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Acupuncture During Pregnancy: An Expert Discussion

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RICHARD C. NIEMTZOW: Welcome to this very important roundtable covering guidelines on the use of acupuncture for female patients during pregnancy.

I would like to state that many acupuncturists become very hesitant to treat pregnant females, because these acupuncturists' concern is safety. And some people feel that, if something goes wrong, there are malpractice implications. The consequence, in my point of view, is that this population of females during the time that they are pregnant go neglected, especially in the United States. Elsewhere in the world, the situation is a little bit different and we may discuss that during the course of this roundtable. I would like to introduce my co-moderator, Debra.

DEBRA BETTS: Thank you for the introduction and the opportunity to have this discussion. My name is Debra Betts. I am living in New Zealand, and my background is that of nursing. In terms of my acupuncture practice, I work with midwives and pregnant women; and this has also resulted in, for the last 10 years, working in a hospital in New Zealand, where we have a maternity outpatient clinic. This is run through the New Zealand School of Acupuncture and TCM [Traditional Chinese Medicine] with students treating patients under supervision.

Next, I ask the members of the panel, to introduce themselves briefly.

SARAH BUDD: Thank you. I am Sarah Budd. I am located in Devon, England, in the United Kingdom. I am a midwife as well as an acupuncturist. I started a maternity acupuncture service in 1988—a long time ago—with our National Health Service. I was fortunate to run the acupuncture service for 24 years, with 2 colleagues who joined me due to the great demand. Now, I mostly do private acupuncture and teaching obstetric acupuncture.

CLAUDIA CITKOVITZ: I am Claudia Citkovitz. I work in New York City in the United States. Since 2004, I have been running an inpatient acupuncture service at an urban community hospital in Brooklyn, New York, at New York University–Langone Hospital. One of the main units that we are on is the obstetrics unit, which is involved with mainly labor and delivery, but also includes some antenatal and postpartum care.

In 2006, we conducted a study[1] of acupuncture during labor and delivery that showed many fewer cesarean sections in patients who had acupuncture than in the matched controls. Since then, we have been looking at different ways to deliver that care, including going to the prenatal clinics and keeping relationships with people through their pregnancies. With changes in leadership, we have not had the right combination of institutional support and grant funding to follow through on research, but, for 16 years now, we have trained many acupuncturists in pregnancy and perinatal care.

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ZENA KOCHER: Hello, I am Zena Kocher. Since 1995, I have had a private practice, where, as a generalist, I also offer perinatal care. Since 2006, I have been part of an integrative medicine group at a large hospital in Minneapolis, Minnesota, as the Mother/Baby acupuncturist on the team. Since our inception in 2004, we have provided more than 100,000 integrative medicine treatments and more than 25,000 acupuncture treatments to patients in the hospital. Our Mother/Baby Center specializes in high-risk pregnancy as well as labor, delivery, and postpartum care, giving us the unique opportunity to bring our medicine to the perinatal care in the hospital. In the past 3 years, our work expanded to 2 other Mother/Baby Centers in our hospital system, and we are now a team of 6. We offer internships to acupuncture students and teach nurses, doctors, and staff members throughout the system about integrative medicine with the goal of promoting whole-person care.

A retrospective study, investigating the association of integrative medicine therapies for helping patients maintain their pregnancies when experiencing preterm labor before 34 weeks, has been conducted based on our work.[2] When patients receive standard care, they stay pregnant longer—an average of 8.6 days. And, when they have integrative medicine care on top of that standard care, they stay pregnant an average of 19.8 days [longer than average]. This is significant, as lengthening gestation time has a significant effect on infants' long-term health and well-being and mothers' well-being, and lowers the high costs of neonatal intensive care unit healthcare.

