Integrating Acupuncture in an Inpatient Setting

B. Basia Kielczynska¹, Benjamin Kligler², and Eileen Specchio³

Abstract
Acupuncture, a licensed health care profession in the United States, is poorly integrated into the American health care system, despite the evidence of its effectiveness. The purpose of this study was to offer a phenomenological description of the experience of acupuncturists who delivered acupuncture care in a tertiary teaching hospital in New York City. We analyzed data using methodology proposed by Colaizzi and identified four major clusters of themes: (a) acupuncturists’ excitement about practicing in a hospital setting and frustration about organizational obstacles to effective acupuncture integration; (b) pride in being holistic practitioners; (c) attempts to preserve the holism and effectiveness of acupuncture while adjusting to the limitations of an inpatient setting, and (d) acupuncturists’ realization that the medical staff knew very little about acupuncture and “it’s all about trust.” Practitioners of other healing traditions and therapies might find our study helpful in their own efforts toward similar integration.

Keywords
health care administration; health care, alternative and complementary; health care, interprofessional; health care, teamwork; health care, transcultural; health policy / policy analysis; lived experience; phenomenology; research, interdisciplinary; research, qualitative

The development of acupuncture¹ as a health care profession in the United States is a relatively recent phenomenon. Acupuncture has been accepted as safe (Lao, Hamilton, Fu, & Berman, 2003); researched for its effectiveness and utilization (MacPherson & Hammerschlag, 2012; Witt, Brinkhaus, Reinholdt, & Willich, 2006); and studied for physiological mechanisms (Cabioglu & Cetin, 2008). Acupuncturists are licensed providers in most states and can practice without a physician’s referral or supervision. In the past 40 years the biomedical profession’s attitudes toward acupuncture have changed from open hostility to various levels of acceptance, including attempts to integrate acupuncture with biomedical care (Kaptchuk & Miller, 2005). Despite these efforts, acupuncture care is present in only a handful of medical centers in the United States (Dusek, Finch, Plotnikoff, & Knutson, 2010; Johnstone, Polston, Niemtzow, & Martin, 2002).

The inpatient setting presents challenges to an acupuncturist’s training and practice. Acupuncture education includes a basic knowledge of biomedical pathophysiology and required training in practice safety in accordance with the standards set by the Centers for Disease Control and Prevention (National Acupuncture Foundation, 2009). These components of acupuncture education are adequate for the private setting but might not be adequate for a hospital practice. In addition, acupuncture clinical education is based on the philosophy of Chinese medicine, which is different from biomedicine in a number of ways.

Acupuncturists are taught to evaluate the source manifestation of imbalance rather than the linear relationships between cause and effect (known as “treating the root rather than the branch”), to think interactively (Cassidy, 2010), and to practice holistically (Farquhar, 1994). They forge deep relationships with their patients, provide health and self-help education, utilize touch in evaluation and treatment, and frequently employ metaphors and rituals as healing agents (Anderson, 2010). Whereas some acupuncturists might utilize biomedical diagnosis in their evaluation, others do not diagnose in the biomedical sense but rather treat patients based on palpatory evaluation and the symptomatic presentation.² The variety in acupuncture practice styles is the outcome of the long history of Chinese medicine allowing for diverging interpretations.

¹Beth Israel Medical Center, New York, New York, USA
²Albert Einstein College of Medicine, New York, New York, USA
³College of St. Elizabeth, Morristown, New Jersey, USA

Corresponding Author:
B. Basia Kielczynska, Continuum Center for Health and Healing, Beth Israel Medical Center, 245 Fifth Ave., New York, New York 10016, USA.
Email: bkielczynska@chpnet.org
of medical classics and incorporating contradictory positions (Unschuld, 1987). This focus on clinical pragmatism over theoretical consistency might present a challenge in collaborating with biomedical providers who value homogeneous models and are less comfortable with contradictions.

Little is known about how the incompatibilities between acupuncture and biomedicine emerge and are expressed in a hospital environment, how acupuncturists and medical staff negotiate cooperation, and how the limits of an inpatient setting can impact the effectiveness of acupuncture care. Cassidy (1998) suggested that “[h]ow acupuncturists are trained and how they deliver care may influence reforms in the American health care system” (p. 189). Similarly, acupuncturists can learn from other nonbiomedical professions that have implemented various models of integrative care in the United States (Kligler et al., 2011) and other countries (Singer & Adams, 2012). We hope to contribute to this discussion by describing the experience of acupuncturists who provided acupuncture inpatient care in a teaching hospital in New York City.

