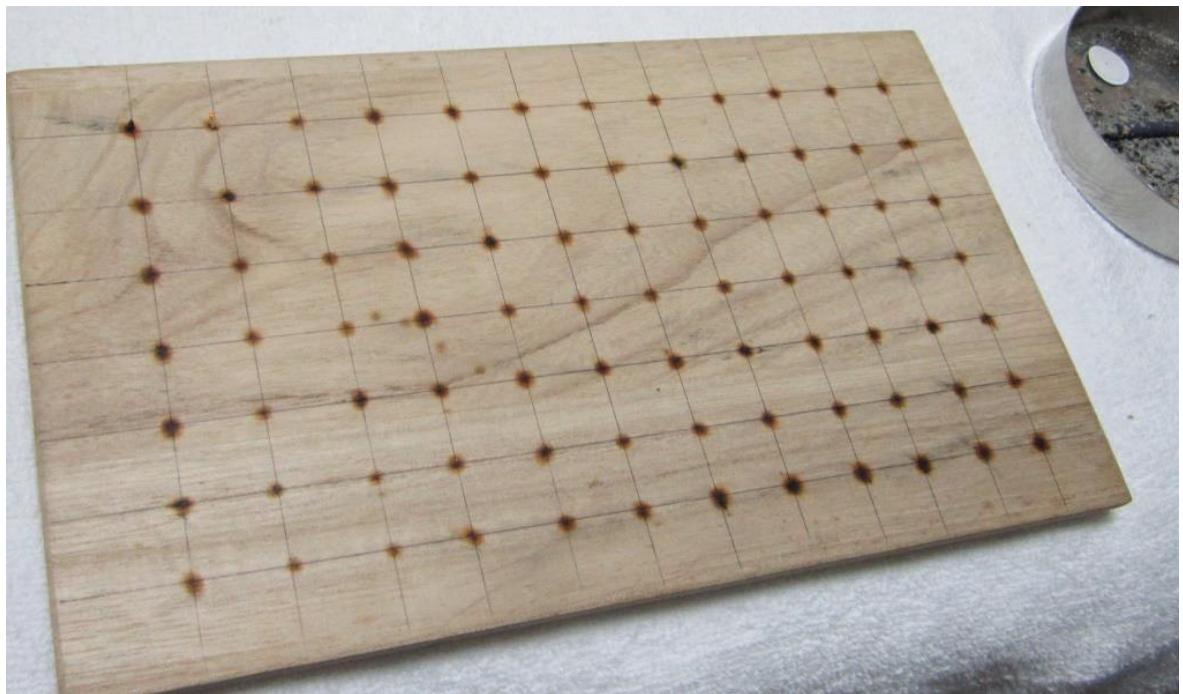


Figure 7.82 Direct moxibustion placement practice wooden surface

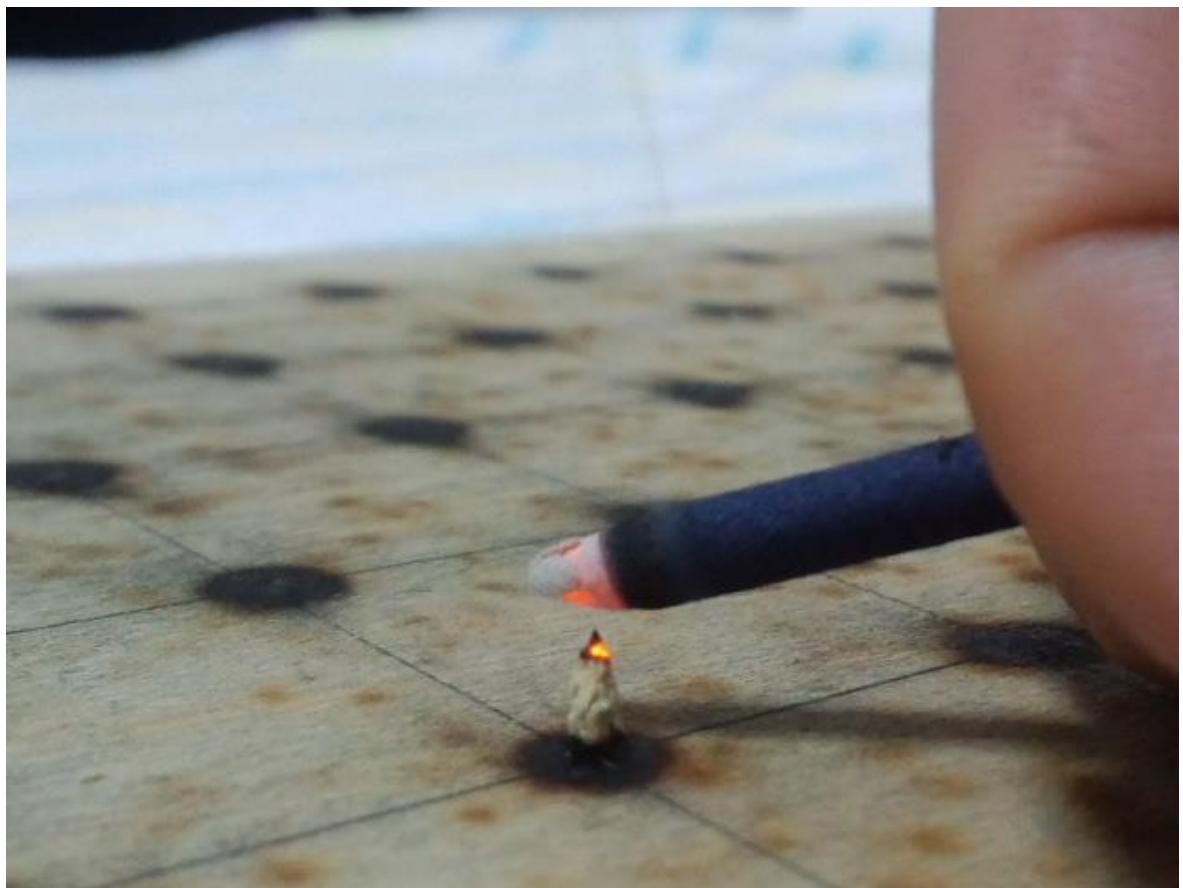


Figure 7.83 Demonstrating the wooden moxa practice surface



Figure 7.84 Moxa cone temperature gauge for practice

The use of rice grain sized cones was a feature of TEAM model practitioners' moxibustion methods. Treatment until an effect was confirmed, attention to patient comfort, high levels of technical detail in application and skin stimulation were all aspects of moxibustion which were common themes of treatment principles in general.

Incomplete moxibustion

[I use] incomplete moxibustion if patients have sprains or injuries or when they have an excess. So for things like tight shoulders or a stiff neck too.
(Toko: acupuncture practitioner).

During incomplete moxibustion, small cones of moxa floss, up to around the size of a soy bean were burnt directly on the skin (Figure 7.85). When the patient communicated that they felt any heat, or when the heat became uncomfortable, the burning moxa was removed (also called heat sensing moxibustion). Removal of the moxa cone was also found to be instigated without communication from the patient.

Hachibun kyu or “eight parts moxibustion” was a form of incomplete moxibustion where the practitioner did not seek confirmation of heat sensation from the patient. A practitioner could remove the cone any moment before the smouldering floss reached close to the skin, around when the cone was burnt about half or 80% of the way through. This was considered a somewhat mild treatment method compared to the heat sensing moxibustion.



Figure 7.85 Stages of incomplete moxibustion

From left to right, the figure shows three stages of incomplete moxibustion. First the cone is lit, then it is allowed to burn down a short way, and the final photo shows the moxa cone just before it is extinguished.

Penetrating heat moxibustion

Basically, when I want to do tonification, I apply penetrating heat moxibustion. I only use incomplete moxibustion when I want to do reduction.
 (Iwamatsu: acupuncture practitioner/professor)

During the application of penetrating heat moxibustion, the practitioner controlled the intensity of the heat produced by the smouldering floss, usually without relying on an indication from the patient (Figure 7.86).

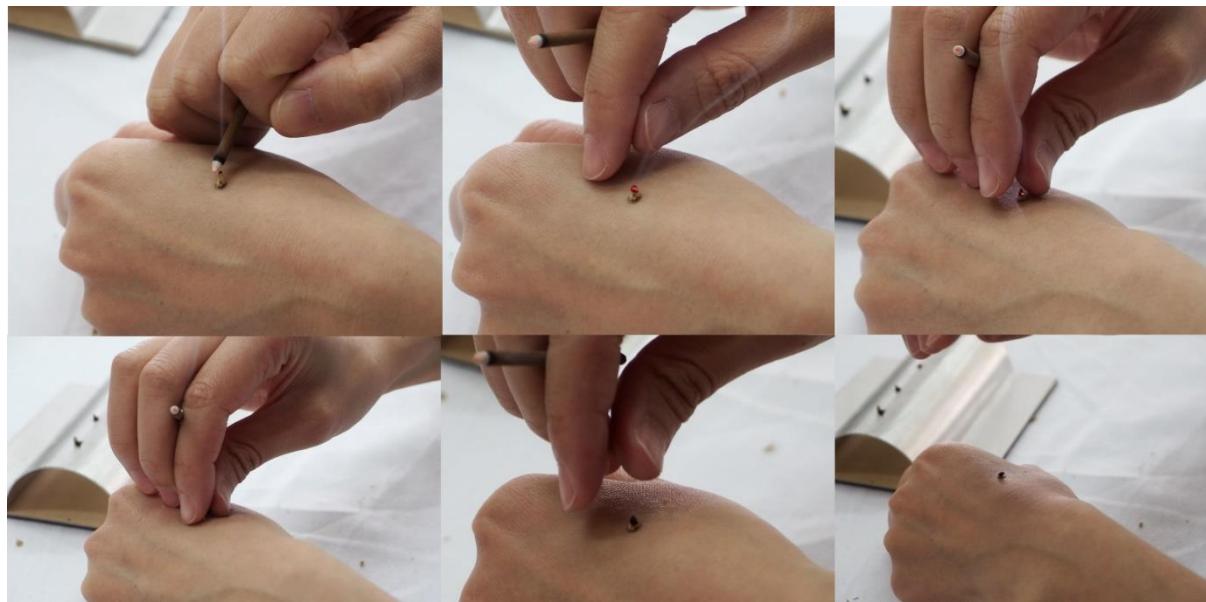


Figure 7.86 Lighting and regulating heat from direct moxibustion

The figure shows penetrating heat moxibustion. The sequence begins in the top left photo where the moxa cone is lit, progresses to the right, down to the second row on the left and finishes in the bottom right.

In addition to using the fingers to control the heat of penetrating heat moxibustion, one practitioner was found to do so using a glass test tube (Figure 7.87). This was reportedly an adaptation of the *Fukaya* moxibustion method which traditionally uses a bamboo tube. Although the *Fukaya* moxibustion method was only found to be used by one practitioner in this study, it was reportedly a popular style of moxibustion among Meridian Therapy practitioners in Japan and its use is probably somewhat prevalent among TJM acupuncture practitioners. Additionally, use of such tools for direct moxibustion is probably a unique aspect of TJM acupuncture.



Figure 7.87 Controlling the oxygen and heat sensation with a glass test tube

The amount of stimulation applied with penetrating heat moxibustion was aligned to the philosophical concepts of Yin/Yang, confirmation of treatment effects and prescription formulas according to symptomology. According to traditional Chinese philosophical concepts, odd and even numbers represent Yang and Yin, respectively. Because moxibustion relies on fire, it was associated with Yang and as a result, the number of cones ideally burned at a treatment locations should reportedly be an odd number such as one, three, five, seven or nine. Practitioners who preferred the moxibustion theories guided by traditional cosmology and Yin and Yang tended to apply either three or five cones on any one particular treatment location. For practitioners who preferred the philosophical concept of the eight principles and Ki, direct moxa stimulation was often determined by the treatment objectives and was achieved by adjusting the type and intensity of heat. Stronger heat was reducing or moving while milder heat was tonifying. It was also found that some practitioners applied moxa until a treatment effect could be confirmed. These effects were confirmed by the observation of redness around the treatment location or by changes in treatment site confirmed by palpation.

Acupuncture/judo therapy practitioners were said to earn more money from performing judo therapy, or other physiotherapeutic or orthopaedic treatments than they did from moxibustion. Patients can use their national health insurance to get reimbursement for judo therapy treatments for any musculoskeletal symptom. However, in order to get reimbursement for acupuncture or moxibustion treatment, patients need a medical doctor's referral for the treatment of one of only six government approved diseases including neuralgia, rheumatism, frozen shoulder, lower back pain and cervicobrachial syndrome. If patients do not have a doctor's certificate validating a diagnosis of one of those six diseases, and do not have permission to receive acupuncture or moxibustion from their medical doctor, then they have to pay the full price of treatment themselves. Acupuncture/judo therapy practitioners could provide acupuncture or moxibustion to their patients as part of the treatment at no extra cost, but they would be incurring a financial loss because of the materials and time involved, especially in the case of moxibustion. When acupuncture/judo therapy practitioners did perform moxibustion, they tended to use more time effective, indirect moxibustion methods such as stick-on moxa.

Because I use moxa, my treatments take much longer. . . If you only use needles its quick, like 'bang bang' right? For penetrating heat moxibustion you have to apply cones five or 10 or sometimes 30 times on the same acupuncture point. . . And when I use indirect moxibustion I need to leave it for 10 or 15 minutes or so to warm up. (Toko: acupuncture practitioner)

7.4.4 Section summary

In relation to the techniques of moxibustion, three themes are discussed: categories of moxibustion, indirect moxibustion and direct moxibustion. The first theme includes details about the diversity of moxibustion methods and organises them according to indirect/direct and scarring/non-scarring techniques. The different kinds of moxibustion techniques are described and contextualised in terms of what was found to be performed by practitioners.

It is shown how the most important moxibustion methods were stick-on, incomplete and penetrating heat moxa, which are outlined under the second and third themes. How these methods were applied to achieve the treatment objectives

of normalising body tissue abnormalities, relieving pain, warming cool areas and activating treatment point actions and indications are detailed.

That several small cones made from higher grade moxa floss were used to produce mild stimulation when applying direct moxibustion is described. In addition, it is shown how the confirmation of effects at the local site of moxibustion was an indicator of the therapeutic end point. It is also suggested that like needling, moxibustion seemed to be applied at many different treatment sites with minimal stimulation until some kind of effect was confirmed. Aspects of moxibustion were interpreted as showing a commitment to patient comfort and a strong sense of technical application. Table 7.14 summarises the most important moxibustion classification, tools and methods.

Table 7.14 Summary of Moxibustion

Class (a)	Indirect	Direct	
Class (b)	Non-Scarring	Scarring	Non-Scarring
Category	Stick-on and Stick	Penetrating Heat	Incomplete
Material	Pre-packaged stick-on moxa	Higher grade moxa floss	Higher grade moxa floss
Purpose	Warming, activate actions/indications of point locations, address body tissue abnormality and pain	Activate actions/indications of point locations, address body tissue abnormality	Warming, address body tissue abnormality and pain
Application	Adhesive cone	Half/Full-rice grain sized cones	Soy bean sized cones
Dose	1-3 product units	3,5,7 or up to 30 Cones	Many cones over an area

In the next section, events surrounding the confirmation of treatment effects are described in three themes: timing of confirmation, markers of confirmation and consultation time. This is the last section related to treatment principles and is the final section presenting data and proposing analysis.

7.5 Confirmation of Effects

The needle won't go any further in; it feels like it's hitting something and bounces back. The body will reject it from going in any further. . . Then after about 10 minutes, it'll go smooth, the place where the needle was hitting will have no tension at all. [So you check it one more time?] Yes, when it gets to that state it's good. [That'll take about 10 minutes?] Yeah, or 15 to 20 minutes. [Then after you withdraw the needles, what do you do?] I do a final examination. Make sure everything is ok; I check colour, body temperature and the skin condition. I might also ask them if everything feels all right.
 (Ume: acupuncture/massage practitioner)

Confirmation of effects means establishing the results of an intervention at a specific treatment location or by a measure believed to be significant and representative of the patient's general condition. To a certain extent, confirming the treatment effects depended on practitioners' ability to perceive differences in the patient after or during an intervention relative to their pre-treatment condition. This ability seemed to require expertise in the skills similar to those used in diagnosis: palpation, observation, inquiry and listening/smelling. The most important of which, were found to be palpation and observation.

Three themes are covered in this section: timing of confirmation, markers of confirmation and consultation time. The first theme offers data and analyses on the procedural and sequential aspects of confirmation during, directly after and after a series of interventions. It is shown how confirmation occurs at micro, meso and macro levels. The differences and implications of confirmation at these different levels are examined.

The second theme includes the signs which mark the effects of treatment. Additionally, how an effect was perceived, why it was considered an outcome and what amounts to a therapeutic result are considered.

The final theme relates to the total consultation time. How long treatments lasted and how many patients were treated at any one moment is detailed. What this means in terms of practitioners' knowledge and values is analysed, and how

diagnostic procedures and treatment principles in general influence consultation time is discussed.

7.5.1 Timing of confirmation

When the area around the insertion point of the needle changes colour to red or white, then this is a good sign that Ki is moving. You can take the needle out at that point. (Iwamatsu: acupuncture practitioner/professor)

Confirmation was interpreted to occur at different levels of timing and treatment areas during the clinical encounter: micro, meso and macro. These divisions represent the time and scale of confirmation over a physical area (Figure 7.88).

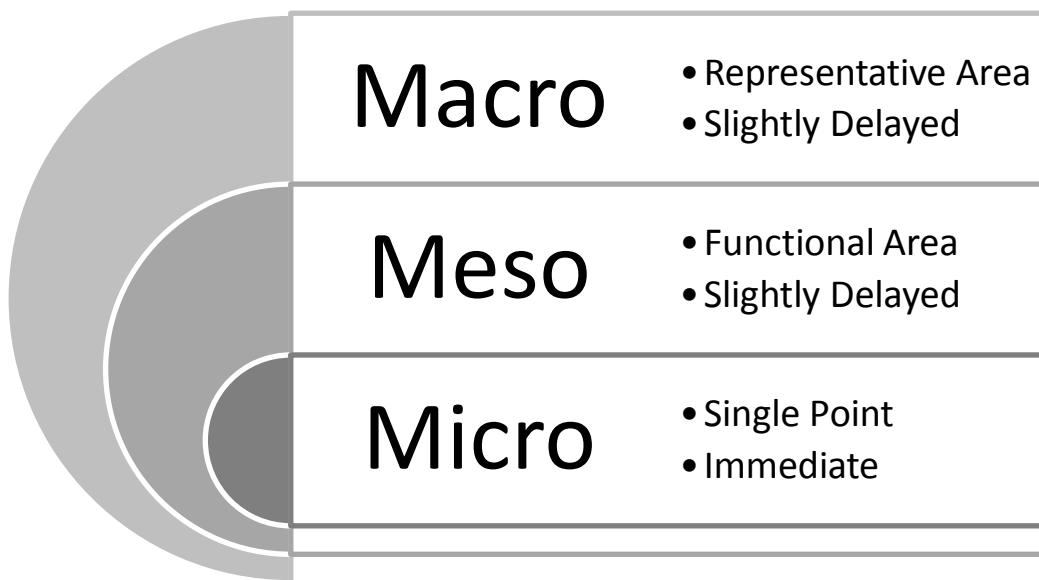


Figure 7.88 Timing and levels of confirmation

Timing of confirmation was a theme identified in data from 80% (n=28) of the 35 practitioners who contributed to treatment principles. Practitioners expressed micro, meso and macro level confirmation differently and in differing combinations in interviews and observed treatments. Micro level confirmation was found in data from 54% (n=19) of practitioners, meso from 63% (n=22) and macro from 51% (n=18).

Micro level confirmation was performed during the application of interventions. It includes a constant assessment of the effects of the currently

performed intervention at the local treatment site. Soliciting a response at the micro level was important because it was thought to have benefits at the local site, and also influence the meso and macro level treatment effects. The practitioners' skills of manipulating the intervention and their sensitivity in sensing changes in condition were valued as important features of causing and confirming therapeutic effects.

Observation with Kinu (acupuncture practitioner/senior lecturer)

Kinu gently manipulated the needle with the sparrow pecking technique by pressing and releasing the needle tip against the tissue under the treatment location with her right hand, the needling hand. Her pressing hand rested lightly on the patient's skin and pinched the needle shaft at the insertion point with the index finger and thumb. As she manipulated the needle, she felt for any changes in resistance or tension with the pressing hand and through the needle with the needling hand.

Meso level confirmation occurred over functional areas of body tissue or areas of anatomic significance. Confirmation at the meso level was found to be performed after a series of successive interventions within or around significant or functional areas and was usually the central indicator of whether the patient's main complaint had improved. The main complaint often existed in a functional group of malfunctioning tissues, or as a result of various interacting pathogenic influences rather than at a single treatment location or in relation to general health and wellbeing. After a series of interventions were applied locally or distally, confirmation of any changes in the condition at the symptomatic area was diagnosed. Use of meso level confirmation also depended on the condition of the patient. Illnesses which were difficult to judge whether a change had been achieved (such as insomnia or cancer), were not suitable for meso level confirmation.

Observation with Ginnosuke (acupuncture practitioner)

Ginnosuke asked the patient exactly where his pain was. The patient pointed at an area from behind the back of their right shoulder to the base of their neck. "Around here" he said. Ginnosuke considered that

where the patient had indicated lay along the Small Intestine channel and decided to treat the point SI 3 on their left side. He stood in front of the patient, holding the small gold teishin in his right hand with it touched it against the point SI 3 on the patient's left. As he held the teishin against the point with his right hand, Ginnosuke palpated the patient's right radial pulse with his other hand. After a few moments, Ginnosuke removed the teishin and asked the patient to move in a way that would aggravate the pain to see if it had changed at all. The patient did, and indicated that there was no change. Ginnosuke then treated SI 3 on the right side with the teishin as he had just done so on the left. Once again, the patient indicated that there was no change.

Macro level confirmation was found to be applied when practitioners considered that ensuring the body as a whole was in a state of good health was important, both to the main complaint of the patient and the maintenance of their health in general. Confirmation at the macro level was performed at significant areas of anatomy which were believed integral to, or representative of, the proper functioning of the body. Palpation and observation of significant anatomical areas including the pulse, abdomen, back, tongue, skin and body structure (bone and muscle alignment), were used to confirm treatment effects at the macro level.

I try not to put any strength in the needle. Just stay still and wait for the body to change. [What do you do once you feel the change?] I check the pulse and do the next point. . . If when I check the pulse and it's flat or ok, if it's in good condition, I will finish the treatment. (Takizou: acupuncture practitioner)

7.5.2 Markers of confirmation

I use the reductor tool with the patient sitting on the examination table or chair. . . In my opinion, it equalises internal pressure and returns the body structure back to its normal state. [How do you know if there is a change in condition?] Firstly, by palpation. Also by movement, and I can see where the body shape has changed. . . Then, if I feel like I have achieved today's goal for the patient, I finish the treatment. (Shinokichi: acupuncture/massage/judo therapy practitioner/lecturer)

The methods for confirming the effects of treatment are similar to those in diagnosis: inquiry, observation, palpation and listening/smelling. The markers for confirmation are also the same as in diagnosis, with the addition of needle sensations perceived by the patient or practitioner (Table 7.15). Positive differences in the condition of a range of body tissues compared prior to treatment were indicative of a therapeutic result.

Table 7.15 Markers of Confirmation

Abdominal Tympanic Qualities
Alignment, Shape and Indurations of Body Structures/Tissues
Colour
Muscle Tension
Needling Sensations Perceived by Patient
Needling Sensations Perceived by Practitioner
Patient Comfort
Practitioner Intuition
Pulsations
Pulse
Range of Movement
Skin Texture
Strength of Movement
Swelling
Temperature
Tongue Condition

Palpation and observation were found to be the most important methods for confirming treatment effects. Palpation of the pulse, palpation of the body tissues through the needle or with the hand, and the observation of body tissues and range of movement were the most significant methods for confirming the effects among practitioners.

We can find out the difference before treatment and after treatment from the pulse. You must train how to feel the pulse and if at first you can learn how

to judge the difference of the pulse condition both before and after treatment, it's a great start. (Kojiro: acupuncture/massage practitioner)

Confirmation methods sometimes included solicitation of a Ki obtaining response and other painful or uncomfortable sensations. Once this was achieved, treatment was often ceased at the location. Confirmation was achieved through expression by the patient either vocally, and through movement or palpation of tissue through the needle. The purposeful employment of methods which may have caused patient discomfort was seen as positive markers for treatment efficacy. This kind of confirmation contrasts with many of the themes related to patient comfort interpreted from the data. However, it is important to note that although rare in this study, these kinds of methods probably represent routine elements of TJM acupuncture for some practitioners.

Practitioners appeared to have defined expectations of health. These expectations enabled them to recognise abnormalities in relation to a predicated healthy norm through the application of specific techniques. Whether the techniques were effective or not was the process of immediately checking the presence of changes in condition. Treatment effects were confirmed by establishing a comparative improvement in the patient's condition. The health condition was found to be a constantly changing reference point throughout the clinical encounter and interventions were believed to potentially result in an immediate regression of symptoms during the clinical encounter. This value reflects the possibility of changes in a relative health condition to a state which is not perfect, but is an achievable or acceptable benchmark for an individual. Practitioners believed this regression could occur moment by moment during the clinical encounter, and was a result of their skills and experience.

7.5.3 Consultation time

I take about half an hour for my treatments, but my teacher usually does one in 15 minutes. (Otoemon: researcher/acupuncture practitioner)

Total consultation time includes the time from when patients were invited into the treatment space from the reception area, to when they left the treatment space and

exited back to the reception area. The consultation time includes diagnosis, treatment and any other required procedures.

Data related to consultation time was obtained from 97% (n=34) of practitioners who contributed to data concerning treatment principles. The shortest consultation time was found to be 10 minutes and the longest stated to be 120 minutes. The median consultation time was 40 minutes or under.

Table 7.16 shows data about practitioner qualifications, consultation time in minutes, the maximum number of treatments a practitioner performed concurrently, the maximum number of assistants found to help the practitioner during a treatment, and the number of treatment tables in the clinic facility. Practitioners did not always treat the maximum number of patients that their clinic could accommodate; there were sometimes more tables in the clinic than patients treated concurrently. Reportedly, this could assist clinic operations. All sole traders treated their patients independently. However, some practitioners at multi-staffed or multi-modality clinics were sometimes assisted by other practitioners to treat patients and operate the clinic. Although data concerning practitioner qualifications and consultation time could be collected from 34 practitioners, data related to patients, staff and treatment tables was not available from all practitioners.

Table 7.16 Qualifications, Patients & Treatment Time

Qualifications	Consult Time (Minutes)	Maximum Concurrent Treatments	Maximum Assistants	Treatment Tables
Acupuncture Moxibustion	45	4	1	4
Acupuncture Moxibustion	60	1	0	1
Acupuncture Moxibustion	60	1	0	1
Acupuncture Moxibustion	30	1	0	1
Acupuncture Moxibustion Judo Therapy	60	1	1	4
Acupuncture Moxibustion Massage	60	Not Available	Not Available	Not Available
Acupuncture Moxibustion Chiropractic	10	1	3	1
Acupuncture Moxibustion	60-120	1	0	1
Acupuncture Moxibustion Judo Therapy	30	Not Available	3	8
Acupuncture Moxibustion Massage	40-60	1	0	3
Acupuncture Moxibustion Massage	60	1	Not Available	Not Available
Acupuncture Moxibustion	30	1	0	1
Acupuncture Moxibustion Judo Therapy	30-60	Not Available	Not Available	Not Available
Acupuncture Moxibustion	40	1	1	Not Available
Acupuncture Moxibustion	50-70	1	0	1
Acupuncture Moxibustion Massage	40-60	2	1	Not Available
Acupuncture Moxibustion	40	1	1	2

Qualifications	Consult Time (Minutes)	Maximum Concurrent Treatments	Maximum Assistants	Treatment Tables
Acupuncture Moxibustion	90	1	0	1
Acupuncture Moxibustion	40	1	0	2
Acupuncture Moxibustion Judo Therapy	40	2	1	4
Acupuncture Moxibustion	60	2	Not Available	Not Available
Acupuncture Moxibustion	60	1	0	Not Available
Acupuncture Moxibustion	40	2	Not Available	Not Available
Acupuncture Moxibustion	15-50	1	Not Available	Not Available
Acupuncture Moxibustion	40	1	Not Available	Not Available
Acupuncture Moxibustion	30	Not Available	Not Available	Not Available
Acupuncture Moxibustion	30	Not Available	Not Available	Not Available
Acupuncture Moxibustion Chiropractic	40	Not Available	Not Available	Not Available
Acupuncture Moxibustion	30	Not Available	Not Available	Not Available
Acupuncture Moxibustion	30	1	0	1
Acupuncture Moxibustion	60	Not Available	Not Available	Not Available
Acupuncture Moxibustion	60	Not Available	Not Available	Not Available
Acupuncture Moxibustion	30	3	2	4
Acupuncture Moxibustion	30	1	2	4

Consultation times were found to vary depending on the age of the patient, whether the practitioner accepted insurance claims and on the health condition of the patient. Consultation times were reportedly shorter for children, sometimes taking around 15 minutes when an adult might receive a 30 minute consultation time. Consultation time was also found to be shorter for patients who were eligible for insurance reimbursements and when patients were in a state of poorer health. In general, longer consultation times were sometimes found with initial patients.

Methodological differences between practitioners somewhat correlated with total consultation times. One practitioner who retained needles for generally no longer than five minutes, had a total consultation time of around 10 minutes. In contrast, another practitioner who retained needles for around 20 minutes had a total consultation time of around one hour. However, retention time was not a sole correlating factor influencing consultation time. The number of treatment locations treated, and the method of treatment also appeared important in determining the time spent in consultation.

When a large number of treatment locations were treated, total consultation times became longer. The practitioner who had the total consultation time of around 10 minutes had a needle retention time of only a few minutes, and they also usually needled one or two treatment locations. However, some practitioners who treated many treatment locations (over 25) had shorter consultation times than others who applied interventions at less treatment locations. This was in part due to the techniques used in applying treatment interventions. Techniques which included teishin (needle-like contact tools), minimal insertion and the tanshi method (needle insertion and instant withdrawal) were performed relatively quickly and resulted in shorter consultation times. There were also techniques and tools which contributed to producing longer consultation times. These primarily included how often or diligently a practitioner attempted to confirm the effects of treatment, tool manipulation time, the use of direct moxibustion and whether multiple patients were treated simultaneously by a sole practitioner.

Of the practitioners who provided data relating to consultation time, some (18%, n=6) were found to treat more than one patient at once. In regards to multiple patients receiving treatment at once, the most patients observed was four

and the least was two. Multiple patients receiving treatment was observed at two acupuncture only clinics, three educational institutions and one acupuncture/judo therapy clinic. This study included only four acupuncture/judo therapy practitioners (11% of total practitioners: n=38). Results may have been different if more acupuncture/judo therapy practitioners were included due to the apparent alternate style of clinic practices found by non-judo therapy practitioners in this study.

