

The contested reality of acupuncture effects: measurement, meaning and relations of power in the context of an integration initiative in Norway

Gry Sagli

University of Oslo, gry.sagli@medisin.uio.no

Abstract

With the current health policy of evidence-based medicine, efforts to introduce new therapies in public health care are inevitably linked to the necessity of providing evidence for the therapies' efficacy. By focusing on differences between patients' viewpoints as to what counts as the effects of acupuncture and the outcomes measured by physicians in a study, I discuss the contested reality of effects in the context of an initiative aimed at the integration of acupuncture in a public hospital in Norway. In the analysis, I draw on ethnographic data from fieldwork at an acupuncture clinic where patients with rheumatoid arthritis (RA) were offered acupuncture as part of a pilot clinical study, which was the first step in an integration attempt. Applying Pierre Bourdieu's concept of symbolic power, I discuss the power dimensions implicit in the evaluation of medical therapies and integration processes. To conclude, I suggest that for actors interested in the integration of acupuncture and other forms of alternative and complementary medicine, it seems a necessary step to recognise the need for better measures to counteract the illegitimate consequences of biomedical authority when plans for integration are designed.

KEYWORDS: acupuncture, alternative and complementary medicine (CAM), public health care, power relations, patients' experiences, medical anthropology

Introduction

Acupuncture and other forms of complementary and alternative medicines (CAM)¹ are to an increasing extent being established – or are considered being established – within public health-care systems. This trend towards integrated medical care is visible internationally (Baer 2004; Barrett 2003; Ruggie & Cohen 2005) and in Norway (Gamst, Haahr, Kristoffersen & Launso 2006; Salomonsen, Grimsgaard & Fønnebo 2003). In this article, I shall

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¹ This article complies with the definition of complementary and alternative medicine (CAM) used by WHO as a 'broad set of health practices that are not part of the country's own tradition and are not integrated into the dominant health care system' (Bodeker, Ong, Grundy, Burford & Shein 2005: xii).

discuss an initiative aimed at the integration of acupuncture in a public hospital ward in Norway. This analysis seeks to contribute to the understanding of why CAM therapies, such as acupuncture, are accepted or rejected as a result of integration attempts. To be more specific, I aim to demonstrate that a focus on differences between patients' and biomedical physicians' viewpoints on acupuncture effects and how these effects are constituted may be useful in elucidating important aspects of the integration process.

With the current health policy of evidence-based medicine (EBM), efforts to introduce new therapies in public health care are inevitably linked to the necessity of providing evidence for the therapies' effect (*Det kongelige helsedepartement 2002–3*; Lambert, Gordon & Bogdan-Lovis 2006; Sackett & Rosenberg 1995). As scholars have pointed out, the present emphasis on *evidence* gives reason to undertake a critical examination from social and cultural perspectives into the issue of how evidence is produced and thereafter applied in health care, and not only to produce new medical evidence (Barry 2006; Lambert et al. 2006; Mizrachi & Shuval 2005). When biomedically accepted evidence of a specific therapy does not exist, efforts to evaluate the effects seem like a logical first step when aiming at the adoption of this CAM in public health. However, what should count as *evidence* is much contested in the case of several CAM therapies (Barry 2006; Jackson & Scambler 2007; Nahin & Straus 2002; Verhoef, Casebeer & Hilsden 2002; Shea 2006). CAM integration attempts thus raise questions as to what should count as legitimate treatment effects in the context of such initiatives. What do patients consider to be treatment effects? What do physicians see as relevant outcomes to be measured? When certain accounts of effects are privileged while others are silenced or softened, how does this influence the further progress of integration initiatives?

To discuss the contested reality of treatment effects in the context of integration and evidence-based medicine, I shall draw on ethnographic data from fieldwork at an acupuncture clinic where patients with rheumatoid arthritis (RA)² were offered acupuncture as part of a pilot clinical study.³ Specifically, an acupuncturist at the clinic treated a group of patients who were participating in the pilot study; whereas physicians working at a rheumatology ward at a hospital in the same district were in charge of measuring the potential effects of the acupuncture. This pilot study was planned as the first step in a process aimed at determining whether or not acupuncture should be included among

² Rheumatoid arthritis is biomedically defined as a chronic, autoimmune disorder that primarily affects the joints, but that might also attack internal organs and other tissues of the body. The RA diagnosis is normally established by a set of criteria described by the American Rheumatism Association (Arnett, Edworthy, Bloch, McShan, Fries, Cooper et al. 1988).

