

Etat des lieux de l'acupuncture en Belgique

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Le Centre fédéral d'expertise des soins de santé

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Contact

Centre fédéral d'expertise des soins de santé (KCE).
Cité Administrative Botanique, Doorbuilding (10^{ème})
Boulevard du Jardin Botanique, 55
B-1000 Bruxelles
Belgium

Tel: +32 [0]2 287 33 88

Fax: +32 [0]2 287 33 85

Email : info@kce.fgov.be

Web : <http://www.kce.fgov.be>

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TOM DE GENDT, ANJA DESOMER, MIEKE GOOSSENS, GERMAINE HANQUET,
CHRISTIAN LEONARD, RAF MERTENS, JULIEN PIERART, JO ROBAYS,
DOMINIQUE ROBERFROID, OLIVIER SCHMITZ, ANN VAN DEN BRUEL,
IMGARD VINCK, LAURENCE KOHN

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- Titre : Etat des lieux de l'acupuncture en Belgique
- Auteurs : Tom De Gendt (De Gendt Advocaten), Anja Desomer (KCE), Mieke Goossens (De Gendt Advocaten), Germaine Hanquet (KCE), Christian Léonard (KCE), Raf Mertens (KCE), Julien Piérart (KCE), Jo Robays (KCE), Dominique Roberfroid (KCE), Olivier Schmitz (KCE), Ann Van den Bruel (KCE), Imgard Vinck (KCE), Laurence Kohn (KCE)
- Relecture : Christoph Schwierz (KCE)
- Experts externes : Peter Leysen (UA), Herman Nys (KUL), Prat Dominique (CHU Nîmes), Emmanuel Simons (CEBAM)
- Remerciements : Carine Algoet (Mutualités Socialistes), François Beyens (Centre d'Études de Médecine Chinoises et d'Acupuncture), Michiel Callens (Mutualité Chrétienne), Luc Detavernier (Mutualités Libres), Peter Devilder (OTCG), Marc Faes (ABADIC), Claire Gignion (ABADIC), Jean-Luc Hody (ABADIC), Peter Jonckheere (Yin Tang), Gilbert Lambrechts (ABMA-BVGA), Paul Lauwers (UPMAB-BVGAB), Wilfried Legein (OTCG), Francis Lenders (Europe Shanghai College), Francis Lorette (ETTC), Vera Machtelinckx (UPMAB-BVGAB), Marc Mollekens (BAF), Johan Roose (Eufom), Bruno Ruebens (Mutualités Socialistes), Danny Van Laethem (ICZO), Thibault Voglaire (Mutualités Libres), Ghislain Weets (Mutualités Socialistes).
- Validateurs externes: Norbert Fraeyman (Ugent), Raymond Massé (Université Laval-Québec), Jo Nijs (VUB)
- Conflits d'intérêt : Norbert Fraeyman (Ugent) donne des cours sur les médecines alternatives et a publié ses notes de cours sous forme d'un livre. Peter Leysen est membre du comité scientifique de l'UPMAB-BVGAB. Jo Nijs mène une étude indépendante financée par deux associations professionnelles d'acupuncteurs.
- Disclaimer :**
- Les experts externes ont été consultés sur une version (préliminaire) du rapport scientifique. Leurs remarques ont été discutées au cours des réunions. Ils ne sont pas co-auteurs du rapport scientifique et n'étaient pas nécessairement d'accord avec son contenu.
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PREFACE

Depuis quelques années, l'actualité ne fait plus abstraction de la Chine. Ce pays joue un rôle de plus en plus important sur la scène internationale. Sa puissance technologique connaît une ascension phénoménale et ce n'est vraisemblablement qu'un début. Mais la Chine offre également un autre visage. La Chine est aussi le pays millénaire de Confucius, du Tao et du Bouddhisme-Zen, le pays du yin et du yang avec sa médecine traditionnelle et ses « docteurs aux pieds nus ». C'est de cette Chine-là que nous vient l'acupuncture bien qu'elle n'y soit plus aussi populaire qu'on le croit.

L'acupuncture est sans aucun doute la plus exotique des quatre médecines alternatives qui ait été étudiée par le KCE à la demande de la ministre. Son raisonnement et son décorum nous ramènent dans la Chine traditionnelle bien qu'il existe certains courants qui essaient d'intégrer l'acupuncture dans le modèle bio-médical occidental. Quel est donc la place de l'acupuncture dans le système de soins de notre pays ?

Le KCE a à nouveau choisi d'apporter un regard multidimensionnel sur cette médecine. Nous avons bien entendu recouru au cadre d'analyse de l'Evidence-Based Medicine. Bien que les preuves d'efficacité soient à nouveau très limitées, cette médecine jouit néanmoins d'une popularité considérable, notamment, dans une certaine mesure, au sein du corps médical. Ce pourquoi les aspects socio-anthropologiques de ce phénomène ont également été explorés dans le cadre de cette étude. Ceci afin de fournir au législateur l'avis le plus pertinent possible pour l'élaboration d'un cadre juridique adapté. Face à la demande manifeste et aux attentes de la population, le législateur se doit de veiller à la transparence pour les usagers ainsi qu'à leur sécurité.

Et bien que ce rapport ne puisse satisfaire à toutes les demandes des praticiens de l'acupuncture, nous souhaitons remercier le très grand nombre d'entre eux qui nous ont aidé à fournir un portrait clair et nuancé de leur médecine telle qu'ils la pratiquent aujourd'hui dans notre pays.

Jean Pierre CLOSON
Directeur général adjoint

Raf MERTENS
Directeur général

Résumé

CADRE DE L'ÉTUDE

A la demande de la Ministre des Affaires Sociales et de la Santé Publique et, le KCE devait dresser un état des lieux des quatre thérapies non conventionnelles encadrées par la « loi Colla » depuis 1999 en Belgique, à savoir l'acupuncture, l'homéopathie, la chiropraxie et l'ostéopathie. On définit ces médecines comme un "groupe de divers systèmes médicaux et de soins de santé, de pratiques et de produits qui ne sont pas actuellement considérés comme faisant partie de la médecine conventionnelle"^a. Ces thérapies sont qualifiées de 'complémentaires' lorsqu'elles sont utilisées conjointement avec des traitements conventionnels, et d'alternatives' lorsqu'elles le sont à la place d'un traitement conventionnel.

Le présent rapport concerne l'acupuncture.

L'acupuncture est une pratique basée sur la médecine traditionnelle, d'origine chinoise et qui date d'il y a plus de 2000 ans.

Celle-ci repose sur des concepts chinois tels que les méridiens, le Qi, le Yin et le Yang.

Elle consiste en l'insertion d'aiguilles dans la peau et les tissus en des points spécifiques. Des techniques connexes telles que la stimulation des points par la chaleur (moxibustion), des pressions, la stimulation par l'électricité ou les ultra sons sont également utilisées.

L'acupuncture s'est établie en Belgique durant la seconde moitié du XXème siècle. Elle est principalement pratiquée par des kinésithérapeutes et des médecins.

OBJECTIFS

Ce rapport a pour objectifs de répondre aux questions suivantes :

1. Quelle est l'efficacité de l'acupuncture ? Quels en sont les bénéfices et les risques ?
2. Comment cette médecine se définit-elle elle-même et comment est-elle utilisée par la population belge ?
3. Quel est le statut légal de l'acupuncture et comment est-elle organisée en Belgique?
4. Comment les thérapeutes sont-ils formés ?

METHODOLOGIES

Pour appréhender ces médecines dans leur complexité, le KCE a opté pour une approche multidimensionnelle, à la fois médicale, sociologique, anthropologique, juridique et organisationnelle. Pour chacune de ces dimensions, le KCE a fait appel à des méthodes adaptées:

- une revue systématique de la littérature scientifique destinée à évaluer l'efficacité clinique et la sécurité de l'acupuncture,
- une enquête par téléphone destinée à mesurer l'importance du recours aux pratiques non conventionnelles dans un échantillon représentatif de la population générale (n=2000),
- une enquête par entretiens de type socio-anthropologique destinée à appréhender les perceptions des usagers réguliers (n=8) et de thérapeutes (n=11),

a National Center for Complementary and Alternative Medicine;c 2007 [cited 04/11/2008]. CAM Basics. Available from: <http://nccam.nih.gov/health/whatisacam/pdf/D347.pdf>

- une enquête en ligne auprès des praticiens destinée à décrire leur profil et pratique (n=329/593),
- une analyse détaillée du cadre juridique et organisationnel et de ses enjeux et, enfin,
- la consultation des unions professionnelles et d'experts permettant de décrire la manière dont l'acupuncture s'organise et dont les praticiens sont formés.

RÉSULTATS

EFFICACITÉ CLINIQUE ET RISQUES

Un effet limité bien démontré pour certaines indications précises

L'acupuncture réduit la douleur de manière modérée, particulièrement en cas de lombalgie. Il n'y a pas de preuve que la localisation précise des points stimulés soit importante. En effet, l'acupuncture 'simulée' (sham) apporte également de meilleurs résultats que l'absence de thérapie.

Certaines études indiquent également un effet sur le succès des fécondation in vitro en termes de grossesses et de naissances vivantes.

Pour les autres indications les études sont peu convaincantes.

Risques peu documentés par manque de données

Les études mentionnent des effets indésirables bénins : hématomes, irritations, rougeurs, somnolence, douleur, hypertension, saignement, etc. Des cas isolés de complications plus graves (pneumothorax) ont été signalés.

Les risques de transmission de maladies infectieuses inhérent à l'usage d'aiguille n'est en principe plus d'actualité étant donnée que les thérapeutes affiliés à une union professionnelle s'engagent à utiliser des aiguilles stériles jetables.

SITUATION EN BELGIQUE

Cadre légal

La discussion du cadre légal est commune à toutes les pratiques non conventionnelles.

L'établissement d'un diagnostic et la mise en place d'un traitement pour une affection physique ou psychique sont légalement réservés aux détenteurs d'un diplôme en médecine. Les acupuncteurs qui posent des diagnostics et instaurent des traitements dans le cadre de leur profession et qui ne sont pas médecins travaillent donc dans l'illégalité. Hormis ce cas de figure, les patients qui consultent des acupuncteurs qui ne sont pas médecins, ne peuvent donc bénéficier d'aucune garantie de la part du gouvernement en termes de qualité des soins reçus ou de sécurité. L'exécution de la loi « Colla » devrait pouvoir apporter plus de clarté à cette situation.

Cette loi « Colla » a été promulguée le 29 avril 1999. Afin de garantir que les patients reçoivent des soins de qualité, il y est entre autres prévu un système de double enregistrement : l'enregistrement des pratiques (disciplines) non conventionnelles et l'enregistrement de chaque praticien de ces pratiques.

Pour ce faire, une commission paritaire doit être constituée afin, entre autres, de rendre un avis sur les conditions générales s'appliquant à l'exercice de toutes les pratiques non conventionnelles et les conditions auxquelles doivent satisfaire les praticiens d'une pratique non conventionnelle reconnue pour pouvoir être enregistrés individuellement, comme par exemple le fait d'être affilié ou non à une union professionnelle reconnue et des exigences de formation.

La loi prévoit que la commission paritaire soit constituée pour moitié de membres proposés par les facultés de médecine, et pour l'autre moitié de praticiens d'une pratique non conventionnelle proposés par les chambres qui doivent être mises en place, à raison d'une chambre par médecine non conventionnelle reprise dans la loi Colla.

Il n'apparaît pas dans l'article 5 que les praticiens membres de la commission paritaire doivent être enregistrés. Et la loi ne définit pas non plus ce qu'on entend par « praticien d'une pratique non conventionnelle ».

Par contre la loi précise bien dans son article 8 § 1 que nul ne peut exercer une pratique non conventionnelle sans avoir fait l'objet d'un enregistrement.

Cette situation imprécise devrait être clarifiée.

Consommation: surtout pour des plaintes relatives au système musculo-squelettique et au stress

En 2009, 3% des personnes interrogées (enquête téléphonique) avaient consulté un acupuncteur au cours des 12 derniers mois. Ils ne rejettent en général pas la médecine conventionnelle mais recourent à cette pratique plutôt dans le cadre d'une démarche complémentaire, principalement sur base du bouche à oreille ou via Internet.