CAMERON MUMMERY: My name is Cameron Mummery. I work for the American Acupuncture Council [AAC]. I work with acupuncture colleges and large groups. I also help draft policies and applications, along with various supporting insurance documents. I work with the legal department in assessing risks and make recommendations on how to work with risks. In addition to consulting with more than 50 acupuncture colleges on their risks, I teach risk management in ~40 acupuncture colleges in the United States.

DR. BETTS: Great; and I will mention briefly here in terms of research that *Medical Acupuncture* was very helpful in terms of working with me on an article about an observational study in which we looked at what midwives were doing with pre-birth acupuncture, acupuncture once a week for 3–4 weeks. These were midwives who had completed a course, adding acupuncture into their practices. Not every woman had acupuncture—just those patients the midwives thought might have difficult births because of the patients' histories or patients who were first-time mothers.

Over 4 months, the acupuncturists treated 169 women, and it did mirror the midwife feedback that these patients were less likely to be induced and that they had reduced medical interventions in labor. Although this was not a randomized controlled study, and further research would be needed, the study did reflect what the midwives found in their daily practices.

So, we have talked about our backgrounds, let us move on to this question: Under what circumstances do you as practitioners consider acupuncture to be safe in pregnancy and why?

MS. BUDD: Thanks, Debra. In my experience, we treated ~8000 women in our National Health Service maternity acupuncture service, and I am pleased to report absolutely minimal adverse events. I think the main consideration lies clearly in the training of the providers. In my view, the key issue is standardization of undergraduate training in obstetric acupuncture, followed-up with high-quality continuing professional development.

The evidence from our audit, and our anecdotal evidence, is that obstetric acupuncture is an extremely safe treatment, particularly when compared to some other modalities. Therefore, in the hands of well-trained practitioners, I think it is a completely safe service.

DR. BETTS: Sarah, with the number of women that you were treating, can you briefly encapsulate the sorts of conditions that were routine treatments for you in your clinic?

MS. BUDD: Sure, our referrals came at all stages of pregnancy and postnatally. So, we would be treating women in very early pregnancy for nausea and vomiting and hyperemesis from as early as 5 or 6 weeks of pregnancy. Then, all the way through pregnancy, we would be treating sickness, backaches, pelvic pain, and a long list of other problems, such as constipation and headaches. The word got around with the doctors, the general practitioners, and the hospital consultants that we seemed to be able to treat all of the conditions of pregnancy, which other practitioners found very difficult to offer help with, as well as providing pain relief for labor and postnatal issues.

DR. BETTS: Zena, you are coming from a different perspective of treating women being admitted to the hospital. What is your perspective on safety and on what you are treating?

MS. KOCHER: I actually have a very similar perspective. I am treating high-risk pregnancies, and the women are in the hospital under care of the doctors as well as receiving integrative care. We have found our treatments to be very effective and also very safe. We have never had any adverse effects.

Our medicine is helpful for supporting the treatment that they are getting medically. For instance, patients who have

preeclampsia are getting treated with hypertensive medications and magnesium sulfate by the doctors. We support that treatment by lowering blood pressures, treating intrauterine growth restriction, supporting liver and kidney organ systems, and reducing edema and headache pain with acupuncture. Because we tailor our treatments to individual patients and help them feel better by decreasing pain and increasing well-being, our medicine maximizes and humanizes the overall care, which is essential for growing babies' and mothers' well-being. And, I will highlight what Sarah said, about the importance of good training. When working in a system, it is crucial to know when to be cautious, when to hold off treatment, or when and how to treat.

DR. CITKOVITZ: I agree with what Sarah and Zena have said, that, particularly for high-risk cases, the umbrella of collaboration with primary-care providers is important. I also think training is critical, especially for high-risk cases. High-risk cases do better when they are treated. It is not a question of if we going to hurt them; it is that, as Richard said, withdrawing the treatment or refusing to give the treatment, because we are frightened of it, actually could lead to worse outcomes, at least in our experience.

