While the term ‘hybridisation’ is particularly well suited to describe innovations consisting of (literally) existing ingredients, the term is problematic in that it implies the existence of non-hybridised culture. However, societies without processes of transfer, exchange and transformation are rare. When Elwert (1996) described culture as the social organisation of syncretism, he strengthened the idea of culture as open and dynamic structures instead of static and isolated formations. Nederveen Pieterse (1994: 180) talked of the ‘hybridisation of hybrid cultures’. If every culture is hybridised, the term loses its significance. It may only still be relevant for challenging essentialist discourses (Rosaldo 1995). Is it obsolete for other research topics?

I will first look for an original version of Chinese medicine in China (I). Having outlined various forms of Chinese medicine in the West (II), and after a short history of acupuncture in Europe (III), I will describe hybridised forms of Chinese medicine in Germany (IV), and in Britain (V). Then I will look for hybridisation in the acupuncture education (VI) and present a British medical conception of minimal acupuncture (VII). Finally I will outline recent results of German acupuncture RCTs and their potential consequences (VIII).

I. Is there an original Chinese medicine in China?

Anthropologists often know about the original versions of, say Asian, cultures and their elements, and they contempt their Western imitations. This is especially true for versions that became popular in the West, and the disdain results from that of Western popular culture, in general. The thesis of the McDonaldization of the world (cf. Ritzer 1993) does not derive from a deep admiration of McDonald’s, but from its contempt. On the other hand, non-European cultural elements are admired for their originality and for being adapted to local circumstances and requirements. They are embedded, and on their way to Europe they become dis-embedded. A hint to economy de-legitimises this process and its results.¹

If we relate this criticism to the Westernisation of Chinese medicine, we could state that there is a broad tradition of medical knowledge in China, well embedded in Daoist and Confucian philosophy. Some elements of this rich tradition migrated to Europe and to the USA, where they became dis-embedded from their philosophical background, and decayed to mere technologies,

¹ A special thanks to Robert Frank/ Berlin, who commented on earlier versions of this paper.
² In the field of medicine, the Asian original admired is less Chinese than Indian medicine. See for instance Boode 2004 for the industrial production of Indian pharmaceuticals, or Zimmermann’s (1992) criticism of the Maharishi Ayurved. For a history of yoga that shows its spiritualisation before its way to the West, see de Michelis 2004.
adapted to biomedical conceptions. A poor shadow of the originals, minimised for economic reasons.

But if we look at recent descriptions of Chinese medical knowledge (cf. Hsu 1999; Scheid 2002), there is not a mere original, but there are many faces of Chinese medicine in China. Parts of the broader tradition were transformed into the curricula of TCM that are taught at Chinese colleges. The TCM and few other elements of Chinese medicine migrated to Europe. In the cities of mainland China, Hsu observed different ways and social settings of the transmission of traditional medical knowledge:

- First there are popular and folk practitioners. Herbalists and qi-gong-masters practice folk medicine outside the clinics. They established an oral tradition of secret knowledge, Daoist verses, which accompany the breathing techniques of qi-gong in their pronunciation and emphasis.
- Chinese medical doctors work in or outside clinics, and pass on personal knowledge, consisting of long classical Chinese texts, which are reproduced by heart. These texts remain polysemic, the practices are virtuous.
- Traditional Chinese medicine doctors work in clinics, and reproduce a standardised body of knowledge consisting of shorter passages from medical textbooks. These texts aim at reducing the polysemic character of the classics. Theory and practice are clearly separated, like they are in biomedicine.

These three knowledge styles may be illustrated by three conceptions of qi. In the secret knowledge of qi-gong, qi can be felt by touching the body surface. In personal knowledge, its movement can be realised by pulse diagnosis. Standardised knowledge stresses the permanent fluctuation of qi, and contrasts that to blood and other bodily fluids (cf. Hsu 1999: 235 f.).

Thus, we cannot simply state that a Chinese original became polluted by migrating to the West.

II. Various forms of Chinese medicine in the West

In the USA developed a medical counter-culture in the 1960’s. It comprised European American Acupuncturists. Some of them had learned TCM in mainland China. Barnes (2003) lists two other groups of acupuncturists in the US:

Older Chinese Americans had learnt acupuncture through lineage systems, often from older generations, and/ or in pre-war educational programs. Practice in the American Chinese

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3 Cf. Nordstrom 1988, who found many faces of Ayurveda in modern India.
4 Qi can be described as similar to an immaterial force/ energy. Its paths through the human body can be localised on twelve routes, called meridians, most of them connected to an organ, even though these organs differ strongly from their biomedical equivalents.
community. Chinese American practitioners from mainland China had gained various biomedical qualifications in China, and had additionally achieved some acupuncture knowledge. ‘Most European American practitioners neither speak nor read Chinese (…).’ They ‘define themselves (…) as holders of a working knowledge that approximates aspects of the curriculum in Chinese medical schools.’ (Barnes 2003: 268)

Authors differ in their interpretation, whether the counter-culture changed into a complementary culture or not. Baer (2002: 405) keeps the flag of the social movement flying: ‘An authentically holistic and pluralistic medical system would not simply provide working-class people, peasants, and indigenous people with traditional medicine as a cheap alternative but would need to be part and parcel of democratic socialist global system that would provide all with the benefits of both biomedicine and heterodox healing systems.’