Les taux de satisfaction des patients par rapport aux thérapeutes non conventionnels sont assez proches de ceux exprimés au sujet des thérapeutes conventionnels.

D'après les praticiens interrogés en ligne, l'acupuncteur est consulté principalement par des adultes pour des plaintes du système musculo-squelettique ou liées au stress (dont les migraines et insomnies). Trente à 40% des praticiens reçoivent des enfants et des adolescents et moins de 20% des bébés.

Un praticien sur dix rapporte que ses patients le consulte de manière préventive, tous les 3 mois environ.

Des entretiens qualitatifs avec les usagers, il ressort que la recherche de bien-être est également invoquée.

Qui sont les thérapeutes ?

Près de 600 acupuncteurs affiliés à une union professionnelle exercent en Belgique début 2011.

Suivant l'enquête en ligne auprès des praticiens, ils sont en majorité kinésithérapeutes de formation (54%). Un tiers est à la base docteur en médecine (32%).

Plusieurs filières de formation en acupuncture existent en Belgique, dont une réservée exclusivement aux médecins.

Les formations sont dispensées à temps partiel et durent 2 à 3 ans. Dans un tiers des cas, les acupuncteurs ont également suivi une formation en Asie et y ont parfois effectué un stage.

Seuls les thérapeutes médecins, kinésithérapeutes ou paramédicaux tels que définis par l'AR 78 peuvent obtenir le titre d'acupuncteur. Toutefois, les non-médecins n'étant pas formés à la base pour pouvoir poser un diagnostic médical, des cours complémentaires sont nécessaires. Ceux-ci semblent lacunaires dans les cursus actuels en acupuncture en ce qui concerne le diagnostic différentiel et la symptomatologie médicale, faisant courir le risque au patient d'un diagnostic manqué, erroné ou tardif ou d'un retard dans la mise en place d'un traitement conventionnel essentiel.

Aucune formation n'est contrôlée par un organisme officiel belge bien que certaines écoles collaborent avec des instituts reconnus (hautes écoles) pour utiliser leurs locaux ou bénéficier d'une homologation.

D'un point de vue organisationnel, les acupuncteurs se regroupent au sein de quatre unions professionnelles. Elles sont toutes enregistrées dans le cadre de la loi Colla. Pour pouvoir prétendre à une affiliation en tant que membre à part entière dans une association professionnelle, celles-ci utilisent les critères d'accès suivant: formation de base (AR 78) et formation en acupuncture dans une école Belge ou une école homologuée par une des cinq universités chinoises. L'UPMAB-BGAB (Union professionnelle des médecins acupuncteurs de Belgique - Beroepsvereniging van Geneesheren-Acupuncturisten van België) est réservée aux médecins formés à l'ABMA-BVGA (Association Belge des Médecins Acupuncteurs –Belgische Vereniging van Geneesheren-Acupuncturisten).

Ces différentes unions professionnelles sont liées aux différentes filières d'enseignements correspondantes, proposées en Belgique. Elles diffèrent quant à leur orientation plus ou moins traditionaliste.

De manière générale, les acupuncteurs revendiquent le droit de pouvoir intervenir en première ligne, dans une approche complémentaire à la médecine conventionnelle mais sans prescription médicale, ce que font actuellement les praticiens non médecins en l'absence de législation.

Les consultations

Suivant les données de l'enquête en ligne auprès des praticiens, l'acupuncture est davantage exercée en Flandre (58% des praticiens) qu'en Wallonie (24%) ou à Bruxelles (18%).

D'un point de vue pratique, les aiguilles sont utilisées par la plupart des thérapeutes. Plus de la moitié utilise la moxibustion et 44% l'acupuncture auriculaire.

A noter que les acupuncteurs affiliés à une union professionnelle se sont engagés à utiliser des aiguilles stériles jetables.

Aspects financiers

Nos différentes enquêtes indiquent que les consultations d'acupuncture peuvent coûter jusqu'à 50 euros pour une première consultation et jusqu'à 35 euros pour une consultation de suivi. Aucun remboursement par l'assurance maladie obligatoire n'est prévu, si ce n'est la consultation du médecin le cas échéant. Toutefois, certaines mutualités, dans le cadre de leur assurance complémentaire, ainsi que certaines assurances privées interviennent sous certaines conditions.

CONCLUSION

En conclusion, la littérature abondante relative à l'acupuncture apporte quelques preuves d'efficacité pour certaines indications. Il n'y a pas de preuve que la localisation précise des points stimulés soit importante. Seuls des risques bénins sont décrits dans la littérature.

Environ 3% de la population fait appel à cette pratique non-conventionnelle et en est généralement satisfaite.

Les thérapeutes diplômés en Belgique et affiliés à une association professionnelle sont au minimum détenteurs d'un diplôme inscrit dans le cadre de l'AR 78 sur les professions des soins de santé, garantissant d'emblée un certain type de formation. Toutefois les formations dispensées actuellement ne couvrent pas forcément suffisamment les domaines permettant de garantir la sécurité des patients.

Les praticiens non-médecins pratiquent actuellement dans l'illégalité et les patients n'ont aucune garantie de la part de l'Etat quant à la sécurité ni à la qualité. L'exécution de la loi Colla devrait pouvoir apporter de la clarté à cette situation.

RECOMMANDATIONS^b

Attendu que les acupuncteurs qui ne sont pas médecins exercent dans l'illégalité tant que la loi Colla n'est pas appliquée et compte tenu du phénomène social observé de la pratique et de la consommation courantes d'acupuncture en Belgique, il faut de manière urgente prendre les mesures nécessaires pour garantir la sécurité des patients, en tenant compte des recommandations suivantes :

Diagnostic et prescription

- Pour des raisons de sécurité des patients, il faudrait limiter les autorisations d'exercer l'acupuncture aux titulaires d'un diplôme de médecin, de kinésithérapeute, d'infirmier ou d'accoucheuse.
- Seuls les médecins sont habilités à poser un diagnostic et à prescrire ; il n'y a pas d'argument scientifique pour donner aux acupuncteurs qui ne sont pas médecins plus de compétences en matière de diagnostic et de travail sans prescription qu'aux autres professions réglées par l'AR n°78 du 10 novembre 1967 relatif à l'exercice des professions de soins de santé qui, pour certaines interventions, sont légalement tenues de ne travailler que sur prescription.

Composition de la commission paritaire et des chambres:

- Il faudrait veiller à ce que leur composition prenne en compte les différentes orientations existantes dans la discipline concernée.

Formations, enregistrement et titre octroyé:

- Une attention particulière doit être portée aux éléments permettant de veiller à la sécurité des patients (connaissance de la sémiologie notamment) dans les formations qui bénéficieraient d'une reconnaissance officielle.
- L'enregistrement des praticiens devrait être conditionné notamment par la réussite d'une formation reconnue et conduire à l'obtention du titre d'acupuncteur dans le cadre de l'AR n° 78 , en application de l'article 10§2 de la loi Colla.
- L'enregistrement d'un praticien ne devrait pas être lié à son adhésion à une union professionnelle.

Sécurité:

- Dans l'exercice de l'acupuncture, il convient d'utiliser dans tous les cas des aiguilles stériles à usage unique. Par ailleurs, il serait nécessaire de mettre sur pied un système de monitoring des effets secondaires et accidents comme recommandé précédemment par le KCE.

Information des patients:

- Une fois la loi Colla mise en application, l'obligation d'information qu'elle contient va se superposer à celle prévue par la loi relative aux droits des patients et offrir un cadre juridique quant à l'information dont doivent disposer les patients. Il y aura lieu d'informer tous les praticiens nouvellement reconnus sur cette loi et sur les obligations qu'elle implique.

Remboursement :

- Compte tenu du peu d'efficacité clinique clairement démontrée, il n'est pas recommandé de mettre à charge de l'assurance maladie obligatoire un remboursement de l'acupuncture.

^b Le KCE reste seul responsable des recommandations faites aux autorités publiques

Scientific summary

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ABBREVIATIONS

ABADIC	Belgian Association of Acupuncturists graduated from China / Association Belge des Acupuncteurs Diplômés de Chine
ABMA-BVGA	Belgian Association of Medical Acupuncturists / Association Belge des Médecins Acupuncteurs -/ Belgische Vereniging van Geneesheren-acupuncturisten
AETSA	Andalusian Agency for Health Technology Assessment
AMED	Allied and Complementary Medicine
AR	Arrêté Royal
BAF	Belgian Acupunctors Federation
BDMA	Belgian Direct Marketing Association
BIG (loi)	(Wet) Beroepen in de Individuele Gezondheidszorg
BMA	British Medical Association
CAM	Complementary and Alternative Medicine
CATI	Computer Assisted Telephone Interviewing
CDSR	Cochrane Database of Systematic Reviews
CEN	Comité Européen de Normalisation European committee for Standardization
CI	Confidence Interval
CINHAL	Cumulative Index of Nursing and Allied Health Literature
CRD	Centre for Reviews and Dissemination
EBM	Evidence Based Medicine
ETTC	Enseignement des Thérapies Traditionnelles Chinoises
EUFOM	European Federation for Oriental Medicine
FNRS	Fonds National de la Recherche Scientifique
HTA	Health Technology Assessment
JAMA	The Journal of the American Medical Association
KATHO	Katholieke Hogeschool Roeselare
MB	Moniteur Belge
MD	Mean Difference
MeSH	Medical Subject Heading
MWD	Mean Weighted Difference
NCCAM	National Center for Complementary and Alternative Medicine
NICE	National Institute for Health and Clinical Excellence
NRS	Numerical Rating Scale
NSAID	Non Steroidal Anti-inflammatory Drug
OTCG	Opleidingsinstituut voor Traditionele Chinese geneeswijzen
PEDro	Physiotherapy Evidence Database
RCT	Randomised Controlled Trial
RD	Royal Decree
RMDQ	Roland Morris Disability Questionnaire
RR	Relative Risk
SIGN	Scottish Intercollegiate Guidelines Network
SMD	Standardised Mean Difference
SPF	Service Public Fédéral
TCM	Traditional Chinese Medicine
TENS	Transcutaneous Electric Nerve Stimulation
UK	United Kingdom
ULB	Université Libre de Bruxelles

UPMAB-BGAB	Union of Medical Acupuncturists in Belgium / Union professionnelle des médecins acupuncteurs belges / Beroepsvereniging van Geneesheren-Acupuncturisten van België
US(A)	United States (of America)
VAS	Visual Analog Scale
VATAP	Veterans Affairs Technology Assessment Program
WAD	Whiplash Associated Disorder
WMD	Weighted Mean Difference
WMHTAG	West Midlands Health Technology Assessment Group
WUG	Wet op de Uitoefening der Geneeskunst

I INTRODUCTION

I.1 BACKGROUND

Acupuncture, chiropractic, osteopathy and homeopathy are treatment methods classified as complementary and alternative medicines. In 2007, the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institute of Health (US) defined these medicines as a 'group of diverse medical and healthcare systems, practices and products that are not currently considered to be part of conventional medicine'. These therapies are referred to as 'complementary' where they are used jointly with conventional treatments, and as 'alternative' where they are used instead of conventional treatment.

Prior to this, in 1993, the British Medical Association¹ defined them as 'those forms of treatment which are not widely used by the orthodox health care professions and the skills of which are not taught as part of the undergraduate curriculum of orthodox medical and paramedical health care courses'.

The WHO defined them as: 'a broad set of health care practices that are not part of the country's own tradition and are not integrated into the dominant health care system'².

In Belgium, performing a diagnosis and dispensing treatment for a physical or psychological disorder are legally restricted to the holders of a diploma of medicine approved by the competent medical commission (Royal Decree 78)³. In principle, only they can use Complementary and Alternative Medicines (CAMs) to care for patients. There are a number of treatments that can be dispensed legally by physiotherapists – on medical prescription – that may form part of a non-conventional treatment.

