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MASTERARBEIT

Titel der Masterarbeit

WHEN ACUPUNCTURE TRAVELS

Transporting and Translating Acupuncture to the Austrian Context

Verfasserin

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angestrebter akademischer Grad

Master of Arts (MA)

Wien, 2014

Studienkennzahl lt. Studienblatt: A 066 906

Studienrichtung lt. Studienblatt: Masterstudium Science-Technology-Society

Betreuerin: Univ. Prof. Dr. Ulrike Felt

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2 Entering the World of Acupuncture

The term “acupuncture” was first introduced into the Western context by the Dutch physician Willem ten Thijne. In the 17th century, he formed the term by combining the Latin word “acus”, which means “needle” or “tip”, with the word “punctura”, meaning “to sting”. Despite other mishaps that might have later occurred when translating acupuncture texts from the original Chinese, the translation of the name itself is actually quite close. After all, the Chinese word zhen, which translates to “treatment and/or therapy with needles”, was traditionally used alternating with the word ci, which means “sting”. Thus, the Western word “acupuncture” could be seen as a merger of both the concept of zhen, and ci. (Tessenow, 2013/1) However, the meaning of the words “treatment” and “therapy” are lost in ten Thijne’s translation.

This might be interpreted as a small oversight in translation; an effect of transferring a term into a language very different from the one it originated from. However, it can also be seen as a sign, or a symbol. The name “acupuncture” has had over the years is not a static entity – what the term entails, implies and covers has not remained the same. This holds true for the treatment form itself, as well. Acupuncture has travelled through space and time, and has thus been transformed in the process. Instruments used to practice acupuncture underwent a metamorphosis from stone to needles, and the techniques used diversified, being combined with a myriad of other treatment forms, or used on its own. Acupuncture slowly spread not only throughout Mainland China, but also to Taiwan, the Korean peninsula, Japan and South towards Vietnam. (Unschuld, 1985) And from there on out, starting in the late 16th century, acupuncture was transported to the rest of the world, being one more “good” to be exported from one continent to another, in a world ever closer connected through shipping and trade routes – so the story goes. (Tessenow, 2013/1)

This thesis does not wish to historically trace the routes and paths acupuncture took. It does not wish to search for the “facts” concerning the origins of acupuncture. Otherwise, the story might go something like this: Acupuncture’s origin as a medical treatment has roots in China, with drawn and written records regarding its practice dating back as early as 1600 BCE, and found objects suggesting acupuncture predating even this. (Unschuld, 1985) The anecdotes and tales aiming to explain how acupuncture came to be vary greatly. Some argue that acupuncture developed out of a personal, evidence based medicine from the very beginning, with people reporting an improvement in pain and other symptoms after an area of their

body was (self-)stimulated, e.g. through massages. This led to accumulating knowledge about such “healing points”, which were translated into acupuncture points today. Other, more colorful legends speak of soldiers’ skin being punctured by arrows. After having recovered, they suddenly noticed a vast improvement in previously existing medical conditions. Observing where the soldiers were punctured, so this specific tale, led to medical practitioners experimenting with treating the skin in a similar, though less violent fashion, through which acupuncture was born. (Chang, 1976)

The starting points of acupuncture might be opaque, with facts and fiction being neither established nor relevant. However, there is anthropological evidence tracing the development of acupuncture over time. Burial objects in Hunan, a province in current China, provide detailed insight into the philosophical theory on which acupuncture is based, or was based at the time. Approximately 200 CE, these written texts give details as to where and how patients should be treated via acupuncture, which tools are to be used, but especially why these techniques were thought to be beneficial. (Tessenow, 2013/1) As early as these texts are, two common assumptions described still are commonly perceived as the basis of acupuncture teaching and practice today. According to this, lines of “Qi”, which has been translated to mean something like “energy” or “life force”, runs through the human body, in a fashion comparable to blood veins in Western medical tradition. In Traditional Chinese Medicine, these “lines” are referred to as “pathways”, or, more commonly, “meridians”. These twelve main meridians function as a “map” of placing acupuncture needles. According to the patients’ symptoms and needs, specific points on or near the meridians are stimulated. (Chang, 1976)

Interestingly, the texts found in the Hunan province do not yet speak of twelve meridians, but only eleven – another was seemingly added later on. Furthermore, it is not only recommended to puncture the skin in order to stimulate it; rather “burning” or “heating”, perhaps comparable to today’s moxa treatments, is discussed in the scriptures. (Harper, 1998) When speaking of puncturing the skin, sharp, pointy rocks are recommended in some texts. However, the distinction between using them to practice acupuncture, or for them to function as a form of scalpel, e.g. to drain puss from a wound, is not yet clear. Perhaps due to this lack of distinction, needles used specifically for acupuncture are described as an improvement to the “sharp rocks” in later texts. Early needles found in graves were made from bone, bronze, and gold. An evolution in metal making led to needles being manufactured from iron instead, and being propagated as the superior material for acupuncture application. (Tessenow, 2013/2) The importance of stimulating very specifically defined points is not stressed the same way it is done in later texts, either. Additionally, other

ways of enhancing the flow of the Qi are described, such as practicing correct breathing techniques. (Tessenow, 2013/1)

This brief and incomplete overview of the origins of acupuncture shall be used to portray the starting point of this research project. Acupuncture, as a treatment form, has been and is further evolving. While metal needles were considered the golden standard for centuries, new, less invasive treatment methods, such as laser acupuncture, are being used and tested. Acupuncture is used on its own, or in combination with almost every other Traditional Chinese or Western medical approach imaginable.

It is ever changing, ever adapting and evolving, being shaped not only by practitioners' and their patients' experiences in treatment, but especially through legal and/or medical regulatory systems in place. Hard and soft policies impact acupuncture treatment on an everyday basis. They define who can practice it on whom, in which spaces acupuncture can be researched and treatment provided, and even the promises that may or may not be made regarding possible treatment outcomes. In Austria, these regulations are perceived as being very strict. According to acupuncture providers, namely trained physicians and midwives, this highly regulated system ensures the very best treatment of patients. After all, it is said to provide quality standards in acupuncture education and patient care. This system actually turns out to be a set of well-communicated soft policies, rather than hard legislative realities.

As all things acupuncture, it evolved over time. While there were several attempts to introduce acupuncture to Austria on a broad scale, the current practice can be traced back to the 1950s, when a team of physicians studied Traditional Chinese Medicine in China, and opened an acupuncture clinic in Vienna upon their return. However, this research project was not conducted to clarify when and by whom acupuncture was brought to Austria, nor how specifically policies regulating acupuncture in place today came to be. Rather, this project focuses on how the system existing today is seen, interpreted and enacted by actors involved.

Thus, empirical data was collected by qualitatively interviewing members of these groups holding (perceived) agency. Including further materials provided a data triangulation through a document analysis. The materials used for this analysis consisted of different sources, such as acupuncture journals, texts on the content of and access to acupuncture education in both China and Austria, and acupuncture organization's websites. The document analysis was used both to prepare for the qualitative interviews, which are transcribed in the annex, and to supplement them. Differences and similarities regarding interviews and documents

were compared and contrasted for further insights. This is discussed in depth in the chapter “Research Questions, Materials, and Methods”.

The gathered data was interpreted using a Science-Technology-Society based theoretical framework, which is portrayed in the chapters “Mapping Acupuncture: State of the Art”, and “Theoretical Framework and Sensitizing Concepts”. The overarching concept used is Co-Production, as described in “States of Knowledge. The Co-production of Science and Social Order” by Sheila Jasanoff. (Jasanoff, 2004) Notions of policy and governance, authority and Boundary Work, as well as standardization and medicalization are also applied. Furthermore, the literature of other sociological and anthropological authors studying alternative medicine will be discussed.

Following the discussion of theories and literature, and the introduction of the research methods, is the empirical analysis, which is the centerpiece of this thesis. The original empirical data collection aimed to study policies on three main levels: The regulation of practice, education, and financing of acupuncture in Austria. This original approach provides a structure for this thesis, and each individual element will be discussed in the empirical analysis. However, another layer emerged in the analysis process. Therefore, I firstly want to convey how policies are perceived and enacted by those involved in them. However, and perhaps more important still, this thesis aims at portraying how acupuncture, in and of itself, is transported and translated to the Austrian context in this process. Thus, the focus glances beyond mere policies, to view how a specific “Austrian version” of acupuncture is implemented, practiced and taught.

The first chapter, “A Man with a Mission? Histories of Practicing Acupuncture in Austria”, provides a narrative of the history, or more accurately, histories of acupuncture in Austria. It focuses on the view of acupuncture practitioners, such as physicians and midwives, the two groups “licensed” to provide acupuncture treatment in Austria through the system of soft policies in place. How this “license” was (said to have been) obtained will be the content of the second chapter: “License to Acupuncture? Agents Authorized to Practice Acupuncture in Austria - Groups and their (Imagined) Agencies”. The third chapter goes on to explain the time dimension of acupuncture education in Austria, and how this aspect shapes the perception of how acupuncture is to be learned: “Time (Needed) to Acquire the ÖÄK-Diploma for Acupuncture”. The discussion of how long it takes to be able to successfully practice acupuncture closely ties into the question of how much skill, and philosophy, are needed to be a good acupuncture practitioner.

Thus, the question of the essence of acupuncture is posed, which includes how much of its history and traditions must be taught, or can be forsaken, in order to ensure a “scientific”, but also effective, acupuncture practice. Hence, the fourth chapter is called: “Pinpointing Understanding: The Debate of Skill versus Philosophy”. This chapter opens up the debate of how “past” present-day acupuncture needs. This, on the other hand, is a question not just of history, but also concerns where acupuncture is performed. The title of the fifth chapter, “The Role of Space and Place in Acupuncture Research, Practice and Education”, refers to two dichotomies. The first debates how “scientific” acupuncture should be, and what this notion of science implies. Should acupuncture be researched in a laboratory setting, or is this ludicrous considering centuries of evidence collected through patient reports? It also opens up the question of which culture can claim the “best” acupuncture practice. While Chinese origins are not debated, this chapter explores how a “scientific” version of acupuncture, to which Western medical standards are applied, could be considered superior.

The sixth chapter, titled “Side Effects? The Role of Risk in Justifying the System”, takes this notion of standardization and expertise to another level. It explores possible dangers brought about by acupuncture, and how these are utilized to cement the policy system in place. The seventh and last chapter of the empirical analysis looks into how acupuncture is or is not legitimized through the financing system of insurance agencies: “To Pay or Not to Pay? Insurance Agencies’ Standpoint on Acupuncture”. The public message insurance agencies send through the way they choose to finance acupuncture is a powerful one, as it gives or prevents legitimacy of acupuncture as a medical treatment form.

The empirical analysis is followed by a conclusion, which combines findings discussed in the chapters described above. Hence, it aims to explain how acupuncture has been, and still is being, translated and transformed, as it travels the Austrian context.

3 Mapping Acupuncture: State of the Art

The introduction above both mapped out the structure of this paper, as well as giving a brief history of the development acupuncture underwent in the past. The following chapter is literature based, providing insight into how acupuncture, as well as other forms of alternative and complementary medicine, are practiced in the present and very recent past. It examines the role language, agency, and professional authority play when a marginalized treatment form is striving for acceptance. Furthermore, the concepts of governance and authority of knowledge are explored with regards to the role they play in regulating what is considered “scientific” medical research, and medical practice.

3.1 Sociological and Anthropological Literature on Marginalized Medicine

A crucial article for this thesis is **“The Acupuncture Wars: The Professionalizing of American acupuncture – A View from Massachusetts”** by Linda Barnes, which was published in the journal of Medical Anthropology. (Barnes, 2003) This was one of the few pieces of literature available with research interests and questions overlapping my own, though Barnes chose the role of professionalization as the overarching concept of her research, which plays a lesser role in mine. This already becomes clear in the language Barnes uses: She refers to people practicing acupuncture as “acupuncturists”, and goes on to describe which processes of professionalizing education lead to certain groups of people being included or excluded from this term. What becomes clear is that the people described by Barnes see themselves, their identity, and professional lives as being largely defined by acupuncture. (Barnes, 2003) This does not hold true to the same extent in Austria, where people practicing acupuncture acquired the permission to do so in addition to another type of education within a medical profession. This is the reason I opted to call these people in Austria “acupuncture practitioners”, rather than the “acupuncturists” described by Barnes. This difference also explains why the concept of professionalization cannot be directly transferred to this research project. As I will show, the process taking place in Austria is closer to an incorporation of acupuncture practice into already established professions, rather than establishing acupuncture as a profession itself. Therefore, the concept of professionalization plays a secondary role in the analysis, and when used, will be adapted to suit the Austrian context.

Linda Barnes published two further articles on acupuncture in the USA. **“American Acupuncture and Efficacy: Meanings and Their Points of Insertion”** will be used to debate what the goal of a “successful” acupuncture treatment should be, and how differences in the understanding of this concept are seen according to the acupuncture organizations in Austria. (Barnes, 2005) The definition of an “efficient” acupuncture treatment also has deep implications on acupuncture education and research, as the patient-oriented goal definition of a medical treatment also shapes how future treatment providers shall be taught, which kind of research questions should be asked, and through which methodology they can best be answered.

In **“Practitioner Decisions to Engage in Chinese Medicine: Cultural Messages Under the Skin”**, Barnes uses a framework of agency to conduct a study on the personal reasons why individuals opted for practicing Traditional Chinese Medicine, with a special focus on the cultural meaning of these choices. Thus, many interviewees participating in Barnes’ study have a cultural background linking them to China, though their place of residence and practice is now in the United States. (Barnes, 2009) The motives described by Barnes can be linked to one of the acupuncture organizations in Austria, namely the Chinese Physician’s Community for Acupuncture, which strives to include not only acupuncture, but the culture of TCM in general, into the practice in Austria, following the “original Chinese acupuncture method”. (URL 11)

Like Barnes, Wen-yuan Lin also conducts an agency analysis when he describes the case of dialysis patients in a clinic in Taiwan in the article **“Displacement of Agency: the Enactment of Patients’ Agency in and beyond Haemodialysis Practices”**. However, the agency viewpoint in this case study is the patients receiving treatment, not the physicians practicing it. Using an Actor-Network-Theory approach, he shows how the clinical setting in which biomedical dialysis treatment is performed creates an environment structurally disallowing alternative medical practices to be used in addition to the forms of treatment offered by the clinic. Thus, patients receive the message that they have to choose between receiving biomedical treatment in the clinic, or opt for alternative medicine as a sole approach to treating their severe condition. (Lin, 2012) This case study was interesting in the sense that the Austrian use of acupuncture promotes a model that is the exact opposite, in which acupuncture is being promoted as a treatment to be combined with a standard Western medical approach in what is commonly referred to as a “cross-over” treatment. While patients in Taiwan created agency for themselves by e.g. seeking alternative medicine outside of the dialysis clinic, Austrian physicians often offer Western medical treatment, as well as acupuncture, not only in the same space of a doctor’s office or day clinic, but

acupuncture is often even performed by the same person, as acupuncture diplomas can be easily acquired by physicians.

Mitra Emad discusses the possible loss of meaning when Chinese language regarding acupuncture practices is translated into English in her text: **“The debate over Chinese-language knowledge among culture brokers of acupuncture in America”**. (Emad, 2006) Emad points out that in the United States of America, this is a crucial question of identity amongst acupuncturists and Chinese Medicine practitioners. She claims that the question of language is one of cultural translation, as much as actual translation. Barnes agrees with this, pointing to the fact that only very few of the acupuncturists in the United States actually speak Chinese, one of the main languages in which original text on acupuncture was written. (Barnes, 2003)

In the text **“The establishing of Chinese medical concepts in Norwegian acupuncture schools: the cultural translation of jingluo (‘circulation tracts’)**”, Gry Sagli uses concrete examples of terms from original acupuncture texts, where the meaning gets lost or obscured in the translation process striving to target a biomedically oriented readership students. (Sagli, 2010) As similar examples came up in the course of the interviews conducted for this research project, Sagli’s text allows a comparison towards different ways of dealing with problems encountered in the translation process. Furthermore, the research conducted for this paper also has a strong focus on how acupuncture is being taught, and how this in turn impacts how it will be practiced and perceived later on. Sagli does not have a strong focus on researching policies regarding acupuncture, but focuses instead on a finitist perspective, which “offers an opportunity to demonstrate how new and foreign understandings of the body have been introduced and accepted while well established notions of the body, both biomedical and other, continue to flourish.” Nonetheless, a shared approach is the strong focus on acupuncture education, which I believe is one of the main scenes upon which policies are enacted.

In his text **“The Maintenance of Professional Authority: Acupuncture and the American Physician”**, Paul Wolpe describes the biomedical community in the United States as actively taking measures to gain control over acupuncture in a field where people not educated in Western medicine had been successfully offering acupuncture treatment. This control was enforced by a twofold strategy, namely by regulating the group of people allowed to practice acupuncture, but also claiming possession of the knowledge associated with it. The latter goal was reached by both demanding and conducting research in the standardized form of clinical trials. (Wolpe, 1999) In how far this strategy can be transferred to the Austrian context is debatable. Several interviewees mentioned the use of similar

clinical trials and how they impact the teaching practices of acupuncture, however the trials that were quoted were often conducted outside the country, Germany-based trials being quoted most often. (Kurt König, Rainer Kluger) However, there is also an acupuncture clinic in Vienna collecting data on acupuncture's efficiency and field of application in the course of their practice, rather than through a controlled trial (Appendix: Survey of Acupuncture Ambulance), and this clinic played a crucial role in establishing acupuncture in the Austrian context.

Nina Degele's text **"On the Margins of Everything: Doing, Performing, and Staging Science in Homeopathy"** does not deal with acupuncture, but homeopathy, a very different form of alternative or complementary medicine. Nonetheless, the author used three levels of analysis very similar to this research project, namely "research, education, and everyday work", all of which will play an important role in this empirical analysis as well. Degele makes a point of stressing that adhering to strict biomedical protocols for clinical trials has not proven to increase the recognition for homeopathy in the community of Western medicine. Despite following the rules of the game, homeopaths were not accepted as players on a large scale, though perhaps to a greater extent than they would have been otherwise. As this strategy did not yield the hoped-for results, so Degele, homeopaths stopped following it so strictly, coming up with their own methods of conducting research. (Degele, 2005) Interestingly, homeopathy is relatively well-suited to be used within the scope of a standardized clinical trial, as homeopathic medicine can also be given orally, and placebo control groups can be given non-medicated, but similar-looking pills. With acupuncture, this is not the case. In order to conduct double blind tests, or even blind tests, new versions of trial settings had to be created, with varying success. The pitfalls of testing acupuncture in clinical trials came up several times in the data collection of the empirical material, and opinions varied as to the success outside of acupuncture community. As with homeopathy however, the community of acupuncture practitioners itself seems to be of great need for results of conducted trials, and uses these outcomes both in education and in practice.

Jean Langford, like Degele, is another author who wrote about an alternative medicine other than acupuncture, but whose concepts are nonetheless applicable to this thesis. In her book *"Fluent Bodies. Ayurvedic Remedies for Postcolonial Imbalance"*, she explores the indigenous healing practice of Ayurveda, with a special focus on the role it played in establishing Indian identity in a postcolonial world. As with acupuncture, Ayurveda has been changed in the process of practicing it throughout history in order to adapt it to varying institutional and societal contexts. (Langford, 2002)

3.2 Acupuncture and Governance

In the book **“The governance of Science: Ideology and the Future of the Open Society”**, Steve Fuller states “that science both governs and is governed without being formally constituted as a government implies a paradox.” (Fuller, 2000) This paradoxical notion will be used in the context of acupuncture in Austria. I will argue that the Board of Physicians has established itself as being the primary institution transporting scientific findings regarding acupuncture to a policy level by establishing physicians the “scientific” practitioners of acupuncture. Though the physicians represented are not (exclusively) scientists in the sense that they do research, they have undergone the self-reproducing scientific system described by Fuller, in which scientists are the decision makers constituting who will be considered a scientist in the future through educational systems. (Fuller, 2000) Thus, the Board of Physicians has taken over roles otherwise limited to governmental institutions, such as devising policies. The paradoxical notion extends further, as this research project will show that the communicated policies are far from being hard laws, but are perceived as such by the actors involved in the system.

Fuller, though criticizing this development, states that science is increasingly judged by its “economic competitiveness” in the post-Cold War era, meaning whether scientific research can be translated into profit on an economical level (Fuller, 2000), with Sheila Jasanoff agreeing that “knowledge (was discovered) as a resource” to capitalize on “in a world increasingly driven by the market’s logic”. (Jasanoff, 2004) According to Fuller, a higher ranking in the scale of economic competitiveness could lead to a greater chance of research being funded (Fuller, 2000). Numerous studies to prove or disprove acupuncture’s effectiveness have been conducted. For this thesis, I would like to argue that acupuncture is not by definition profitable, as it can be offered relatively cheaply, certain circumstances of practice provided. Which circumstances these might be, and that they do exist even within the formalized medical system, will be described in the chapter on the “Acupuncture Clinic” in the Hietzing Hospital.

However, acupuncture can be and is being manufactured to be costly, e.g. by ensuring only a limited group of people, such as medically educated personnel, are allowed to offer treatment. Thus, acupuncture research and practice have a strong bearing on each other: Standardized and medicalized research trials on acupuncture, especially when providing a positive correlation between treatment and symptom improvement (Melchart, 2005 / Haake, 2003 / Vincent and Lewith, 1995), acupuncture will gain greater acceptance as a medical treatment, and will thus yield greater profits, as it is sought after more often. The ways in

which trials are conducted binds them strongly into the system of standardized Western medical practices, thus making it more plausible that only medically educated personnel may provide treatment. In his book **“Knowledge politics. Governing the Consequences of Science and Technology”** (Stehr, 2005), Nico Stehr discusses current society’s increasing need to regulate if and how knowledge is used on a political and policy level. His book is an attempt to answer the seemingly simple question: “Which knowledge needs to be regulated, and who needs to regulate it?” (Stehr, 2005) Though Stehr discusses perhaps more controversial knowledge related topics such as nanotechnology or transgenic human engineering, his work can be used nonetheless, or perhaps even more so, in the context of alternative / complementary medicine. Acupuncture is actually not considered a particularly dangerous form of knowledge, as the chapter “Side Effects? The Role of Risk in Justifying the System” will discuss. Still, the strides made to regulate who can acquire and use the knowledge surrounding acupuncture seems to be quite strong, with medical personnel being given the exclusive right to do so. Along these lines, Stehr poses the question: “In particular, one has to ask whether the claims, assumptions, and principles now encountered in economic discourse have a bearing on the dynamics of the fabrication, distribution, and consumption of knowledge in economic processes.” (Stehr, 2005) Applied to the current project, this could help pose the question of which group of people are profiting or losing out financially because of the way acupuncture-related knowledge is regulated. This will be further discussed in the chapter: “License to Acupuncture? Agents Authorized to Practice Acupuncture Acupuncture in Austria - Groups and their (Imagined) Agencies”.

However, limiting the practice and research of acupuncture to medical personnel can be used as a strategy to justify increased costs of acupuncture treatments (Barnes, 2003), which, in turn, makes acupuncture more profitable, thus encouraging further research funding. Fuller’s model of economic competitiveness focuses on a restricted set of players, primarily limiting research to a University level, with economic incentives being given by firms, and differentiates between the supply and demand sides of economic incentives for science. (Fuller, 2000) I would like to adapt this model to include a broader range of players not explicitly mentioned by Fuller on both the supply and demand side. The reason for this is that acupuncture poses a special case in the sense that the researchers are sometimes also the profiteers of the research, not merely in the sense that they receive more funding for their research, but because the “product” they are researching is “sold” by them. In the course of this thesis, I will show that physicians involved in research on acupuncture’s effectiveness and areas of application, also offer acupuncture in their private offices. Acupuncture is not a form of knowledge that can be produced in order to then be marketed. Rather, research in this case is about proving the worth - for health and for the economy - of

something that is already known, thus making it marketable. While there is no explicit product to be marketed, as is the case with pharmaceuticals described by Adele Clarke et al. in “Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine” (Clarke et al., 2003), research can nonetheless be used to turn acupuncture into a marketable medical commodity. In this process, supply and demand of research, as described by Fuller, (Fuller, 2002) becomes blurred.

Authors, such as Adele Clarke, often portray this system of having medicine firmly adhering to and embedded in economic principles as perhaps not being in patients’ best interest (Clarke et al., 2003). Others go further yet, such as Bradford Gray in his book **“The Profit Motive and Patient Care. The Changing Accountability of Doctors and Hospitals”**, where he argues that too strong a focus on the profitability of medical institutions can lead to care being centered exclusively around creating larger profit margins. (Gray, 1993) However, other authors stress that commodification must not necessarily lead to a negative outcome for patients. While stressing that control is crucial in a for-profit health care system in order to fight corruption, Rene Almeling and Stefan Timmermans also portray possible upsides of commodification, saying that it “might benefit patients by bringing new products to the market (and) raising awareness of treatment options.” These findings, covered in the text **“Objectification, standardization, and commodification in health care: A conceptual readjustment”** (Almeling et al., 2009), are partially applicable to this research topic. Acupuncture was initially not covered in Austria by the public health care system. However, a group of physicians opted to offer it anyhow. According to a popular narrative of acupuncture’s development in Austria, a large enough number of patients choose to utilize this treatment option for it to become profitable, and thus more accepted within physicians’ practice. Ultimately, this can be interpreted as being part of the dynamic that lead to acupuncture’s acceptance in society and the medical field, which was mirrored in health policies, as well.