There is no evidence at all to suggest that we harm a pregnancy, an ordinary pregnancy. There are the malpractice insurance executives whom I have spoken to who say—at least off the record—that they have not seen, over the last 30 years, any lawsuits related to pregnancy-related harm with acupuncture treatments. Pregnant people may have sued for the same moxa burns or heat lamp-burns that nonpregnant people might sue for, but nobody seems to have sued for a pregnancy-related problem.

The reason that training is so important for safety is that sometimes the problem comes from hypo function and sometimes it comes from hyper function. There are very different reasons why someone might be in trouble—and an experienced East Asian medicine practitioner is really good at parsing out which of those situations applies and what treatment to give.

So, when research is done on a generic point prescription, it really does not adequately capture the good we have the potential to do for people, nor the importance of getting the treatment right. The more the patient is high-risk, the more so we can help, but the more so the training needs to be solid with experience and mentorship.

DR. BETTS: Great points made there. I would like to pick up on what you said, Claudia, about the research possibly not reflecting what we see in clinical practice, and that is partly because of the point prescription.

This all follows through that, if we had people who were trained in acupuncture and who understood what was happening in clinical practice, aspects such as the induction research would be very different because that is a classic case of people taking point prescriptions and applying them to women who perhaps have not yet started labor for a variety of reasons and not taking into consideration what is happening in the pregnancy or what the acupuncture is capable of for different constitutions.

I think we do have an evidence base for safety, so all of the evidence, whether you look at the safety reviews or the Cochrane reviews, demonstrate quite clearly that there is a safety base there. However, whether or not acupuncture is effective does not always come through and that is, to our way of thinking, partly because of the types of point prescriptions that might be used in research. Would you agree with that, Claudia?

DR. CITKOVITZ: Completely. I mean, acupuncture does have a strong nonspecific effect, so the great 2012 trialists collaboration article[3] shows quite clearly that, if you treat many people with acupuncture for pain, the effect of having had acupuncture alone—leaving aside whether the acupuncturist chose points well—has an effect that is comparable to taking an ibuprofen. There is a pretty good effect just from having had acupuncture, which is well and good for pain in a generic population.

When you want to be extra-sensitive to the needs of a pregnant person, then again you need to have a practitioner who understands both what is going on per the differential diagnosis from a Chinese medicine point of view and also what is happening in the pregnancy at that particular week of the pregnancy. You need both components of the training.

MS. KOCHER: Yes, if you add the additional component of someone being high-risk in the hospital, in a more acute situation, it is another layer of compromise that the patient is in. And knowing how to read those nuances and knowing how to support someone in that situation takes a certain amount of training and experience.

DR. BETTS: I will briefly add to the point of safety in delivering acupuncture in the outpatient clinic. We are working with students. It is something that is very achievable, to be able to deliver the training, to be able to treat these women.

Back pain and pelvic pain are the most-treated conditions we see in the outpatient clinic, followed by preparation for labor, wherein women come in seeking to have treatment in preparing for cervical ripening and dealing with fear, discomfort, pain, and lack of sleep. They may have hemorrhoids or vulvar varicosities.

A lot of that is also preparation emotionally for labor, so that they go into labor in the best possible state to cope with what happens in labor. The reason we see so many people for pre-birth is that the midwives are sending them. I will briefly add that, in New Zealand, midwives are independent practitioners, so 80% of women have births with midwives who are not under or within the hospital system. They can take women to hospitals but these midwives are the

independent caregivers of the women during their pregnancies. And, if there were problems, a patient would get referred to a consultant or an obstetrician.

So, what we are doing here is working with independent midwives and, every 3 years, these midwives go before a committee, and they have to look at their practices statistics and discuss what has happened in their practices. These midwives keep very good records of medical interventions—of problems that have come up in pregnancies—and it is a real validation to me that they come back after the course and say that it really does change and improve their practices when they start using the acupuncture.