But Barnes (2003: 291) remains sceptical: ‘There continues to be a large number of acupuncturists who, while they may no longer see themselves as “alternative” practitioners working in opposition to biomedicine, still define themselves as “complementary”; that is, as distinct from biomedical practice but able to work as partners.’

In Western Europe, we find various forms of Chinese medicine. In a traditional immigration country like the UK there exists a Chinese folk medicine sector, but its use seems not to be widespread in the Chinese community. In the German and British indigenous population, qi-gong and shiatsu became popular in the wellness and massage areas; Chinese herbal teas are served in expensive wellness hotels; Chinese herbal medicine is spreading over the UK; and acupuncture is practiced by many biomedically oriented physicians as well as by non-medically qualified personnel. China is not more than a frame of reference for all of them. In this paper, I will especially look at acupuncture.

III. A historical overview of acupuncture in the West

Chinese medical tradition includes many therapeutic forms like drugs, movement and respiration (qi gong etc.), massage etc. Acupuncture is one aspect of the Chinese medical sub-discipline ‘acupuncture and moxibustion’ (zhenjiu) in China. It is distinctive for two reasons: first, it is based on a theory of the body that views the body as permeated with channels (or ‘meridians’), jingluo, which reach from the extremities to internal body parts. Second, it makes use of particular instruments, needles. According to Chinese medical theory, the manipulation of the needles in particular points on the channels regulates the balance of qi, yinyang and the so-called five agents

5 Cf. in a similar way, but less enthusiastically, Brown & Zavestoski 2004 on social movements in health.
6 71% of the Chinese population never visited a traditional Chinese doctor, though 54% agreed that for some health problems traditional might be better than Western medicine. 59% agreed that traditional medicine is too expensive to be used regularly (cf. Sproston 1999: 99).
(wuxing) in the body. These ideas can be traced to the earliest canonical writings on acupuncture and moxibustion in China, the Huangdi Neijing (The Yellow Emperors’s Inner Canon; of the 1st century BCE or CE).

The European history of acupuncture is marked by different attitudes towards the needling therapies that their promoters called ‘acupuncture’. Well-known are the publications of physicians of the East India Company, like that of the Dutch Willem ten Rhyne in 1683 and of the German Engelbert Kämpfer in 1712, who reported with admiration on these techniques – based on information from Jesuit missionaries (ten Rhyne reported on needling only, but Kämpfer also on moxa). However, just as physicians who wrote with admiration on Chinese pulse diagnostics (Floyer 1707), faced hostility among the emerging university-based medical colleagues, those advocating needling were severely criticised throughout the 18th century, in Germany and Britain. This changed drastically in the early years of the rise of clinical medicine in France, when there was an upsurge of experimentation with needling techniques. However, by the beginning of the 20th century, acupuncture had vanished from medical practice in Europe.

The recent spread of acupuncture in the West started before the Second World War with Soulie de Morant (1934) in France. From there it spread, after the War, to Western Germany in the 1950s (cf. Gleditsch 2001): The founding father of the DÄGfA, Dr. Gerhard Bachmann (1895 – 1967), adopted the conceptions of Dr. Roger de la Fuye (1890 – ?), who had worked as a military physician in Indochina, and had published textbooks on acupuncture and on ‘homoeosiniatry’, a combination of homoeopathy and acupuncture. Dr. Heribert Schmidt, who chaired the DÄGfA from 1967 to 1970, had learned kanpo, the Japanese form of Chinese medicine, in Japan. Thus, non-Chinese forms of acupuncture were prevalent in these years. The Chinese form disseminated in the 1970s, when American journalists reported about acupuncturist analgesia. Today, the professional organisations mostly teach Chinese forms of acupuncture.

In Eastern Germany (GDR), acupuncture met the hostility of powerful persons and institutions. In the 1970s, a set of needles was officially destroyed in Ichtershausen (close to Arnstadt and Erfurt). Otto Prokop, head of the Berlin Institute for Forensic Medicine, published many articles against heterodox medicine and especially acupuncture, which he declared to be a form of magic (cf. Hahn 2002: 50ff., 70ff.). Thus, there were only few physicians practicing and training acupuncture in their personal networks. In the 1980s, some of them had the opportunity to study acupuncture in

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8 In France, e.g. Berlioz in 1816, Haim in 1819, Beclard in 1821, Sarlandière in 1825; in Britain, e.g. Churchill in 1822; in Germany, e.g. Kerber in 1832; in Italy, e.g. Da Camino since 1834.