In the book **“The New Politics of Medicine”**, Brian Salter goes into further detail of this supply and demand relation with regards to medicine and medical care in society, highlighting the crucial role the state plays in it: “For both medicine and state, the most important political product of this arrangement is the ability of the profession to regulate the relationship between patient demand and health care supply.” (Salter, 2004) While Almeling et al. explicitly call for regulatory measures to fight corruption, Salter opts to take more of an observers’ view on the subject of regulation in medicine, describing how some medical actors are empowered through regulation more than others. (Salter, 2004 / Almeling et al., 2009) A state-sanctioned monopoly of medical providers, as described by Salter, is certainly

stronger and more heavily enforced in some areas of medicine than in others, with acupuncture not being an absolute priority, as the risks associated with its practice are comparatively low. Furthermore, I would argue that acupuncture is less embedded in the chain of regulatory measures set up by the state in order to ensure physicians' privileges in medical care. For example, no medicine is needed to practice acupuncture, which is regulated through access to pharmaceutical products, the prescription of which is reserved for doctors. Furthermore, it is not necessary to perform acupuncture treatment in an institutionalized clinical setting. Thus, the tools for and the place in which acupuncture is practiced are not subject to state control. Nonetheless, the state still allows for physicians to have a privileged position within acupuncture care, be it only through passively allowing the Austrian Board of Physicians to regulate acupuncture treatment as they see fit. "However configured, the terms of the orthodox medicine-state concordat give doctors a set of privileges which enable them to keep the patient in a subordinate market position." (Salter, 2004)

3.3 Literature on Authorities of Knowledge

Though the Austrian state does give preference to physicians practicing acupuncture, there are limits to the consequences of this preferential treatment. In the book "**The Paradox of Scientific Authority. The Role of Scientific Advice in Democracies**", Bijker, Bal and Hendriks describe the paradoxical system in which scientists are asked for their opinion on a variety of social and health related issues, but the advice received is often viewed quite critically by both policy makers and the public. (Bijker et al., 2009) A parallel can be drawn here to alternative / complementary medicine in the sense that a group of scientists – in this case, (researching) physicians – helped form a set of policies allowing their own group to practice acupuncture. They are continuing to produce evidence of acupuncture's efficiency in providing symptom relief or cures for a variety of illnesses, and the state does not question their right to being in a privileged position to provide this treatment. Yet the public health insurances, despite being linked directly to the health ministry and thus subordinate to state power, do not translate these findings into their policies in the sense that acupuncture is covered by insurances in the same way that Western medical practices are. Some recognition is given to acupuncture performed by physicians – but not by other social groups – through providing some coverage, thus formally recognizing acupuncture as a valid form of medical treatment. The Paradox of Scientific Authority will be applied in the chapter "To Pay or not to Pay? Insurance Agencies' Standpoint on Acupuncture".

This only partial recognition of acupuncture's effectiveness might be explained by the difference in how scientific expertise came to impact policy making processes. After all, in the case study described by Bijker et al., the Health Council of the Netherlands actively sought out scientists to participate in decision-making processes. (Bijker et al., 2009) While this might be the case in Austria regarding other medical questions, it cannot directly be translated to the case of acupuncture, as it was scientists that actively strove to impact policies from the very beginning, rather than being invited to do so by a government institution. This will be discussed in the chapter "A Man with a Mission? Histories of Practicing Acupuncture in Austria".

Furthermore, it should be noted that the scientific community conducting research on acupuncture cannot be seen as a uniform group working together with practicing physicians ascertaining acupuncture's scientific gravitas. There seems to be a disconnect between the stress placed on the importance of acupuncture studies and the findings distributed, as well as how these studies are implemented in the everyday practice of acupuncture. After all: "Several qualitative studies of clinicians reflecting on how they implement scientific evidence have shown that, at best, published scientific evidence is one of many elements taken into consideration during decisions." (Almeling et al., 2009) The complicated relation between evidenced-based effectiveness and the newest studies' findings in everyday practice of acupuncture will be discussed in the chapter "Pinpointing Understanding: The Debate of Skill versus Philosophy", as well as "The Role of Space and Place in Acupuncture Research, Practice and Education".

4 Theoretical Framework and Sensitizing Concepts

Having described the most important pieces of referential literature this thesis is based on, the following chapter will introduce the five main sensitizing concepts that will be used throughout the empirical analysis: Policy, co-production, boundary work, standardization, and medicalization. These concepts will not merely be introduced and explained, but also contextualized with regards to their use of the analysis of the empirical material.

4.1 Co-production

Feeding into the term of policy used for this thesis, a crucial sensitizing framework for this thesis will be that of co-production, as described in the book “States of Knowledge. The Co-production of Science and Social Order”, edited and partly written by Sheila Jasanoff. A co-productionist approach will be used to explain the complex system in which policies regarding alternative or complementary medicine are formed in, especially with regards to the role accepted knowledge plays. The processes through which this knowledge came to be accepted are of interest, as: “scientific knowledge, in particular, is not a transcendent mirror of reality”, but rather it “(...) both embeds and is embedded in social identities, institutions, representations and discourses.” (Jasanoff, 2004) This idea of a developing and somewhat fluid, but (at least momentarily) stabilized acceptance of what is to be considered as scientific knowledge will play a role especially when analyzing the history of acupuncture in the Austrian context, as well as the mechanisms of ongoing embedding of acupuncture in a medical setting. On a policy level, both of these aspects impact the forming and enacting of (soft) policies and regulations, as “ways of knowing the world are inseparably linked to the ways in which people seek to organized and control it.” (Jasanoff, 2004)

Jasanoff, as well as her co-authors, stress that there is no natural, technological, scientific, or social determinism in the concept of co-production (Jasanoff et al., 2004), meaning that there is no starting point from which events run an automated course. Rather, there are multiple “starting points” in any co-productionist analysis, which themselves were beforehand co-produced. For acupuncture, this means that the analysis cannot be assumed to begin at the point in time when acupuncture was introduced into the Austrian context, into a neutral social space. Rather, notions of acupuncture’s rich history in other social contexts, but also the pre-existing established hierarchies of medicine in Austria, as well as the role

actors play within these frameworks, all impinge upon the development and shaping of acupuncture and the policies regulating it, up to the present.

Jasanoff et al. describe and use four objectives shaping their co-productionist analyses, namely description, explanation, normativity, and prediction, all of which will be applied to greater or lesser extent throughout the thesis. Ideas such as that of the causality loops, co-evolution and positive feedback will also be drawn upon. (Jasanoff et al., 2004)

Needless to say, the analysis conducted for this research project cannot give a full overview of all the influencing factors at play in the historical and present co-production of what is considered as acupuncture in Austria. As is the case with all co-productionist analyses, this thesis merely aims to present a snapshot of an extremely complex structure. It both tries to avoid an obscuration resulting from falsely assuming a deterministic course of events, and to include a broad range of impacting factors and actors, “organizational, material (and) embodied”. The making and shaping of “identities, institutions, discourses, and representations” in a co-produced fashion helps to gain “explanatory power” in portraying acupuncture, and the policies surrounding it, in Austria. (Jasanoff, 2004)

4.2 Policy and Governance

A crucial term used for this thesis is that of policy. This term is, for the context of my thesis, not limited to formal policies, but also soft policy and regulation, set in place by certain groups aiming to establish agency. In the course of my thesis, I intend to analyze how the policy system regarding acupuncture is seen by those involved in shaping it, and, to a lesser degree, by those affected by it. The narratives of why this policy system was chosen and how it is justified, and why it is said to be helpful or hindering for acupuncture in Austria, will be further elaborated.

In order to better understand the formation and enactment of the policies regarding acupuncture in Austria, it is important to get a better understanding of the governance system regulating medicine in general. In his text ““Soft Bureaucracy”, Governmentality and Clinical Governance: Theoretical Approaches to Emergent Policy”, Rob Flynn describes the situation of medical governance in England in the past, saying “Many measures have relied upon extensive self-regulation by the professional bodies”, naming the General Medical Council as a key example of such a body. (Flynn, 2004) In Austria, the equivalent or comparable body to England’s General Medical Council is the Austrian Board of Physicians, which is extremely influential in creating medical policies and legislations. Flynn goes on to describe that changes in the political system in England lead to the introduction of so-called

“clinical governance”, which “was introduced as the best way of achieving the devolution of responsibility combined with accountability for performance.” Although “empirical evidence about the implementation and impact of clinical governance properties has emerged only slowly”, (Flynn, 2004) the introduction of clinical governance in England seems to have challenged existing and previously unquestioned structures of authority and power, such as the General Medical Council. In Austria, a comparative development is not explicitly noticeable, with physicians and the Board representing them, still holding a majority sway over the system of medical policy making. In this existing set of circumstances, where the physicians’ authority is not substantively challenged, I would like to argue that the Austrian Board of Physicians perhaps does not need to have real legislative power, as they are influential enough to enforce policies they create without it.

In the “The Architecture of Authority. The Place of Law in the Space of Science”, Sibley and Ewick argue that science is regulated “from a distance”, with the main aim of governmental authorities being to protect the public from harm. In this sense, the need to regulate acupuncture through governmental authorities is less important than is the case with more invasive medical practices, such as surgery. While medical practice is not identical to scientific research, I would argue that many of Sibley and Ewick’s observations apply to both. As the potential harm that can be done to patients through acupuncture is limited, the government in Austria has opted not to directly, legislatively regulate who may or may not practice it (though implicit regulations are in place).

Thus, acupuncture practitioners are in a position where publicly communicated self-regulation can greatly improve their realm of power: “In the spatial regulation of science, processes of social control are largely internalized, sustaining science and the scientists’ authority for autonomy and self-governance.” (Sibley / Ewick, 2003) In the case of acupuncture in Austria, self-governance is not requested by outside regulators, but rather is opted for by physicians due to the freedom of choice left by the lack of regulations in place. Thus, an ultimate form of self-regulation is reached: It is not required from outside regulators at all, but deemed beneficial by its subjects, and is thus enforced internally, ultimately subjecting other social groups to its consequences. A narrative of risk is created, as the chapter “Side Effects. The Role of Risk in Justifying the System” will show, and thus precedence for the necessity of regulation is created. Sibley and Ewick further add that by not specifically defining which spaces of science are to be regulated, and how, “regulation from a distance” allows non-appointed actors and groups to become regulators themselves: “This distance is (...) constitutional, In that regulation is achieved through a variety of nonpolitical experts and authorities (including medical experts (...))”. These nonpolitical

actors can become unintended enforcers of regulations even if this was not an intended effect of actively chosen regulatory measures. (Sibley / Ewick, 2003) However, this research project does not assume a top-down model of regulation. Hence, by unintended non-political actors becoming regulators, the regulation outcome changes from what it was originally intended to be – that is, if there was a clear regulatory course to begin with. By the multitude of direct and indirect regulators involved with acupuncture in Austria, this course may seem opaque in retrospect. This vagueness, however, is the starting point of the research project at hand. Rather than trying to find out hard “facts” regarding the history of acupuncture in Austria, actors’ interpretation of this history, and what they themselves perceive as facts, is the basis for this study. Thus, a narrative of co-produced assumptions and beliefs emerges.

Another policy-related approach used in this thesis sheds light on the way soft medical policies are enforced and enacted in Austria, which is described by Lawrence Busch as the “Tripartite Standards Regime”. (Busch, 2011) This refers to a system of policies in which standardized processes, functioning as soft policies and regulations, play a crucial role. Triple Standard Regimes “differ from state-based modes of governance in that they are often a cobbled-together network of persons, organizations, and things, rather than being constructed on a formal hierarchy of status relations.” Busch then goes on to describe that, while both the state and the market are involved in constituting the network at some point to varying extents, neither of them fully control the network. While there may be some legislations forming the TSR-network, and the state might give some actors more power than others through them, this does not mean that only one actor is fully in control. The applicability of this concept to acupuncture in Austria becomes clear when looking into how existing medical legislations are enacted by various social groups, such as the Austrian Board of Physicians, or the midwives, even though no laws directly regulate acupuncture by making its practice illegal, per se. Busch adds: “Such networks can and do work, producing a growing portion of the qualified persons, products, processes, and practices found in the world today.” (Busch, 2011)

In the chapter “A Man with a Mission? Histories of Practicing Acupuncture in Austria”, Tripartite Standards Regime networks, like the one largely regulating Austrian acupuncture on a policy level, develop over time - an aspect not described in detail by Busch. I would like to show how the network in place today came to be, and developed up to a point where it is self-sustaining and soft policy forming, changing only at “breaking-points” at which inside or outside pressure becomes too great to remain stable, and (small) adaptations have to be made in order to continue the general line of policies. A problem pointed out by Busch is the

TSR network's lack of accountability, an aspect that will be touched upon when describing the Austrian Board of Physicians, as well as different acupuncture organizations in Austria, and their views on the impact they have had on the enactment and shaping of policies regarding acupuncture.

4.3 Authority and Boundary-Work

The concept of boundary-work will be used to describe strategies and negotiation processes used by social groups active in shaping, enacting and enforcing soft policies regarding acupuncture practice in Austria. As stated by Thomas Gieryn in his text "Boundary-Work and the Demarcation of Science from Non-Science: Strains and Interests in Professional Ideologies of Scientists", "'Boundary-work' describes an ideological style found in scientists' attempts to create a public image for science by contrasting it favorably to non-scientific intellectual or technical activities." Though medical practitioners are not necessarily defined as scientists by every definition of the word, the empirical analysis will show that the interviewed physicians' self-perception is consistent with being representatives of the science constituting "scientific" acupuncture practice, through a longstanding demarcation process including, but not limited to, acupuncture teaching (Turner, 1978) and research practices. As the empirical analysis will show, established boundaries include medically practiced acupuncture in an effort for medical personnel "justifying their privilege" (Gieryn, 1983) in contrast to acupuncture practiced by non-medical acupuncturists, using the concept of risk and the establishment of trust in licensed authorities. (Busch, 2011) Another drawn boundary is that of (medicalized) acupuncture against the broader, more vague concept of "Traditional Chinese Medicine", which is framed as a "pseudo-science" (Gieryn, 1983) and the descriptive, "non-scientific" language used in this context. These existing boundaries strengthen each other in the context of Austrian acupuncture and were, as Gieryn points out, by no means constructed to make decisions regarding policies "in an impartial way". (Gieryn, 1983) Rather, scientific and especially medical knowledge, and the boundaries constructed around it, is never completely free of value: politics and profitability play a large role. (Collins et al., 2005)

However, demarcation processes are not only used to draw a line between science and non-science, but also within what is considered to be "science" by the actors involved. (Gieryn, 1983) In the case of acupuncture practiced by physicians in Austria, boundary-work is done by the different acupuncture organizations involved, establishing themselves as being "more scientific" through different and contradictory strains of arguments. Gieryn states that "scientists distinguish their doing from others "institution of science": to its practitioners,

methods, stock of knowledge, values and work organization” (Gieryn, 1983), and I would argue that these aspects of boundary-work also hold true within the Austrian acupuncture community, the difference being that acupuncture practitioners emphasize more the “scientific-ness” of their particular brand of acupuncture, which takes precedence over they themselves *being* more scientific. In their self-perception, other values play a role as well, leading to a specific kind of boundary work that combines aspects of science with emotional value; the aim of this process being to gain greater recognition within the acupuncture network, along with associated benefits.

This opens the question of which boundary-object(s) can be used to fulfill the role of establishing acupuncture as scientific, and some acupuncture organizations as more scientific than others, while also enacting a specific role as to being excellent caretakers of patients. In his text “From Changshan to a New Anti-Malaria Drug: Re-Networking Chinese Drugs and Excluding Chinese Doctors”, Sean Hsiang-lin Lei describes how Chinese drugs, meaning medication used in Traditional Chinese Medicine, were used as boundary objects in the conflict between “Western-style” and “Chinese” doctors over the question of medical authority in China as early as 1929. In the case described by Lei, these drugs were re-defined as being “just natural raw material”, and thus could easily be transferred from one medical context into the next without breaching ownership rights, while aiming to illegalize their use in the original context. (Lei, 1999) In the Austrian context, where drugs associated with Traditional Chinese Medicine play only a minor role, a different boundary object emerges, namely acupuncture needles. The aim to constitute acupuncture needles as part of a legislation regulating the puncturing of the human skin – a right reserved to physicians – will be discussed in the analysis.

4.4 Standardization and Medicalization

The next concept used repeatedly in this thesis is that of standardization, which can be applied to acupuncture in a number of ways, with a special focus on acupuncture education and clinical trials conducted for acupuncture’s effectiveness and areas of use. In the article “A World of Standards but not a Standard World: Toward a Sociology of Standard and Standardization”, Steven Epstein and Stefan Timmermans write that “standards and standardization aim to render the world equivalent across cultures, time, and geography.” (Epstein/Timmermans, 2010) This is an important notion in the sense that acupuncture did not emerge from Austria, but was introduced to it by a group of physicians adhering, in large parts, to the principles of standardization: “Many doctors, hospitals and health insurers have embraced evidence-based medicine, promoting standard guidelines to make decisions

about how patients should be treated. An ever-increasing number of national and international standard-setting bodies devote themselves to determining which standards should rule and how standards might be enforced.” (Epstein/Timmermans, 2010) Thus, the physicians who, in a way, imported acupuncture to Austria, did so in a standardized form, adapting it further as they strove to increase its acceptance in Austrian society, as will be discussed in the chapter “A man with a mission? Histories of Acupuncture in Austria.”

However, it shall be noted that standards are never politically neutral, even if it might seem so at first sight. (Epstein/Timmermans, 2010) In the case of acupuncture, standards are used in the persuasion of several different goals, all of which are more easily reached by presenting this treatment method as a highly controllable and standardized medical approach. Incentives for having acupuncture follow standardized procedures include, but are not limited to, increasing acupuncture’s acceptance as a efficient treatment form within the medical community and society in general, while simultaneously not overly emphasizing its realm of possible applications (Barnes, 2005), so it does not threaten the biomedical system in place. Furthermore, practices of standardization, such as standardized “scientific” trials, help link acupuncture more strongly to professionalized medical personnel, thus ensuring privileges not only of research, but also of practice. In their book “Sorting Things Out. Classifications and its Consequences”, Susan Leigh Star and Geoffrey Bowker point to the fact that although standards were formally or legally negotiated in a process at one point in time, this negotiation process becomes invisible over time, and standards are inscribed into society as factual, making them ever more powerful precisely by not being seen. (Bowker et al, 1999)

In the text “Objectification, standardization, and commodification in health care: A conceptual readjustment“, Stefan Timmermans and Rene Alemeling deconstruct the notion of standardization and commodification in medicine necessarily leading to an objectification and dehumanization of the patient in all possible scenarios. Rather, the authors argue that standards can also be a method of making medicine effective and efficient, with both of these qualities being needed when taking into consideration concerns of national health. (Timmermans/Almeling, 2009) This approach of “getting things done” can help explain interviewed physicians’ views on the necessity of standardized trials regarding the effectiveness of acupuncture. It is often argued that acupuncture does not (fully) fulfill the criteria and does not fit within paradigms necessary for standardized and randomized medical trials (Haake, 2003; Melchart, 2005; Vincent/Lewith, 1995), thus, in a way, having to be forced within the outlines prescribed by the trials. Bowker and Star note that there are both “ideal standards and contingencies of practice”, and that there is considerable leeway

between them. (Bowker et al, 1999) Thus, acupuncture might not fit perfectly within the criteria of standardized trials, but it fits “good enough” (Bowker et al, 1999) to justify the process. After all, the alternative of not conducting such trials for acupuncture might seem as the greater of two evils, when viewed from the perspective proposed by Timmermans and Almeling.

Shaping educational systems through systematic standardization is described in the book “Standards: Recipes for Reality” by Lawrence Bush. Especially the chapter “Certified, Accredited, Licensed, Approved”, focuses on this aspect of standardization, and will be used in the context of acupuncture education in Austria. Bush argues that trust, established through a communicational social process over time, is what gives standards value, such as the ones found in certified education. Speaking of trust in purchases, Busch argues that “(...) it is possible for some of the trustworthiness of persons to be transferred to things.” (Busch, 2011) Thus, people put trust in a product they buy because they initially trusted the person or people who made this product. Thus, a transfer of trust takes place from an animate to an inanimate object. I would argue that the same could be said for standardized education degrees. In the case of this research project, people were perhaps initially willing to trust a doctor, to “never deliberately act with malice”. (Busch, 2011) As physicians undergo a medical education, the outcome of which is a certified degree, people transferred their trust in physicians to the degree certifying them, namely the one distributed by a medical university. At this point, it becomes clear that trust can also be transferred from one inanimate object to another. The acupuncture diploma physicians in Austria receive thus benefits from the credibility the medical diploma holds in society, namely that physicians, because they have received a medical diploma, are certified to treat patients in a way that ensures a low “statistical probability of harm”: “Since certifications are displace forms of trust, they can also be seen as a means of reducing unwanted risks.” (Busch, 2011)

I would argue that, in fact, the two diplomas of medicine and acupuncture actually strengthen each other: The medical diploma gives the acupuncture credibility, while the acupuncture diploma increases the medical diploma’s value, as it accredits the physicians’ willingness to continuously broaden their medical competence.

The term “medicalization” describes the incorporation of realms of the social and physical into a biomedical understanding or setting, although they were originally not defined or situated within this context, oftentimes with the negative connotation of an “illness or disorder”. (Clarke et al., 2003) In his book “The medicalization of society: on the transformation of human conditions into treatable disorders”, Peter Conrad clearly states that medical professions themselves were key players in defining or redefining conditions as

medical problems (Conrad, 2007), with Clarke et al. stressing that clinical innovations also play an essential role in this process. (Clarke et al., 2003) Examples include conditions formally considered as deviances or character flaws, such as alcoholism or gambling addictions, but also psychosomatic illnesses or learning disabilities. (Conrad, 2007) Furthermore, medicalization can stretch to include not merely illnesses, but also states of being, such as pregnancy, as described by Kristin Baker in “A ship upon a stormy sea: the medicalization of pregnancy”. (Barker, 1998) The latter notion will be used when discussing the role midwives play in the policies regarding acupuncture in Austria, and the justification of the state of pregnancy used to include them in the system of acupuncture practice.

Similarly to the strain of argument Jasanoff et al. use to describe the term co-production, White uses a variation of this concept adapted to so-called “scientific” medical practices, stating that they “shape() and (are) shaped by the society in which (they) develop()” in the book “An Introduction to the Sociology of Health and Illness”. (White, 2002) While White states that professional groups are key actors in defining the definition of disease, I would like to argue that they also shape the definition of treatments for diseases; in the case of this thesis, what acupuncture is to include and exclude. For example, physicians practicing acupuncture in Austria clearly split this form of treatment from other, though historically related practices, such as Traditional Chinese or Korean herbal medicine. (Kim, 2007 / Lei, 1999) Thus, through a process of standardization, but also translation of meaning (Emad, 2006), acupuncture itself has been medicalized to fit within the realms of biomedicine, and Western medical practices.

A point White makes, which I would also like to address (though only indirectly related to medicalization) is the impact class, race, gender, and ethnicity has on medical practices and receiving medical care. (White, 2002) For the purpose of this research project, inequalities due to these factors can be traced to two levels. Firstly, I will argue that as either a by-product, or an intended result of the policies regarding acupuncture, it is a form of treatment that is comparatively expensive, with public health insurances only covering a small portion of it. Therefore, it is a treatment only available to those affluent enough to afford private health care, or are able to come up with the expense in another way. This, in turn, feeds into the paradox described by White, namely that less affluent social classes have an increased chance of being ill, with one of the factors leading to this correlation; they cannot afford the same range of treatment options as wealthier members of society. White adds that the chain of events is often reversed, and thus poorer classes are blamed for their own sickness (White, 2002), which is part of a trend not only limited to the fiscally disadvantaged, and

described by Clarke et al. as “health (being) a moral obligation”, and an “individual goal”. (Clarke et al., 2003)

Race or ethnicity is indirectly part of this analysis, as the biological heritage of people offering acupuncture treatment seems to influence patients’ views of the practitioners’ competence in some cases. More important however, will be the question of the importance of the cultural heritage of acupuncture practice itself. In the chapter “The Role of Space and Place in Acupuncture Research, Practice, and Education”, the meaning of acupuncture’s origins will be questioned, with regards to whether or to what degree it (should) impact acupuncture practice in the present.

5 Research Questions, Materials and Methods

After having given an overview of the relevant medical and theoretical literature, as well as the main concepts used for this research project, I would now like to continue with the introduction of the concrete research questions underlying the empirical analysis. Next, this chapter will introduce the materials and methods that were used to answer these research questions on an empirical level, and how the data generated from this research was analyzed.

5.1 Research Questions

The main aim of this research project was to closely examine and analyze how acupuncture was transferred to Austria on a socio-political level. An important aspect of this process are the policies in place shaping the system surrounding acupuncture. Using the example of acupuncture as a case study, the relation between policies and alternative or complementary medicine in Austria was a main subject of the studies conducted for this project. This relation between policies and medical practices is nowhere near one-sided: Physicians and other key actors have actively shaped the policies in place, in accordance with the strategies of establishing acupuncture's acceptance, as well as in pursuit of personal goals of establishing agency and power of knowledge. The research questions arising from this policy system are:

- *How is the policy system seen by those involved in and directly affected by it, namely key players of the acupuncture field in Austria?*
- *Which narratives, justifications and explanations are used to explain why this set of policies was decided upon as acupuncture was established in Austria? In which ways are these policies currently enforced?*
- *Which narratives aim to explain why the policies in place have a positive or negative effect on acupuncture practices in Austria?*

In this struggle of shaping acupuncture practice in Austria, two crucial dimensions were identified:

Firstly, the Austrian Board of Physicians only permits educated physicians, as well as a select few other medically educated groups, to practice acupuncture in Austria. The first dimension through which this form of acupuncture practice is regulated is **education** of acupuncture practitioners. The access to education is highly restricted for non-licensed groups. Thus, the first level of analysis for this research project is the educational system for acupuncture in Austria, examining how it shapes who is allowed to provide this treatment, and is thus who is included in the official system of acupuncture practitioners. Out of this dimension of analysis, the following research questions arose:

- *Which views on acupuncture are put forth through the quality and quantity of the education in Austria, and how do the key players reflect on them?*
- *Which inclusions and exclusions are enforced on acupuncture practitioners through means of educational access?*

Thus, main focus of this thesis will be on how the human body and acupuncture itself are transformed into the Austrian context through educational and soft policies. However, another dimension also became apparent during the data collection for this project, and will be included, though to a lesser degree. This dimension regards the **(non-)financing** of acupuncture through the public and private health insurance system, as well as rules and regulations determining in which cases, and to what extent, acupuncture is (not) financed. Here, aspects of (non-)recognition of acupuncture as a form of treatment through (insufficient) insurance coverage will be considered. As interviews with public insurance employees, as well as insights into insurance documents, were not possible (for more on this subject see the chapter “Policy of Secrecy”), the main empirical data gathered on this level was acupuncture practitioners’ views on the subject, leading to the following research questions:

- *What is the acupuncture practitioners’ take on the system of insurance (non-) coverage of acupuncture in Austria?*
- *How does this (non-)coverage impact the acupuncture practice in Austria?*

The research questions regarding soft policies - which regulate acupuncture education, financing, and practice -, were absolutely crucial for this research project. They also formed the guideline along which the qualitative interviews were conducted. Details regarding the qualitative interviews, and other empirical research methods used, will be discussed in the following sub-chapter.