In thinking about pain—which is something that I feel most acupuncturists would be confident treating—the back pain and the pelvic pain that is seen in pregnancy is so prevalent in these women. It interferes so much with their lifestyles and can be so exhausting for them. The evidence base for that in a Cochrane review in 2015 does clearly state that acupuncture is a very useful tool.[4]

If practitioners are feeling reluctant or concerned about pregnancy, it is something that they might want to consider treating in terms of being able to provide some truly excellent relief for these women.

DR. NIEMTZOW: I am interested to hear from this group of experts on this question: What would you *not* do during pregnancy in terms of acupuncture treatment?

DR. BETTS: That is a great question. I think it comes back to the understanding of what is happening in the pregnancy in that particular time, in the different trimesters. It is understanding the pregnancy physiology and understanding how you are framing your treatment plan and diagnosis.

When I am working with the students, every acupuncture point is thought through and every intervention that we use has a sound rationale of how it relates to the pregnancy and how it relates to each person's condition.

One of the things that I have seen not be successful is overtreatment—just doing a lot of treatment to try and cover your bases. I think, in pregnancy, it is a time for a very well-thought-out specific treatment.

I personally do stay away from points that would stimulate any type of labor intervention until that is what we want. For me, there are certain points that have specific functions in terms of stimulating uterine contractions, helping the cervix ripen, and I would not use those points unless I wanted this to occur, which is only when a medical induction has been planned. I think there is an awful lot we can do, and it is a case of having an understanding of the pregnancy physiology and what you want to do, and, then, a clear rationale for your acupuncture intervention. Sarah, did you want to add into that?

MS. BUDD: Yes, it is a good question, Richard, and an important one. For me, it comes back to being well-trained. Practitioners must understand, and have good training about, the ''red flags'' of pregnancy to recognize when a condition needs a medical referral. An examples might be someone with severe dehydration with hyperemesis, recognizing that the patient is ketotic and needs rehydration with a drip. Recognition of severe bleeding or the possibility of an ectopic pregnancy.

Another example is understanding the contraindications to using moxibustion for breech presentation—so, understanding when it is not appropriate to do that treatment with a breech presentation. And, as Debra says, a good understanding of which points should not be used during pregnancy, because they may stimulate contractions. For me, these are the kind of cautions that should be incorporated very strongly into students' training so that the treatments are safe. In terms of what perhaps acupuncturists should *not* do in pregnancy, that is where those issues come out.

DR. CITKOVITZ: It is important to point out that these contraindicated points that Debra and Sarah are mentioning are very-well-discussed, both in Debra's excellent book, *The Essential Guide to Acupuncture in Pregnancy & Childbirth*,[5] and, also, Sarah and Debra, did you not write an article together about the contraindicated points?

MS. BUDD: Yes, it was published in the *Acupuncture in Medicine* journal.[6]

DR. BETTS: Claudia, did you want to add any comments about what acupuncturists should be very cautious about?

DR. CITKOVITZ: Yes; I agree completely with avoiding the contraindicated points. I agree with the idea of do not needle anything that you do not have a solid rationale for. The way I say that to my students is, ''if you are not sure, keep asking. Do not treat until you know exactly what you are trying to treat, to do. But, if you are sure, then it is better for the patient to treat than not to treat.''

In general, I am deeply suspicious of anything that lowers the Qi unless the patient has hypertension. I tend to raise the Qi in almost everything I do.

It is also important to take into account the red flags, as Sarah says, both in terms of things that ought to go immediately to the care plan and things that patients might not want to go to the doctor for but, still, yet they should see a doctor. It is important that we not provide an excuse for people not to seek conventional medical care.

MS. KOCHER: One thing I might add, influenced by my education and teacher, is to never treat the abdomen after the first 12 weeks of pregnancy.