9 For a modern form see Ebert 1992.
Austria and even in China (ibid. 44). Since that time, this therapy has become established within the frame of the Working Group for Neural Therapy (Arbeitsgemeinschaft für Neuraltherapie), which had a membership base of some 900 physicians in the late 1980s (ibid. 59f.). In 1990, the name changed for DGfAN, which was divided into sections for acupuncture and neural therapy\(^\text{10}\) (ibid. 64).

IV. Acupuncture in Germany

It is currently impossible to gauge the number of acupuncturists as well as the extent of acupuncture use. The following table shows that many German physicians and fewer non-medical practitioners are members of acupuncture organisations.

Table 1: Membership of acupuncturist associations in Germany, 2003

<table>
<thead>
<tr>
<th>Association</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>German Academy for Acupuncture and Auriculomedicine (DAAAM; established 1974)</td>
<td>13,600(^\text{11})</td>
</tr>
<tr>
<td>German Acupuncture Society for Physicians (DÄGfA, established 1951)</td>
<td>11,000(^\text{12})</td>
</tr>
<tr>
<td>German Society for Acupuncture and Neural Therapy (DGfAN; in the former GDR, established 1971)</td>
<td>3,200(^\text{13})</td>
</tr>
<tr>
<td>German Acupuncture Society Duesseldorf, 2002 (DAGD)</td>
<td>1,600(^\text{14})</td>
</tr>
<tr>
<td>Association for Classical Acupuncture and TCM (AGTCM; non-medically qualified Heilpraktiker; established 1954)</td>
<td>1,050(^\text{15})</td>
</tr>
</tbody>
</table>

The extent of treatment through acupuncture is thus difficult to gauge. Holding an acupuncture qualification does neither necessarily mean practicing acupuncture on all patients, nor necessarily on any patient. Acupuncture will usually be one out of several treatments carried out by any one practitioner. Robert Frank and I (2004 a & b) found different types of the hybridisation of Asian

\(^{10}\) Neural therapy following Huneke is a medical concept eliminating disruptive fields by injecting local anaesthetics.

\(^{11}\) Personal information provided by Dr. Frank Bahr, Munich, September 2003; also website www.akupunktur-arzt.de.

\(^{12}\) Personal information provided by Dr. Wolfram Stöhr, Munich; also website www.daegfa.de.

\(^{13}\) Greater part of the members of the DGfAN practice acupuncture, and not neural therapeutics. Personal information by Dr. Reinhart Wagner, Ebersdorf/ Thüringen; also website www.dgfan.de.

\(^{14}\) Personal information provided by Dr. Gabriel Stux, Düsseldorf; also website acupunctureworld.com/ge/deakdu.. 

\(^{15}\) Personal information provided by Andreas A. Noll, Berlin; also website www.agtcm.de.
and biomedicine in German medical practice. From interviews with medical acupuncturists we constructed the following types of hybridisation:

Table 2: Types of hybridisation

<table>
<thead>
<tr>
<th>Gravitational Centre</th>
<th>Biomedicine</th>
<th>Heterodox Medicine</th>
</tr>
</thead>
</table>
| **Degree of Hybridisation** | - complementing biomedical practice with Asian medicine  
- criteria: biomedical disease category; patients’ demands  
- no further meta-theory | - complementing heterodox medical practice with biomedical procedures (at least diagnostics)  
- no further meta-theory  
- loose combination |
| **Weak** | - inclusion of Asian medicine in biomedical paradigms  
- use of Asian medicine in predominantly biomedical practice | - fusion of all conceptual ingredients into universal model of medical theory and practice |
| **Strong** | - complementing biomedical practice with Asian medicine  
- criteria: biomedical disease category; patients’ demands  
- no further meta-theory | - complementing heterodox medical practice with biomedical procedures (at least diagnostics)  
- no further meta-theory  
- loose combination |

In the introduction I asked, whether the term ‘hybridisation’ is obsolete in cultural studies, because every ‘original’ culture is hybridised. Like may be seen from the table above, we tried to escape this terminological dilemma by pursuing an empirical path. We break down this rather vague concept into different modes of hybridisation. We firstly differentiated for the gravitational centre of the process: Was it biomedicine or heterodox medicine? Secondly we looked for weak and strong degrees of hybridisation. The combination of these criteria produced a matrix containing four fields.

- The first one shows a biomedically dominated coexistence of biomedicine and heterodox medicine. I give an example for this mode of hybridisation from our interviews with medical acupuncturists: ‘I believe that Western and Eastern medicine should complement each other. Both have their areas of application’ (acupuncturist no. 3). Most of ‘our’ medical acupuncturists practiced acupuncture in this way.

- The second field shows a coexistence of biomedicine and heterodox medicine subject to heterodox dominance. Here is an example, again: ‘For me, decent diagnostics have to precede acupuncture. I never insert needles in anyone who comes in here saying, ‘I’ve got
The third field shows a biomedical incorporation of Asian medicine. For example: ‘There is feedback in the brain, which triggers the selective distribution of opiates. Reflexes are triggered and a selective relaxation takes place – particularly in muscular and orthopaedic conditions. I don’t think it would be too difficult to prove that scientifically’ (A2). This pattern is widely represented in teaching Asian medicine, but we could rarely find in medical practice.