However, when interpreting the gathered empirical material, it became apparent that these policy-related questions were not the only layer to be found, and adhering to their focus only would hinder reaching a deeper insight of the subject. In a way, they were more of a tool to reach another dimension of analysis, while they brought interesting insights to the research project nonetheless. Concluding, I would argue that through the soft policies enacted in Austria, acupuncture was changed and transformed on a fundamental level. It was “transported” and “translated”, as the title of this thesis suggests. In this process, acupuncture as a treatment form was not the only thing that was adapted to fit within the Austrian socio-political and especially medical system. The human body itself, through which treatment is sought, changes in the way it is perceived by acupuncture practitioners. Thus, as a Meta-level of analysis, the following final research questions were used:

- ***How does acupuncture, as a treatment form, change through the perceived and enacted system of policies in Austria?***
- ***How is the human body perceived, as portrayed by the type of acupuncture offered in Austria by licensed practitioners?***

These research questions were answered using a number of methods and materials, which will be introduced in the following subchapters.

5.2 Entering the Field: Qualitative Interviews

The primary source used for data generation for this research project was a collection of semi-structured, qualitative interviews with key actors in the practice of acupuncture in Austria. As the policy system regulating acupuncture in Austria is not (solely) consistent of concrete laws, but rather enacted through soft regulations and narratives, by members of the existing network, gathering and analyzing the views of these actors is crucial to my research project.

The interviews were conducted and analyzed according to the guidelines described by David Silverman in his book about qualitative research: “Interpreting Qualitative Data. Methods for Analyzing Talk, Text and Interaction”. While providing some questions and topics, which were used to generate comparability in the evaluation process, interviewees were given the chance to elaborate on topics of priority to them. Though similar questions were used in all of the interviews, the order of the questions was varied to fit with the natural flow of the conversation, and individual follow-up questions were asked when necessary. I referred back to my list of interview questions mainly as a reference point when the conversation was

slowing down, or if I felt that major points of my research had not been addressed yet. (Silverman, 2006)

Conducting interviews in this individualized way allowed sensitive topics to be addressed in a manner as to increase the interviewee's trust, and thus create a greater openness, as Bridget Bryne points out in her text "Qualitative Interviewing". This can enable the interviewer to bring up topics and other aspects the interviewees would at first otherwise feel reluctant to talk about, once again at a later stage of the interview, possibly in a different context, rather than stressing they be answered at once. This way, the flow of the conversation is not disrupted to a great extent, and a more comfortable interview situation is provided, in which interviewees could conceivably be more willing to share their views. According to Byrne, this type of open-ended interview is a good method especially for attaining knowledge about the interviewees' "attitudes and values", which is a major part of my research interest with regards to the policy system of acupuncture. (Byrne, 2004)

Whenever possible, the interviews were audio recorded and transcribed. This allowed me to focus primarily on the conversation, rather than on note taking, as described in "Making and Managing Audio Recordings" by Duncan Branly. (Branley, 2004) However, two interview partners (Dr. Daniela Stockenhuber and Manfred Richard) objected to audio recordings. In this case, I both took notes during the interview, and completed them immediately after the interview was concluded, in order to have as many details as possible despite the lack of an audio recording. Furthermore, I discovered that Mr. Richard had published a book about his work in the Acupuncture Clinic, which made some similar points to the ones made in the interview. In this case, I have referred to the book, rather than the interview, in order to provide more detailed quotes.

Anonymity was offered to all participating interviewees, though none of them asked to make use of this opportunity. This was helpful, especially as some of the interviewees hold prominent positions in the Austrian medical context, and trying to avoid using their name would have put me in the difficult position of also having to be careful about statements I make about their role in the medical community, in addition to acupuncture organizations. Though explicitly mentioning the names of interviewees does not further the research project, mentioning the positions the interviewees hold in the acupuncture community does, as this insight furthers the understanding of the role they play within the acupuncture network.

The interviews were all conducted in German, and direct and indirect quotes were translated into English. However, the full transcripts of the interviews were left in the original German,

as I felt that some of the meaning gets lost in translation. This way, it was possible to consult the original text for a deeper understanding of what was said in the language the interviews were originally held in. In cases in which I felt an English translation could not fully portray the original German meaning, phrases were also translated back to German in the footnotes of this text, in addition to a more elaborate description of the meaning behind a phrase. This way, I hope to convey the message given by the interviewee as closely as possible into the language used for this thesis. Below, there is a general list of the interview questions which was used as a guideline.

Questionnaire:

- *How did you get started with acupuncture?*
- *Why did you decide to become an acupuncturist?*
- *In which areas of medicine can acupuncture be used most successfully? / In which areas of medicine should acupuncture be used more often?*
- *What was your educational process of becoming an acupuncturist?*
- *Which experiences did you make in this process?*
- *What does “learning” or “being educated in” actually mean in the case of acupuncture? Does this form of “learning” differ from practices at the medical university, and if so, how?*
- *How do you see the Austrian educational system of becoming an acupuncturist in an international comparison?*
- *Currently, certified doctors and other medical personnel are almost exclusively allowed to practice acupuncture in Austria. What is your opinion on this form of regulating acupuncture?*
- *Which benefits, if any, are there for patients if acupuncture can only be practiced by medically certified personnel? Are there drawbacks?*
- *In Austria, acupuncture treatment is only covered by medical insurance in some specific cases. How do you think this system of coverage came to be? Which criteria played a role in it, which experts were involved, etc.?*

- *Would it make a difference if acupuncture were to be covered by medical insurance on a more general basis (e.g. for patients, doctors/midwives offering acupuncture, the health care system)?*

Additional questions for those physicians also teaching acupuncture:

- *What are the most important skills or knowledge you try to teach acupuncture students?*
- *Why are these especially important?*

Additionally, individual questions were added according to the interviewee's exact position in the network of acupuncture in Austria, and to their personal experiences with acupuncture. These individual questions were based on research done prior to the interviews¹, as well as in reference to other previously held interviews. The latter proved a helpful way to design more individualized research questions, as the network of acupuncture practitioners is closely interlinked; some interviewees referred to each other on several occasions.

An interesting observation in the process of organizing the empirical data collection was the accessibility of interview partners. As a rule, midwives took less time to respond to the initial contact email than in the case of physicians, agreeing to be interviewed without posing further questions. Though only one midwife interview was included in the end, many more interviews could have been set up due to the willingness of participation by the possible interviewees. They were excluded due to the limited scope of this research project, and because of the fact that a saturation point had been reached with the interviews, in which further interviews would not have brought a markedly deeper insight into the field.

The language used in the process of arranging to be interviewed by midwives was much less formal than in the case of physicians, though the emails that were sent out requesting an interview were identical. Also, the included midwife interview was the only one conducted in which the interviewee was addressed by using the German "Du", rather than "Sie", a much less formal tone of conversation, equivalent to being on a first-name-basis in the English language. Once again, this lesser degree of formality was initiated by the midwife, and I responded accordingly in order to adapt to the situation and not make the interviewee feel uncomfortable. Furthermore, it should be noted that all of the midwives immediately offered their personal cell phone numbers, whereas the physicians usually arranged the appointment via email entirely, giving out their phone numbers late, if at all, during the

¹ Also see chapter: „Triangulation: Document Analysis“

process of arranging or even conducting the interviews, in case further questions were to come up. It seemed that the contacted physicians needed a longer time period to establish a relationship of trust, and withholding their personal phone numbers was part of this process.

Nonetheless, the physician interviewees were also quite easily accessible, with one exception. As will be described in the chapter “The Snowball Method”, interviews were increasingly easy to set up once the first few had been conducted, due to a system of referrals within the community. In the case of the very first interview, conducted with Daniela Stockenhuber of the Austrian Society of Acupuncture, over two months went by between first requesting an appointment, and the interview taking place. The first scheduled appointment was postponed by the interviewee when I was already at the location, so I had to return at a later point in time, which was several weeks thereafter. However, after these initial difficulties, I encountered few further problems.

The interviewees seemed interested in the project, which I had briefly outlined in my initial contact email, and eager to be participating in it. They were very accommodating, with one of the interviewees even offering to drive into Vienna from his place of work and residence outside the city so I would be spared the trip. The interviews took place in various settings. While members of the Austrian Society of Acupuncture, as well as the interviewed midwife, all requested to be interviewed in their work environment, interviewees of the Austrian Scientific Physicians Association for Acupuncture asked me to come to their home, or a café. Slightly challenging situations arose when two interviewees forgot the appointment had been scheduled, but was resolved by rescheduling in the one case, and conducting the interview spontaneously in the other.

Several interviewees offered to give or send me additional material after the interview, mostly regarding scientific research on the uses of acupuncture. All of the interviewed people offered to contact them at a later point in time if necessary, and asked to be sent the finished thesis, in case this was possible for me. An ethical difficulty as a researcher arose only in one case, when a member of an acupuncture society told me about a scholarship that was available for researchers writing about the role their organization plays in promoting acupuncture. I decided it best not to openly address the problems that would arise from accepting this offer regarding a possible bias in my research.

5.3 Role of “Expert” Interviews – More than Expertise Required

A special case was that of using conversations with experts in the field as interview sources exclusively. These interviews can be considered as a certain form of Expert Interviews. The

interviewees are educated in acupuncture, are practicing it, and in some cases, even teaching it to students. I asked questions about the use of policies regarding acupuncture – their field of expertise. The interviewees seemed very confident, much like they would be in an interview set up exclusively to retrieve information they hold in their position of being experts. Harry Collins and Robert Evans describe in their book: “Rethinking Expertise” that “traditional analyses of the word “expert” refers only to rare, high-level, specialists” (Collins / Evans, 2007), and in the course of the interviews it became clear that many of the interviewees thought of themselves in this traditional sense of the word; as having a special status being “contributory experts” in the field of acupuncture. (Collins / Evans, 2007) They accredited me with having a certain degree of “tacit, primary source knowledge” (Collins / Evans, 2007) through the process of having done research for this project, which became apparent when they used complex medical terminology, and expected me to understand it with little or no further explanation.

This form of interpreting the interview situation had both advantages and drawbacks. On one hand, it created a situation in which the interviewees felt safe to speak openly about their experience, which was helpful for the atmosphere of the interview. However, there was a noticeable notion that the interviewed experts did not expect a context in which their statements could be strongly questioned or disagreed with, as they imagined the interview to be held to obtain their contributory expert knowledge. This notion ties strongly into the type of interview that was taking place, and the perception of it by the interviewees involved. The interviewees were informed before the interviews took place that the focus was not only on their “expert” knowledge on acupuncture itself, but rather also that their personal opinions and views on the subject were of crucial interest to the research project. When I asked questions accordingly, however, they at times seemed surprised to some degree and then went on to stop in their flow of prepared and ever repeated narrative. The interviewees often seemed surprised that I was not exclusively interested in the facts and figures surrounding acupuncture and acupuncture policies, but especially on their personal takes on these actualities. These were the moments, these breaks in stories already told many times before, when I felt I got the information most valuable to my project.

In this sense, the interviewees are considered to be experts because of their acknowledged levels of expertise in the field. The raw information about the theoretical aspects of acupuncture, such as treatment, research, history, etc., which they transported through the interviews, was incorporated in this thesis. However, what made the interviewees’ participation even more valuable for this project is their position in the network of making and enacting policies regarding acupuncture. In this sense, the interviews can only partially be

considered “expert interviews” in the classical understanding of this term, as the experts were interviewed partially for who they *are*, and the role they play for acupuncture in Austria, rather than primarily focusing on what they *know*.

5.4 The Interviewees

In the following part, I would briefly like to introduce the interviewees participating in the empirical part of the research project. Special focus shall be put on the role they play within the network of practicing and regulating acupuncture in Austria. Some of them are members of two of the three organizations licensed to teach acupuncture in Austria by the board of physicians (ÖÄK). These three organizations are the Austrian Society of Acupuncture² (URL 9), and the Austrian Scientific Physicians Association for Acupuncture³ (URL 10), as well as the Austrian Society of Regulated Acupuncture and Traditional Chinese Medicine⁴ (URL 11). I conducted interviews with members of the first two organizations, as members of the third, a smaller organization based in Linz, proved not to be available for an interview. Furthermore, I interviewed a midwife practicing acupuncture, and an expert on acupuncture’s history in Austria.

Dr. Daniela Stockenhuber is a standing member of the Austrian Society of Acupuncture. She functions as an educational advisor for this society, and thus offered insights on how acupuncture is taught in Austria on an organizational and structural level. Furthermore, she actively practices acupuncture at the Hietzing Hospital (Neurological Center Rosenhügel) in Vienna. This is the only institute in Austria offering acupuncture covered by common health insurances to full extent, because research of acupuncture’s effectiveness is conducted here. Therefore, Dr. Stockenhuber is also involved in collecting data on this subject.

Like Dr. Stockenhuber, **Dr. Michaela Bijak** is also a member of the Austrian Society of Acupuncture, and also practices acupuncture at the Rosenhügel Center of Hietzing Hospital. Furthermore, she is responsible for scientific publications on acupuncture’s effectiveness and application range. She brought interesting insights to my project as she is the link between collecting data on acupuncture in the clinical setting, and transporting it to the public through publications in scientific journals and non-scientific media sources. She is therefore a key actor in publicizing the acupuncture research conducted in Austria, both nationally and abroad.

² Österreichische Gesellschaft für Akupunktur

³ Österreichischen Wissenschaftliche Gesellschaft für Akupunktur

⁴ Österreichische Gesellschaft für Kontrollierte Akupunktur und TCM

Manfred Richart also works in the head office the Austrian Society of Acupuncture, and poses an exception in the sense that he is the only interviewee who does not practice acupuncture himself, and is not a medical professional. Conducting an interview with him was recommended to me, by applying the snowball method, by Dr. Stockenhuber. In his longstanding function in the society, he has become a self-made expert on the history of acupuncture in Austria, which lead to the publication of his book: “Johannes Bischko – A Life for Acupuncture” (Richart, 2005). Bischko is generally considered to be one of the “founding fathers” of acupuncture in Austria by the network of interviewees, and Richart proved to be very insightful on Bischko’s biography and the history of acupuncture in Austria in general, more so then the physicians working for the same organization. Therefore, I opted to include this interview in my empirical material.

Dr. Rainer Kluger is the current president of the Austrian Scientific Physicians Association for Acupuncture, and teaches acupuncture to students for the ÖÄK acupuncture diploma. As the president of the association, he offered a broad overview of the policies regarding acupuncture in Austria on an educational and fiscal level. He is a specialist for orthopedic surgery at the social medical center of the Donau Hospital in Vienna. In his private orthopedic practice, he offers acupuncture as a treatment option in addition to, or instead of, surgery.

Dr. Kurt König is also an educator for the Austrian Scientific Physicians Association for Acupuncture. He himself was educated in acupuncture both in Vienna and in Beijing, and thus offered comparative insights regarding the educational programs in the two countries. He has a private internal medicine and acupuncture practice in Perchtoldsdorf, a town just outside of Vienna. Furthermore, he was chosen as an interviewee because his father, Dr. Georg König, is considered the second “founding father” of acupuncture in Austria besides Bischko. Therefore, Dr. Kurt König also offered historical insights, as Manfred Richart did.

Dr. Chenfei Chen is a founding member of Chinese Physician’s Community for Acupuncture⁵ (URL 12). This organization is not a major player in the field of acupuncture in Austria, and does not hold a license to teach. Nevertheless, it is an interesting example of an organization that, though perhaps unable to change policies, found its own place within the existing system, and is practicing acupuncture successfully. She was educated to full extent in both China, where she acquired a degree as a Traditional Chinese Medicine physician, and Austria, where she received her degree as a general physician and the ÖÄK acupuncture diploma. Thus, she offered a direct comparison of teaching and learning

⁵ Chinesische Ärztegemeinschaft für Akupunktur

methods and practices in both countries. She also provided some thoughts on the (non-)acceptance of acupuncture degrees acquired abroad in Austria, and reflected on hierarchies and transferability of knowledge between places and cultures.

Gabriele Sprung, Midwife is educated and specialized in pre- and post-natal acupuncture. She was chosen as a representative of one of the few groups allowed to practice acupuncture besides physicians (see chapter “Licensed to Acupuncture. Agents Authorized to Practice Acupuncture in Austria - Groups and their (Imagined) Agencies”), in order to obtain her view on the policy allowing her to use acupuncture within her field of pre- and post-natal care. Furthermore, she contributed to this research by offering insights on how acupuncture education takes place for non-physicians, who are excluded from acquiring the ÖÄK diploma.

5.5 Snowball Method

The first interviews were centered around the cluster of people working at the Acupuncture Clinic, which was located at the Kaiserin Elisabeth Hospital at the beginning of this research project, and was later relocated to the Neurological Center Rosehügel. However, as these interviewees are all members of the Austrian Society of Acupuncture and are closely working together on a day-to-day basis, the picture arising from research conducted in this focused method quickly appeared to be insufficient in creating an overview of acupuncture in the Austrian context. While the interviews with this group of physicians were by no means identical, they did agree on some major points, and narrated their relevance similarly, which could be at least partly due to the strongly interlinked social group of which they are a part.

Therefore, an expansion of the pool of interviewees seemed beneficial. One method used to broaden the perspective on possible interviewees was the Snowball Method, as described by Biernacki and Waldor in their book “Snowball Sampling: Problems and Techniques of Chain Referral Sampling”. (Biernacki and Waldor, 1981) Thus, interviewees were asked for their opinions regarding other relevant representatives regarding the topic of my research. This method of snowball sampling yielded relevant interviews and deeper insights into the field which might have been overlooked otherwise, such as the one with Manfred Richart. Not being an acupuncture practitioner himself, he would not naturally come up in my own search for relevant actors in the acupuncture field in Austria. Furthermore, being referred by one interviewee tended to be helpful with scheduling the next interview, perhaps because the new interviewee felt obliged or honored by the referral, or had greater interest in participating in the research if his/her colleague had. It was noticeable that further interviews were relatively easy to schedule, once an actor of a group had been interviewed.

However, the downside of this was that some groups could not be included in the research project, since no member was willing or able to schedule an interview appointment. Therefore, the indirect benefits of the snowball method could not be used to generate more interviews from the same group. In one case, even a negative example of a chain referral took place. In the Austrian Society of Regulated Acupuncture and Traditional Chinese Medicine, the two founders are two physicians married to each other, and sharing an acupuncture office, both of whom I contacted to schedule an interview. Dr. Leopold Dorfer responded that he would not be able to provide an appointment for an interview due to lack of time, but his wife, Dr. Sandra Lemp-Dorfer, would be happy to, thus assuming that the issue was settled. Scheduling an interview with Dr. Sandra Lemp-Dorfer turned out to be impossible as well, leaving no further leading members of the organization to interview. Therefore, this organization was not included in the research project through means of interviews at all, and alternatives to include this society in the empirical research had to be found.

However, the snowball method aided in providing interesting insights as to who constitutes as a relevant actor in the field, according to the interviewees. This showed how the network of relevant actors changes according to who is asked, which gave evidence of the priority systems of the interviewees. (Biernacki and Waldor, 1981) For example, when asked to give recommendations of whom to contact for the research project, interviewees usually suggested speaking with other members of their own acupuncture organization (Kurt König, Daniela Stockenhuber), or actors considered neutral in the field, such as educational organizers of the Austrian Board of Physicians (Rainer Kluger). This could be a sign of the lack of cooperation between the different acupuncture organizations, which is partly due to their history and conflicts of interest.⁶

Interviewees who were not members of one of the major acupuncture organizations, however, made no specific recommendations as to further interviews (Chenfei Chen), or referred to their own acupuncture educators (Gabriele Sprung), which could be an indicator of less interaction taking place between these marginalized groups, when compared to the stronger links created through an active acupuncture organization's network.

⁶ This history, or, rather, varying accounts of histories, will be elaborated on further in the chapter "A Man with a Mission? Histories of Practicing Acupuncture in Austria".

5.6 Triangulation: Document Analysis

Norman Denzin describes in “The Research Act: A Theoretical Introduction to Sociological Methods” the necessity of triangulating data as a form of giving initially gathered empirical data validity, and this notion was incorporated the research. Danzin describes four different forms of triangulation. Investigator Triangulation, namely the reduction of personal biases through the use of a research team rather than an individual researcher, was not possible for the scope of this thesis, but partially abided through input given by my supervisor and colleagues when presenting the research project. The approach of Theory Triangulation is also partially incorporated, as this research project draws upon several theoretical approaches such as Co-production, Boundary-Work and Demarcation processes, Medicalization, Professionalization and Standardization, as well as Hierarchies of Knowledge and concepts of establishing Expertise.⁷ (Denzin, 1978)

This chapter, however, mainly focuses on Data and Methodological Triangulation. (Denzin, 1987) Though the interpreted qualitative interviews with the people listed above created the bulk of information gathered for this research project, other sources were used additionally in the form of a document analysis. Thus different sources were used to check if they would lead to similar findings, and if this was not the case, how differences could be explained. However, I also opted for including a document analysis for other reasons. Firstly, the sources presented below were used as initial research to prepare for the qualitative interviews. This presented a way of checking the validity of information given during the interviews, as well as lead to a more critical interpretation of both sources. Secondly, including documents in the empirical data helps attain information and insights not available through the interviews, or not to a sufficiently detailed extent.⁸

Furthermore, both the interviews and the documents used offered an additional pool of information the other could not. While the documents lacked the acupuncture practitioners’ personal insight on the subject, the interviews could not provide the same scope of information as could be obtained through documents. It is not feasible, nor striven for, to include interviews with all relevant actors in the field, but a document can be included to obtain specifics of what an additional interview might have shown. This was particularly beneficial when an originally planned interview proved to be impossible to conduct, as was the case with members of the Austrian Society of Regulated Acupuncture and Traditional

⁷ For detail see chapter „Mapping Acupuncture: State of the Art“

⁸ For example, interviewees loosely quoted the Diploma Guideline of the Austrian Board of Physicians, but I referenced it directly for a more exact phrasing of the content.

Chinese Medicine. Documents were used to compensate for information that might have been obtained through the interview. Thus, it was still possible to include all the organizations teaching acupuncture in the empirical analysis, therefore giving a more complete portrait of the field.

At this point, the analyzed documents will be briefly introduced and contextualized for a complete overview of all the materials used for the following empirical analysis. The **websites of the acupuncture organizations** (URL 9/10/11/12) included in this research project were used to assess who the key members of the organizations were for possible interviews. Furthermore, the official self-portrayal of the organizations and the focal points of their efforts were analyzed.

The **Physicians' Statute**⁹ (URL 13) was used as a legal reference point of policies regarding acupuncture in Austria, as this statute defines which practices are legally restricted to physicians. It was referenced repeatedly in the interviews, and thus was included as a direct, rather than an indirect, source. The **Diploma Guideline of the ÖÄK** (URL 2/3) is an official document published to showcase the Board of Physicians' take on the prior knowledge acupuncture practitioners should have, and in which cases acupuncture treatments are applicable. It will be used to show the soft message that is being transported on a policy level through documents and publications, without having an actual legal standing. As the analysis will show, the Physicians' Statute and the Diploma Guideline portray overlapping claims that are not always coherent to each other.

Websites offering information on the **ÖÄK acupuncture diploma about contents** (URL 1), **schedules** (URL 7) and **costs** (URL 6) of the course will be used to give details on the physicians' acupuncture education, and to compare it to interviewees' statements on the topic. The website on **Medical Studies at Austrian Universities** (URL 8) will permit a comparison of the physicians' acupuncture education and general medical education in Austria. **Information on acupuncture education in China** (URL 4) will give additional information about education practices abroad, as described by some interviewees.¹⁰ (Chenfei Chen, Rainer Kluger) This issue will be further contextualized in a chapter on the meaning of space and place in acupuncture, and the hierarchical associations attached to this factor. **Information on midwives' acupuncture education and Continued Professional Development** (URL 5) will be used to compare and contrast physicians' and

⁹ Ärztegesetz

¹⁰ China was used as an example due to several interviewees referencing it, not because a hierarchy of acupuncture education abroad prioritizes China.

midwives' education requirements in Austria, thus establishing a portrait of hierarchies in professional proficiency.

A **survey of the Acupuncture Ambulance** (see appendix) assessing patients' conditions and improvements before and after acupuncture treatment will be used to portray how data on acupuncture's efficiency is gathered in a clinical context in Austria. Furthermore, five consecutive editions of the "**German Journal of Acupuncture and Related Techniques**" (Deutsche Zeitschrift für Akupunktur) (editions used see appendix) were analyzed with regards to recurring categories, as well as specific topics and their implicit messages. Though the "German" in the title might imply a strong focus on Germany as a location, the magazine features a total of six publishing acupuncture organizations in detail, three of which are German, two Austrian and one Luxembourgian, though they share German as a publishing language. The journal is published four times annually. It provides relevant information for this research project, as two of the acupuncture organizations whose members were interviewed utilize the journal as an official way of publishing their research. The journal is used both for acupuncture organizations to share knowledge amongst each other, and, to a lesser degree, to make it accessible to the public. The two Austrian organizations publishing in the journal are the Austrian Society of Acupuncture and the Austrian Scientific Physicians Association for Acupuncture. As two (of three) organizations authorized to train new acupuncture practitioners, these organizations play a crucial role in shaping acupuncture in Austria. Thus, using their medium of choice for communicating research on acupuncture is a useful tool to triangulate statements made regarding research and practice in the interviews. Furthermore, Thomas Ots, the vice president for the Austrian Scientific Physicians Association, also functions as the editor in chief for the journal, giving its publications further gravitas in terms of this research project, as he has to approve the totality of the articles published. I spoke with Michaela Bijak of the Austrian Society of Acupuncture, a publishing member of the journal, as she holds the position of publicizing new research findings of her organization to the public, e.g. the "German Journal of Acupuncture and Related Techniques". (Ots (ed.), 2012/1-2013/1)

The interviews at times portrayed the two acupuncture organizations represented in the journal as antagonists, whose differences made it impossible to be united under one umbrella organization, despite having similar roots. Their both publishing in a shared journal was a first indicator of their differences perhaps not being as great as the interviewees communicate them to be – a hunch that was backed up by the analysis of the interviews. (Ots (ed.), 2012/1-2013/1)

As a last source of the triangulation process, I tried to obtain **public insurance agencies' documents** on the (non-)coverage of acupuncture, but this was not possible, as they are not accessible to the public. Reflections on the policy of secrecy will be included nonetheless.

6 Empirical Analysis

Above, the collection of the empirical data through qualitative interviews, and their triangulation through a document analysis, were discussed. The following empirical analysis strives to answer the research questions by combining and interpreting the gathered data, as well as linking it to previously outlined literature and sensitizing concepts. The first subchapter of the empirical analysis enters the world of acupuncture in Austria by showing how its history is perceived and narrated by those involved in its creation.