In 1999, a law concerning non-conventional medicines was promulgated. This law covers homeopathy, chiropractic, osteopathy and acupuncture, and also holds out the possibility of recognising other alternative or complementary therapies. The purpose of the law is to allow practitioners of these practices to be registered as such and to practice legally the non-conventional medicines concerned. For this to happen, the non-conventional practices must also be registered. The law establishes the creation of a joint commission (one for all four practices) and four chambers (one for each non-conventional medicine) to advise the Minister for Public Health on the practice of CAMs. This includes among others the conditions for the registration of practitioners and the practices themselves, treatments not authorised for non-doctor practitioners and membership of recognised professional unions.

Since 1999 very little of the Colla law has been executed. A Royal Decree and a ministerial order have been published, which describe the recognition procedure and the conditions for the recognition of professional unions for non-conventional practices. In addition, a number of professional unions have been recognised by this Royal Decree.

Ten years later, the law of 1999 has only been partially implemented because neither the commission nor the chambers have been established. At the end of 2010, a number of initiatives have been taken to execute the law. The Minister for Public Health and Social Affairs have meanwhile asked the Federal Healthcare Knowledge Centre (KCE) to draw up a report on the situation of these practices in order to review or implement the law of 1999.

The alternative medicines project includes the publication of three reports: the first published report dealt with osteopathy and chiropraxy; the second is devoted to acupuncture; the third will be dealing with homeopathy.

I.2 OBJECTIVES AND METHODS

The report aims to respond to the following questions:

1. How effective are alternative medicine? What are their benefits and drawbacks?
2. How are these medicines defined and how are they used by the Belgian population?
3. What is the legal status of these medicines and how are they organised in Belgium?
4. How are the therapists trained?

To this aim, specific methodologies have been employed (See appendix): an analysis of the literature to assess the clinical effectiveness and safety of the therapies under study; a telephone survey of a population sample to measure the level of demand of these therapies; a socio-anthropological interview-based survey to gauge the perceptions of regular users and therapists; an online survey of practitioners to describe the practitioners and practices; a detailed analysis of the legal and organisational framework to help to understand the Colla law, the hold-ups and issues; and finally meetings with the professional unions and experts to describe how these professions are organised and how their practitioners are trained.

I.3 HISTORICAL BACKGROUND

I.3.1 Definition of acupuncture

Acupuncture is the “Insertion of a needle into the skin and underlying tissues in special sites, known as points, for therapeutic or preventive purposes”⁴. Acupuncture has a long history from the early time of traditional Chinese medicine (TCM) to its modern development into a “scientific acupuncture”. Numerous related techniques have been developed during that 2000 years (or more): point stimulation by heat (moxibustion), pressure (acupressure, shiatsu, tui na), electricity (electroacupuncture), laser (laser-acupuncture, low-level laser therapy) or ultrasound⁴. The historical aspects are important in order to understand the conflicting views on modern versus traditional acupuncture as practiced in Belgium.

I.3.2 The Chinese origins of acupuncture

Acupuncture is one of the main therapies of traditional Chinese medicine along with moxibustion, massage, exercise and diet therapy. The theoretical foundations of TCM have been synthesized for the first time 2000 years ago in the *Huangdi Neijing* "the Inner Classic of Huang Di". This book is traditionally attributed to the legendary "Yellow Emperor" (Huang Di) who is generally regarded as the inventor of medicine, acupuncture and moxibustion⁵. This book is actually the result of a collaborative writing over several centuries (from 5th to 1st century BC). The *Neijing* adopted the philosophy in vogue at that time and expressed fundamental medical principles in holistic terms such as *Yin-Yang*, the *Qi* and the Five Element theories (*Wu Xing*)⁶⁻⁸. Globality and maintaining harmony are two central concepts that appear in the book. They concern both the physiology, pathology, diagnosis and treatment [see box below].

Traditional Chinese Medicine: an introduction

“Most of the principles of TCM were derived from the philosophical basis that contributed to the development of Taoism, and Confucianism. Ancient Chinese scholars noted that all natural phenomena could be categorized into *Yin* and *Yang* (two opposite, complementary, interdependent, and exchangeable aspects of nature), everything in the universe consisted of five basic elements (wood, fire, earth, metal, and water), and the universe was constantly changing towards dynamic balance or harmony. Such knowledge was applied to understand, prevent, and cure disease.

In TCM, *Yin* refers largely to the material aspects of the organism and *Yang* to functions. There is a circulation of *Qi* (energy) and blood. The organs work together by regulating and preserving *Qi* and blood through the so-called channels and collaterals. Disease occurs after a disturbance in *Yin–Yang* or flow of *Qi* or blood, or disharmony in the organs caused by pathogenic (eg, sadness, joy, lifestyle) and climatic factors (dampness, heat, cold). Treatment aims to expel or suppress the cause and restore balance.

Imbalance is assessed by four traditional examination methods: looking, listening and smelling, asking, and touching. Observations of the pulse, face, tongue, urine, and stool provide essential information. The diagnosis is derived with theories such as the eight diagnostic principles to differentiate between *Yin–Yang*, exterior–interior, deficiency–excess, and cold–heat, the five elements theory to assess the relations between organs and functions, and the visceral manifestation theory to establish the disease location”.
(Tang,2008⁹ p.1939)

These theoretical principles of TCM apply to acupuncture to which many sections of the *Neijing* are dedicated. The first book devoted entirely to the practice of acupuncture is the *Zhenjiu Jiayi Jing* (A classic of acupuncture and moxibustion) written in the late third century (between 259 and 260 AD)⁶. Three centuries later, acupuncture is officially recognized as a medical specialty by the Imperial Medical Bureau of the Tang Government (618). At that time, acupuncture spread to neighbouring countries (Japan and Korea in the sixth century, Vietnam in the seventh century)¹⁰.

Holism in acupuncture: an introduction

One fundamental principle of TCM is that human being is inextricably linked to nature (as it was already written in the *Nei Jing*)⁵. Some concepts like *Yin* and *Yang*, the five basic elements (wood, fire, earth, metal and water), or the *Qi* (pronounced “chee”), are used to interpret natural phenomena as well as human conditions⁷. Disease may happen when human body doesn’t succeed to adapt to environmental (social or natural) changes⁵. Following that principle, a chinese diagnosis can be compared to a practical “weather report” and acupuncture is used to shift a person’s unique “climate”⁷. In that conception, any imbalance in *yin-yang* and its connecting *Qi* may be corrected by using fine needles inserted in specific points located on channels. A state of “harmony” (or equilibrium) is linked to a good circulation of energy.

Another fundamental principle of TCM is that human body is considered as a whole, integrated and interactive: channels and collaterals are linked to organs, limbs and joints; the organs work together; vital substances like *Qi* and blood are circulating through the body⁵. In acupuncture, “classic theory recognizes about 365 points, said to be located on 14 main channels (or meridians) connecting the body in a weblike interconnecting matrix”⁷. Energy, circulation and equilibrium are the three paradigms which structure the holistic epistemology of acupuncture and of many alternative medicines¹¹.

1.3.3 Importing acupuncture into Europe

Acupuncture has appeared in Europe in the 16th century with Jesuit missionaries. The word "acupuncturist" made its appearance at that time as a contraction of the Latin words "acus" (needle) and "pungere" (prick). Physicians such as Ryhne Wilhelm (1683) or Englebert Kaempfer (1712) then made more detailed accounts of this practice by trying to explain acupuncture in more familiar terms to western physicians practicing humoral or anatomical medicine. By the end of the 18th century, a scientific interest to acupuncture grew up in medical circles, particularly in France¹². By the second decade of the 19th century, diverse group of practitioners took up the technique. In France, Dr Berlioz, wrote his *Mémoire sur les maladies chroniques et l'acupuncture* (1816) and the chevalier de Sarlandière his *Mémoire sur l'électropuncture et sur l'emploi du moxa japonais en France* (1825)¹³. In Great Britain, a surgeon named James Churchill published in 1822 a *Treatise on acupuncturation*. At that time of growing success in French or British mundane or artistic world, acupuncture was declining in its own native country. In 1822, acupuncture was excluded from the Imperial Medical Institute then outlawed in 1929.

Knowledge about acupuncture has seemingly been transmitted to Britain, and presumably to the rest of Europe, in two waves; the first slowly building over the course of the 18th century and peaking in the first decades of the 19th, and the second beginning in the 1950s, landmarked in France by the work of Soulié de Morant (in 1929) followed later by the foundation of the French association of acupuncture (1943), and in Britain by the 1959 foundation of the Medical Acupuncture Society.

In 1949, the newly created Popular Republic of China favored an integration of TCM with western medicine in training. The China Medical association invited US and UK doctors in 1971, to observe surgical operations with acupuncture used as natural anaesthetic. In this context, the Nixon's visit to China (in 1972) contributed to popularize acupuncture through the USA and all western countries¹⁴.

However, TCM is repeatedly criticized by medical circles in Europe and in China too. From the 19th century onwards, as the occidental medicine and the natural sciences developed in China, the Chinese authorities have several times tried to abolish TCM. Only from 1980 onwards, that the TCM was truly institutionalized in its native country but remains actively debated¹⁵.

1.3.4 Acupuncture between tradition and modernity

Medical historian recently discovered that "the mapped body underlying Asian acupuncture had played no visible role in the French experimental exploration of the therapy and these were the sparks for British interest in the early nineteenth century"¹⁶. And it is this apparent lack of theory that made acupuncture attractive and available to a range of physicians.

"As during the 1800s, 1960s and 1970s acupuncturists emphasized the pragmatism of their acupuncture use. Medically trained advocates of acupuncture have responded by seeking a biomedical, neuroanatomical or physiological basis for acupuncture, creating in the process a 'science of acupuncture'" (Bivins, 2001¹⁶p.12).

George Ulett in the USA and Felix Mann (the founder and past-president of the Medical Acupuncture Society (1959–1980) in UK) are known to have devised the "Scientific Acupuncture". The incessant use of latest technology of the time (electropuncture, laseropuncture, medical imaging) also contributed to establish a so-called modern acupuncture, independent from TCM¹⁰. Meanwhile in the Occident, mainly in UK, acupuncturists and scientists discuss the relevance of the new "scientific acupuncture", supposedly unrelated to TCM.

1.3.5 The origins of acupuncture in Belgium

In the early 1970s, acupuncture grew up in Belgium following two directions: Medical and paramedical. The first association of acupuncturists was dedicated to physicians: the Belgian Association of Medical Acupuncturists (ABMA-BVGA). Created in 1973, some of the founding members were trained as acupuncturists in China. They progressively developed teaching and training programmes inside this association. The advocacy of professional interests was pursued later within the Professional Union of Medical Acupuncturists in Belgium (UPMAB-BVGAB). Founded in 1981, this Union was based on the French Union of Medical Acupuncturists (created in 1946). At the same time, in early 1970s, non-physician acupuncturists were following the teaching of pioneers trained in Asia as Pierre-Joseph Struelens. One of the oldest Belgian schools, Ying Ming, was founded in 1979 for non-physician acupuncturists. Professional associations were then linked to Belgian schools of acupuncture and finally complemented by -or transformed into- unions. Three unions of non-physicians are currently recognized by the Colla law: the Belgian Acupuncture Federation (BAF), the Belgian Association of Acupuncturists graduated from China (ABADIC) and the European Federation for Oriental Medicine (EUFOM).

Since 1974, The Union of Medical Acupuncturists in Belgium had instituted a series of legal action for unauthorized practice of medicine against non-physicians practising acupuncture. In 1979, the Belgian Medical Association (Ordre des médecins/Orde van geneesheren) declared to be not competent to answer to the question: is acupuncture part of medical exercise ? but considered that physiotherapists were not allowed to practice acupuncture (following the article 2 of the Royal Decree no. 78 of 10 November 1967)¹⁷. A year later, referring to an advice of the the Royal Academy of Medicine of Belgium, the Belgian Medical Association mentioned that acupuncture might not be assimilated, at that moment, to a method scientifically rooted but had to be considered as an attempt of medical technique¹⁸. In 1999, the Law Colla (see chapter 5) questioned the chances of success of such legal actions taken by physician acupuncturists against non-physician acupuncturists.