The [acupuncture/judo therapy] clinics make their (very good!!!) money in the “belt-conveyor style” on a constant stream of patients. And their business (style) may very well put acupuncturists out of business. But somehow I cannot endorse that kind of treatment style. That is probably one reason why I don’t make any money. (Koremitsu: acupuncture practitioner)

7.5.4 Section summary

This section presents data and analysis concerning the confirmation of treatment effects in three themes: timing of confirmation, markers of confirmation and consultation time. The first theme includes how confirmation could be performed at the micro, meso and macro level. These levels were interpreted as representing both the location of confirmation and extent the role holism played in practitioners practice. It is shown how almost all practitioners sought confirmation on all levels.

The second theme lists which body tissues or features were used to assess whether an effect had been achieved through the application of interventions. It is also shown that these were essentially the same as the markers used to make a diagnosis. The major difference being that any needling sensation felt by the practitioner or patient was considered a confirmation marker of treatment effects. Palpation of the pulse, palpation of body tissues through the needle or with the hands, observation of body tissues and observation of body movement are outlined as the most significant methods for confirming the effects of treatment.

The confirmation of positive effects was a signpost for successful treatment and reflective of the value of effects through technique. Immediately confirmable signs of improvement were valued because this meant that not only could the patient feel better at that moment, but that this could also lead to potential future benefits which may not eventuate without an immediate reaction. The practice of

confirming treatment effects also signified an acceptance of the limits of what could be achieved during an appointment: once an effect had been attained at a treatment site or over a treatment area, treatment was often suspended at that location. This was interpreted as a manifestation of the ideals of economy of time, movement, resources and attention to not overtreat a patient. It was also interpreted to represent the de-emphasis of the circulation of Ki according to traditional acupuncture literature.

The final theme includes details about how patient age and condition, insurance claims, clinic size, treatment table number, assistant number and the commitment to various knowledge and beliefs may have influenced how much time patients received in clinics. It is shown that at the shortest, treatments lasted for around 10 minutes, at the longest could be for around two hours, and the most common consultation time was about 40 minutes or under.

7.6 Chapter Summary

[Why do you think Japanese acupuncture developed differently compared to China or Korea?] One of my professors went to China with his wife who got very sick and was hospitalised there. When the Chinese make herbal medicine, they combine many kinds of herbs with the benefits believed to be determined by the mixture ratio of the formula. The formula ratio is very important to them, but the amount isn't, so they let patients take a large volume of it. They don't seem to mind whether patients take a lot, but for Japanese people, we can't tolerate large amounts. Her sickness got worse and worse because she kept taking a lot of medicine. My professor thought his wife would die if she stayed there, so they left the hospital and went straight back to Japan to get suitable treatment for her. . . Chinese people don't seem to worry too much about the amount or quantity. The Japanese constitution is not strong enough to tolerate large amounts. Because our bodies are sensitive, we can feel changes even when inserting shallowly with thin needles. Chinese people can endure treatments with thick needles because they have a strong constitution. Gentle needling suits Japanese people. We also closed our country off during the Edo period, and during that time Japanese acupuncture developed independently in unique ways.

(Sasuke: acupuncture practitioner/senior lecturer)

This chapter discusses treatment principles in TJM acupuncture. The data and analysis are organised into five major themes: tools, pre-intervention preparation, needling, moxibustion and confirmation of effects.

The first theme lists the major direct application tools and any assistant tools found to be used alongside them. Filiform needles with guide tubes around 0.14 mm in diameter and 40 mm long, high grade raw moxa floss, stick-on moxa and contact tools seem to be important tools for TJM acupuncture practitioners. The use of these tools demonstrates the commitment of TEAM model practitioners to the concept of *Ki* and to the idea that stimulation of the skin surface is enough to cause an instantly verifiable effect either in the local tissue or at an area of anatomical significance. Physically and functionally, many of the tools used by practitioners represent the value of patient comfort.

The second theme includes pre-intervention preparation techniques, such as point selection, sterilisation procedures, point location, use of the pressing hand, pre-needling and pre-moxibustion. Sites on the body that exhibit some kind of abnormality directly or in relation to the main complaint were commonly selected as treatment locations. Sterilisation practices and their effect on therapeutic interventions are described in three aspects: that entire areas of skin were sterilised, that practitioners commonly allowed their fingers to come into contact with the needle shaft, and that needles were commonly withdrawn and reused on the same patient. These three aspects of sterilisation demonstrate the importance of the *tanshi* method and pressing hand in TJM acupuncture. Point location procedures are specified, and it is described how the knowledge from textbooks, mentors and clinical experience are used to find treatment locations. In addition, the observation and palpation of body tissue abnormalities were found to be important factors in locating points. Next, pre-needling, contact and the importance of the pressing hand to maintain accuracy are described, along with the assistant tools used to prepare the skin for moxibustion. All these tools were used to maintain patient comfort and to assist in the smooth execution of moxibustion techniques.

The third major theme is needling and associated techniques. Needles were inserted by tapping and then manipulated by altering aspects of form, speed repetition and depth. After manipulation, needles were retained for around 15

minutes to achieve a therapeutic benefit in regards to Ki or normalising abnormal body tissue. Additionally, the retention of needles assisted clinic operations and patient time management by allowing practitioners to move between different tools, techniques and patients. Finally when withdrawing needles, the pressing hand was seen to play an important role in terms of safety and assist in manipulating Ki when this was a priority for practitioners. The withdrawal and reloading of a needle single handed into the guide tube for the tanshi method is a unique element of TJM acupuncture needle withdrawal routines.

The fourth major theme focusses on moxibustion by describing categories of moxibustion, indirect moxibustion and direct moxibustion. The most important distinctions between moxibustion methods were interpreted as scarring/non-scarring and direct/indirect. Techniques of indirect moxibustion include stick-on, stick, insulated and miscellaneous methods. Stick-on moxa was the main method for activating the actions and indications of points and for warming cool areas with indirect methods. Direct moxibustion includes two important techniques: incomplete and penetrating heat moxibustion. How the methods of moxibustion are performed according to the value of minimal stimulation and patient comfort are demonstrated.

Finally, the confirmation of treatment effects is explored in three sub-themes: timing of confirmation, markers of confirmation and consultation time. Pulse and body tissue palpation and observation were found to be the most significant methods for confirming treatment effects at micro, meso and macro levels of confirmation.

Findings related to philosophical concepts, diagnostic methods and treatment principles in practitioners' practice of TJM acupuncture demonstrate several unique features when compared to other acupuncture styles internationally. These unique features are explored in full and compared to literature pertaining to TCM acupuncture in the next chapter. In addition, an explanation and rationalisation of the implications of the findings in relation to education, practice and theory is provided and possible directions of future research suggested.

Chapter 8: Discussion and Conclusion

This study examines the ideas, experiences and practices of TJM acupuncture practitioners. It does this to understand TJM acupuncture through philosophical concepts, diagnostic methods and treatment principles. Using the ethnographic methodology, this research identifies philosophical concepts of TJM acupuncture and describes how interactions between knowledge, and beliefs and values result in clinical processes. This study also suggests a typology of diagnosis and treatment, interprets motivations for clinical actions, and offers details about the nature, expression and type of routine and unique elements of TJM acupuncture protocols for diagnosis and treatment. Many of the insights discussed here are presented for the first time in research related to TJM acupuncture.

Much of the data and themes analysed in regards to clinical routines may appear obvious, as a matter of course and are generally taken for granted aspects of clinical processes. However, despite how evident some of these routines may seem, their rigorous and deliberate recording, together with thorough and critical analysis has until now, been absent from the published English language literature. Documenting and evaluating accepted norms is important; it establishes a baseline from which the epistemological considerations of beliefs and behaviours can be questioned, and is the starting point of a true understanding of phenomena. To date, peer reviewed English language literature on TJM acupuncture, and specifically how it is practiced in Japan, does not adequately describe TJM acupuncture. The literature also fails to sufficiently link philosophical concepts with clinical practice in culturally meaningful ways, and is inconclusive in collectively identifying therapeutic protocols related to diagnosis and treatment. This study aims to resolve the limited understanding of TJM acupuncture by investigating four important questions:

- 1) How do practitioners of TJM acupuncture describe or exhibit the philosophical concepts, diagnostic methods and treatment principles of their acupuncture practice and TJM acupuncture in Japan in general?

- 2) How do clinic procedures, environment and clinic artefacts reflect the philosophical concepts, diagnostic methods and treatment principles of TJM acupuncture?
- 3) How do the patient records, clinic documents and other locally sourced literature reflect the philosophical concepts, diagnostic methods and treatment principles of TJM acupuncture?
- 4) What, if anything, makes TJM acupuncture identifiable as a distinct style of acupuncture?

The following sections discuss how this study has met the project goals and how closely the findings correlate with published English language literature. To examine these issues, this chapter is divided into two sections:

- Conclusions and contextualisation
- Implications and future direction

The first section provides a synthesis of findings and shows how the research questions have been addressed. How the findings contribute and connect to the existing understanding of TJM acupuncture is also examined. In addition, results from this study are compared to TCM acupuncture literature to identify areas of similarity and contrast between the two styles.

The second section discusses the consequences of the findings and provides perspective on what they mean in relation to the education, practice and theory of TJM acupuncture. This section also examines the questions that were raised and left unanswered through the research process and suggests how they may be reframed as possible areas of future research.

8.1 Conclusions and Contextualisation

To investigate TJM acupuncture, a theoretical framework of categories was developed to give structure to the research process. This structure was developed specifically to provide a platform for exploring TJM acupuncture in this study, but may also be useful for future research into other acupuncture styles. This

developed structure included the thematic categories of philosophical concepts, diagnostic methods and treatment principles. These three categories were supplemented by themes interpreted from the data to create a rubric for describing TJM acupuncture. This rubric was then used to further analyse the themes, and compare and contrast them with TCM acupuncture literature.

It is beyond the scope of this research to comprehensively analyse TCM acupuncture in terms of philosophical concepts, diagnostic methods and treatment principles. Nor is it possible to analyse how TCM acupuncture has been adapted for use in different Western countries and compare these to each other, to TCM acupuncture in China and to TJM acupuncture. Therefore some of the differences between the acupuncture styles proposed in this chapter may be incomplete or may exaggerate the contrasting elements of TCM and TJM acupuncture; this may be due to the nature of tabular categorisation and the limitations of the available English language literature used to inform the comparison.

TJM acupuncture is the primary topic of this study and has been analysed in detail. As a result, a more complete picture of TJM acupuncture is presented. Elements of TCM acupuncture provided for comparison in this chapter reflect the analysis of available published English language literature. Tables of comparison (Tables 8.2, 8.3, 8.6, 8.7, 8.8, 8.9, 8.10 and 8.11) are provided at the end of each section and are summaries of the referenced literature reviewed and analysed in text. These comparisons are not necessarily the personal thoughts and opinions of practitioners, nor do they necessarily reflect the reality of clinical practice in China or other countries. The elements of comparison should not be considered in isolation either. Styles of acupuncture are not defined by singular elements; they are more than the total sum of the themes that can be found within them. This study offers these comparisons as an overview of the interpreted findings from the study data together with themes found in the current published English language literature. This is presented as a point of reference, and not as a means to justify or judge aspects of each style.

8.1.1 Philosophical concepts

Philosophical concepts are socially and culturally constructed systems of knowledge and values. In Japan, they play a large and multifaceted role in shaping not only health care systems related to TEAM, but also other professional, popular and folk medical systems. In the TJM acupuncture setting, philosophical concepts interact with beliefs and behaviours concerned with health and illness, and with health care activities that are included in its practice. Philosophical concepts are socially ingrained, have developed and been culturally legitimised over time, and influence values, expectations, clinical settings, clinical relationships and the roles practitioners play in the professional medical arena with patients as well as in society at large. Philosophical concepts also assist in the development of strategies and evaluative standards that guide choices related to health care practices, and assist in assessing the processes and outcomes of clinical interventions and care. They guide the intellectual and interactive procedures for managing sickness, which involve disease labelling, differentiating and offering meaningful explanations of health, illness and the health care experience. In addition, philosophical concepts guide the provision of all types of therapeutic interventions and advice related to health enhancing or illness prevention behaviours. Finally, philosophical concepts direct the management of clinical outcomes, including improvement of the health condition, cure, treatment failure, progression and management of long-term illness, disability and death.

Philosophical concepts as an analytical category have been used by commentators to compare, contrast and describe acupuncture styles (Dann, 2007; Manaka, 2009; O'Brien and Birch, 2009; Patwardhan et al., 2005). However, the category itself was found to be insufficient to account for the complexity and cultural diversity that influences priorities and preferences in the application of basic TEAM medical theories. In this study, data analysis resulted in the interpretation of two separate themes which constitute philosophical concepts:

- Knowledge
- Beliefs and values

The classification of philosophical concepts into these two themes is an essential distinction in the description of acupuncture styles, and is made for the first time in research specifically related to TJM acupuncture by this study. This study finds parallels with other psychology and business research (Chipulu et al., 2014; Knott, 2014; Ridi, 2013) that views understanding values as a crucial element of knowledge provision. Scheid (2007), Ryan (2003) and Kaptchuk (1985) have suggested that developing an appreciation of local values, understanding history and cultural concepts, will assist in the adaptation of the education and practice of TEAM (especially acupuncture) in those local, non-Chinese contexts. This study agrees that acupuncture practice and knowledge can, and should be adapted to local environments by developing an understanding of local beliefs and values. Furthermore, this study proposes that garnering an awareness of the beliefs and values of international acupuncture styles will contribute to professional practice in local contexts; specifically, those from TJM acupuncture.

Knowledge: explanatory models of medicine

The knowledge base of TJM acupuncture practitioners was found to be grounded on three models of medicine:

- TEAM
- Biomedicine
- Orthopaedics

Biomedicine and orthopaedic medicine were interpreted as important aspects of TJM acupuncture practitioner knowledge. This study agrees with other authors (Katai, 2010b; K. Matsumoto, 2000; Murata, 1999; Nagato, 2000; Shudo, 2000; Yasui, 2010b) who describe TJM acupuncture as being strongly rooted in medical science. Additionally, this study is able to provide previously unreported insights into how this is manifested in clinical practice (see Chapter 6 and 7).

In addition to labelling TJM acupuncture practitioners as TEAM, biomedical or orthopaedic model practitioners, this study categorised practitioners into two groups based on educational qualifications:

- Acupuncture only practitioners
- Acupuncture and judo therapy practitioners

Practitioners from both groups appeared to align either with TEAM knowledge, or biomedical and orthopaedic knowledge. One of the trends which emerged from analysis was that acupuncture only practitioners tended to have preferences and commitment to TEAM knowledge, while acupuncture and judo therapy practitioners seemed to have allegiances with orthopaedic knowledge. This finding is compatible to the discussion by Nishikitani, Inoue and Yano (2008), and additionally contributes that there was competition not only between judo therapy practitioners and other orthopaedic medical professionals, but also between acupuncture practitioners and acupuncture and judo therapy practitioners. There appears to be divisions between those groups which, in general, remain unbridged by contrasts in philosophical ideology, professional identity and personal preference. Competition between them conceivably contributes to the tension between the legitimacy of contrasting knowledge bases within the TJM acupuncture discipline itself and the Japanese health care system in general.

As a result of recruitment opportunities, this study focussed on TEAM knowledge in TJM acupuncture. However, there were TJM acupuncture practitioners who were not committed to that knowledge. Some practitioners were found to ignore TEAM knowledge in favour of biomedical and orthopaedic knowledge. For some, this kind of biomedical or orthopaedic acupuncture was considered the orthodoxy of TJM acupuncture practice, while for others was seen as an abandonment of the classical acupuncture traditions.

Possibly, the majority of acupuncture and judo therapy practitioners in Japan do not incorporate much, if any TEAM knowledge into their practice. It seems reasonable that the majority of acupuncture practice in Japan is performed by acupuncture and judo therapy because there are probably more of them than acupuncture only practitioners (see Table 8.1). However, how often acupuncture and judo therapy practitioners actually use acupuncture methods in clinic is unknown. Although acupuncture and judo therapy practitioners probably outnumber acupuncture only qualified practitioners in Japan, it could be that they do not perform acupuncture methods as much as acupuncture only practitioners.

Table 8.1 (adapted from Yamamoto, 2016) shows examinee numbers for acupuncture, moxibustion and judo therapy qualifications in the national registration examination for licensure in Japan from 2012 - 2016. Typically, acupuncture and moxibustion qualifications are taken together, and it is reasonable to assume that almost all examinees for acupuncture and moxibustion registration are the same. However, it is also common for students to study acupuncture, moxibustion and judo therapy, and take qualifications in all three disciplines. The statistics do not show how many individual examinees participated in the different examinations. However, according to study participant Heijiro sensei, who was the department head of an educational institution, more than 90% of their acupuncture and moxibustion graduates also studied judo therapy. It is likely that every year in Japan, more examinees take part in the acupuncture, moxibustion and judo therapy examinations than the acupuncture and moxibustion examinations only.

Table 8.1 Acupuncture, Moxibustion and Judo Therapy Examinees in Japanese National Exams (Adapted from Yamamoto 2016)

	Year	2012	2013	2014	2015	2016
Acupuncture	Total	5015	5157	5036	4946	4775
	Successful	3651	4005	3892	3808	3504
Moxibustion	Total	4996	5235	4998	4893	4732
	Successful	3498	4138	3946	3773	3550
Judo Therapy	Total	6754	6503	7102	6858	7122
	Successful	5227	4438	5349	4503	4583

Non-acupuncture treatments performed by practitioners with judo therapy qualifications can provide treatments which are covered directly under the national health insurance system without a medical doctor's referral when diagnosing patients with an orthopaedic condition. However, acupuncture treatments are only covered under the national health insurance system when a medical doctor provides a referral for the patient to receive treatment for only one of a possible six conditions: neuralgia, rheumatoid arthritis, frozen shoulder, lower back pain, cervicobrachial syndrome and cervical sprain sequelae (Okabe, 1998; Ono, 2010). This insurance system probably has ramifications on the way patients seek out acupuncture treatments, how acupuncture is practiced and researched in Japan,

and on the shaping of attitudes towards the various types of therapies, therapists and treatments of both practitioners and patients. The laws and insurance policies may also have ramifications on the way acupuncture is taught and how economically competitive it is against other health care modalities. It appears that relevant and plausible physiological and anatomical explanations of measurable clinical information detected in biomedical/orthopaedic defined systems of reference, enhance the acceptance and understanding of TJM acupuncture in Japan. This could be true in other cultural environments too.

Acupuncture and judo therapy practitioners are a minority group in this research, but it was constantly reported and believed by many of the recruited practitioners that acupuncture/judo therapy practitioners were not committed to TEAM philosophical concepts, in part due to education and health insurance laws. A disregard for TEAM knowledge was also observed in some acupuncture only practitioners' practice, including those who were generally aligned with the TEAM medical model, but not with biomedical or orthopaedic models. That TJM acupuncture includes practitioners who consider themselves traditional acupuncturists, but do not rely on standard TEAM concepts, is a unique feature of TJM acupuncture. In line with other literature (Oura, 2007; Matsuda, Brown & Dann, 2009), this study believes this phenomena is due to the incorporation of Japanese indigenous cultural practices with other medical innovations into TJM acupuncture. Future research should endeavour to describe the practice of practitioners who generally ignore TEAM knowledge in favour of Japanese indigenous cultural practices. Additionally, future research should examine how, when and what biomedical and orthopaedic philosophical concepts are synthesised and applied with TEAM philosophies in TJM acupuncture in detail.

TEAM knowledge

This study confirms discussion (Anryu, 2002; Baker, 2003, p. 152; Cha et al., 2007; Kim et al., 2005; Kim et al., 2011; Kobayashi et al., 2008; WHO, 2007, p. 9; Yin et al., 2007) suggesting that TJM acupuncture seems to be based on the same fundamental pool of TEAM knowledge as TCM acupuncture. TCM acupuncture is largely practiced according to pattern identification and syndrome differentiation, and appears to emphasise the philosophical concepts of Yin-Yang, viscera and

bowels, six excesses, six meridian theory, warm disease theory, triple energiser theory, channels and collaterals, and the fundamental substances (Barnes, 1998; Dale 1997; Dong & Zhang, 2001, p. 18; Flaws, 1992; Fruehauf, 1999; Ikeda, 2002; Ishida, 2004; Kaptchuk, 1985; Kim et al., 2011; Lao, 1996; Liangyue, 2001, p. 81; Low & Ang, 2010; MacPherson et al., 2010; WHO, 2007, p. 9; Yu et al., 2006).

TJM acupuncture practitioners who were committed to TEAM philosophical concepts seemed to prefer certain aspects of the knowledge included in TCM acupuncture. Consistent with others (Anryu, 2003; Birch, 1994; Chikurin, 2003; Ikeda, 1997; Ikeda, 2001; Iwashita, 2010; Kanazawa, 1996; Kobayashi, 2001; Manaka, 2006b; Nishijima, 2003; Okabe, 1998; Scanlon, 1996; Shimada, 2006; Yanagishita, 2001a), this study found that knowledge of the five phases and channels and collaterals are some of the emphasised elements of TEAM knowledge in TJM acupuncture. For the first time in research based literature, this study clarifies how TJM acupuncture specifically highlights the 12 primary and eight extra channels, Yin-Yang, five phases, Ki and the pathogenic factors of Heat and Cold in clinical practice (Chapter 5). Additionally, it is shown that the eight principles are a core element of TJM acupuncture knowledge. Although TCM and TJM acupuncture are based on the same fundamental pool of knowledge, there are elements of that knowledge which seem to be emphasised or undervalued in each style (Table 8.2).

Table 8.2 Summary of Preferences: Knowledge in TCM and TJM Acupuncture

	TCM Acupuncture	TJM Acupuncture
Knowledge	Viscera & Bowels	5 Phases
	6 Excesses	Primacy of Heat & Cold
	6 Meridian Theory	8 Extra Channels
	Warm Disease Theory	Primacy of Ki
	Triple Energiser Theory	8 Principles

Beliefs and values

Beliefs and values were found to be identifiable with Japanese nationality in general and somewhat bound to the socioeconomic, political and religious actions and beliefs prevalent in Japan and the Japanese people as a society. It is reasonable to assume that personal motivations, history, geographical and professional environments, status, affluence, traditions, family, socio-political concepts, religion, traditions and other cultural and personal aspects all contribute to the beliefs and values which inform clinical decisions and patient practitioner interactions. One example from Japanese culture highlights the importance of patient comfort and customer service throughout the whole service, manufacturing and design industries in Japan.

Alongside Zen Buddhism, the Japanese cultural concept of *omotenashi* is of national significance, with influence over many aspects of Japanese life, including TJM acupuncture. *Omotenashi* is the term used to describe the Japanese spirit of hospitality, which incorporates ideals such as selflessness, anticipation of the guest/customer's needs (even things that the guest/customer may not realise they need or want themselves), a unique individual experience and attention to detail, among other qualities. In respect to TJM acupuncture, *omotenashi* is a heavily nuanced idea of hospitality where the practitioner attempts to make the patient comfortable and provide outstanding service, but that it is partly the patient's responsibility to appreciate and trust the actions of the practitioner. Heartfelt hospitality is not unique to Japan, but that it is so defined in the term *omotenashi*, which is specific to anticipating the needs of Japanese cultural sensitivities (not always appropriate for non-Japanese), and that it is prevalent in almost all social engagements, is a demonstration of how cultural concepts are recognisable themes in the practice of TJM acupuncture.

In general it seems that traditional Chinese cultural values have influenced how TCM acupuncture is performed, especially in relation to the tripartite coalition of Confucianism, Buddhism and Taoism (Deadman et al., 2009; Flaws, 1992; Kaptchuk, 1985; Low, 2011; Ma, Zhao, & Liao, 2015; Yao, 2000). In addition, herbal medicine, Western religious beliefs, science, technology, political concepts and "sustainable development" (Ma et al., 2015) have also shaped the way value

judgements are made by TCM acupuncture practitioners (Deadman et al., 2009; Flaws, 1992; Fruehauf, 1999; Kaptchuk, 1985; Low, 2011; Yao, 2000). Fruehauf (1999) created one of the most comprehensive and clearly produced tables outlining the characteristics, in terms of knowledge and beliefs, of TCM acupuncture. The one provided below (Table 8.3) is a summarisation of Furehauf's and other authors' work alongside the findings relating to TJM acupuncture values and beliefs from this study.

Table 8.3 Summary of Differences: Beliefs and Values in TCM and TJM Acupuncture

	TCM Acupuncture	TJM Acupuncture
Beliefs & Values		
	Confucianism	Zen Buddhism
	Taoism	Effect through technique
	Buddhism	Instant effects of treatment
	Modern science and technology	Anatomical areas of significance
	Western politics	Resolution of abnormalities
	Sustainable development	Minimal stimulation
	Herbal based methods	Patient comfort and customer service

Aside from personal discussions of Zen as it may be related to acupuncture (Moore, 2012; Turetsky, 2010) and Buddhist styles of TJM acupuncture (Fratkin, 1997; Takahashi, 2012), the values and beliefs of TJM acupuncture are largely ignored in the literature in favour of the description of knowledge and skills. This study is the first research to describe beliefs and values in TJM acupuncture and has paid particular attention to highlighting these important aspects (Chapter 5). The beliefs and values of TJM acupuncture were interpreted to closely connect to, and inform, skills and knowledge application. Acupuncture education should include a thorough examination of the inherent beliefs and values of acupuncture practice, and not just knowledge and skills. Developing an understanding of beliefs and values may promote awareness about how these are manifested in clinical actions and inform clinical reasoning through cognitive biases.

This study suggests that TJM acupuncture beliefs and values could be taught and successfully integrated with acupuncture practice outside of Japan, especially:

- Effect through technique
- Instant effects of treatment
- Minimal stimulation over many treatment sites
- Resolution of abnormalities

These values and beliefs do not rely on a commitment to any spiritual or religious agenda nor is there any need for subscription to TEAM, biomedical or orthopaedic models. However, it may be useful that methods and techniques based on these values be trialled for clinical efficiency in future research in order to assess if and when they have a therapeutic effect.

Styles

Part of the theoretical framework of this study is the hypothesis that philosophical concepts inform diagnostic methods and treatment principles which in turn challenge or verify philosophical concepts through clinical experience. This constant feedback is believed to be the process for the establishment of rules of practice which depend on cultural environments and become socially embedded over time. Variability in practice is believed to emerge as a result of different emphasis of unique combinations of clinical elements. Combinations of these clinical elements became popularised and formed particular styles of treatment.

Some TJM acupuncture styles identified in the data are consistent with discussion in published English language literature: Ishizaka, Meridian Therapy, Mubun, Sugiyama, Taikyoku and Tanioka styles. These styles may be more popular than other styles reported by this study. There is a possibility that historical factors, lineage, publication power and lucky timing gave national significance to certain styles of TJM acupuncture which helped them spread domestically and internationally.

The Meridian Therapy style has been popularised in the literature and is described as representative of TJM acupuncture (Birch, 1994; Birch, 1997; Birch,

1999; Bishop, 1999; Dann, 2000; Dreu, 1995; Drue, 1994; Fratkin, 1995; Hayden, 1998; Hayden, 2001; Ikeda, 1999; Jansson, 2001; Kaneko, 1998; Kenner, 1994; Loew, 2000; Maeda, 1998; Murata, 2001; Murata, 2006; Ogawa, 1996; Ogawa, 2013; Ohue, 2010; Okabe, 1998; Okada, 2004; Ota, 2011; Pershouse, 1997; Petrucci, 2014; Romano, 1994; Seem, 1995; Takahashi, 1995; Williams, 2007; Wolf, 2009; Yackel, 2008; Yanagishita, 2001a). However, results from this study indicate that although Meridian Therapy informs the practice of some TJM acupuncture practitioners (especially those operating from the TEAM model of medicine), Meridian Therapy is not representative of TJM acupuncture in general and it may in fact be a minor part of the discipline even among TEAM acupuncture model practitioners. This argument is consistent with that presented by some Japanese authors (Matsuda, 2013; Takashima, 2013), but especially with Ogawa, Katai and Shinohara (2004) and Ogawa, Katai and Minowa (2011). Rather than the Meridian Therapy style, the efforts of three dominant individuals have probably had more influence on TJM acupuncture, particularly in the practice of TEAM model practitioners: Isai Misono, Waichi Sugiyama and Bunshi Shirota.

Isai Misono, Waichi Sugiyama and Bunshi Shirota have all advocated somewhat contrasting approaches to TJM acupuncture throughout TJM acupuncture history. Yet between them, they have possibly been the greatest influences on modern TJM acupuncture philosophy and practice. Isai Misono was a practitioner in the early 16th century (Matsumoto, 2000; Takahashi, 2003) who diverged from traditional Chinese medical theory by generally ignoring the theory of channels and collaterals to focus diagnosis and treatment almost exclusively on the abdomen by using a single, large blunt needle (dashin) that was repeatedly tapped around the abdomen with a mallet (Vigouroux, 2008a). Isai Misono's style of treatment became one of the defining features of TJM acupuncture. However, the general abandonment of TEAM knowledge by Isai Misono, somewhat conflicts with the teachings of Waichi Sugiyama (17th century). Waichi Sugiyama developed the needle guide tube, and techniques surrounding its use, while also closely following traditional Chinese medical knowledge (Vigouroux, 2008a). Although Waichi Sugiyama carefully adhered to traditional Chinese medical knowledge, he diverged from the Chinese acupuncture tools and techniques to focus on a treatment style which emphasised practitioner sensitivity. Finally, in the post-World War II period,

Bunshi Shirota began a rejection of certain aspects of TEAM knowledge and made a move away from some of the classical concepts such as the channels and collaterals, and focussed on what could be felt directly in the patient, such as responsive or abnormal body tissue (Ogawa, 1999; Yasui, 2010a). Bunshi Shirota seemed to combine elements from the teachings of Isai Misono and Waichi Sugiyama, and combine them with biomedical ideas to create a unique modern approach to acupuncture. Isai Misono, Waichi Sugiyama and Bunshi Shirota have links to the Mubun, Sugiyama and Taikyoku styles of TJM acupuncture, and it is these styles which are probably more representative of acupuncture in Japan than Meridian Therapy.

Due to the high numbers of successful TJM acupuncture registrants in Japan, it seems that the industry is highly competitive. This can be compared to Australia where there are a total of 4603 registered acupuncture practitioners (Chinese Medicine Board of Australia, 2015); in Japan the yearly rate of new registrants alone is more than the entire number of registered practitioners in Australia. Not only are practitioners in Japan competing against each other for business, but probably against other complementary and alternate medical services as well. This competition may be an important influence on the practice of acupuncture and moxibustion in Japan. The struggle for success in a competitive market might have contributed to the evolution of a variety of uniquely Japanese philosophical concepts, diagnostic methods and treatment principles designed to occupy a niche or capture an edge over competition in the market.