³ The data I draw on in this discussion come from a wider research project ('New Strategies of Coping: A Qualitative Study of Strategies of Coping and Patients' Experiences of Alternative Medicine') in which experiences from participation in Chinese health practices in Norway were the prime focus of the investigation. This larger project was a multi-sited ethnographic enquiry, and fieldwork was conducted in public health institutions as well as in private clinics and other arenas outside public health. The project was approved by the Regional Ethical Committee for Medical Research Ethics (REK) and by the Norwegian Social Science Data Services (NSD). The project was financed by the Norwegian Health and Rehabilitation Foundation, funding applied for through Norwegian Rheumatism Association.

the therapies at the ward where the physicians work.⁴ My material from this acupuncture clinic, therefore, is particularly relevant in order to gain insights into various aspects of an integration attempt.

As part of the fieldwork, I observed acupuncture treatment sessions, interviewed patients and engaged in conversations with the acupuncturist and occasionally with the physicians. In addition, I gathered relevant documents, and the research protocol for the pilot study and documents concerning the test instrument used by the physicians (such as questionnaires and laboratory tests), constitute part of my material.

As I will explain in the following, there were important differences in what kinds of effects patients with RA described as relevant when interviewed by me and the outcomes that were measured by the physicians. To understand how such differences in viewpoints influence the further progress of acupuncture integration, I shall argue that we need to address the uneven distribution of power between the different health agents. I suggest that Pierre Bourdieu's analysis of symbolic power may usefully be applied to shed light on this situation (Bourdieu 1977; 1993).

In sum, this article attempts to weave together two closely inter-connected lines of inquiries. First, while the vast majority of research in the field of acupuncture consists of studies applying biomedical parameters to either establish or disprove the clinical efficacy of acupuncture (Ernst, Pittler, Wider & Boddy 2007), I aim to contribute to the small, but growing, body of literature exploring acupuncture effects as seen from the patients' perspectives (e.g. Alraek & Baerheim 2001; Cassidy 1998a,b; Gould & MacPherson 2001; Paterson 2006; 2007; Paterson & Britten 2003). More specifically, this article adds to the very limited number of studies focusing on the experiences of patients with RA who are receiving acupuncture (Hughes 2008).

A central conclusion from former qualitative studies on patients' experiences of acupuncture is that the outcome measures employed in clinical trials of acupuncture tend to be too narrow (e.g. Hughes 2008; Hughes, Goldbart, Fairhurst & Knowles 2007). As a second trait, I seek to extend the relevance of this conclusion from the problem of methodology in clinical trials to the issue of the dynamics of integration initiatives in the context of evidence-based medicine. Attempts to integrate CAM in public health have proved to be difficult (Gamst et al. 2006; Coulter 2004; Mulkins, Eng & Verhoef 2005; Ruggie & Cohen 2005; Shuval, Mizrachi & Smetannikov 2002). I wish to contribute to the understanding of why it is so by focusing on the power dimension implicit in evaluations of medical therapies. Thus, this presentation adds to the literature in medical anthropology that examines the inter-connectedness between the dominant biomedicine and forms of CAM therapies (Adler 2002; Badone 2008; Barnes 2005; Cant & Sharma 1999; Nisula 2006). This article demonstrates certain particularities of how biomedical power is played

⁴ The physicians played the dominant role in deciding on the questionnaires and the other test instruments that were adopted in order to measure the effects of acupuncture. However, some other researchers were also involved in the designing of the pilot study. For clarity of discussion, I refer to 'the physicians' only. In addition to the measuring of effects, the pilot study aimed at clarifying the practical barriers to the establishing of an acupuncture clinic at the hospital. The issue of practical hindrances will not be discussed within the limits of this article.

out in a specific context where it has not been studied before: a CAM integration initiative in Norway at a moment when evidence-based medicine is flourishing in public health.

The case: An acupuncture integration initiative in the context of evidence-based medicine

The direct occasion that caused the physicians to consider the introduction of acupuncture at the rheumatology ward in Norway was a visit to China, as part of a program for collaboration in the field of health between the People's Republic of China (PRC) and Norway.⁵ In China, the visiting physicians observed acupuncture being offered to persons with arthritis in public hospitals. As is well known, acupuncture is one of the treatment methods that have been promoted as part of modern traditional Chinese medicine (TCM) and have been integrated into the public health-care system in China (e.g. Hsu 1999; Scheid 2002).