Significance

The significance of this study lies in the novelty of both the research subject (acupuncture in the inpatient setting) and the methodology (phenomenology in acupuncture research). Acupuncture has been extensively studied by biomedical researchers as a clinical intervention (Vickers et al., 2012), but acupuncture research has been dominated by positivist inquiry even though the epistemology of traditional East Asian medicine derives from human experience (Unschuld, 1985). These epistemological tensions have engendered disagreements among acupuncturists about methodologies that are most appropriate to study the effectiveness of acupuncture care (Birch, 2004). The understanding of acupuncture as a cultural and professional phenomenon has been advanced by anthropologists (Barnes, 2009), but little has been written about the experience of integrating acupuncture into the American health care system.

In examining subjects that are not well understood, phenomenology can be a useful tool. The phenomenological approach adds knowledge and richness to acupuncture research by describing and interpreting acupuncturists’ experience in the world. The experience of acupuncturists who have dealt with the challenges of bringing their practice into an inpatient environment can help clarify the necessary steps in the process of acupuncture integration. We hope to contribute to a richer model of an “evidence mosaic” in acupuncture research, as compared to the model of an “evidence hierarchy” (MacPherson, Hammerschlag, Lewith, & Schnyer, 2007, p. 7). Because healing and wholeness are as fundamental in the practice of acupuncture as they are in the practice of nursing (Wojnar & Swanson, 1997), we have chosen the phenomenological tradition in nursing as a starting point for the broader introduction of this qualitative method into the field of acupuncture research.

Phenomenological Perspective

A positivistic paradigm is not well suited to the study of certain phenomena because it does not offer methods to describe meaning, values, and experiences. Husserl offered phenomenology as a science of intentional consciousness, in which intentionality indicates interdependence between the human being and the world she or he experiences (Kockelmans, 1994). He proposed phenomenological reduction as a means to describe general features of experience in a phenomenological process of “reducing” the natural world to the world of pure phenomena. Phenomenological researchers attempt to put aside theoretical knowledge and presuppositions in the process of bracketing, although they acknowledge that it is not possible to inquire without preconceptions (Merleau-Ponty, 1956). Additionally, some authors have argued that bracketing has “little sense in the study of health experience” when the need to identify gaps in clinical knowledge comes from professional judgment (Thorne, 2011, p. 446).

In phenomenological research the question is not searched for; it comes from the researcher’s life. Phenomenological researchers study phenomena because they are truly interested in them and they observe and interview participants to elicit their stories, uncover meanings in everyday events, and present them as thematic and analyzed narratives (Benner, 1985). Their basic assumption is that the core of common experiences is the same in different individuals who belong to similar groups (Van Kaam, 1959), and the researcher, as an interpreter, should share the general experience of the group she or he studies (Bergum, 1991). This inevitably introduces the potential for bias, which must be actively and consciously addressed in every step of the process. As researchers we were committed to an open-minded exploration of the phenomenon of interest and we made every effort to be aware of the theories and opinions we have developed as health care professionals—the first author as an acupuncturist in a biomedical institution; the second author as an integrative physician with acupuncture training and as clinical faculty in a residency program; and the third author as a nurse clinician, researcher, and educator.

Research Setting

The setting of our study was a tertiary teaching hospital in New York City with a long tradition of providing care to
an underserved population and a mission to remain open to and accepting of “the other.” In the late 1990s, a group of nurses, physicians, and administrators at the hospital spearheaded the opening of an outpatient integrative clinic, where the first and second authors have been providing acupuncture and integrative medicine, respectively. In 2008 the hospital established the Department of Integrative Medicine, through which an acupuncture fellowship was created as an exploratory program to make acupuncture available to inpatients.4

Between 2008 and 2011, the fellowship attracted 20 licensed acupuncturists, all of whom had experience in the private-practice setting but who had no experience in a structured biomedical environment. The acupuncture fellows were expected to provide care to patients in the hospital for at least 8 hours per week in collaboration with medical staff and to participate in weekly lectures and case conferences. The educational objectives of the program included improving the fellows’ understanding of safety protocols, contraindications in an inpatient environment, and hospital documentation; developing their skills in negotiating the logistics of acupuncture integration in the conventional care setting; communicating the acupuncture paradigm and its effectiveness to hospital personnel; and improving patient outcomes. Acupuncturists were not paid for the care they provided to hospital patients and were asked to pay tuition for the educational component of the fellowship.

