

Commentary: Controls for acupuncture—can we finally see the light?

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Irnich et al are to be congratulated for performing this rigorous trial. Funding is not easy to obtain for trials of acupuncture, so a sample size of 177 is considered large in this specialty. The result is hard to interpret. Advocates of acupuncture will call it a “positive” result. Opponents will argue that acupuncture is no better than placebo and that a similar trial on low back pain gave the opposite result.¹ We are left to speculate on whether acupuncture has specific efficacy in neck pain. A response rate of 57% would certainly be typical of an effective treatment in acute and chronic pain,² but even if this trial had shown a significant effect of acupuncture over sham laser acupuncture, we would still be unsure of the size of the non-specific component related to the needle.

Sham laser acupuncture was a good choice of control when this trial was designed. It can be considered inert, and it controls for the concept of having “acupuncture” in the mind of a participant who recognises it as a valid form of treatment. We cannot be sure, however, that this would equate to controlling for the concept of needle insertion. In the past, researchers have focused on the concept of acupuncture points, and, ironically, controls were often chosen simply by missing the real point—that is, inserting needles at sites not classically described as acupuncture points. The pressure stimulus applied to the nervous system from a solid needle, however, in the absence of direct impingement on a nerve bundle, is likely to be comparable at any soft tissue site within the same region, so the stimulus applied in such trials was virtually identical in the real and control groups. The response rate seen with such controls often reaches 50%. Reviews that fail to take this into account, by assuming that penetrating sham controls represent inert placebos, are open to criticism.³

Within the past three years the “placebo” needle has been developed. Such a device aims for credible simulation of needle penetration with minimal sensory stimulus. Rather like a stage dagger, the shaft of the placebo needle disappears into its own handle as the blunted tip presses on to the skin at the site of simulated insertion. The remaining challenge is in supporting the needle if it is to be left in place for any length of time. The first randomised controlled trial to use such a device yielded positive results for acupuncture in the treatment of supraspinatus tendonitis.⁴ Further trials with a similar type of needle are underway at the department of complementary medicine in Exeter University.

In the light of these methodological developments, the suggestion from Irnich et al that acupuncture is likely to be more effective in the myofascial pain syndrome, and the considerable empirical support for this suggestion, we can be confident that future studies of sufficient size will determine whether or not the acupuncture needle has efficacy beyond placebo. Musculoskeletal pain has such an important impact on the community⁵ that we must find funding for large scale, methodologically sound trials of this simple, relatively safe, and potentially efficacious technique.

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- 2 McQuay HJ, Moore RA. *An evidence-based resource for pain relief*. Oxford: Oxford University Press, 1998.
- 3 Cummings TM. Teasing apart the quality and validity in systematic reviews of acupuncture. *Acupunct Med* 2000;18:104-7.
- 4 Kleinhenz J, Streibberger K, Windeler J, Gussbacher A, Mavridis G, Martin E. Randomised clinical trial comparing the effects of acupuncture and a newly designed placebo needle in rotator cuff tendinitis. *Pain* 1999;83:235-41.
- 5 Woolf AD, Åkesson K. Understanding the burden of musculoskeletal conditions. *BMJ* 2001;322:1079-80.

Specialist registrars’ plans for working part time as consultants in medical specialties: questionnaire study

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Almost 40% of all specialist registrars who hold national training numbers in medical specialties are women.¹ Little is known about their career intentions, and specifically on how they plan to cope with the competing pressures of family and career when they become consultants. Questions on this issue were therefore included in a recent national survey of specialist registrars.

Participants, methods, and results

The Royal College of Physicians sent a questionnaire in December 1999 to all 2495 trainees in England,

Wales, and Northern Ireland holding national training numbers in medical specialties. Replies were received from 1362 (55%), of whom 1311 answered the question, would you like a part time (eight sessions or less) post when you become a consultant? They had five options: “yes—definitely,” “yes—probably,” “yes—possibly,” “no—probably not,” and “no—definitely not.” The number and percentage of women (n=541) giving each response were 83 (15%), 105 (19%), 186 (34%), 120 (22%), and 47 (9%), and those of men (n=770) were 19 (2%), 34 (4%), 117 (15%), 265 (34%), and 335 (44%). A total of 1309 answered the question about whether they would consider a “job share”

Positive responses to part time working or job sharing as a consultant. Values are numbers (percentages) of specialist registrars who answered "yes—possibly," "yes—probably," or "yes—definitely" when asked whether they would consider a part time post (≤ 8 sessions) or a job share when they became a consultant