In Norway, in contrast, acupuncture is generally not available in the public health services, neither in rheumatology wards nor in other hospital departments. Although some hospitals – most notably pain clinics and maternity wards – recently have adopted the use of acupuncture (Salomonsen et al. 2003), these are exceptions rather than the rule. The majority of acupuncture clients receive the treatment in the private sector, which is very small in comparison the public sector in Norway.⁶

Despite this situation, many factors motivate the idea of introducing acupuncture to the hospital. In Norway, as internationally, acupuncture is increasingly popular among a large proportion of the population (Eisenberg, Davis, Ettner, Appel, Wilkey et al. 1998; Fønnebø and Launsø 2007; Opinion 2006; Tindle, Davis, Phillips & Eisenberg 2005). Moreover, studies indicate that patients with chronic diseases, in particular persons with musculoskeletal complaints such as arthritis, are particularly frequent users of acupuncture (Cassidy 1998a; 1998b; Ernst 1998; Fønnebø & Launsø 2007; Hughes 2008; MacPherson, Sinclair-Lian & Thomas 2006). There are also some studies showing that patients with arthritis, including RA, feel that they benefit from acupuncture (for an overview, see Hughes 2008: 68). The World Health Organisation (WHO) describes acupuncture as a useful treatment for persons with RA; moreover, it recommends that countries worldwide integrate acupuncture into their health-care systems (WHO 2002a,b).

However, the fact that a recent summary from the prestigious authority of evidence-based medicine, the Cochrane Database, had concluded that there was little evidence of acupuncture relieving RA symptoms, discouraged any plan of integration (Casimiro,

⁵ The physicians' visit to China was part of a co-operation between the Ministries of Health in Norway and the PRC. It was the Norwegian coordinators of the China-Norway collaboration who initially suggested the idea of establishing acupuncture at the hospital to the physicians.

⁶ For an introduction to the health care system and the welfare state in Norway, see Johnsen 2006; Kildal & Kuhnle 2005. As a general principle, Norwegian law does not prohibit other than authorized health personnel to treat patients. A new law (Act No. 64 of 27 June 2003 Relating to the Alternative Treatment of Disease, Illness, etc) has been in effect since January 2004 (CAM therapies, including acupuncture, are referred to as 'alternative treatment' in Norwegian legislation). A new voluntary registration scheme for practitioners of alternative treatment (anchored in the same new Act) was also established in 2004. Members of associations which have been accepted by the health authorities can register (Det Kongelige Helsedepartement 2002–3).

Barnsley, Brosseau, Milne, Robinson & Tugwell et al. 2005). According to this powerful source, acupuncture was not to be recommended for patients with RA.

This conclusion from the Cochrane Database was noted in the research protocol for the pilot study. The Norwegian physicians, however, also noticed that acupuncture research applying individualised approaches according to traditional Chinese medicine had not been included in the Cochrane conclusion. This finding was considered significant, as they knew examples of acupuncture research that had incorporated the characteristics of TCM acupuncture in its design and which had proved to document better results for some groups of patients (e.g. Alraek & Baerheim 2003). It was therefore decided to take the integration plan one step further, in spite of the Cochrane conclusion. Hence, a study was planned in which the potential effects of being treated by an acupuncturist who was practising according to the principles of traditional Chinese medicine would be measured.

In the context of evidence-based medicine, this was an important feature of the Norwegian acupuncture pilot. Much of the discussion concerning EBM related to CAM has focused on how evidence is produced and rated within this paradigm. Evidence drawn from randomised clinical trials (RCT) is the gold standard within the evidence hierarchy of EBM (Sacket & Rosenberg 1995). As has frequently been pointed out, the RCT research design – originally designed for the testing of pharmaceutical drugs – does not go well together with complex, individualised forms of CAM modalities (Barry 2006; Jackson & Scambler 2007; Verhoef et al. 2002). To the extent that CAM has been tested in RCTs, it has primarily been in simplified forms, greatly changed from how they are normally used in clinical practice.⁷ Hence, when the physicians in Norway chose to study the effect of being treated by a traditional acupuncturist and not by standardised needling, they addressed some of the most common critiques raised against EBM with relation to CAM. However, in the contexts of the topic discussed here, the question of how this strategy influenced the progress of the pilot study and the integration attempt remains to be further explored.

The acupuncture treatment in the pilot study

A local acupuncturist was engaged to conduct the treatments. The acupuncture was carried out in the clinic where the acupuncturist usually works. The RA patients were offered a series of ten acupuncture treatments. In contrast to most clinical studies, the acupuncturist was not instructed to adjust the treatments to any other study criteria.