Research Methods

Our study was approved by the Beth Israel Medical Center and Drew University Institutional Review Boards (IRBs). We contacted the current and former acupuncture fellows via email, described our project, and asked for their participation. In addition, the fellowship administrator announced the launching of the study to the fellows. Only the first author, who does not have a formal administrative or evaluation role in the fellowship program, was involved in recruiting and interviewing the study participants. Out of the 20 former and current fellows contacted, 10 expressed an interest in participating. Initially, 3 fellows were interviewed and the data examined. After the initial data analysis we recruited an additional 2 participants, for a total of 5 acupuncturists. At that point the saturation of the emerging themes suggested no need for further recruitment. Out of the 5 acupuncturists in the study, 4 were women and 1 was a man. All were middle-aged and White, representing several regions of the United States, diverse acupuncture traditions, and varying levels of clinical experience.

To contextualize the acupuncturists’ experience, we decided to include in our research physicians, nurses, and hospital administrators who collaborated with the acupuncturists in patient care. Via email, the first author contacted 2 administrators, 7 physicians, 2 physician’s assistants, and 3 nurses from the departments participating in the acupuncture fellowship. Of those who responded, 1 administrator, 2 physicians, and 1 nurse agreed to participate. The participants (5 acupuncturists, 1 administrator, and 3 medical personnel) were interviewed between January and December 2011.

The interviews were between 30 and 120 minutes in duration. The locations of the interviews were determined by the participants: the administrator and 3 acupuncturists were interviewed in the first author’s office, 2 acupuncturists were interviewed in their private offices, and the medical staff were interviewed on the hospital floors in private areas. All interviews were tape-recorded and later transcribed for analysis. The interviews began by our asking the fellows how it was for them as acupuncturists to practice in a hospital setting. We asked the medical staff and the administrator how it was for them to have acupuncturists providing care in their departments. We sought the details of the participants’ experiences through follow-up questions that asked for examples, stories, explanations, clarifications, and expansions. The first author followed two of the interviews with short emails asking for additional explanations.

Ethical Considerations

Prior to the interviews, each participant received the written information required for informed consent. We explained the purpose and the design of the study, the safeguards to protect the participants’ privacy, and the voluntary nature of participation, which could be terminated at any point during the study without penalty or reward. The participants were encouraged to ask questions about the study, and the informed consent included safeguards to protect the participants’ privacy, and the voluntary nature of participation, which could be terminated at any point during the study without penalty or reward. The participants were encouraged to ask questions about the study, and the informed consent included safeguards to protect the participants’ privacy, and the voluntary nature of participation, which could be terminated at any point during the study without penalty or reward. The participants were encouraged to ask questions about the study, and the informed consent included safeguards to protect the participants’ privacy, and the voluntary nature of participation, which could be terminated at any point during the study without penalty or reward.

To contextualize the acupuncturists’ experience, we decided to include in our research physicians, nurses, and hospital administrators who collaborated with the
of the fellowship. Furthermore, we both shared clinical space with the acupuncture fellowship’s director at the hospital’s outpatient clinic. This created a power differential, and we therefore made all possible efforts to create a situation in which no pressure to participate was exerted on the fellows. In the initial email, we explicitly stated that the fellowship director was not an investigator in the study and would not have access to any research data collected from the participants until it was published. We also explicitly reassured the participants that their decision to participate (or not) in the study, as well as their opinions about the hospital and the fellowship, would have no bearing or impact on their standing in the program or in future evaluations or recommendations. Two of the fellows asked detailed questions about the relationship between the study investigators and the fellowship administrators before deciding to participate. No incentives were given to the fellows to join the study.

**Scientific Rigor**

We applied the four criteria for scientific rigor in qualitative research proposed by Lincoln and Guba (1985). The credibility of our research was assured by the verbatim transcriptions, immersion in the data, and ongoing refinement of the emerging themes. We assured trustworthiness through the process of bracketing, the use of memos, and consultation with colleagues. To strengthen confirmability, we established an audit trail of transcripts and notes of our meetings, refined themes, and recognized biases.

It is generally agreed that descriptive methods do not require a representative sample, but rather a set of participants who can reflect on their experience and share their “reality” (McNamara, 2005). Any individual participant “can generate hundreds or thousands of concepts, [thus] large samples are not needed to generate rich data sets” (Starks & Trinidad, 2007, p. 1375). In phenomenological research, interviews are conducted until the phenomenon is explored and theoretical saturation occurs (Drew, 1989), with typical sample sizes ranging from 1 to 10 (Morse, 2000). The data from the 5 acupuncturists who participated in our study saturated the emerging themes, and as such we did not seek additional participants. There is of course a possibility that new themes might have emerged from our study had we enrolled additional participants, and further research might explore this possibility.