6.1 A Man with a Mission? Histories of Practicing Acupuncture in Austria

Compared to other European countries, acupuncture has a relatively long history of being used in a medical context in Austria. It holds a unique position in the sense that its practitioners not only cooperated with the Western medical system in place, but actively worked to become a solid part of it from the very beginning. A key point towards achieving this goal was the fact that the first people officially offering acupuncture practice were part of the medical community themselves, having been formally educated, as well as having gained experience as physicians before engaging in acupuncture. The narrative of how acupuncture “came to be” in Austria, as told by the Austrian physicians practicing acupuncture, seems linear, perpetual, and straightforward. Upon taking a closer look, this seemingly clear and unambiguous picture begins to crumble. (Jasanoff, 2004)

Firstly, the story told varies heavily, depending on the person telling it. More than one acupuncture organization in Austria claims to have been founded by the true “founding father or mother” of acupuncture in this country. The Austrian Society of Acupuncture truly celebrates their history and especially praises their very own founding father, Prof. Dr. Johannes Bischko. (URL 9) According to a book dedicated to his biography, written by Manfred Richart, one of the organization’s members, Bischko studied acupuncture in China after finishing his Western medical education in Austria. Upon returning to Europe, he founded the Austrian Society of Acupuncture (Österreichische Gesellschaft für Akupunktur) in 1954, which still exists today. 18 years later, he is said to have made acupuncture “famous” in Austria by removing inflamed tonsils in a non-anaesthetized patient by exclusively using acupuncture needles for pain control, which was the first of 300 such operations performed by him. (Manfred Richard / Richart, 2005 / URL 16)

The story of treating a patient without anesthesia reads like that of a daring hero, and the language used in Manfred Richard's book "Johannes Bischko – A life for acupuncture" supports this form of narrative. According to Volker Schneid's book "Chinese Medicine in Contemporary China: Plurality and Synthesis", using acupuncture to anesthetize patients is only a very minor form of applying acupuncture compared to the manifoldness of other possible uses (Schneid, 2003), and is rarely used in today's times. However, anesthetizing patients so they do not have to suffer during surgery is one of modern Western medicine's great accomplishments, so demonstrating acupuncture can do the same might have been a strategy applied by Bischko to get the public's attention and prove acupuncture's worth by establishing a form of symmetry.

Bischko is described as a person who gave his entire life to selflessly bring acupuncture to the people of Austria, and is celebrated accordingly. (Manfred Richard / Richart, 2005 / URL 16) However, what is barely mentioned in this narrative is that Bischko did not go to China alone, and was not the only person who came back to start a tradition of acupuncture in Austria. In fact, he travelled and studied there with this friend, Dr. Georg König, whose son is also an acupuncture practitioner and one of the interviewees for this research project. Georg König is left out of the narrative the Austrian Society of Acupuncture, but, on the other hand, the Austrian Scientific Physicians Association for Acupuncture, co-founded by Dr. Georg König in 1972, did not make a reference to Dr. Bischko, either. (URL 16) This neglect to acknowledge acupuncture as having co-evolved through more than one organization can be seen as a sign of a "conflict(...) between alternative, institutionalized knowledge-power formations." (Jasanoff, 2004)

In 1972, Austria's first acupuncture clinic was opened as part of a hospital, and in 1986 the first lecture on acupuncture was held at the medical university. Both Dr. Bischko and the founding members of the Austrian Scientific Physicians Association for Acupuncture clearly stated their goal of integrating acupuncture into Western medicinal practice. Thus, an integration of acupuncture into the physical setting of biomedical practice by opening a clinic within an established biomedical hospital, as well as teaching it at the official medical university, can be seen as milestones to inscribing acupuncture into "pre-stabilized beliefs" (Clark Miller, 2004) and creating a "foundation of long-term medical power". (Salter, 2004) This strategy of cooperating with the existing system in place, while constantly stressing that acupuncture had no intention of competing with it, but merely wanted to aid, was highly successful. In 1986, acupuncture was officially recognized as a "scientific form of treatment" (Manfred Richard / Richart, 2005 / URL 16), which marks a first turning point in the demarcation process initiated by the two acupuncture organizations mentioned above.

(Gieyring, 1983) Therefore, acupuncture was successfully integrated into the biomedical system, and could then enjoy the privileges it possessed: “The power relations embedded in the medicine-state relationship determine both the nature of medical self-regulation and the possible responses to the demands for change.” (Salter, 2004)

This power relation tilted further in favor of acupuncture in 1991, when the Austrian board of Physicians agreed to create a special diploma of acupuncture (ÖÄK-Specialdiplom Akupunktur). It is a diploma both educated physicians and medicine students in their last semester of studies can pursue. The educational program, as well as the diploma, are provided and regulated by the Board of Physicians (ÖÄK). In order to receive the diploma, (future) physicians have to partake in theoretical and practical courses and pass an examination at the end of their education. (URL 1 & 2) The course is not open to non-physicians, and the diploma received at the end of it is an official document, allowing the physicians who possess it to be recognized and listed as an acupuncture practitioner certified by the ÖÄK. Other people licensed to practice acupuncture, which will be described below, receive a “certificate” at the end of their educational program, rather than a “diploma”. Though the name of the document received at the end might give no indication as to the quality of the content of the education, it does bring certain implications to the table. A “diploma” is associated with a long course of education, similar to what is obtained after studying at a university. A certificate, on the other hand, implies some knowledge collected in passing, and thus sounds less credible, tilting the weight of who is best qualified to practice acupuncture in Austria towards the physicians. The ÖÄK special diploma of acupuncture can also be acquired as a CPD (continued professional development), which refers to the further education program physicians have to go through each year in order to uphold their license, after having finished their university medical degree. (URL 2 / URL 3)

The Austrian Board of Physicians, whose areas of responsibilities stretch to include the establishment and maintenance of the register of medical practitioners, the negotiation of contracts between public and private insurance companies as well as the development concepts and suggestions for the Austrian health system, is a very powerful institution in the Austrian medical field. It also has regulatory functions for medical education in Austria, in addition to continued professional development after the completion of formal medical education. (URL 15) Though not strictly speaking a legislative authority, the broad range of points of influence demonstrates the power the Austrian Board of Physicians possesses, and cooperating with acupuncture by giving it status through the special diploma has helped promote this form of treatment greatly, while also linking it closer to physicians as practitioners.

Both acupuncture organizations mentioned above, as well as a third, the Austrian Society of Regulated Acupuncture and Traditional Chinese Medicine in Linz (URL 11), were licensed to teach acupuncture to physicians. Nevertheless, three different organizations emerged, even though they might have been stronger in lobbying for acupuncture united, raising the question of why this split took place. Kurt König, the son of Georg König, said that not only ideological reasons lead to the break of the two initial acupuncture organizations, but also personal differences. Even though this is only hearsay, it just might be what eventually led to the breaking up of physician's acupuncture in Austria: the simple fact that two former acquaintances were no longer getting along on an interpersonal level. Which differences there were on a methodological or ideological level of acupuncture is very difficult to trace, as members of both organizations claim to want to convey the "scientific" aspects of acupuncture in a way that would be compatible with Western medicine. Thus, "demarcation processes are used also within what is considered to be "science" by the actors involved", namely acupuncture organizations consisting of physicians, "establishing themselves as being "more scientific" through different and contradictory strains of arguments" (Gieryn, 1983), which will be discussed in more detail in the chapter: "Pinpointing Understanding: The Debate of Skill versus Philosophy".

However, what might have been an openly fought conflict at one point between the acupuncture organizations seems to have mellowed out over time. As one interviewee said: "As there is the ÖAMTC and the ARBÖ (the large automobile clubs in Austria similar to AAA in the USA), there are different acupuncture organizations, and they surely have come closer to each other (over time). (...) The acupuncture organizations work together in a reasonably sensibly and also the theoretical differences have been reduced." (Kurt König) However, the interviewee went on to add that his organization had changed the least (Kurt König), implying that the process of working together had been initiated by the other organizations, presumably because they realized the errors of their ways.

As a closing remark to this chapter, it should be noted that the "history" of acupuncture, as told by the interviewees, focuses exclusively on the acupuncture practiced by physicians, almost as if other forms of acupuncture did not exist, or at least were not introduced into Europe beforehand. This, of course, is not the case, as acupuncture was practiced in Europe at least two centuries before Dr. Bischof and Dr. König travelled to China. (Unschuld, 1987) Only one interviewee briefly mentioned this. This way of telling a unified story of acupuncture in Austria as being physicians' acupuncture already hints at how possible practitioners of this treatment form are implicitly envisioned.

6.2 License to Acupuncture? Agents Authorized to Practice

Acupuncture in Austria - Groups and their (Imagined) Agencies

As shown above, acupuncture was introduced to the Austrian context by physicians, and was quickly regulated in a way to ensure that physicians would remain the primary providers of acupuncture treatments. This poses the question of which relevant groups and organizations have helped shape this regulatory process, and through which methods do they ensure the stability of the current system. Rather than presenting reasons of why this policy system is or is not satisfactory, this chapter will aim to introduce social groups that have shaped this system, as well as their take on the system, and the messages transported within the system through the policies in place.

6.2.1 The Importance of the Austrian Board of Physicians in shaping Acupuncture Practice

As described in the previous chapter on the history of acupuncture, the Austrian Board of Physicians has played an elementary role in shaping the policies in place. A main strategy of impacting policies has been to regulate the education needed to officially practice acupuncture. By offering a diploma, which physicians need in order to legally practice acupuncture, they have established themselves as a gatekeeper institution in the field. As the definition paper of Austrian Board of Physicians puts it: "(...) only physicians are proficient in practicing professionally qualified acupuncture. To master the diagnosis and therapy forms of modern medicine is thus seen as a prerequisite in the advanced training guidelines of attaining the acupuncture certification through the Austrian Board of Physicians and is not included in the offered course. The advanced training shall convey knowledge and skills in theory and practice. It is open to all physicians. The theoretical part is also open to students of medicine." (URL 3, 30th August 2013)

As can be seen in this text, the education for the ÖÄK diploma was designed for physicians possessing a previously acquired knowledge about anatomy and medicine, which is therefore not included in the course. However, by presuming a participant of the course to already possess this form of knowledge, a person not possessing it cannot – even theoretically - be construed as a course participant. Therefore, an imagined criterion of participation and the participants leads to a real exclusion taking place in acupuncture education on a policy level.

Physicians have the almost exclusive right (with very few exceptions) to be licensed to educate others in acupuncture. This is an important step in the process of boundary-work, as professional autonomy is established and defended by portraying physicians as the only experts in the field knowledgeable enough to pass their knowledge on to others. (Gieryn, 1983; Turner, 1978) While exceptions might be made to allow others to practice acupuncture, teaching it remains a firm privilege of physicians, establishing a clear hierarchy of knowledge levels. Another important step in boundary-work is that of demarking theoretical science – in this case, “scientific” acupuncture – from its practical applicability. (Gieryn, 1983) By establishing physicians as acupuncture teachers enabling others to practice it, this binary theory–practice boundary is enforced.

Furthermore, physicians teaching acupuncture provide education almost solely to other physicians: with the ÖÄK special diploma being an especially exclusive example in that it is absolutely not available to non-physicians. This leads to a certain exclusivity of this diploma, even when compared to other diplomas attained by groups also legally permitted to practice acupuncture. This physicians’ diploma is a so-called “ÖÄK-CPD” (Continuing Professional Development). (URL 2, 30th August 2013) As a requirement of upholding a physicians’ license in Austria, a certain number of further education hours, or teaching units, has to be completed each year, in addition to having acquired the university medical degree. By allowing the ÖÄK diploma to meet the requirements of a Continuing Professional Development course, learning to be an acupuncture practitioner can help physicians to upkeep their regular medical license as well. It shall be argued that regulating acupuncture education this way has a number of implications on how this form of treatment is viewed by the medical community.

Firstly, offering the ÖÄK acupuncture diploma as part of the Continuing Professional Development program sends the message that having an acupuncture diploma is considered beneficial for physicians by the Austrian Board of Physicians. Because the continued further education program was designed to keep practicing physicians up to date with new developments in the medical field, including acupuncture in this program indicates that this treatment form is to be considered not only relevant for medical practice, but also state of the art. This makes acupuncture appear as a practice that should be taken seriously, rather than a marginalized, or even questionable, form of treatment.

Furthermore, giving physicians credits for the obligatory CPD program when acquiring the acupuncture diploma encourages higher participant rates in the diploma course. Rather than voluntarily spending time and money on a special diploma they might not need in practice, physicians can kill two birds with one stone by both meeting their CPD requirements and

getting a new diploma as well, thus lowering the threshold needed to motivate physicians to participate in the program.

As many other CPD courses or lectures only hand out certificates of participation rather than official diplomas, completing the acupuncture course might prove to be more beneficial in the long run. After all, a diploma can be used as an advertisement for a physician, whereas a certificate might not have the same impact. However, the message being sent through this policy measure is that acupuncture education is something that can be done in passing, as part of a CPD, as opposed to being seen as its own form of treatment, which requires time and patience to learn. Also, it implies that the acupuncture diploma can be attained exclusively for the purpose of the CPD, even if the physician has no intention of practicing acupuncture afterwards. This, in turn, shows that merely having an ÖÄK acupuncture diploma has no weight to how much experience the physician has in practicing acupuncture on patients.

It is further noticeable that the acupuncture diploma, unlike a general medical degree, does not request physicians to participate in a CPD program. Once the diploma is attained, no further education for acupuncture is required, implying that acupuncture, as opposed to general medicine, does not need any further proof of proficiency in the field.¹¹ In this context, one interviewed physician compared the diploma to operating a automated vehicle, saying: “The driver’s license test, that is the ÖÄK diploma, it brings you to a point at which you can treat patients sensibly, not all indications from the beginning, but the most important indications can be treated, just as with just having received the driver’s license, you can drive on the highway and in the inner city, and though you are no racing world champion, but you safely reach home, and that’s the point.” While there seems to be an understanding that the ÖÄK diploma alone is not enough to successfully practice acupuncture for all possible medical conditions, and further practice might be required, this requirement is not inscribed on a policy level, e.g. by demanding CPD. Instead, the physicians are merely trusted to practice acupuncture carefully on their own until they are sufficiently qualified. It should be added that further acupuncture courses are offered post diploma, but they are entirely on a voluntary basis. (URL 9, URL 10, 30th August 2013)

¹¹ Interestingly, this does not hold true for other groups licensed to practice acupuncture, as the chapter “Permissions Attained: Midwives Practicing Acupuncture” will demonstrate.

6.2.2 Permission attained: Midwives Practicing Acupuncture

As described above, the Austrian Board of Physicians has historically introduced a number of measures to ensure that physicians become and remain the main source of acupuncture providers. However, some exceptions have been made to legally include other groups in this practice. One example of such an official exception to the rule is the case of midwives. According to Gabriele Sprung, the interviewed midwife, the Austrian Midwife Council¹² requested to receive this permit. However, this permission could only be attained with the help of several physicians, primarily gynecologists working closely together with midwives, who advocated for this change as well. (Gabriele Sprung) Sprung strongly conveyed the impression that this modification of the policy system would not have happened without the support of physicians.

They were able to make themselves heard within their community, thus translating the Midwife Council's request to a level where policy changes could be initiated. This model of gaining permission is quite opposite to some others described in the literature on alternative or complementary medicine. In this other model, people already practice within their field, and then go on to demand claims of legitimacy and professionalism for what they are already successfully doing. It is what Barnes, quoting Last, refers to as a "grass-roots version of legitimacy", or "professionalization from below". (Barnes, 2003, quoting Last, 1990) I would like to argue that the case of the midwives practicing acupuncture in Austria, on the other hand, presents a "professionalization from above", or at least with help from above in the hierarchy of medicine. Only with physicians' help and support was a claim of legitimacy realized. Whether this claim was used to acknowledge a practice existing prior, but not in the open, or, on the other hand, opened up the field of practice that was previously actually closed to midwives, remains unknown. However, it can be noted that the legalized form of midwives practicing acupuncture was not an unsupported grass-root movement.

It is interesting to note that no official mention of this exception is made allowing midwives to practice acupuncture in the Board of Physicians's documents, which state: "It should be emphasized that acupuncture is only to be practiced by physicians educated accordingly." (URL 3, 30th August, 2013) Though several interviewed physicians mentioned the regulation to include midwives in acupuncture practice, they did not specify how this permission was concretely attained or how it is reflected through laws or regulations. Sprung could not provide any further information, saying: "I don't know anything about a law. (...) But that doesn't mean there isn't something."

¹² Österreichisches Hebammen Gremium

Considering the lack of a hard change in the legal system to permit midwives to practice acupuncture, the narrative of having fought for this right and being grateful to having obtained it, seems somewhat counterintuitive. When looking deeper into the regulations, however, things become clearer. The reason midwives required permission at all has to do with the use of needles, more specifically the use of acupuncture needles, as needles penetrate the skin, a right otherwise reserved to physicians: "Puncturing with a needle is technically a bodily injury. And bodily injuries are only permitted under certain circumstances. And one of those is for diagnostic and therapeutic means." (Kurt König) König is hereby referring to the Physician's Statute, which does indeed restrict the use of needles to physicians in most cases, without, however, specifically regulating acupuncture. (URL 13, 30th August, 2013) Sprung was also aware of the connection between a general ban of non-physicians puncturing the skin, and its effect on acupuncture regulations: "(...) a form of legal clearance (was needed, comment), as acupuncture is an invasive procedure, as I am puncturing the skin; everything that is invasive is usually only permitted to physicians. (...) Anything where you permeate the body's barrier (...) is delicate."

Due to the legal limitations mentioned above, an exception to the Physician's Statute was agreed on, permitting midwives to "cause bodily harm" in order to perform acupuncture. Nonetheless, limitations have been made to this exception, which prevent midwives from providing a full range of acupuncture treatment: "As a midwife, I support (women, comment), I am an accoucheur, I help women through the whole process, but I don't treat them." (Gabriele Sprung)

This insistence of not providing treatment for pregnant women was especially interesting when compared to the list of cases in which Sprung (and other midwives) use acupuncture: "Starting in early pregnancy, especially nausea, problems with, comment the locomotive system or the sciatica, if a pregnant women has a cold, the flu (...), to strengthen the immune system, during the birth, and then after birth to support the production of milk after birth, galactostasia, the prevention of mastitis, etc." (Gabriele Sprung) Though using acupuncture to improve these medical conditions is difficult to differentiate from a so-called "treatment", Sprung insists it is not the same, as her using acupuncture is limited to the perinatal field. It seems interesting that this criterion seems enough to justify that midwives are following the legal restrictions they are obliged to, especially as some of the conditions acupuncture is used for are absolutely not pregnancy related, such as the cold or the flu. Apparently, the subject of the (non-)treatment - namely a pregnant women, or even a women who has recently given birth - rather than the condition the subject is suffering from, is seen as relevant to the question of whether a midwife is allowed to intervene by using

acupuncture. This could be a method of ensuring that midwives do not become competitors to physicians in the market of acupuncture providers. After all, limiting midwives' acupuncture not only to one gender, but also to a very limited time period for this gender, ensures that women seeking non-perinatal acupuncture treatment will turn to physicians.

When Sprung was asked if placing acupuncture needles in pregnant women varies from other patient groups, she clearly rebutted, saying: "They (pregnant women, comment) have the same system of meridians as everyone else. It's always the same." Though midwives are thus theoretically trained to use acupuncture on pregnant and non-pregnant people alike, this was not perceived as a problem by the interview. As she put it: "But why should I (treat not pregnant women, comment)? I am not allowed to TREAT. They should go to a doctor. (...) The only person allowed to treat is a doctor. (...) That's the law." (Gabriele Sprung) Though Sprung stated that she does not wish to share her own opinion regarding this law, which leaves a possible critical view on it open for question, she seemed content that midwives, as a group, have received a legal permission to use acupuncture at all: "We are, as I said, the only group (except physicians, comment) who are allowed to use acupuncture at all. (...)," adding, in a tone of voice that conveyed sarcasm,: "We aren't physicians. We don't have an ever so comprehensive medical education as a physician does." Despite this subtle comment of midwives' medical ability compared to physicians, Sprung said that, actually would not want or need permission to use acupuncture outside her field of expertise, and finds it dangerous to overestimate one's own capability. Within her own field, however, acupuncture is very popular – about 80 percent of her clients seek acupuncture "treatment" before, during, and/or after giving birth. (Gabriele Sprung)

Midwives receive a basic education and training in order to be officially allowed to practice acupuncture, similar to the one undergone by physicians, though with a stronger focus on perinatal conditions. (URL 14, 30th of November, 2013) This education is not, provided by only one organization, such as the Board of Physicians in the case of physicians, but rather by a number of private medical educators, such as Pro Medico, Bacopa, and others. However, these educating institutions have, as a common denominator, physicians functioning as teachers to midwives. (Gabriele Sprung) This means that physicians are the sole group passing on knowledge about acupuncture to midwives, thus sending a message of superiority of knowledge. Though midwives are now allowed to use acupuncture, they are not considered to have sufficient expertise to teach it, even though physicians might be lacking insight into the practice of being a midwife, and thus learning from physicians and midwives alike might be beneficial.

Other than physicians, midwives need to generate proof of 20 hours of Continued Professional Development every two years in order to maintain their license. Sprung says this is merely needed for legal protection in the unlikely case of a lawsuit, as there is no controlling institution to check if the CPD demands are met. Nonetheless, she also added that she finds it very important to stay up-to-date on acupuncture through CPD. However, she is aware of two sets of standards being applied on a policy level: “That’s the difference to physicians, yes, they can do whatever they want, whether or not they’re good.” (Gabriele Sprung) Sprung is grateful that midwives are allowed to practice acupuncture for perinatal care, and were supported by some physicians in striving to do so. She does not wish to change the current policy system in place, but she does criticize the double standard in education and assumed competence.

6.2.3 The Great Unknown – Non-Licensed Acupuncture Practitioners and the Threats they Pose

The only two groups mentioned explicitly by the interviewees in the context of being licensed to practice acupuncture in Austria were physicians and midwives. Although it became clear that exceptions to the “physician-ness” of acupuncturists can be made legally possible and even acceptable on a policy level – as the example of the midwives demonstrates – an extension of this “permission” to other groups was perceived as neither necessary nor feasible.

However, interviewees did mention the existence of other groups practicing acupuncture without having attained permission to do so. Who these “others” were, remained rather imprecise. This lacking concreteness did not, however, stop the interviewees from describing drastic scenarios which could occur if acupuncture were to be practiced by actors not licensed and/or trained to do so: “Of course there are also acupuncture “doctors” working here illegally, but that’s not advisable, as so much can happen if one doesn’t have the classical medical education; it’s so dangerous. It can even become life threatening, because, for example, most physicians don’t even puncture the back, because of the lung, yes, one has to have exact knowledge of the anatomy to know how to puncture. If a lay person, who doesn’t know the anatomy, and has only done an acupuncture course somewhere, if this person punctures too deep or not well, this can become life threatening.” (Chenfei Chen) As can be seen from this quotation, a narrative of worst-case scenarios is being used to portray the dangers of acupuncture being practiced by those not included in the community of licensed acupuncture practitioners. Less drastic outcomes of a treatment performed under

such circumstances, such as patients spending money without experiencing health benefits due to lack of training by the practitioner, are not elaborated on or even mentioned.

This suggests that a narrative of danger and risk is being used to distinguish licensed from non-licensed actors. On a level focusing on individuals, this warning of the existence of danger could prevent possible acupuncture patients from visiting a non-licensed practitioner. This could bring financial benefits to those licensed practitioners. Acupuncture treatments are comparatively expensive in per-treatment-costs (excluding the theory that perhaps a fewer number of treatment sessions might be necessary when compared to other treatment options for the same medical condition), and are usually not covered by public health insurance. Hence, acupuncture treatments often provide a source of income for physicians more fiscally beneficial than the fixed rates received for treatments covered by the public health insurance companies.

The message that patients might be endangering themselves by visiting non-licensed, and thus, implicitly, unqualified acupuncture practitioners, was transported in the interviews: “I can’t say if it is better for the patient to receive the treatment cheaper and, in turn, to have a practitioner who does not know his limits, or to rather get a slightly more expensive treatment, but in return constantly have someone, for every single treatment, who makes sure, if there is a reason to for example end acupuncture as a treatment form and try something different.” (Rainer Kluger) By conveying this message of receiving a higher quality of treatment when visiting a licensed practitioner, and avoiding possible harm, the chance of patients opting for a treatment carried out by a physician or midwife is increased.

As non-licensed acupuncture practitioners do not generally publicly advertise their practice out of concern for legal consequences, a comparison to their rates for a treatment to those of a physician or midwife could not be made for this study. However, one of the interviewed physicians mentioned that most of the non-licensed practitioners operate in an illegal realm of informal labor¹³, meaning that they would not pay taxes or give out invoices, and perhaps even work out of their homes, rather than maintaining an official place of work. (Chenfein Chen) This could put non-licensed practitioners in a position to charge less for acupuncture treatment sessions than those offered by official practitioners, as they do not have to cover the same costs arising from taxes, office space, etc. As a result, official practitioners might lose business, and thus income. Therefore, both regulating acupuncture and disparaging

¹³ The German colloquial term for this type of work, as used in the interview, is “Schwarzarbeit”.

non-licensed practitioners could partly be a strategy of providing an exclusive – and costly – service.

It should be noted that a price difference in acupuncture treatments is already noticeable between physicians and midwives. While physicians charge within a range of 60 to 100 Euros, the interviewed midwife said she charges “30 Euros per session. There are colleagues, for example at the Golden Cross who charge 40, at Saint Joseph’s¹⁴, I think, it costs 25 Euros (...)”. (Gabriele Sprung) While it can be argued that midwives only provide a service for a limited amount of conditions, while lacking the training and/or the license to treat non-maternity related health problems, the price difference is still considerable, especially considering that midwives are officially licensed to practice acupuncture. Thus, the threat posed by illegal practitioners on lowering asking prices for treatments could make physicians feel threatened. This may increase their incentive to verbally (though not practically) criminalize illegal practitioners, and warn patients of potential dangers. Since the Austrian Board of Physicians already showed considerable reluctance to – even partially - include other medical groups, such as midwives, in the system of licensed acupuncture practitioners, the assumed or real threat posed by the non-licensed becomes more graspable. Following Fuller’s notion of the necessity of knowledge’s economic competitiveness (Fuller, 2002), it appears that physicians in Austria partially guarantee that the research conducted on acupuncture’s effectiveness will pay off on a fiscal level by regulating the supply of acupuncture providers. At the same time, research is also used as a tool to increase the demand for acupuncture treatments, which in turn helps to conduct more research on the subject. This will be further discussed in the chapter “The Acupuncture Brand: Quality Guarantee and Control through Standardization and Medicalization.” Regulating who can and cannot practice acupuncture in Austria is thus but one step in a complex structure of making not only acupuncture practice, but also research on the matter, more profitable.