From observations of treatment sessions and interviews, I learned that the treatments varied quite significantly in content. Initially in the first consultations, the acupuncturist engaged the patients in a detailed interview concerning status of their health, including symptoms and pains, treatments and medication, temperament and constitution, sleep and reactions to seasonal and temperature changes, work and hobbies, food, drink and other lifestyle habits, as well as other important circumstances in their lives, in the

⁷ Recently advocated methodology (referred to as ‘whole systems research’ or ‘pragmatic trials’) better reflects acupuncture as it is used in real life situations (MacPherson, Nahin, Paterson, Cassidy, Lewith & Hammerschlag 2008).

present and in the past. The acupuncturist also undertook a physical examination, including examination of the tongue and pulse. On the basis of her examinations, she arrived at six different acupuncture diagnoses.⁸ Correspondingly, each of the diagnoses had to be followed up by specific treatment strategies. In addition, the acupuncturist adjusted the needling from session to session to address the patients' specific needs or problems of the day. The acupuncturist explained that in her treatment strategy she addressed all kind of problems and not only those intrinsic to RA.

The acupuncturist employed other treatment tools in addition to the needles. *Moxibustion* (dried Chinese mugwort) was the supplementary method she used most often.⁹ Furthermore, the acupuncturist commonly complemented the treatments she applied in the clinic with recommendations concerning lifestyle changes or other measures she thought would be useful to the patient. Her advice covered a wide scope of domains; for example from advice relating to activities of everyday life (to buy more suitable shoes, to make changes in diet, to alter modes of exercise) to suggestions concerning other health-care services (to have blood tested, encouraging a patient to have a tumour examined by x-ray experts).

In sum, the acupuncture conducted by the acupuncturist in the Norwegian pilot study was beyond doubt different from the standardised needling strategies included in the Cochrane review (Casimiro et al. 2005). The treatment approach employed by this acupuncturist was truly complex and varied in content. By being so, the description of the treatments she provided complies with the characterisation of acupuncture described in other studies of traditional Chinese acupuncture, in China as well as in Western contexts (Hsu 1999; Scheid 2002; Hughes 2008; MacPherson & Thomas 2008). This raises questions as to whether this had any impact on what kinds of effects the physicians' measured, what kinds of effects the patients talked about, and importantly, on the conclusion of the integration attempt.

A diversity of acupuncture effects

The outcomes measured by the physicians

What kinds of effects did the patients with RA consider to be relevant acupuncture effects? To what extent were these effects part of the range of outcomes measured by the physicians? The following enquiry into these questions is based on both data from interviews with participating RA patients and observations from acupuncture sessions as well as on information about the test instruments used by the physicians.

The pilot study was designed to be of small scale. Only thirteen patients participated. I observed acupuncture sessions and interviewed six of the thirteen.¹⁰ The group of

⁸ The six diagnoses were: Boney Bi, cold Bi, Wind Bi, Heat Bi, Spleen-Damp related, and Invasion of Cold. For an introduction to Bi syndromes, see e.g. Maciocia (1994).

⁹ In China needling (zhen) and moxibustion (jiu) is normally coupled into one concept *acumoxa* (zhenjiu) (e.g. Hsu 1999; Scheid 2002).

¹⁰ In compliance with the sampling strategy for the larger research project the fieldwork at this acupuncture clinic was part of, only six patients were selected for interviewing. I applied a strategy for sampling aiming at maximum variation within the group of interviewees. The patients were interviewed twice; first in the course of the series of treatments and a second time, approximately half a year later. All the interviewees gave permission to tape record the dialogues.

six, although small, was highly diverse and their reflections on acupuncture and experiences from receiving this treatment, when seen together, showed considerable complexity. I regard this experienced complexity as sufficient background for a discussion of the outcomes used to measure effects by the hospital physicians.

To measure the effect of being treated with acupuncture, the physicians employed laboratory blood tests, examination of blood pressure and a set of questionnaires. The set of questionnaires encompassed questions concerning activities of daily living (using the so-called Modified Health Assessment Questionnaire MHAQ¹¹), length of morning stiffness, degree of pain, general assessment of disease activity, number of swollen joints and number of painful joints, degree of fatigue, questions concerning their general sense of how active the disease is and its influence in their lives, and finally a part about use of medication and medical events. The patients were asked to select options or indicate on a scale the answer they felt matched their condition.

The specific questionnaires had been chosen because they were from the repertoire of test instruments that are standard in rheumatology wards in hospitals in Norway. They were all validated, and they are normally used to test measures of all kinds with regard to their helpfulness for persons with rheumatoid arthritis.¹² Importantly for the discussion here, this also implies that neither the particularities of traditional Chinese acupuncture nor the individual patients were the starting point for the choice of research instruments.