Ido no Nippon is a popular journal of acupuncture and moxibustion in Japan. Surveys were conducted through *Ido no Nippon* in 1971, 1978 and 1993 which tried to assess the main diagnostic and treatment methods used by practitioners (Ogawa, 1998). Ogawa (1999) summarises the results of the surveys and the situation of acupuncture and moxibustion in Japan by stating that the practice of TJM acupuncture is:

. . . Focused on body realignment based on Western Medical diagnosis and treatment of affected muscles, nerves, blood vessels and tender point and indurations. From an overall perspective, all forms of Meridian Therapy

(including Shudo style, Toyohari style and Nagano style) make up only a minor part of Japanese acupuncture.

It seems that by 2011, the situation has changed little. According to Ogawa et al., (2011) the styles used in modern day acupuncture practice in Japan can be broken into several basic approaches: Eclectic (a combination of modern Western and TEAM theories), Modern Western (based on Western medicine or anatomy and physiology), Meridian and classic theory, TCM and others. Table 8.4 was developed by combining Japanese survey data from 1994 and 2004 presented in Yamashita and Masuyama (2010) with survey data from Ogawa et al., (2011).

Table 8.4 Styles Reported by Practitioners in 1994, 2004 and 2011

Style mainly used in clinic	% of practitioners surveyed 1994	% of practitioners surveyed 2004	% of practitioners surveyed 2011
Eclectic		42	43.3
Modern Western	32.9	37	19.3
Meridian and Classic theory	23.3	9	17.8
TCM	2.5	4	3.1
Others		8	6.8

Data from this study correlates with the results from these surveys, suggesting that the majority of TJM acupuncture practice is an eclectic style which incorporates a combination of modern medicine and classical theories. This study also finds agreement with Yamashita and Masuyama (2010) who state that although Meridian Therapy may be representative of TJM acupuncture for some non-Japanese acupuncture practitioners, TJM acupuncture is based more on an eclectic approach consisting of biomedical and traditional strategies for treatment. It should be emphasised that TJM acupuncture is not equal to Meridian Therapy.

This investigation reports previously unknown styles of TJM acupuncture (Chapter 5). The styles which were discovered in this study may not be found anywhere else in the country or may never be mentioned in future research discussing TJM acupuncture styles again. The tradition of a student naming a style after their master may have contributed to the existence of many unofficial or family

styles relatively unknown by most people. Some of these styles may be transmitted only to a single student from a master. This student may study under a number of different masters and develop a unique approach to treatment which they pass on to students of their own who name the style after that master. In such a fashion, a vast number of transient styles are born and die over the course of several generations of TJM acupuncture practitioners.

8.1.2 Diagnostic methods

In relation to diagnostic methods, the literature describes TCM acupuncture as relying on the four examinations with an emphasis on pulse palpation, observation of the tongue, and the clinical interview which result in a detailed pattern of disharmony (Ahn et al., 2007; Dong & Zhang, 2001, p. 18; Flaws, 1992; Kaptchuk, 1985; Kim et al., 2011; MacPherson et al., 2010; Yu et al., 2006). In comparison, results from this study indicate that TJM acupuncture (especially in relation to the TEAM model of medicine) highlights the clinical inquiry, pulse and body tissue palpation (including anatomical areas of significance), which may result in simple and multiple patterns of disharmony.

Point selection and patterns of disharmony

Pattern differentiation described in TEAM terms by TJM acupuncture practitioners appeared less complicated than in TCM acupuncture. In TCM acupuncture, a diagnosis consisting of a complex series of pathologies including multiple organs, vital substances and pathogenic factors is common. In addition, a detailed treatment principle may be prescribed according to the main complaint and final diagnosis in TCM acupuncture (Table 8.5).

Table 8.5 Example of Diagnosis and Treatment Principles in TCM Acupuncture

Diagnosis	Treatment Principle
Spleen Qi and Liver Blood deficiency with Damp Heat invading the Gall Bladder	Nourish Spleen Qi and Liver Blood, clear Damp Heat from the Gall Bladder and relieve pain

The above formula gives the practitioner a detailed script addressing the complex interactions between aetiology, symptoms, the location of disease and pathophysiological processes. The diagnosis provides the practitioner with a platform from which they can deduce the most appropriate formula of points to address the complete pattern of disharmony based on the category, actions and indications of acupuncture points while considering patient history and possible aetiologies.

In apparent contrast to TCM acupuncture, TJM acupuncture practitioners in this study did not always make attempts to fit all signs, symptoms or abnormalities into a single pattern of disharmony, nor did they always make an effort to explain aetiology. TJM acupuncture practitioners tended to formulate simple patterns of disharmony and probably as a result, diagnosed patients with a number of different patterns of disharmony throughout the clinical encounter. The use of simple patterns of disharmony also resulted in the formulation of simple diagnostic outcomes and principles of treatment, with seemingly less direction than those in TCM acupuncture.

More diagnostic details included in a pattern of disharmony provide practitioners with more clues about which points are appropriate to incorporate or exclude in a treatment point formula. When diagnosing a detailed pattern of disharmony, practitioners with a comprehensive understanding of acupuncture point actions and indications can deduce a point formula which addresses the diagnosed pattern of disharmony and the treatment principle. This may be further refined by relying on their own, peers, teachers or empirical acupuncture points well-known for their general actions and indications. In contrast, minimally described patterns of disharmony contain fewer indicators to guide the point selection process and a great many number of points may appear to be appropriate.

This is similar to finding a location by postal address: the more details there are describing the exact location, the easier it is to find. Consider trying to locate a specific TJM acupuncture clinic in “Osaka, Japan” compared to “#403 Grand Annex Building, 1-12-7, Ju Hachi Jo, Yodogawa Ward, Osaka City, Japan, 532-0001”. With the latter address, one may go directly to the location but with the former example, a lot of additional searching and investigation is required. In TJM

acupuncture, patterns of disharmony are probably less descriptive because TJM acupuncture practitioners considered searching for the appropriate location an important aspect of the clinical encounter. They also appeared to prefer to make use of a small selection of famous points, well-known for their general actions.

The lack of direction in treatment objectives apparently resulted in some TJM acupuncture practitioners diagnosing and treating in a manner of trial and error, constantly confirming the effects of interventions to see if they had reached their treatment objectives. This could be perceived as clumsy diagnostic skill. However, it is indicative of the value of applied technical skills over the theoretical knowledge of actions and indications of treatment locations, and value in the belief that the patient's condition can change in immediate response to appropriately applied interventions.

Diagnostic methods resulting in basic patterns of disharmony that focus on the simplest tangible qualities of disease may allow a practitioner to have greater success in recognising differences pre and post treatment. Recognising treatment effects instantly could be difficult with a diagnoses resulting in a complicated pattern of disharmony, which is relatively common in TCM acupuncture. Perhaps this is why the belief in instantly recognisable effects of treatment, especially relating to acupuncture, does not seem to be a feature of TCM acupuncture.

Diagnostic methods and procedures

In contrast to other literature (Ahn et al., 2007; Anryu, 2002; Birch, 1997; Fukumoto, 2006; Goto, 2005; Katai, 2006; Katai, 2010b; Kobayashi, 2001; Kobayashi et al., 2008; H. Matsumoto, 2000; Mizutani, 2012; Nagato, 2000; Ogawa, 1996; Shudo, 2000; Yasui, 2010b) which emphasises palpation and observation as the most important diagnostic methods in TJM acupuncture, there is evidence to suggest that inquiry is an equally significant method in forming diagnostic conclusions. The importance of the clinical interview has probably been understated in the current published English language literature. The literature generally focusses on discussions of skills and techniques; inquiry employs less obvious skills and is more abstract than observable methods such as palpation. However, the motivations for lines of inquiry and the meaning given to patient answers is important and

representative of many aspects of the TEAM model of TJM acupuncture, especially when inquiry results in the formation of a pattern of disharmony. The importance of inquiry in TJM acupuncture is probably a similarity with TCM acupuncture diagnostic priorities.

In addition to inquiry, observation was also found to be an important method of diagnosis in TJM acupuncture. This is consistent with previous literature (Birch, 1997; Goto, 2005; Kobayashi, 2001; Nagato, 2000; Ogawa, 1996; Seki, 2008; Toda, 2005). Specifically, this study identified that observation was used to:

- Give general indicators about disease states
- Select areas to be investigated with palpation
- Contribute information to forming patterns of disharmony

Examination by observation identified abnormalities in body structure, movement and colours. When observation was directed to the tongue, diagnostic markers based on the colour, shape and other features appeared important. In common to literature discussing tongue diagnosis in TJM acupuncture (Murata, 1999; Nagato, 2000; Scanlon, 1996; Seki, 2008; Shudo, 2000; Toda, 2005) it was identified as present within the diagnostic repertoire of TJM acupuncture practitioners. However, practitioners in this study did not commonly use tongue diagnosis, and when they did, it was apparently used differently to the standard method in TCM acupuncture.

Tongue diagnosis in TCM acupuncture may contribute to patterns of disharmony by identifying one or more diseased organs, or channel based locations with one, or often more pathogenic factors. In TJM acupuncture, tongue diagnosis appeared to result in simple descriptions of illness similar to how patterns of disharmony were described in general: a viscera, bowel or fundamental substance excess or deficiency, in addition to the possibility of a pathogenic factor. The tongue was also often divided into zones representing the upper, middle or lower areas of the body (also present in TCM acupuncture) rather than zones representing viscera or bowels. Using the tongue to confirm the effects of treatment in TJM acupuncture is also in contrast to TCM acupuncture, where it is generally regarded that the tongue changes too slowly to show any differences post treatment. Tongue observation is probably not a major diagnostic method in TJM acupuncture. It is not

clear why tongue observation is not a preferred diagnostic method among TJM acupuncture practitioners in this study. However, practitioners in this study reported that tongue observation was much more important for Japanese herbal medicine practitioners than TJM acupuncture practitioners. This correlates with other ethnographic accounts of Japanese herbal medicine (Ohnuki-Tierney, 1984, p. 93).

The results of this study confirmed those of other authors (Ahn et al., 2007; Anryu, 2002; Birch, 1997; Fukumoto, 2006; Goto, 2005; Katai, 2006; Katai, 2010b; Kobayashi, 2001; Kobayashi et al., 2008; H. Matsumoto, 2000; Mizutani, 2012; Nagato, 2000; Ogawa, 1996; Shudo, 2000; Yasui, 2010b) who regard palpation as a significant diagnostic method in TJM acupuncture. In relation to palpation, two general categories were interpreted from the data: pulse and body palpation. A strong and recurring theme in the published English language literature is the importance of six position pulse diagnosis. Although it was found that six position pulse palpation is a common diagnostic method among TEAM model practitioners, its importance is probably overstated in the literature; three position pulse palpation is probably equally important for TEAM model practitioners. However, pulse palpation in general may only be performed by practitioners who are committed to the TEAM medical model.

The general characteristics of radial pulse palpation used in TJM acupuncture are probably similar to those used in other TEAM acupuncture styles. However, palpating both radial pulses at once with the patient supine may be a unique feature of TJM acupuncture. This kind of radial pulse palpation technique found to be performed by TJM acupuncture practitioners in this study directly contrasts with what is considered correct TCM acupuncture procedure in foundational English language textbooks (Figures 8.1 and 8.2 in Maciocia, 2006, p. 359).

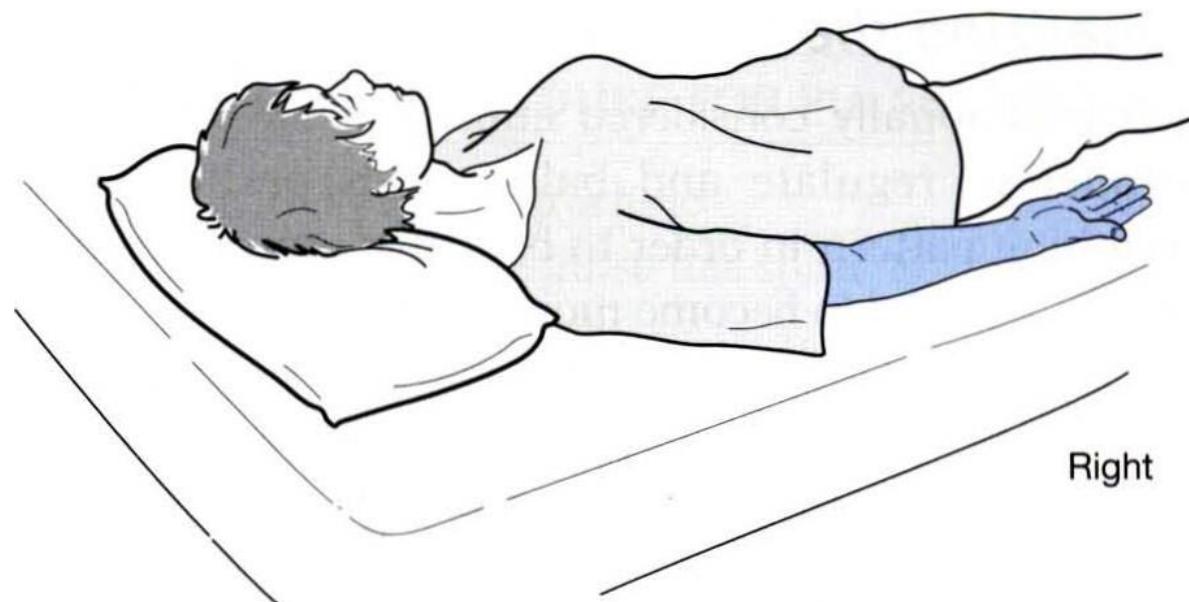


Figure 8.1 Correct pulse palpation method in TCM acupuncture (Maciocia, 2006, p.359)

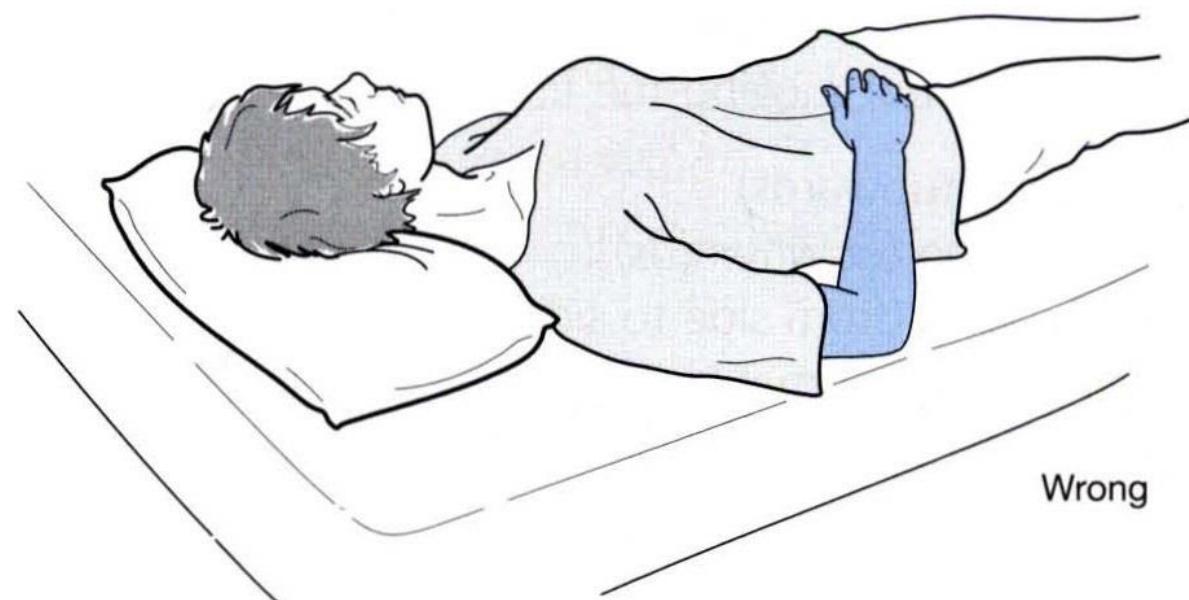


Figure 8.2 Incorrect pulse palpation method in TCM acupuncture (Maciocia, 2006, p.359)

Essentially, such textbooks describe palpating both radial pulses at once with the patient supine (Figure 8.3), as is found in TJM acupuncture, as incorrect.

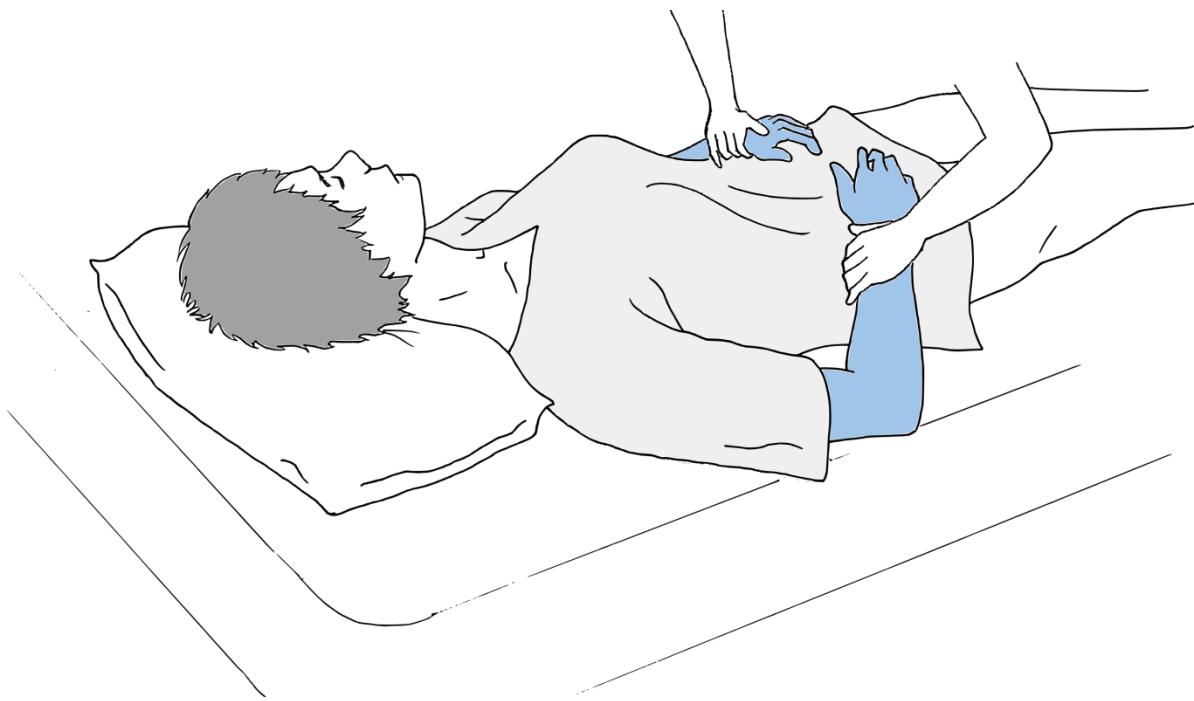


Figure 8.3 Simultaneous wrist pulse palpation method in TJM acupuncture

In addition to pulse palpation performed simultaneously at both wrists, the palpation of only a single radial pulse may also be a unique feature of TJM acupuncture. In such methods, the assignment of pulse positions to different viscera and bowels is ignored. Disregarding such a foundational diagnostic theory may also contrast with TCM acupuncture. While pulse palpation may be limited to certain groups of TJM acupuncture practitioners, body palpation seemed ubiquitous among all groups.

Findings from this study complement the literature which discusses the importance of body tissue palpation in TJM acupuncture (H. Matsumoto, 2000; Kubota, 2007; Obaidey, 1996; Shirota, 1998; Takahashi, 2003; Tanioka, 1997). It was found that body tissue palpation appeared to be important when practitioners prioritised anatomical areas of significance. Analysis also confirmed literature commenting on the importance of abdominal, channel, point and skin palpation (Ahn et al., 2007; Anryu, 2002; Fukumoto, 2006; Goto, 2005; Katai, 2006; Katai, 2010b; Kobayashi, 2001; Kobayashi et al., 2008; H. Matsumoto, 2000; Mizutani, 2012; Nagato, 2000; Shudo, 2000; Yasui, 2010b). Although abdominal palpation was found to be used by TEAM model practitioners, non-TEAM model practitioners were rarely found to apply it. It is probable that the absence of abdominal diagnosis in non-TEAM medical models, especially for acupuncture and judo therapy

practitioners, means that although abdominal palpation is a uniquely emphasised diagnostic method in TJM acupuncture, it might not important for the majority TJM acupuncture practitioners in Japan.

In addition to abdominal palpation, channel and acupuncture point palpation were found to be performed to locate abnormalities or treatment sites. This research corresponds with that of Kawakita, Okada and Kawamura (2005) who state that palpation of the skin, especially for abnormally hard areas of tissue, is important in TJM acupuncture. Except for one notable exception (Wang & Robertson, 2008), this kind of palpation does not seem to be highlighted in the literature as a feature of TCM acupuncture. Additionally, this study reports that in TJM acupuncture, sites of tissue abnormality are often considered more important, and are often selected as treatment sites more regularly than traditional channel based acupuncture points by TJM acupuncture practitioners.

Abnormal areas of body tissue were not usually palpated in order to contribute diagnostic information to a pattern of disharmony. In relation to body tissue palpation, the resolution of abnormalities is probably valued more strongly than the motivation to combine and reconcile as many signs and symptoms as possible to formulate an overall pattern of disharmony in TJM acupuncture. Locating and remedying abnormal body tissue on diagnostically or therapeutically significant areas, such as the skin, abdomen or spine, is an acceptable method of diagnosis and treatment by TJM acupuncture practitioners. This is probably not a major feature of TCM acupuncture unless the body area is the site of the main complaint for the patient.

In common with the literature, this study found that listening/smelling was the least performed and least significant diagnostic method in TJM acupuncture. Listening to the voice and listening to body sounds is described by some authors as a diagnostic method in TJM acupuncture (Nagato, 2000; Shibata, 2001). Although such methods were not apparent in the results of this study, it does seem reasonable that some practitioners may employ such methods. However, comparable to other literature (Ingengo, 2006; Tanioka, 2000), auscultation of abdominal percussion was found to be performed. Auscultation of abdominal percussion may be a unique feature of TJM acupuncture diagnostics. Smelling the

patient on the other hand, does not appear to be a common diagnostic method in TJM acupuncture; no practitioners in this study were found to actively smell patients to inform diagnosis. Smelling the patient was one of the least used diagnostic methods in TJM acupuncture, which is probably true for TCM acupuncture as well.

Diagnostic methods not easily categorised into the traditional four examinations were also evident in the data. These include esoteric, biomedical or orthopaedic based diagnostic methods. The presence of esoteric, biomedical or orthopaedic diagnostic methods in TJM acupuncture represents the diversity of education and individual practitioner allegiances.

Esoteric methods described in the literature, such as *tekazashi* (Takahashi, 2003) and applied kinesiology (Manaka, 2006a), were observed in clinics. The esoteric methods identified in this study were interpreted as being based on a sense of spirituality, the belief in, and awareness of Ki, and on using oneself as the diagnostic medium. Additionally, intuition or insight was reportedly used by TJM acupuncture practitioners in this study. Some practitioners provided explanations about intuitive judgements related to the feeling of Ki as the basis for their decisions, while others gave no motivations for judgements based without conscious reasoning. The use of intuition as an esoteric method of diagnosis was interpreted to depend on a practitioners' awareness of Ki or their belief in some spiritual preternatural phenomenon. In addition, intuition could be attributed to other psychological factors including subconscious memories of knowledge and clinical experiences, and was therefore not defined as an esoteric method of diagnosis in this study. However, when practitioners diagnosed patients using their intuition, it was probably due to what they understood as an acute sense of Ki awareness. This acute awareness parallels the way diagnosis is performed through direct palpation and reinforces the importance of practitioner sensitivity in TJM acupuncture. The use of intuition or awareness of Ki in diagnosis is also probably present in TCM acupuncture.

Biomedical and orthopaedic neurological (reflex, iris), strength, balance, flexibility, reflex, movement and pain tests were confirmed to be used by TJM acupuncture practitioners as stated in the literature (Kobayashi, 2001; Matsumoto, 2002; Murata, 1999; Nagato, 1999; Scanlon, 1996; Shudo, 2000). Sometimes the

results of these biomedical and orthopaedic diagnoses were translated into a pattern of disharmony. However, the majority of cases seemed to be understood through modern anatomy and pathophysiological processes. This study defines how these were generally used, and identifies that acupuncture and judo therapy practitioners, or acupuncture practitioners not committed to the TEAM model were more likely to use such diagnostic methods. This may be related to the conditions patients commonly presented with to such practitioners and the laws surrounding health insurance and rebates.

Diagnosis and treatment

Diagnosis and treatment were not always performed sequentially; they were interactive processes with mutually dependent qualities. A fluid transition between diagnosis and treatment was seen to occur during the clinical encounter. This was especially so with palpation and observation, and to a lesser extent with inquiry and listening/smelling. Following one of the four diagnostic methods, typically after having made some inquiries or feeling the pulse, some TJM acupuncture practitioners applied an intervention to a specific location to aid differential diagnosis. This involved treating a certain location and then re-evaluating the signs and symptoms through their preferred diagnostic methods. If there was an improvement, this confirmed their diagnosis. However, if there was no improvement then an alternate approach was taken until the practitioner either made some improvement in the patient's condition or changed approach.

Treatment tested differential diagnosis relied on the diagnostic skills of the practitioner to notice potentially minor improvements or changes in the patient's condition pre and post application of interventions. It was also dependent on experience and confidence in selecting an appropriate test point and the practitioner's ability to achieve an immediate tangible effect on the patient through their preferred treatment intervention. TJM acupuncture practitioners also believed that improvements in their personal skill level could lead to faster diagnosis and treatment times. The importance of practitioner skills and confidence in the immediate effects of interventions is a feature of TJM acupuncture. This phenomenon is described and analysed for the first time in research literature related to TJM acupuncture by this study.

Although TCM and TJM acupuncture use similar diagnostic methods, there are procedures which are emphasised differently between the styles. Table 8.6 shows probable main points of difference in diagnostic methods between TCM and TJM acupuncture.

Table 8.6 Summary of Preferences: Diagnosis in TCM and TJM Acupuncture

	TCM Acupuncture	TJM Acupuncture
Diagnostic Methods	Primacy of the 10 Questions	6 Position Pulse Palpation
	Tongue Observation	Single/No Pulse Palpation
	Pulse palpation	Skin Palpation
	Detailed Patterns of Disharmony	Simplified or No Patterns of Disharmony
		Diagnosis of Abnormality
		Abdominal Palpation & Percussion

8.1.3 Treatment principles

Treatment principles are discussed in five themes which represent stages of clinical interaction between the practitioner and patient:

- Treatment tools
- Pre-intervention preparation
- Needling
- Moxibustion
- Confirmation of effects

Treatment tools

In relation to needles, the literature describes TCM acupuncture as utilising thick needles which are inserted deeply and manipulated so that a strong stimulation is solicited (Ahn et al., 2007; Birch, 1994; Dale, 1997; Dann, 2007; Deadman et al., 2009; Dong & Zhang, 2001, p. 18; Flaws, 1992; Kaptchuk, 1985; Katai, 2010b; Kobayashi et al., 2008; Lao, 1996; MacPherson et al., 2010; Manaka, 2009; Okabe, 1998; Romano, 1994; Yasui, 2010b). It could be assumed that needles used in a

non-TJM acupuncture setting should be larger and longer in order to cause greater stimulation and be inserted deeper. Although it was found that needles up to 0.30 mm in diameter and 50 mm long were, on occasion, employed by TJM acupuncture practitioners (similar to reported needle sizes in China [Dann, 2007; Katai, 2010b]), those in this study generally used relatively thinner and longer filiform needles. This could be attributed to a difference between the needling techniques of TJM acupuncture practitioners in Japan and TEAM acupuncture practitioners outside of Japan.

Shorter and thicker needles may be easier to insert deeper than longer thinner needles. The decrease in resistance to bending of shorter and thicker needles means that they are less likely to bend on insertion, making them easier to insert deeper. Single handed needle reloading into the guide tube may also be a significant factor which warrants the use of longer needles; longer needles are easier to withdraw and reload single handed into guide tubes than shorter needles. In regards to thinner needles, the smaller diameter size popular with TJM acupuncture practitioners could provide a greater level of sensitivity for feeling tissue through the needle than a thicker needle, while also decreasing the likelihood of patient discomfort. The values of immediately perceivable effects, confirmation of treatment effects and the importance placed on the ability to sense subtle changes in the condition of the patient, as well as on patient comfort, make relatively longer, thinner filiform needles an important tool in TJM acupuncture. As a result of describing and analysing culturally embedded beliefs and values with clinically relevant diagnostic methods and treatment principles, this insight is reported for the first time by research related to TJM acupuncture in this study.

This study confirms literature (Dann, 2007; Katai, 2010b; Kobayashi et al., 2008; Manaka, 2009; Oura, 2007) that discusses how the needles generally used in Japan are inserted with the assistance of guide tubes. Additionally, by providing details about methodological procedures relating to insertion, manipulation and withdrawal, why and how guide tubes were used, are described (see Chapter 7). From the literature, it is difficult to know how prevalent guide tube use is in TCM acupuncture in China. However, in Western countries such as Australia, Britain and the USA, it appears that plastic guide tubes are gaining popularity to assist needle insertion. Despite the emerging popularity of disposable plastic guide tubes

internationally, the use of metal guide tubes to not only assist insertion, but also have therapeutic treatment effects, is a unique feature of TJM acupuncture in Japan.

Discussion surrounding moxibustion tools and techniques in TCM acupuncture is not as fully explored in the literature as that of needling tools and techniques. However, it appears that in TCM acupuncture, more use is made of larger amounts of lower grade moxa floss and raw floss moxa sticks compared to TJM acupuncture (Chant, 2016; Huang, 2016; Matsumoto et al., 2016; Wheeler, Coppock & Chen, 2009). This study agrees with other authors (Fukushima, 2008; Honda, 2003; Kobayashi, 2002; Kokubo, 2003; Matsumoto, 1997; Menjyo, 2011; Mizutani, 1994; Mizutani, 2014; Murata, 1999; Ohara, 2011; Ota, 2011; Seki, 2011; Suzuki, 2015) who state that TJM acupuncture practitioners tend to use small amounts of higher grade moxa floss when applying moxa. Additionally, this study reports that stick-on moxa was also commonly used in TJM acupuncture clinics, as well as by lay people in general society. A range of specialised moxa assistant tools were also found to be used by practitioners in this study (see Chapter 7); these may be unique to TJM acupuncture. Detailed instruction about construction and application of moxa cones, and the use of other moxa tools in TJM acupuncture clinics and general Japanese society has, until this study, been absent from research literature related to TJM acupuncture.