6.2.4 Level of Knowledge about Authorized Agents

As a closing observation to this chapter, the level of knowledge the interviewees displayed regarding the agents authorized to practice acupuncture should be mentioned. Some interviewees claimed that exclusively physicians hold this right (Daniela Stockenhuber, Manfred Richart), with Bijak emphasizing: “I am glad that it is reserved for physicians in Austria.” (Michaela Bijak) It appears that in these cases the narrative of acupuncture being

¹⁴ The Golden Cross and Saint Josephs are both Viennese hospitals.

limited to physicians had formed such deep roots that even other groups legally permitted to do so are not mentioned in this context.

Other interviewees, however, did mention the inclusion of midwives, without having any concerns regarding this recent change in policies, provided midwives obeyed the limitation to perinatal care. (Kurt König, Rainer Kluger) Furthermore, two interviewees explicitly mentioned the fact that physiotherapists sometimes offer acupuncture without permission. Sprung said that in order to avoid legal problems, some physiotherapists use acupuncture knowledge, but not needles, by providing acupressure or laser acupuncture. (Gabriele Sprung) Kluger also added that he knows of some physiotherapists that do use needles, but did not see a grave danger in this, as they at least have some medical knowledge: "It's not about investigating everyone who does anything like with the police, but rather about having a basic intention, sentiment and morale about the topic." (Rainer Kluger) This quote underlines that frequently there are no real legal consequences if a non-licensed person, such as a physiotherapist, provides acupuncture treatment. Moreover, there is no system in place to control who is actually offering acupuncture. Nonetheless, the "basic morale" regarding acupuncture in Austria seems strong enough for a number of people to accept it as the law, and there might be reasons to leave the system as it currently is.

In the chapter "Normativity: erasures and silences", Jasanoff explains that not only explicit signs of enforced power portray the system in place, but that "marginalized alternatives" should also not be overlooked. (Jasanoff, 2004) There seems to be an ambivalence in physicians arguing that patients are put at risk through non-licensed acupuncture practitioners, but then do not go on to insist that these "illegal" practitioners be brought to justice. Social groups practicing acupuncture without a license, on the other hand, such as some physical therapists, do not seem to actively strive to gain more power through official, legal recognition of their practicing acupuncture. It thus appears that both sides could profit from remaining in the status quo, thus engaging in "strategic silence", rather than insisting on "explicit articulations" in order to change or enforce the system of policies in place. (Jasanoff, 2004) If physicians demanded that non-licensed acupuncture practitioners be penalized, this might publicly point to the fact that there is no hard legal system in place allowing them to be punished at all, encouraging more non-licensed acupuncture practice to take place. Thus, physicians could ultimately end up losing power by actively enforcing the system of policies currently in place. On the other hand, if social groups marginalized in the current acupuncture practice system were to demand more power, the outcome could be that the current set of soft policies might turn into more vigorously enforced hard laws, and could thus prevent them from practicing acupuncture at all. Consequently, the silent equilibrium

might be preferred to an open “acupuncture war”, as it took place in other countries. (Barnes, 2003 / Lei, 1999 / Wolpe, 1985)

6.3 Time (Needed) to Acquire the ÖÄK-Diploma for Acupuncture

The ÖÄK-Diploma for Acupuncture requires a total of 200 teaching units, of which 120 are theory units and 80 are practice units, to be completed over a time period of at least 24 months. (URL 1) Teaching units, in this case, are not to be confused with hours, as one teaching unit equals 45 minutes. (URL 3) Hence, the full education cycle consists of a total of 150 hours. Furthermore, there is a restriction of offering no more than ten teaching units a day (URL 3). Considering this limitation, it is thus theoretically possible to complete the entire program leading up to the ÖÄK-Diploma exam in 20 days. This, however, is not realistic, as not all course elements are offered back to back. Many physicians have to fit their education to receive ÖÄK-Diplomas into their own professional schedules, so courses are often offered blocked on weekends. (URL 7) It is, thus, possible to complete the education over the course of ten weekends.

While the ÖÄK-Diploma guidelines state that two years’ time have to pass between participating in the first lesson and attempting the exam (URL 3), there is no regulation regarding the intervals at which the teaching units should be distributed within this time period. Furthermore, there is no mention of if or how the course participants should practice or study acupuncture in the time between participating in teaching units. One might argue that it would not be possible to pass the exam at the end of the course without additional practice, but this is not the substance of the guidelines. Furthermore, “the exam can be repeated any number of times in the case of a negative grading.” (URL 3) So, if a physician has not studied or practiced enough prior to the exam, this is little or no cause for concern, as the exam can simply be repeated as often as necessary. As for the grading scheme of the final exam, there is merely a differentiation between having passed or not having passed (URL 3), rather than a differentiated scheme using grades or percents.

In review, this means that the ÖÄK guidelines for the acupuncture diploma make no suggestion as to how and with what time expenditure physicians should prepare for the final exam. Not having prepared, and thus performing poorly or knowing little, is merely sanctioned with a “no pass”, which leads to another attempt at the exam. Having prepared, on the other hand, leads to a simple “pass” and then the physician receives his or her diploma. This procedure is vastly different from the system of passing or failing exams while studying medicine at a University in Austria, which most of the physicians participating in the ÖÄK acupuncture program have done. At the medical University, exams are always graded,

using a grading system of 1 through 5 (one being the best grade). Furthermore, each exam can only be repeated four times. After having failed the last attempt, the student is excluded from the studies entirely. (URL 8)

Thus, the message being sent through the exam regulations for the ÖÄK diploma could be understood as acupuncture studies being less relevant than medical studies. It is not considered problematic if a physician fails the exam repeatedly, then finally passes, and goes on to practice acupuncture. This could be interpreted as there being no considerable negative consequences of low quality acupuncture treatments. Furthermore, by not grading in a differentiated way, the physician attempting the exam has no way of telling if he or she is particularly good at practicing acupuncture, or just barely passed. Rather than trying to excel, this grading system could promote a mentality of being merely “good enough” not just to pass, but also to practice acupuncture, which might be problematic for the treatments given later. A real feedback system from the examiners to the examinee does not exist formally.

This system also does not leave future patients with the possibility to pick an acupuncture practitioner who performed particularly well at the exam – every physician who participated in the needed hours of the course and passed the final exam eventually is thus equalized in the eyes of the unknowing patients.

Despite the disputable exam practices of the ÖÄK diploma, it is difficult to pass judgment on whether 150 hours / 200 teaching units (or 105 hours / 140 teaching units, as it was up to last year) of acupuncture education are an adequate amount of time to learn this treatment form. One could argue that other countries’ boards of medicine call for a much longer acupuncture education time period, or require no formal training at all. However, the fact remains that merely comparing the hours spent to receive the ÖÄK-Diploma to other formal programs has little significance. After all, hours can be filled very densely with a very high quality of education, making little time count, rather than passing a large number of hours with less helpful education. So, instead of focusing on the exact number of hours, the interviewees’ views on those hours are relevant for this research project. This includes their explanations as to why this number is or is not sufficient to become a “good” acupuncture practicing physician.

In the interviews, it became apparent that most interviewees used “course units” and “hours” interchangeably, despite the fact that one course unit is actually 45 minutes. This interchangeability, however, might be connected to how the term “hour” is generally used in the German language with regards to the educational system. For example, already in the

pre-University educational “one hour” of a school subject actually refers to a teaching unit of 45 of 50 minutes.

It is also important to note that there has been a recent policy change in 2012 in the ÖÄK regarding the required time, which increased the number of teaching units necessary to complete the diploma. Before this change, only a total of 140 teaching units were required. In the policy change, the required practical hours were significantly increased.

Due to both the interchangeability of term “hour” and “teaching unit” in the German language, and the recent change in the number of teaching units required, different interviewed physicians mentioned varying numbers of hours needed to complete the diploma. These statements concerned both what the physicians think the requirements currently are, and which requirements they themselves had to meet when they completed their acupuncture course in the past. The factors mentioned above obscure the extent of knowledge the interviewed physicians possess about the time the diploma requires. Furthermore, if a physician participated in this course a long time ago, they cannot be expected to remember in detail the make up of the program. Nonetheless, some confusion was evident even in those physicians teaching the course currently. As one of them said, when trying to argue that the increase in teaching hours was vastly unnecessary: “I dare to say, because I have been teaching these courses for 20 years, what we have now, with 250 hours, is actually a lot already. 140 were also okay.” # Yes? # Yes.” (Rainer Kluger) Here, the interviewee is using his own close proximity to the ÖÄK acupuncture program – being one of its long-standing teachers – as an asset in being in a position to make a negative judgment regarding the recent change in requirements in completing the program. Interestingly enough, in doing so, the interviewee referred to an incorrect number of current teaching units or hours.

Out of five physicians interviewed, only one used the correct number of hours in the ÖÄK program, even referencing that the changes in the course requirement occurred gradually from 120 hours, to 140, to 200 currently. She furthermore reflected on the difference between hours and teaching units, and the fact that one has to consider this difference when converting one to the other. (Michaela Bijak)

6.3.1 Changing Times: Adapting to International Standards

Most of the interviewed physicians agreed that the recent change in the course program was unnecessary, or at least not particularly beneficial, though the reasons given for this opinion varied. (Rainer Kluger, Kurt König, Michaela Bijak, Daniela Stockenhuber) Despite having

strong views on the subject, when asking the interviewed physicians about what reasons they suspected led to the adding of hours, their answers were surprisingly vague. Kurt König, for example, spoke of an “assimilation” to international standards that was deemed necessary, but did not go on to specify by whom, adding: “Yes, with regards to this I am already a bit too far away from politics (...) What exactly the underlying causes were, I can only say a little about it. But ultimately, the reason was some pressure, because, in the European comparison, there are simply more hours. (...)”, adding that he “personally didn’t think it was necessary.” (Kurt König) König also pointed to the fact Kluger might be able to provide more insight on the subject (Kurt König), as Kluger was currently more involved with the teaching process of the ÖÄK, but Kluger had not provided more details on the question in his interview. Michaela Bijak, when asked the question of why the hours were upped, answered: “I don’t know. That was certainly also a political decision. A team of the Board of Physicians, I think the Academy of Physicians, issues this diploma, they thought you need more educational hours in order to reach the diploma now, but what motives there were, I can not really say.” (Michaela Bijak) Interestingly enough, Bijak refers back to the Academy of Physicians, of which both König and Kluger are members, saying they might have more answers as they are the ones issuing the diploma.

When seeing the different Austrian acupuncture institutions and its members and an interlinked network, there seems to be a system of pushing away responsibility for the (mostly unpopular) changes in the scope of the course program. Interviewees refer to vague, not further elaborated “political motives” and “outside (political) pressure” to make these changes. Who was the initiator of this pressure – which, after all, was apparently strong enough to make some considerable changes – remains, however, opaque. Furthermore, the party responding to this pressure by making the changes is not explicitly mentioned in any of the interviews, despite questions addressed directly regarding this issue. An interviewee said the “Academy of Physicians” (Michaela Bijak) initiated this change, despite the fact that a total of three acupuncture organizations are directly involved in the education leading up to the ÖÄK diploma, one of which is the organization she herself is a crucial part of.

The theory of the acupuncture organizations responding to an outside pressure, which might have been expressed directly or indirectly by international colleagues, is likely. It could be an explanation as to why even those physicians directly involved in making policies regarding acupuncture education are critical of these recently taken measures. Course requirements in other countries were mentioned in the interviews on several occasions, e.g. Kluger referred to acupuncture education England and the USA with up to a thousand hours (Rainer Kluger), König also mentioned the “acupuncturists” in the USA with extensive course

programs (Kurt König), and Stockenhuber and Bijack both referenced the intense education of healing practitioners in Germany (Daniela Stockenhuber, Michaela Bijak). All of these examples refer to acupuncture education systems, which according to the interviewees, are more elaborate than is the case with the ÖÄK diploma. Since the physicians are nonetheless convinced that the ÖÄK education was a good and sufficient program, the theory is supported that the course was intensified primarily to defend the niveau of the Austrian program against outside criticism.

Chen, educated in acupuncture in both China and Austria, adds further insight as to the length of the acupuncture education in Austria in an international comparison. When asked about the differences in her experiences in both studies, the amount of time necessary to become certified actually came up as the first and main point she mentioned. “They (the acupuncture education in Austria and China, remark) are very different. In China, normally in China, if one studies TCM, if one wants to become an acupuncture physician, one has to do a TCM-Degree. Yes? These studies IN THEMSELVES take five years. Yes? Afterwards, after the studies one has to still work at least one year in the hospital, that’s the practical year, only after this you can practice. Okay? And in Austria, of course, if one has been educated in General Medicine, one doesn’t have to learn all of that completely, but here (in Austria, remark) one doesn’t learn (...) nearly enough. With 120 hours, I think 100 of them are theory, 20 practice, that’s much too little. Yes? And of course regarding the time frame, one has 18 months to learn that¹⁵. Only that is, yes, speaking from my experience that is too little regarding basic knowledge.” (Chenfein Chen)

6.4 Pinpointing Understanding: The Debate of Skill versus Philosophy

As described above, there are vast differences in what is considered enough time to be properly educated to practice acupuncture, both amongst the people interviewed for this study, and worldwide amongst experts on the topic. This chapter tries to explain how these different time frames are justified through the frame of what acupuncture education is expected convey to its students. Questions not only about the time frame for acupuncture education, but also about its contents and focus points are strongly linked to the understanding not only of how acupuncture is to be taught, but also to how it is to be practiced; to the understanding of acupuncture per se.

¹⁵ Dr. Chen is referring the first version of of the ÖÄK acupuncture diploma education, which, in fact, required 120 teaching units to be completed over a period of 18 months.

A dichotomy generating disagreement about this question is the debate of the necessity of possessing acupunctural skills, versus understanding the philosophy underlying acupuncture. Is it sufficient to be able to place needles correctly to the benefit of the patient's condition, or does one have to understand the reasons behind placing the needle in a specific way? Is one even possible without the other, and to what extent? How does this dichotomy – if it even is to be understood as such – shape the perception of the human body that acupuncture is performed on? And which role does language, and possible cultural and paradigm-based differences it is shaped by and, in turn, shapes, play in intensifying the debate? Thus, this chapter aims to open the black box of the hotly debated opinions regarding the time needed to learn (to do) acupuncture.

6.4.1 The Relation of Theory to Practice, and Acupuncture to TCM

The dichotomy described above often was mentioned in interviews, coming up in different contexts and used to argue various points of opinion. Interestingly, what the interviewees universally agreed upon was that a theory-practice-divide in acupuncture is feasible. This divide is applicable to two levels, namely that of acupuncture practice, and education, though the differentiation is more pronounced in the latter¹⁶. (Kurt König, Michaela Bijak, etc.) As the schedule of the ÖÄK special diploma shows, the hours needed to complete the course requirements are split into theory and practice units. The taught theory includes lessons on the “Scientific foundation of acupuncture, classification of the points and meridians, physiology and pathophysiology in Traditional Chinese Medicine, techniques of acupuncture, (and) nutrition.” (URL 1) As can be seen by the names of some of these lessons, it becomes clear that the acupuncture taught here was adapted to fit within a biomedical paradigm, and demarking it from “non-scientific” acupuncture. Barnes describes a similar process taking place in the USA, where the Higher Education Coordinating Council

¹⁶ What should be noted at this point is that the German word “Ausbildung”, which is used throughout the interviews to describe acupuncture education, is a rather broad term, stretching to include the transfer of knowledge, as well as a practical training. It can mean education (for trades, professions, etc.), but also schooling, (practical) training, or even an apprenticeship. Thus, it was not always initially clear which aspects of this broad term the interviewees were referring to when speaking of acupuncture “Ausbildung”, and other indicators throughout the interviews had to be used to identify the interviewees’ standpoint on the subject; to see which aspects of the term they valued or emphasized the most.

demanded that more biomedical disciplines be added to the curriculum. (Barnes, 2003) However, in Austria this approach was done voluntarily, rather than being forced by outside institutions.

As the interviews conveyed, structuring the acupuncture lessons for physicians in this way was done strategically, so their paradigms would not be questioned to a point where they would reject acupuncture, rather than embrace it. Bijak, responsible for scientific publications for the Austrian Society of Acupuncture, clearly stated that acupuncture courses for physicians were adjusted accordingly: “We try to convey a medical view of acupuncture, if I may say so. (...) One has to reach out to medically educated physicians, by not beginning immediately with the philosophy of Chinese medicine, but rather build upon studies that were done around 1970, in order to explain how acupuncture works, and this is compliant to what one hears while studying (at a medical university). To really be presented the hard facts of what acupuncture can do and how it works.” (Michaela Bijak)

Thus, a line is drawn not only between acupuncture and other forms of complementary medicine, but also within acupuncture practice, emphasizing that not all acupuncture is created equal: “scientists distinguish their doing from others “institution of science”: to its practitioners, methods, stock of knowledge, values and work organization” (Gieryn, 1983) Thus, the acupuncture learned in the course of the ÖÄK special diploma is classified as “scientific”, implying that other acupuncture courses, and practitioners having undergone them, practice a form of acupuncture less compatible with a sensible, biomedical world paradigm.

Furthermore, it should be noted that some of the lessons labeled as “theory” actually concretely prepare for the practical applications of acupuncture already, as the points that will be punctured are taught (URL 1), rather than going into the details of the theory that gives reason to these points. What was referred to as the broad term of “theory” in the empirical material used for this study actually turned out to include a vast range of partially opposing, or at least varying, definitions, and these differences in using the term have to be reflected upon in order to understand what medical personnel truly mean when speaking of “theory”. Two main lines along which the term can be differentiated are what I would like to refer to as “practical theory” and “philosophical theory” of acupuncture. It is self-evident that some practical theory is needed before practicing on a human subject, as medical personnel need to know where and how to puncture a patient. Thus, practical theory is a way of teaching a skill, or know-how, before allowing students to actually perform acupuncture for the first time.

However, the importance of the philosophical theory, meaning the teachings explaining the meaning behind practical theory, often by using texts from the cultures acupuncture originated from, is highly debated. In other countries, such as Norway, including teaching content of this kind seems to be standard practice, as Sagli points out, adding that learning philosophy even was a requirement before engaging in any type of practical acupuncture activity: “Typically, as in the three final cases, the students learned about specific meanings of jingluo as part of the knowledge required to perform acupuncture as a practical skill.” (Sagli, 2010) Chen, an acupuncture practitioner educated both in China and in Austria, said that far too little theory, especially philosophical theory, is taught in Austria, with basic knowledge for Traditional Chinese Medicine being neglected as well. “Acupuncture *looks* really easy. Therefore, you learn the wrong things, you only learn the points (to puncture, comment), and then immediately to make out a prescription: Which diseases, which points.” (Chenfei Chen) She was not the only one stressing the connection of acupuncture to Traditional Chinese Medicine. Bijak, having previously strongly advocated for the strategy of adapting acupuncture lessons to physicians’ biomedical paradigms, later went on to admit that she ultimately thinks acupuncture cannot be separated from TCM philosophy entirely, and therefore should also be taught to physicians, though perhaps not at the very beginning of the course, so as to ease them into the subject. (Michaela Bijak)

Bijak is, amongst other responsibilities, also in charge of publicizing findings on acupuncture in the “German Journal for Acupuncture and Related Techniques”¹⁷, one of the most renowned journals for acupuncture and Traditional Chinese Medicine in the German language. The two Austrian organizations partaking in the journal are the Austrian Society of Acupuncture, whose interviewees were Stockenhuber, Bijak, and Richart, as well as the Austrian Scientific Physicians Association for Acupuncture, represented by Kluger and König. Both organizations contribute to the journal on a regular basis, and the journal was mentioned repeatedly in the interviews as a way of communicating scientific findings regarding acupuncture among acupuncture organizations, physicians, and even patients. Thus, I would argue that most of the interviewees accept the “German Journal for Acupuncture and Related Techniques” as obliging to good scientific practice, especially since Thomas Ots, vice president of the Austrian Scientific Physicians Association for Acupuncture, functions as an editor in chief.

When examining the content of several editions of this journal, however, it becomes apparent that acupuncture is not its only subject. Without going into an in-depth analysis of

¹⁷ Deutsche Zeitschrift für Akupunktur (DZA)

the journal, its recurring categories include not only “acupuncture”, but also topics such as “herbal therapy”, “Traditional Chinese Medicine and Acupuncture” and “dietetics”. (Ots (ed.) (2012 – 2013) Interestingly, the German title of the Journal could be directly translated to mean “German Journal for Acupuncture”, yet the English translation chosen was augmented to include the “Related Techniques”, as well. It might be too speculative to interpret possible deeper meanings underlying the choice of the journal’s name. However, the official English title is more suitable when viewing the content, and even the advertised editorial pieces, of the journal. For example, one editorial piece was called “Pathogenic spiritual beings – aspects of demon medicine in China, German Journal of Acupuncture and Related Techniques” (Ots (ed.), 2012/1), another ““Doctor, will you read the old buddhist (sic!) scriptures to me?” Integrating psychotherapy into current practise (sic!) of traditional medicine in China”” (Ots (ed.), 2012/3). These journal articles adhere strictly to formal standardized principles of scientific publishing, and were written by members of what is accepted to be the scientific community. This, according to Busch, is a key way in which expertise reinforces itself. (Busch, 2001) However, some of the journals’ content forms a stark contrast to the clinical, highly medicalized and standardized process of placing needles in the right spots, which is described by some of the interviewees as being the golden standard of medically sound acupuncture. (König, Kluge) The analysis of the journal showed that amongst acupuncture practitioners in the German speaking area, the extent of philosophical theory perceived as necessary for good practice varies greatly. Two of the main acupuncture organizations in Austria, both of which publish in the “German Journal for Acupuncture and Related Techniques”, seem to be leaning towards the side which argues for only little philosophical acupuncture theory.

The Austrian Society for Acupuncture, to which Bijak, Stockenhuber and Richart belong, seems to be slightly more moderate in their tolerance for or even encouragement of (some) philosophical theory. (Bijak, Stockenhuber) This careful plead to include a little philosophical theory, or the theory embedding acupuncture in or connecting it to TCM, is highly criticized by some of the other interviewees. Interviewed members of the Austrian Scientific Physicians Association for Acupuncture, namely König and Kluger, tended to be more critical of a theoretical approach to teaching and practice. König, an educator for the Austrian Scientific Physicians Association for Acupuncture, even went so far as to argue against learning (philosophical) acupuncture theory because, according to him, some of it is not just unpractical, but simply incorrect: “Acupuncture emerged by someone observing something, yes? And then, over the course of time, some theories developed to explain it, so it can be assumed that there are certainly also things that probably aren’t correct, of the theory, yes? But, yes, that’s just the way it is, right?” (Kurt König) However, it should be

noted that the same could be said for biomedical medication, as König added, where substances showed an effect and are used in this context, without always having been designed to fulfill this function, or being fully understood in how the function is achieved. “We are much more efficient with (teaching) theory than in China.” (Kurt König) This, of course, poses the question of the deeper meaning of the concept of “efficiency”, because, as Barnes states: “By its very definition, efficiency’s meanings remain fluid, their particularities contingent on context.” Barnes explains that biomedical paradigms often merely use medical symptoms, or lack thereof, as a referential framework for considering a treatment’s “efficiency”, rather than inquiring if the patient feels better as a whole being; mentally, emotionally, spiritually, and physically. Barnes claims that some forms of Traditional Chinese Medicine aim to meet all of the needs mentioned above, and is only considered “efficient” when they are met. (Barnes, 2005) On the other hand, “efficiency” might depend on the patient being pain or symptom free, according to how acupuncture should be taught in König’s view, and perhaps philosophical theory is less relevant in such a framework of judging what is not only efficient teaching, but also efficient acupuncture treatment.

Rainer Kluge, educator and president of the same acupuncture organization as König, essentially agreed with him, though he argued in a different way, saying that endless theory education merely delays getting to the most essential part of acupuncture education, which, in his view, is practicing on patients: “Because one has to also start at one point. You can’t just keep going to educational courses and educational courses, and when you start, you keep learning and we teach our youth what to start with and that they should do so with appropriate self criticism and modesty and then they automatically learn everything else; it doesn’t all have to be done sitting on a school bench.” (Rainer Kluger) Kluger, however, failed to reflect on what might happen if physicians lack the presumed self-awareness with which they should approach their patients when gaining first experience with practicing acupuncture. Furthermore, it was unclear how everything will be “automatically learned” if there is lacking supervision while doing acupuncture, and therefore no sufficient feedback loop to ensure improvement.

What König and Kluger label as “efficiency”, refers to teaching practically applicable theory, while leaving out the philosophical dimension of it almost entirely, which is exactly what Chen and others criticized about acupuncture education in Austria. Despite this criticism, arguing for less (or even no) philosophical theory in acupuncture education stems not from intended carelessness, but rather from a different notion: the idea that extended practice can compensate theory. One of the differences between two of the main acupuncture organizations lays exactly at this gap of opinions: While the Austrian Scientific Physicians

Association for Acupuncture advocate for the vast importance of experience value over the neglectable philosophy (Kurt König, Rainer Kluger), the Austrian Society of Acupuncture believes that at least some of philosophical theory – though adapted to physicians – can be considered beneficial for being able to approach the practical aspects of acupuncture. (Michaela Bijak, Daniela Stockenreiter) Chenfei Chen, on the other hand, being a key member of the Chinese Physician's Community for Acupuncture, advocates for truly delving into the philosophical theory of acupuncture, but also Traditional Chinese Medicine in general, as an absolute prerequisite for truly being able to meet patient's needs through acupuncture practice. (Chenfei Chen) Gieryn reflects on this range of opinions regarding the relation of theory to practice with regards to scientific research, saying: "There is, in science, an unyielding tension between basic and applied research, and between the empirical and theoretical aspects of inquiry." (Gieryn, 1983) Thus, varying opinions on how much, and which kind of theory acupuncture needs, can ultimately also be seen as a way of acupuncture organizations distinguishing and demarking themselves from others.