Patients' accounts of acupuncture's effect

Among the six patients (whom I engaged in interviews and whose acupuncture sessions I observed), only two had ever tried acupuncture before.¹³ Responding to the question of why they chose to participate in the acupuncture study, a common answer was that they wished that acupuncture would prove to be beneficial for patients with RA, so it could be part of public services provided for these patients. In their perception, acupuncture was certain to be a harmless, safe treatment. In contrast, they argued, the treatments normally offered to RA patients by conventional 'school medicine' (which is the term commonly used for biomedicine in Norway), are potentially harmful medication or surgery, often intrusive and sometimes risky.¹⁴

¹¹ See Uhlig, Haavardshold and Kvien (2006) for information on MHAQ.

¹² The questionnaires were (partly) from a study in which five Norwegian centres of rheumatology collaborate (the so-called NOR-DMARD register, see Kvien, Heiberg, Lie, Kaufmann, Mikkelsen & Nordvag et al. (2005). The questionnaires are available on the internet: http://www.nrrk.no/modules/module_123/proxy.asp?D=2&C=634&I=2478 Accessed on the 31 December 2009.

¹³ The six were selected on the basis of being different with regard to sex (two men and four women), age (25-65), and being with or without previous experience of acupuncture (two with some experience and four with none) (Patton, 2002; Pope & Mays 2006). All but one of the six had received their RA diagnosis more than ten years ago. They were all seriously affected. Yet in spite of their problems and with some modifications with regard to their environments, all but one was capable of full participation in studies or working life. Three had undergone surgery as part of a regime to counteract RA symptoms. At the time of the study, half of them were regular users of anti-inflammatory medication. Among the other three, two avoided medication because they were very reluctant to risk the intake of potentially harmful medicine, whereas one had earlier experienced serious side-effects and for this reason tried to avoid it.

¹⁴ These RA patients' viewpoints comply with research on safety issues in acupuncture practice (e.g. MacPherson, Thomas, Walters & Fitter 2001).

In addition to seeing their participation in the pilot study in a wide perspective as an act with potentially beneficial consequences for RA patients as a group, the patients (as expected) also spoke of expectations and hopes of help from the acupuncture for their own individual problems. Many of the topics that the patients described in my interviews as important to them were included in the physicians' questionnaires. However, I also learned that there were important differences between the patients' viewpoints on what constitutes acupuncture effects and those represented in the questionnaires.

As a start of a discussion concerning differences in viewpoints, I will recall parts of the account of one of the patients. I have chosen Ann's story as it is very rich in content. Her story articulates a broad range of experienced effects. Many of the categories of effects talked about by one or more of the other patients are exemplified in Ann's account.¹⁵

Ann had lived many years with the diagnosis of rheumatoid arthritis. The acupuncture provided as part of the hospital's study was Ann's first experience with this form of treatment, although to see an acupuncturist had been on her agenda for some time.

In the period before she was invited to participate in the acupuncture study, she had felt that her condition was gradually worsening. She was on her way into a bad period, or into an 'evil cycle' as she put it. She had begun to feel 'aches and pain all over' and 'then it was stiffness and pain in the mornings'. She mentioned a whole series of body sensations that she recognised as bad signs. The deterioration of her condition gradually influenced many areas of her life, such as work, leisure activities, and family.

To her satisfaction, this 'evil circle' was broken after the first couple of acupuncture sessions. Ann had, however, greater expectations as to what she would achieve from receiving acupuncture. She expected a more general healing process to be generated. She explained that she had expected acupuncture would help her to have less pain and feelings of stiffness, to gain more flexibility, and that she would feel less tired and more energetic. She also hoped the acupuncturist would address her problems with her stomach and digestion, as well as her menstrual problems. In addition, she also wished that acupuncture would give her more self-confidence, improve her ability to take care of herself and help her to relate better with friends, family and her partner.

Ann was primarily treated with acupuncture needling, but on some days the acupuncturist also used *moxibustion*. Ann also received lifestyle advice. She was, for example, advised to make changes in her diet and to begin taking a nourishing tonic. In the end, when the study's ten treatments were completed, Ann had experienced positive changes with regard to most of the problems she had presented to the acupuncturist. She felt she was in a good process. She had less pain and felt more flexible in her joints. She was able to grasp objects that had been out of reach for her. She felt more energetic and generally 'more alive'. Her severe menstrual problems were completely gone and her digestion problems had also improved significantly. She did not feel completely exhausted after work anymore and she even had the energy to join a fitness class. Moreover, she felt more confident in the sense that she had the vigour to take care of herself. She also regarded her relationships with other people as more balanced.