Consistent with the majority of TJM acupuncture related published literature, practitioners in this study routinely used needles and moxa. However, this study also found that at times, TJM acupuncture practitioners did not use either needles or moxibustion; practitioners operating from the TEAM model were found to use a range of non-inserted contact tools, and those committed to the orthopaedic model included manual methods combined with electronically operated equipment to facilitate treatments. That needles and moxa are not always necessary (or desired) in treatment, is a unique feature of TJM acupuncture and one of the greatest contrasts in tools with TCM acupuncture. In contribution to the literature about teishin and friction tools (Birch & Ida, 2015; Funamizu, 2015; Hayden, 1997; Kawase, 2012; Kudo, 2005; Kuwahara & Nakano, 2015; Manaka, 2002; Nishijima, 2003; Quinn, 2014; van Huffelen, 2015; Yanagishita, 2001b) this study explored and described, for the first time in research related to TJM acupuncture, the details

of exactly how and why these are used (Chapter 7). The elucidation provided here is an important addition to literature describing non-needle techniques in TJM acupuncture.

TJM acupuncture practitioners were found to employ machines similar to those used in physiotherapy, especially practitioners who did not use needles, contact tools or moxibustion as their main treatment tool. There seemed to be a significant professional crossover between some aspects of physiotherapy and the practice of acupuncture and judo therapy practitioners. The use of specialised electronic equipment is demonstrative of the acceptance and inclusion of modern orthopaedic treatment methods in TJM acupuncture practice. Electronic needle stimulators were found to be present in clinics. Their use contrasts with the way in which non-electrical stimulated needle practice is performed in TJM acupuncture: longer needle retention times, deeper insertion and stronger stimulation. This emphasises diversity in TJM acupuncture in relation to treatment tools and methods used in their application. Table 8.7 shows the likely main points of difference in tools used between TCM and TJM acupuncture.

Table 8.7 Summary of Preferences: Tools in TCM and TJM Acupuncture

	TCM Acupuncture	TJM Acupuncture
Tools	Thicker needles	Thinner needles
	Lower grade moxa floss	Longer needles
		Guide tubes
		Higher grade moxa floss
		Contact tools

Pre-intervention preparation

The rules which guide point selection in TJM acupuncture are described as being based on five phase theory and either guided by the principles of tonifying deficiency or reducing excess (Anryu, 2002; Ikeda, 2001; Ikeda, 2002; Kajima et al., 2008; Katoh, 2008; Kawase, 2012; Kudo, 2005; Menjyo, 2012; Mizutani, 2012; Ota, 2011; K. Suzuki, 2004; Yanagiya, 2002). Results of this study correspond to this

literature and contribute that specifically in regard to TEAM knowledge, TJM acupuncture emphasises the connections and associations between channels: particularly those of the five phases on the regular channels and the extraordinary channels. However, the biggest parallel to the literature was found with Nagato (1999) and the discussion regarding treatment principles: TJM acupuncture practitioners who are committed to the TEAM medical model focus on the patient's overall constitution with the purpose of balancing the pulse or areas of anatomical significance according to five phase and eight principle theory, and treat symptomatically based on palpation informed with health science knowledge.

In general, the actions and indications of points seem to be devalued in TJM acupuncture in favour of finding points which appear abnormal. Compiling point formulas based on the actions and indications of individual points is similar to creating a herbal medicine formula by combining the actions and indications of certain plants to produce desired effects. TJM acupuncture practitioners are more distanced from the philosophy and practice of herbal medicine in comparison to TEAM acupuncture practitioners in countries which combine the education and regulation of acupuncture and herbal medicine. This may contribute to the preference for palpation in selecting treatment locations over theoretical deliberation about which points to choose.

In addition to point selection, point location was also found to be performed at areas of anatomical significance. Meaning was conferred to abnormal findings at areas of significance in different ways. Sometimes meaning was found in terms of the five phases, eight principles, microsystem correspondences or health science knowledge. Additionally this study found that the meaning of an abnormality could be graded against a standard of normality. In such cases, abnormalities were not necessarily categorised as manifestations or symptoms of illness according to any knowledge system; abnormalities were findings which should be remedied in order to improve the patient's specific symptoms or condition in general. In addition to the abdomen and skin being significant areas of anatomy, other body tissues such as the spine, sacrum, occiput and tissue connected to an area of complaint were also important. This research finds correspondence with literature (Matsumoto, 1997; Yamada, 2007) which describes TJM acupuncture as sometimes omitting TEAM knowledge entirely in favour of a more modern health perspective style of

treatment, including use of myofascial trigger points and dry needling. That acupuncture points or treatment locations can be located anywhere, especially if the location exhibits abnormalities, is an important aspect of TJM acupuncture for practitioners committed to any model of medicine.

Point location in TCM acupuncture is generally conducted by performing anthropometric measurements according to traditional knowledge (Deadman et al., 2001; WHO, 2008). These measurements are typically learnt from textbooks which list channels, points and their locations. Although the WHO has published international standards relating to point locations (WHO, 2008) there are a variety of point locations unique to Japan not included in that publication. These TJM acupuncture specific locations were found to be taught in educational curricula and applied in treatment. The differences in point locations between TJM and TCM acupuncture should be officially recognised, clarified and developed more completely in future attempts to standardise acupuncture point locations. TJM acupuncture practitioners also did not tend to perform point location according to anthropometric measurements; they generally marked the location of points by the presence of observed or palpated body tissue abnormalities. This phenomenon is explored in detail for the first time in research related to TJM acupuncture by this study.

In regards to pre-intervention preparation, one of the most unique aspects of TJM acupuncture is the deliberate and specific use of the pressing hand during pre-needling patient contact. This study is consistent with literature discussing the importance of the pressing hand in TJM acupuncture (Honda, 2006; Ikeda, 2001; Katai, 2014; Kawase, 2012; Kudo, 2005; Murata, 2001; Shudo, 2000; Takahashi, 2000; Yanagishita, 2001b). In addition to the current understanding of how the pressing hand is used, this study contributed that needling techniques in TJM acupuncture rely on skilful use of the pressing hand to:

- Prepare the skin for tool application
- Palpate for abnormalities and changes
- Maintain location accuracy
- Insert needles
- Regulate technique

- Hold guide tube or contact tool
- Withdraw needles

The pressing hand was found to be an important aspect of TJM acupuncture which appeared to guide how needling techniques were performed. Exactly how and why the pressing hand relates to the main needling techniques and characteristics of needle insertion and manipulation is detailed for the first time in research related to TJM acupuncture by this study. Table 8.8 shows apparent preferences in pre-intervention preparation between TCM and TJM acupuncture.

Table 8.8 Summary of Preferences: Pre-intervention Preparation in TCM and TJM Acupuncture

	TCM Acupuncture	TJM Acupuncture
Point Selection	Actions/Indications of points	Point/Channel connections
	Viscera/Bowels	8 Principles
	Pathogenic Factors	5 Phases
	6 Levels	Point by point needling
	Point formulas	
Point Location	Anthropometric measurements	Abnormalities are points
Pre-needling		Pressing hand

Needling

This study agrees with the literature (Dann, 2007; Katai, 2010b; Katai, 2013a; Kobayashi et al., 2008; Manaka, 2009; Oura, 2007; Suzuki, 2013) which reports that in general, TJM acupuncture makes use of thin needles that tend to be inserted shallowly, with less emphasis on achieving a needle sensation and that needles are retained for short periods of time. This study also confirms that TJM acupuncture includes very superficial needle insertion and that there are practitioners who consistently only needle superficially. However, not all TJM acupuncture needling is performed superficially; this study found that TJM acupuncture can also include consistent deeper needle insertion (up to four and five centimetres) by TEAM, biomedical and orthopaedic model practitioners. That TJM acupuncture includes deeper needle insertion, is to some extent in conflict with the majority of the

published English literature, and is analysed in detail for the first time in research related to TJM acupuncture by this study (Chapter 7).

After insertion, practitioners manipulated needles to stimulate the treatment location. Needle stimulation was provided through different manipulation methods which were believed to produce alternate effects. Different methods were also used to achieve the same objective when one method was not resulting in the desired effect. This research finds correspondence with other authors (Kokubo, 2016; Shinbara et al, 2011; Suzuki, 2013) who describe a range of different needling methods in TJM acupuncture. In particular, Shinbara et al. (2011) state that there are 17 needle methods in TJM acupuncture which are commonly taught at educational institutions, of which the most basic are single inserting, twisting, rotating, sparrow pecking and retaining. The findings of this study seem to confirm that in general, TJM acupuncture practitioners prefer the most basic kinds of needle manipulations to stimulate treatment sites, thus reinforcing the value of simplicity in TJM acupuncture.

When a needle sensation was required by a TEAM model practitioner, it was usually found to be in connection to Ki. For practitioners with a commitment to the philosophical concept of Ki, less importance seemed to be placed on waiting for Ki to fully circulate than on causing it to start circulating through needle manipulation. TCM acupuncture practitioners seem to value the sustaining of a Ki obtaining feeling (Hui et al., 2007; Langevin & Yandow, 2002; Yang et al., 2013; Zhou & Benharash, 2014), while study findings suggest TJM acupuncture emphasises the awareness of Ki arrival. Some practitioners believed that the arrival of Ki can be felt by the practitioner and not usually by the patient. They also believed that stimulation, sufficient to cause a therapeutic response, had been achieved once a practitioner felt that arrival of Ki. Other practitioners believed that the obtaining of Ki or a needle sensation was required to achieve a therapeutic response and that this response can (and possibly should) be felt by the patient, similar to TCM acupuncture. In order to facilitate the arrival of Ki, the needle was found to be manipulated a number of times. However, needle manipulations involved small, rather than large increments of movements. This probably makes the needle site stimulation feel more comfortable than when performed with large movements.

Study findings indicate that TJM acupuncture includes minimal stimulation needling, but not all TJM acupuncture needling is minimally stimulated.

Some practitioners of TCM acupuncture emphasise “sending” the Ki obtaining feeling in certain directions when stimulating points, sometimes known as propagating sensations along a meridian/channel (Kuo, Lin, & Ho, 2004; Li et al., 2013; Yang et al., 2013). For instance, when needling GB 20, TCM acupuncture practitioners may make a decision about trying to send a sensation to the patient’s nose or to their eyes, depending on the patient’s symptoms. Another example includes needling GB 30, where practitioners may want to stimulate a sensation from the buttocks to either the foot or groin depending on a patient’s symptoms. Although TJM acupuncture practitioners were found to stimulate a Ki obtaining sensation around the needling point itself, they never attempted to send the Ki obtaining feeling to a distal location related to the patient’s symptoms. This is another likely point of difference between TCM and TJM acupuncture in regards to obtaining Ki and needle stimulation.

TJM acupuncture is described as painless and applies minimal needle stimulation (Feldman, 1997; Fratkin, 1998; Ikeda, 2012; Maeda, 1998; Nagato, 1997; Shirota, 2003; Shirota, 2001; Takahashi, 1997; Takahashi, 1998). This study supports observations that describe some TJM acupuncture practitioners as providing mild stimulation during insertion and manipulation. However, findings from this study are to some extent, in contrast with these opinions. Although TJM acupuncture practitioners appeared very careful not to cause accidental pain or discomfort to patients when performing interventions (there were many inherent qualities of tools and techniques which supported the value of patient comfort and customer service), there were times when purposeful solicitation of a needle sensation was desired. TJM acupuncture was sometimes found to be painful or uncomfortable for patients, and some practitioners were also seen to solicit a strong needling sensation. This apparent contrast emphasises the diversity and flexibility of TJM acupuncture. It especially highlights that practitioners accept that treatments can be applied in response to patient reactions or to the patient’s condition; sometimes a patient may require stronger stimulation. However, there is a general belief in TJM acupuncture that not every patient is likely to require such stimulation all the time and that in general, small doses of stimulation is better.

This study confirms literature (Dann, 2007; Katai, 2010b; Kobayashi et al., 2008; Manaka, 2009; Oura, 2007) that discusses how the needles generally used in Japan are retained for a short period of time. Results of this study contribute to the understanding that needles are retained for a short period of time because of the significance given to the arrival of Ki, confirmation of treatment effects on the micro level, and to assist clinic operating procedures. Treating a different location with other tools or procedures while the patient is retaining needles is probably common to TEAM acupuncture in general. However, in TJM acupuncture, the application time of extra tools or methods may be shorter due to a generally short needle retention time.

Short retention times may represent the value of maximum efficiency with minimum effort: doing what is necessary, as economically as possible. However, short retention times are in conflict with some aspects of TCM acupuncture knowledge. According to classical literature, it is suggested that needle retention time be around half an hour so that Ki can fully circulate through the channels (Sun, Eisenstark, & Zhang, 2014, p. 340). TCM acupuncture seems to emphasise the healing actions of individual points and a practitioner's ability to choose them (Choi, Jiang, & Longhurst, 2012; Deadman, Al-Khafaji, & Baker, 2001, p. 8; Xing, Zeng, Li, Zhuang, & Liang, 2013) conversely, TJM acupuncture seems to emphasise a practitioner's ability to find individual points and apply the correct technique at them.

Details regarding needle retention, withdrawal, single handed guide tube reloading and the needling method of tanshi are explained, analysed and described for the first time in research related to TJM acupuncture by this study (Chapter 7). In general, the withdrawal methods of quick-slow supplementation and draining, open-closed supplementation and draining and respiratory supplementation and draining found to be used by practitioners, are not unique to TJM acupuncture. However, the use of the pressing hand (as described in this study) during withdrawal probably is. Additionally, withdrawal and reloading the needle into the guide tube is a unique method of TJM acupuncture used to assist in performing the tanshi method.

TJM acupuncture practitioners found it acceptable that treatment locations can be needled in isolation, one at a time, even when combining points in a

formulaic prescription. In addition, formulaic prescriptions in TJM acupuncture seemed to involve a small number of retained points. However, when points were not retained, TJM acupuncture practitioners preferred to select many treatment sites by searching for locations with abnormalities. That tool manipulation and stimulation is performed in small amounts over many different treatment locations is distinctive of TJM acupuncture. Table 8.9 shows potential preferences in needling technique in TCM and TJM acupuncture.

Table 8.9 Summary of Preferences: Needling in TCM and TJM Acupuncture

	TCM Acupuncture	TJM Acupuncture
Needling	Strong/sustained manipulation	Minimal stimulation
	Deep insertion	Superficial insertion
	Obtaining of Ki	Arrival of Ki
	Sending Ki obtaining sensation	Obtaining Ki is non-essential
	Circulation of Ki	Short retention time
		Hand skill and technical ability
		Single hand needle reloading
		Tanshi
		Small manipulation movement
		Many treatment locations

Moxibustion

In common with literature surrounding moxibustion in TJM acupuncture (Fukushima, 2008; Honda, 2003; Kobayashi, 2002; Kokubo, 2003; Matsumoto, 1997; Menjyo, 2011; Mizutani, 1994; Mizutani, 2014; Murata, 1999; Ohara, 2011; Ota, 2011; Seki, 2011; Suzuki, 2015), this study confirms the distinction between various categories, and use of a range, of moxibustion techniques. To different extents, these categories and techniques are likely present in other TEAM acupuncture styles. However, the way direct moxibustion methods (particularly incomplete and penetrating heat moxibustion) are performed, are probably the most unique to TJM acupuncture. In a practical sense, this is largely related to moxa cone construction, cone application and how heat dosage is managed. This applies

specifically to the key elements identified for the first time in research related to TJM acupuncture by this study: cone size, cone consistency, cone shape, oxygen availability during application, timing of cone removal/extinguishing and pressure applied around the cone during application. The defined rules for the construction of small sized moxa cones (rice grain sized and smaller) with high quality moxa floss that are applied with minimal stimulation and may not necessarily provide any heat stimulation, are unique features of moxibustion in TJM acupuncture.

Some practitioners (especially acupuncture and judo therapy practitioners) tended not to perform direct moxibustion. This was probably due in part to the health rebate system, time intensity, by-products of moxa use (such as smoke and ash) and the availability of other tools (including heat lamps) which were considered to create similar effects more conveniently. As a result, direct moxibustion is probably not a major method of TJM acupuncture in general, which is comparable with discussion by Onishi (2013). The use of moxibustion in TJM acupuncture may be overstated in the literature. Although there seem to be unique elements to moxibustion in Japan, they are probably not used by the majority of practitioners, even those who operate from the TEAM model. This may especially be the case with direct moxibustion methods such as incomplete and penetrating heat moxibustion.

TCM acupuncture seems to include both indirect and direct moxibustion methods (Deng & Shen, 2013). Generally, TCM acupuncture seems to use larger cones of moxa and can include larger doses of heat stimulation than moxibustion in TJM acupuncture (Chant, 2016; Huang, 2016). In relation to direct moxibustion, the emphasis on customer service, patient comfort and hand skill in TJM acupuncture seems to place the responsibility on the practitioner to provide a comfortable yet therapeutic treatment. Comparatively in TCM acupuncture, responsibility appears to be given to the patient to endure a stronger stimulation which will provide a therapeutic outcome if it can be sustained. This study suggests that TJM acupuncture practitioners probably do not use stick or insulated moxa as much as TCM acupuncture practitioners. However, the presence of moxibustion only practitioners in Japan is likely a unique feature of TJM acupuncture. Table 8.10 outlines some likely differences in preferences between moxibustion practice in TCM and TJM acupuncture.

Table 8.10 Summary of Preferences: Moxibustion in TCM and TJM Acupuncture

	TCM Acupuncture	TJM Acupuncture
Moxibustion	Large doses of moxa	Direct moxibustion
	Provision of heat	Rice grain sized cones
	Stick and insulated moxa	Hand skill
		Patient comfort
		Higher grade moxa floss

Confirmation of effects

During and after the application of interventions, TJM acupuncture practitioners tended to confirm the effects of treatment. There is limited discussion outlining the realisation of a therapeutic end point in TJM acupuncture (Ahn et al., 2007; Katai, 2006), although the idea of immediate effects of treatment and confirmation are implicitly implied by some authors (Birch, 2014; Katai, 2013a; Katai, 2013b; Matsumoto, 2013a; Miyakawa, 2015b; Suzuki, 2013; Takashima, 2014). The findings from this study suggest that the confirmation of treatment effects is a significant aspect of treatment principles in TJM acupuncture.

It is the belief in the instantaneous effects of treatment, the value of effect through technique and economy of time and resources which exemplify the philosophical qualities of the confirmation of treatment effects. Practically, this is demonstrated in the varying levels at which confirmation takes place throughout the treatment period: micro, meso and macro. Continually monitoring results of treatment at a range of time and body location increments seems to be an important and unique element of TJM acupuncture practice which is reported for the first time by research related to TJM acupuncture by this study. Conversely, the instantaneous effects of treatment and confirmation of treatment effect does not appear to be a feature of TCM acupuncture.

In regards to TCM acupuncture, discourse surrounding the confirmation of treatment effects is limited. The topic is absent from descriptions of TCM in published English language literature that attempts to clarify, classify or compare TCM acupuncture (Ahn et al., 2007; Barnes, 1998; Chaudhury & Rafei, 2001; Dale,

1997; Deadman et al., 2009; Dong & Zhang, 2001, p. 18; Fruehauf, 1999; Kaptchuk, 1985; Kim et al., 2011; Lao, 1996; Low & Ang, 2010; MacPherson et al., 2010; WHO, 2007; Yu et al., 2006). The absence of a strategy to confirm effects during a treatment in TCM acupuncture may mean that treatment effects are assessed the next time the patient presents at the clinic. It is also possible that the literature is not a true representation of real life TCM acupuncture practice. The confirmation of treatment effects may be assumed to be a healthcare professional's duty. However, exact details about how, when and why confirmation is performed in TEAM acupuncture is generally missing from published literature.

The constant evaluation of how patients respond to therapeutic interventions may be important in advancing the skills of practitioners. Improvement of skill and the development of expertise rely on deliberate application and the frequency, quality and immediacy of feedback (Ericsson, 2014; Kahneman, 2011, p. 241). Increasing proficiency and the professional skills related to affecting and perceiving changes in the patient's condition requires awareness, frequent experience and the instantaneous responses of unambiguous indicators of change. The constant feedback gained by repeated intervention and confirmation may be conducive to rapid gains in expertise. Practitioners of TEAM acupuncture styles who do not attempt to confirm the immediate effects of treatment may seek to obtain feedback over the course of several treatments. The lower frequency of this feedback, spaced sequentially possibly over weeks, lowers the quality of the feedback and is not as useful in gaining clinical experience in regards to what tools, techniques and applications resulted in which clinical outcomes. The acquisition of expertise and skill are much more challenging in such clinical situations because of the long delay between the application of interventions and any perceivable outcomes. The model of constant confirmation performed by TJM acupuncture practitioners which promotes the accrual of immediate feedback could be useful to develop the skills of TEAM acupuncture practitioners in international contexts.

TJM acupuncture practitioners seem to regularly place emphasis on achieving a therapeutic effect at a treatment site immediately. TJM acupuncture practitioners also seem to focus on achieving a therapeutic reaction at abnormal treatment locations and in the patient's condition in general during, and immediately after treatment. This contributes to an increased value on practitioner sensitivity and

techniques including the tanshi method. TEAM acupuncture practitioners outside Japan may expect treatments to have a result sometime after the clinical encounter, perhaps several days later. This expectation could be a product of performing acupuncture according to the philosophies commonly employed in herbal medicine. If a patient is prescribed herbal medicine, they may leave the clinic with a prescription and after a few days of consumption, effects may begin. TJM acupuncture practitioners do not prescribe herbal medicine and may be divorced from the philosophical concepts surrounding its practice.

The confirmation of treatment effects is somewhat correlated to how practitioners applied technical skills to achieve a modification in the patient's condition, practitioner sensitivity, and competence in the perception of changes in condition. If a practitioner was unable to achieve a change, then they may have attempted different avenues of treatment through a process of trial and error by using different techniques or treatment locations. Trial and error emphasises the practitioner's role in the healing process and devalues the belief in the body's natural ability to heal itself. This may be a unique feature of TJM acupuncture.

Preferences for gaining an immediately perceivable result may also be somewhat related to how often patients come to the clinic for treatment. In Japan, patients may attend the clinic for treatment weekly, once a fortnight and even more sporadically. This means that follow up information on the effectiveness of treatments and the opportunities for patients to achieve some therapeutic result during treatment are limited. Table 8.11 shows probable differences in preferences for confirming treatment effects in TCM and TJM acupuncture.

Table 8.11 Summary of Preferences: Effect Confirmation in TCM and TJM Acupuncture

	TCM Acupuncture	TJM Acupuncture
Effect Confirmation	Effects peak after treatment	Immediate effect confirmation
	Confirmation next treatment	Trial and error
		Avoiding overtreatment
		Micro, meso and macro confirmation

8.1.4 Section summary

TJM acupuncture can be basically summarised in four points:

- Acupuncture points themselves do not have an effect; it is through them that an effect is achieved by the skilful application of interventions.
- Textbooks give only rough locations of acupuncture point sites because points exist as treatment locations depending on the condition of the body.
- Points known to be effective for certain conditions should be used and points at anatomical areas of significance are also important.
- Practitioners should match interventions and dosage to the patient's condition. This means that a patient should be treated until a reaction is achieved, but not overtreated.

TJM acupuncture seems to rely less on the actions and indications of points and more on the category of points, location of points and techniques used at point locations. The importance placed on technical skills including point location and needling technique are hallmarks of TJM acupuncture which seems to emphasise practical skills and tangible phenomena.

The findings of this study validate the practice of TJM acupuncture as a distinct and independent style of acupuncture within TEAM and when compared to TCM acupuncture. However, differences or emphasis on different aspects of practice in TJM acupuncture compared to other styles does not mean that TJM acupuncture should be described in terms of those differences or emphases; TJM acupuncture is not the sum of its differences to other styles. Table 8.12 shows a summary of the emphasised and unique philosophical concepts, diagnostic methods and treatment principles which were found in this study.

Table 8.12 Emphasised and Unique Elements of TJM Acupuncture

Philosophical Concepts	Diagnostic Methods
Knowledge	Methods
<ul style="list-style-type: none"> • Five Phases • Primacy of Heat and Cold • Eight Extra Channels • Primacy of Ki • Eight Principles 	<ul style="list-style-type: none"> • Six Position Pulse Palpation • Single / No Pulse Palpation • Skin Palpation • Abdominal Palpation and Percussion
Beliefs & Values	Outcomes
<ul style="list-style-type: none"> • Zen Buddhism • Effect Through Technique • Instant Effects of Treatment • Anatomical Areas of Significance • Resolution of Abnormalities • Minimal Stimulation • Patient Comfort and Customer Service 	<ul style="list-style-type: none"> • Diagnosis of Abnormalities • Simplified / No Patterns of Disharmony
Treatment Principles	
Tools	
<ul style="list-style-type: none"> • Guide Tubes • Longer Needles • Thinner Needles • Contact Tools • Higher Grade Moxa Floss 	<ul style="list-style-type: none"> • Arrival of Ki • Obtaining Ki is Non-Essential • Short Retention Time • Hand Skill and Technical Ability • Single Hand Needle Reloading
Point Selection	
<ul style="list-style-type: none"> • Point/Channel Connections • Eight Principles • Five Phases • Point by Point Needling 	<ul style="list-style-type: none"> • Tanshi • Small Manipulation Movement • Many Treatment Locations
Point Location	Moxibustion
<ul style="list-style-type: none"> • Abnormalities are Points 	<ul style="list-style-type: none"> • Direct Moxibustion • Rice Grain Sized Cones • Cone Construction and Application
Pre-Needling	Confirmation
<ul style="list-style-type: none"> • Pressing Hand 	<ul style="list-style-type: none"> • Micro, Meso and Macro • Immediate Effect Confirmation
Needling	
<ul style="list-style-type: none"> • Minimal Stimulation • Superficial Insertion 	<ul style="list-style-type: none"> • Overtreatment • Trial and Error

8.2 Implications and Future Direction

This section outlines how the findings of this study may be applied to education, clinical practice and future research. The scale of describing the entirety of TJM acupuncture is extensive and multifaceted even on the level of individual practitioners. To generate a more complete understanding with regards to philosophical concepts, diagnostic methods and treatment principles, there is need for more research to allow further assessment of TJM acupuncture in Japan. This section firstly explores implications for education and professional development. A discussion of the implications on research and practice concludes the section.

8.2.1 Implications for education and professional development

The research paradigm developed for this study is a tripartite typology including philosophical concepts, diagnostic methods and treatment principles. Classifying and categorising TJM acupuncture was possible using the framework developed for this study, and in combination with the themes identified in the data could be a successful rubric in the teaching of TJM acupuncture and potentially other TEAM acupuncture styles. This rubric (Table 8.13) outlines the important elements, and categorises, clarifies and conceptualises the philosophical concepts, diagnostic methods and treatment principles of TJM acupuncture. In doing so, a comprehensive system of classification and protocols have been constructed to describe TJM acupuncture through the themes interpreted from the data.

Table 8.13 Rubric for TJM Acupuncture

Philosophical Concepts	Diagnostic Methods
Knowledge	Inquiry
• Structure and Function of the Body	Observation
• Order, Balance, Movement & Cycles	Reading
• Identification and Location of Disease	Palpation
Beliefs and Values	<ul style="list-style-type: none"> • Pulse Palpation • Body Tissue Palpation
• Zen Buddhism	
• Effect Through Technique	Listening
• Instant Effects of Treatment	Smelling
• Anatomical Areas of Significance	Esoteric
• Resolution of Abnormalities	Diagnostic Outcomes
• Patient Comfort & Customer Service	<ul style="list-style-type: none"> • Patterns of Disharmony • Body Tissue Abnormality • Pain and Discomfort
Treatment Principles	
Tools	<ul style="list-style-type: none"> - Needle Retention - Duration - Number of Needles Retained - Tasks During Retention • Withdrawal
• Needles	
• Moxa	
• Contact Tools	
• Others	
Point Selection	<ul style="list-style-type: none"> - Methods
Point Location Procedures	<ul style="list-style-type: none"> - Withdrawal and Reloading
Skin Preparation	Moxa and Techniques
• Pressing Hand	<ul style="list-style-type: none"> • Indirect Moxibustion
• Sterilisation	<ul style="list-style-type: none"> - Stick-on
• Pre-needling and Contact	<ul style="list-style-type: none"> - Stick
• Pre-moxibustion	<ul style="list-style-type: none"> - Insulated
Needling and Techniques	<ul style="list-style-type: none"> - Miscellaneous
• Insertion and Placement	<ul style="list-style-type: none"> • Direct Moxibustion
• Tube Assisted Insertion	<ul style="list-style-type: none"> - Moxa Cones
• Manipulation	<ul style="list-style-type: none"> - Incomplete Moxibustion
- Form	<ul style="list-style-type: none"> - Penetrating Heat Moxibustion
- Depth	Confirmation of Treatment Effects
- Speed	<ul style="list-style-type: none"> • Timing of Confirmation
- Repetition	<ul style="list-style-type: none"> - Micro
- Pressure	<ul style="list-style-type: none"> - Meso
• Retention	<ul style="list-style-type: none"> - Macro

This study supports the literature (Ryan, 2003) which claims that acupuncture curricula should be adapted to reflect local beliefs and values. However, like Talcott (2013), this study also considers it essential that the body of knowledge currently being taught at educational institutions should be expanded so that TJM acupuncture is taught alongside TCM acupuncture in undergraduate training. Acupuncture education in the United Kingdom and Australia has a special focus on clinical practice (Xue et al., 2015). Incorporating the methods and skills of TJM acupuncture into undergraduate training will add to the diversity of skills students may use to confront clinical problems in clinical practice and may improve educational curricula. TJM acupuncture is a highly relevant and unique system of practice that should be incorporated into acupuncture education worldwide. Acupuncture curricula already include some aspects of TJM acupuncture; most notable is the use of guide tubes which were developed in Japan. Acupuncture product suppliers also provide tools internationally which are made and designed in Japan; especially needles, moxibustion products and contact tools.

Although some of these tools have been integrated into clinical practice outside Japan, the use of these tools is probably not being taught as they were intended, nor to their full potential in undergraduate curricula outside Japan. Non-Japanese trained educators may not be competent in the proper use of tools and methods developed in Japan, such as the guide tube needle insertion method. The application of TJM acupuncture tools using knowledge and values from local non-Japanese cultures, a range of TEAM acupuncture styles and other medical models is important in the development of practices suitable in local non-Japanese contexts. However, this study suggests that it would be highly beneficial to firstly have a comprehensive understanding and training in the methods, techniques and skills which underpin these tools so that practitioners can benefit from centuries of tool development and clinical experience from Japan. This understanding and training may better equip practitioners to develop practices suitable to their local contexts. Outside of Japan, educational institutions probably do not have access to the specialists required to teach all the appropriate skills of TJM acupuncture. However, it is important that a way is found to outsource the education of these important aspects of acupuncture to those who can provide adequate instruction. In this way, educational institutions outside of Japan can begin to create their own

experts over time with a self-sustainable professional program, similar to how TCM acupuncture has developed in non-Chinese environments.