Key messages

- **Acupuncture is one of the five therapies included in traditional chinese medicine derived from the philosophical basis that contributed to the development of Taoism, and Confucianism.**
- **Recent development of medical acupuncture in Europe (especially in UK) aimed to disconnect it from its traditional origins and transform it into a "scientific acupuncture" by seeking a biomedical, neuroanatomical or physiological basis for acupuncture.**
- **These two versions of acupuncture (traditional versus scientific) coexist in Belgium from early seventies.**

2 EFFICACY AND ADVERSE EVENTS

2.1 INTRODUCTION

A literature research documenting the effects of acupuncture for all conditions including at least one systematic review was done. The focus was on reviews of randomised controlled trials. Some physiological explanations have been put forward, such as the release of opioids^a and the 'gate control theory'^b, but we did not focus on evidence for these mechanisms, neither did we cover topics such as utilisation in the population or social aspects. All interventions related to acupuncture and based on more or less the same concepts, including acupressure and electro-acupuncture, were included, our websurvey amongst practitioners reveals the use of these techniques by them .

2.2 METHODS

We have used an iterative search strategy, starting with HTA reports and followed by systematic reviews. No additional search for primary studies was performed.

2.2.1 Databases and search terms

2.2.1.1 HTA reports

For HTA reports, the CRD database was searched. Additionally, individual websites of HTA agencies were consulted (next tableTable 1).

- CRD database, with the terms: MeSH Acupuncture Therapy EXPLODE OR MeSH Acupressure EXPLODE OR MeSH Electroacupuncture EXPLODE OR (acupressure OR acupunct* OR electro?acupunct*)
- Additional HTA agencies, searched with the terms acupuncture, acupressure and electroacupuncture:

Table 1: individual HTA agencies

HTA agency	Website
SBU	http://www.sbu.se/en/
NICE	http://www.nice.org.uk/
DACEHTA	http://www.sst.dk/english/
MSAC	http://www.msac.gov.au/
MAS	http://www.health.gov.on.ca/
HAS	http://www.has-sante.fr/portail/jcms/j_5/accueil
AHRQ	http://www.ahrq.gov/
BCBS	http://www.bcbs.com/
AETSA	http://www.juntadeandalucia.es/
AATRM	http://www.gencat.cat/
CCOHTA	http://www.cadth.ca/index.php/en/home
ECRI	https://www.ecri.org/Pages/default.aspx
DIMDI	http://www.dimdi.de/static/de/index.html
IQWIG	http://www.iqwig.de/index.2.en.html

^a An opioid is a chemical that works by binding to opioid receptors, which are found principally in the central and peripheral nervous system and the gastrointestinal tract, and plays a role in pain control.

^b Gate theorie of pain, put forward by Ron Melzack and Patrick Wall in 1965, is the idea that physical pain is not a direct result of activation of pain receptor neurons, but rather its perception is modulated by interaction between different neurons.

2.2.1.2 Systematic reviews

Systematic reviews and meta-analyses were searched in Medline, Embase and the Cochrane Database of Systematic Reviews; primary studies were searched in Medline, Embase and Cochrane Central, using the following strategies:

PubMed: 16/06/2009: (("Acupuncture Therapy"[Mesh] OR "Acupressure"[Mesh]) OR "Electroacupuncture"[Mesh] OR electro?acupunct* OR acupressure OR acupunct*) AND systematic[*sb*]

Embase: 18/06/2009: 'acupuncture'/exp OR 'acupressure'/exp OR 'electroacupuncture'/exp OR 'acupressure'/exp OR acupunct* OR electro?acupunct* AND [*embase*]/lim AND ([meta analysis]/lim OR [systematic review]/lim)

Cochrane Database of Systematic Reviews: 18/06/2009

(MeSH descriptor Acupuncture Therapy explode all trees OR MeSH descriptor Acupressure explode all trees OR acupuncture next therapy) AND Cochrane Reviews

2.2.2 Selection criteria

HTA reports and systematic reviews have been selected according to the following criteria:

P: patients suffering from any condition

I: acupuncture

C: any comparison: alternative intervention, sham acupuncture (sham acupuncture mimics true acupuncture but is different in one or more aspect: other needling points, stimulation but not skin penetration.), placebo

O: patient relevant outcomes, such as mortality, morbidity, quality of life

D: HTA reports or systematic reviews

Exclusion criteria have been defined as:

Narrative reviews, editorials, letters, primary studies, economic evaluations. Only publications in English, French, German or Dutch were included in the present report.

2.2.3 Quality assessment

Systematic reviews were assessed using the checklist developed by the Dutch Cochrane collaboration.^c

Reviews that scored positive on less than 4 items were excluded.

In addition, considering that for some indications several reviews were available, the systematic review with the highest quality rating, most recent literature search or most comprehensive scope was included (in this order of importance).

2.2.4 Clinical relevance

One of the problems in judging the clinical relevance is the absence of an agreed threshold (minimal clinically important changes) for many conditions and clinical outcomes. For some indications a consensus exists: For low-back pain, the Cochrane low back pain review group considers following changes as clinically relevant:

30% from baseline or 15 mm absolute on VAS/NRS for pain and 2 to 3 points (or 8 to 12%) on the Roland-Morris Disability Questionnaire for function. *For neck pain, consider 3.5 to 5 U on the 50-U Neck Pain Disability Index or 7 to 10% change for function and 2.5 on an 10-U NRS (25% change) for pain^{19, 20}.

For effect size, most authors use Cohen's 3 levels, but these criteria may often not be context specific enough.

^c <https://www.cebp.nl/media/m242.pdf>

Small: WMD less than 10% of the scale (e.g., ± 10 mm on a 100 mm VAS); SMD or “d” scores ± 0.5 ; relative risk, ± 1.25 or ± 0.8 (depending on whether it reports risk of benefit or risk of harm).

Medium: WMD 10 to 20% of the scale; SMD or “d” scores from 0.5 to ± 0.8 ; relative risk between 1.25 to 2.0, or 0.5 to 0.8.

Large: WMD $\pm 20\%$ of the scale; SMD or “d” scores ± 0.8 ; relative risks ± 2.0 or ± 0.5 .

VAS indicates Visual Analog Scale; NRS, Numerical Rating Scale; SMD, standardized mean difference; WMD, weighted mean difference.

2.3 RESULTS

2.3.1 Selected reports and papers

2.3.1.1 HTA reports

CRD database: search date 16/11/2010, 32 possible HTA reports

Individual websites,

- SBU: 0 hits
- NICE: 0 hits
- MSAC: 0 hits
- Ontario Health Technology Assessment Series: 0 hits
- HAS: 1 hit on rheumatoid arthritis which was not relevant for the research question
- AHRQ: 145 hits, of which 2 were relevant for the research question but were already captured by the database search (acupuncture for fibromyalgia and acupuncture for osteoarthritis)(the search function captured a lot of doubles, comments.
- Blue Cross Blue Shields: 4 hits of which none was relevant for the research question
- Agencia Andaluza de Evaluación de Tecnologías Sanitarias (AETSA) : 0 hits
- AATRM : 78 hits of which none was relevant for the research question
- CCOHTA: 0 hits
- ECRI: 2 hits of which none was relevant for the research question
- DIMDI: 1 hit which was not relevant for the research question
- IQWIG: 0 hits

Out of the identified HTA reviews two covered all possible indications for acupuncture (VATAP and WMHTAG). The VATAP HTA report had the most recent search (2006); it was included in our report as a starting point and updated to November 2010 using systematic reviews.

Six HTA reports were identified that have been published consecutive to the literature search of the VATAP report. Of these, three HTA reports were published in 2007 by the Andalusian Agency for Health Technology Assessment (AETSA), covering the value of acupuncture for migraine, lumbar pain and chronic pain. Three reports were published in 2006, one on migraine (ECRI), one on allergic rhinitis (WMHTAG) and one on back pain (IECS).

The three Andalusian reports were in Spanish and were therefore excluded. The ECRI report was not available for inclusion in full text; the WMHTAG citation was not an HTA report but a systematic review and will be covered in that section. Finally, the IECS report on back pain evaluated transcutaneous electrical nerve stimulation, which is performed with electrodes and not with acupuncture needles. This report was thus excluded.

In conclusion, the most recent HTA report is the one of the Veteran's Affairs Technology Assessment Program, who has a literature search up until 2006.

2.3.1.2 Systematic reviews

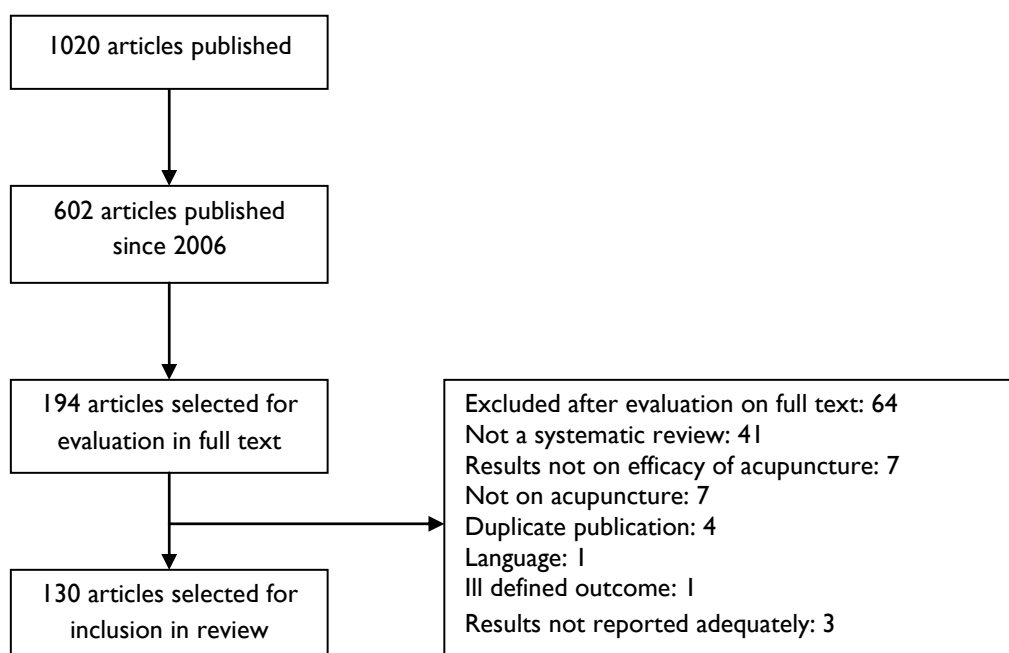
A search of systematic reviews starting from 2006, the search date of the Veteran's Affairs Technology Assessment Program, was performed.

It yielded the following number of articles: Medline - 812 possible systematic reviews; Embase - 517 possible systematic reviews; CDSR - 71 possible systematic reviews.

Discarding duplicates, 1020 articles were retrieved in total, out of which 602 have been published since 2006. After applying inclusion and exclusion criteria on title and abstract, 194 citations were reviewed in full text, out of which 64 were excluded after applying inclusion and exclusion criteria on full text. The reasons for excluding these 64 studies are listed in the flow chart.

Thus, 130 systematic reviews were included in this report. Table in appendices lists all included reviews with their clinical subject, along with the quality assessment. A summary of the overall quality of all included systematic reviews is also presented in appendices. The reviews that were finally included are marked in a table in appendices.

Figure 1: flow chart of the literature search



2.3.2 Main findings on published effects

2.3.2.1 Addiction

Systematic reviews on alcohol dependence, cocaine dependence and tobacco dependence were available.

Results were not significant for most outcomes, except for cocaine craving (1 study, n=30, comparator: sham) and smoking cessation at 6 weeks (1 study, n=120, comparator: advice).

For alcohol dependence, no effect was found on completion rates, withdrawal symptoms or alcohol craving²¹.

The study showing less craving with auricular acupuncture was the only study reporting a significant difference out of five studies in total. However, the other four studies did not detail their results. Consequently, they could not be included in the meta-analysis.