Despite this heated debate on theory, an absolute consensus was found, surprisingly, amongst the interviewees regarding acupuncture practice. If there was any (self-)criticism on acupuncture education in Austria, this was often the subject of it. There was agreement on the fact that the practical experience offered e.g. in course of acquiring the ÖÄK special diploma is not sufficient to become an excellent acupuncture practitioner. Some interviewees stated that this might be a reason to extend the course to include more supervised practice, or at least make good use of what was seen as an imposed increase course hours that recently took place. Bijak, for example, stated that she was very lucky to have a teacher who offered additional, though voluntary, practical lessons in which he gave feedback and input. (Michaela Bijak)

The interviewees arguing more vehemently against the recent change in policy regarding the course length, however, were of the opinion that additional, though needed, practice should not be included in the curriculum of the course. Rainer Kluger, for example, compared an acupuncture course to acquiring a driver's license, saying that one will not be a "racing world champion immediately", but one could "safely get home". Transferring this metaphor to acupuncture, Kluger stated that "the most important medical indications can be treated" "sensibly" on one's own. (Rainer Kluger) Advocating against extended practice time in the acupuncture course thus is based on the assumption that medical personnel has to merely be taught to practice safely, which is a neglectable criterion due to their prior education in the medical field: "We start with an extremely well-informed level and with this, starting from this level, we again go into this special direction of Chinese medicine." (Rainer Kluger)

Therefore medical personnel have merely to become mediocally proficient during the acupuncture education course, and then continue to learn on their own. That this process of continued learning by doing takes place on patients perhaps paying for more than a “sensible” acupuncture treatment was not reflected on by advocates of this approach.

However, it is also important to look into the reasons additional practice is not, or can be, included in the course. Some interviewees suggested this is not due to students’ unwillingness to practice acupuncture under supervision to gain experience, but also for the lack of opportunities to do so. Chenfei Chen explained that she regularly gets requests from acupuncture students to do (unpaid) internships with her in order to profit from her knowledge, but she is not able to meet these requests. After all, patients receiving acupuncture treatments are paying for them without public insurance coverage in most cases, and therefore expect to be met with the privileges they associate with private medical care, which do not stretch to include students being present and taught during their treatments. (Chenfei Chen) This problem of lacking patients for acupuncture students to practice on seems to also have been recognized by the Austrian Scientific Physicians Association for Acupuncture. Though key members of this organization denied that more practice is needed in the ÖÄK special diploma course, their website offers an opportunity to fill the void that is left by said course. Concretely, the organization offers special educational trips for physicians during or after the process of completing the ÖÄK course. The aim of these trips is to take physicians to clinics in China, where acupuncture is regularly used as a treatment form on large numbers of patients for a great variety of medical conditions. There, on a voluntary basis and at their own expense, the physicians receive the opportunity to get the practice they need, but was apparently not, after all, covered by the ÖÄK course. (URL 4) Interestingly, none of the interviewed physicians from this organization mentioned these trips, though both of them said they themselves had spent time in China. This could be due to the fact that they were defending not only the quality, but also the quantity, of the Austrian acupuncture education for physicians, and the study trips to China could question these statements. Not only the quality of acupuncture treatments offered by physicians who did not opt for such additional training, but also the respect towards patient agency (Lin, 2012) of the subjects (paying) Austrian doctors were practicing on in Chinese hospitals, was not reflected upon.

Concluding, I would argue that the reduction of theory, with a strong focus on practice, in the Austrian acupuncture system is a sign of a process of simplification that is taking place. Acupuncture becomes relatively easily doable and learnable as a skill, not a philosophy, and thus can be incorporated into a biomedical practice learned beforehand by medical

professionals. Absolutely all interviewees agreed, to greater or lesser extent, that medical and anatomical knowledge acquired prior to becoming an acupuncture practitioner was beneficial for the acupuncture education, and would cut needed time out of the theory part of the education. (Rainer Kluger, Daniela Stockenreiter, etc.) However, most interviewees took this notion one step further, arguing that acupuncture not only can, but should build on the foundation of medical knowledge, and the seemingly brief process of learning to “do” acupuncture is merely simple because the complex, but necessary, biomedical knowledge and expertise is already given.

For example, König argued that other countries have a stronger focus on the theoretical aspects of acupuncture due to the fact that non-physicians practice it, and they have to found their *raison d’être* on these extended insights, supposedly to compensate for the fact that they did not study general medicine. “In Chinese medicine, it’s like, you can disassemble it into 100 separate parts, yes? From my perspective, this comes to nothing, yes? Because the therapy is the same, yes? There is so little difference, that this does not pay off.” (Kurt König) Linda Barnes makes a reference to this process of simplification regarding the context of Massachusetts, saying: “Having simplified the technique and minimized its claims, physicians then argued that acupuncture was not as broadly effective as was initially imagined, that it posed no significant challenge to the biomedical model, and that physicians were best qualified to evaluate, explain and oversee it.” (Barnes, 2003) No judgment can be made regarding the question of whether more practice is, indeed, able to replace a lack of theory in acupuncture education, or if ongoing patient experience as an acupuncture practitioner trumps recurring further educational courses, as many of the interviewees suggested. However, what can be questioned is the fact that the interviewees also agreed that a lack of practice is a problem in acupuncture education in Austria. Additionally, most physicians and midwives practicing acupuncture do this in addition to, not instead of, their regular medical practice (Kurt König), indicating that they might also lack the ongoing practice required. Therefore, it can be concluded that there are deficits in both theory and practice in acupuncture in Austria, when compared with the states other countries with a different set of policies regulating the matter.

6.4.2 Perception of the Human Body in Acupuncture Practice

In the previous chapter, different aspects of acupuncture theory and practice were discussed, as well as the necessity to engage in them in order to become a good acupuncture practitioner. The next step is to examine how views on the subjects discussed above shape the other aspects of acupuncture, such as the paradigms in which the human body is seen. The process of simplification and medicalization used to make acupuncture

manageable, which was described above, also might lead to a view of reduced complexity when factoring the patient into the equation – at least this is what proponents of philosophical acupuncture theory reproach its opponents for. Chen, for example, argued the complexity of causes for disease in TCM to explain the pitfalls of not teaching them accordingly: “In Chinese Medicine, emotions are part of what triggers diseases, yes? In Chinese Medicine, we have seven different emotions, and every emotion, if it is too much, can lead to a disease.” (Chenfei Chen) Instead of teaching the complex details and implications of these emotions, as would be appropriate, Chen believes that the Austrian version of acupuncture aims for a quick solution to a complex system of knowledge, thus reducing the time needed to learn acupuncture practice: “One learns the totally wrong thing, one learns only the points (to puncture), and at the same time a prescription is being issued: Which diseases, which points. People are not the same. Even patients who come with the same symptoms, the same ailments, they have different causes, yes? That’s the reason why for TCM, for acupuncture, you need a solid basic knowledge, yes?” (Chenfei Chen) Chen clearly thinks that this type of knowledge can and should be taught in acupuncture education, to then be applied in theory, and as it is lacking in the educational process, which she herself underwent, it must also be missing in acupuncture practice.

While this cannot be proven or disproven, what can be said is that other interviewed medical personnel practicing acupuncture also mentioned the role emotions play in the development of diseases. Rainer Kluge, who advocates relatively strongly against intensified teaching of philosophical acupuncture theory, strongly praised model clinics in Germany offering a holistic practice, where acupuncture is offered along side Western medical treatments to combat a set psychosomatic symptoms. (Rainer Kluge) “And in these cases acupuncture is massively in the rise, because it is able to take the patient as a whole and translate this into a path of treatment. (...) The holistic aspects of acupuncture are comprised of not only seeing the physical and the psychical of the patient, but that the Chinese theory and the Chinese medical teachings can concretely do something about such combined diseases.” Kluge argues that acupuncture is a better fit for some of these “combination diseases”, as he calls them, because Western medicine is split up into different professional disciplines, thus failing recognize the patient as whole.

Thus, Chen argues for different sets of emotions causing diseases, and those emotions lead to a diagnosis that will decide which TCM or acupuncture treatment is appropriate. Kluge, on the other hand, wants to use acupuncture to treat negative emotions alongside physical symptoms, as there is a correlation between the two. While these two approaches of factoring in the psyche of patients into acupuncture are by no means identical, both do strive

to consider the patient in a holistic way, rather than an assemblage of pieces, as they accuse Western medicine of doing. Nonetheless, it could be argued that the approach that neglects philosophical theory is less efficient in treating patients. Here, members of this view argued that this is where “experience value” comes in, arguing that what worked for a number of similar patients with similar symptoms can be assumed to work for others. Kluger claims that he has diagnosed and treated “three football stadiums full of people” in his career, concluding that such experience is extremely valuable, and might trump a few extra hours spent in classes on acupuncture theory.

Nonetheless, opinions arguing for and against the importance of philosophy both acknowledged that the human body has to be seen and treated in a holistic way in order to achieve the best possible treatment outcomes. This could be seen as an example of how Western medicine could profit from the input of acupuncture theory, thus broadening its own perspective in a helpful way. (Rainer Kluger) As Sagli put it: “This encourages us to study how the adoption of Chinese medical therapies contributes to peoples’ perceptions of the body in health and illness.” (Sagli, 2010)

6.4.3 Lost in Translation? The Role of Language in Understanding Acupuncture

It is apparent that the differences of perception of the theory-practice in relation to acupuncture practice and education, as well as in the understanding of the human body connected to it, are rather large. However, this poses the question of how this gap can be explained. One angle that should be examined in this context is the use of language in acupuncture texts.

Firstly, it should be noted that the first written form of knowledge regarding acupuncture was obviously not German, or even a language closely related to it, and thus was by no means relatively easily translatable. Assuming meanings could get lost to some extent in this process of translation, the question arises if it is necessary for acupuncture practitioners to become familiar, at least on a rudimentary level, with the language the acupuncture knowledge was originally written in. In her text “The debate over Chinese-language knowledge among culture brokers of acupuncture in America”, Mitra Emad researches the question of the necessity of acupuncture scholars and practitioners learning (some) Chinese in order to better understand acupuncture’s cultural roots: “Cultural translation transfigures into literal translation for several of American acupuncture’s luminaries.” (Emad, 2006) Though Barnes comes to the conclusion that physicians practicing acupuncture in the USA don’t generally speak or read Chinese, at least there seems to be an ongoing debate of

whether or not it would be beneficial to their practice if they were able to do so. (Barnes, 2003) The same does not hold true for the Austrian context. None of the interviewees saw any benefit in going back to the original texts on acupuncture to retrieve more accurate or detailed insights.

If anything, it seemed more important to retrieve the essence out of the original texts, without being sidetracked by the unnecessarily detailed or descriptive language used within them. König, for example, described the pitfalls some acupuncture practitioners, as well as patients, fell victim to when acupuncture first was introduced in Europe: "(...) things that are relatively worthless, that have little meaning, were especially emphasized, because it had something to do with energy or heavenly or whatever, yes? (...) I don't need all of this fancy stuff, I don't need an energy or something divine or whatever, yes?" This view regarding elements considered an important part of the original teachings of acupuncture, a connection of healing and spirituality, is clearly belittled, even ridiculed, in this quotation. It is seen as an add-on to the "practical" aspects of acupuncture that acupuncture practitioners can clearly do without, and would primarily sidetrack from what is actually to be considered important. Emad states that "when a millennia-old set of medical practices is appropriated from one socio-cultural setting and adopted into a markedly different one, language becomes a core site for cultural translation." (Emad, 2006) However, in the interviews conducted for this project, it sometimes appeared as if no attempt had even been made in Austria to fully translate all the cultural aspects of acupuncture. Bijak stated that she does expect students to be slightly more flexible with language in the acupuncture courses than would be the case in Western medicine, as more "pictures", meaning symbolisms and visual comparisons, are being used to describe processes. (Michaela Bijak) However, the extent of these differences in acupuncture and biomedical language did not seem to be fundamental in the case of any of the interviewees.

Rather than translating an accepted cultural practice, and perhaps adapting it slightly when needed, it seems that a process of sifting through material has taken place when acupuncture was introduced in Austria, in which aspects considered unnecessary have been discarded of and disregarded from there onwards. When asked if acupuncture loses out if terminology is adapted (to medical standards), König simply stated it doesn't. (Kurt König) It appears that the "true essence" had to be "found" and translated in order to make acupuncture medically acceptable: "Biomedicine had no means of assessing the validity of these cultural models", as Wolpe phrases it. (Wolpe, 1985)

Examples of such of a translation of paradigms, as much as language, were described by König and Chen. König used the example of "perverse chi", as described in one original text

on acupuncture, adding that this does not make much sense in a biomedical use of language. Chi is often translated as “energy”, and what a “perverse energy in the stomach” might imply remains opaque. König therefore suggests translating “chi” with “function”, rather than with “energy”, and using “reverse”, rather than “perverse”. (Kurt König) Thus, a reverse stomach-function becomes vomiting, a term well established in the biomedical context. In this case, a translation had to be found to match biomedical language, in order to avoid confusion. Essentially, however, König claims that “vomiting” was actually what was meant by the original text, but this meaning was lost in translation by sticking to the exact phrasing of it. König thus holds the opinion that translating original acupuncture texts is even more about correct interpretation, rather than merely correct translation. (Kurt König) Medical conditions, especially ones as common as vomiting, are strictly defined within the medical context. While their treatment might allow some flexibility, stretching to include acupuncture, the aim to change the definition of the condition itself might not seem feasible: “Terminological standards, such as the International Classification of Diseases, ensure stability of meaning over different sites and times and are essential to the aggregation of individual elements into larger wholes.” (Epstein/Timmermans, 2010) By interpreting the language used by original acupuncture texts to fit the definition of a condition, as described by König, might open up the option of introducing acupuncture as its treatment. A similar example is described by Sagli using the word “jingluo“, a very common term in acupuncture texts often translated with “meridians”, a translation which cannot be transported into the biomedical context. To make “jingluo” more suitable and teachable to physicians, it was sometimes translated as “nerves” or “blood vessels”, but Sagli clearly states that this translation was much too reductionist to fully convey “jingluo’s” original meaning. (Sagli, 2010) Thus, what seems as a fitting translation when viewed from the point of a biomedical paradigm might actually prove to be a compromise in order to make it more understandable.

However, there is also the case when interpretation per se is not necessary, but rather using the most fitting translation of a word amongst several options. A common term used in acupuncture texts is e.g. that of a weakness of the kidneys, which entails an overall condition the patient is in, and might or might not indicate kidney problems amongst a range of other symptoms, with an actual involvement of the kidneys as organs not being the determining factor. König describes this term originally being translated with kidney “deficiency”, rather than “weakness”. When acupuncture practitioners then went on to claim being able to cure a kidney deficiency on a level of the organs with acupuncture alone, they lost credibility. (Kurt König)

Nonetheless, there are also examples where current biomedical language unwittingly uses terms very closely related to ancient acupuncture terminology. Chen presents a condition described in acupuncture texts in which, symbolically, the “fire was extinguished” in a patient. (Cheinfei Chen) This implies that they overexerted themselves and have no more physical and mental resources left to draw on. In a biomedical or psychological language, this condition is also known, being referred to as “Burn-Out Syndrome”. It is not likely to argue that biomedicine drew from acupuncture texts when first describing this syndrome; rather, it shows that some symbolisms apply cross-culturally.

Even if there are cases of overlapping use of language, as described by Chen, it appears that more often than not language is being transported from the traditional, more holistic paradigm used in original acupuncture texts into the paradigm of biomedicine. In this process, the language is both standardized and simplified severely, whilst being argued that nothing of essence is lost in this process. (Kurt König) This approach might seem rather radical and disrespectful for the wealth of diverse traditions of acupuncture and the language expressing them. However, when looking into the reasons for opting for this type of translational process, it became clear that a hierarchy of knowledge paradigms was not the only motive of action. Rather, opting to e.g. largely leave out spiritual elements of acupuncture teachings was used strategically to further acupuncture’s acceptance amongst the medical community, being fully aware of the power relations in place. König explains this as follows: “Modern medicine has actually gone through a learning process, yes? And this (elements of spirituality, etc., comment) just doesn’t fit in a scientific paradigm, which we have had for 120, 130 years, and also apply to medicine. Or if you live in a world where science is valid, and where something unbelievable, or esoteric, is less valid, then it is difficult, then you have to speak the language of science, of those in power, yes?” (Kurt König)

Gieryn describes that one of the first methods of demarcation in history was to decouple science from religion or superstition. I would like to argue that cutting out seemingly spiritual elements from the language used to describe acupuncture is a strategy for arguing that acupuncture is not founded on so-called “superstitions”, and is not linked to religious practice. Thus, language is used as a tool to draw a boundary between acupuncture and other, “less scientific” complementary medical practices, but also from “non-scientific” acupuncture, as it was, and partially still is, practiced in countries it originates from. Barnes describes a similar process taking place with acupuncture in the USA. One of the issues US American acupuncturists struggled with was that Traditional Chinese Medicine was being associated with or being perceived as deriving from religious practices. Therefore, it was

necessary to promote acupuncture as being entirely unrelated to superstitions in order to place it within the realms of medical practice (Barnes, 2003), which was accomplished in Austria partially through changing the language of acupuncture.

6.5 The Role of Space and Place in Acupuncture Research, Practice and Education

This chapter aims to discuss two dimensions of space and place, and how they relate to the establishment and enactment of policies in the context of Austrian acupuncture. The first “space” refers to transferring acupuncture in a medicalized environment, namely through conducting research and clinical trials in laboratory settings, but also by shifting acupuncture practice to physicians’ offices and hospitals. Thus, acupuncture is bound spatially, as well as mentally, to the practices of Western medicine. While this trend took place worldwide, not merely in Austria (Unschuld, 1987), the implications for the local context shall be discussed. The second sphere opened by this chapter is the “place” where acupuncture is practiced; in the case of this research project, its transferal from countries of original practice, such as China or Korea, to Austria. Place and space are not value free (Bryson et al., 2000), so a special focus point of this analysis shall be the hierarchies of knowledge connected to them, as well as the question of if, and how knowledge is transferrable from one context to the next.

6.5.1 The Acupuncture Brand: Quality Guarantee and Control through Standardization and Medicalization

As described in the State of the Art, many attempts to make acupuncture fit within the criteria of standardization demanded by Western medicine have been made in the present and past, for example by devising forms of double blind or partially blind testing methods in order to rule out placebo effects. (Melchart et al, 2005 / Haake, 2003 / Vincent, 1995) These are, in essence, ways of trying to establish acupuncture’s effectiveness in a way recognized by Western medicine, and consequently those practicing Western medicine, and those seeking it for treatment. Helen Lambert suggests in her article “Accounting for EBM: notions of evidence in medicine” that the outcomes of trials are often not clear or insufficient, or the way trials were conducted does not meet the necessary standards of randomized clinical trials. (Lambert, 2006) Some of the interviewees mentioned the difficulties acupuncture faces when being conducted in the setting of a randomized clinical trial. (Kurt König, Rainer Kluger) König also added that acupuncture trials are costly, as a treatment has to be performed every time the patient comes in, rather than simply giving him or her medicine to

take. (Kurt König) Furthermore, each patient has to be treated as an “(individual) human, not as a collective” (Rainer Kluge), which opens up the question of whether the findings of a trial can be applied to any other set of patients and practitioners. After all, the quality of the acupuncture practitioner participating in the trial might not be identical to those of a practitioner sought out by any patient, especially as one study description says: “Participating physicians were recruited whose qualifications met or surpassed those of physicians currently accredited for providing acupuncture by state health funding agencies in Germany.” (Melchart et al., 2005) Thus, outcomes of trials could be distorted by the fact that the participating physicians are above averagely qualified. As Emad puts it: “Medical practices are often assumed to be immutable, static, and objectifiable entities” (Emad, 2006), but this does not seem to be the case with standardized clinical acupuncture trials.

Despite all of these disadvantageous aspects of acupuncture trials, the acupuncture practitioners interviewed for this project referred continuously to the importance of conducting research in just such a way, and distributing its results. (Rainer Kluge, Gabriele Sprung, etc.) Rather than focusing on their own positive experiences they had when practicing acupuncture, trials conducted by others were quoted to express acupuncture's efficiency and areas of application. Even when explicitly asked for their own impression on the areas in which acupuncture could have the most beneficial effects, some interviewees quickly referred back to research findings: “Luckily, I don't have to make something up; today, this is written down, the indications, they stand firm.”, adding a list of “proven” applications of acupuncture. (Rainer Kluge) Perhaps this method of quoting “scientifically” conducted trials is a sign that acupuncture practitioners still feel more vulnerable to their form of practice being challenged due to its relative marginalization compared to Western medical practices.

This focus on scientific “facts” rather than personal experience is also interesting, especially as many acupuncture studies make a note of participating physicians saying that they would have treated patients differently if they had been regular patients in their practice, rather than trial subjects. (Melchart et al., 2005) As Paul Wolpe points out, referring to the situation in the USA, the increasing demand for research on acupuncture, primarily through the use of clinical trials, was nothing but a way of gaining control over the matter, adding that these trials had questionable impact on the type of acupuncture that was tested: “To (conduct clinical trials that met the “gold standard” of Western biomedicine), the entire theoretical framework of traditional Chinese acupuncture had to be replaced.” (Wolpe, 1985) However, if the type of acupuncture that is tested in trials is changed to fit the boundaries given by standardized clinical trials, it is likely that this also impacts the way acupuncture is practiced

and taught. Thus, adhering to principles of standardization also deeply impacts the things that are being standardized. (Epstein et al., 2010 / Busch, 2011)

As mentioned above, acupuncture is actually only a small part of what is considered Traditional Chinese Medicine, and acupuncture treatment is usually not done alone, but combined with other approaches, such as herbal-based medicine. Yet, this practice of combining TCM approaches is not generally used by physicians in Austria, who tend to focus on acupuncture. One reason for this might have to do with the standardizability of trials to prove efficiency. As one physician said: “The medications, the mixtures, are not as standardized as a needle prick is, and here (with medication) the individual, the uniqueness of the patient is the important aspect.” (Rainer Kluger) It almost appears to be something that cannot reputably be tested in the scope of a clinical trial, and it loses value in practice, as well. It is also interesting that Kluger, an acupuncture teacher and the current president of the Austrian Scientific Physicians Association for Acupuncture, portrays the “prick of the needle” as something that is highly standardized and standardizable, yet simultaneously argues that acupuncture is so effective especially because the individual human aspect is not left out of the equation, as is sometimes the case in Western medicine. This seems contradictory, as standards strongly rely on the unifying and equalizing the diverse.

Some of the interviewees pointed to the importance of the existence of clinical trials not only for the acceptance of acupuncture practice, but especially for the teaching practices of acupuncture to physicians. For example, Bijak, responsible for publications for the Austrian Society for Acupuncture, said that in the early days of teaching acupuncture to physicians in Austria, the very first trials that were published on acupuncture around the 1970s played a crucial role in convincing students that acupuncture was relevant in terms of Western medical practices. (Michaela Bijak) Kurt König added that before such trials were conducted, acupuncture teachers had to use general “known neurophysiological data or knowledge” to explain how acupuncture works. (Kurt König) Thus, the functionality of acupuncture was explained using biomedical language from the very beginning of standardized education on the subject.

Here, a difference can be noted in the case study described by Linda Barnes in her article “The Acupuncture Wars: The Professionalizing of American acupuncture – A View from Massachusetts”, about the method used to establish acupuncture as being located within the realms of biomedicine. Over the course of time, the various forms of being educated in acupuncture practice in the United States of America increasingly resembled biomedical training, thus making it comparable to other medical practices, as well more standardized. This was done by teaching courses unrelated to acupuncture, in the scope of training to

become acupuncturists. (Barnes, 2003) In the Austrian case, changing acupuncture education in this way was necessary to a much lesser degree, as a standardized, regular medical education is needed prior to obtaining an acupuncture degree. Therefore, the mindset of medical practitioners, which was trained prior to the process of being educated in acupuncture, is brought into complementary medical courses, which is then perceived from this viewpoint. As the people teaching acupuncture in Austria are also located well within the community of physicians, acupuncture education is taught through this paradigm, and an adaption of acupuncture education to increasingly fit within this paradigm was only necessary in the sense that new knowledge is linked to the already existing paradigm.

Seeing the state of recognition of acupuncture in Austrian society as it is today, the method of linking acupuncture to biomedicine through clinical trials and education seems to have been highly successful. However, I would argue that not only the strategy itself was the reason for this success, but also the group of people pursuing it. As described in the chapter on the history of acupuncture in Austria, physicians actively worked to gain an almost exclusive right to practice acupuncture on a soft policy level. Although there is no legal system in place to punish non-physicians who practice acupuncture, standardization and medicalization in research, education, and practice of acupuncture have driven non-physicians into a highly precarious situation in the view of the public. After all, the language used by the interviewees did not differentiate between “illegal” acupuncture practitioners, who are simply unable to obtain a license in the current policy system despite being capable, and those who are actually un(der)trained or un(der)educated and could therefore possibly pose a threat to patients.¹⁸

Therefore, capability of practicing acupuncture correctly and beneficially, and having access to a policy permission to do so, is implicitly equated. When inverting this line of argumentation, the message being sent is that those excluded from the permission of practicing were exempt for good reason, rather than a policy oversight, or perhaps even an inadequate policy system. This not only enforces the policies in place, but also sets a certain standard for acupuncture practice in Austria. Within this policy system, in which only medically educated personnel with additional education in acupuncture are licensed to offer acupuncture treatments, acupuncture is transformed into a highly medicalized method, positioning it closely to other medical processes through the regulation of education and practice. (Clarke et al., 2003) By only allowing medical personnel to provide acupuncture, acupuncture is established as essentially *being* a biomedical treatment method.

¹⁸ The actual scope of this threat will be discussed in the chapter “Side Effects? The Role of Risk in Justifying the System”.