Several factors can limit the transferability and confirmability of our findings. Although providing important insights into the meaning of the participants’ experiences, phenomenology does not seek to explain causes, developments, or consequences; it seeks to elicit the essential structures of the participants’ experiences. Because the study sample demographics were not necessarily reflective of the general profile of acupuncturists practicing in inpatient settings throughout the United States, the degree to which that structure is transferable to other acupuncturists’ experience is limited. Furthermore, because the study participants were those fellows who expressed a willingness to share their experience, there most likely was some selection bias. In addition, the first two authors’ affiliation with the fellowship might have influenced how and to what degree the participants shared their frustrations about some aspects of the program. At the same time, the first author’s many years of experience as an acupuncturist in an integrative setting allowed for a more in-depth intuitive interview and exploration of the fellows’ experience, adding to the strength of our study. The role of the third author, who was not affiliated with the fellowship, was to serve as an external reviewer of the data collection, coding, and analysis to minimize the study biases.

**Data Analysis**

We analyzed our data with a slightly revised version of the methodology proposed by Colaizzi (1978), which is frequently used in nursing research (Beck, 1992; Thomas, 2005). In Colaizzi’s method, the researchers follow seven steps: reading and rereading of the participants’ descriptions; extracting significant statements and phrases from each interview; formulating meanings from the participants’ statements; organizing the emerging themes into clusters; integrating data into an exhaustive description of the phenomenon; validating findings by sharing with the participants; and incorporating participants’ comments into the final description. We made an adjustment to Colaizzi’s methodology and, following Giorgi’s (2006) rationale, we did not ask study participants to validate our findings. Our ultimate goal was to present the essential structure of the phenomenon, which Swanson-Kauffman and Schonwald (1988) compared to a “universal skeleton that can be filled in with the rich story of each informant” (p. 104).

**Results**

As the outcome of our analysis process, we organized the fellows’ experience of providing holistic acupuncture care in the challenging environment of the inpatient setting around four clusters of themes: (a) dream come true, (b) my philosophy of treatment is balanced, (c) you always compromise, and (d) it’s all about trust.

**Dream Come True**

The first cluster of themes describes the fellows’ initial excitement about practicing and learning in a hospital setting, and some of the adjustments the fellows had to make when their dreams met the reality of acupuncture.
integration. The fellows’ excitement about learning was one of the major themes that emerged from our study. The decision to apply to the fellowship was driven mostly by the participants’ passion for expanding their knowledge, as evidenced by these quotes from the interviews: “I love learning.” “I love expanding my horizons.” “I enjoy looking for new experiences that give me ‘juice.’” “I get nuts if I don’t learn.” “I wanted to learn more ins and outs.” “I expected to be challenged.”

These statements referred not only to the acquiring of new clinical information, but also to a general quality of being curious and placing value on personal growth. One acupuncturist said that she wanted the fellowship to “change her” so that she would not be “just an everyday acupuncturist”; she wanted a “bigger experience.” The word “elated” was used by a fellow to describe her feelings when she envisioned herself being part of an integrative program at one of the major teaching hospitals in the country. She was

[just off my head happy of combining the two worlds. . . . I think it’s important to remain expansive. . . . You’re not going to get all the answers unless you’re open to another modality’s philosophy. I think it’s important for us to be open to [Western medicine] philosophy. There’s a lot to be said for Western medicine.

The fellows looked forward to expanding their knowledge of biomedicine, testing their acupuncture skills in a new environment, learning the hospital culture and hierarchy, and developing collaborative relationships with medical staff. One acupuncturist summarized her expectations of being introduced to the departments: “Diseases Treated 101:. . . This is the environment you are going to be going to, this is how you wrap your head around it so that you do a good job.” The fellows felt clinically prepared to provide good acupuncture care to hospital patients, but they did not feel well prepared to function safely and confidently in the inpatient setting. Once on the hospital floors, they were surprised not to receive a formal introduction to hospital culture and the specifics of each department, and not to be efficiently integrated within the system:

Tangible [things], like the hospital structure: how the power works, whom I should know and talk to, and how it ran. I was pretty naive, and I didn’t even know what an attending was, honestly. I had to figure all that out. That would have helped—some basic understanding of the hierarchy. . . . Understanding of emergency protocols, where everything was. . . . Maybe even following director or a leader in a hospital as opposed to other fellows showing you what they figured out on their own.

The discrepancy between expectations and reality led the acupuncturists to look for creative and innovative ways to adjust to the limitations of the inpatient setting. Some fellows minimized their expectations and limited their interactions with physicians; other fellows became more proactive, developed new initiatives, or expanded their care to new, more welcoming departments. One fellow described it as follows:

It was a growing-up thing—less about the educational opportunity and more about how I’m structuring who I want to work with and what I want to learn than it was about my expectations of this educational infrastructure. . . . It was almost like a postdoc experience in my head: “What am I fashioning this into?”