Specialty	Women		Men		All	
	Part time	Job share	Part time	Job share	Part time	Job share
All specialties	374/541 (69)	411/537 (77)	170/770 (22)	194/772 (25)	544/1311 (41)	605/1309 (46)
Cardiology	7/31 (54)	8/13 (62)	31/118 (26)	24/119 (20)	38/131 (29)	32/132 (24)
Dermatology	31/39 (79)	28/39 (72)	11/29 (38)	8/29 (28)	42/68 (62)	36/68 (53)
Endocrinology	24/43 (56)	29/43 (67)	8/52 (15)	9/52 (17)	32/995 (34)	38/95 (40)
Gastroenterology	32/47 (68)	35/47 (74)	31/132 (23)	25/135 (19)	63/179 (35)	60/181 (33)
Geriatric medicine	47/66 (71)	52/66 (79)	16/68 (24)	21/68 (31)	63/134 (47)	73/134 (54)
Genitourinary medicine	19/24 (79)	22/24 (92)	3/13 (23)	4/13 (31)	22/37 (59)	26/37 (70)
Haematology	37/50 (74)	37/50 (74)	6/34 (18)	12/34 (35)	43/64 (51)	49/58 (58)
Infectious diseases	4/8 (50)	7/9 (78)	6/21 (29)	12/21 (57)	10/29 (34)	19/30 (63)
Medical oncology	15/24 (63)	18/24 (75)	8/30 (27)	10/30 (33)	23/54 (43)	28/54 (52)
Neurology	14/22 (64)	16/22 (73)	7/51 (15)	11/50 (22)	21/73 (29)	27/72 (38)
Palliative medicine	38/43 (88)	36/41 (88)	3/12 (25)	6/12 (50)	41/55 (75)	42/53 (79)
Renal medicine	13/27 (48)	20/26 (77)	9/42 (21)	10/42 (24)	22/69 (32)	30/68 (44)
Respiratory medicine	22/38 (58)	26/37 (70)	16/91 (18)	24/91 (26)	38/129 (29)	50/128 (39)
Rheumatology	36/46 (78)	39/45 (87)	9/41 (22)	12/41 (29)	45/87 (52)	51/86 (59)

consultant post at some stage in their career, and had the same response options. The number and percentage of women ($n = 537$) giving each response were 64 (12%), 100 (19%), 247 (46%), 95 (18%), and 31 (6%), and those of men ($n = 772$) were 11 (1%), 26 (3%), 157 (20%), 241 (31%), and 337 (44%). The table shows the number and percentage of men, women, and all specialist registrars in the major specialties who replied "yes" to the questions on working part time and job sharing. These comprised 69% and 77% of women, 22% and 25% of men, and 41% and 46% of all respondents. The proportions responding positively in the specialties varied markedly, depending mainly on the gender ratio of trainees, from about 25% of those in cardiology to 75% of those in palliative medicine.

Comment

More than 40% of all specialist registrars in medical specialties (about 75% of women and 25% of men) are considering working part time as consultants. Whether those who expressed an interest in part time work actually take up such posts depends on many factors, including whether specialist part time jobs become available. Yet feedback from focus groups has confirmed that most women trainees envisage working part time when they have young families, and that an increasing proportion of men seek greater participation in family life and perhaps a more balanced lifestyle. These results are entirely consistent with other recent surveys of trainees and consultants.²⁻⁴ The financial imperative to work full time is reduced if both partners in a relationship hold professional posts. Additionally, the availability of women (and men) to take up consultant posts is often compromised by the need to be close to their partners' place of work, especially as about half of women trainees have partners who work in medicine.²

The impact of these factors on the future supply of consultants is obvious and potentially devastating, particularly in specialties with a high proportion of female trainees. Yet no allowance has been made for this in the calculations of the Specialist Workforce Advisory

Group. In the light of the findings of this survey plans to reduce the totals of national training numbers in some major specialties may be badly misguided. Many more part time consultant posts will be needed to use the skills of women and men who seek part time work, and correspondingly more trainees will be required to maintain an adequate supply of consultants in future years.

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Endpiece

The family doctor

There was an ancient and respectable institution called the family doctor, who disappeared about the time I became a member of this Faculty. . . . He was paid by the year, after the Chinese fashion, and his visits were frequent and lengthy. . . . This man must be brought back again with added knowledge, enlarged sympathies and increased powers of usefulness.

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