DR. BETTS: Right. That leads to something that I think is useful: When we talk about points that we might be staying away from, or be cautious about, or forbidden points, one of

the barriers to acupuncture practice—and that creates a lot of fear among practitioners or reluctance to treat—is that there are some lists with many points that have been labeled as ''cautious.'' And these lists do not really have a rationale that stands up in terms of traditional use, how the points were used, or in terms of what we might see today in clinical practice.

Sometimes this caution appears to have come out of people's ideas and taught to students over time and taken from these lists. And you have points, such as, Liver 3 or certain Heart points, and you have these quite comprehensive lists of 20-something points in some books that are on what to not use in pregnancy.

That creates a lot of uncertainty and perhaps it would be helpful for us to clarify that there are a variety of points that you can use for very good reasons. In addition, the ones that we tend to be cautious about are the ones that we have seen in clinical practice or the ones that we use to actually induce contractions or ripen the cervix or actually promote efficient labor.

In our outpatient clinic, for 10 years, we have been treating between 100 and 150 women a year. We treat a lot of back pain. As an aside, for me, I am happy to cup the lower back. I see that as improving the blood flow to the muscles. It is releasing the tension. We follow-up with women after 3 treatments with questionnaires about adverse events, and we have not had any problems with cupping a lower back, which is something we have now done on hundreds of women all throughout pregnancy.

In terms of points, I am very clear about staying away from points that—such as Bladder 31, 32, 33—I see as very stimulating in labor. Sarah and I covered these in our article.[6]

I think there are two aspects to this: One is unnecessary fear and one is appropriate caution.

MS. KOCHER: That is really well said, Debra. I feel like that is the key. It is about discerning which points you want to use for each individual, in each specific situation. Also, the relationship that we have with our points plays an important part. I have certain points in my repertoire that I use with certainty to treat particular conditions, wherein I know when and how to use them. So, I like to confirm this idea of being mindful of why you are using a point and what its purpose is. When that is clear, in my experience, it goes well. How we create treatments is an art and a discernment all at once.

DR. CITKOVITZ: I will add that I think Stomach 30 and Stomach 31 is a really good example there—Stomach 30 has an indication to treat nausea, and it works very well for that. But it is right above the pubic bone on the belly and it is where women often feel most vulnerable about being needled.

My thinking, after 16 years in a hospital, is what would the worst-case scenario be? It's true that women miscarry; that happens. So, if by coincidence, a woman was to miscarry right after she had been needled in the lower abdomen and not felt great about it but not felt comfortable saying anything to stop it, there would be bad feelings in the air that just did not need to be there.

So, as it happens, Stomach 31, the next point down the channel from Stomach 30, works very well to treat nausea. It is at the top of the leg and is in an area that does not feel threatening to people. You do not need to drape them much or anything.

The whole process feels different and I would rather err on the side of caution and develop relationships with points that do not make patients nervous.

DR. BETTS: Cameron, the big question here is about acupuncture being safe in pregnancy and what constraints there should be on providers' practices. Can you address that for us?

MR. MUMMERY: First, I want to say that I work for the AAC, and we insure the majority of acupuncturists in the United States. So, my answers are related to what the AAC does, not what the entire insurance profession does.

With that in mind answering this question, the AAC does not have restrictions covering the pregnancy condition, as long as an acupuncturist treats a patient in Eastern medical terms. Over the years, we have established that the use of acupuncture while a patient is pregnant is a safe form of treatment. We do have specific exclusions in the AAC policy dealing with turning of breech babies, inducing labor, and needling a patient while she is in labor. In the case of turning of breech babies and inducing labor, the exclusion says that coverage through the policy is available if these modalities are done in coordination with the patient's obstetrician/gynecologist. When labor begins, the risk factors increase, so there is an exclusion in the policy for treating once labor starts. Claudia has told me that the definition of when labor begin varies.

However, we are the only insurance company, that I am aware of, that has a program to include coverage for needling while in labor. If an acupuncturist can prove sufficient training in the needling while in labor protocol, we can cover during this time. There is a rate assessed for coverage for needling while a patient is in labor because this type of coverage does have enhanced risk.