Undergraduate acupuncture students from countries such as Australia, commonly have the opportunity to participate in clinical observation and practice in Chinese hospitals through their educational institution's study program. These clinical hours often contribute to the curricula requirements of the degree in lieu of on-campus education. Presently, no educational institutions in Australia arrange for their students to undertake clinical observation or placement in Japan. TJM acupuncture is an important, clinically relevant and internationally appropriate body of knowledge and skills to which acupuncture practitioners should be exposed. It is for these reasons that this study suggests educational institutions all over the world provide opportunities for their students to conduct clinical training in Japan. This was also the hope expressed by many TJM acupuncture practitioners and educational institutions that aspire to co-operate in such ways with foreign acupuncture practitioners in providing meaningful academic and clinical exchange cross-culturally. Additionally, in light of the emerging popularity of TJM acupuncture, a deeper understanding of acupuncture from Japan also appears to be of worth and interest to practitioners worldwide. This understanding is not only of interest, but also essential to develop the knowledge and skills of acupuncture practitioners beyond contemporary limits of education which do not include comprehensive training in TJM acupuncture.

8.2.2 Implications for research and practice

This study explores acupuncture practices that move beyond traditional standards of understanding in the West. TJM acupuncture techniques such as superficial insertion, contact needling and use of contact tools, challenge the contemporary routines of acupuncture practice and research; especially concerned with sham and placebo interventions in clinical trials. There were TJM acupuncture practitioners who based their entire clinical practice around superficial insertion and skin contact methods, especially in the field of paediatrics. This does not validate or justify such practices therapeutically, but in line with other authors, such as Streitberger (2010), it does raise questions over the legitimacy of current sham acupuncture protocols.

The effects of superficial insertion, contact needling and use of contact tools should be thoroughly trialled clinically in future research.

Other TJM acupuncture methods elucidated by this study should also be investigated by future research. Examples of educational and clinically related future research areas include:

- How does the real life experience of Japanese acupuncture practitioners (represented by the rubric of TJM acupuncture developed by this study) compare to acupuncture education curricula in Japan or elsewhere? Are there any inconsistencies, and if so, what are they?
- There may be therapeutic differences in the treatment of symptoms depending on how they are diagnosed: pattern differentiation or palpating for abnormalities may be more beneficial in certain illnesses.
- Do simpler patterns of disharmony, combined with the selection of palpated body tissue abnormalities have any benefits (therapeutically or for promoting practitioner competence) over more complicated patterns of disharmony treated by considering the actions and indications of acupuncture points?
- Do tympanic alterations in abdominal percussion correlate to measurable levels of health and wellbeing?

In addition to raising questions, there were some that this study was unable to adequately provide evidence to answer. The research question of how patient records, clinic documents and other locally sourced literature reflect case management, and the philosophical concepts, diagnostic methods and treatment principles of TJM acupuncture, remains largely unanswered by this project. Although some patient records and clinic documents (medical intake forms) could be observed, they were not permitted to be copied or subjected to extensive document analysis.

Patient records and clinic documents are sensitive materials which require time to be explained by practitioners so that the meaning of the information can be established. It remains unknown how patient records and clinic documents

contribute to the understanding of TJM acupuncture. Future research should attempt to answer this question.

Locally sourced literature, including magazines, journals and textbooks, has potential to provide significant descriptive information about TJM acupuncture. However, due to the volume of materials and translation challenges, analysing local literature should be an independent study. Although specific literature or documents which were shared by practitioners provided insight into their practice and TJM acupuncture as a whole, a complete review of local literature was beyond the scope of this study. Future research should analyse relevant documents and published Japanese language literature to broaden the understanding of TJM acupuncture in English.

In addition to outlining future areas of research, the findings of this study also have implications for government regulations on acupuncture practice. The major element of TJM acupuncture which appears to be popular among practitioners in the West, include the techniques of minimal needle stimulation and ensuring the patient experiences as little discomfort as possible. Acupuncture practice which uses thinner needles with a guide tube and is purportedly painless, is somewhat of a misnomer for TJM acupuncture in Australia and probably other countries in the West; although TJM acupuncture is popularly known for these attributes and includes these elements of practice, “painless”, superficial and minimal needling does not define TJM acupuncture. Practitioners who have had no official training in TJM acupuncture may be claiming to practice “Japanese acupuncture” in order to garner a niche and gain an economical advantage in the market. This is not fair for consumers and practitioners. Policy makers should consider regulating the title of acupuncture practitioners so that consumers can receive services as advertised by acupuncture practitioners.

That this study was able to advance the understanding of TJM acupuncture by describing philosophical concepts, diagnostic methods and treatment principles which were not evident in the current published English language literature indicates that the understanding of TJM acupuncture is still in its infancy. It reflects that due consideration has not been given to understanding differences in basic acupuncture training, continual professional development and experience from

diverse and culturally distinct groups of TEAM acupuncture practitioners. It could also indicate that publishing power lies with those who are affiliated or have allegiances to styles other than TJM acupuncture. Even within TJM acupuncture, some styles or associations seem to have more publishing power than others. It is important not to misinterpret publishing power with prevalence or accuracy. Current published English language literature related to TJM acupuncture is mostly discussion based, representing opinion and theory rather than empirical and evidence based research outcomes. This raises doubts and difficulties about endeavours to successfully standardise acupuncture using current published English language literature.

Groups with publishing power can manipulate standards, and it is possible that those with the most financial, human and political power may have more influence on establishing standards than groups which do not. Although it is important to have international standards that serve as a reference point for international understanding and communication, it should be clear that established standards are not standard for everyone, even if such standards were based on solid, comprehensive and inclusive empirical research. If a method or theory is not presently described in published literature which claims to be an authority of standardisation, it does not mean that it is not a valid and important part of TEAM acupuncture. This is especially evident in the *WHO International Standard Terminologies on Traditional Medicine in the Western Pacific Region* (2007) which fails to acknowledge TJM acupuncture as a distinct style of acupuncture.

The disparity between published literature and real world scenarios in this study may not just be a symptom of misunderstanding TJM acupuncture or literature bias. Discrepancies between published literature and data obtained from clinical fieldwork could also indicate that the standard education and understanding of TEAM acupuncture in general does not match real world clinical situations. Scheid, Ward and Tuffrey (2010) indicate that similar discrepancies exist in relation to TCM and herbal medicine. Perhaps a complete re-evaluation of assumed knowledge of TEAM acupuncture, as well as how it is taught and used in clinical trials is needed before greater advances in research and treatment can be made with acupuncture.

Future research should also investigate other prominent acupuncture styles such as TKM (Traditional Korean Medicine) acupuncture that may also contribute to the current understanding and clinical practice of acupuncture. Additionally, increasing student and practitioner exposure to a diversity of philosophical concepts, diagnostic methods and treatment principles by the provision of formalised training in TKM acupuncture (in addition to TCM and TJM acupuncture) may be of benefit in education, professional development, research and practice.

8.3 Conclusion

The research findings demonstrate that as a consequence of the differences with other acupuncture styles and combination of unique features, TJM acupuncture is an independent style of acupuncture. An explanation and rationalisation of the implications of the findings in relation to education, practice and theory is provided, and possible directions of future research are suggested by addressing questions raised through this study. In light of this, it is proposed how a more formal inclusion of knowledge, beliefs and values, diagnostic methods and treatment principles from TJM acupuncture into mainstream TEAM acupuncture education in the West is a valid and necessary implementation of the findings from this research.

This study moves beyond discussion, case studies and the focus on clinical trials in the field of acupuncture. It does this in the belief that by better understanding acupuncture styles internationally, and not just from China, that education, professional practice and eventually research in clinical efficacy with acupuncture and associated techniques can be improved. This study focusses on understanding and describing TJM acupuncture, a discipline with an emerging popularity in the West. This emerging popularity has been accompanied with misunderstandings, partial information and has suffered from a lack of clarity due to its early stage of development in English. Accordingly, methods not previously explored in researching the discipline (ethnography) were used to advance understanding by observing clinical procedures and engaging in discourse with a range of professionals in the hope of contributing an improvement to acupuncture education and practice in health care.

This study identifies the knowledge and values in TJM acupuncture, revealing homogeneity in knowledge, but diversity in values when compared to TCM acupuncture and discussion of TJM acupuncture in the literature. In view of these differences, it is demonstrated how diagnostic methods and treatment principles reflect the unique interplay between TEAM knowledge in general and culturally specific values of the Japanese people. A typology for the description of TJM acupuncture techniques is also suggested. The motivations and methods for diagnosis and treatment are described in detail, and it is proposed that these should be included in contemporary curricula in the education of acupuncture alongside well established TCM acupuncture practices.

TJM acupuncture has been only partially described and generally underrepresented in the published English language literature. In particular, Meridian Therapy is often described as TJM acupuncture. Although this study confirms that there are common elements of practice between ranges of styles including Meridian Therapy, this study suggests that TJM acupuncture is much more complex than what has been discussed in the literature, and what can be described in this thesis. This study also provides evidence to support some of the unique features of TJM acupuncture as described in the literature. These unique features are expanded and described in terms of knowledge, values, techniques, methods and procedures. The philosophical concepts, diagnostic methods and treatment principles are explored in depth to show how TJM acupuncture is a distinct discipline separate to TCM acupuncture, and should be considered equal in the pedagogy of TEAM acupuncture internationally.

This study attempts to provoke a global awareness of acupuncture and foster an atmosphere of collaboration and acceptance of practices novel to the standard understanding of TEAM in English. The study proposes that what was known about TJM acupuncture was not complete knowledge, and that TJM acupuncture includes a diverse array of practices both committed to, and divorced from the TEAM medical model. This should not challenge our sense of acupuncture identity, but should contribute to the understanding that TEAM acupuncture is a varied and evolving health care discipline which needs to be understood contextually in order to provide a satisfying and therapeutically beneficial therapy for patients and practitioners alike.

Epilogue: Ejima Sugiyama Shinden Shrine

One of the most influential and important figures in Japanese acupuncture was the first son of a samurai family, Waichi Sugiyama (1610 – 1694). Waichi went blind after being afflicted with smallpox at a young age, and although could retain the elite Samurai status, would never be able to take the place as head of the family when his father died. As a result, Waichi was sent to study medicine firstly in Kyoto and eventually in the capital Edo under Master Takuichi Yamase. Waichi proved a clumsy acupuncturist and somewhat useless disciple, and he was expelled from his apprenticeship.

Throughout his life, Waichi had always been a devotee of the Shinto goddess Benzaiten. After his expulsion, he sought solace at the island shrine of Enoshima dedicated to her. In a cave on that island, Waichi contemplated, prayed and fasted for several weeks. When he finally emerged, somewhat exhausted and weak from the fasting, Waichi stumbled on a rock. He tripped, hit his head and fell unconscious.

After some time, Waichi awoke. He was uninjured, but had an unusual sensation in his leg. Reaching down, he felt that a pine needle had become stuck in his foot. Somehow rolled around the pine needle, was another large leaf.

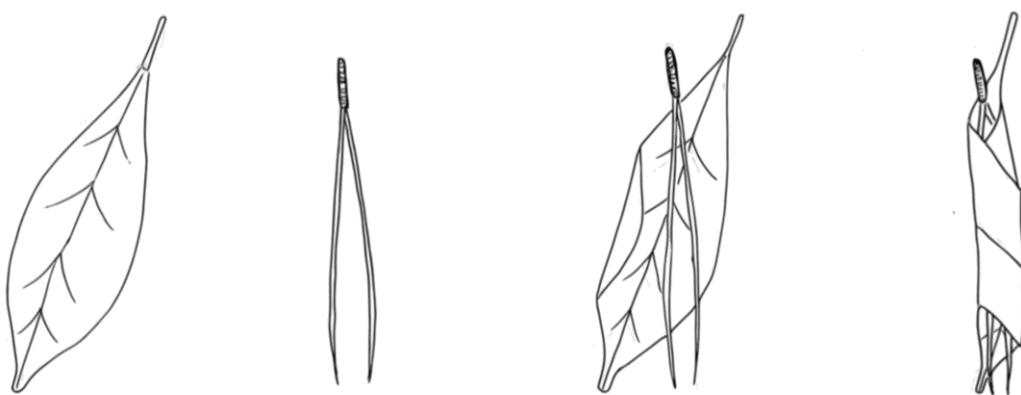


Figure E.1 Inspiration for modern day Japanese acupuncture needles and guide tubes

To Waichi, this was a great gift from the goddess Benzaiten. He was inspired; pine needles can be inserted into the body relatively painlessly because they are thin and sharp, but they are also flexible and can bend easily which makes them difficult

to insert. To assist insertion, some kind of tool was necessary: the rolled up leaf was the perfect shape to prevent the needle from bending on insertion.

Waichi quickly returned to Edo and started to practice acupuncture again, where he began using thinner needles and fully developed his guide tube idea. He was very successful and as his reputation grew, many disciples came to study acupuncture under his tutelage. Waichi Sugiyama's teachings were published in several texts which discuss needle techniques in detail, including needle insertion and stimulation with the guide tube. His methods include 18 basic needle insertion and manipulation techniques, with an additional 14 tube based needle stimulation methods. These methods form the basis of his treatment system and are combined to give a total of over 100 specific needle insertion and manipulation methods used for different pathologies. The Sugiyama style focusses on technique, with emphasis on practitioner sensitivity and perception at, and around the needling site during manipulation. Importance is also placed on the pressing hand as well as the needling hand which work together during manipulation. This attention to feeling over theory, and incorporation of shiatsu techniques with acupuncture, is perhaps as a result of Sugiyama's blindness, but it is a practice which is continued in the treatments of many present day practitioners of acupuncture in Japan.

Waichi Sugiyama eventually received the highest title which could be bestowed on the visually impaired, and in the 1680's he established schools to teach acupuncture and massage to the blind. Late in his life (1685), Waichi had the prestigious honour of treating the Shogun (military leader of Japan), who at the time was quite ill. The Shogun recovered completely from his sickness as a result of Sugiyama's treatment. As reward, the Shogun granted Waichi a feudal estate where he was permitted to build a replica to the shrine in Enoshima dedicated to the goddess Benzaiten, the place where he first received inspiration for the needle and tube method.

This shrine still exists today, and is called Ejima Sugiyama Shinden Shrine; located on the other side of station to the Sumo stadium in downtown Tokyo at Ryogoku. This small shrine is perhaps the most important monument in Japanese acupuncture history, and has stood here in some form for the last 350 years as testament to the man who developed one of the crowning achievements of

Japanese acupuncture. Waichi Sugiyama has since been somewhat deified and in modern times, acupuncture students from all over Japan make the trip here to the shrine in the hope to be graced with the intellect to pass their acupuncture exams and develop the skills to become great practitioners.

The shrine seemed like an appropriate place for me to come, reflect on my time in Japan and perhaps at last, the end of my PhD journey. As I arrived, I spoke briefly with the priestess who welcomed and pointed me in the right direction. The shrine was quiet, and I strolled through the enclave, admiring the sanctitude of the altars, mini shrines and ambiance of the departure from inner city Tokyo. It made me remember that I had not always appreciated such things.

The shrine offers a prayer service and ritual ceremony for those who want the full blessing of Benzaiten. Friends had suggested I participate in the ceremony, and as I was the only one there, I had the shrine all to myself for the ritual. The priestess led me through to the tatami room inside the shrine itself. As instructed, I sat before the altar, closed my eyes and bowed my head. The priestess began the ceremony

...

Through the chanting and the incense, I thought about all my hopes and dreams. I thought about all my anxieties and fears. I wondered what I would do once the research was all over, and if even I could bring myself to leave Japan; after all, I had become somewhat culturally indoctrinated by now. On my brief returns to Australia I would find myself bowing at everyone and not being able to remember the English word for “spring onions” despite it being readily available in Japanese. However, through all my concerns, a single prevailing feeling grew inside of me. It was one of complete gratitude. Gratitude to all the people who had helped, inspired and encouraged me throughout the long and challenging period of fieldwork in Japan.

Sitting in the shrine, I thought of the many people who have contributed to this work in ways they probably do not themselves realise. Thomas was instrumental in bringing me to Japan, and he continues to be a great practitioner and spokesperson for Japanese acupuncture. His book, *Acupuncture: The easy way – or the hard way*, provides a fascinating perspective about Japanese acupuncture with his

unique commentary. Hiroshi organised visas, signed forms, taught me so much and involved me in everything he could. Haruka too was so generous with her time, invited me to every workshop and seminar she attended and was a constant, very welcomed presence from well before I started this research. Hide invited me to his family home and introduced many of his colleagues to the study. Akira too brought me into his home and shared his knowledge without reserve. Nobuyuki was so kind to me, despite me not being able to speak Japanese well when I met him, and he was extremely active in introducing me to so many people. His wife Rie turned out to be a fantastic friend and colleague, and together we sighed, rolled our eyes and laughed through the challenges we both faced. Hitoshi was a great mentor who included and involved me wherever he could give me opportunities and chances I would otherwise never have had. Yumiko was extremely kind and supportive of my project, introduced me to many people and gave me help and opportunities to improve the research whenever she could. I must also thank Yoko Nakanishi (also a magnificent networker), Sayuri Shimizu and Hitomi Yamazaki for their fantastic translation support early in my project. Finally, my wonderful illustrator Moe Sato. She did an amazing job converting my verbal descriptions and charades into the amazing pictures that are found throughout this thesis.

After the ceremony I thanked the priestess and before leaving, took one final look back over the shrine. I thought of all the great masters of Japanese acupuncture who went before me, and all the living masters who I had the privilege of meeting during fieldwork. All of them pioneers, dedicated to improving the quality of life for people who suffered; passionate men and women who have worked hard to heal the sick, prevent disease and promote health and longevity. I was glad to have had the opportunity to get insight into their ideas, methods and techniques; to see what they did and how they did it. I walked back onto the busy street away from the shrine, still thinking about the Japanese masters of acupuncture. What a waste for the whole world not to know of their efforts. If only everyone knew about them. . . If only everyone could see the amazing things they did, and learn how to do it too. . .

References

Adams, G. (2002). Shiatsu in Britain and Japan: Personhood, holism and embodied aesthetics. *Anthropology & Medicine*, 9(3), 245-265. <https://doi.org/10.1080/13648470216334>

Adusumilli, P. S., Ben-Porat, L., Pereira, M., Roesler, D., & Leitman, I. M. (2004). The prevalence and predictors of herbal medicine use in surgical patients. *Journal of the American College of Surgeons*, 198(4), 583-590. <https://doi.org/10.1016/j.jamcollsurg.2003.11.019>

Ahn, A. C., Bennani, T., Freeman, R., Hamdy, O., & Kaptchuk, T. J. (2007). Two styles of acupuncture for treating painful diabetic neuropathy: A pilot randomised control trial. *Acupuncture in Medicine*, 25(1-2), 11-17. <https://doi.org/10.1136/aim.25.1-2.11>

Åkerström, M. (2006). Doing ambivalence: Embracing policy innovation: At arm's length. *Social Problems*, 53(1), 57-74. <https://doi.org/10.1525/sp.2006.53.1.57>

Al-Hajri, F. (2014). English language assessment in the Colleges of Applied Sciences in Oman: Thematic document analysis. *English Language Teaching*, 7(3), 19-37. <https://doi.org/10.5539/elt.v7n3p19>

Amira de la Garza, S. (2013). The Four seasons of ethnography. In M. K. Asante, Y. Miike & J. Yin (Eds.), *The global intercultural communication reader* (2nd Ed.)(pp. 151-173). New York, USA: Routledge.

Anryu, I. (2002). My method of acupuncture: Analysis, checking and contact needling (1). *North American Journal of Oriental Medicine*, 9(24), 10-12.

Anryu, I. (2003). Treatment of hay fever with traditional Japanese acupuncture. *North American Journal of Oriental Medicine*, 10(27), 19-21.

Atkinson, P., & Pugsley, L. (2005). Making sense of ethnography and medical education. *Medical Education*, 39(2), 228-234. <https://doi.org/10.1111/j.1365-2929.2004.02070.x>

Bailey, J. (2008). First steps in qualitative data analysis: Transcribing. *Family Practice*, 25(2), 127-131. <https://doi.org/10.1093/fampra/cmn003>

Baker, D. (2003). Oriental medicine in Korea. In H. Selin (Ed.), *Medicine across cultures* (pp. 133-153). New York, USA: Kulwer Academic Publishers. https://doi.org/10.1007/0-306-48094-8_7

Baldry, P. (2005). The integration of acupuncture within medicine in the UK: The British Medical Acupuncture Society's 25th anniversary. *Acupuncture in Medicine*, 23(1), 2-12. <https://doi.org/10.1136/aim.23.1.2>

Barnes, L. L. (1998). The psychologizing of Chinese healing practices in the United States. *Culture, Medicine and Psychiatry*, 22(4), 413-443. <https://doi.org/10.1023/A:1005403825213>

Baumbusch, J. (2010). Semi-structured interviewing in practice-close research. *Journal for Specialists in Pediatric Nursing*, 15(3), 255-258. <https://doi.org/10.1111/j.1744-6155.2010.00243.x>

Becker, H. S., Geer, B., Hughes, E. C., & Strauss, A. L. (1961). *Boys in white: Student culture in medical school*. Chicago, USA: University of Chicago Press.

Biernacki, P., & Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research*, 10(2), 141-163.

REFERENCES

Birch, S. (1994). Dr. Yoshio Manaka's yin-yang balancing treatment. *North American Journal of Oriental Medicine*, 1(1), 4-8.

Birch, S. (1997). Forming a prognosis. *North American Journal of Oriental Medicine*, 4(10), 4-8.

Birch, S. (1999). Keiraku chiryo-Japanese Meridian Therapy. *North American Journal of Oriental Medicine*, 6(15), 13-15.

Birch, S. (2010). Reflections on NAJOM's 50th issue. *North American Journal of Oriental Medicine*, 17(50), 3.

Birch, S. (2012). Overview of Japanese acupuncture in Europe. *Japanese Acupuncture and Moxibustion*, 8(1), 1-3.

Birch, S. (2014). Traditional needling techniques as practical constructions from reading historical descriptions. *North American Journal of Oriental Medicine*, 21(60), 3-7.

Birch, S., & Ida, J. (2015). The teishin: Thoughts and uses. *North American Journal of Oriental Medicine*, 22(64), 9-10.

Bird, C. M. (2005). How I stopped dreading and learned to love transcription. *Qualitative Inquiry*, 11(2), 226-248. <https://doi.org/10.1177/1077800404273413>

Bishop, C. (1999). I hate needles. *North American Journal of Oriental Medicine*, 6(17), 25-26.

Black, R. E. (2012). *Porta Palazzo: The anthropology of an Italian market*. Pennsylvania, USA: University of Pennsylvania Press. <https://doi.org/10.9783/9780812205794>

Blasejewicz, T. (2013). *Acupuncture: The easy way – or the hard way*. Kanagawa, Japan: Author.

Bloom, S. W. (1965). The sociology of medical education: Some comments on the state of a field. *The Milbank Memorial Fund Quarterly*, 43(2), 143-184. <https://doi.org/10.2307/3349028>

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal*, 9(2), 27-40. <https://doi.org/10.3316/QRJ0902027>

Brandner, R., van der Haak, M., Hartmann, M., Haux, R., & Schmucker, P. (2002). Electronic signature of medical documents: Integration and evaluation of a public key infrastructure in hospitals. *Methods of Information in Medicine - Methodik der Information in der Medizin*, 41(4), 321-330.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77 -101. <https://doi.org/10.1191/1478088706qp063oa>

Brinkhaus, B., Hummelsberger, J., Kohnen, R., Seufert, J., Hempen, C. H., Leonhardy, H., . . . Schuppan, D. (2004). Acupuncture and Chinese herbal medicine in the treatment of patients with seasonal allergic rhinitis: A randomized controlled clinical trial. *Allergy*, 59(9), 953-960. <https://doi.org/10.1111/j.1398-9995.2004.00540.x>

Brooks, J., McCluskey, S., King, N., & Burton, K. (2013). Illness perceptions in the context of differing work participation outcomes: Exploring the influence of significant others in persistent back pain. *BMC Musculoskeletal Disorders*, 14(1), 1-11. <https://doi.org/10.1186/1471-2474-14-48>

Browne, A. J. (2007). Clinical encounters between nurses and First Nations women in a Western Canadian hospital. *Social Science & Medicine*, 64(10), 2165-2176. <https://doi.org/10.1016/j.socscimed.2007.02.006>

Bryant, R. (2010). *The Past in pieces: Belonging in the New Cyprus*. Pennsylvania, USA: University of Pennsylvania Press. <https://doi.org/10.9783/9780812206661>

Cha, W. S., Oh, J. H., Park, H. J., Ahn, S. W., Hong, S. Y., & Kim, N. I. (2007). Historical difference between traditional Korean medicine and traditional Chinese medicine. *Neurological Research*, 29(Supplement 1), 5-9. <https://doi.org/10.1179/016164107X172293>

Chae, Y., Park, H. J., Hahm, D. H., Hong, M. S., Ha, E., Park, H. K., & Lee, H. (2007). fMRI review on brain responses to acupuncture: The limitations and possibilities in traditional Korean acupuncture. *Neurological Research*, 29(Supplement 1), 42-48. <https://doi.org/10.1179/016164107X172284>

Chant, B. (April, 2016). An Australian acupuncturist's perspective of moxibustion practice in East Asian countries. In Chant, B. (Chair) & Yamashita, H. (Chair), *Acupuncture Symposium*. Symposium conducted at The 18th International Congress of Oriental Medicine, Okinawa, Japan.

Chant, B., Madison, J. and Dieberg, G. (2016). Cross-cultural differences in acupuncture: A review. *Australian Journal of Acupuncture and Moxibustion*, 10(2), 12-18.

Chapman, A., Hadfield, M., & Chapman, C. (2015). Qualitative research in healthcare: An introduction to grounded theory using thematic analysis. *The Journal of the Royal College of Physicians of Edinburgh*, 45(3), 201-205. <https://doi.org/10.4997/JRCPE.2015.305>

Chaudhury, R. R., & Rafei, U. M. (Eds.). (2001). *Traditional medicine in Asia*. New Delhi, India: World Health Organization.

Chikurin, T. (2003). Meridian balancing-It's not just about the pulse: A report on Iwashina Anryu's October seminar. *North American Journal of Oriental Medicine*, 10(27), 22-23.

Chinese Medicine Board of Australia. *Registrant data. Reporting period: December 2015*. Retrieved from: <http://www.chinesemedicineboard.gov.au/About/Statistics.aspx>.

Chipulu, M., Ojiako, U., Gardiner, P., Williams, T., Mota, C., Maguire, S., . . . Marshall, A. (2014). Exploring the impact of cultural values on project performance: The effects of cultural values, age and gender on the perceived importance of project success/failure factors. *International Journal of Operations & Production Management*, 34(3), 364-389. <https://doi.org/10.1108/IJOPM-04-2012-0156>

Choi, E. M., Jiang, F., & Longhurst, J. C. (2012). Point specificity in acupuncture. *Chinese Medicine*, 7(1), 1-5. <https://doi.org/10.1186/1749-8546-7-4>

Cooper, K. L., Harris, P. E., Relton, C., & Thomas, K. J. (2013). Prevalence of visits to five types of complementary and alternative medicine practitioners by the general population: A systematic review. *Complementary Therapies in Clinical Practice*, 19(4), 214-220. <https://doi.org/10.1016/j.ctcp.2013.06.006>

Crabtree, B. F., & Miller, W. L (1999). Using Codes and Code Manuals: A template organizing style of interpretation. In B. F. Crabtree & W. L. Miller (Eds.), *Doing Qualitative Research* (2nd Ed.)(pp. 163-177). Thousand Oaks, CA: SAGE.

Cramer, H., Chung, V. C., Lauche, R., Zhang, Y., Zhang, A., Langhorst, J., & Dobos, G. (2015). Characteristics of acupuncture users among internal medicine patients in Germany. *Complementary Therapies in Medicine*, 23(3), 423-429. <https://doi.org/10.1016/j.ctim.2015.04.009>

REFERENCES

Crang, M., & Cook, I. (2007). *Doing ethnographies*. Thousand Oaks, CA: Sage. <https://doi.org/10.4135/9781849208949>

Curry, L. A., Nembhard, I. M., & Bradley, E. H. (2009). Qualitative and mixed methods provide unique contributions to outcomes research. *Circulation*, 119(10), 1442-1452. <https://doi.org/10.1161/CIRCULATIONAHA.107.742775>

Dale, R. A. (1997). Demythologizing acupuncture: Part 2, the systems and methods. *Alternative and Complementary Therapies*, 3(3), 200-211. doi:10.1089/act.1997.3.200. <https://doi.org/10.1089/act.1997.3.200>

Dann, J. (2000). Intensive certificate program of Japanese traditional acupuncture. *North American Journal of Oriental Medicine*, 7(19), 31-32.

Dann, J. (2007). Staying superficial in order to go deep. *North American Journal of Oriental Medicine*, 14(39), 19-21.

Davies, R., & Ikeno, O. (Eds.). (2002). *The Japanese mind*. North Claredon, USA: Tuttle.

Deadman, P., Al-Khafaji, M., & Baker, K. (2001). *A manual of acupuncture*. East Sussex, United Kingdom: Journal of Chinese Medicine Publications.

Deadman, P., MacPherson, H., Maxwell, D., Moir, F., & Scheid, V. (2009). Chinese medicine in the West. *Journal of Chinese Medicine*, 90, 6-18.

Deng, H., & Shen, X. (2013). The mechanism of moxibustion: Ancient theory and modern research. *Evidence-Based Complementary and Alternative Medicine*, 2013, 1-7. <https://doi.org/10.1155/2013/379291>

DeWalt, K. M., & DeWalt, B. R. (2011). *Participant observation: A guide for fieldworkers* (2nd Ed.). Plymouth, United Kingdom: AltaMira Press.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, 40(4), 314-321. <https://doi.org/10.1111/j.1365-2929.2006.02418.x>

Dilley, P. (2004). Interviews and the philosophy of qualitative research. *The Journal of Higher Education*, 75(1), 127-132. <https://doi.org/10.1353/jhe.2003.0049>

Dong, H., & Zhang, X. (2001). An overview of traditional Chinese medicine. In R. R. Chaudhury & U. M. Rafei (Eds.), *Traditional medicine in Asia* (pp. 17 - 29). New Delhi, India: World Health Organization

Dreu, M. (1995). Encounters with Ki: Part 5. *North American Journal of Oriental Medicine*, 2(5), 19-20.