Once acupuncture is established as a medical treatment, numerous possibilities are opened, both for acupuncture itself, and for the people practicing it, especially by gaining recognition through state institutions as being located within the realms of biomedicine: “What is significant here, though, is that the vital importance of public health always kept open to the profession of medicine a privileged conduit to governmental backing for its monopolistic claims.” (Larson, 1977) Thus, it is not surprising that the Diploma Guideline of the Austrian Board of Physicians stresses this official recognition by the state and its bodies: “The question of to what extent acupuncture can be seen as a scientifically accepted method of treatment is, in principal, affirmed by the Medical Consultants (Sanitätsrat). The efficiency of acupuncture is documented objectively.” Interestingly enough, the description of the possible applications of acupuncture is, however, limited in the text: “(...) especially in the field of analgesia. Furthermore, this healing method can be labeled as scientific when limited to the group of diseases regarding bones, joints, and soft parts – the rheumatic spectrum disorder in the most broad sense.” Barnes describes a similar approach of “limiting the claims” of acupuncture, as to not make it appear as a threat to the established Western medical system. (Barnes, 2003) Despite the claims of acupuncture’s use having been minimized, the Diploma Guideline goes on to stress exactly who should be practicing acupuncture in Austria: “It is important that acupuncture only be practiced by physicians trained accordingly.” This part of the Diploma Guideline might be the opinion of the group of people who wrote it, but it cannot be considered as factual in the sense that only physicians have acquired permission or a legal basis from which to practice acupuncture. As shown above, midwives absolutely have the right to practice acupuncture, though only in the limited timely space defined by pregnancy and birth. Even beyond the exception of midwives, other groups of people loosely connected to the medical field also seem to be practicing acupuncture without any legal consequences. However, when reading the Diploma Guideline, it almost appears as if anyone practicing acupuncture not having acquired a medical degree beforehand is breaking the law, and subject to punishment. Seemingly official documents, such as this one, take the place of any legislative foundation for disallowing non-physicians to practice acupuncture. Thus, a set of believed policies is formed merely by claiming or implying to have legal grounds for implementing it. Larson warns that: “State sponsorship, in short, is not sufficient to give a profession autonomous control over all its potential markets. In the best of cases, state sanction can eliminate competitors, but it cannot force consumers to consume, except in minimal and routinized areas (...).” (Larson, 1977) However, this “elimination of competitors” seems to have worked fairly well in the Austrian context, and an informal “negotiation of cognitive exclusiveness” (Larson, 1977) seems to have taken place through publications such as the one mentioned here, as well as the messages that are being sent through them.

The Diploma Guideline goes on to not only limit the medical conditions for which acupuncture may be used, but also the extent to which it should be used within these conditions: “There is agreement on the fact that a diagnosis according to the rules of modern medicine must be made prior to practicing acupuncture. Only then is the decision to be made, whether one of the methods of modern medicine, or additionally acupuncture, or, in isolated cases, exclusively acupuncture, is indicated (as treatment).” (URL 3) The last part of the text, indicating that acupuncture should barely ever be used as a substitute to Western medical practices, was also referred to by some of the interviewees, using the term “cross-over approach”. (Rainer Kluger) According to this interviewee, using the strategy of “cross-over”, rather than pushing for acupuncture to replace standard forms of biomedical treatment, proved to be highly successful in creating cooperation with organizations outside of the acupuncture community. As an example, he gave the Austrian Headache Association, which is now open to accept acupuncture as one of several possible treatment forms for tension headaches.

In conclusion, limiting the group of people who can practice acupuncture, the medical conditions it can be used to treat, and the importance of being used for these conditions, ironically proved to be a great strategy to generate a greater acceptance of acupuncture within the medical community.

6.5.2 Acupuncture in Austria and China: A Hierarchy of Place

As an opening remark to this subchapter, I would like to point out that acupuncture originates and was developed in a multitude of countries and cultures, as was discussed in the introduction to this thesis. China thus was only one of several countries which developed acupuncture to what it is today, though some claim this is where it originate from in the beginning. Nonetheless, a binary comparison between Austria and China was chosen for this analysis. This does not imply a judgment of which country of culture has a right to claim the origins of acupuncture. Taking this path was more of an analytical tool - it was done merely because it mirrors the information and opinions given by the empirical material, which strongly focuses on China as the country TCM, including acupuncture, originated from.

In her case study, Barnes describes that there was a phase in the development of acupuncture education in the United States of America when a teacher from Mainland China was considered as offering the best possible prerequisite for this function. This trend partially continues until today, with teachers educated in, and preferably also originating from China being seen as having guarantee of “authenticity” and playing the role of “knowledge brokers”: “Their identities (of acupuncture practitioners from China teaching in the USA) is

also shaped by how European American students perceive them. These students often want reassurance that they are receiving the “highest teachings”. (Barnes, 2003) While this notion brings its own set of questionable prejudices to the table, it should be noted that this view described by Barnes is in stark contrast to the findings of this study. If anyone does believe in Chinese acupuncture practitioners being advantageous for the treatment, it is the patients, rather than other physicians, as Chen points out, adding that nationality or origin can by no means be correlated, positively or negatively, to competence. (Chenfei Chen)

Other interviewees supported this view, but took a it yet step further, by implying that Chinese (educated) acupuncture practitioners might actually make worse teachers due to overemphasizing philosophical theory of acupuncture (Kurt König), as described in the chapter: “Pinpointing Understanding: The Debate of Skill versus Philosophy.” As mentioned above, several key players of acupuncture in Austria feel that original philosophical acupuncture theory is not up to date with modern standards of medicine, and not needed to efficiently practice acupuncture. While this is debatable, what should be noted is that they do not portray this “excess” information merely as unnecessary or inefficient in the use of time, but rather even as hindering in understanding the “true essence” of acupuncture. Thus, it is implied that acupuncture adapted to fit into biomedical standards is actually a superior form of acupuncture, and the language used to transport this notion was, at times, rather disparaging. (Kurt König, Daniela Stockenhuber) This seems counterintuitive especially as the same acupuncture organization some of these interviewees teach for offer students to participate in study trips to learn in China, and the interviewees themselves have spent an extensive time studying there. (Kurt König, Rainer Kluger)

However, claiming that one country offers better acupuncture teaching than the other was not one-sided. Chen, when asked about how the method of teaching acupuncture in Austria compares to the one in China, she answered: “It’s entirely different. In China, if one studies TCM, if one wants to become an acupuncture doctor, you have to do TCM studies. Yes? These studies ALONE take five years, yes? Later, after the studies one has to work in a hospital for at least a year, that’s the practical year, then one is allowed to practice. Okay? And in Austria (...) one does not learn enough (...).” (Chenfei Chen) She then went on to criticize that many acupuncture students start to practice “blindly” after completing their course, and that she would strongly recommend spending time in China to “see how one treats (patients) decently and thoroughly¹⁹ there.” (Chenfei Chen)

¹⁹ The German word used here was “ordentlich“, which means “neat” in a strict sense of the word, but was used colloquially in this context, and thus translated with

This last comment was made in a way portraying the Austrian acupuncture education in a very poor light. However, it should be added that not only physicians educated in China claim they profited greatly from this experience, but also that acupuncture practitioners in Austria seem to feel that it would be beneficial for them to study abroad. If this were not so, there would not be a market for study trips organized to China by the acupuncture organizations. (URL 4) Barnes describes that in the USA, Traditional Chinese Medicine is seen as superior to other forms of similar alternative or complementary medicine, but that this did “not prevent anyone from studying other systems; it merely added the inconvenience of also having to take TCM exam-preparation courses.” (Barnes, 2003) It seems that a similar trend holds true within acupuncture in Austria. While every physician has to undergo the standard of the ÖÄK special diploma, some physicians do feel that they would like additional, or different, education as well, and do so despite extensive efforts and expenditure.

Chenfei Chen gave interesting insight of how hierarchies of place impact everyday decision making processes, and how messages of hierarchy are subliminally transported through institutional practices. As mentioned above, Chen was fully educated in Western medicine at the University of Vienna. Afterwards, she went on to study to become a Traditional Chinese Medicine doctor in China, a process that required five years of full-time study, making it an only slightly shorter process than the education she received in Austria. However, upon returning from China, Chen found that she was not allowed to practice acupuncture despite her extensive training. Initially, she was told that her education in China had to be acknowledged by the Austrian Board of Physicians, and she would then receive a formal license through the process of recertification. In order to receive this acknowledgment, an extensive description and translation of all the education she had completed in China was necessary, and she started handing in the required documents. However, in the end, she was told that her education would not be accepted instead of the ÖÄK course and diploma, as the education she received was unfortunately not compatible. According to her account, Chen even volunteered to participate in the examination at the end of the ÖÄK course alongside the other students, in order to demonstrate her knowledge and skills of acupuncture. Nonetheless, she was told this would also not be an option, and she had to undergo the entire process of completing the ÖÄK course, meaning both theory and practice hours, as well as the final examination, and was only then allowed to offer acupuncture treatments. (Chenfei Chen)

two appropriate words in English to portray the meaning transferred by the interviewee.

Chen most likely received more extensive acupuncture training in China than most students do in Austria. However, this cannot be seen as a guarantee that the knowledge she acquired can be adapted to fit into the requirements of the Austrian acupuncture education system, as each school might have a different understanding not only of how many lessons are necessary to learn, but also which specific content should be taught within them. Knowledge is only partially transferrable and translatable from one context into another, and hours spent in a classroom or clinic might not be sufficient indicators of the set of information and abilities required. It is difficult to devise a method of controlling and measuring equivalence of taught knowledge in a complex and diverse worldwide system of teaching and learning. What is less understandable, however, is that Chen was not allowed to do the final examination, thus proving that her school in China taught her the content needed to pass it. This might be an indicator of the standardized educational system the ÖÄK offers not being flexible enough, and putting their own teaching content above that of other countries hierarchically. Interestingly, the Board of Physicians did not refuse Chen's education upfront, indicating that there is no general rule of every physician having to undergo his or her training within Austria, and a flexible solution could be found if deemed plausible. It would be interesting to see which, if any, courses of acupuncture study from abroad are recognized within the system of the ÖÄK, and if specific places are, consciously or not, discriminated against.

Barnes describes difficulties with recertification from China to the USA as well, but in this case refers to being a recognized biomedical physician. Though some of the theoretical knowledge would have been accepted, they could not have started to practice immediately, but would rather have had to undergo the residency program. Interestingly, practicing acupuncture instead of biomedicine was considered a feasible solution: "some of these China-trained MDs choose instead to take the state and national licensing exams to become certified as acupuncturists, for which they are usually sufficiently prepared by their training in China." (Barnes, 2003) In Austria, this would not be possible, as an acupuncture exam is not sufficient to prove one's proficiency, but having undergone the education itself seems to be a requirement in many cases. This, however, questions the credibility of the ÖÄK exam itself, in a way devaluing it. If passing it does not prove that one is a qualified acupuncture practitioner, it opens the question of transparency of the system. After all, the diploma received after passing the exam is how patients assume and assess their physicians is a competent acupuncture practitioner. There are no previous requirements to the exam, except physically being present during the needed course hours. Thus, an exam that is not sufficient in creating enough proof of competence to be licensed as an acupuncture

practitioner in Austria is the only way for ÖÄK students to show that they are proficient enough in acupuncture practice to be permitted to hold a license.

6.6 Side Effects? The Role of Risk in Justifying the System

The narrative of potential side effects in acupuncture – or lack thereof – was mentioned in different contexts in the course of the interviews. The existence of side effects was used as a reoccurring theme in arguing the importance of exclusively physicians practicing acupuncture, in order to protect patients from harm. This was used often as a knockout-argument: The interviewees firstly established that non-physicians could do harm to patients by practicing acupuncture. Statements like these imply that negative scenarios are unlikely to happen if acupuncture is in fact, done by physicians. When accepting this argument, no one would then go on to advocate for acupuncture practice being opened up to non-physicians in Austria, as it would essentially mean making a plea for endangering patients.

However, acupuncture was also advocated for by the interviewees as having very few side effects, and thus being an option for patients not responding well to other treatment forms. Before plunging into possible questions arising from this oxymoron, the different aspects of directly harming and/or putting patients in danger through acupuncture, as seen by the interviewed physicians, shall be elaborated on.

6.6.1 Puncturing Incorrect Points vs. Puncturing Points Incorrectly

An assumption a layperson might make regarding acupuncture is that if puncturing a certain point has a positive effect on a patient, the conclusion would be that puncturing an incorrect point could have an adverse effect. However, as absolutely all the interviewed experts stated, this is not the case. Dr. Bijak actually went so far as to say: “There aren’t any really wrong points. (...) The worst case scenario is that acupuncture remains ineffective.” (Michaela Bijak) Dr. Chen, laughing, labeled acupuncture as “harmless”. In a different section of the interview, she went into detail about how patients are often over-medicated and thus have to cope with the side-effects resulting from taking high doses of medication, or from being permanently medicated over a long period of time. She then went on to describe acupuncture as an excellent alternative in cases like these, as patients can reduce or even live without medication entirely. (Chenfein Chen) According to these narratives, acupuncture is described as being completely void of the negative side-effects medication might have, even if incorrect points are punctured, as thus would merely have no effect at all. Furthermore, if used correctly, acupuncture can even lead to no longer relying on medication that does have side effects. To summarize this thread of argument: Puncturing

the wrong point will remain sterile, but also without side effects. Puncturing the correct point will improve the patients' condition. If the condition is improved, other side-effect causing treatment forms will no longer be required. Thus, the "risk" of puncturing incorrect points seems fairly low compared to possible gains when choosing the correct ones.

The side effects the physicians were referring to do thus not stem from placing a needle correctly into the wrong place of human skin. Rather, dangers can arise from placing needles using a wrong technique, whether or not the points themselves are correct being irrelevant. "(...) if one doesn't have a classical medical education, so much can happen, it is very dangerous. It can also become life threatening, because, for example, most physicians don't even prick on the back, because there's the lung²⁰, yes, one has to know the anatomy in detail to puncture. (...) If one punctures too deeply or not well, it can become life threatening." (Chenfein Chen) This occurrence of a pneumothorax is the only side effect Chen named explicitly as occurring through incorrect puncturing through non-physicians. Bijak, however, refused to even classify an occurring pneumothorax as a side effect. "This is just not a side effect, but rather it just must not happen in correct practice." (Michaela Bijak) Hence, the line between side effect and malpractice in acupuncture seems to be rather thin. When arguing that e.g. a pneumothorax is to be considered due to poor technique, or even malpractice, the question arises if it is not to be excluded from the list of possible side effects entirely.

On the one hand, Dr. Bijak argued that worst-case scenarios such as a pneumothorax simply should not occur. He spoke of practicing acupuncture "correctly, this means knowing anatomical facts. So I should not endanger the lung, I also should not puncture large blood vessels, veins, nerves..." On the other, she also argued that only physicians should practice acupuncture *in case* such a worst-case scenario occurred, as then they would be properly trained to initiate first aid measures. (Michaela Bijak) Thus, the physician-ness of acupuncture practitioners is seen as crucial both to avoid mistakes, and correct them.

A condition of the pneumothorax, however, was the only side effect named in the interviews in which case the non-physician-ness of acupuncture practitioners might be to blame as having caused a negative impact. Interestingly enough, medical literature does reference other adverse effects caused by insufficiently trained acupuncturists (infections, etc., unsterile needles, etc. REFERENCE), but these were not discussed in the interviews.

²⁰ This phenomenon, caused by puncturing the lung, as described here, is medically referred to as a pneumothorax, a medical condition in which one or both lungs can no longer expand and breathing becomes difficult. It can be caused e.g. by acupuncture, but can also occur randomly.

6.6.2 (Acupuncture) Needles and Side-Effects

However, there are also side effects that can be caused by acupuncture, even if practiced correctly. Acupuncture is generally considered an invasive treatment technique for the simple reason that a needle is usually used to penetrate the skin.²¹ The consequences of this were described as follows: “It might hurt a bit while pricking, and you can get a hematoma, bleeding afterwards, for example if a blood vessel is gotten to under the skin, or if afterwards, when one takes the needle out, if one doesn’t press firmly, it can turn blue a bit, yes, if for example a patient who takes blood thinners, yes, it can also be that it bleeds a bit more afterwards, that one gets bruises, besides that, there are no consequences, no side effects.” (Chenfein Chen) Bijak added that individuals sometimes also faint before or during acupuncture treatments. When reading this rather frightening list of side effects, it might seem as if the interviewee is deliberately downplaying possible consequences in the aftermaths of acupuncture treatment. Making side effects such as the ones listed above, appear harmless was a narrative technique used by all interviewed physicians. However, it shall be noted that these side effects described – such as bleeding, hematomas, pain through the needle prick, passing out at the sight of a needle – do not exclusively occur in acupuncture. Rather, they can appear whenever a needle is used to penetrate the skin, or patients have a phobia of needles. This would hold true for practices such as taking blood, giving vaccinations/injections, or drip infusions. This practice of normalization of side effects used in physician narratives might not stem from having practiced acupuncture at all, but rather from accepting the puncturing of the human skin with needles as a necessary part of treating human illness in medicine.

This holds true especially when examining for which conditions or circumstances acupuncture is labeled as effective in improving patients’ wellbeing. Two major areas in which clinical studies have been done on acupuncture’s effectiveness are pain or dysfunction in the musculoskeletal system (or locomotor system), and in accompanying pregnancy. (Rainer Kluger, Daniela Stockenhuber) Regarding the pain in the musculoskeletal system, e.g. shoulder pain, conservative treatment forms include repeated pain numbing injections, or surgery. (Rainer Kluger) Both treatment forms require the use of needles. Pregnancies, being heavily medicalized, also include taking blood for monitoring. Furthermore, the process of giving birth very often includes administering medication through injections or infusions, or anesthetization, all of which involves needles, and thus could produce the same, if not more severe, “side effects” as acupuncture does. With

²¹ Non-invasive forms of acupuncture do exist. Please see medical terminology chapter.

acupuncture needles being much smaller and thinner than regular needles used in medicine, and penetrating the skin much less deep than injections or infusions, the chances of side effects occurring could actually be considered slimmer. Therefore, using acupuncture needles does not seem to be a far stretch in the medical realm of the musculoskeletal system or pregnancies.

An increased risk of side effects caused by acupuncture seems to occur, as mentioned above, with patient on blood thinners. (Chenfein Chen) When analyzing the language used by the physician, the level of disengagement seems to almost imply that actually not acupuncture, but rather a pre-existing condition inherent to the person being treated, is the reason for increased risk of side effects, rather than the treatment method or the person providing treatment. While it might be an acupuncturist's responsibility to weigh the costs of increased suffering post treatment versus possible benefits in such cases, the same holds true in regular needle-related medical tests or treatments. However, patients on blood thinners still regularly have their blood taken, etc., with the physician in charge perhaps administering slightly more care post procedural. The same, however, can be done in acupuncture, e.g. by putting pressure on the perforated spot after the removal of the needle.

It could be argued that trained physicians list needle-related side effects as being consequences of acupuncture treatment, yet, having been trained in a clinical environment, see these side effects as a regular risk of practicing medicine in general. Very few physicians would refrain from e.g. taking a patient's blood when necessary, due to the fear of a possible bruise. This is probably even the case if a patient has an increased likelihood of bruising, because they are receiving medication such as blood thinners. This is to say that using needles in medicine has become completely normalized, and this mindset might, in physicians, have stretched to include acupuncture.

At the same time, it should be added that many non-physicians regularly have to use needles, e.g. to self-administer medication. Thus, it seems counterintuitive that physicians point to a particular danger of non-physicians using needles in the case of acupuncture because needle-related side effects might be caused.

6.6.3 Side effect – No effect

There was only one side effect mentioned in the interviews that could actually be traced directly to acupuncture: being tired during or after the treatment. This Dr. Bijak described being due to acupuncture being acting as a stimulation or input to the body, which then has to process or handle this. In this phase patients might feel like they are lacking energy, can't

be as active as usual, or feel slightly fatigued. This phase, however, lasts only during or perhaps a very short time period after the treatment is concluded, thus barely impacting patients' everyday lives. "Other than this, there are no usual side effects." (Michaela Bijak)

However, another unwanted effect, if not a side effect, of acupuncture is it having no effect at all: "The worst thing about this method (pause), well, the good thing is, you can't do anything wrong, or make anything worse. Symptoms cannot get worse through acupuncture. It's only that it has no effect, okay?" (Chenfein Chen) Every single interviewed person agreed to this, claiming that beyond the various dangers stemming from the incorrect or correct use of needles, acupuncture can do no harm. Considering the vehemence with which different groups in the acupuncture field advocated for limited agency of practicing, this seems remarkable. Claiming acupuncture basically cannot be done incorrectly in a harmful way, yet saying it is too dangerous to be practiced by anyone other than a trained physician, seems slightly oxymoronic.

When questioning whether medical conditions really don't ever deteriorate during the course of an acupuncture treatment cycle, König admitted this is not the case for very serious health conditions, ones "where you can't do anything wrong anyway". (Kurt König) However, with fatal conditions, even stabilization, rather than improving, of a state of health could be considered as acupuncture being "effective". Thus, a deterioration of said state despite acupuncture treatment, could, indeed be considered as acupuncture having no effect.

What was, however, described in interviews is the negative consequences of inaccurately done acupuncture none the less being effective. König described a large study conducted in Germany. What began as a blind experiment, with the patient not knowing if the needles were placed correctly, turned out to be problematic in the sense that patients in the control group experienced very potent positive placebo effects. König reasoned that even puncturing a spot in the right segment of the body rather than a specific point can lead to a positive outcome. Considering the physicians' strong advocacy as to being the only agents capable of providing adequate acupuncture treatment, Königs reference to even finding an area, rather than a spot to place the needle, being close enough, questions the depth of skill really required to achieve positive results with acupuncture. According to König, the publication of the study described above discouraged German insurance companies to continue covering acupuncture, as they claimed it to be an imprecise treatment form with little claim as to why or how it works. (Kurt König)

Thus, according to König, a study showing that there was no real need for acupuncture to be practiced exactly had an adverse impact on acupuncture in Germany. Yet, the fact that

acupuncture is claimed to have no effect, rather than a side effect, is viewed as an upside to this form of treatment, rather than reducing its credibility. While this nothing-can-go-wrong-mentality might be comforting for potential acupuncture patients, it could have implications on a policy level. When acupuncture is practiced incorrectly and nothing happens, how can a differentiation take place to acupuncture being practiced correctly, but still having no effect? And, in yet another scenario, there what does it mean if both patients being treated correctly, and incorrectly, have identical improvements of their conditions?

In the narrative of standardization, a comparability of medical circumstances is not given. This can have a very real impact on the financing system of acupuncture treatments through insurance companies, as well as money for further research projects on if or how acupuncture works. So, on a policy level, a no-effect side effect could, indeed, have very real consequences. Limiting the concept of side effects merely to patients' well being, rather than including a broader sociopolitical dimension, might therefore explain why incorrectly practiced acupuncture having no effect at all is celebrated by the interviewees.

6.6.4 Misdiagnosis – a Side Effect

Another set of side effects mentioned by several interviewees can occur when using acupuncture after incorrectly diagnosing a medical condition. This misdiagnosis then leads to deciding acupuncture being the best course of treatment, when, in fact, it should be used only combined with another form or forms of treatment. This would be the case especially with particularly severe diseases, such as aggressive forms of cancer. (Chenfein Chen) Rather than using surgery or chemotherapy, possibly while supplementing these conservative forms of treatment with acupuncture for an optimal outcome, an incorrect assessment of the medical problem could lead to an underestimation of the problem at hand, as e.g. Chen pointed out. König agreed, adding: "Well, with acupuncture, I mean the most important thing is, I always say, the non-indication, meaning that you treat something that shouldn't be treated with acupuncture." (Kurt König) The risk of misdiagnosing a condition, or underestimating the danger of a disease, when followed by an acupuncture treatment, is regularly labeled as a side effect of acupuncture in the interviews. Therefore, the interviewed physicians argued for the necessity of only medically educated people practicing acupuncture, so as to not be limited to exclusively using acupuncture in potentially life threatening conditions, and thus endangering patients.

However, one could also argue that a misdiagnosis does not require acupuncture to be considered problematic. Even if acknowledging that physicians might have a lower rate of misdiagnoses than non-physicians, and should thus be the ones making diagnoses, this

does not explain why they should necessarily be the ones practicing acupuncture afterwards. After all, this process could simply be split, as is the case e.g. in Germany, where only physicians are allowed to make a diagnosis, whereas patients are free to receive acupuncture treatments from a healing practitioner, who has received acupuncture and some anatomical education. Barnes also refers to this (later discarded) form of regulation in the context of acupuncture in the USA: “Until 1999, when it was repealed, the law required any patient seeking the help of an acupuncturist first to receive a biomedical diagnosis for his or her condition.” (Barnes, 2003) When presented with this option, Dr. Stockenhuber contemplated, admitting that this might be an option, if a close cooperation between physician and acupuncturists not just at the beginning, but also during the course of the treatment.

Over all, it seems that many of the “side effects” presented by the interviewees are not inherent to acupuncture practice itself, but are inscribed into it, in order to make it more dangerous when practiced by “non-professionals”, which usually implies non-physicians, or at least people who cannot be considered medical personnel. Hence, the only “side effect” really referring to acupuncture treatments, rather than treatments involving needles in general, could be that the patient is not receiving other treatment forms in the meantime; a concern that is often unfounded, as different treatment forms are generally provided simultaneously in Austria in a “cross-over approach”. (Rainer Kluger) Simultaneously, it is also argued that acupuncture is considered to be very low on the scale of causing side effects, if done by a sufficiently trained practitioner. This double message can be seen as a strategy to promote not acupuncture as a treatment form in general, but the specific acupuncture treatment offered by physicians, and, in a limited time span, midwives. By exaggerating risk on the one hand, and benefits on the other, a narrative is created in which patients are convinced of acupuncture in general, while also being warned of unqualified people performing the treatment.

6.7 To Pay or Not to Pay? Insurance Agencies’ Standpoint on Acupuncture

As acupuncture is a fairly expensive form of treatment for an individual to afford, health insurance providers play a crucial role in the (non-)financing of acupuncture. Whether or not acupuncture is affordable for a large part of the population, in turn, has implications on how widely it will be sought after as a form of treatment, thus impacting the system in place.

In order to better understand the (non-)coverage of acupuncture by the Austrian health care system, a brief overview of the institutions it is represented by, as well as the system of insuring individuals, will be given. In Austria, there is a system of “Pflichtversicherung”, meaning every working resident making more than 395,31 Euros a month, or 30,35 Euros a day, has to be insured by his or her employer. However, there are also family insurance plans for non-working family members, such as spouses, or children, if they pursuing education and are no older than 27. Furthermore, unemployed people’s health insurance is covered as part of unemployment benefits, which guarantees health insurance even if a person no longer receives fiscal unemployment benefits. Pensioners’ health insurance is covered as part of their pension; pensioners in this sense are not only elderly people not working any longer, but also people unable to work because of disability, or (half-)orphans. (URL 16) This system of providing health insurance coverage on a broad scale leads to approximately 98 to 99 % of the population being ensured – these numbers are not exact, as around half of the uninsured do not hold a residence permit, and therefore do not officially fall into statistics. Nonetheless, the percentage of people covered by health insurance is relatively high in international comparison.

However, the type of health insurance one has is not a matter of choice, but linked to the employer. Hence, a large part of the population is insured through the GKK (Gebietskrankenkasse), the public health insurance provider. Certain job groups, such as civil servants or agriculturalists, have their own insurance, with the location of the employer also being relevant. As there is no choice of insurance companies, their policies regarding the (non-)coverage of acupuncture directly affects patients potentially interested in receiving acupuncture treatments.