The fourth field shows a great melting pot. A last example: ‘I combine acupuncture with other modes of treatment – homeopathy or bioresonance – in 80% of my cases. I use Chinese concepts – like the five elements or touching the meridians – for everyone. I decide later whether to insert needles or proceed differently. Right now, I avoid it whenever possible’ (A9). Few of ‘our’ acupuncturists came close to this pattern.

The prevalence of the biomedically dominated coexistence of biomedicine and acupuncture shows that acupuncture is widely used in a complementary, and not in an alternative manner.

Acupuncture is not taught at universities or medical schools. There is but one German professorship officially entitled to teach Chinese medicine.16 Acupuncture is rather taught within the framework of further medical education. The German Medical Association has published guidelines for this education in general. In the 1980’s, the professional acupuncturist organisations adapted their education schemes to these guidelines, and the regional medical chambers accepted these schemes within the framework of natural curing procedures in the 1980’s.

Official medical organisations moved from scepticism against acupuncture to a series of trials and regulatory models. The older scepticism is represented by memoranda of the Scientific Advisory Council of the German Medical Association (Wissenschaftlicher Beirat der Bundesärztekammer) in 1957 (cf. Gleditsch 2001: 181) and 1992, and by the German Physicians’ Drug Commission (Arzneimittelkommission der deutschen Ärzteschaft), which in 1998 recommended not to include CAM into the public health insurance schemes. As late as 2001, the Federal Joint Committee (Bundesausschuss der Ärzte und Krankenkassen)17 published a sceptical report about acupuncture:

16 The chair for natural healing science at the University of Essen, established in 2004. Prof. Gustav J. Dobos is holding this chair.
17 Its members come from federal organisation of physicians practising in the statutory sickness funds, and from these funds themselves. It admits new diagnostic and therapeutic methods etc.
its efficacy was said to result for the most part from the care given by the healer, and such efficacy was not considered to depend on the healer’s training or on a specific medical conception. Thus acupuncture is situated on the level of many other therapies that have not been tested in RCTs (cf. Bundesausschuss 2001: 8). However, in 1999 a group of German public insurance companies have embarked on a huge trial regarding the efficacy and efficiency of acupuncture and other heterodox therapies. I will comment on these RCTs later on. They will not only change the status of reimbursement for acupuncture treatment, but also be relevant for the regulation and further spreading of acupuncture knowledge among German physicians.

In 2003 the German Medical Association published special rules for further education in acupuncture, which will become a model for respective rules to be published by the medical chambers of the German states. These rules establish an additional title (Zusatzbezeichnung) ‘medical acupuncturist’.

V. Acupuncture in the UK

The 20th century history of acupuncture in the UK\(^\text{18}\) is fairly distinct from that on the continent, though in the UK, as in Germany, Japanese, South-East Asian and other non-Chinese forms of acupuncture were widespread until the 1970s (cf. Eckman 1997). In the UK, one particular person, Jack R. Worsley (1923-2003), has been extremely influential.\(^\text{19}\) Not that he was the first to practice acupuncture in 20th century Britain,\(^\text{20}\) but he trained many non-medically schooled practitioners in Five Element theory.\(^\text{21}\) Those practitioners later educated themselves further - some started to practice acupuncture and Chinese herbal medicine according to entirely different medical paradigms than Five Element theory – and several founded acupuncture colleges in the 1980s. These mainly British acupuncturists have more recently made efforts to re-unite themselves under the auspices of the BAcC, and after a meeting in October 2001, decided to set up standards for self-regulation. Quite apart from those, exponents of the British medical profession have continuously made use of acupuncture as a technique, and have trained physicians in these techniques. At last, there is a third current of practitioners to consider: after the economic reforms in the People’s Republic of China, the UK has seen an unprecedented influx of Chinese who practice Chinese herbal medicine, acupuncture, \textit{qigong} and other martial arts.

\(^{18}\) The passages on Britain owe many details to Elisabeth Hsu and Verena Timbul, Oxford.

\(^{19}\) ‘… the so called Worsley style (…) is very „personality“ based and has a strong emphasis on emotional manifestations of the 5 phases.’ (www.medicinechinese.com/A55800/tcmforum.nsf; 9/15/2002). Cf. Barnes 2003.

\(^{20}\) Felix Mann, for instance, was another early proponent. Cf. Baldry 2005.