DR. CITKOVITZ: So, am I right in applying a layperson's general understanding of the idea that, if there is not an additional premium for something, that means that the insurance company has decided that that ''something'' does not add risk for a practitioner of a lawsuit or other adverse things happening?

MR. MUMMERY: An insurance company has a department called an actuarial department and that department will look at various types of risks. And the actuarial department will make recommendations in three different areas. One is to restrict a risk through the insuring agreement—a restriction in the type of coverage that is being done. The

second thing is to eliminate it by excluding it from the policy in the exclusions section. The third option is to charge an additional premium to account for what is perceived as additional risk.

With our AAC policy, none of those three things are being done for pregnancy, with one exception—needling while in labor. We can cover needling while in labor up to when the birthing process starts, but that does have an additional premium attached to it.

DR. BETTS: Claudia, from the perspective of practitioners in the United States, is that the general understanding you have from Cameron's clarification?

DR. CITKOVITZ: That is AAC's coverage scenario—and they are certainly not the only insurance company in the country but they do have experience covering the vast majority of acupuncturists for 30 years. So, I take very seriously the accumulated weight of that insurance company's experience—that treating patients while pregnant is not something that they need to restrict.

As a non-insurance person, my thinking is that if the company were paying money out for lawsuits or anticipated having to do so, the company would need to be charging higher premiums. The fact that the AAC has been insuring most of the acupuncturists in our country for 3 decades and are not doing anything special about pregnancy, I take as a very special kind of anecdotal evidence.

DR. BETTS: Richard, you started off this roundtable by discussing the perception of safety and that many acupuncturists were concerned about safety in pregnancy. And we have just heard from Cameron that, from risk assessment, there does not appear to be a layer that they consider there. Do you have any further thoughts on this?

DR. NIEMTZOW: That is very helpful in terms of getting the message out there, especially the statement that, except for labor, the pregnant female is treated as a regular acupuncture patient, without any restrictions. I think that is a very important statement, Cameron.

MR. MUMMERY: Yes, and I am comfortable with that statement. I would like to build on what Claudia just said. Thirty years ago, insurance companies would not cover acupuncture for pregnancy in any shape or form. Back then, it was near-impossible to find reinsurers willing to cover that risk. Over the years, we have educated our reinsurers about what acupuncture is, and how safe acupuncture is, and have been able to liberalize the policy tremendously from where it was 30 years ago. I think many practitioners who do not want to get involved with pregnancy remember malpractice insurance coverage from many years ago.

I suspect, as we continue down this path, that we will continue to be able to liberalize the policy in areas that were far more restrictive 30 years ago than they are today. I think the malpractice insurance policies will be more liberal when it comes to pregnancy as we go along. Because, to date, the types of claims that acupuncturists report have not been too severe. Conducting and publishing studies helps us inform and educate our insurance partners, which helps move the profession forward in broadening areas of medicine that we have been previously restricted.

DR. NIEMTZOW: I will agree. I remember when my insurance company said to me that, if you treat a pregnant female, your insurance is void and you cannot renew it. So, it has come a long way, that is for sure.

DR. BETTS: That is an incredibly important update that many acupuncturists may not be aware of. Richard, would you say that is the case?

DR. NIEMTZOW: I think especially in the military, where a lot of work is being done with Battlefield Acupuncture,[7] I often get questions on whether or not placing the needle in the ear is taboo in terms of treating the pregnant female for pain? So, we had been saying we do not recommend Battlefield Acupuncture, which I think you all know is a 5-needle technique done in the patient's ear. Now, I am beginning to think that we should perhaps say that it is an O.K. procedure.

DR. BETTS: Having met you at a conference a long time ago, Richard, and hearing about your Battlefield Acupuncture, I must just say—and you very kindly talked to me about what you were doing—I have used Battlefield Acupuncture on a woman who had broken ribs, who had been in a lot of pain.