Drew, S. E., Duncan, R. E., & Sawyer, S. M. (2010). Visual storytelling: A beneficial but challenging method for health research with young people. *Qualitative Health Research*, 20(12), 1677-1688. <https://doi.org/10.1177/1049732310377455>

Drue, M. (1994). Encounters with Ki. *North American Journal of Oriental Medicine*, 1(1), 9.

Duckworth, T. E. (2005). Concerning Kototama life medicine and Meridian Therapy's evolution. *North American Journal of Oriental Medicine*, 12(35), 27.

Eccher, C., Purin, B., Pisanelli, D. M., Battaglia, M., Apolloni, I., & Forti, S. (2006). Ontologies supporting continuity of care: The case of heart failure. *Computers in Biology and Medicine*, 36(7), 789-801. <https://doi.org/10.1016/j.combiomed.2005.07.002>

Emad, M. (1997). Twirling the needle: Pinning down anthropologists' emergent bodies in the disclosive field of American acupuncture. *Anthropology of Consciousness*, 8(2-3), 88-96. <https://doi.org/10.1525/ac.1997.8.2-3.88>

Endo, M. (2000). On the effectiveness of direct moxibustion. *North American Journal of Oriental Medicine*, 7(19), 4-6.

Engebretson, J. (2011). Clinically applied medical ethnography: Relevance to cultural competence in patient care. *Nursing Clinics of North America*, 46(2), 145-154. <https://doi.org/10.1016/j.cnur.2011.02.002>

Ericsson, K. A. (2014). Expertise. *Current Biology*, 24(11), 508-510. <https://doi.org/10.1016/j.cub.2014.04.013>

Faircloth, A. (2015). Acupuncture: History from the Yellow Emperor to modern anesthesia practice. *AANA Journal*, 83(4), 289-295.

Feldman, M. (1995). The value of pulse diagnosis. *North American Journal of Oriental Medicine*, 2(5), 21.

Feldman, M. (1997). My experience treating HIV/AIDS with acupuncture. *North American Journal of Oriental Medicine*, 4(10), 9-13.

Ferdous, T., & Harreveld, B. (2011). Reciprocal knowing for diabetes literacy among culturally and linguistically diverse individuals in Australia. *International Journal of Health, Wellness and Society*, 1(4) 203-217.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, 5(1), 80-92.

Ferrigno, P. A. (2007). *A reading of Qi* (Doctoral dissertation, Victoria University, Australia). Retrieved from <https://core.ac.uk/download/pdf/10834588.pdf>

Flaws, B. (1992). Thoughts on acupuncture, internal medicine and TCM in the West. *Journal of Chinese Medicine*, 38, 1-7.

Flick, U. (2009). *An introduction to qualitative research*. London: Sage.

Forsey, M. G. (2010). Ethnography as participant listening. *Ethnography*, 11(4), 558-572. <https://doi.org/10.1177/1466138110372587>

Forsythe, D. E. (1999). "It's just a matter of common sense": Ethnography as invisible work. *Computer Supported Cooperative Work (CSCW)*, 8(1), 127-145. <https://doi.org/10.1023/A:1008692231284>

Fratkin, J. P. (1995). Sushi versus stir-fry. *North American Journal of Oriental Medicine*, 2(4), 27-29.

Fratkin, J. P. (1996). Root and branch: Applications of Japanese Meridian Therapy. *North American Journal of Oriental Medicine*, 3(7), 9-13.

Fratkin, J. P. (1997). Healing in the fire of moxa. *North American Journal of Oriental Medicine*, 4(10), 31-34.

Fratkin, J. P. (1998). Koei Kuwahara's workshop on pediatric shonishin. *North American Journal of Oriental Medicine*, 5(14), 27-28.

Fruehauf, H. (1999). Chinese medicine in crisis: Science, politics and the making of "TCM". *Journal of Chinese Medicine*, 61(6), 6-14.

Fu, J. Y., Zhang, X., Zhao, Y. H., Tong, H. F., Chen, D. Z., & Huang, M. H. (2012). Scientific production and citation impact: A bibliometric analysis in acupuncture over three decades. *Scientometrics*, 93(3), 1061-1079. <https://doi.org/10.1007/s11192-012-0737-2>

Fujimoto, S., Inoue, M., Nakajima, M., & Itoi, M. (2011). Difference between therapeutic effects of deep and superficial acupuncture needle insertion for low back pain: A randomized controlled clinical trial. *Japanese Acupuncture and Moxibustion*, 7(1), 37-45. <https://doi.org/10.3777/jjsam.61.208>

Fukumoto, K. (2006). From the perspective of Meridian Therapy. *North American Journal of Oriental Medicine*, 13(38), 7-9.

Fukushima, T. (2008). Fukaya-style moxibustion. *North American Journal of Oriental Medicine*, 15(43), 32-33.

Fukushima, T. (2015). Fukaya-style moxibustion: Significance and characteristics. *North American Journal of Oriental Medicine*, 22(65), 6-8.

REFERENCES

Funamizu, T. (2015). Teishin treatment of the face. *North American Journal of Oriental Medicine*, 22(64), 26-28.

Furue, T. (2013). Syndrome patterns in traditional medicine. *North American Journal of Oriental Medicine*, 20(59), 30-31.

Furuya, E., Nayuki, T., Yakame, M., Furuumi, H., Shinohara, R., Nimura, R., . . . Sakamoto, A. (2009). The effects of press tack needle treatment on upper back muscle stiffness: Comparative study using sham needle. *Japanese Acupuncture and Moxibustion*, 5(1), 12-21.

Ganiel, G., & Mitchell, C. (2006). Turning the categories inside-out: Complex identifications and multiple interactions in religious ethnography. *Sociology of Religion*, 67(1), 3-21. <https://doi.org/10.1093/socrel/67.1.3>

Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative Health Research*, 14(10), 1429-1452. <https://doi.org/10.1177/1049732304270394>

Gobo, G. (2008). *Doing ethnography*. London, United Kingdom: Sage. <https://doi.org/10.4135/9780857028976>

Goldstein, A. E., & Reiboldt, W. (2004). The multiple roles of low income, minority women in the family and community: A qualitative investigation. *The Qualitative Report*, 9(2), 241-265.

Goodson, L., & Vassar, M. (2011). An overview of ethnography in healthcare and medical education research. *Journal of Educational Evaluation for Health Professions*, 8(4), 1-5. doi:10.3352/jeehp20118.4

Goto, M. (2005). Stuck on acupuncture; Curing diseases with one needle. *North American Journal of Oriental Medicine*, 12(34), 3-7.

Goto, S. (2010). Japanese acupuncture educational and licensure system. *The Journal of Kampo, Acupuncture and Integrative Medicine*, 1(Special Edition), 82-83.

Guion, L., Diehl, D., & McDonald, D. (2011). *Triangulation: Establishing the validity of qualitative studies*. (Technical Report No. FCS6014): University of Florida IFAS Extension. Retrieved from: <http://edis.ifas.ufl.edu/fy394>.

Halcomb, E. J., & Davidson, P. M. (2006). Is verbatim transcription of interview data always necessary? *Applied Nursing Research*, 19(1), 38 - 42. <https://doi.org/10.1016/j.apnr.2005.06.001>

Hammersley, M. (2006). Ethnography: Problems and prospects. *Ethnography and Education*, 1(1), 3-14. <https://doi.org/10.1080/17457820500512697>

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd Ed.). New York, USA: Routledge.

Han, J., & Ho, Y. (2011). Global trends and performances of acupuncture research. *Neuroscience and Biobehavioral Reviews*, 35(3), 680 - 687. <https://doi.org/10.1016/j.neubiorev.2010.08.006>

Hara, O. (2005). Treatment of facial pain and facial nerve paralysis with shakuyu therapy. *North American Journal of Oriental Medicine*, 12(35), 10-14.

Hawkins, Y., Ussher, J., Gilbert, E., Perz, J., Sandoval, M., & Sundquist, K. (2009). Changes in sexuality and intimacy after the diagnosis and treatment of cancer: The experience of partners in a sexual relationship with a person with cancer. *Cancer Nursing*, 32(4), 271-280. <https://doi.org/10.1097/NCC.0b013e31819b5a93>

Hayden, R. (1997). A day in Osaka. *North American Journal of Oriental Medicine*, 4(9), 18-19.

Hayden, R. (1998). On self study. *North American Journal of Oriental Medicine*, 5(14), 18 - 20.

Hayden, R. (2001). Thoughts on teaching Meridian Therapy to TCM students. *North American Journal of Oriental Medicine*, 8(22), 10-11.

Ho, E. Y. (2006). Behold the power of Qi: The importance of Qi in the discourse of acupuncture. *Research on Language and Social Interaction*, 39(4), 411-440. https://doi.org/10.1207/s15327973rlsi3904_3

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research*, 3(3), 345-357. <https://doi.org/10.1177/1468794103033004>

Holstein, J. A., & Gubrium, J. F. (2011). The constructionist analytics of interpretive practice. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (pp. 341-357). Thousand Oaks, CA: Sage.

Honda, A. (2003). A nail massage. *North American Journal of Oriental Medicine*, 10(29), 7.

Honda, A. (2006). Thoughts on oshide (the supporting hand). *North American Journal of Oriental Medicine*, 13(38), 25.

Hopkins, C. (2002). 'But what about the really ill, poorly people?' (An ethnographic study into what it means to nurses on medical admissions units to have people who have harmed themselves as their patients). *Journal of Psychiatric and Mental Health Nursing*, 9(2), 147-154. <https://doi.org/10.1046/j.1365-2850.2002.00473.x>

Hsu, E. (1999). *The transmission of Chinese medicine*. Cambridge, UK: Cambridge University Press. <https://doi.org/10.1017/CBO9780511612459>

Huang, T. H. (April, 2016). The effects of moxibustion on obese adolescent girls: Taiwanese experience. In Chant, B. (Chair) & Yamashita, H. (Chair), *Acupuncture Symposium*. Symposium conducted at The 18th International Congress of Oriental Medicine, Okinawa, Japan.

Hui, K. K., Nixon, E. E., Vangel, M. G., Liu, J., Marina, O., Napadow, V., . . . Kennedy, D. N. (2007). Characterization of the "deqi" response in acupuncture. *BMC Complementary and Alternative Medicine*, 7(1), 33. <https://doi.org/10.1186/1472-6882-7-33>

Hurtado, A., & Sinha, M. (2008). More than men: Latino feminist masculinities and intersectionality. *Sex Roles*, 59(5-6), 337-349. <https://doi.org/10.1007/s11199-008-9405-7>

Hurtak, J. J. (2002). An overview of acupuncture medicine. *The Journal of Alternative & Complementary Medicine*, 8(5), 535-538. <https://doi.org/10.1089/107555302320825020>

Hyman, I., Guruge, S., & Mason, R. (2008). The impact of migration on marital relationships: A study of Ethiopian immigrants in Toronto. *Journal of Comparative Family Studies*, 149-163.

Ichihashi, K. (2001). Kurumadani school acupuncture and kam pou herbal formula. *North American Journal of Oriental Medicine*, 8(21), 20-23.

Ikeda, M. (1997). Point selection for branch treatment. *North American Journal of Oriental Medicine*, 4(11), 12-15.

Ikeda, M. (1999). Resolving the misunderstanding of Stephen Birch. *North American Journal of Oriental Medicine*, 6(16), 16-18.

Ikeda, M. (2001). Discussion on clinical experience. *North American Journal of Oriental Medicine*, 8(21), 5-7.

Ikeda, M. (2002). The secrets of traditional medicine. *North American Journal of Oriental Medicine*, 9(24), 26-27.

Ikeda, M. (2011). My Opinions on the subject of the "Master-Disciple" relationship. *North American Journal of Oriental Medicine*, 18(52), 37.

REFERENCES

Ikeda, M. (2012). Deficiency-excess and tonification-dispersion (kyo-jitsu & ho-sha). *North American Journal of Oriental Medicine*, 19(54), 3-4.

Iliffe, S., Wilcock, J., Austin, T., Walters, K., Rait, G., Turner, S., . . . Downs, M. (2002). Dementia diagnosis and management in primary care developing and testing educational models. *Dementia*, 1(1), 11-23. <https://doi.org/10.1177/147130120200100111>

Ingegno, T. (2006). Lessons reinforced by four-legged patients. *North American Journal of Oriental Medicine*, 13(38), 31.

Ishida, H. (2004). The relationship between the ideology of Qi and science (2): Toward a plan for a traditional acupuncture college. *North American Journal of Oriental Medicine*, 11(30), 11-14.

Ishihara, K. (2005). From my clinical experience. *North American Journal of Oriental Medicine*, 12(35), 22-24.

Ishii-Kuntz, M., & Maryanski, A. (2003). Conjugal roles and social networks in Japanese families. *Journal of Family Issues*, 24(3), 352-380. <https://doi.org/10.1177/0192513X02250890>

Iwashita, S. (2010). The best way to assist qi flow in the clinic. *North American Journal of Oriental Medicine*, 17(49), 34-36.

Jansson, A. (2001). A road less travelled. *North American Journal of Oriental Medicine*, 8(2), 35-36.

Janz, S., & Adams, J. (2011). Acupuncture education standards in Australia: A critical review. *Australian Journal of Acupuncture and Chinese Medicine*, 6(1), 3 - 15.

Jingfeng, C. (1998). A historical overview of traditional Chinese medicine and ancient Chinese medical ethics. *Ethik in der Medizin*, 10(1), 84 - 91. <https://doi.org/10.1007/PL00014827>

Kahneman, D. (2011). *Thinking, fast and slow*. New York: Farrar, Straus and Giroux.

Kajima, I., Sai, G., Inoue, E. & Susuki, I. (2008). The potential of the head as a treatment zone. *North American Journal of Oriental Medicine*, 15(44), 3-9.

Kamiya, K. (2003). Moxibustion variations. *North American Journal of Oriental Medicine*, 10(27), 49.

Kanazawa, S. (1996). Two day workshop with Shudo sensei. *North American Journal of Oriental Medicine*, 3(8), 36-37.

Kanazawa, S. (1998). A stroll through kampo history (5). *North American Journal of Oriental Medicine*, 5(14), 19.

Kaneko, E. (1998). About the traditional Japanese acupuncture association. *North American Journal of Oriental Medicine*, 5(13), 33-34.

Kaptchuk, T. (1985). Acupuncture in the West: A discussion between Ted Kaptchuk, Giovanni Maciocia, Felicity Moir and Peter Deadman. *Journal of Chinese Medicine*, 17, 22-31.

Katai, S. (2005). The circumstances surrounding and the significance of standardization of point locations. *North American Journal of Oriental Medicine*, 12(35), 25-27.

Katai, S. (2006). A response to Mr. Peter Yate's article: "My opinion on the standardization of acupuncture points location". *North American Journal of Oriental Medicine*, 13(38), 16-17.

Katai, S. (2010a). Academic societies related to Japanese acupuncture and moxibustion. *The Journal of Kampo, Acupuncture and Integrative Medicine*, 1(Special Edition), 98-104.

Katai, S. (2010b). Characteristics of Japanese acupuncture and moxibustion. *The Journal of Kampo, Acupuncture and Integrative Medicine*, 1(Special Edition), 10 -13.

Katai, S. (2013a). Round table discussion: How to locate treatment points - Part 1. *North American Journal of Oriental Medicine*, 20(58), 3-7.

Katai, S. (2013b). Round table discussion: How to locate treatment points - Part 2. *North American Journal of Oriental Medicine*, 20(59), 3-8.

Katai, S. (2014). Round table discussion: How to locate treatment points - Part 3. *North American Journal of Oriental Medicine*, 21(60), 28-34.

Katoh, H. (2008). Treating catamenial pneumothorax with shakujyu therapy. *North American Journal of Oriental Medicine*, 15(43), 27-31.

Kawakita, K., Okada, K., & Kawamura, H. (2005). Analysis of a questionnaire on the characteristics of palpable hardenings: A survey of experienced Japanese acupuncturists. *Japanese Acupuncture and Moxibustion*, 1(1), 1-8.

Kawakita, K., Kim, Y.-S., Yamaguchi, N., Lin, X.-P., Arai, M., Takazawa, N., & Shan, Y.-S. (2015). Multiple comparisons of traditional acupuncture therapies of Japan, Korea and China: A preliminary report of three countries' acupuncture (TCA) project. *Open Journal of Immunology*, 5(3), 79-89. <https://doi.org/10.4236/oji.2015.53009>

Kawase, K. (2012). Memorable clinical cases using dashin and shindohappi. *North American Journal of Oriental Medicine*, 19(54), 14-15.

Kenner, D. C. (1994). The Japanese approach: The hara, Qi, and palpation. *North American Journal of Oriental Medicine*, 1(2), 18-19.

Kim, J. (2007). Alternative medicine's encounter with laboratory science: The scientific construction of Korean medicine in a global age. *Social Studies of Science*, 37(6), 855-880. <https://doi.org/10.1177/0306312707076600>

Kim, J. (2009). Transcultural medicine: A multi-sited ethnography on the scientific-industrial networking of Korean medicine. *Medical Anthropology*, 28(1), 31-64. <https://doi.org/10.1080/01459740802640909>

Kim, J. Y., Pham, D. D., & Koh, B. H. (2011). Comparison of Sasang constitutional medicine, traditional Chinese medicine and Ayurveda. *Evidence-Based Complementary and Alternative Medicine*, 2011, 1-7. <https://doi.org/10.1093/ecam/nea052>

Kim, Y. K., Sich, D., Park, T. K., & Kang, D. H. (1980). Naeng: a Korean folk illness, its ethnography and its epidemiology. *Yonsei Medical Journal*, 21(2), 147-155. <https://doi.org/10.3349/ymj.1980.21.2.147>

Kim, Y. S. (2010). Acupuncture treatment for low back pain in Korea. *Japanese Acupuncture and Moxibustion*, 6(1), 65-69.

Kim, Y. S., Jun, H., Chae, Y., Park, H. J., Kim, B. H., Chang, I. M., . . . Lee, H. J. (2005). The practice of Korean medicine: An overview of clinical trials in acupuncture. *Evidence Based Complementary and Alternative Medicine*, 2(3), 325-352. <https://doi.org/10.1093/ecam/neh102>

Klein-Franke, F., Ming, Z., & Qi, D. (2001). The passage of Chinese medicine to the West. *The American Journal of Chinese Medicine*, 29(3 - 4), 559-565. <https://doi.org/10.1142/S0192415X01000587>

Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural systems. *Social Science & Medicine. Part B: Medical Anthropology*, 12, 85-93.

Kleinman, A., & van der Geest, S. (2009). 'Care' in health care: Remaking the moral world of medicine. *Medizinische Anthropologie*, 21(1), 159-168.

REFERENCES

Klien, S. (2011). Bullfighting and meaning in life in Oki, Japan. *Asian Anthropology*, 10(1), 101-120. <https://doi.org/10.1080/1683478X.2011.10552606>

Knott, K. (2014). Religion, values and knowledge-power in contemporary secular spaces: The case of an English medical centre. *Scripta Instituti Donneriani Aboensis*, 19, 160-181.

Kobayashi, A., Uefuji, M., & Yasumo, W. (2008). History and progress of Japanese acupuncture. *Evidence-Based Complementary and Alternative Medicine*, 7(3), 359-365. <https://doi.org/10.1093/ecam/nem155>

Kobayashi, S. (2001). Shakuju therapy. *North American Journal of Oriental Medicine*, 8(22), 8-11.

Kobayashi, S. (2002). Shakuju therapy (3). *North American Journal of Oriental Medicine*, 9(24), 5-9.

Kokubo, J. (2003). Acupuncture and moxibustion treatment for shingles. *North American Journal of Oriental Medicine*, 10(27), 21.

Kokubo, J. (2016). Acupuncture and moxibustion treatment for insomnia. *North American Journal of Oriental Medicine*, 22(66), 3-4.

Kubota, N. (1997). Ishizaka style acupuncture. *North American Journal of Oriental Medicine*, 4(9), 17.

Kubota, N. (2003). Kubota zone acupuncture for anti-aging and age reversal. *North American Journal of Oriental Medicine*, 10(28), 31.

Kubota, N. (2007). Kubota zone acupuncture and the chart that is its key. *North American Journal of Oriental Medicine*, 14(41), 15-19.

Kudo, Y. (2005). The guide tube technique. *North American Journal of Oriental Medicine*, 12(35), 20-21.

Kuo, T. C., Lin, C. W., & Ho, F. M. (2004). The soreness and numbness effect of acupuncture on skin blood flow. *The American Journal of Chinese Medicine*, 32(01), 117-129. <https://doi.org/10.1142/S0192415X04001825>

Kurup, P. N. V. (2001). Ayurveda. In R. R. Chadhury & U. M. Rafei (Eds.), *Traditional medicine in Asia* (pp. 3 - 16). New Delhi, India: World Health Organisation.

Kusenbach, M. (2003). Street phenomenology: The go-along as ethnographic research tool. *Ethnography*, 4(3), 455-485. <https://doi.org/10.1177/146613810343007>

Kuawahara, K. (1995). Stop trying to cure them and they will get better. *North American Journal of Oriental Medicine*, 2(5), 22-25.

Kuawahara, T., & Nakano, T. (2015). Clinical trials of non-insertion Needles. *OCMT Journal of Acupuncture and Moxibustion Research*, 2(1), 1-13.

Langevin, H. M., & Yandow, J. A. (2002). Relationship of acupuncture points and meridians to connective tissue planes. *The Anatomical Record*, 269(6), 257-265. <https://doi.org/10.1002/ar.10185>

Lao, L. (1996). Acupuncture techniques and devices. *The Journal of Alternative and Complementary Medicine*, 2(1), 23-25. <https://doi.org/10.1089/acm.1996.2.23>

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3), 21-35. <https://doi.org/10.1177/160940690300200303>

Lee, B. Y., LaRiccia, P. J., & Newberg, A. B. (2004). Acupuncture in theory and practice part 1: Theoretical basis and physiologic effects. *Hospital Physician*, 40(4), 11-18.

Lee, H.J., Chae, H., Lim, Y.K., & Kwon, Y.K. (2015). Attitudes of Korean and Chinese traditional medical doctors on education of East Asian traditional medicine. *Integrative Medicine Research*, 5(1), 63-68. <https://doi.org/10.1016/j.imr.2015.11.001>

Lee, S. I., Khang, Y.-H., Lee, M.-S., & Kang, W. (2002). Knowledge of, attitudes toward, and experience of complementary and alternative medicine in Western medicine and oriental medicine trained physicians in Korea. *American Journal of Public Health*, 92(12), 1994-2000. <https://doi.org/10.2105/AJPH.92.12.1994>

Li, C. R., Lin, Y., Guan, H. Y., Liang, Z. R., Zhang, Z. X., Kim, A., . . . Gu, Z. Y. (2013). Different Surface Electromyography of Propagated Sensation along Meridians Produced by Acupuncturing Quchi Acupoint (LI11) or Control Points. *Evidence-Based Complementary and Alternative Medicine*, 2013, 1-4. <https://doi.org/10.1155/2013/198451>

Liangyue, D. (2001). Chinese acupuncture-moxibustion. In R. R. Chaudhury & U. M. Rafei (Eds.), *Traditional medicine in Asia* (pp. 75 - 91). New Delhi, India: World Health Organization.

Lieber, M. (2012). Traditional Chinese medicine in Switzerland: Issues in cultural and professional legitimacy. *Swiss Journal of Sociology*, 37(3), 461-480.

Lillis, T. (2008). Ethnography as method, methodology, and “Deep Theorizing”: Closing the gap between text and context in academic writing research. *Written Communication*, 25(3), 353-388. <https://doi.org/10.1177/0741088308319229>

Lim, M. Y., Huang, J., Zhao, B., & Ha, L. (2015). Current status of acupuncture and moxibustion in China. *Chinese Medicine*, 10(12), 1-5. doi:10.0086/s13020-015-0041-1

Lim, S. (2009). WHO standard acupuncture point locations. *Evidence-Based Complementary and Alternative Medicine*, 7(2), 167-168. <https://doi.org/10.1093/ecam/hep006>

Liu, B. (2010). Acupuncture treatment for low back pain in China. *Japanese Acupuncture and Moxibustion*, 6(1), 61-64.

Liu, Z., & Liu, L. (Eds.). (2009a). *Essentials of Chinese medicine* (Vol. 1). New York, USA: Springer.

Liu, Z., & Liu, L. (Eds.). (2009b). *Essentials of Chinese medicine* (Vol. 2). New York, USA: Springer.

Lock, M. (1980). *East Asian medicine in urban Japan: Varieties of medical experience*. Berkeley, USA: University of California Press.

Loew, B. (2000). Toyohari teacher training camp in Tokyo. *North American Journal of Oriental Medicine*, 7(20), 30.

Lopez, G. I., Figueroa, M., Connor, S. E., & Maliski, S. L. (2008). Translation barriers in conducting qualitative research with Spanish speakers. *Qualitative Health Research*, 18(12), 1729-1737. <https://doi.org/10.1177/1049732308325857>

Lotfali, M. (2006). *Engaging East Timorese men in the process of establishing gender equality*. (Doctoral dissertation, University of New England, Australia).

Low, K. C. P. (2011). Confucianism versus Taoism. *Conflict Resolution & Negotiation Journal*, 2011(4), 111-127.

Low, P. K. C., & Ang, S. L. (2010). The Foundation of Traditional Chinese Medicine. *Journal of Chinese Medicine, Scientific Research* 2010(1), 84-90. doi: 10.4236/cm2010.13016

REFERENCES

Lu, G. D., Needham, J., & Lo, V. (2002). *Celestial lancets: A history and rationale of acupuncture and moxa*. Abingdon, England: Routledge.

Ma, Y., Zhao, Y., & Liao, M. (2015). The values demonstrated in the constitution of the People's Republic of China. In M. Ladikas, S. Chaturvedi, Y. Zhao & D. Stemerding (Eds.), *Science and technology governance and ethics: A global perspective from Europe, India and China* (pp. 73-81). Heidelberg: Springer. https://doi.org/10.1007/978-3-319-14693-5_6

Maciocia, G. (2006). *The foundations of Chinese medicine* (2nd Ed.). London, United Kingdom: Elsevier Churchill Livingstone.

MacLean, L. M., Meyer, M., & Estable, A. (2004). Improving accuracy of transcripts in qualitative research. *Qualitative Health Research*, 14(1), 113-123. <https://doi.org/10.1177/1049732303259804>

MacPherson, H., Altman, D. G., Hammerschlag, R., Youping, L., Taixiang, W., White, A., & Moher, D. (2010). Revised Standards for Reporting Interventions in Clinical Trials of Acupuncture (STRICTA): Extending the CONSORT statement. *Journal of Evidence Based Medicine*, 3(3), 140-155. <https://doi.org/10.1111/j.1756-5391.2010.01086.x>

Maeda, N. (1998). The story of an acupuncture needle manufacturer. *North American Journal of Oriental Medicine*, 5(14), 16-17.

Mahoney, J. S. (2001). An ethnographic approach to understanding the illness experiences of patients with congestive heart failure and their family members. *Heart and Lung: The Journal of Acute and Critical Care*, 30(6), 429 - 436. <https://doi.org/10.1067/mhl.2001.119832>

Malhotra, S., Jordan, D., Shortliffe, E., & Patel, V. L. (2007). Workflow modelling in critical care: Piecing together your own puzzle. *Journal of Biomedical Informatics*, 40(2), 81-92. <https://doi.org/10.1016/j.jbi.2006.06.002>

Malinowski, B. (2013). *Argonauts of the Western Pacific: An account of native enterprise and adventure in the archipelagos of Melanesian New Guinea*. Enhanced edition. Long Grove, USA: Waveland Press (Original work published 1922).

Manaka, Y. (2002). Massive dose and subtle stimulation therapy. *North American Journal of Oriental Medicine*, 9(24), 17.

Manaka, Y. (2006a). About patterns (sho). *North American Journal of Oriental Medicine*, 13(38), 3-4.

Manaka, Y. (2006b). The Concept of meridians from a systems perspective. *North American Journal of Oriental Medicine*, 13(37), 3-8.

Manaka, Y. (2009). Japanese and Chinese acupuncture: Similarities and differences. *North American Journal of Oriental Medicine*, 16(47), 8-11.

Mansell, I., Bennett, G., Northway, R., Mead, D., & Moseley, L. (2004). The learning curve: The advantages and disadvantages in the use of focus groups as a method of data collection. *Nurse Researcher*, 11(4), 79-88. <https://doi.org/10.7748/nr2004.07.11.4.79.c6217>

Marbach, T. J., & Griffie, J. (2011). Patient preferences concerning treatment plans, survivorship care plans, education, and support services. *Oncology Nursing Forum*, 38(3), 335-342. <https://doi.org/10.1188/11.ONF.335-342>

Marcus, G. E. (2002). Beyond Malinowski and after writing culture: On the future of cultural anthropology and the predicament of ethnography. *The Australian Journal of Anthropology*, 13(2), 191-199. <https://doi.org/10.1111/j.1835-9310.2002.tb00199.x>

Matsuda, H., Brown, S., & Dann, J. (2009). Acupuncture education: A roundtable discussion between Matsuda Hirokimi and Tokyo seminar participants (August 11, 2008). *North American Journal of Oriental Medicine*, 16(46), 16-18.

Matsuda, H. (2013). The origins and ideological roots of acupuncture and moxibustion - Part 3. *North American Journal of Oriental Medicine*, 20(59), 9-11.

Matsumoto, D., & Juang, L. (2012). *Culture and psychology*. Belmont, USA: Wadsworth.

Matsumoto, H. (1994). Acupuncture and moxibustion in Japan. *North American Journal of Oriental Medicine*, 2(2), 11-17.

Matsumoto, H. (1995). Acupuncture and moxibustion in Japan (Part 2). *North American Journal of Oriental Medicine*, 2(3), 8-13.

Matsumoto, H. (1997). Katakori: A Japanese complaint? *North American Journal of Oriental Medicine*, 4(9), 4-5.

Matsumoto, H. (1998). Acupuncture treatment for whiplash syndrome. *North American Journal of Oriental Medicine*, 5(13), 3-6.

Matsumoto, H. (2000). Abdominal diagnosis in oriental medicine (acupuncture) Part 4. *North American Journal of Oriental Medicine*, 7(20), 6-9.

Matsumoto, H. (2002). Nerve entrapment syndromes (2). *North American Journal of Oriental Medicine*, 9(24), 18-23.

Matsumoto, H. (2003). Treatment of cervico-brachialgia. *North American Journal of Oriental Medicine*, 10(27), 16-18.

Matsumoto, H. (2013a). Deficiency excess and tonification dispersion - Part 2. *North American Journal of Oriental Medicine*, 20(57), 3-5.

Matsumoto, H. (2013b). Finding effective treatment points. *North American Journal of Oriental Medicine*, 20(59), 14-15.