My Philosophy of Treatment is Balanced

All acupuncturists in the study emphasized the belief that their care was effective because it was delivered in a holistic manner. They derived joy and satisfaction from providing care that addressed the physical, mental, emotional, and spiritual aspects of patients’ complaints, as well as providing patient education. One of the fellows called this philosophy of care “balanced”:

Asian medicine . . . broaden[s] the understanding of your body. . . . It is set in the yin and yang, and the inhale and the exhale, and the cycle of energy as it goes through the body. . . . so, inherently in the medicine itself there’s this understanding of the pendulum swinging of the opposites, and its constant movement in between. . . . And if it gets stuck, then symptoms start to happen. . . . Philosophically, you don’t really know something very well if you only see one aspect of it. There are always other perspectives on anything.

The acupuncturists believed that both their technical skills and their relationships with patients as healers and teachers played an important part in their clinical effectiveness. They forged these relationships through listening to stories, observing their patients’ bodies, and utilizing touch to evaluate, treat, and comfort. One acupuncturist said that her aim was to

[c]reate a partnership, to educate patients and teach them about their own body so that they aren’t dependent on somebody else to tell them what to do. At least push them towards the right resources and how to listen to themselves, in small ways to change their life and pay attention to what those changes did for them.

Some acupuncturists placed emphasis on explaining to patients the somatic and sensory relationships between body parts as the key to understanding the source of their symptoms. The following is how one fellow described a typical exchange with patients during a treatment:
I acknowledge where they might feel tight, or where they might feel deficient. . . . I might discuss with them at that moment, “Oh, you feel this point? It’s very deficient right here, you know, my thumb goes deep inside. We need to help your Earth and your Earth is all about taking care of yourself and smoothing your digestion and supporting your sleep and regenerating.” So, I can have this conversation that helps the mental level by using my hands on the physical level and the energetic level to support that process. . . . It kind of integrates their emotional body into their physical body and their mental body.

You Always Compromise

Entering the inpatient practice environment changed in many ways the acupuncturists’ ability to utilize the holistic approach to care that they used in private practice. Acupuncture treatments at the hospital focused more on alleviating acute symptoms and less on understanding the root causes of a patient’s complaints and addressing those preventively. Nevertheless, even this limited acupuncture care often proved more effective than the conventional options offered for symptom control.

The hospital environment lacked the tranquility of a private practice setting, and it struck the fellows as “[a] very frenetic energy [with] lots of interruptions.” Acupuncture treatments in the hospital were typically very targeted, and the circumstances did not allow for longer conversations about the patient’s symptoms and the history of illness. Thus, the fellow’s picture of the patient was placed in a medical, emotional, and social context that was much more limited than what they were accustomed to. The basic information about patients was usually gathered from physicians, nurses, and patients’ charts, and treatments were focused on specific acute symptoms (pain, anxiety, or nausea) rather than the whole person:

[Treatments] were much more superficial. You might see a person once, or maybe twice in two days, and once they’re out of the hospital you never see them again. So you don’t have time to build that ongoing relationship, which I really enjoy in my work; so it’s different, definitely different. . . . You always compromise in a hospital setting. . . . You compromise on the [body] position and the amount of needles, you give up privacy, tranquility. You can treat while [doctors and nurses] are treating at the same time. . . . It’s like being on a battlefield, you know. . . . You can be treating people in the hallways of the hospital and multiple patients within thirty minutes. . . . You adapt as you go.

Despite the challenging inpatient environment, maintaining a holistic approach was important to the fellows’ sense of themselves as health practitioners:

People are so scared and so uncomfortable physically and emotionally . . . . It’s the most vulnerable time, heightened beyond what it is in [a private] setting . . . and it is a big deal to share this vulnerable place with someone respectfully and honor it and try to be a healing presence somehow, whether it is treatment or words. . . . You guard your patients carefully and shoo the doctors away, or the person would come with bleach to mop the floor and we told them to come later. . . . [Patients] needed to have a little guardian for twenty minutes, who was there to take care of them. And the needles, you know, fifty percent of the impact is your presence, if you are sitting there or tucking them in, making them comfortable.

Even if the hospital environment put limits on acupuncturists’ clinical options, some fellows found that they could be quite effective in acute situations because patients with acute presentations were more responsive to the needle stimulation:

As soon as you put one needle in, their bodies just reacted. Their bodies were more extremely responsive, the treatment was completely different. In private practice you are taking more time, it takes more needles. . . . [In hospital] you are sometimes more [effective] because the bodies are just ready to let it go, because they’re in so much pain.