¹⁵ The name of the interviewee has been altered to ensure confidentiality.

One experience Ann drew my attention to, was that of aches and pains occurring in joints where she had not suffered such distress for a long time. Ann was not sure how to interpret this. The acupuncturist had in most of the cases managed to remove the new complaint immediately and Ann still felt she was in a generally good process. She found it most likely that the new pain was the sign of a healing process underway. She knew from other forms of alternative medicine that symptoms often become worse before the total condition turns better. She explained that as the disease is withdrawing, imbalances that have been masked by disease symptoms may become evident and that it is common to experience symptoms turning up in sequences that are a reversal of how they appeared in the first place.

Themes from the patients' accounts in the light of the outcomes measured by the physicians

As is obvious from Ann's account, there were many differences between what kinds of effects the patients talked about and those measured by the physicians. The following differences are striking:

1) *A broader repertoire of effects*: The first point I will focus on is that the patients considered a much broader repertoire of effects than the outcomes measured by the physicians. While the themes included in their test instruments were confined to those regarded as relevant in the context of rheumatoid arthritis, the patients as well as the acupuncturist considered a variety of problems and not only those associated with the diagnosis of RA. Ann mentioned problems related to menstruation and digestion. Other patients talked about headaches, poor appetite, poor sleep, common colds, lack of energy and stress.

Moreover, the effects of acupuncture they experienced, were not only somatic and mental, effects in social domains were also mentioned. Ann reported that she felt more self-confident and had achieved a more harmonious relationship with her family and colleagues. Other patients also mentioned effects related to their strength and motivation to nourish social relationships: seeing friends, children and grandchildren, as well as participation in other activities, taking up hobbies and carrying out more physical exercise.

In this context, it is interesting to note that previous studies focusing on patients' perspectives on the effects of being treated with acupuncture – although few in numbers – have also found that the patients reported a broader range of effects than those outcomes registered in commonly used questionnaires (Alraek & Baerheim 2001; Cassidy 1998a,b; Gould & MacPherson 2001; Paterson & Britten 2003). More specifically, a study focusing on patients with RA shows that RA patients reported effects on the physical, mental and social levels, and not merely the effects conventionally associated with RA diagnosis (Hughes 2008; Hughes et al. 2007).

2) *Different frameworks of understanding*: The next point I want to emphasise, is that in some cases patients interpreted their symptoms differently, sometimes in clear opposition to current biomedical interpretations. Ann, for example, tended to see the occurrence of new pains as a sign of that the arthritis was withdrawing. Although Ann was aware that a biomedical doctor probably would see the new pain as a negative sign or as

normal fluctuation of disease symptoms, she experienced that she was in a generally good process and that in this context the biomedical interpretation did not make sense.

Although the patients varied greatly in how much they knew about acupuncture treatment and acupuncture philosophy, the other patients tended to share with Ann the viewpoint that acupuncture is working according to principles different from those of *school medicine*. Correspondingly, they were ready to search for meanings to interpret symptoms that did not immediately make sense to them, which were different from those given by biomedicine.

Concerning this point, it is relevant to remember that much literature in medical anthropology has demonstrated how patients tend to interpret, and thus evaluate, symptoms differently from the logic of biomedical evaluations (e.g. Good 1994; Kleinman 1980).

3) *Complex, fluctuating processes rather than fixed outcomes*: The third point I will emphasise is that patients often talked in terms of processes, good and bad cycles, rather than the kind of definite results that they were asked to register in the questionnaires. Being in bad circles gradually limited their scope of actions, while good circles opened up new initiatives and new actions. The patients mentioned examples such as doing more exercises, reducing their intake of painkillers, taking up a hobby, seeing friends and other activities that they experienced as health enhancing. Some also mentioned that they had the energy to take up activities or duties that they perceived as bad for their health condition but important in their life for other than health reasons (for example, as one patient mentioned initiating a process aimed at a clarification of status regarding disability pension).

Similar to what has been demonstrated in this article, other studies have also illustrated how the experiences and perceptions of CAM are variable over time and space (Broom and Tovey 2008; Paterson & Britten 2004). Gould and MacPherson (2001) found that over time, many of the patients (42 percent) changed their primary reason for attending an acupuncturist; many from their initial physical concern to a new focus of general health and well-being.