It is therefore questionable whether acupuncture has an effect on craving in people dependent on cocaine²².

Acupuncture for tobacco cessation was not shown to be efficacious in trials comparing acupuncture to sham acupuncture or no intervention, neither at short term nor at long term. One study (n=120, comparator: advice) showed ear acupressure has a significant short-term effect at <6 weeks on cessation rates²³.

2.3.2.2 Allergy

One systematic review on allergic rhinitis did not find a significant effect of acupuncture on symptom severity. Another review only dealing with auricular acupuncture could not demonstrate an effect²⁴.

2.3.2.3 Breast cancer

Patients suffering from hot flushes as a consequence of treatment for breast cancer showed a significant reduction in frequency of flushes during treatment with acupuncture (3 studies, n=189). This result was not sustained after treatment once acupuncture was stopped. A review dealing with acupressure for side effects of breast cancer treatment did not identify trials of sufficient quality to reach conclusions²⁵.

2.3.2.4 Neurological conditions

Alzheimer's disease

Electroacupuncture did not have a significant effect on cognitive function compared to conventional drug therapy, and was inferior to conventional drug therapy on activities of daily living (2 studies, n=72)²⁶.

Parkinson's disease

In this review, no significant difference between acupuncture and placebo was found. Comparing acupuncture+drug treatment with drug treatment alone shows mixed results: 4 studies showed an effect in favour of adding acupuncture on symptoms while 2 did not²⁷.

Epilepsy

Eleven small studies of low quality were included in this Cochrane review. Results are mixed, with some comparisons showing significant results. However, after combining the results of four trials that could yield the net effect of needle acupuncture, there was no significant difference between the treatment and the control groups in any reduction of seizure frequency (pooled RR 1.05, 95% CI 0.97 to 1.17)²⁸.

2.3.2.5 Psychiatric conditions

Depression

Compared to sham, acupuncture had a small but significant effect on depression severity (7 studies, n=421): the weighted mean difference is -0.65 (95% CI -1.18 to -0.11). However, the studies were very heterogeneous (I^2 84.1%) and of very low quality. No significant effects on response rates or remission rates were found. This was confirmed in a recent Cochrane update which failed to demonstrate an effect after pooling 30 low quality studies.

The Cochrane review on postnatal depression documents no significant difference in women clinically diagnosed with depression, either immediately after treatment with acupuncture or at final assessment 10 weeks postpartum. However, the review included only one small study (n=35, comparator: sham)²⁹.

Insomnia

Very few studies were available, with small sample sizes. Results were mixed, with significant results for some outcomes and acupuncture variants but not for others. Acupuncture was not significantly more effective than control on subjective insomnia improvement (3 studies) and significant statistical heterogeneity was observed³⁰.

Schizophrenia

Lee et al did a metaanalysis including 13 studies but concluded that methodological quality of the studies was too low to draw any conclusions³¹.

Uremic Pruritus in Patients with End-Stage Renal Disease

Kim et al identified Three randomized controlled trials and three uncontrolled observational with high risk of bias showing a beneficial effect and concluded that the methodological quality of the studies was to low to draw any conclusions³².

2.3.2.6

Pain

Pain relief

The review by Madsen et al.³³ assessed the effects of acupuncture and sham acupuncture for various pain conditions. Based on the results of 12 studies, acupuncture has a significant effect on pain, compared to sham acupuncture: SMD -0.17 (95% CI -0.26 to -0.08, n=2149). This difference corresponds to 4 mm on a 100 mm visual analogue scale. Sham acupuncture has a significant effect on pain compared to no acupuncture: SMD -0.42 (95% CI -0.60 to -0.23, n=1819, I² 66%). This difference corresponds to 10 mm on a 100 mm visual analogue scale. Both results remain significant after restricting the analyses to studies with a defined primary outcome, adequate concealment of allocation and a dropout rate <15%.

Tension-type headache

The number of headache days is significantly lower in patients treated with acupuncture than in patients treated with routine care (1 study, n=182) or sham acupuncture (5 studies, n=653-682). Compared to routine care, the relative risk of responding to therapy was 24.4 (95% 3.4-178.8) compared to sham acupuncture, patients receiving acupuncture had 1.5-1.9 headache days/month less. Headache intensity, analgesic use and headache scores showed mixed results, with some analyses showing no significant difference and others showing a significant difference³⁴.

Migraine

Compared to routine care, patients receiving acupuncture reported significantly less headache days/ months(1.5-1.6; 1-2 studies, n=198-220). However, compared to sham acupuncture, no difference was found. Compared to drug treatment, significant differences of 0.6-0.7 days/month were found (2 studies, n=503-564). Similar results were found for migraine attacks, headache days and headache intensity: significant difference with routine care and drug treatment, but not with sham acupuncture. Analgesic use was not significantly different for any of the comparisons³⁵.

Back pain

Based on 8 trials, the review of Rubinstein et al. concludes that there is evidence of acupuncture providing a short-term clinically relevant effect when compared with a waiting list control: a large significant effect was observed at 8 weeks for pain relief in favour of acupuncture (MWD -24.10, 95% CI -31.52 to -16.68) and for functional status (SMD -0.61, 95% CI -0.90 to -0.33) (low quality evidence) When acupuncture is added to another intervention : A significant, but not clinically relevant effect was observed for pain relief at 1, 3 and 12 months, but not 6 months (for which there was no data) (MWD -9.80, 95% CI -14.93 to -4.67; -16.91, 95% CI -25.18 to -8.64; -14.00, 95% CI -21.83 to -6.17, respectively) [low quality evidence (indirect, imprecise)]. A strong, significant clinically relevant effect was observed for functional status at 1 and 3 months in favour of acupuncture

(SMD -1.04, 95% CI -1.46 to -0.61; -0.66, 95% CI -0.74 to -0.58, respectively) [low quality evidence (indirect, imprecise)]. Clinical relevance was defined here using the criteria of the Cochrane back pain group³⁶,

Neck pain

Ten trials on chronic neck pain were included in the review by Trinh et al. None were combined in a meta-analysis, because of the large variety in acupuncture modalities and comparators. Outcomes reported were pain intensity and disability, both at short term (<3 months), intermediate (3 months – 1 year) and long term (>1 year) follow-up. Pain intensity was also assessed immediately after treatment. For pain intensity, immediately after treatment and at short term follow-up, some studies reported significant differences in favour of acupuncture and others did not find any significant difference. For pain intensity at intermediate and long term follow-up and disability at any time in follow-up, no significant differences were found³⁷.

Dysmenorrhoea & premenstrual syndrome

One review on acupressure for dysmenorrhoea identified 4 small low quality trials, stating that the evidence is promising but inconclusive. One review on acupuncture from the same author for dysmenorrhoea identified 9 small low quality trials, stating that the evidence is promising but inconclusive^{38, 39}.

Fibromyalgia

A systematic review of moderate quality covered a total of 6 studies (323 subjects). No statistically significant differences were observed in terms of pain intensity (VAS): 0.02 (-0.24 a 0.28) or withdrawals: RR 0.91 (0.53 a 1.58) and this systematic review found no evidence of benefit resulting from acupuncture versus placebo, as a treatment for fibromyalgia⁴⁰.

Myofascial trigger point pain

There is limited evidence from one study that deep needling directly into myofascial trigger points has an overall treatment effect when compared with standardised care. However, a meta-analysis of needling compared with placebo controls does not attain statistical significance, the overall direction could be compatible with a treatment effect of dry needling on myofascial trigger point pain. However, the sample size is limited and the quality of the studies is poor. Moreover, there is still debate if this syndrome actually exists⁴¹.

Knee osteoarthritis

Eleven trials were included in the review, out of which 9 reported sufficient data for pooling.

Compared with patients on a waiting list, patients receiving acupuncture reported clinically relevant short-term improvements in pain (SMD -0.96; 95% CI -1.21 to -0.70) and function (SMD -0.93; 95% CI -1.16 to -0.69). Similar differences were found in studies comparing acupuncture to usual care. Compared with a sham control, acupuncture provided clinically irrelevant short-term improvements in pain (SMD -0.35; 95% CI, -0.55 to -0.15) and function (SMD -0.35; 95% CI -0.56 to -0.14) and clinically irrelevant long-term improvements in pain (SMD -0.13; 95% CI -0.24 to -0.01) and function (SMD -0.14; 95% CI -0.26 to -0.03). A recent update reached the same conclusions^{42, 43}.

2.3.2.7 Fertility and pregnancy

Pain during labour

There was no difference in pain intensity, spontaneous vaginal delivery, caesarean section, or augmentation with oxytocin in patients with acupuncture compared to sham acupuncture. Mixed results were found for the use of pharmacological analgesia and length of labour. Studies were of small sample sizes Fertility and pregnancy⁴⁴.

In-vitro fertilisation

Patients receiving acupuncture had significantly more clinical pregnancies (OR 1.65, 95% CI 1.27-2.14; 7 studies, n=1366), ongoing pregnancies (OR 1.87, 95% CI 1.40-2.49; 5 studies, n=1113) and live births (OR 1.91, 95% CI 1.39-2.64; 4 studies, n=885) compared to women receiving sham or no adjuvant treatment^{45, 46}.

Breech presentation

No significant difference in breech presentation compared to expectant management neither for acupuncture nor for acupuncture with moxibustion was documented^{47, 48}.

Uterine fibroids

A Cochrane review didn't identify RCT's on the effectiveness of acupuncture on uterine fibroids⁴⁹.

2.3.2.8 *Gastro-intestinal conditions*

Irritable bowel syndrome

Three studies of small sample sizes were available. Two were statistically significant: acupuncture + psychotherapy compared to psychotherapy alone (RR 1.2, 95% CI 1.03-1.39, 1 study, n=100), and acupuncture versus herbal medicine (RR 1.14, 95% CI 1.00-1.31) resulted in short term improvement in symptoms at the end of treatment⁵⁰.

Postoperative nausea and vomiting

Four reviews on postoperative nausea and vomiting were available, of which the review by Lee et al. was the most recent and of the highest quality.

Compared to sham acupuncture, significantly less patients suffer from nausea (RR 0.71, 95% CI 0.61-0.83; 27 studies, n=2962) when receiving P6 acupuncture. However, heterogeneity is substantial and the result is no longer significant when the analyses are restricted to studies with an adequate concealment of allocation.

In addition, significantly less patients suffer from vomiting when treated with P6 acupuncture compared to sham acupuncture (RR 0.70, 95% CI 0.53-0.83). Again, heterogeneity is substantial but the result remains significant when restricted to studies with an adequate concealment of allocation⁵¹.

Chemotherapy induced nausea and vomiting

Based on 11 studies (n=757-1214), acupuncture (all methods) reduced the incidence of acute vomiting (RR = 0.82; 95% confidence interval (CI) 0.69 to 0.99; P = 0.04), but not acute or delayed nausea severity compared to sham acupuncture, placebo or usual care⁵².

Stroke rehabilitation

Based on the pooled results of four trials, acupuncture results in significantly better improvement in global neurological deficit compared with the control group (OR 6.55, 95% CI 1.89 to 22.76). However this estimate may not be reliable since there was substantial heterogeneity ($I^2 = 68\%$) and the methodological quality of the trials was very low. One trial showed no significant improvement of motor function between the real acupuncture group and the sham acupuncture group (OR 9.00, 95% CI 0.40 to 203.30)⁵³. A review of Wu et al pooled 38 low quality trials and found an OR of 4.33 (3.09, 6.08) with high heterogeneity ($I^2 = 72\%$) and concluded that there was insufficient evidence⁵⁴.

A review of Lee et al reported three randomized clinical trials showing favorable effects of moxibustion plus standard care on motor function versus standard care alone (N=142; standardized mean difference=0.72; 95% confidence interval, 0.37 to 1.08; P=0.0001). Three randomized clinical trials compared the effects of moxibustion on activities of daily living alone but failed to show favorable effects of moxibustion. They concluded that there was insufficient evidence due to the small trials of low quality⁵⁵.