When highlighting the impact they had on easing suffering, the fellows expressed a great deal of professional pride. The effectiveness of acupuncture in the hospital was “visible and documentable and people reported it on a scale from one to ten: measurable changes.” One acupuncturist recounted being called by a physician to help a woman who was in severe, acute pain from a postoperative abdominal incision, and was on the maximum dose of morphine. She had to have her vacuum-assisted closure redressed, but was in too much pain for the procedure. Her doctors were hesitant to take her back to the operating room and put her under anesthesia:

[The patient] could not have any more medication for a number of reasons. She had an incision from the tip of her pelvic bone to just about here [showing her diaphragm], and they closed it while I did acupuncture on her to keep her steady and calm and more comfortable. . . . Pain went from a ten to a three, and she was able to have the procedure done without any more morphine. And the patient was happy. The physicians were blown away. And that’s a very good example of where the acupuncture was the essential thing because it helped to maximize the effect of morphine. . . . And that’s a case where acupuncture was pretty significant.

The acupuncturists stressed that their treatments were not limited to pain management. One told the story of a patient in the dialysis unit who was having devastating itching for which her physicians could not find any remedy. After acupuncture, the itching went away completely, and 24 hours later it was still gone: “The patient was over the moon, and everybody learned a lot, if you see what I
mean.” A fellow on the orthopedic floor was called to treat a patient for pain, but he soon realized that the problem was urinary retention. After providing effective treatment, he had “people coming from the department of urology to seek help.” An acupuncturist on the family medicine floor treated a prisoner:

His blood pressure was up to two hundred over hundred and something. He was cuffed to his bed, he had a guard, and he was a big guy pulling the cuffs and out of control. And one of the attending came by [and asked if I could] make this guy calm down before he had to call more security. . . . And I said, “I’ll try.” And I went in and I talked to him first and then I treated him [with acupuncture]. And we did breathing exercises and his blood pressure immediately came down and he said, “Okay, if you can, come back tomorrow.” . . . And the doctors said, “What? How can you do that?”

**It’s All About Trust**

The fourth theme of the fellows’ experience described the critical role of trust in the acupuncturists’ collaboration with physicians and nurses. The fellows found that the medical staff were largely welcoming, but also often apprehensive about acupuncturists treating their patients. Time, positive feedback from patients, and for many of the staff a personal experience of receiving acupuncture were all important in building mutual trust.

During the 4 years of the fellowship’s existence, many physicians became more open to acupuncture. In some instances, the change was prompted by reading the acupuncture clinical trials literature, as in a case described by a fellow on the surgical floor:

I was questioned by this surgeon [who] told me that acupuncture did not have the studies behind it, that it was not a viable procedure. He asked since when we had been on the surgical floor, and I said that we had been here for about eight months and we had gotten permission from the chief of surgery. I told him that we had a pamphlet full of research. . . . What was fascinating was that later he did come back, asked for the research, and sat down for about twenty minutes and read through it. And then told me that it was okay for me to treat any of his patients and that he appreciated the studies. Yeah, so it was kind of cool.

The general consensus among the fellows, however, was that even if the acupuncturists had shown the physicians “all the studies in the world,” in the final analysis it was the positive feedback from patients that made the biggest difference in the physicians’ attitudes. The acupuncturists found that being able to work side by side with physicians in instances of acute distress and provide an immediate and significant relief in symptoms was what led to future referrals. When asked about a story about the impact of acupuncture treatment on medical staff, one fellow said,

This nurse is popping to my mind. It’s a small thing—it was the woman who had nausea and vomiting that won’t stop. She had had four miscarriages because of this, and she would have to get IV fluids, and then eventually just miscarry. . . . We figured out how to control her nausea and vomiting with acupuncture, really quite simply, and that nurse was so blown away that every time she has someone who’s a little nauseous from the morphine or whatever, she comes and finds me. . . . You can see this stuff click with people, and it’s a small thing but, you know, I think that’s a change.

Patients were important advocates for acupuncture access. One fellow gave an example of a patient who credited acupuncture for her healing:

She did the nicest thing: She wrote a letter to the attending who referred her, telling him how much the treatments helped and how she loved them, and really cared for the fact that he referred her for acupuncture and what that meant to her. And, getting this email was great! It was like, “Wow!” And it completely opened up this attending, a neurologist and pain specialist who’s been in the field for thirty years. So, he started referring more patients.

Even if physicians expressed willingness to add acupuncture services to patient care, they usually knew little about what conditions acupuncturists could address effectively and when to call for an acupuncture consultation:

One physician referred a patient because the patient was a handful [difficult]. And sometimes I took all the patients who were most difficult emotionally, mentally, physically . . . and sometimes I couldn’t do anything because, you know, if the patient is paralyzed they’re paralyzed. I can’t change that. . . . Physicians in that department referred patients to me . . . because they didn’t know what to do, and they were hoping that, “Okay, acupuncture, we don’t know much about it, but maybe something good will happen, so here, try.”