\(^{21}\) There are five element acupuncture traditions, mostly in Taiwan, Japan, and Vietnam. They derive Chinese Tang dynasty (7\textsuperscript{th} to 10\textsuperscript{th} century AD). Cf. Adam Atman – Acupuncture Articles. Adamatman.com/articles/content-USA.shtml. 15/09/2005.
In the UK, acupuncture is taught at acupuncture colleges, at universities (in departments of primary health care or community health care, for instance), and within professional societies who offer short- and long-term courses. There is also a plurality of acupuncture organisations, medical and non-medical. It is furthermore a substantial body of Chinese medical doctors of Chinese origin who offer mostly Chinese herbal medicine. But medical doctors of Chinese origin do only seldom offer training.\(^{22}\)

Table 4: Membership of acupuncturist associations in the UK, 2003\(^{23}\)

<table>
<thead>
<tr>
<th>Relevant Acupuncture Organisation</th>
<th>Estimated Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical practitioners</td>
<td></td>
</tr>
<tr>
<td>British Medical Acupuncture Society (BMAS)</td>
<td>2,200</td>
</tr>
<tr>
<td>Traditional acupuncturists</td>
<td></td>
</tr>
<tr>
<td>British Acupuncture Council (BAcC)</td>
<td>2,400</td>
</tr>
<tr>
<td>Traditional Chinese medical doctors, including acupuncturists</td>
<td></td>
</tr>
<tr>
<td>Legislative Association for Chinese Medicine Practitioners:</td>
<td></td>
</tr>
<tr>
<td>Association of Traditional Chinese Medicine (ATCM), (since Nov 23 03 includes British Society of Chinese Medicine)</td>
<td></td>
</tr>
<tr>
<td>General Council of TCM, which includes the following three:</td>
<td></td>
</tr>
<tr>
<td>The Association of Chinese Medicine Practitioners (ACMP)</td>
<td></td>
</tr>
<tr>
<td>Chinese Medical Institute and Register</td>
<td>1,200</td>
</tr>
<tr>
<td>Chinese Healthcare Institute Register</td>
<td></td>
</tr>
<tr>
<td>Auricular acupuncturists / substance abuse</td>
<td></td>
</tr>
<tr>
<td>SMART (Self Management and Recovery Training)</td>
<td>2,500</td>
</tr>
<tr>
<td>NADA (National Acupuncture Detoxification Association)</td>
<td></td>
</tr>
<tr>
<td>Society of Auricular Acupuncturists</td>
<td></td>
</tr>
<tr>
<td>Physiotherapists</td>
<td></td>
</tr>
<tr>
<td>Acupuncture Association of Chartered Physiotherapists</td>
<td>2,650</td>
</tr>
<tr>
<td>Dentists</td>
<td></td>
</tr>
<tr>
<td>British Dental Acupuncture Society</td>
<td>100</td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
</tr>
<tr>
<td>British Academy of Western Acupuncture</td>
<td>250</td>
</tr>
</tbody>
</table>

Acupuncture is taught at specialised colleges of acupuncture, at universities, and within professional acupuncture associations. The BMAS offers basic and advanced courses to healthcare professionals who are registered by statute in the UK. This includes nurses, midwives, health visitors, physiotherapists, osteopaths, chiropractors, and podiatrists. The BAcC offers education for

\(^{22}\) According to some authors (cf. Gervais & Jovchelovitch, 1998; Sproston et al. 1999), they practice Chinese medicine outside the formal professional system.

non-medical acupuncturists. The BAAB has accredited seven colleges in the UK, and another four are currently stage one accredited and committed to ongoing development of the course to reach full accreditation.

The BMA made a turn in its policy towards acupuncture. In 1986, it presented complementary therapies as ineffective, not evaluated, and sometimes harmful to patients (cf. Fulder 1988: 17). In 1993, it stressed the necessity of regulating education in heterodox practices, and of establishing codes of medical ethics for all forms of medicine (cf. Sharma 1995; Tovey 1997). In 2000, it recommended to formalise education in acupuncture and even to integrate this treatment into the NHS (BMA 2000).

The DH took up official purposes for a statutory regulation of the acupuncture profession. They had been raised by a committee of the House of Lords in 2000, followed by an ACRWG in 2003. The ACRWG suggested establishing a General Acupuncture Council to govern an official register of acupuncturists.

‘Registration should confer to the title “Registered Acupuncturist”. Certain subsidiary designations might be considered in the interests of informed patient choice.’ (ACRWG 2003: 20)

The DH took this proposal up, widened the council proposed to a CAM Council, and suggested the following subsidiary designations for acupuncturists:

‘Traditional acupuncture; Western medical acupuncture; auricular acupuncture’.

In addition, the title of a ‘Traditional Chinese Medicine Practitioner’ might be supplemented by ‘(herbal medicine and acupuncture), or (herbal medicine), or (acupuncture)’ (DH 2004: 11).

The DH consulted many professional organisations for their response to its proposals. While the majority of responses indicated support for the introduction of statutory regulation of CAM, especially the BacC raised a number of concerns (cf. DH 2005: 4). In our context, the criticism of the proposed titles is of special interest:

‘It was suggested that there was no commonly agreed definition of Traditional Chinese Medicine and that the public may not therefore understand the title’s meaning’ (DH 2005: 6).

The BAAB (2004: 4) clearly stated:

25 This board was set up in 1989 by the precursor of the BAcC as an independent body which was intended to set the standards of accreditation for courses offering training in acupuncture.
‘The Board considers that the titles ‘acupuncturist’ and ‘herbal medicine practitioner’ are clear to the public and that these two titles should be the basis for registration’.