Urinary incontinence after stroke

Three small trials all reported fewer participants with incontinence after acupuncture therapy (overall RR 0.44; 95% CI 0.23 to 0.86), decrease in symptoms (mean difference -5.57; 95% CI -7.00 to -4.14) and less nocturia (mean difference -3.18; 95% CI -3.95 to -2.41) compared to no intervention or usual care, but there were particular concerns about study quality as very little information on methods were reported in the original studies⁵⁶.

Dysphagia in acute stroke

Only one study of limited sample size (n=66) was included in the review. No significant differences were reported for recovery or improvement; more patients were reported to have marked improvement in the acupuncture group. However, neither marked improvement or improvement were defined in the original study, warranting caution in the interpretation of the results⁵⁷.

Carpal tunnel syndrome

No evidence was found for the effect of acupuncture in the carpal tunnel syndrome⁵⁸.

Temporomandibular disorders

Some limited evidence was found for a short term pain relief (standardized mean difference 0.83; 95% confidence interval, 0.41-1.25; P=0.00012), but risk of bias of the included studies was high⁵⁹.

2.3.2.9 Hypertension

Three studies were pooled as to their effect on systolic and diastolic blood pressure. There is no significant difference in mean systolic blood pressure and a marginally significant but clinically irrelevant difference in diastolic blood pressure (MD -3 mmHg, 95% CI -6 to 0). However, substantial heterogeneity was present and the quality of the included studies was highly variable⁶⁰.

2.3.2.10 Obesity

In this review, 31 studies were included out of which 20 had the lowest Jadad score⁶¹.

Compared to lifestyle measures such as diet or exercise, acupuncture resulted in a significant difference in body weight (MD 1.72 kg, 95% CI 0.50-2.93, n=237, 5 studies). In addition, significant differences were reported compared with placebo or sham (MD 1.56 kg, 95% CI 0.74-2.38, n=126, 3 studies) and compared with sibutramine (MD 1.9 kg, 95% CI 1.67-2.13, n=208, 2 studies).

Mixed results were found for remission of obesity, although it is not clear what is exactly meant by this outcome. Compared with diet alone, acupuncture + diet resulted in significant more patients achieving 'remission' (RR 2.57, 95% CI 1.98-3.34, n=345, 5 studies). The relative risk of acupuncture alone versus diet alone was not significant.

2.3.2.11 Adverse events

Very few systematic reviews reported information on adverse events. It is unclear whether this is caused by the fact that this information was missing from the original studies.

In the review on breech presentation, cases of premature rupture of the membranes were reported in the intervention groups⁶².

In the review on postoperative nausea and vomiting, the authors report minor adverse events in both the acupuncture groups and the sham groups: haematomas, irritation, redness. Sleepiness was reported during electro-acupuncture. In addition, the review on chemotherapy related nausea and vomiting reported minor and transient adverse events in three of the included studies: skin irritation, feeling of electrical shock and tingling⁵¹.

The review on neck pain reported cases of pain, bruising, and dizziness. Similar events were reported in the review on hypertension: pain, bleeding, but also two hypertensive urgencies (not further defined) in the acupuncture group and one case of congestive heart failure in the control group³⁷.

Finally, the review on obesity also reported mild but also more serious adverse events: redness, pain or discomfort, ecchymosis, sleepiness, hypertension, palpitations and dizziness⁶¹.

2.3.3 Discussion and conclusions

2.3.3.1 *Main findings*

For the following clinical subjects, there is limited evidence that acupuncture has a significant treatment effect:

Pain: compared with sham, acupuncture has a statistically significant effect on pain although for most indications the clinical relevance can be questioned. For low back pain there are more indications that the short term effect may be clinically relevant (the midpoint of the effect estimate is clinically relevant, however the CI does not exclude a non clinical effect). In addition, sham acupuncture was shown to be effective in comparison with no acupuncture, indicating that it does not matter where the needles are put and putting question marks around the underlying theories that underpin acupuncture.

In vitro fertilisation: the finding that acupuncture may result not only in more pregnancies but also in more live births is surprising. In addition, the effect of acupuncture seems to be independent of the control group that was used, i.e. sham or no intervention. There is debate about the possible role of a placebo effect, as most primary studies were not blinded. Manheimer et al argue that placebo effects are unlikely as the outcome (live birth) is not prone to subjectivity⁴⁵. However, Cheong et al argue in their Cochrane review that this cannot be excluded, e.g. because patients are more relaxed⁴⁶.

There is only very limited information on side effects or safety.

2.3.3.2 *Limitations*

Various modalities of acupuncture were included, ranging from needling acupuncture, electro-acupuncture, acupressure, etc.

In addition, control groups consisted of usual care, placebo, sham, waiting lists, etc.

Studies have various ways of defining this sham acupuncture. Strikingly, the review by Madsen et al. shows that sham acupuncture is in itself a therapeutic modality, as it has a larger analgesic effect compared with no acupuncture than acupuncture compared with sham acupuncture. Lack of blinding is inherent for the no acupuncture comparison. However, unblinding of the acupuncturist is also inherent for the sham acupuncture as the acupuncturist knows what is true and what is sham acupuncture.

The quality of the reviews was variable, but a bigger problem was the low quality of the studies included in the reviews. This warrants caution in interpreting the results.

2.3.3.3 *Placebo*

Clinical effects are difficult to separate from placebo effects in acupuncture trials. The question of placebo effects is complex and one can ask if making the distinction placebo-‘real’ effects is always useful in practice.

The power of placebo effects and what is sometimes called ‘enhanced placebo effects’ is amongst others demonstrated for acupuncture and spinal manipulations⁶³. There is an increased attention in the medical literature for the usefulness and importance of placebo effects in clinical practice, and the role it plays when addressing pain, like its role in enhancing the effect of analgesics that have a proven effect beyond placebo, the role of provider knowledge and beliefs when administering pain killers.⁶⁴

Hróbjartsson A & Gøtzsche⁶⁵ did a meta-analysis and meta-regression to measure the effect of placebos and found that it was heterogeneous and that the effect depended on type and credibility of the placebo, where placebos where a form of physical contact was involved worked better and was more outspoken when used for addressing pain. However, measuring the effect of placebo is complicated due to differential drop out, poor acceptability of 'waiting list type' control groups and coping mechanism of suffering patients such as self medication or other forms of health seeking behavior.

2.3.3.4 *Clinical relevance*

Many of the statistically significant results may be questioned on clinical relevance. One of the problems in judging the clinical relevance is the absence of an agreed threshold (minimal clinically important changes) for many conditions and clinical outcomes. For some indications a consensus exist, such as for neck pain or low back pain, and for low back pain there are indications that the effect is clinically relevant.

2.3.3.5 *Conclusion*

Acupuncture is shown to have an analgesic effect for a number of conditions and evidence is strongest for low back pain, but for most conditions substantial uncertainty remains. Future studies on acupuncture should try to increase the quality of the evidence by ensuring blinding where possible and disentangling the effects of acupuncture from the patient-provider interaction. Moreover, additional studies on the use, stability and credibility of the placebo effect would be useful, as placebo effects play a major role in pain relief, one of the major uses of acupuncture.

Key messages

- **Compared with sham, acupuncture has a statistically significant effect on pain although for most indications the clinical relevance can be questioned.**
- **For low back pain the short term effect may be clinically relevant (the midpoint of the effect estimate is clinically relevant, however the CI does not exclude a non clinical effect).**
- **Sham acupuncture was shown to be effective in comparison with no acupuncture, indicating that it does not matter where the needles are put.**
- **There is little published evidence on side effects.**

3 USE OF ACUPUNCTURE IN BELGIUM

3.1 SURVEY AMONG THE POPULATION

3.1.1 Objective

This section aims to measure the prevalence, utilisation and reasons for resorting to alternative medicines, and in particular to homeopathy, chiropractic, acupuncture and osteopathy.

3.1.2 Methods

3.1.2.1 Organization

The Phonocom company conducted a telephone survey of a representative sample of 1999 adults in Belgium from December 2009 to January 2010 by using a CATI (Computer Assisted Telephone Interviewing) software.

3.1.2.2 Sampling

The source file used to survey home phone subscribers was the CD-ROM infobel® 2009. A purely random selection was operated on the totality of the numbers available in Belgium. The people registered on the Robinson list were automatically excluded from this file, in accordance with the code of conduct of the BDMA (Belgian Direct Marketing Association). In order to survey the mobile phone holders, series of numbers of GSM were also randomly created and called.

On a total of 10.000 calls at the beginning, 1999 valid questionnaires were used for the analysis. Eligible people had to be older than 18.

3.1.2.3 Quota

A mixed method of quota sampling and stratified sampling was used by Phonocom. Quotas are presented in appendice with data from the National institute of statistics.

3.1.2.4 Weighting

The sample distribution was similar to the census distribution for age, sex and region of the country (provinces). We weighted the data for education to match our sample to the distribution of the Belgian census.

3.1.2.5 Questionnaire

The questionnaire combines mainly questions resulting from two national surveys published in the JAMA and in the New England Journal of Medicine^{66, 67}. Other more recent national survey questionnaires carried out in Japan⁶⁸, in Australia⁶⁹ and in the United Kingdom⁷⁰ were also used. We asked respondents to report on:

- their demographic and health status,
- the frequency of use of alternative medicine (during lifetime and the preceding year),
- the medical reasons of their visits,
- the global attitudes towards the use of alternative medicine (alternative or complementary, depending on reimbursement),
- The characteristics of their unconventional therapist (diploma, accessibility, charges for visits and treatments),
- Satisfaction with conventional and unconventional therapist,
- Health representation (need for control).

Parents were asked similar questions about their children's health status, frequency of use and medical reasons.

3.1.2.6 *Characteristics of the respondents*

The sociodemographic characteristics of the survey population weighted for education are shown in appendix.

3.1.2.7 *Limitations*

The fact that the survey in the general population was carried out by phone carries a risk of socio-economical or cultural bias because participants need to appear on a list of public numbers. More, only volunteers are participating. Nevertheless, the final sample is rather representative of the Belgian population and weightings were done to correct inadequacies.

3.1.3 The use of alternative medicines in general

In 2009, 33.7% of the interviewees had resorted to an alternative medicine during their lifetime (table 1). Of the 1622 respondents that mentioned at least one medical problem during the twelve months prior to the survey, 14.9% had visited an alternative therapist during this period (table 2). This prevalence appears to be consistent with the results obtained during interview-based health surveys carried out by the Public Health Institute since 1997. The latest report available on the interview-based health survey conducted in 2008⁷⁹ indicates that there has been no increase over time in the use of providers of non-conventional therapies, except in Wallonia for osteopathy.

Just like the interview-based health survey, the survey indicates that during the 12 months prior to the survey the sub-groups of the population with the highest level of the education have consulted an alternative therapist to a higher extent (18.6%) than those with a lower level of education (10.6%) (table 3). Also, these therapies are most often used by middle-aged people (from 14.9% to 18.5% of people aged between 25 and 54 years) (table 4).

No significant difference was observed by gender: 14.3% of men and 15.5% of women have consulted an alternative therapist during the 12 months prior to the survey (table 5).

33.8% of the respondents stated that they did not know about alternative medicines; 25.7% said that they did not trust these medicines and 18.4% said that they did not need them. They were considered to be too expensive by 12.2% (table 6).

Osteopaths and homeopaths have been consulted twice as much as the other alternative therapists (table 7): 6.7% of respondents had visited an osteopath during the 12 months prior to the survey, 5.6% had consulted a homeopath, 2.7% an acupuncturist and 2.2% a chiropractor. Two-thirds of these patients had consulted them more than once during the past 12 months (table 7).

3.1.3.1 *Medical reasons for using alternative medicines*

The four medical reasons most often stated by consumers of alternative medicines during the past 12 months are: back problems (46.7%), neck pain (25.8%), fatigue (12.9%) and headaches (12.9%) (table 8).

Among those who gave only one medical reason for consulting an alternative therapist (166 out of 246 respondents), back problems were the main reason for consultation. This alone represented 70.7% of consultations of chiropractors, 45.8% of visits to acupuncturists, 47.4% for osteopaths and 31.4% for homeopaths (table 9).