And I certainly did not have any reservations about that because we were not using Uterus points in the ear, which is something that I would have more reservations about. Have other people on the panel had experience with that? It brings us back to that idea of developing guidelines and the training—and that is all possible from my point of view—to allow a pregnant woman to have access to this.

MS. KOCHER: Yes, I use auricular acupuncture all the time, though I have not been formally trained in Battlefield Acupuncture. However, it is the ear, so I am curious. I think it is certainly something to look into further.

DR. CITKOVITZ: I e-mailed Richard a while back, very eager to use the Battlefield points. But a lot of our patients have had strokes and we did not want metal things to be in the patients' ears if they needed to go for stat magnetic resonance imaging [MRI]. There's also a concern about infection with the long insertion time. So, I have been doing the Battlefield points with regular needles and strong stimulation and then pulling out the regular needles and replacing them

with ear seeds and strong stimulation. We get terrific results for pain with that.

DR. NIEMTZOW: You can also use titanium needles. They are just like the Aiguille Semi-Permanente® needles for Battlefield Acupuncture, and they are not magnetic. And the patient can actually undergo an MRI procedure without any fear. In fact, some of my MRI studies that I did on Battlefield Acupuncture were done with titanium needles.

DR. BETTS: Thank you. Claudia and Zena, did you have anything to add to that?

DR. CITKOVITZ: I will briefly add that the hospital personnel, once they learned that we were insured, they did not doubt or choose to restrict what we would do any more than they did any other provider. We have a very carefully delineated list of privileges of what we can and cannot treat. Once we are treating, it is at the practitioners' discretion, with the understanding that the practitioners have been carefully screened and that they have had training. The hospital has not put specific guidelines on what we do.

Similar to how Cameron sees liberalization of policies proceeding into the future, I see acupuncture-residency programs going forward into the future. We really ought to be developing that expertise.

MS. KOCHER: A lot of it is also aligning with what each hospital or area has for its own guidelines. This involves becoming knowledgeable about these guidelines and aligning with them, because we are here to work within each hospital's or area's system.

We found, when we were creating guidelines, especially concerning cancer and other ailments, it gets a little tricky, because people are in different stages of their healing. For instance, if someone is at the end of life, we might want to treat areas that we would otherwise avoid. In our guidelines, we emphasized the importance of conversation with the attending physician about our purpose for treatment.

Also, we wanted our present guidelines to allow for integration, as our medicine becomes more accepted and understood, encouraging growth, not hindering it. So, many of our guidelines emphasize communication with the doctors, nurses, and staff members as a critical place to create that growth of integration.

DR. BETTS: Right. And the guidelines that I work with were developed from the physiotherapy guidelines that the hospital already had, and, although the hospital personnel initially said that pregnancy should not be treated, they were quite happy to work with us to just look at basics such as emphasizing hygiene and disposable needles, etc., and then move on to the pregnancy.

So, we have a very free hand, and we are not restricted in what we treat, although caution is advised. If you have preexisting guidelines for the use of acupuncture with physiotherapy, that is another way to adapt that to pregnancy.

Cameron, do you have anything to add about developing guidelines for use within systems?

MR. MUMMERY: Developing guidelines is an important aspect. I was teaching at an acupuncture college in Miami, and we were talking all about boundaries and how to develop and stay within your boundaries. These guidelines are a lot about setting up your boundaries and having guidelines determine your boundaries. I think they are very important to the insurance process to have established written guidelines in place. In our opinion, it makes it for a safer practice.

DR. CITKOVITZ: I had some personal experience working with Cameron and AAC on that many years ago. In the middle of our acupuncture study, it came to light that we were not covered by the policy, because the language was clarified that what we were doing was not covered.

So, we had an emergency session and I sent my study protocol to the company and the company looked it over and we discussed issues. Having it clearly laid out—not necessarily what points you want to needle—but what kinds of approaches you want to take can be very reassuring to institutions.