Though there is no explicit criticism of the proposed title ‘Western medical acupuncture’, this title was not welcomed by any of the professional organisations.

VI. Hybridisation in acupuncture education
Is it appropriate to interpret acupuncture education as minimising acupuncture? In her observations of the New York acupuncture scene, Hare (1993: 31) presented a hybridisation of a Confucian and Daoist model of order and moderation and US individualism that may be forming a US form of Chinese medicine. She reported about a dentist, who had been trained in New York, and later on studied acupuncture in the UK, and commented on Chinese philosophy and acupuncture:

‘Lao Tze is also the basis of Chinese acupuncture – “affect without enforcing.” (...) The foreword of the *I Ching*\(^{26}\) is all about five element acupuncture.’ (Hare 1993: 42)

But we would hardly meet a German (medical or non-medical) acupuncturist, who would be able to comment on classical Chinese texts. Acupuncture education is framed by the rules of further medical education, not as learning a totally new medical system. To get the additional title *acupuncture*, a German physician must be recognised as a medical specialist and visit 200 hours of acupuncture training consisting of 120 hours of theory lessons, 60 hours of acupuncture treatment practice, and 20 hours of seminar courses debating treatment cases. These requirements are quantitatively the same for all additional titles, and there is neither a special reduction nor a special extension for acupuncturists.

University education in Chinese medicine or acupuncture is in its very beginning. The well-established professional organisations offer a smaller and a greater diploma. The *DAAAM* offers a basic course of 140 units, which leads to the *Diplom A* qualification. A further 210 units are required for *Diplom B*. In the *DÄGfa* the basic course (*Diplom A* of 144 hrs) previously offered has now been adapted to the new guidelines for qualification as a ‘medical acupuncturist’ mentioned above. A higher qualification (*Diplom B* of 200 hours), which can be achieved in one of three different course structures, is also offered. The B diplomas include much more medical and philosophical Chinese background, than the A diplomas do, and sometimes offer a small special education in a special medical branch.

The largest non-medical acupuncture association, the *AGTCM*, offers basic courses which last three years and consist of at least 750 hours, as well as a wide variety of specialist courses of

varying durations, underlying a credit system. A certain degree of attendance is compulsory to continue membership.

The British BMAS offers basic and advanced courses to physicians and to other medical professionals. A four days course and a record of 30 treated cases lead to the COBC. After another 100 hours training and more than 100 case records candidates may apply for the COA. The BAcC offers education to non-professionals. The required training was 2400 hours since 1989, and it increased to 3600 hours in 2002. About one third of this training covers anatomy and physiology, pathology, and other related medical topics.27

If you look at the number lessons required for formal registration in Britain, those for medical professional do hardly differ from the German figures. Those for non-professionals are very high, but include a basic medical education. In this respect, it is impossible to compare the German situation directly, because the education of the non-medically qualified Heilpraktiker has not been regulated.28

So far, I cannot speak of a minimal acupuncture for the West. But there are two developments that directly rely to this topic. The first is a medical conception minimising acupuncture for standard therapies. The second is an unexpected outcome of acupuncture RCTs in Germany.

VII. Minimal acupuncture as a British medical conception

Dr. Felix Mann had trained many physicians in acupuncture. As a junior doctor, he had gone to France and Germany in the mid 1950’s, where he was introduced into acupuncture. He completed his studies in Peking, Nanking, and Shanghai. After his return to London in 1958, he started to teach acupuncture in his house in London West End (cf. Baldry 2005). Though Mann had started as a traditional Chinese style acupuncturist, he had his own ways later on. Dr. Anthony Campbell, a homoeopathic physician, who became trained in acupuncture by Mann in 1977, remembered:

‘The first thing Felix told us was that he did not believe in the traditional apparatus of Yin and Yang, meridians, acupuncture points and so on’ (Campbell 1998: 152).

In 1992, Mann published the thesis that acupuncture does work, but its efficacy is not limited to needling the classical points. Campbell propagated the credo of a ‘modern, non-traditionalist acupuncturist’. He explained the efficacy of acupuncture via the nervous system, via endogenous opioids etc., and he taught his practice to doctors and physiotherapists in 2-day courses (cf. Campbell 1998). The development of non-classical forms of acupuncture was on the other hand

28 They must pass an examination, whose regulations vary for the single German states, and even municipalities. The examination requires no special education.
due to conceptualising randomised clinical trials in acupuncture. For superficial acupuncture, special needles were invented. They did not penetrate the skin, but sprang back into their husk. For sham acupuncture, the needle is inserted at a site different from that of the traditional treatment points. In some of the studies which that sham acupuncture had been developed for it proved to be more efficient than a ‘normal’ placebo. This result was taken up by some researchers and doctors for therapeutic means, because it ‘can be learnt by medical practitioners in short courses of between 2 and 5 days which aim to teach knowledge and skills sufficient to treat conditions that are commonly seen in primary care’ (Ross et al. 1999: 5).