Matsumoto, K. (2000). Explaining J.P. Fratkin's misinterpretations. *North American Journal of Oriental Medicine*, 7(18), 17-18.

Matsumoto, T., Katai, S., & Namiki, T. (2016). Safety of smoke generated by Japanese moxa upon combustion. *European Journal of Integrative Medicine*, 8(4), 414-422. <https://doi.org/10.1016/j.eujim.2016.03.005>

Maxwell, J. (1997). Designing a qualitative study. In L. Bickman & D. J. Rog (Eds.), *Handbook of applied social research methods* (pp. 69-100). Thousand Oaks, CA: Sage.

McHugh, E. (2011). *Love and honor in the Himalayas: Coming to know another culture*. Pennsylvania, USA: University of Pennsylvania Press.

McLellan, E., MacQueen, K. M., & Neidig, J. L. (2003). Beyond the qualitative interview: Data preparation and transcription. *Field Methods*, 15(1), 63-84. <https://doi.org/10.1177/1525822X02239573>

McLellan-Lemal, E. (2007). Transcribing data for team-based research. In G. Guest & K. M. MacQueen (Eds.), *Handbook for team-based qualitative research* (pp. 101-118). Plymouth, United Kingdom: Altamira Press.

Menjyo, Y. (2011). Treatment of aphthous stomatitis using heat sensing moxibustion (chinetsu-kyu). *North American Journal of Oriental Medicine*, 18(51), 23.

Menjyo, Y. (2012). Tonification and dispersion in moxibustion. *North American Journal of Oriental Medicine*, 19(54), 10-11.

Menjyo, Y. (2015). A discussion of heat sensing and direct moxa. *North American Journal of Oriental Medicine*, 22(65), 18.

REFERENCES

Menjyo, Y. (2014). Exploring the use of indirect moxa in heat sensing treatment. *North American Journal of Oriental Medicine*, 21(60), 40-41.

Michel, W. (2011). Japanese acupuncture and moxibustion in Europe from the 16th to 18th centuries. *Japanese Acupuncture and Moxibustion*, 7(1), 1-14.

Mitchell, E. D., Rubin, G., & Macleod, U. (2013). Understanding diagnosis of lung cancer in primary care: Qualitative synthesis of significant event audit reports. *British Journal of General Practice*, 63(606), 37-46. <https://doi.org/10.3399/bjgp13X660760>

Mitsuhata, N. (2010). Japanese minimal acupuncture. *The Journal of Kampo, Acupuncture and Integrative Medicine*, 1(Special Edition), 91-93.

Miyakawa, K. (2015a). Pulse diagnosis, palpation, and the PDCA cycle - Part 1. *North American Journal of Oriental Medicine*, 22(64), 35-37.

Miyakawa, K. (2015b). Pulse diagnosis, palpation, and the PDCA cycle - Part 2. *North American Journal of Oriental Medicine*, 22(65), 33-34.

Mizutani, J. (1994). Practical moxibustion therapy (Part 1). *North American Journal of Oriental Medicine*, 1(1), 14 - 18.

Mizutani, J. (1996). Practical moxibustion therapy (Part 7). *North American Journal of Oriental Medicine*, 3(7), 25-28.

Mizutani, J. (1998). Practical moxibustion therapy (13). *North American Journal of Oriental Medicine*, 5(13), 23-25.

Mizutani, J. (2009). Practical moxibustion therapy (32). *North American Journal of Oriental Medicine*, 16(45), 17-20.

Mizutani, J. (2012). Questions & answers about deficiency & excess. *North American Journal of Oriental Medicine*, 19(54), 4-7.

Mizutani, J. (2014). Practical moxibustion therapy. *North American Journal of Oriental Medicine*, 21(61), 10-11.

Mizutani, J. (2015). Practical moxibustion therapy. *North American Journal of Oriental Medicine*, 22(65), 10-11.

Money, A. G., Barnett, J., Kuljis, J., & Lucas, J. (2013). Patient perceptions of epinephrine auto-injectors: exploring barriers to use. *Scandinavian Journal of Caring Sciences*, 27(2), 335-344. <https://doi.org/10.1111/j.1471-6712.2012.01045.x>

Moore, J. B. (2012). Why I became a Zen therapist. *North American Journal of Oriental Medicine*, 19(54), 18.

Moré, A. O., Tesser, C. D., da Silva, J. B., & Min, L. S. (2016). Status and impact of acupuncture research: A bibliometric analysis of global and Brazilian scientific output from 2000 to 2014. *The Journal of Alternative and Complementary Medicine*, 22(6), 429-436. <https://doi.org/10.1089/acm.2015.0281>

Morrill, C., Buller, D. B., Buller, M. K., & Larkey, L. L. (1999). Toward an organizational perspective on identifying and managing formal gatekeepers. *Qualitative Sociology*, 22(1), 51-72. <https://doi.org/10.1023/A:1022183232593>

Motoo, Y., Seki, T., & Tsutani, K. (2011). Traditional Japanese medicine, kampo: Its history and current status. *The Chinese Journal of Integrated Traditional and Western Medicine*, 17(2), 85 -87. <https://doi.org/10.1007/s11655-011-0653-y>

Mukaino, Y. (2008). The meridian test: Acupuncture treatment based on assessment of movement. *North American Journal of Oriental Medicine*, 15(43), 3-7.

Murata, M. (1999). Acupuncture treatment for the lower back and leg pain. *North American Journal of Oriental Medicine*, 6(17), 16-17.

Murata, M. (2001). Shudo style Meridian Therapy. *North American Journal of Oriental Medicine*, 8(22), 14-18.

Murata, M. (2006). Cases using super-superficial insertion (3). *North American Journal of Oriental Medicine*, 13(37), 16-19.

Murata, M. (2011). Master and disciple. *North American Journal of Oriental Medicine*, 18(52), 42-43.

Murata, M. (2013). Clinical application of Shudo-style acupuncture. *North American Journal of Oriental Medicine*, 20(58), 26-29.

Murata, T. (2000). Emergency pain relief. *North American Journal of Oriental Medicine*, 7(19), 17-18.

Murchison, J. (2010). Ethnography essentials: Designing, conducting, and presenting your research. San Francisco, CA: John Wiley & Sons.

Nagato, N. (1997). Case studies of fibromyalgia. *North American Journal of Oriental Medicine*, 4(10), 26-30.

Nagato, N. (1999). A case study of improved locomotion with multiple sclerosis. *North American Journal of Oriental Medicine*, 6(16), 19-20.

Nagato, N. (2000). Case study report: Ovarian cysts eliminated with three treatments. *North American Journal of Oriental Medicine*, 7(20), 22-23.

Nager, A. L., Kobylecka, M., Pham, P. K., Johnson, L., & Gold, J. I. (2015). Effects of acupuncture on pain and inflammation in pediatric emergency department patients with acute appendicitis: A pilot study. *The Journal of Alternative and Complementary Medicine*, 21(5), 269-272. <https://doi.org/10.1089/acm.2015.0024>

Nam, D. (April, 2016). Moxibustion practice in Korea. In Chant, B. (Chair) & Yamashita, H. (Chair), *Acupuncture Symposium*. Symposium conducted at The 18th International Congress of Oriental Medicine, Okinawa, Japan.

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description: The poor cousin of health research? *BMC Medical Research Methodology*, 9(52), 1-5. <https://doi.org/10.1186/1471-2288-9-52>

Neufeld, A., Harrison, M. J., Stewart, M. J., Hughes, K. D., & Spitzer, D. (2002). Immigrant women: Making connections to community resources for support in family caregiving. *Qualitative Health Research*, 12(6), 751-768. <https://doi.org/10.1177/104973230201200603>

Nishijima, I. (2003). Diary of my battle with cancer. *North American Journal of Oriental Medicine*, 10(27), 24-27.

Nishijima, I. (2004). Dealing with acute pain (Part 1). *North American Journal of Oriental Medicine*, 11(31), 9-11.

Nishikitani, M., Inoue, S., & Yano, E. (2008). Competition or complement: Relationship between judo therapists and physicians for elderly patients with musculoskeletal disease. *Environmental Health and Preventive Medicine*, 13(3), 123-129. <https://doi.org/10.1007/s12199-007-0021-x>

Noda, Y., Izuno, T., Tsuchiya, Y., Hayasaka, S., Matsumoto, K., Murakami, H., . . . Nakamura, M. (2015). Acupuncture-induced changes of vagal function in patients with depression: A preliminary sham-controlled study with press needles. *Complementary Therapies in Clinical Practice*, 21(3), 193-200. <https://doi.org/10.1016/j.ctcp.2015.07.002>

Obaidey, E. (1996). Taikyoku therapy. *North American Journal of Oriental Medicine*, 3(6), 12-15.

O'Brien, K. A., & Birch, S. (2009). A review of the reliability of traditional East Asian medicine diagnoses. *The Journal of Alternative and Complementary Medicine*, 15(4), 353-366. <https://doi.org/10.1089/acm.2008.0455>

REFERENCES

Ogawa, T. (1996). Comparison of TCM and Meridian Therapy. *North American Journal of Oriental Medicine*, 3(6), 6-11.

Ogawa, T. (1998). The current situation and future direction of Japanese acupuncture. *North American Journal of Oriental Medicine*, 5(14), 7-10.

Ogawa, T. (1999). The current situation and future direction of Japanese acupuncture (part 2). *North American Journal of Oriental Medicine*, 6(15), 8-12.

Ogawa, T. (2013). The value gained from palpation. *North American Journal of Oriental Medicine*, 20(58), 8-9.

Ogawa, T., Katai, S. & Minowa, M. (2011). The 5th gendai shinkyu gyotai enquête shukei kekka. *Ido No Nippon*, 815, 191-224.

Ogawa, T., Kaitai, S., & Shinohara, S. (2004). Acupuncture treatment on the local area versus the distal area: Questionnaire survey. *Journal of the Japanese Society of Acupuncture and Moxibustion*, 54(1), 14-26.
<https://doi.org/10.3777/jjsam.54.14>

Ohara, Y. (2011). A case study: Osteoarthritis of the knee. *North American Journal of Oriental Medicine*, 18(53), 14-15.

Ohnuki-Tierney, E. (1984). *Illness and culture in contemporary Japan: An anthropological view*. Cambridge: Cambridge University Press.
<https://doi.org/10.1017/CBO9780511621772>

Ohue, K. (2010). Manual for understanding the new textbook: The basics of Japanese acupuncture and moxibustion. *North American Journal of Oriental Medicine*, 17(50), 34-35.

Ohue, K. (2011). Root treatment and branch treatment. *North American Journal of Oriental Medicine*, 18(51), 16-17.

Okabe, S. (1998). Introduction to traditional Japanese acupuncture (Meridian Therapy). *North American Journal of Oriental Medicine*, 5(13), 9-13.

Okada, A. (2000). Shinshin sho (neurotic and psychosomatic disorders) *North American Journal of Oriental Medicine*, 7(20), 10-12.

Okada, A. (2004). Meridian Therapy for digestive disorders. *North American Journal of Oriental Medicine*, 11(31), 3-5.

Oliver, D. G., Serovich, J. M., & Mason, T. L. (2005). Constraints and opportunities with interview transcription: Towards reflection in qualitative research. *Social Forces*, 84(2), 1273-1289. <https://doi.org/10.1353/sof.2006.0023>

O'Mahony, J. M., & Donnelly, T. T. (2007). The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers. *Issues in Mental Health Nursing*, 28(5), 453-471.
<https://doi.org/10.1080/01612840701344464>

O'Mahony, J. M., Donnelly, T. T., Bouchal, S. R., & Este, D. (2013). Cultural background and socioeconomic influence of immigrant and refugee women coping with postpartum depression. *Journal of Immigrant and Minority Health*, 15(2), 300-314. <https://doi.org/10.1007/s10903-012-9663-x>

Onishi, M. (2013). The moxibustion doctor: Hara Shimetaro. *North American Journal of Oriental Medicine*, 20(58), 18-20.

Ono, N. (2010). Medical insurance in Japan. *Kampo and Integrative Medicine*, 1(Special Edition), 105-122.

Orhel, N. (2003). A brief description of the Edagawa method of injection therapy. *North American Journal of Oriental Medicine*, 10(28), 17-18.

Ota, F. (2011). Guided by oriental medicine. *North American Journal of Oriental Medicine*, 18(52), 31 - 33.

Oura, J. (2007). The characteristics and essence of Japanese acupuncture. *North American Journal of Oriental Medicine*, 14(41), 3-6.

Oura, J. (2015). Abdominal diagnostics for toxic and pathogenic factors *North American Journal of Oriental Medicine*, 22(64), 39-42.

Palmer, C. (2010). Observing with a focus: Field notes and data recording. In S. Watt & J. Scott-Jones (Eds.), *Ethnography in social science practice* (pp. 141-156). New York, USA: Routledge.

Park, H., Kim, K., Min, H., & Kim, D. (2004). Prevention of postoperative sore throat using capsicum plaster applied at the Korean hand acupuncture point. *Anaesthesia*, 59(7), 647-651. <https://doi.org/10.1111/j.1365-2044.2004.03739.x>

Park, H. L., Lee, H. S., Shin, B. C., Liu, J. P., Shang, Q., Yamashita, H., & Lim, B. (2012). Traditional medicine in China, Korea, and Japan: A brief introduction and comparison. *Evidence-Based Complementary and Alternative Medicine*, 2012, 1-9. <https://doi.org/10.1155/2012/429103>

Park, S. M., & Shim, W. J. (2011). A hedgehog-like appearance resulting from hari acupuncture. *Canadian Medical Association Journal*, 183(13), 1038-1038. <https://doi.org/10.1503/cmaj.110128>

Patwardhan, B., Warude, D., Pushpangadan, P., & Bhatt, N. (2005). Ayurveda and traditional Chinese medicine: A comparative overview. *Evidence Based Complementary and Alternative Medicine*, 2(4), 465-474. <https://doi.org/10.1093/ecam/neh140>

Penrod, J., Preston, D. B., Cain, R. E., & Starks, M. T. (2003). A discussion of chain referral as a method of sampling hard-to-reach populations. *Journal of Transcultural Nursing*, 14(2), 100-107. <https://doi.org/10.1177/1043659602250614>

Perreira, K. M., Chapman, M. V., & Stein, G. L. (2006). Becoming an American parent overcoming challenges and finding strength in a new immigrant Latino community. *Journal of Family Issues*, 27(10), 1383-1414. <https://doi.org/10.1177/0192513X06290041>

Pershoush, D. (1997). Simplifying your practice. *North American Journal of Oriental Medicine*, 4(11), 8-11.

Pershoush, D. (1998). The Lure of the mainstream. *North American Journal of Oriental Medicine*, 5(12), 20-24.

Petrucci, M. (2014). Introduction to fluid-energy integration: Combining osteopathic lymphatic techniques with traditional Japanese acupuncture. *North American Journal of Oriental Medicine*, 21(61), 29.

Pope, C. (2005). Conducting ethnography in medical settings. *Medical Education*, 39(12), 1180-1187. <https://doi.org/10.1111/j.1365-2929.2005.02330.x>

Popovici, I., Morita, P. P., Doran, D., Lapinsky, S., Morra, D., Shier, A., . . . Cafazzo, J. A. (2015). Technological aspects of hospital communication challenges: an observational study. *International Journal for Quality in Health Care*, 27(3). doi:10.1093/intqhc/mv016.

Quinn, B. (2014). A day in clinic with Iwashina sensei (Dr. Bear). *North American Journal of Oriental Medicine*, 21(61), 34.

Radcliffe-Brown, A. R. (2013). *The Andaman Islanders* (First paperback Ed.). Cambridge, United Kingdom: Cambridge University Press (Original work published 1933).

Ramani, S., & Mann, K. (2015). Introducing medical educators to qualitative study design: Twelve tips from inception to completion. *Medical Teacher*, 38(5) 456-463. <https://doi.org/10.3109/0142159X.2015.1035244>

REFERENCES

Reeves, C. L. (2010). A difficult negotiation: Fieldwork relations with gatekeepers. *Qualitative Research*, 10(3), 315-331. <https://doi.org/10.1177/1468794109360150>

Reeves, S., Kuper, A., & Hodges, B. D. (2008). Qualitative research methodologies: Ethnography. *British Medical Journal*, 337(a1020), 512-514. <https://doi.org/10.1136/bmj.a1020>

Ridi, R. (2013). Ethical values for knowledge organization. *Knowledge Organization*, 40(3), 187-196.

Riessman, C. (2000). Even if we don't have children [we] can live: Stigma and infertility in South India. In C. Mattingly and L. Garro (Eds.), *Narrative and the cultural construction of illness and healing* (pp. 128-152). Berkeley, USA: University of California Press.

Roh, P. (2005). Regional overview: Western Pacific region. In G. Bodeker, C.-K. Ong, C. Grundy, G. Burford & K. Shein (Eds.), *World Health Organization global atlas of traditional, complementary, and alternative medicine* (Vol. 1, pp. 183 - 186). Kobe, Japan: World Health Organization.

Rollins, G. (2010). Metal-water treatments in Kiiko Matsumoto style acupuncture. *North American Journal of Oriental Medicine*, 19(54), 12-13.

Rolls, L., & Relf, M. (2006). Bracketing interviews: Addressing methodological challenges in qualitative interviewing in bereavement and palliative care. *Mortality*, 11(3), 286-305. <https://doi.org/10.1080/13576270600774893>

Romano, A. (1994). My preference for Japanese acupuncture: How and why. *North American Journal of Oriental Medicine*, 1(2), 19-21.

Rubinstein, A. K. (2007). Multiple system integration. *North American Journal of Oriental Medicine*, 14(40), 20-27.

Ryan, J. D. (2003). *A phenomenographic study of beginner acupuncture clinicians' conceptions of practice and learning*. (Doctoral dissertation), Victoria University of Technology.

Sagli, G. (2010). The establishing of Chinese medical concepts in Norwegian acupuncture schools: The cultural translation of jingluo ('circulation tracts'). *Anthropology and Medicine*, 17(3), 315-326. <https://doi.org/10.1080/13648470.2010.526694>

Sakamoto, K. (2011). Hacho moxibustion. *North American Journal of Oriental Medicine*, 18(53), 20-21.

Sakamoto, K. (2012). Hacho moxibustion - Part 2. *North American Journal of Oriental Medicine*, 19(55), 28-29.

Sanghera, G. S., & Thapar-Björkert, S. (2008). Methodological dilemmas: Gatekeepers and positionality in Bradford. *Ethnic and Racial Studies*, 31(3), 543-562. <https://doi.org/10.1080/01419870701491952>

Sasayama, H., Satou, M., Gomi, F., & Takano, T. (Eds.). (2013). *Shosetsu Nihon shi (A detailed explanation of Japanese history)*. Tokyo, Japan: Yamagawa.

Scanlon, G. (1996). Ryodoraku: Autonomic nervous system regulation therapy. *North American Journal of Oriental Medicine*, 3(8), 11-16.

Scheid, V. (2002). *Chinese medicine in contemporary China: Plurality and synthesis*. London, United Kingdom: Duke University Press. <https://doi.org/10.1215/9780822383710>

Scheid, V. (2007). Traditional Chinese Medicine - What are we investigating?: The case of menopause. *Complementary therapies in medicine*, 15(1), 54-68. <https://doi.org/10.1016/j.ctim.2005.12.002>

Scheid, V. (2014). Convergent lines of descent: Symptoms, patterns, constellations, and the emergent interface of systems biology and Chinese medicine. *East Asian science, technology and society*, 8(1), 107-139. <https://doi.org/10.1215/18752160-2407180>

Scheid, V., & MacPherson, H. (2012). Introduction. In V. Scheid & H. MacPherson (Eds.), *Integrating East Asian medicine into contemporary healthcare* (pp. 1-12). Edinburgh, United Kingdom: Elsevier.

Scheid, V., Ward, T., Cha, W. S., Watanabe, K., & Liao, X. (2010). The treatment of menopausal symptoms by traditional East Asian medicines: Review and perspectives. *Maturitas*, 66(2), 111-130. <https://doi.org/10.1016/j.maturitas.2009.11.020>

Scheid, V., Ward, T., & Tuffrey, V. (2010). Comparing TCM textbook descriptions of menopausal syndrome with the lived experience of London women at midlife and the implications for Chinese medicine research. *Maturitas*, 66(4), 408-416. <https://doi.org/10.1016/j.maturitas.2010.03.021>

Schnabel, K., Binting, S., Witt, C. M., & Teut, M. (2014). Use of complementary and alternative medicine by older adults: A cross-sectional survey. *BMC Geriatrics*, 14(1), 1-9. <https://doi.org/10.1186/1471-2318-14-38>

Schulz, P. J., van Ackere, A., Hartung, U., & Dunkel, A. (2012). Prior family communication and consent to organ donation: Using intensive care physicians' perception to model decision processes. *Journal of Public Health Research*, 1(2), 130-136. doi:10.2081/jphr.2012.e19

Scott-Jones, J. (2010). Origins and ancestors: A brief history of ethnography. In J. Scott-Jones & S. Watt (Eds.), *Ethnography in social science practice* (pp. 13-27). New York, USA: Routledge.

Scott-Jones, J. & Watt, S. (2010). Making sense of it all: Analysing ethnographic data. In J. Scott-Jones & S. Watt (Eds.), *Ethnography in social science practice* (pp. 157-172). New York, USA: Routledge.

Seem, M. D. (1995). Looking forward. *North American Journal of Oriental Medicine*, 2(3), 3.

Seidman, I. (2013). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (4th Ed.). New York, USA: Teachers College Press.

Seki, K. (2008). Case history of cancer. *North American Journal of Oriental Medicine*, 15(43), 24-25.

Seki, K. (2011). Case study: Sudden hearing loss. *North American Journal of Oriental Medicine*, 18(51), 20-21.

Seki, K. (2012). Box moxibustion. *North American Journal of Oriental Medicine*, 19(55), 16-17.

Sherman, K. J., Cherkin, D. C., Eisenberg, D. M., Erro, J., Hrbek, A., & Deyo, R. A. (2005). The practice of acupuncture: Who are the providers and what do they do? *The Annals of Family Medicine*, 3(2), 151-158. <https://doi.org/10.1370/afm.248>

Shibata, M. (1995). Illness whispers its presence. *North American Journal of Oriental Medicine*, 2(3), 30-31.

Shibata, M. (2001). Meridian test. *North American Journal of Oriental Medicine*, 8(23), 35-37.

Shibata, M. (2002). Dr. Yamaguchi's bloodletting acupuncture for racehorses. *North American Journal of Oriental Medicine*, 9(24), 38-40.

REFERENCES

Shim, J. M. (2015). The influence of social context on the treatment outcomes of complementary and alternative medicine: the case of acupuncture and herbal medicine in Japan and the US. *Globalization and Health*, 11(1), 1-13. <https://doi.org/10.1186/s12992-015-0103-2>

Shimada, R. (2005). Jing-Well point blood letting: The foundation of blood letting. *North American Journal of Oriental Medicine*, 12(33), 17-20.

Shimada, R. (2006). Points on the sole of the foot: Their relationship to jue. *North American Journal of Oriental Medicine*, 13(38), 19 - 20.

Shimada, R. (2007). Moxibustion on Guanyuan (CV-4). *North American Journal of Oriental Medicine*, 14(41), 31-33.

Shimizu, K. (2004). Akabane treatment for low back pain (1). *North American Journal of Oriental Medicine*, 11(32), 8-10.

Shinbara, H., Okubo, M., Kimura, K., Mizunuma, K., Sumiya, E., & Kitade, T. (2011). Effects of manual acupuncture with the Japanese traditional needle manipulation technique on skeletal muscle blood flow and arterial blood pressure in rats: A comparison of the techniques. *Japanese Acupuncture and Moxibustion*, 7(1), 15-21.

Shinma, H. (2009). The Fukaya multiple-grain moxibustion technique. *North American Journal of Oriental Medicine*, 16(46), 11-13.

Shirota, B. (2003). Case histories of acupuncture using cranial points. *North American Journal of Oriental Medicine*, 10(28), 7-8.

Shirota, F. (1998). What is the Sawada style taiji method? *North American Journal of Oriental Medicine*, 5(13), 7-8.

Shirota, F. (2001). The future of acupuncture. *North American Journal of Oriental Medicine*, 8(2), 3-7.

Shudo, D. (1996). Acupuncture treatment of cervical syndrome. *North American Journal of Oriental Medicine*, 3(7), 21-25.

Shudo, D. (1997). Looking forward. *North American Journal of Oriental Medicine*, 4(11), 4.

Shudo, D. (2000). Low back pain: Its diagnosis and treatment. *North American Journal of Oriental Medicine*, 7(18), 3-7.

Silva, S. (2011). *Along an African border: Angolan refugees and their divination baskets*. Pennsylvania, USA: University of Pennsylvania Press. <https://doi.org/10.9783/9780812203738>

Silva, S., & Fraga, S. (2012). Qualitative research in epidemiology. In N. Lunet (Ed.), *Epidemiology: Current perspectives on research and practice* (pp. 63-84). Rijeka, Croatia: InTech. <https://doi.org/10.5772/32986>

Simmonds, R., Glogowska, M., McLachlan, S., Cramer, H., Sanders, T., Johnson, R., . . . Purdy, S. (2015). Unplanned admissions and the organisational management of heart failure: A multicentre ethnographic, qualitative study. *BMJ Open*, 5(10), 1-13. <https://doi.org/10.1136/bmjopen-2014-007522>

Simmons, M. (2007). Insider ethnography: Tinker, tailor, researcher or spy? *Nurse Researcher*, 14(4), 7-17. <https://doi.org/10.7748/nr2007.07.14.4.7.c6039>

Small, M. L. (2009). How many cases do i need?' On science and the logic of case selection in field-based research. *Ethnography*, 10(1), 5-38. <https://doi.org/10.1177/1466138108099586>

Smith, C. A., Zaslawski, C. J., Zheng, Z., Cobbin, D., Cochrane, S., Lenon, G. B., . . . Xue, C. C. (2011). Development of an instrument to assess the quality of acupuncture: Results from a Delphi process. *The Journal of Alternative and Complementary Medicine*, 17(5), 441-452. <https://doi.org/10.1089/acm.2010.0457>

Sop, C. T. (2001). Koryo system of medicine in DPR Korea. In R. R. Chaudhury & U. M. Rafei (Eds.), *Traditional medicine in Asia* (pp. 69 - 74). New Delhi, India: World Health Organization

Sorimachi, D. (1997). Introduction to seitai shinpo. *North American Journal of Oriental Medicine*, 4(10), 21-23.

Sorimachi, D. (2003). Introduction to seitai shinpo (2). *North American Journal of Oriental Medicine*, 10(27), 28-29.

Streitberger, K. (2010). Non-penetrating sham acupuncture. *Japanese Acupuncture and Moxibustion*, 6(1), 74-79.

Sun, G., Eisenstark, D. D., & Zhang, Q. (2014). *Fundamentals of Chinese Medicine*. Beijing, Peoples Republic of China: Peoples Medical Publishing House.

Suzuki, H. (2015). Practice makes the perfect moxa treatment. *North American Journal of Oriental Medicine*, 22(65), 19-20.

Suzuki, I. (2002). Three successful cases of treating impotence. *North American Journal of Oriental Medicine*, 9(25), 39-40.

Suzuki, I. (2003). Post herpes neuralgia. *North American Journal of Oriental Medicine*, 10(28), 32-33.

Suzuki, K. (2004). Applications of pressure points and the effects of time. *North American Journal of Oriental Medicine*, 11(30), 16-17.

Suzuki, M. (2013). Superficial Needling: Qi movement and miracle cure. *North American Journal of Oriental Medicine*, 20(57), 5-7.

Suzuki, N. (2004). Complementary and alternative medicine: A Japanese perspective. *Evidence-Based Complementary and Alternative Medicine*, 1(2), 113 - 118. <https://doi.org/10.1093/ecam/neh029>

Takahashi, D. (2015). Introduction to Shakuju Therapy - Part 3. *North American Journal of Oriental Medicine*, 22(65), 35-37.

Takahashi, H. (1995). Drawing Ki to the side. *North American Journal of Oriental Medicine*, 2(4), 21-23.

Takahashi, H. (1997). The Taishihari acupuncture clinic. *North American Journal of Oriental Medicine*, 4(9), 21-25.

Takahashi, H. (1998). Experimenting with the dashin technique part (1). *North American Journal of Oriental Medicine*, 5(14), 22-23.

Takahashi, H. (1999). Experimenting with the dashin technique part 2. *North American Journal of Oriental Medicine*, 6(16), 32-33.

Takahashi, H. (2000). Experimenting with the dashin technique (part 4). *North American Journal of Oriental Medicine*, 7(19), 27-28.

Takahashi, H. (2002). Miscellaneous thoughts on shiraku-blood letting. *North American Journal of Oriental Medicine*, 9(25), 41-42.

Takahashi, H. (2003). Jaki and the dashin technique. *North American Journal of Oriental Medicine*, 10(28), 27-28.

Takahashi, H. (2005). Shared vibration in the dashin technique. *North American Journal of Oriental Medicine*, 12(34), 27-29.

Takahashi, H. (2012). The making of a mindful acupuncturist. *North American Journal of Oriental Medicine*, 19(54), 28-29.

Takashima, M. (2013). Characteristics of Japanese-style acupuncture. *North American Journal of Oriental Medicine*, 20(59), 17.

Takashima, M. (2014). The importance of observation. *North American Journal of Oriental Medicine*, 21(60), 18-19.

Talcott. (2013). Enhancement of TCM education with TJM. *North American Journal of Oriental Medicine*, 20(59), 41.

REFERENCES

Taniguchi, K. (2008). Licensing and education systems of acupuncturists and moxibustionists in Japan. *Japanese Acupuncture and Moxibustion*, 4(1), 19-28.

Tanioka, M. (1997). Improving your acupuncture and moxibustion technique. *North American Journal of Oriental Medicine*, 4(10), 23-25.

Tanioka, M. (1998). Thoughts on moxibustion therapy. *North American Journal of Oriental Medicine*, 5(13), 16-17.

Tanioka, M. (2000). Inappropriate stimulation. *North American Journal of Oriental Medicine*, 7(19), 21.

Tashakkori, A., & Teddlie, C. (Eds.). (2003). *Handbook of mixed methods in social and behavioral research*. Thousand Oaks, CA: Sage.