An additional private insurance, which might cover acupuncture to a greater extent, is an option for all those using public health insurance. However, even patients with an additional private health insurance have to try to receive coverage from a public health insurance as a first step, in order to then receive coverage from their private provider. This is a rather complicated process bureaucratically. Hence, public insurance providers’ policies even affect those who additionally have private insurance, and the messages being sent through them impact the entire system of recognizing and validating acupuncture as a legitimate form of treatment.

6.7.1 Policy of Secrecy

When conducting research on the question of whether and in which cases acupuncture is covered by public health insurances, the initial idea was that there would be information on

this subject on the insurances' websites, or at least information on alternative and complementary medicine in general. However, this was not the case. The GKK (Gebietskrankenkasse) is one of the largest public health insurance providers, having a subdivision in each of Austria's nine states. On their website, the only information that could be associated with the coverage of alternative or complementary medicine is to be found under a link referred to as "Wahlärzte", meaning private physicians who do not accept the Austrian "ecard"-the health insurance card ensured citizens hold. (URL 18) "Wahlärzte" covers a very broad spectrum of physicians, since some general practitioners or specialists also do not accept public health insurance, although they do not provide any form of alternative or complementary medicine. The description of if, and how much, will be covered when visiting such a physician is as short as it is vague, saying "the eligibility criteria have to be met", without elaborating on what these criteria might be. (URL 18)

There is, however, a hotline that can be called for further information. When inquiring about the coverage of acupuncture, the information given was that it is covered, to some extent, for a certain set of approved conditions, if a physician prescribes it. Although there is an official list of covered conditions, this list is not open to the public, meaning to the people insured with GKK themselves. This is interesting, as it shows there is no transparency in the system, and no way for policy holders to find out if their health condition justifies acupuncture treatment coverage, before requesting it to be covered, which can only be done after the first treatment was received. The person working for the hotline unofficially gave out information regarding some of the conditions that are covered, but added that this was no binding statement, and she actually wasn't allowed to give out any information at all. As to the rates covered by the GKK, there are slight variations from state to state, with Vienna's coverage being the lowest, at 7,64 Euros. However, none of the rates exceed 16 Euros per acupuncture treatment.

A similar conversation took place with a representative of the BVA, the public health insurance for state employees. They cover 11,35 Euros per treatment, but the transparency is even less than with the GKK. There is no list of covered conditions at all, but rather physicians working for the BVA make a decision on a case-by-case basis. Thus, there is no system of outside accountability, or comparability of covered cases. Furthermore, no reasoning is given as to why some cases are or are not covered, and no traceability of the decision-making processes which have lead to this policy.

With both of the public insurances contacted, I was informed that no information on the policies of (non-)coverage of acupuncture can be given out, not to an insurance policy holder, and also not to a researcher studying the subject. The message being sent through

this turbid system of coverage is subliminal. Patients do not receive coverage for acupuncture immediately, but only in retrospect several weeks later. This means that only patients who can afford to pay for treatments without immediate coverage can receive acupuncture treatment at all. Theoretically, patients could be reimbursed for a small part of the fee they paid for an acupuncture treatment, given that it is performed by a licensed physician. Thus, the policy of physicians having an almost exclusive right of providing acupuncture treatment is inscribed into the system on yet another level.

Furthermore, the process of finding out if patients will receive reimbursement at all is tedious, as is the paperwork needed to file for it. Rather than openly denying coverage, public insurance agencies opted instead to make the process of reimbursement so complicated that only a small number of people would file at all, and not all of their conditions would be deemed eligible for reimbursement.

6.7.2 Avoiding Debate by Paying (a) Little

Nonetheless, it should be acknowledged that all public insurance companies do, in theory, provide coverage for acupuncture treatment. This can be seen as a crucial milestone in having acupuncture recognized as an official form of medical treatment. After all, public insurance coverage implies that acupuncture has surpassed the stage of being recognized as a treatment form without actual consequences, but is rather almost fully integrated into the system of medical care.

While this formal and practical recognition was important for acupuncture's acceptance in society, this does not, however, change patients' realities of the affordability of acupuncture care. One single session of acupuncture costs between 65 and 90 Euros, with the initial session usually being more expensive than these rates. According to all the acupuncture practitioners that were interviewed for this research project, at least five sessions, but usually ten, are necessary to notice health improvements for any type of health condition. Usually, at least a second or third cycle is needed for more complicated medical conditions. Furthermore, some conditions will require another cycle several months or years later, in case symptoms start reappearing. So, depending on where in Austria one is insured, and which condition one suffers from, the GKK covers roughly between 10 and 20 % of treatment costs. For one single treatment cycle of ten sessions, the non-covered costs would hence be approximately between 580 Euros and 830 Euros. Thus, large parts of the costs created by acupuncture treatment are left uncovered by public health insurances, making the treatment affordable only for a more affluent part of the population.

Therefore, the public insurances can argue that they do, in fact, cover acupuncture treatments, thus being out of the range of criticism for refusing to do so. Nonetheless, the amount covered is so little that it does not effectively enable patients to receive treatment who would not be able to afford it without the reimbursement rates.

This way of dealing with the (non-)coverage of acupuncture treatment by the public health care insurances could be seen as an enactment of the paradox of scientific authority described by Bijker, Bal and Hendriks. Policy enactors, such as insurance agencies, do partially listen to scientists, but remain skeptical. In this context, to cover a small part of acupuncture treatments' costs could be seen as a form of compromise within the paradox. Instead of openly questioning acupuncture's effectiveness by not covering any treatment costs, or bluntly interfering with the question of who is allowed to provide acupuncture treatments, a relatively stable status quo is accepted. (Bijker et al., 2009)

6.7.3 The Cost of Acupuncture: Physicians' Views

One interviewee, Kluger, expressed his opinion of public insurances using a small payment to avoid a bigger debate: "That is not compensation, but a pure alibi, no? (...) That is simply the propaganda of this insurance (referring to GKK), that says: 'We pay for acupuncture.'" (Rainer Kluger) Sprung agreed, saying that in the case of acupuncture performed by a midwife, there is no reimbursement at all, and she couldn't offer this service to her patients unless they were willing to pay for it on their own. (Gabriele Sprung)

The opinions as to whether the extent of coverage by public health insurances impact patients' ability or willingness to make use of acupuncture as a treatment form varied amongst the interviewees. Chenfei Chen said that the small sum reimbursed by the public health insurances is by no means sufficient to unburden the patient enough for him or her to be able to afford the care they need, adding "barely anyone can afford (acupuncture)" to the extent ideally required. (Chenfei Chen) Rainer Kluge, however, ultimately believes that the unwillingness of public insurance to cover acupuncture treatment fully will not hinder anyone from opting for it when necessary. "If the level of suffering is high enough and acupuncture is the right method, then you just invest in it. Nobody would wait for ten years until public health insurance covers it." (Rainer Kluger) Kluge did, however, recognize that sum reimbursed by public health insurance is, indeed, very low: "You can't get anything for this money, except maybe two sandwiches at Ströck (a local bakery chain)." (Rainer Kluger) How these differences in opinion regarding the affordability of acupuncture can be explained is not clear.

According to Chen, having additional private insurance can help, but this is also no guarantee to full coverage. She claimed that one well-known Austrian private insurance initially promised to cover TCM treatments, but when one of her patients presented them with a large bill, they refused to cover it, and excluded TCM a short time later from their list of covered expenses. (Chenfei Chen)

Many of the interviewees mentioned the situation of coverage in Germany and Switzerland, saying that a much higher percentage is paid for, and that this would prove to be a much better strategy of investment in the long run, both for the patients, who could opt for acupuncture instead of other, less suitable treatment forms, but especially for the health care system itself. They said they were sure that acupuncture could often prove to be a less invasive and more cost efficient treatment form with fewer short and long term side effects. (Kurt König, Rainer Kluger, etc.)

7 From Zhen and Ci to Acupuncture in Austria: Drawing a Conclusion

Over three hundred years ago, a Dutch physician made a minor mistake when he translated a Chinese term to a Latin-inspired one, which was to be used throughout Europe and the Western medical system. Willem ten Thijne chose the term “acupuncture” to describe a treatment form he had witnessed in China, but the name he selected did not, in fact, encompass the word “treatment” at all, which it does in the language it was translated from.

This was only the very first of many changes that “acupuncture”, which was no longer “zhen”, nor “ci”, underwent after having left China. Those who feel critical of or sentimental towards the way acupuncture changed when it came into contact with Western medicine, might see the changed name as a first sign, or omen, of things yet to come. Were treatment and therapy abandoned for the sake of merely puncturing the skin?

This sets the stage for discussing how acupuncture changed when it was transported and translated to the Austrian context. The translation that took place was not merely one regarding two languages, and the transportation was not limited to bringing something from one place to the next, unaltered. Acupuncture was altered when it was moved, and continued to do so over the next decades. One of the aims of this thesis was to examine how acupuncture changed once it entered the system of policies regulating it in Austria. However, this aim is too one-dimensional. After all, most of the policies regulating acupuncture today were only created once acupuncture appeared, in order to shape and control its research and practice. Of course, some of the policies were based in previously existing medical codes. For example, physicians claimed the exclusive right to puncture the human skin, e.g. for taking blood or performing surgery, long before acupuncture was introduced. Enjoying this “privilege” has led to numerous other debates in Austria over the years, most recently over responsibilities of nursing personnel and patient caretakers.

Nonetheless, I would argue that the debate surrounding acupuncture is unique even within Austria. Legal documents, such as the Austrian Physician’s Statue ([URL 13](#)), are interwoven with documents resembling soft policies at best, such as the Diploma Guideline of the Austrian Board of Physicians ([URL 2](#)), the latter of which entails no actual legal consequences when broken. However, using the power connected to being an “expert” of a field, and authority of knowledge, physicians were able to claim acupuncture for themselves.

This stance, as far as my research showed, is not openly questioned, especially not to a degree in which the system in place will change any time in the foreseeable future. Those groups who could pose a threat to the physicians' monopoly of power in acupuncture are, in theory, ones that already have some established legitimacy in practicing it. However, quite the opposite is true. Midwives have received the "permission" to offer acupuncture treatment, as long as they stay within the realms of treating pregnant women, for pregnancy related conditions of health and wellbeing. Who gave this permission, and how it was given, is completely untraceable; showing, of course, that no legislation had to be changed to allow this "exception to the rule". Midwives, as the nature of their job is to care for pregnant women, have little incentive to extend their acupuncture practice to include other areas. By enabling midwives to practice acupuncture, as long as it is limited to their own field, physicians have actually created powerful allies in claiming acupuncture for certain medical personnel only. Physicians are sought-after speakers in acupuncture education for midwives (URL 14), further cementing their status as experts, even though their expertise differs from the one needed by midwives.

Physicians' exclusivity in being able to provide acupuncture treatment is supported by the Austrian public health insurance system. It is willing to reimburse patients for part of the cost of an acupuncture treatment, sending a powerful message regarding acupuncture's effectiveness and close ties to Western medical treatment methods. However, only acupuncture practiced by physicians is reimbursed. This is not generally the case in Austria. For example, when seeking (private) physiotherapy treatment provided by non-physicians, a reimbursement of costs is entirely possible. With acupuncture, this is not the case. Thus, even if acupuncture practiced by non-physicians were to be considered legal, a de facto two-class system of acupuncture treatment would be in place. After all, there would be physicians' acupuncture, worthy of reimbursement by the health care system itself – and other forms.

However, this short recapitulation of the status quo could be interpreted as having been actively shaped by physicians. After all, the outcome of the policy making process regarding acupuncture might, indeed, be considered as being beneficial mainly for physicians. They have a monopoly on a fairly expensive and increasingly sought-after product: acupuncture treatments.

Nonetheless, I believe the empirical research does not show at all that physicians alone shaped the policy system in a way that would benefit them. Rather, I believe there is a long history of not greatly questioning perceived authority figures in Austria. Physicians, who are thought to be not only highly educated, but also a-political figures with the patients' best

interest at heart, are the ultimate authority figures not to be questioned. And, after all, it was a group of physicians who first introduced acupuncture to Austria's public, setting up a paid-for clinic offering treatment. Other social groups never "lost" a debate over who is and is not allowed to offer acupuncture treatments – as far as I can tell, there was never a large, open discussion on the subject. Physicians' authority was inscribed into the medical system long before acupuncture gained gravitas as a treatment form. Thus, by tying acupuncture within the realm of Western medicine, conflict of who could and could not practice it was prevented and avoided.

A first conclusion regarding the transformation of acupuncture in the Austrian context would therefore be that it is, always and necessarily, physicians' acupuncture. Even supposedly illegally offered acupuncture becomes defined in this dichotomy as being non-physicians' acupuncture. Needless to say, there is a strong implicit judgment concerning the quality of the non-physicians' acupuncture in place.

By tying acupuncture closely to Western medicine, the narrative shifts from acupuncture as a treatment form, to it being one (of several) form of treatment. As acupuncture is almost exclusively practiced by physicians, it seems logical for a physician to use all of the tools available to them to improve a patients' condition. Thus, it seems a stretch to perceive acupuncture as the only available treatment. Therefore, several of the physicians argued for using acupuncture in addition to, not instead of, medication and/or surgery. Acupuncture becomes the only treatment form solely in cases in which other treatments have failed to produce results, or in which it was weighed against other options and deemed the most effective. Hence, acupuncture in Austria always refers to a complementary, never alternative, form of medical practice.

Next, I would argue that the empirical material shows the "physician-ness" of acupuncture described above is closely tied to perceptions of science. Acupuncture research, which more or less adheres to standardized testing procedures of Western medicine, is conducted on a regular basis. However, every interviewee referred to such research in order to "prove" acupuncture's effectiveness. While the Austrian Society of Acupuncture does gather data on acupuncture treatments' effects on patients (see survey of acupuncture ambulance in empirical sources), this does not hold true for every interviewee. Scientific research on acupuncture thus becomes a tool to make one's own practice more credible, even when quoting studies conducted in Germany, and never having functioned as a (researching) scientist. However, acupuncture is a highly individualized and patient-specific treatment form, as most interviewees agreed and even emphasized. Thus, a standardized study says

little about the quality of care offered by a specific acupuncture provider. Nonetheless, interviewees saw acupuncture studies as significant.

These trials should adhere to standards of clinical trials as much as possible. Acupuncture treatment is, of course, rather different from offering a placebo-controlled, double blind test involving pills or even surgery, and interviewees are well aware of differences in trial concepts. It almost appeared as if trials are considered a steppingstone on the path to getting acupuncture scientifically accepted. This, of course, creates another dichotomy. If there is scientific acupuncture – similar to the one used for conducting trials – there must also be none-scientific acupuncture practice. This is where notions of space and place for acupuncture are relevant. Acupuncture practitioners interviewed for this thesis made a strong case for one place being inadequate for producing scientifically sound acupuncture, with another being amply qualified. This led to claims that acupuncture taught in Austria, or China, might be preferable to the other. Even though some Austrian physicians purposefully went to China to further their knowledge of acupuncture practice, the claim of it being “unscientific” remained. Labeling acupuncture as “scientific” was a strong demarcation boundary.

Interestingly, there is a discrepancy between acupuncture practiced in clinical trials, and the type the interviewees wished to offer to their patients. Independent of how much, or little, philosophical theory on acupuncture was proclaimed to be necessary for good practice, the personal connection to the patient was identified as a key component in the success of acupuncture treatment. Even those interviewees, who claimed that the basic skills needed to practice acupuncture could be easily obtained, added that a patient could only benefit from the one-on-one contact so often lost in Western medical practice. I would thus argue that acupuncture in Austria is positioned and advertised as being not only scientific, but also providing personal care. The seemingly stark contrast between standardized trials focusing on puncturing certain points, and one-on-one patient care with individualized treatment plans, is overlooked. Rather, acupuncture is portrayed as being an ideal treatment form, as it combines both science and care, and even without side effects (as long as practiced by medical personnel).

This opens up the question of how acupuncture practiced in Austria shapes the view practitioners have of the human body. When referring to the importance of clinical trials, the subject of the trial, namely diseased bodies, become very impersonal. Needles are placed into the body, and (improved) symptoms are measured. The same can be said for acupuncture education. Some physicians referred to “prescriptions” used to treat certain ailments, saying that it is easy to learn how to execute this on the human body. This

complies with a very action-oriented view of Western medicine: There is a symptom, and a prescription -be it a medication or acupuncture- can be applied to cure the problem or relieve pain.

However, there was a strongly noticeable disconnect when physicians advocating such skill-based approach to acupuncture spoke about trials and education, and then went on to speak about patient care. A human element was suddenly noticeable, with physicians stressing repeatedly that the on-patient experience far outweighed techniques taught in the course. This cannot possibly be deduced from an approach seeing the human body as a mere accumulation of meridians and points in which needles can be placed as means to an end. Thus, I would argue that the type of acupuncture taught and researched in Austria is different from the one seen as good acupuncture in practice.

The acupuncture taught in courses is a highly simplified version compared to what could possibly be learned; although, of course, what is necessary to learn is entirely debatable. Nonetheless, taught and researched acupuncture is a simplified version, with many different layers of complexity purposefully left out, as to not over-complicate things. For example, most interviewees offered a view in which not only acupuncture philosophy was deemed unnecessary, but in which acupuncture was also more or less detached from other Traditional Chinese medical practices. Therefore, acupuncture becomes easily learnable and teachable.

Practicing it, however, especially on a successful level, is not as easy, so the claim goes. After all, what reintroduces (desired) complexity into acupuncture in Austria is, in fact, the patient. Several interviewees mentioned the options acupuncture treatment offers for mental illnesses, a field where the patients' complex emotional world cannot be completely excluded. According to the interviews, the individual patient is generally considered to a greater extent with acupuncture than with other forms of Western medical treatment. Thus, different "golden standards" seem to apply depending on the acupuncture setting, with personalized acupuncture deviating heavily from the acupuncture being taught and researched.

Acupuncture has successfully travelled to and arrived in Austria about sixty years ago. It has undergone many changes since then, but the outcome of this metamorphosis is, surprisingly, not *one* new form of acupuncture. Rather, the system of soft policies and beliefs in place has produced several different forms of acupuncture, which are enacted and narrated depending on the context they are connected to. There is a system of compromises

in place in Austrian acupuncture, which ultimately shapes acupuncture practice more strongly than any system consisting of hard or soft policies ever could:

Physicians firmly hold the claim on practicing acupuncture in Austria, but exceptions can nonetheless be made for midwives, and deviators from the policy are not pursued legally. Acupuncture is a treatment method with basically no side effects, but should never be practiced by non-qualified personnel, as it holds immense danger. Acupuncture is accepted by the public health insurance system as an effective treatment form, but reimbursement for its cost remains minimal. Physicians regularly visit China to seek further acupuncture education, but a physician's extensive training there cannot be recognized in Austria. Acupuncture is seen as scientifically proven to be effective, but can only ever be considered a complimentary form of treatment. Scientifically conducted trials are seen as crucial to furthering acupuncture's acceptance, although their limits as to adhering to standardization processes are self-evident. And lastly, the logical, clinical approach to the acupunctured body taught and researched dissolves during direct contact with patients.

These varying versions of what Austrian acupuncture entails, as well as the compromises that stem from these different faces of acupuncture, seem to be counterintuitive at times. Nonetheless, the system in place provides a functional environment in which acupuncture is practiced, taught and researched.

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8.2.4 Survey of Acupuncture Ambulance (Document Analysis)

AKUPUNKTUR-AMBULANZ
 Krankenhaus Hietzing - Neurologisches Zentrum Rosenhügel
 Riedelgasse 5, A-1130 Wien, Tel. +43/1/860 00/590 , Fax+43/1/860 00/599

KH HIETZING
NZ ROSENHÜGEL

BEURTEILUNGSBOGEN

Versuchen Sie bitte, den Schweregrad Ihrer Beschwerden oder Schmerzen wie ein Lehrer in der Schule zu bewerten.

1 kein Schmerz, keine Beschwerden ☺
 2 leichter Schmerz, leichte Beschwerden
 3 mäßiger Schmerz, mäßige Beschwerden ☹
 4 stärkerer Schmerz, stärkere Beschwerden
 5 sehr starker Schmerz, sehr starke Beschwerden ☹

VAS:

vor der Akupunkturtherapie
Die Beschwerden sind 1---2---3---4---5 ☺ ☹ ☹
Das Wohlbefinden allgemein 1---2---3---4---5
Ich schlafe jetzt 1---2---3---4---5
Meine Konzentration ist 1---2---3---4---5
Nervosität, Gereiztheit 1---2---3---4---5
Stuhl 1---2---3---4---5
Menstruation 1---2---3---4---5

VAS:

nach der Akupunkturtherapie
Die Beschwerden sind 1---2---3---4---5 ☺ ☹ ☹
Das Wohlbefinden allgemein 1---2---3---4---5
Ich schlafe jetzt 1---2---3---4---5
Meine Konzentration ist 1---2---3---4---5
Nervosität, Gereiztheit 1---2---3---4---5
Stuhl 1---2---3---4---5
Menstruation 1---2---3---4---5

Insgesamt beurteile ich den Therapieerfolg im Jahr 20... : 1---2---3---4---5
 ☺ ☹ ☹

8.2.5 Interviews

Dr. Daniela Stockenhuber

Manfred Richard

Dr. Rainer Kluger

Dr. Michaela Bijak

Dr. Chenfein Chen

Dr. Kurt König

Gabriele Sprung

9 Curriculum Vitae

MAGDALENA EITENBERGER

STUDIES

Since October 2011	University of Vienna Master Studies: Science-Technology-Society
Since March 2011	University of Vienna Master Studies: Publication and Communication Studies
September 2012 - February 2013	University of Maastricht Master Cultures of Arts, Science, and Technology Semester abroad with Erasmus
2007 - 2011	University of Vienna Political Science Studies (Bachelor's Degree February 2011)
2005 - 2007	Schubart-Gymnasium Ulm, Germany High School (Gymnasium) Abitur (High School degree) passed in June 2007

RESEARCH PROJECTS

Master's Thesis Science-Technology- Society	When Acupuncture Travels - Transporting and Translating Acupuncture to the Austrian Context
Master's Thesis Communication Studies	Health Communication in Austria: Analysis of the „Fleisch bring't's“ (“Meat is good for you”) Campaign
Further Research Project Participation	Patenting Knowledge - Sharing and Withholding Information in the Process of Commercializing Biomedical Research Maastricht University
Bachelor's Thesis	Prenatal Diagnostics and Power: An Analysis from a Foucaultian Perspective

10 Abstract

„Akupunktur auf dem Weg – Wie Akupunktur in den österreichischen Kontext transportiert und übersetzt wird“, so der Titel dieser Masterarbeit. Da Akupunktur ursprünglich aus China stammt, wurde diese Therapieform in den bereits bestehenden Kontext der westlichen Medizin eingeführt. Die grundlegende Fragestellung dieser Arbeit befasst sich damit, ob und inwiefern Akupunktur sich in diesem Prozess der Anpassung an die westliche medizinische Praxis, und speziell den österreichischen politischen Kontext, verändert hat. Des Weiteren soll erforscht werden, wie Körperbilder des behandelten, akupunktierten Körpers sich verändert haben. Ein wichtiger Aspekt, der der Analyse dieser Fragestellung dient, ist die „policy“-Ebene. So wurde untersucht, wie das Praktizieren von Akupunktur indirekt über die Ausbildung und Finanzierung reguliert wird, und welche Hierarchie-Vorstellungen dabei eine Rolle spielen. Die empirische Analyse bezieht sich auf insgesamt sieben qualitativ geführte Interviews mit ÄrztInnen und einer Hebamme, die Akupunktur in Österreich praktizieren. Zur Vorbereitung der Interviews und Überprüfung der Daten diente eine Dokumenten-Analyse. Das Material dazu umfasste etwa die Websites der österreichischen Ärztekammer, der medizinischen Universität Wien, und von Akupunktur Organisationen, sowie Akupunktur Magazine.

Die Ergebnisse der empirischen Analyse zeigten, dass in Bezug auf die Regulierung von Akupunktur in Österreich zahlreiche Widersprüche herrschen. Es gibt keine festen Gesetze, die eine Bestrafung vorsehen, wenn Akupunktur ohne Ausbildung praktiziert wird. Dennoch wurde auf policy-Ebene ein System geschaffen, in dem angenommen wird, dass ausschließlich ÄrztInnen Akupunktur ausüben dürfen. Gleichzeitig sind Ausnahmen dieser Regulierung für bestimmte Personengruppen, vor allem Hebammen, möglich, solange sich diese auf den Bereich von Geburtsvor- und -nachbereitung beschränken. In dem empirischen Material wurde Akupunktur als sehr nebenwirkungsarm beschrieben und angepriesen, doch gleichzeitig wird betont, dass unzureichend qualifizierte Praktizierende massiven Schaden anrichten könnten. Akupunktur wird für manche Erkrankungen von dem öffentlichen Krankenkassensystem als wirksame Therapiemethode anerkannt. Gleichzeitig werden Kosten jedoch nur zu einem sehr geringen Teil übernommen; der Rest ist Privatleistung. Viele ÄrztInnen, die Akupunktur praktizieren, besuchen regelmäßig China, um dort ihre Ausbildung zu vertiefen. Doch in China in Akupunktur ausgebildete ÄrztInnen können ihre Ausbildung in Österreich nur sehr schwierig, wenn überhaupt, anerkennen

lassen. Häufig wird eine Hierarchie der Akupunktur beschrieben, in der österreichische Akupunktur als höher, da wissenschaftlicher, erachtet wird. Akupunktur wird als Therapieform beschrieben, die auf wissenschaftlicher Basis geprüft wurde und nachgewiesenermaßen effektiv ist. Gleichzeitig wird sie jedoch kaum als alleinige Behandlungsmethode eingesetzt, sondern lediglich komplementär. Wissenschaftliche Doppel-Blind-Tests werden als notwendig erachtet, um die Akzeptanz von Akupunktur voranzutreiben. Es ist jedoch offensichtlich, dass standardisierte Prozesse im Falle von Akupunktur-Untersuchungen nicht in dem selben Ausmaß gewährleistet werden können wie bei klinischen Studien zu Medikamenten oder Operationen. Zudem besteht ein großer Unterschied zwischen dem sehr klinischen Zugang zu Akupunktur Ausbildung und Forschung und dem sehr persönlichen Ansatz, der Patienten beim Akupunktieren entgegen gebracht wird. So entsteht ein System scheinbarer Widersprüche. Nichtsdestotrotz besteht in Österreich ein System, in dem Akupunktur erfolgreich ausgeübt, gelehrt und erforscht werden kann.