Ballegard (1998: 11f.) found ‘no significant between the effect of the traditional and non-standard acupuncture on angina pectoris, both effecting a reduction in nitroglycerin consumption and in anginal attacks. Thus, it was concluded that the clinical improvement was due either to a specific effect of both methods or a placebo effect’.

Davies (2001) could not report statistically significant results from his study on minimal and traditional acupuncture in minimising hot flushes following breast cancer treatment. Ross et al. (1998) give an account of the use of ‘minimal acupuncture’ for neck pain. ‘Doctors were free to decide what areas or acupuncture points to treat (…). This (…) study has found the majority of patients (…) were apparently successfully treated with between one and six brief sessions of minimal acupuncture.’

This acupuncture is dis-embedded from the Chinese philosophical background, indeed: It is intentionally dis-embedded. But this medical conception is in the minority.

VIII. German randomised trials on acupuncture

There had been a debate about how to proof the efficacy and efficiency of CAM therapies since the 1990s. Authors often aimed at better recognition of these therapies by medical science, at reimbursement of the patients by insurance schemes, and at separating the wheat from the chaff. While RCTs were criticised as scarcely viable for CAM therapies, and even for ethical aspects (cf. Kiene 1994), RCTs became increasingly accepted in the CAM scene, like it may be seen from the foundation of the journal Forschende Komplementärmedizin. In 1999, a group of German health insurance companies initiated acupuncture RCTs.

Patients who had been treated for chronic diseases like low back pain, arthrosis, and migraine for a longer time were offered to receive an acupuncture treatment. In a first stage of the tests, the patients were interviewed by scientific institutes for feeling better or not. The second stage of the

30 For an overview of studies using acupuncture and sham-acupuncture in RCTs see Cummings 2004.
31 There is a stream in the BMAS advocating this ‘modern, Western-orientated form’ of acupuncture (Baldry 2005: 10).
tests was formed by one-side blinded\textsuperscript{32} randomised studies, which were performed at the physicians’ offices, and supervised by university institutes. The physicians had to hold the (smaller) \textit{A diploma} at least, and they got a special training for the tests. The patients who were willing to take part in the trials were divided into groups according to the respective disease, and then subdivided into three groups, again:\textsuperscript{33}

- The first group received a series of 12 semi-standardised acupuncture sessions. They were needled at certain basic points according to a common acupuncture textbook; some other points could be needled in addition. The physicians aimed at producing a \textit{De Qi}.\textsuperscript{34}
- The second group was supposed to be the control group. These patients received sham-acupuncture, which was called minimal acupuncture in the directory. Physicians were told not to talk of a placebo. They should neither manipulate the needles, nor produce a \textit{De Qi}. The needles should be stabbed to at least 5 out 10 points which varied for the three diseases treated, and which were no common acupuncture points. Three experienced acupuncturists and two associations\textsuperscript{35} had agreed upon the localisation of these points (cf. Linde et al. 2003: 187).  
- The third group received verum acupuncture, but only after six months of a waiting list.

The most astonishing results were those of the minimal (sham) acupuncture groups.\textsuperscript{36} The researchers had presented first results on a conference in Berlin in May 2004. The results were almost the same for all diseases tested. First published were those on patients with tension headache (cf. Melchart et al. 2005), and with migraine (cf. Linde et al. 2005). 296 headache patients were randomised in the way described above. In the end, 132 received verum acupuncture, 63 minimal acupuncture,\textsuperscript{37} 75 were in the waiting list. The number of days with headache decreased by 7.2 days in the verum, by 6.6 days in the ‘minimal’, and by 1.5 days in the waiting list groups. The response rates\textsuperscript{38} were 46\% in the verum, 35\% in the minimal acupuncture, and 4\% in the waiting list groups\textsuperscript{39}.

As for the migraine patients, 304 were randomly assigned, and finally valid data were available for 132 patients in the verum acupuncture, for 76 in the sham acupuncture groups, and for 64 patients on the waiting list. The days with headache of moderate or severe intensity decreased by a mean of 2.2 days in the verum, of 2.2 days in the sham acupuncture, and of 0.8 days in the waiting list.

\textsuperscript{32} Blinding has been introduced into clinical trials (originally of drugs) in order to correct personal influences. One side blinding means that the physician knows whether he gives a verum or a placebo, while the patient does not. In double blinding neither the physician nor the patient knows.  
\textsuperscript{33} For the trials cf. Linde et al. 2005; Melchert et al. 2005.  
\textsuperscript{34} An itching feeling of the circulation of qi, starting from the needled point, and caused by manipulating the needle.  
\textsuperscript{35} The DÄGfA and the \textit{International Society for Chinese Medicine}, both situated in Munich.  
\textsuperscript{36} A Norwegian study on sinusitis patients produced no clear results (cf. Rössberg et al. 2005).  
\textsuperscript{37} The authors of the ART-Studies call the control group sometimes minimal (Melchart et al. 2005) and at other times sham acupuncture group (Linde et al. 2005).  
\textsuperscript{38} Defined by a reduction of at least 50\% in headache days.  
\textsuperscript{39} For a smaller study on acupuncture for chronic headache see Coeytaux et al. 2005.
groups. The response rates to the treatment were 51% in the verum, 53% in the sham acupuncture, and 15% in the waiting list groups.