3.1.3.2 *The therapist-patient relationship*

A large majority of the users of alternative medicines (87.4%) also consulted conventional doctors (table 10), most frequently for the same medical reason (table 11).

85.2% of all users of alternative medicines have total confidence in their therapist, whether it is a conventional or non-conventional doctor. Only 4.6% did not trust their conventional doctor but they did trust their non-conventional therapist (table 12). 91.1% of users stated that they understood the responses of the therapist to their questions, whether an allopath or alternative therapist. Problems of comprehension were not associated more with one or other medicine (conventional or alternative) (table 13).

In general, there was great satisfaction concerning the care received. Once again, patients that were dissatisfied with their conventional doctor also tended to be dissatisfied with their alternative therapist (table 14).

3.1.3.3 *The price of a consultation*

The last time that they had used an alternative therapist, 43.8% of patients had paid between 25 and 50 euros. More than a quarter of respondents (27.7%) did not remember the amount they had paid (table 15). The percentage that had been reimbursed by their insurance was 35.9% (table 16).

3.1.4 Use of acupuncture

For the 1612 respondents who reported at least one medical condition in the 12 months before the survey, 3% have visited an acupuncturist during this period (table 7). Most of them (73%) have visited an acupuncturist more than once in the past 12 months (table 17). The report from the 2008 Health Interview Survey indicates that there is no significant increase in use of acupuncture between 1997 and 2008⁷¹.

For patients who reported only one medical condition in past 12 months, back problems are the most often cited medical reason (46%) to visit an acupuncturist (table 9). Among patients having visited an acupuncturist in past 12 months, 80% have also visited another provider of alternative medicine (table 18).

Key messages

- **33.7% of the interviewees had resorted to an alternative medicine during their lifetime**
- **14.9% of respondents that mentioned at least one medical problem during the twelve months prior to the survey had visited an alternative therapist**
- **The four medical reasons are: back problems (46.7%), neck pain (25.8%), fatigue (12.9%) and headaches (12.9%)**
- **2.7% of the population consulted an acupuncturist at least one time in the last 12 months**
- **73% of acupuncture users consult several times per year**
- **The principal medical reason to visit an acupuncturist is low back pain (45.8%)**

3.2 INSURANCE COVERAGE

3.2.1 Objective

This chapter aims to describe the actual situation of the reimbursement policies on non-conventional medicines, particularly acupuncture.

3.2.2 Methods

The information about the insurance cover was gathered by sickness funds and private insurance companies during meetings at the KCE and by phone. The results are limited to the reimbursement policies of the 5 biggest sickness funds in Belgium, i.e. Christian, Socialistic, Liberal, Neutral and Independent sickness funds.

3.2.3 Results

3.2.3.1 *Reimbursement policy for ambulatory treatments*

The compulsory health insurance does not cover the reimbursement of non-conventional medicine services. Nevertheless, most of the sickness funds provide a partial reimbursement of these non-conventional medicines under the coverage of the complementary health insurance. All sickness funds have a national department, the national alliance, which can set up the criteria for reimbursement. Still, the local departments are also free to set up their own criteria, resulting in local differences in criteria within a sickness fund.

This partial reimbursement is restricted to an average of 10 euros per session, with a ceiling for the number of sessions per calendar year (maximum 5 sessions of non-conventional medicine per calendar year). These 5 sessions comprise the four non-conventional medicines. For example: the reimbursement of 5 sessions non-conventional medicines can be used for 3 acupuncture sessions and 2 treatments by an osteopath.

In addition to reimbursement by the sickness funds, patients can also claim reimbursement through outpatient costs insurance. These policies cover up to 80% of outpatient medical costs, including the non-conventional medicines. Such services must have been prescribed in advance by a doctor. Only consultations with qualified practitioners are reimbursed.

3.2.3.2 *Reimbursement policy for hospital-related treatments*

Some insurance companies reimburse 40 to 50% of the fees under the coverage of a hospitalisation insurance. The main criteria are: a direct link with the reason for hospitalisation, the treatments have to be performed under medical prescription and by qualified therapists.

3.2.3.3 *Specificities for acupuncture*

The sickness funds have agreed to restrict the reimbursement of acupuncture to the treatment by a physician-acupuncturist. But nowadays some sickness funds broaden out these criteria to all acupuncturists (physician-acupuncturists and acupuncturists without a medical preliminary training). The Socialistic and Christian sickness funds are an exception to this. The Socialistic sickness and French-speaking Christian sickness funds still restrict the criteria for recognition of the therapists to the acupuncturists with a basic training in medicine, whereas the Flemish Christian sickness funds have no reimbursement policy for acupuncture.

In general, the sickness funds request:

- A certificate as described in the royal decree 78 (medical or paramedical training);
- The coverage of a professional liability insurance for the therapist
- A certificate of a training in acupuncture;

- A declaration of the paramedical trained acupuncturists not to charge the fee for a non-conventional medicine simultaneously with the fee for a conventional medicine.

A major difference between the sickness funds is the addition of paramedical trained acupuncturists (physiotherapists and nurses). These sickness funds restrict this reimbursement to the treatments provided by members of the professional unions (BAF, EUFOM and ABADIC). No agreement has been achieved between the sickness funds concerning the reimbursement of paramedical acupuncturists, resulting in lists of recognised therapists by each sickness fund and an individual attestation for the treatment per sickness fund, in contrast to the lists of recognised osteopaths and chiropractors and its attestation.

An overview of the results is given in the appendix.

3.2.4 Discussion

The results indicate some differences between the reimbursement policies between the sickness funds, which can be reduced to the difference in recognition of the paramedically trained acupuncturists. The lack of a mutual agreement and the competition between the sickness funds result in different criteria for recognition. The reimbursement policy itself (the number of treatments and the amount of reimbursement) is similar to the reimbursement of the other non-conventional medicines: (osteopathy and chiropractic), and is identical between all sickness funds.

Acupuncture is part of the traditional Chinese medicine, next to herbal medicine. Herbal medicine can be harmful and is regarded to be a medical therapy modality (provided by a physician) . As all acupuncturists are trained in the traditional Chinese medicine, the sickness funds agreed to restrict the recognition of acupuncturist to the therapists with a medical degree to reduce the risk of the potentially harmful effects of herbal medicine. Nowadays, the schools in acupuncture for the paramedics restrict their training to the training in acupuncture and teach only the main principles of the traditional Chinese medicines. This way, paramedically trained acupuncturists are recognized by the sickness funds.

To ensure a minimal quality of the therapists, the sickness funds limit the recognition of paramedically trained acupuncturists to members of professional unions. These professional unions (BAF, EUFOM, ABADIC) are recognised by the law of April 2010. The restriction of membership to a professional union does not hold for the physician-acupuncturists. A critical note is necessary concerning the quality of the acupuncture practice: until the profession is not regulated and the education in acupuncture is not put through an independent quality control system (similar to all postgraduate trainings), the quality of medical practice remains is not assured.

Also the reimbursement puts physicians in an advantageous position. Whereas the paramedical acupuncturists must not double count a same treatment session as a conventional (for example a treatment by a physiotherapist) and a non-conventional therapy, the physician-acupuncturist may count both therapies; once in the framework of the compulsory health insurance and once by the complementary insurance. This results in a double reimbursement for the patient and will advantage the physician-acupuncturists in comparison to the paramedically trained acupuncturists. Notwithstanding the lack of an active control system set up by the government, paramedically therapists will be warned by the sickness fund in case of complaint.

The reimbursement of alternative medicines being voluntary, it may serve as a marketing tool for the sickness funds in order to compete with the other sickness funds. Naturally, this has opened the possible reimbursement of all kind of unrecognised therapies. Nowadays, the use of non-conventional medicines is still increasing, leading to higher expenditure for the sickness funds. Proponents use this increase in spending as an argument to quickly regulate these non-conventional medicines. The rising expenditure in the complementary sickness insurance may also be the result of the long period between the set up of the law Colla and the final execution of this law.

3.2.5 Conclusions

Several factors characterise the actual reimbursement of non-conventional medicines in Belgium: the lack of regulation affects the quality control of these therapists and the lack of mutual agreements between the sickness funds affects the homogeneity in reimbursement policy. The separation of acupuncturists into physician-acupuncturists and paramedically trained acupuncturists (as discussed in the chapter on the profession) is maintained by the sickness funds.

Key messages

- **The partial reimbursement of consultations for acupuncture is provided by the complementary sickness insurance companies.**
- **The Christian sickness funds do not reimburse acupuncture sessions, whereas the Socialistic sickness fund reimburse sessions provided by the physician-acupuncturist only. The other sickness funds reimburse both physician-acupuncturists and paramedically trained acupuncturists (with the restriction of membership to a professional union).**
- **The reimbursement level varies depending on the sickness fund and insurance policy.**

3.3 SOCIOLOGICAL ASPECTS: USAGE AND PRACTICE OF ACUPUNCTURE IN BELGIUM TODAY

3.3.1 Scope of this section

This section describes the concrete practices of acupuncturists in Belgium and the words of the individuals concerned by the practice of acupuncture in Belgium today, i.e. practitioners and patients.

It therefore:

1. Touches on the specific experiences of acupuncture users in order to better understand their motivations and expectations of this medicine.
2. Provides empirical data on the manner in which acupuncture is practiced in Belgium today.

3.3.2 Material and methods

3.3.2.1 *Methods*

Empirical material was collected using a semi-directed, qualitative, interview-based survey method among acupuncture patients and practitioners.

3.3.2.2 *Samples*

A more or less equal number of users (n=8) and practitioners (n=11) were interviewed in the French-speaking and Dutch-speaking parts of the country.

Users

To take part in the study, we selected for interview in the French-speaking and Dutch-speaking parts of the country, 10 'regular', 'old' users, in other words those who have consulted an acupuncturist more than once a year for at least five years. They therefore represent a specific category of users, distinct from occasional or periodic users.

These users were polled via the social networks of the researchers that conducted the survey, through an advertisement placed in the publication of a sicknessfund sent to its members, as well as through an announcement placed in certain pharmacies and shops that sell health products.

Table 1 : Interviewed acupuncture's users

User	Langage	Sex	Age range	Profession	Domicile (province)
1	FR	M	30-40	architect	Brussels
2	FR	F	30-40	Artist dancer	Brussels
3	FR	F	30-40	sociologist	Brussels
4	FR	F	50-60	State employee	Namur
5	FR	F	60-70	Retired teacher	Flemish Brabant
6	FL	F	30-40	Tour operator	East-Flanders
7	FL	F	40-50	nurse	East-Flanders
8	FL	M	50-60	Acupressure therapist	East-Flanders

M : male, F : Female, FR : french-speaking, FL : Flemish-speaking

Practitioners

Eleven acupuncturists are recruited in the French-speaking and Dutch-speaking parts of the country to take part in our study.

The practitioners were contacted because their names had been mentioned by users, by contacting professional associations or because they had shown an interest in our study.

Table 2 : Interviewed Acupuncturists

	Langage	Sex	Initial training	Training in acupuncture (year)	Place of practice (province)
1	FR	M	General practitioner	Taiwan	Hainaut
2	FR	M	orthopedist surgeon	Belgium, ABMA (2000)	Hainaut
3	FR	M	General practitioner	Belgium ABMA (1989)	Brussels
4	FR	M	General practitioner	Belgium	Brussels
5	FR	M	General practitioner	Hong Kong, Taiwan (1978)	Brussels
6	FR	F	physiotherapist	Shangai (fin 70's)	Brussels
7	FL	M	acupuncturist	Belgium (1985)	East-Flanders
8	FL	M	General practitioner	Belgium ABMA (2009)	Antwerp
9	FL	F	physiotherapist	Jing Ming (2002)	West-Flanders
10	FL	F	Nurse (emergency)	Europe Shanghai College (1995)	Flemish Brabant
11	FL	F	Nurse and sociologist	OTCG	Brussels

M : male, F : Female, FR : french-speaking, FL : Flemish-speaking

3.3.2.3 Collection tools

The interviews were structured around a thematic matrix inspired by the socio-anthropological literature concerning the usage and practice of acupuncture in different Western European countries⁷²⁻⁷⁵.