Teddlie, C., & Yu, F. (2007). Mixed methods sampling. *Journal of Mixed Methods Research*, 1(1), 77-100. <https://doi.org/10.1177/2345678906292430>

Temple, B. (2002). Crossed wires: Interpreters, translators, and bilingual workers in cross-language research. *Qualitative Health Research*, 12(6), 844-854. <https://doi.org/10.1177/104973230201200610>

Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research*, 4(2), 161-178. <https://doi.org/10.1177/1468794104044430>

Terayama, H., Yamazaki, H., Kanazawa, T., Suyama, K., Tanaka, O., Sawada, M., . . . Masuda, R. (2015). Multi-acupuncture point injections and their anatomical study in relation to neck and shoulder pain syndrome (so-called katakori) in Japan. *PLoS One*, 10(6), 1-13. <https://doi.org/10.1371/journal.pone.0129006>

Tilley, S. A., & Powick, K. D. (2002). Distanced data: Transcribing other people's research tapes. *Canadian Journal of Education/Revue Canadienne De L'éducation*, 27(2 & 3), 291-310. <https://doi.org/10.2307/1602225>

Toda, S. (2005). Acupuncture treatment for depression symptoms caused by going to work. *North American Journal of Oriental Medicine*, 12(33), 11-13.

Tokuyama, F. (2013). Delving into the wisdom of acupuncture. *North American Journal of Oriental Medicine*, 20(57), 24-25.

Tsuchiya, K. (2016). Anma, massaji, shiatsushi, harishi, kyushi, youseishisetsu zenkoku ichiran. *Ido No Nippon*, 75(3), 186-187.

Turetsky, T. (2010). The Zen practice of acupuncture. *North American Journal of Oriental Medicine*, 17(49), 30.

Unschuld, P. U. (1985). *Medicine in China: a history of ideas. Comparative studies of health systems and medical care*. Berkley, USA: University of California Press.

Unschuld, P. U. (2010). *Medicine in China: A history of ideas*. London, United Kingdom: University of California Press.

van Huffelen, T. (2007). Brushing your teeth: An article on home moxibustion. *North American Journal of Oriental Medicine*, 14(40), 28.

van Huffelen, T. (2015). Touched by the magic wand: Using the teishin. *North American Journal of Oriental Medicine*, 22(64), 11-15.

van Maanen, J. (1996). Ethnography. In A. Kuper & J. Kuper (Eds.), *The Social Science Encyclopedia*. London, UK: Routledge.

Ventres, W., Kooienga, S., Vuckovic, N., Marlin, R., Nygren, P., & Stewart, V. (2006). Physicians, patients, and the electronic health record: An ethnographic analysis. *The Annals of Family Medicine*, 4(2), 124-131. <https://doi.org/10.1370/afm.425>

Vigouroux, M. (2008a). Acupuncture and moxibustion in the Edo period. *North American Journal of Oriental Medicine*, 15(42), 13-16.

Vigouroux, M. (2008b). In search of Japanese acupuncture heritage. *North American Journal of Oriental Medicine*, 15(44), 10 - 13.

Vigouroux, M. (2011). Siebold and Ishizaka Sotetsu. *North American Journal of Oriental Medicine*, 18(52), 28-31.

Walford, G. (2009). For ethnography. *Ethnography and Education*, 4(3), 271-282. <https://doi.org/10.1080/17457820903170093>

Walton, B., & Shudo, D. (2006). Questions about super-superficial insertion. *North American Journal of Oriental Medicine*, 13(38), 34.

Wang, J., & Robertson, J. D. (2008). *Applied channel theory in Chinese medicine: Wang Ju-Yi's lectures on channel therapeutics*. Seattle, USA: Eastland Press.

Wang, Y. (2008). *Micro-acupuncture in practice*. St. Louis, USA: Elsevier.

Watt, S., & Scott-Jones, J. (2010). Let's look inside: Doing participant observation. In J. Scott-Jones & S. Watt (Eds.), *Ethnography in social science practice* (pp. 107-125). New York, USA: Routledge.

Welden, J. (2010). Medical identity in China and Southeast Asia. *The Lantern: A Journal of Chinese Medicine*, 7(1), 42 - 51.

Welden, J. (2011). Medical parallels between China and Southeast Asia. *The Lantern: A Journal of Chinese Medicine*, 8(1), 21-30.

Wheeler, J., Coppock, B., & Chen, C. (2009). Does the burning of moxa (*Artemisia vulgaris*) in traditional Chinese medicine constitute a health hazard? *Acupuncture in Medicine*, 27(1), 16-20. <https://doi.org/10.1136/aim.2009.000422>

White, A. (2009). Western medical acupuncture: A definition. *Acupuncture in Medicine*, 27(1), 33 - 35. <https://doi.org/10.1136/aim.2008.000372>

White, A., & Ernst, E. (2004). A brief history of acupuncture. *Rheumatology*, 43(5), 662 - 663. <https://doi.org/10.1093/rheumatology/keg005>

White, P., Golianu, B., Zaslawska, C., & Seung-Hoon, C. (2006). Standardization of nomenclature in acupuncture research (SoNAR). *Evidence Based Complementary and Alternative Medicine*, 4(2), 267-270. <https://doi.org/10.1093/ecam/nel095>

Whiting, L. S. (2008). Semi-structured interviews: Guidance for novice researchers. *Nursing Standard*, 22(23), 35-40. <https://doi.org/10.7748/ns2008.02.22.23.35.c6420>

Wilcox, L. (2009). *Moxibustion: A modern clinical handbook*. Boulder, USA: Blue Poppy Press.

Williams, G. (2007). The pulse, meridians, and nature of points in root treatments. *North American Journal of Oriental Medicine*, 14(41), 11-13.

Williamson, D. L., Choi, J., Charchuk, M., Rempel, G. R., Pitre, N., Breitkreuz, R., & Kushner, K. E. (2011). Interpreter-facilitated cross-language interviews: A research note. *Qualitative Research*, 11(4), 381-394. <https://doi.org/10.1177/1468794111404319>

Willis, P., & Trondman, M. (2000). Manifesto for ethnography. *Ethnography*, 1(1), 5-16. <https://doi.org/10.1177/14661380022230679>

Wilson, H. S., & Hutchinson, S. A. (1991). Triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory. *Qualitative Health Research*, 1(2), 263-276. <https://doi.org/10.1177/104973239100100206>

REFERENCES

Wilson, R. E., Gosling, S. D., & Graham, L. T. (2012). A review of Facebook research in the social sciences. *Perspectives on Psychological Science*, 7(3), 203-220. <https://doi.org/10.1177/1745691612442904>

Wolf, M. (2009). From TCM to Toyohari: A personal journey. *North American Journal of Oriental Medicine*, 16(45), 28-30.

Wong, Y.-M. (2014). Skin Resistance Measurement in Japanese Acupuncture. *Biofeedback*, 42(4), 161-162. <https://doi.org/10.5298/1081-5937-42.4.07>

World Health Organisation. (2007). *WHO international standard terminologies on traditional medicine in the Western Pacific region*. Manila, Philippines: World Health Organization.

World Health Organisation. (2008). *WHO standard acupuncture point locations in the Western Pacific region*. Manila, Philippines: World Health Organization.

Xing, J., Zeng, B.-Y., Li, J., Zhuang, Y., & Liang, F. (2013). Acupuncture point specificity. In B. Y. Zeng, K. Zhao & F. R. Liang (Eds.), *International Review of Neurobiology* (Vol. 111, pp. 49-65). London, United Kingdom: Elsevier. <https://doi.org/10.1016/b978-0-12-411545-3.00003-1>

Xue, C. C., Wu, Q., Zhou, W. Y., Yang, W. H., & Story, D. (2006). Comparison of Chinese medicine education and training in China and Australia. *Annals Academy of Medicine Singapore*, 35(11), 775-779.

Xue, C. C., Zhou, W., Zhang, A. L., Greenwood, K., Da Costa, C., Radloff, A., . . . Story, D. F. (2008). Desired Chinese medicine practitioner capabilities and professional development needs: A survey of registered practitioners in Victoria, Australia. *BMC Health Services Research*, 8(1), 1-9. <https://doi.org/10.1186/1472-6963-8-27>

Xue, P., Zhan, T., Yang, G., Farella, G. M., Robinson, N., Yang, A. W., & Liu, J. (2015). Comparison of Chinese medicine higher education programs in China and five Western countries. *Journal of Traditional Chinese Medical Sciences*, 2(4), 227-234. <https://doi.org/10.1016/j.jtcms.2016.01.010>

Yackel, A. (2008). Building a solid foundation: The Japanese acupuncture certificate program in Victoria, B.C. *North American Journal of Oriental Medicine*, 15(44), 43.

Yamada, H. (2005). Japan. In G. Bodeker, C. K. Ong, C. Grundy, G. Burford & K. Shein (Eds.), *World Health Organization global atlas of traditional, complementary, and alternative medicine* (Vol. 1) (pp. 193 - 198). Kobe, Japan: World Health Organization.

Yamada, K. (2015). Theoretical discussion of Sawada style Taikyoku Therapy. *North American Journal of Oriental Medicine*, 22(65), 3-5.

Yamada, M. (2007). Retaining needle onto the superior cervical ganglion for treatment of hay fever (seasonal allergic rhinitis). *North American Journal of Oriental Medicine*, 14(40), 17-19.

Yamamoto, M. (2016). Dai 24kai amashi, harishi, kyuushi, juuseishi, kokkashikengakkoubetsu goukakushajoukyouhappyou. *Ido No Nippon*, 75(5), 73.

Yamashita, H., & Masuyama, S. (2010). Acupuncture treatment for low back pain in Japan: A brief review based on clinical research papers. *Japanese Acupuncture and Moxibustion*, 6(1), 70-73.

Yanagishita, T. (1998). An acupuncture system with wide application: Background on Meridian Therapy in Japan. *North American Journal of Oriental Medicine*, 5(12), 6.

Yanagishita, T. (2001a). Muno treatment. *North American Journal of Oriental Medicine*, 8(22), 19-20.

Yanagishita, T. (2001b). Naso treatment. *North American Journal of Oriental Medicine*, 8(21), 8-9.

Yanagiya, S. (2002). Techniques of tonification and dispersion with practical applications. *North American Journal of Oriental Medicine*, 9(26), 34.

Yang, X. Y., Shi, G.-X., Li, Q. Q., Zhang, Z.-H., Xu, Q., & Liu, C. Z. (2013). Characterization of deqi sensation and acupuncture effect. *Evidence-Based Complementary and Alternative Medicine*, 2013, 1-7. <https://doi.org/10.1155/2013/319734>

Yano, T. (2010). Current status of acupuncture in Japan. *The Journal of Kampo, Acupuncture and Integrative Medicine*, 1(Special Edition), 76-81.

Yao, X. (2000). *An introduction to Confucianism*. Cambridge, UK: Cambridge University Press. <https://doi.org/10.1017/CBO9780511800887>

Yasui, H. (2007). Medical history in Japan: Dosan Manase and his medicine (1). *The Journal of Kampo, Acupuncture and Integrative Medicine*, 2(1), 30-33.

Yasui, H. (2010a). History of Japanese acupuncture and moxibustion. *The Journal of Kampo, Acupuncture and Integrative Medicine*, 1(Special Edition), 2-9.

Yasui, H. (2010b). Japanese acupuncture schools and their characteristics. *The Journal of Kampo, Acupuncture and Integrative Medicine*, 1(Special Edition), 40 - 45.

Yasushi, M. (2008). Shiunko (purple cloud cream) and chronic pain. *North American Journal of Oriental Medicine*, 15(42), 20-22.

Yates, P. (2011). Novice to mentor. *North American Journal of Oriental Medicine*, 18(52), 36-37.

Yeonseok, K. (2011). The characteristics of Korean medicine based on time classification. *China Perspectives*, 2011 Special feature (3), 33-41.

Yin, C. S., Park, H. J., Chae, Y., Ha, E., Park, H. K., Lee, H. S., . . . Ryu, Y. H. (2007). Korean acupuncture: The individualized and practical acupuncture. *Neurological Research*, 29(Supplement 1), 10-15. <https://doi.org/10.1179/016164107X172301>

Yu, F., Takahashi, T., Moriya, J., Kawaura, K., Yamakawa, J., Kusaka, K., . . . Kanda, T. (2006). Traditional Chinese medicine and Kampo: a review from the distant past for the future. *The Journal of International Medical Research*, 34(3), 231-239. <https://doi.org/10.1177/147323000603400301>

Yuki, M. (2010). Dr. Yoshito Mukaino and the amazing M-Test. *North American Journal of Oriental Medicine*, 17(49), 26-28.

Zhan, M. (2001). Does it take a miracle? Negotiating knowledges, identities, and communities of traditional Chinese medicine. *Cultural Anthropology*, 16(4), 453-480. <https://doi.org/10.1525/can.2001.16.4.453>

Zheng, Z. (2014). Acupuncture in Australia: Regulation, education, practice, and research. *Integrative Medicine Research*, 3(3), 103-110. <https://doi.org/10.1016/j.imr.2014.06.002>

Zhou, W., & Benharash, P. (2014). Significance of "Deqi" response in acupuncture treatment: myth or reality. *Journal of Acupuncture and Meridian Studies*, 7(4), 186-189. <https://doi.org/10.1016/j.jams.2014.02.008>

Zhu, B., & Wang, H. (Eds.). (2010). *Basic Theories of Traditional Chinese Medicine*. London, UK: Singing Dragon.

Appendix A

Table A1 Original Observation Guidelines

Clinic Environment	
• Geographic location of clinic in context & importance to its neighbourhood	
Clinic Rituals	
• Spatial elements of the clinics, layout, designs & functionality	
• Staff, uniform & relationships between organisation members	
• Sounds, smells & sights within the clinic, aesthetics & intrusions	
• Administrative aspects	• Clinic accessibility
• Tools and equipment	• Rationale of participants
Treatments – Patient/Practitioner Interactions	
• Administrative rituals including inventory & book keeping	
• Preparing for patients	• Receiving a patient
• Main body of treatment	• Payment, rebooking & farewell
• Conclusion of appointment	• Time management
• Opening and closing the clinic	• Cleaning
• Breaks	• Rationale of practitioners
• Interpretations of the practitioner in relation to philosophy & aetiology	
• Diagnosis and methods, depth of analysis and duration	
• Duration of treatment & certain techniques	
• Patient/practitioner dialogue	• Patient/practitioner behaviors
• Case taking/return assessment	• Treatment techniques and principles
• Tools and equipment used	• Interpreting results of treatment
• Treatment plan	• Advice/ancillary methods
• Prognosis	• Patient compliance
• Referrals	• Record keeping
• Case management	• Rationale of practitioners

Table A2 Original Interview Schedule

Demographic Data
<ul style="list-style-type: none"> • Age • Birthplace • Professional experience • Average service fee • Gender • Educational qualifications • Average patients per week • Average consultation time
Q1 Please describe a typical day in your clinic
<ul style="list-style-type: none"> • Probe for procedures in relation to receiving, treating and concluding with patients • Probe for how their procedures have evolved or might be compared to others • Probe for how or if this changes during the year
Q2 How would you describe your style of acupuncture?
<ul style="list-style-type: none"> • Probe for philosophical concepts, diagnostic methods and treatment principles • Probe for how their style fits in with what they consider as Japanese acupuncture in general • Probe for how their style fits in with any schools of thought they know about • Probe for the most important aspects of their style
Q3 What, if any, are the unique aspects of Japanese acupuncture in relation to acupuncture elsewhere?
<ul style="list-style-type: none"> • Probe for philosophical concepts, diagnostic methods and treatment principles • Probe for any procedural differences • Probe for a rationale of their opinions
Q4 What do you think patients expect from your treatments?
<ul style="list-style-type: none"> • Probe for how clinical encounters have shaped their current practice • Probe for any differences in patients between them and their colleagues
Q5 If you gave a workshop or seminar on your style of acupuncture abroad, what would you teach and talk about?
<ul style="list-style-type: none"> • Probe for philosophical concepts, diagnostic methods and treatment principles • Probe for a rationale of their opinions
Q6 In your opinion, what is the future of Japanese acupuncture?
<ul style="list-style-type: none"> • Probe for what they want to know more about • Probe for what they want other therapists to know about • Probe for hopes and fears for the future of acupuncture
Q7 If you were interviewing Japanese acupuncturists about how they classify, clarify and describe acupuncture, what questions would you ask?
<ul style="list-style-type: none"> • Probe for a rationale of their opinions • Probe for other aspects of acupuncture not related to classification or description
Q8 If after the interview some issues are unclear, the researcher would like to contact you to clarify any outstanding issues. The researcher may also ask for your opinions and interpretations on the data obtained during the study. Do you agree to be contacted for this?

Table A3 Additional Important Questions

Philosophical Concepts
<ul style="list-style-type: none"> • What knowledge do you think is most important when treating a patient? • What medical models do you think are present in the practice of Japanese acupuncture and what do you apply in your practice?
Diagnostic Methods
<ul style="list-style-type: none"> • What's the first thing you do when a patient arrives? • What kind of diagnosis is the most important to you? • 10 questions, other lines of questioning? • Where and what kind of things do you look at? • What do you think about tongue diagnosis? • What do you think about 3 and 6 position pulse diagnosis? • What kind of things do you look for in the pulse? • Are there any special areas on the body you think are of particular importance? • How do you use listening/smelling? • What things do you look for when trying to make a diagnosis? • What are some examples of the kind of diagnoses that you make? • What are your main objectives when you start a treatment? • What do you think about patterns of disharmony?
Treatment Principles
<ul style="list-style-type: none"> • What tools do you use in clinic? • Why did you decide to use these tools? • What are the most common types of tools you use in your clinic? • What length and gauge needles? • How do you insert the needle? • What things do you pay attention to when you insert it? • Do you stimulate or manipulate needles? How? Why? • What are you trying to stimulate and what does this achieve? • How deep do you insert needles? Why? • How many treatment locations do you treat? • Do you retain needles? If so, how many, how long and why? • What do you do while needles are retained? • Do you pay any special attention to anything when you withdraw needles? What and why? • Do you use intradermal needles or press studs?

- Any other take home tools you apply to patients?
- What do you think about moxa?
- Do you use moxa? Why/not?
- Could you describe how you generally use moxa?
- What kind of moxa do you use and why?
- What do you think about stick moxa? Stick-on moxa? Raw floss?
- What is moxa indicated for?
- What is the best kind of moxa?
- What is your advice on using both indirect/direct moxa?
- What size cones do you use and for what?
- What kind of contact tools do you use in your treatments? Why/not?
- What kind of machines do you use? Why/not?
- How do you decide what points or where you will treat?
- How do you find the points you want to use?
- What do you think about the pushing hand?
- What do you think about tanshi?
- When do you decide to stop manipulation? Why?
- How long is a treatment? Why?
- Do you think it's important to confirm the effects of treatment? Why?
How/When/Where do you perform this?
- Do you affiliate with any special style of treatment?

Appendix B



**School of Science and Technology
Armidale, NSW 2351
Australia
Head of School:
Professor Aron Murphy**

INFORMATION SHEET for PARTICIPANTS (practitioners)

Research Project: *Cross Cultural Differences in Acupuncture: An Understanding of Japanese Acupuncturists*

I wish to invite you to participate in my research on the above topic. This letter outlines the details for the study and I hope you will consider being involved. My name is Benjamin Chant and I am conducting this research project as part of my thesis at the University of New England. My supervisors are Dr. Gudrun Dieberg, Adjunct Professor Jeanne Madison and Dr Paul Coop of the University of New England. Dr. Dieberg can be contacted by email at gdieberg@une.edu.au or by phone on +61 (0)2 6773 2321. Adjunct Professor Madison can be contacted by email at jmadison@une.edu.au or by phone, Dr Coop can be contacted by email at pcoop@innerpath.com.au or by phone on +61 (0)2 6772 3894 and I can be contacted by email at bchant2@une.edu.au, curiousfu@gmail.com or by phone on +61 (0)409 903 121 or in Japan on 0804 123 6771.

Aim of the study:

This study aims to investigate Japanese acupuncture in order to describe the theory and practise of acupuncture in Japan and clarify the relationships between philosophical concepts, diagnostic methods and treatment principles.

Please consider participation in this study if:

- You conducted your undergraduate or equivalent acupuncture/moxibustion training in Japan
- Are practising or teaching acupuncture/moxibustion

- Are above 18 years of age

Time requirements:

- Observation of your clinic procedures for at least 1 treatment or 1 business day between operating hours.
- An interview lasting approximately 1 hour that may be electronically recorded.

Observation:

The researcher will observe clinic procedures and the way in which treatments are performed. These observations will be recorded by hand in field notes. If you agree, photographs may be taken of the clinic space, and any photos of people (after their written consent) will be unidentifiable. The objects, layout and physical space will be detailed in the notes. The clinic procedure for conducting a treatment will be noted before the patient arrives until they depart. Following completion of the observations and examination, an explanation of the notes will be made available to you, should you wish so.

Patient record analysis

To contextualise the treatment, it will be useful to obtain patient records of the cases observed. The researcher will ask to have a copy of the patient records for the observed cases. All identifying and contact details will be removed and the records will be coded to the observation so that the records remain anonymous.

Interviews

There will be a series of open-ended questions that will explore your views and practices related to acupuncture. These interviews will be noted by hand, voice recorded or electronically captured and later transcribed. Any information you give during interviews may be quoted in the publication and will remain anonymous. Following the interview, a transcript will be provided to you if you wish to see one. You will have a chance to agree to be contacted for follow up questions to clarify any outstanding issues at the end of the interview.

Follow up questions

If after interviews and observations some issues are unclear, the researcher would like to contact you to clarify any outstanding issues. The researcher may also ask for your opinions and interpretations on the data obtained during the study.

Any information or personal details gathered in the course of the study will remain confidential. No individual or organisation will be identified by name in any publication of the results. All names will be replaced by pseudonyms; this will ensure that you or your organisation are not identifiable. Please note that some of the data obtained may be of a sensitive or personal nature and if there is anything that you feel uncomfortable about, you are able to withdraw from the study at any time.

Participation is completely voluntary. If you decide to participate, you are free to withdraw your consent from the project and discontinue at any time without having to give a reason and without consequence if you decide not to participate or withdraw at any time.

The voice recordings, written notes and patient records will be kept in a secure file on the researcher's personal computer or locked securely in my home office. All data collected as part of the study will be held for a minimum of five (5) years following the successful submission of my thesis. After this period all data will be disposed by deleting relevant computer files and destroying or shredding hardcopy materials. Only the investigators will have access to the data.

Research process:

It is anticipated that this research will be completed by the end of 2016. The results may also be presented at conferences or written up in journals without any identifying information.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No. HE12-142, Valid to 31/12/2016)

Should you have any complaints concerning the manner in which this research is conducted, please contact:

Thomas Blasejewicz
Thomas' Acupuncture Clinic
Kanagawa ken, Miura gun, Hayama machi, Horiuchi 815
〒240-0112, Japan
Tel/Fax: 046-876-3077
tom@einklang.com
www.einklang.com

Or the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351.
Telephone: (02) 6773 3449 Facsimile (02) 6773 3543
Email: ethics@une.edu.au

Thank you for considering this request and I look forward to further contact with you.

Regards

Benjamin Chant



**School of Science and
Technology
Armidale, NSW
2351
Australia
Head of
School:
Professor Aron
Murphy**

Consent Form for Participants (practitioners)

**Research Project: Cross Cultural Differences in Acupuncture: An Understanding of
Japanese Acupuncturists**

I, have read the information contained in the Information Sheet for Participants and any questions I have asked have been answered to my satisfaction. Yes/No

I conducted my undergraduate or equivalent acupuncture/moxibustion training in Japan and am a practicing or teaching acupuncturist. Yes/No

I agree to participate in having the researcher observe my treatments, if informed consent is granted by my patient, realising that I may withdraw at any time. Yes/No

I agree to participate in interviews, realising that I may withdraw my consent at any time. Yes/No

I agree to provide patient records or clinical notes from treatments if informed consent is granted by the patient. Yes/No

I agree to being contacted by the researcher for follow-up questions. Yes/No

I agree that research data gathered for the study may be

published using a pseudonym. Yes/No

I agree to the interview having my voice recorded, transcribed and to being quoted in any publications. Yes/No

I understand that I can withdraw consent at any time during the study without reason or consequence. Yes/No

I am 18 years or older. Yes/No

.....
Participant

.....
Date

.....
Researcher

.....
Date



**School of Science and Technology
Armidale, NSW 2351
Australia
Head of School:
Professor Aron Murphy**

ご協力者の方々へ

研究プロジェクト:

文化間における鍼灸治療の違い – 日本鍼灸の理解を促進する

上記の私の研究についてご協力をお願いしたく、ご連絡申し上げます。
この文章は研究の目標を概説したものです。
ご賛同いただけるかどうか、ご検討の程よろしくお願いいたします。

私はベンジャミン チャントと申します。大学卒業論文の一部として、この研究プロジェクトをニューイングランド大学で行っています。私の担当教授は、ニューイングランド大学の Dr. G. ディーベルク (Dr. Grudrun Dieberg) ならびに客員教授 J. マディソン (Prof. Jeanne Madison) 博士, P. クープ (Dr. Paul Coop) 博士です。

連絡先は以下の通りです。

Dr. Dieberg メール: gdieberg@une.edu.au
Tel: +61 (0) 2 6773 2321

Prof. Madison メール: jmadison@une.edu.au
Tel: +61 (0) 2 6773 3667

Dr. Coop メール: pcoop@innerpath.edu.au
Tel: +61 (0) 2 6772 3864

ベンジャミンチャント: メール: bchant2@une.edu.au / curiousfu@gmail.com
Tel: +61 (0) 409 903 121 / 0804 123 6771

研究の目的:

本研究の目的は日本の鍼灸師の先生方がそれぞれ実践されている、各鍼灸術の理論・実技を考察し、日本の鍼灸における哲学的概念、診断法と治療方針の関係を解明することです。

日本の鍼灸師および鍼灸学生の方々に、この研究への参加をお願いしております。

時間要件:

- 1 営業時間内の、少なくとも一件の治療の見学、または開業時間内における1営業日で貴院の診療手順の観察。
- 2 約1時間ほどの会話/インタビュー(電子メディアで記録させて頂く場合もあります)。

観測:

私、研究者は、クリニックの状態や治療方法を観察し、手書きでノートに記録します。もし許可をいただけましたら、診療所内の写真撮影をお願いさせて頂く場合もありますが、患

者様を撮影する事は一切ありません。院内の設備とその配置、および物理的なスペース等をノートに詳述します。また治療の手順の記録として、患者様が来院された時から、お帰りになられるまでの、一連の流れを記録します。そして、私がノートに記録させていただきました内容につきまして、ご確認頂くために後で説明させていただきたいと思います。

患者記録分析

守秘義務が守られる範囲内で、見学させていただきました患者様の治療記録の複製(ただし患者様個人を特定できる氏名や生年月日等の情報が除外されたもの)をご提供いただくことが可能であれば、本研究にとって、それはとても有用な資料となりますので、可能であれば是非ともご協力お願い致します。

インタビュー:

先生の実践されている鍼治療の実際について、いくつかのイエス・ノー形式のご質問、又は自由回答式質問をさせていただく思っております。これらのインタビューでの会話は手書き、音声記録または電子メディアを用いての記録を考えております。ご希望があれば、記録させていただきましたもののコピーを提供致します。

フォローアップ:

インタビューや見学後に不明な点があれば、私、研究者はご協力いただきました方に対して電子メール、電話または直接訪問にて、その内容についてご確認をさせて頂きたいと存じます。研究者が協力者に試験中に得られたデータに関するご意見や解釈を伺う場合もあります。

研究中に得られた全ての情報(個人情報についても)は機密に扱われます。研究結果発表の際はどなたの名前も公表されません。先生方の名前も特定できないためすべての名前が仮名に置き換えられます。

ご協力頂くことに関して完全に任意です。一度、ご協力頂けるという意思表示・同意を下さった後からでも、常に理由を述べる必要性なく協力への同意を撤退し、協力の中止をすることが出来ます。プロジェクトに協力しない、又は途中で撤退しても、先生には何のご迷惑もおかけしません。

本見学にて収集させていただきます音声録音、書かれたメモや患者様の記録は、研究者のコンピュータで保護されているファイル、あるいは安全な非公開な場所で保管されます。当研究で得られたすべてのデータは論文提出後に5年間保護された形で保管されます。その後、全てのデジタルデータの消去及び書類の破棄を行います。研究データにアクセス出来るのは調査員のみです。

研究プロセス:

本研究は2016年末までに完了する予定です。結果は会議で発表、または識別可能な情報を使用せずに雑誌に掲載かれことがあります。

このプロジェクトは、ニューイングランド大学のヒューマン研究倫理委員会(承認番号: HE12-142, 31/12/2016 有効な)によって承認を受けております。

この研究が行われる方法に関するご意見がありましたら、以下のアドレスにて研究倫理担当役員にご連絡ください。

日本でのお問い合わせ先:

Thomas Blasejewicz

トマス鍼灸院

神奈川県三浦郡葉山町堀内 815

〒240-0112

TEL / FAX:046-876-3077

tom@einklang.com

www.einklang.com

リサーチサービス

ニューイングランド大学

アーミデール、ニューサウスウェールズ州 2351。

電話: (02) 6773 3449

ファックス(02) 6773 3543

メールアドレス: ethics@une.edu.au

この依頼書をお読みいただきありがとうございます。先生とさらなる交流を楽しみにしています。

どうぞ、よろしくお願ひ申し上げます。

ベンジャミン・チャント



**School of Science and Technology
Armidale, NSW 2351
Australia
Head of School:
Professor Aron Murphy**

プロジェクト参加への同意書

研究プロジェクト:文化間における鍼灸治療の違い – 日本鍼灸の理解を促進する

私は、…………… 本研究の概略を読み、その中で疑問に思った事柄について、研究者から満足できる回答を得て、理解することができました。 **はい/いいえ**

私は日本の国家資格を持つはり師・きゅう師、または日本のはり師・きゅう師に係る大学または専修学校の学生です。 **はい/いいえ**

私は、研究者から治療を観察・記録されることについて同意しますが、その同意は 後からいつでも無条件に撤回出来るという事を理解しています。 **はい/いいえ**

私は、常にこの研究からいつでも無条件に撤退出来ることを認識しながら、インタビューに参加します。 **はい/いいえ**

私は、患者様から同意を頂けた場合、その患者様の治療記録を提供することに合意します。 **はい/いいえ**

フォローアップのインタビューのため、研究者が私に電子メール、電話連絡、または直接訪問して連絡することに同意します。 **はい/いいえ**

私は研究において収集された研究データが、仮名を使用して公表されることがあり得るという事に同意します。 **はい/いいえ**

インタビューの際、自分の発言が録音、又転写されるという事を理解しています。 **はい/いいえ**

私は、転写されて、私の声を記録するインタビューに、

および任意の出版物で引用されることに同意します。 はい/いいえ

ご協力頂くことに関して完全に任意です。一度、協力に同意した場合でも、常に理由を述べる必要性なく協力への同意を撤回し、協力の中止をすることが出来ます。 はい/いいえ

私がプロジェクトに協力しない、又は途中で協力を放棄しても、何の影響も被らないということを理解しています。 はい/いいえ

私は 18 歳以上です。 はい/いいえ

.....
協力者 日付

.....
研究者 日付