The fellows considered treating medical staff to be an effective way to teach them about acupuncture: “To the extent I’m treating doctors, I’m impacting patients.” Acupuncturists looked at it as both a hands-on clinical training (“We train them to understand when to refer someone to us”) and as a process of planting seeds for acupuncture expansion into the health care system (“When you treat medical staff, they start looking at their own insurance policies: Do I have acupuncture coverage?”). One fellow treated “almost half of the staff” on the surgery floor. Most of these treatments involved placing small “seeds” to press on acupuncture points on the
ear—acupuncturists call this treatment simply “ear seeds.” She had “many, many stories of ear seeds,” and considered treating staff with ear seeds “a big thing.” She said,

When we first came in [to the surgery floor], some people were very welcoming and they were the bridge to the other residents, because I put ear seeds on somebody and they said, “Oh you should put ear seeds on him because he’s really stressed out today.” So, okay, I put them on him and then, “Oh, he needs it too, please!” So, after that they were a little bit warmer . . . more open after I gave them ear seeds and they got to know me a little bit more . . . It was all about trust. . . . It was a little bit of building trust and a little bit of [quieting] fears . . . [Eventually] the doctors were happy that we were treating their patients because it was helping them and allowed them not to give as much pain medicine, so they didn’t get as many phone calls.

Discussion

The acupuncturists entered the fellowship with three major interests in mind: to learn more about conditions treated in a hospital and about the practice of biomedicine; to find opportunities to treat patients with medical conditions acupuncturists usually do not see in private practice; and to develop collaboration with physicians and promote the integration of acupuncture into biomedical care. Reflecting on their experience as inpatient acupuncture providers, the fellows expressed mixed emotions, ranging from excitement and professional pride to some impatience and frustration.

The hospital setting placed significant limitations on how the acupuncturists could utilize their holistic approach to care. The difference between the environment of care in their private offices and what they had to work with in the hospital significantly impacted the logistics of acupuncture treatments (the length of time, the body parts treated, number of needles, and the application of various treatment techniques). It limited the provider–patient relationship and the fellows’ ability to provide health education, both of which are important elements of standard acupuncture care. Being “stuck with this very limited arsenal” was frustrating at times, but despite these limitations, acupuncturists viewed their targeted care for acute symptoms as effective, and described many instances when treatments they provided were “essential . . . not just a nice complement.” They treated a broad spectrum of acute conditions, including pain, nausea, vomiting, panic attacks, anxiety, depression, sleeping problems, elevated blood pressure, constipation, and urinary retention.

The fellows’ assessment of the importance of their presence in the hospital was corroborated by the medical staff who worked with them on three different floors: surgery, orthopedics, and family medicine. The two physicians and the nurse who participated in our study described the acupuncture fellowship as a program that was “cutting edge and innovative, and enhance[d] the department,” giving it “more of the twenty-first century . . . modern effect.” The fellowship’s presence in a teaching hospital offered a positive example of interdisciplinary professional education and collaborative learning (Pew–Fetzer Task Force, 1994). This collaborative environment created an opportunity for acupuncturists and medical staff to challenge their beliefs about other health professional cultures (Pecukonis, Doyle, & Bliss, 2008) and dispel some of the stereotypes about each other’s commitment and contribution to patient care. Medical staff were not only no longer ignorant of the effectiveness of acupuncture, but were interested in integrating this profession into the medical team. In that sense, the acupuncture presence had a lasting effect on some medical staff, as expressed by nurses from the surgery floor, who were “sad that acupuncture wasn’t on the floor consistently anymore” when the fellowship was not able to sustain acupuncture coverage in that area.

The fellows thought that the program needed improvement to assure a more effective utilization of the acupuncturists’ time and clinical expertise; however, being pioneers in this environment, although difficult at times, was of great importance: “Where is the book that tells me how to work in a hospital? Nobody has written that yet. Do you see how ahead of the curve we are?”

Conclusion

The phenomenological description we offer here provides important insights into how a group of acupuncturists navigated the process of integration into inpatient hospital care. Their experience in negotiating a working role in the hospital team despite the initial resistance of the medical staff can be useful to other health professions as well, when they seek to move more fully into the conventional health care system.

One important lesson drawn from this inquiry was the degree to which acupuncturists were forced to adapt from the holistic environment of their outpatient settings—an environment perhaps poorly understood by the medical staff they were working with—to the “battlefield” of inpatient care, and how successful they were in doing this. A second, perhaps even more important lesson was that although developing an understanding of the evidence base for acupuncture might have been a necessary background element for the medical team, it was the direct interactions with the acupuncturists and the direct experience of the therapeutic potential of acupuncture for their patients (and themselves) that proved more essential to hospital staff. This second lesson is especially important.
in this time of strong movement toward team-based, interdisciplinary health care, as it highlights that empirical exposure and personal interactions across the disciplines are at least as important in the process of building effective interdisciplinary teams as is exposure to the evidence.