‘Results in the sham acupuncture tended to be slightly better than those in the acupuncture group, but the differences were not significant’ (Linde et al. 2005: 2122).

Indeed, the results for the sham (or: minimal) acupuncture group are most astonishing. How is the phenomenon explained by the authors? Firstly, they stress that the data are valid, and that the sham results are above those expected from a mere placebo:

‘An interesting finding of our trial is the strong response to sham acupuncture. The improvement over and the differences compared with the waiting list group are clearly clinically relevant. (…) response rates in placebo groups are typically around 30%. (…) The strong response to sham acupuncture in our trial could be a chance finding. It could also be that the study patients with high expectations of acupuncture treatment reported positively biased data. However, the validity of our results is supported by the consistency of findings as judged by a variety of instruments including a headache diary and validated questionnaires on quality of life, disability, and emotional aspects of pain.’ (p. 2124)

The authors offer two explanations. The first one is that of an active placebo:

‘… we cannot rule out that this (sham; G.S.) intervention may have had some physiological effects. The non-specific physiological effects of needling may include local alteration in circulation an immune function as well as neurophysiological and neurochemical responses. (…) our minimal acupuncture intervention was clearly an appropriate sham control although it might not be an inert placebo’ (ibid.)

The second explanation offered is that of potent placebo effects:

‘Another explanation for the improvements that we observed could be that acupuncture and sham acupuncture are associated with particularly potent placebo effects. There is some evidence that complex medical interventions or medical devices have higher placebo effects than medication. Furthermore, acupuncture treatment has characteristics that are considered relevant in the context of placebo effects, including exotic conceptual framework, emphasis on the “individual as a whole”, frequent patient-practitioner contacts, and the repeated “ritual” of needling.’ (ibid.)

While the first explanation is situated on a physiological level, the second is a cultural one: ritual and holism, associated with alternative medicine, might produce health effects in their respective believers. I do not aim at searching for the correct answer. But which consequences might these results have? If the classical ‘very’ acupuncture points are less relevant than the needling process itself, this may firstly strengthen the tendency to dis-embed acupuncture from its philosophical and cultural background, and secondly weaken the motivations of Western physicians to achieve the higher diplomas offered by the acupuncturist organisations. Trigger or acupuncture points, Indian

40 This explanation has been used by Ezzo et al. (in: Stux & Hammerschlag 2000) before, as a result of acupuncture systematic reviews.

chakras or Chinese meridians: a great melting pot of medical conceptions is offered behind a number of convergent practices.

IX. Conclusion
Going West, acupuncture has certainly been dis-embedded from its original philosophical and theoretical background. But this at least partly true for the TCM in China already, like I said in the beginning. In Western practice, acupuncture became isolated from other forms of Chinese medical practices. It became hybridised with various forms of biomedicine, and also with other CAM therapies, especially with homeopathy. But this does not necessarily imply that acupuncture became minimised. Medical professional organisations and a few universities take care for acupuncture in the same ways, in which other medical specialities are cared for. Minimal acupuncture as a medical conception remained marginal. But the extension of Chinese medical philosophy and a re-embedding of acupuncture to its original background cannot be expected.

Concerning hybridisation, the term proved to open paths for empirical research. Though you will look in vain for non-hybridised cultural forms, it makes sense to look for different modes of hybridisation. In Western Europe, I could present some forms of acupuncture hybridised with biomedicine. But that does not necessarily imply that they represent minimised shadows of an Eastern original.

List of abbreviations
ACRWG: Acupuncture Regulatory Working Group
AGTCM: Arbeitsgemeinschaft für klassische Akupunktur und traditionelle Chinesische Medizin - Association for Classical Acupuncture and TCM
BAAB: British Acupuncture Accreditation Board
BAcC: British Acupuncture Council
BMA: British Medical Association
BMAS: British Medical Acupuncture Society
CAM: Complementary and Alternative Medicine
COA: Certificate of Accreditation
COBC: Certificate of Basic Competence
DAAAM: Deutsche Akademie für Akupunktur und Aurikulomedizin - German Academy for Acupuncture and Auriculomedicine
DÄGFA: Deutsche Ärztegesellschaft für Akupunktur - German Medical Association for Acupuncture
DGFAN: Deutsche Gesellschaft für Akupunktur und Neuraltherapie - German Society for Acupuncture and Neural Therapy
DH: Department of Health
NHS: National Health Service
RCT: Randomised Clinical Trial
TCM: Traditional Chinese Medicine

42 Cf. Shang (in: Stux & Hammerschlag 2000) for a comparison.
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