4) *Between zero and zero*: While the patients were asked to respond in terms of exact numbers when answering the questionnaires or in ways that could easily be converted to numbers, the patients' narratives and my own observations showed very clearly that pains, aches and other problems were flowing, unstable phenomena, not easy to grasp in numbers.

In Ann's as well as in other patients' cases, it happened that symptoms not being experienced when the acupuncture series started turned up during the period of receiving acupuncture. This means that to the extent these problems were addressed by the acupuncturist, she treated problems that were not there when the acupuncture series started, whereas in cases when these were successfully treated, the problems were not there at the end of the series. As the patients were tested by the physicians once shortly before the start of the series with acupuncture treatments and twice afterwards, these problems were therefore not registered by their research instruments. In such cases, the number registered for the symptom would be zero, while the patients had experienced successful healing events in the period between zero and zero. In fact, incidents of the immediate effect of acupuncture (e.g. headaches that disappeared or pains in muscles and joints that were considerably re-

duced while the needles were inserted) experienced during or shortly after the acupuncture treatment were often mentioned by the patients to illustrate the basis for their trust in the treatment, also when these effects proved to be only temporary. This last point has, as far as I know, not been discussed in previous studies on acupuncture effects.

In summation, as the examples show, the patients considered a wider repertoire of effects from acupuncture than the selection of outcomes measured by the physicians' research instruments. Moreover, the patients' accounts show the effects of acupuncture increasing or reducing in magnitude as they were woven into the complexity of life-events and diversities in frameworks of interpretations. These findings obviously supply reasons to raise important questions concerning the methodology, in particular the range of outcomes, in acupuncture clinical research. Correspondingly, methodological conclusions are underscored in many of the studies just mentioned (Cassidy 1998a; 1998b; Gould & MacPherson 2001; Hughes 2008; Hughes et al. 2007; Paterson & Britten 2003).

Power Relations in the Context of the Integration Initiative

For the discussion in this article, however, it is the consequence of the pilot study seen in the context of the integration initiative, which is of prime interest. What is the role of the research instruments applied by the physicians in the process that, in the end, will result in the rejection or acceptance of acupuncture in a hospital ward? To be able to take the acupuncture integration initiative one step further, evidence of the effects of this treatment is needed. Yet the physicians have chosen research instruments that lack the capacity to grasp the nuances and the full range of patients' experiences of therapeutic effects. The physicians are therefore risking underestimating the value of acupuncture as experienced by the patients. This result may reduce the chances of introducing acupuncture.

However, the laboratory tests and the questionnaires test the outcomes that the biomedical community sees as relevant, concerning patients with rheumatoid arthritis. Since the set of questionnaires used in the acupuncture study is standard in hospitals in Norway, the results are likely to be considered credible, and they are easy to communicate back to the biomedical community in rheumatology wards in other hospitals. In contrast, the underlying logic of healing and disease processes according to the philosophy of traditional acupuncture often contradicts biomedical assumptions (Hsu 1999; Sagli 2003; Scheid 2002). Knowledge from acupuncture perspectives is therefore less likely to be found convincing by physicians. Similarly, patients' subjective accounts of effects are not infrequently refused recognition by the biomedical community.

Importantly, in the argumentation above I implicitly take for granted that the various accounts of acupuncture effects from the perspectives of the patients, the acupuncturist and the physicians are assigned different statuses. When these accounts are presented within public health care, they are judged as more or less credible descriptions of reality. They imply different knowledge claims, brought forth by actors occupying widely divergent positions of power. In order to understand the course of the further progress of the acupuncture initiative, it is therefore necessary to bring the issue of *power* more explicitly into the discussion.

The power to 'construct reality', what Pierre Bourdieu called 'symbolic power' (Bourdieu 1977; 1993), is a very relevant form of power to consider in this context. According to Bourdieu's analysis, the power to define the reality that is taken for granted – the reality that is *doxic* – is a particularly efficient form of power (Bourdieu 1977: 159–197). Bourdieu did not study health care, but (arguably) public health care in Norway is in some aspects a field that would fit the characterisation of being *doxic* in Bourdieu's terminology. The system of public health care is *doxic*, for instance, in the sense that biomedical disease categories, such as rheumatoid arthritis, are seen as neutral descriptions of processes of the body, not as knowledge constructed from specific, biomedical perspectives.