We hope that this descriptive research and the lessons learned will have a substantive impact on policymakers and hospital administrators in their considerations regarding integrative health care in the future. We also hope that we have begun to demonstrate the importance of qualitative research approaches in developing a better understanding of the process of interdisciplinary integration.

Acknowledgments
We gratefully acknowledge Arya Nielsen and Woodson Merrell for their creation of the acupuncture fellowship program, and Joslyn Cassady for her generous comments on our research.

Authors’ Note
Preliminary findings of this study were presented at the 2012 International Research Congress on Integrative Medicine and Health in Portland, Oregon, May 15–18, 2012, and the Society for Acupuncture Research International Conference at the University of Michigan, Ann Arbor, Michigan, April 18–21, 2013.

Declaration of Conflicting Interests
The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding
The authors received no financial support for the research, authorship, and/or publication of this article.

Notes
1. The terminology used to describe the practice of acupuncture in the United States is not universally defined and is explained here in an effort to not stereotype. Acupuncture is a healing tradition in which thin needles are inserted into acupuncture points; a number of adjunctive techniques are included in acupuncture practice (Bisio & Butler, 2007; Matsumoto & Euler, 2002; Nielsen, 2013). The term “East Asian medicine” is used in anthropological literature to describe traditional medical practices, which are based in the ancient Chinese medical classics and have over the years spread throughout East Asia and the West, enriched by local cultures and medicines. In the United States, the term “Oriental medicine” was adopted to describe acupuncture, Chinese herbology, and manual therapies. Acupuncture schools and the professional governing bodies in the United States use the term “acupuncture and Oriental medicine,” but many states, including New York where we conducted our research, license only acupuncture practice. For that reason, we use the term “acupuncturist” to describe a practitioner of East Asian medicine without distinguishing those who have additional training in Chinese herbology.
2. The level of diversity of acupuncture traditions and styles of practice is often underappreciated. Many equate acupuncture practice with traditional Chinese medicine (TCM), which is a modernized and biomedicalized approach to acupuncture and herbal practice developed in the People’s Republic of China (Karchmer, 2010). Acupuncture practice in the United States represents many traditions, and a number of acupuncture schools focus their education on a particular acupuncture style (Connelly, 1979; Seem, 2000).
3. A model of integrating acupuncture with a dominant biomedical system has been in place in mainland China for more than a half a century, where doctors of TCM have been working alongside physicians in the state-sponsored health care system. This system, however, is not transferrable to American circumstances for a number of reasons. Acupuncture practice in the United States is more diverse, and the majority of practitioners resist the level of biomedicalization and standardization of acupuncture that persists in China and view the Chinese model more as cooption than integration (Fruehauf, 2006). Furthermore, Scheid (2012) argued that this cooption creates tension between how the Chinese model defines disease in terms of biomedical science but treats it according to the pattern manifestation and the uniqueness of each episode. In Scheid’s opinion, the “intrinsic instability” (p. 14) of this tension calls into question the stability of the Chinese model of integration.
4. Departments that participated in the acupuncture fellowship: Family Medicine, Pediatrics, Internal Medicine, General Surgery, Orthopedics, Oncology, Pain and Palliative Care, and Pulmonary Rehabilitation.
5. A number of authors are of the opinion that qualitative health researchers have unnecessarily created a set of rigid methodological rules in an attempt to objectify their research (Thorne, 2011), and in the process, brought the standards for scientific rigor closer to “rigor mortis” (Sandelowsky, 1993, p. 1). Giorgi (1987) argued that credibility understood as a demand for a procedure to check the labor of the researcher is an improper imposition of the positivist paradigm, whereas Janesick (2000) criticized many qualitative researchers for privileging methodology over practical issues related to the improvement of patient care or health care policy.

References


Author Biographies

B. Basia Kielczynska, DMH, MS, LAc, is an acupuncturist in faculty practice in the Department of Integrative Medicine, Beth Israel Medical Center, New York, New York, USA, and a visiting researcher at the University of Westminster, London, United Kingdom.

Benjamin Kligler, MD, MPH, is a vice chair and research director at the Department of Integrative Medicine, Beth Israel Medical Center, and an associate professor at Albert Einstein College of Medicine, New York, New York, USA.

Eileen Specchio, PhD, RN, is a professor of undergraduate and graduate nursing at College of St. Elizabeth, Morristown, New Jersey, USA.