If you have a large institution, whether it is an insurance company or a hospital, that is not fully comfortable with something, it can be worth using a guideline as an intermediate document to get the institution comfortable with the process and then, over the course of time, to reduce restrictions, as has happened with the insurance company.

DR. BETTS: Thank you all. We have discussed the variety of our experiences and how, for us, practicing in these areas and being within medical systems, the great benefits we see from treating these women and the issues around training. And that, moving forward, guidelines would be very beneficial as well as training residency programs.

The potential to deliver this care to women is enormous, and we have such personal satisfaction with being able to help them at this time of their lives. Acupuncture is such a fantastic tool, and I just do not see as being utilized as much as it could be within our profession.

DR. BETTS: Sarah, could you give us any concluding thoughts?

MS. BUDD: Thanks, to Richard, for the opportunity to come together for this article. We all know each other very well now. so it is lovely to be able to share our experiences with you.

I hope that your readers will see that maternity acupuncture is an amazing treatment to offer these women and the comments that we saw mostly at the hospital were that we were able to help in a way that (A) saved money and (B) worked effectively. Women do not feel threatened by our

treatment, and they do not instinctively want to go down the medication route, which I think is fairly universal.

Most importantly, it works and it is fairly easy to demonstrate that with simple outcome audits. I do not think we need to be held back by comments of lack of evidence because it is just not true.

DR. CITKOVITZ: I am very grateful and pleased to be able to share all of our cumulative decades of experience. Often, people still think of acupuncture just for pain or perhaps for nausea. However, I hope that providers considering referring patients for acupuncture will take to heart that, for situations when there has been a previous bad outcome or current miscarriage or preeclampsia, or when there are medication conditions—often, we can help. When there is a pregnancy with diabetes, hypertension, or drug use, that causes symptoms throughout that pregnancy—such as vomiting, itching, and Intrahepatic Cholestasis of Pregnancy (ICP)—we can help with that.

Then, we can help women in the third trimester—approaching labor and delivery—especially now that, for Western care, medical professionals are starting to think about inducing earlier in the United States. I think that, for helping people to go into labor in a timely manner, and with vaginal birth after a cesarean section, acupuncture is indispensable. I hope people will understand what a broad range of situations we can be extremely helpful in.

DR. BETTS: Thanks. That is absolutely correct. Things such as preeclampsia and gestational diabetes—and using acupuncture to improve the outcomes for these women in all sorts of ways. It works for truly a wide range of conditions.

MS. KOCHER: Thanks to all of you—true pioneers in our field. I feel so grateful for all that you have done in forging the path forward. We are in exciting times right now, when peoples' ideas are liberalizing and they are starting to see the safety of acupuncture and to understand its value. As this consciousness is broadening, we are at a new plateau and are becoming more essential. As Asian medicine is derived from different cultures and languages, it is up to us to continue to bridge among them and expand this realization.

MR. MUMMERY: Yes, the people in this roundtable, the people that read this publication, are what I would call trailblazers in this profession. Going forward and drafting guidelines, drafting protocols, and coming up with the proper language to use helps everyone in the profession behind them. It helps us all grow.

It helps us to liberalize our insurance policies and make it easier for us to cover things. Due to the community of people surrounding this journal and in this field who are working together, collaborating, and coming up with unified protocols, unified guidelines, and driving language that you use truly helps in the process of being able to provide that safety net underneath the profession.

DR. BETTS: Thank you all for your thoughts. I am really hopeful that aspects of this discussion are going to change the ability of women to be able to access this care more easily and of practitioners who want to engage in maternity acupuncture.

DR. NIEMTZOW: This is just the beginning, and I think all of you have launched something that is going to be very powerful for the pregnant female. I think this will continue and it is going to produce a wave of excitement. Thank you all for this important panel discussion.

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