This has consequences for the design of the acupuncture pilot study and the integrations initiative. The physicians' research instruments (laboratory tests and questionnaires) have outcomes produced on the background of a biomedical understanding of RA. These instruments captured only those patients' experiences that had been reduced to, or transformed into, what could be measured in biomedically acceptable terms, while the acupuncturists and the participating patients considered a wide scope of problems. In this sense, one may claim that the research tools made the physicians incapable of grasping some of the experiences that were valued by the patients.

Bourdieu's perspectives are helpful in order to recognise more clearly that this problem is not simply a matter of neutral methodological technicalities as former research has concluded. Another way of looking at the research instruments used by the physicians is to acknowledge that they carry the capacity to keep experiences and knowledge that is not in accordance with biomedical assumptions outside the institutions of public health. They serve as instruments to maintain biomedical dominance and to suppress alternative, competing accounts of acupuncture effects.

At this point, it should be emphasised that the physicians who were responsible for the acupuncture pilot study expressed positive interest in acupuncture. Their interest was also evident through their engagement in the acupuncture integration initiative. In this case, it may therefore be even more necessary to include notions of power in the analysis, because the exercising of power in this case was not obvious. Symbolic power, as elucidated by Bourdieu, is hidden, structural and impersonal. Therefore it is not recognised as an exercise of power (cf. Bourdieu 1977). Thus, I argue, the actors involved in the integration initiative, regardless of their personal viewpoints on and interest in acupuncture, seem to be caught into a vehicle of production and re-production of biomedical dominance.

Concluding remarks

In this article, I have discussed the contested reality of acupuncture effects in the context of an acupuncture study, which was a first step in an integration initiative. As for the quantitative data produced by the research tools applied by the hospital physicians, these have not yet been thoroughly analysed. However, the initial reading of the results of the study did not seem to legitimise a new larger trial as a next step in the initiative.

Establishing integrated care in public health has, for a variety of reasons, proved to be complicated (Gamst et al. 2006; Coulter 2004; Mulkins et al. 2005; Ruggie and Cohen

2005; Shuval, Mizrachi and Smetannikov 2002). I have attempted to demonstrate that a focus on differences between the views of RA patients and biomedical physicians on what constitutes legitimate acupuncture effects can be fruitful in shedding light on some aspects of the question of why forms of CAM, such as acupuncture, have become accepted or rejected as a consequence of such initiatives. The analysis presented here has underscored that the uneven relations of power prevailing in health care in Norway cannot be ignored when we attempt to understand the processes of rejection or acceptance.

The acupuncture initiative in Norway is an example of a new trend seen in Norway and internationally, where the establishment of forms of CAM in public health care is being considered. Yet, in a historical and global perspective, there is of course nothing new in therapies originating in different medical traditions being combined and mixed in new ways. Various forms of interaction between a dominant biomedicine and various forms of CAM are well documented in the literature of medical anthropology (Adler 2002; Badone 2008; Barnes 2005; Cant & Sharma 1999; Leslie 1980; Nisula 2006; Shuval et al. 2002). The issue of how the efficacy of traditional, non-biomedical medicine should be accounted for has been a central concern in this research (Quah 2003; Waldram 2000). However, the current health policy of evidence-based medicine (EBM) forms new, strongly influential contextual premises for recent attempts to integrate acupuncture and other forms of traditional therapies.

While it is entirely reasonable and reassuring that physicians in a public hospital initiate measures to establish or disprove that a certain therapy works for the group of patients for whose medical care they are responsible, evidence – as my research contributes to with new examples of – is never neutral. Thus, what will count as legitimate treatment effects in the context of CAM integration initiatives stands out as a core issue. Rejection or acceptance of new therapies in public health seems to be closely associated with the answer to this question.

On the basis of the analysis of the integration initiative in Norway, it can be concluded that for actors interested in the integration of CAM in public health it seems a necessary step to recognise the existence of uneven power relations when plans for integration are developed. It is, of course, not uncommon in social science research to acknowledge power dimensions between actors in public health care. However, in debates among health professionals there is, as some observers have noted (e.g. Grimen 2009), a strange lack of discussions about power. My analysis suggests that when integration plans are discussed, power is an issue that needs to be explicitly addressed.

To the extent results of uneven power relations are recognisable, measures to counteract illegitimate consequences need to be developed. In this Norwegian study, an acupuncturist who practices according to traditional Chinese medicine was engaged to conduct the treatments. Apparently, this would serve to work against biomedical authority. However, as my analysis has shown, such a step was not sufficient to counteract biomedical dominance. New initiatives will, as a minimum, have to include measures that ensure that patients' voices and perspectives are granted more weight and value.

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