The interview guide for users covered the following themes: the circumstances of the first use of acupuncture; the frequency and reasons for current usage; the place of acupuncture among all uses of healthcare by users; the interest of users in acupuncture; the attitudes of users regarding the place of acupuncture in the health system (prices, access, etc.).

The interview guide for practitioners covered supervised training; aspects of the practice of acupuncture (content and form of treatments); their point of view regarding clients; collaboration with other health professionals; the views of practitioners on the current place of acupuncture in the health system.

The interview guides are found in the appendices.

3.3.2.4 *Conducting the interviews*

The interviews were conducted in the following steps: 1) contacting the participant; 2) in the case of a favourable response, making a rendezvous; 3) at the start of the interview, prior information on the purpose of the study and requesting signature of the informed consent document; 4) recording of the interview and taking notes; 5) transcription of the interview.

3.3.2.5 *Analysis of the interviews*

The interviews were transcribed and analysed using a thematic and conceptual analysis structural induction matrix: the first interviews conducted for each category of actors was analysed in depth in order to identify the first theoretical and analytical elements. Subsequent interviews were used to validate, invalidate or refine the hypothetical-analytical structure progressively elaborated as the material was examined. We then made a comparison between the responses obtained to each of our questions.

This empirical and exploratory study was carried out among a sample of acupuncture users (n=8) and practitioners (n=11). The aim is to throw additional light on the usage and practice of this medicine in Belgium. The conclusions that we draw from an analysis of these interviews therefore cannot be deemed to be general conclusions on the discipline.

3.3.3 The experience of users

3.3.3.1 *Brief description of users*

Our 'sample' of users is composed mainly of women (4 out of 5) with a level of education higher than upper secondary. With the exception of one retiree, all participants were working.

3.3.3.2 *The factors involved in recourse to acupuncture*

How and why do users decide to visit an acupuncturist? Which factors affect their choice of this type of medicine?

The role of the entourage

The family or professional milieu of the user played a dominant role in the first use of acupuncture by the persons interviewed, because it was most often at the recommendation of close friends or family that users visited an acupuncturist for the first time. It is at this stage that the influence of the entourage on the choice of the individual seems to be most evident. Naturally, this influence must find an individual favourably predisposed towards acupuncture. But even these may be partly 'constructed' by the entourage of the user, in the sense that some of their family or friends tell them of favourable experiences with acupuncture, for example.

« Je suis allée une première fois chez cette personne, ne sachant pas très bien ce que cela allait m'apporter. C'était il y a déjà dix ou quinze ans... C'est une cousine qui m'avait donné ses coordonnées... » (usager 1)

« Pour les deux derniers (acupuncteurs consultés), c'est par le bouche-à-oreilles. Le troisième, c'était ma sœur, pour le dernier, c'est par un collègue de travail... Quand on vous dit d'aller trouver telle personne parce qu'elle est compétente, on y va... Ce sont des gens qui ont 'bonne presse', et c'était justifié... » (user 4)

« Ik heb in de jaren 70 enkele jaren geneeskunde gedaan en ik heb toen een jonge dokter ontmoet die in de Verenigde Staten woont. Die was al afgestudeerd en die had dat allemaal laten vallen in functie van een studie van de Oosterse geneeskunde. Hij had alles gelezen. En dat was toen ook macrobiotiek. Die gaf voordrachten in Gent in de jaren 70 en ik ben daar naartoe gegaan. En er werden toen ook voordrachten over acupunctuur en homeopathie gegeven. » (user 8)

But the entourage does not only influence the choice of therapy, and therefore the itineraries of users, it also has a key influence on their attitudes to health in general, because they are formed in a cultural sphere which is largely that of the social group to which the user belongs.

Reasons for and attitudes towards therapies

The reasons given by users for consulting an acupuncturist are often linked to negative experiences of conventional medicine or critical attitudes towards it. The rejection of 'medicinal' medicine and therefore the quest for a 'different' medicine is the reason most frequently given to justify the choice of acupuncture.

« Je suis allée la voir pour un problème de peau, qu'elle m'avait dit être lié à la perte de quelqu'un... c'était une tache sur le visage. J'étais allée voir un dermatologue qui m'avait prescrit une crème à la cortisone. Je l'ai mise, mais ça ne changeait rien... Je suis allée la voir, elle a mis des aiguilles, et c'est parti vraiment tout seul... » (user 3)

« Je ne supporte pas les médicaments, donc j'ai cherché une autre manière de me soigner, et c'est pourquoi je me suis naturellement tournée vers les médecines alternatives, homéopathie, acupuncture, et ostéopathie... » (user 4)

“Ik heb al een 10tal jaar slokdarmontsteking en heel veel reflux. Daarbij ook een maagbreuk. Je gaat dan van de ene specialist naar de andere natuurlijk, het enigste wat ze jou geven zijn zuurremmers. Ik was echt hopeloos, ik wist niet meer wat ik moest doen. Ik werd ook altijd maar zwakker en zwakker. Ik had totaal geen energie meer.” (user 6)

“Ik ben naar een huisarts gegaan die ook acupuncturist was voor een allergie. Ik had last van een zware hooikoorts. En ik was dat beu van al die anti-histaminica te nemen en dan ben ik bij een acupuncturist gegaan.” (user 7)

In other words, the insertion of needles into the body is more easily accepted by these users than the ingestion of medicinal products, which are associated with 'secondary effects'.

« Pour moi, l'acupuncture est une médecine comme une autre, mais différente, c'est-à-dire qu'à la place d'avoir un médicament, on a des aiguilles... » (user 4)

The use of acupuncture often goes hand in hand with recourse to various non-conventional medicines such as osteopathy and homeopathy, which would appear to show that, from the point of view of users, each medicine offers something different, and that they are not mutually interchangeable.

The use of acupuncture does not indicate that users are definitively turning their backs on conventional medicine.

« Ce n'était pas du tout par déception à l'égard de la médecine classique, mais plutôt une envie de tester une autre médecine... » (user 1).

« Dat is natuurlijk bij die alternatieve geneeswijzen. Ze bekijken gans de mens, je emoties, trauma's, alles speelt een belangrijke rol; die antroposofie ook, die bekijken je helemaal als een type. Dat wordt in de Chinese geneeskunde ook gedaan. Iedereen is verschillend, zeker naar voeding toe. Dat is zo individueel en subjectief. Je moet als het ware een filosofie hebben die gericht is op de persoon zelf, en dat is echt een holistisch beeld. En zolang er in de klassieke geneeskunde in vakjes en schuifjes wordt gedacht, gaan er veel chronische gevallen blijven bestaan. Het is symptoombestrijding en de oorzaak wordt totaal niet aangepakt.” (user 6)

“Ik heb nog een klassieke huisarts, maar ik ben denk ik nu al 2 en een half jaar niet meer geweest. Omdat ik ook niet meer ziek ben geweest. Ik gebruik hem alleen voor diagnose. Meestal schrijft hij iets voor, maar ik zeg dan altijd “ik ga eerst iets anders proberen en als het niet helpt dan...”, maar ik heb nog nooit zijn briefjes nodig gehad.” (user 7)

Conventional medicine remains the reference for serious illnesses such as cancer, which often turns up as an example of a health problem for which users would not go to see an acupuncturist, but would put themselves in the hands of traditional doctors.

« Toutes ces médecines parallèles, ce sont des médecines préventives, pour moi, ça ne répare pas quelque chose de grave, comme le cancer » (user 2).

« Il est évident que si un jour on me dit que j'ai le cancer, je ne vais pas aller chez mon acupuncteur, je sais que l'acupuncture ne va rien donner du tout » (user 4).

“In de acupressuur hebben ze ook therapie gevonden tegen hersenvliesontsteking, omdat ze in die tijd nog geen andere middelen hadden, maar als er iemand bij mij in de familie hersenvliesontsteking zou krijgen, dan ga ik direct naar de spoed voor antibiotica. Zo gek zijn wij ook niet. Ook al bestaan daar mogelijkheden, dat is levensbedreigend. Wij verwerpen dus eigenlijk ook niets.(...) Het heeft totaal geen zin om zich diametraal tegenover elkaar [natuurgeneeskunde en klassieke geneeskunde] op te stellen. Vandaar dat men spreekt van complementaire geneeskunde, die kunnen elkaar perfect aanvullen.” (user 8)

In other words, users resort to acupuncture whenever they can do without conventional medicine.

- **The family and professional circles have a major influence on users resorting to the services of an acupuncturist.**
- **The use of acupuncture may result from the rejection of medicinal medicine.**
- **The use of acupuncture often goes hand in hand with the use of other non-conventional medicines. These medicines are not seen as mutually interchangeable by users.**

Two types of usage

Two different types of usage emerge:

- Either users resort to acupuncture for specific problems that they identify as 'indications' for its use (selective usage). In this case, we could say that users consult an acupuncturist episodically, whenever they feel the need, in the same way as they would use another non-conventional therapist in other circumstances.

« Je vais la voir quand je n'en peux plus, quand je sens que mon corps est fatigué ... L'année passée, j'y suis allée parce que je n'étais pas bien du tout. » (user 3)

« En fonction du mal que j'ai, je vais voir tel ou tel practitioner... » (user 4)

“Voor hetgeen ik zelf weet, durf ik aan zelfmedicatie te doen, voor het geen dat wij niet weten, gaan we voort op onze huisarts. Wij hebben wel een alternatieve huisarts, die acupunctuur, kruiden en klassieke geneeskunde combineert.” (user 8)

- Or they use the services of an acupuncturist for all health problems that they encounter (exclusive usage).

3.3.3.3 Complaints and symptoms for consulting an acupuncturist

The 'problems' for which people most often consult an acupuncturist vary from one user to the next, although it is possible to identify in the list a classification logic that coincides with the different types of usage referred to above.

- One-off health problems: sinusitis, colds, digestion problems, etc., for which 'exclusive' users consult their acupuncturist because of a general preference for acupuncture.

« J'y suis allé pour une sinusite, et après une séance, en deux ou trois jours, elle a disparu totalement... » (user 1)

“...vooral fysieke letsels, dan ga ik bij de acupuncturist. Ik zeg niet dat acupunctuur niet zal werken bij allergie, maar ik ga zelf eerder voor spierklachten. Ik ben onlangs nog geweest voor een spierscheur, tenniselleboog. Mijn partner ging voor rugklachten, mijn schoonzus voor artrose. Mijn allergie heb ik daar niet meer laten behandelen. Vooral pijnklachten, fysiek.” (user 7)

- Chronic problems or pain

« Je vais surtout chez lui pour diminuer les douleurs de l'arthrose. Cela m'aide beaucoup, parce qu'avant, je ne savais pas dormir, tellement j'avais mal, et avec ces petites aiguilles, j'ai réussi à dormir, ça fait de l'effet... » (user 5)

“In mijn jeugd had ik veel hoofdpijn en sinusitis, dat is allemaal weg. Allemaal verbeterd door anders te gaan eten en ook door oefeningen te doen, tai chi enzo. Ook door een beetje acupressuur. Als ik hoofdpijn heb, dan ga ik puntjes gaan duwen bij mezelf en meestal ook een, en dat is een macrobiotische principe, een bouillon drinken. En meestal is dat voldoende, na een paar uur is dat weg.” (user 8)

- General states of tension or insomnia, for example, that to some extent disrupt the lives of these users.

« J’y suis allé pour de l’insomnie, avec une efficacité évidente, parce que cela joue sur les questions de détente, de bien-être... » (user 1)

« Les deux premiers acupuncteurs que j’ai consulté, c’était plutôt pour un problème de nervosité, de stress, en gros, tandis que chez le médecin chez qui je vais toujours, c’était plutôt pour un problème digestif, des insomnies, etc., mais il y a toujours du stress à la base... » (user 4)

“Vorig jaar had ik ook heel veel problemen met vermoeidheid, echt een heel rare vermoeidheid in mijn hoofd. Ik heb een heel stresserende job, waarschijnlijk had het daar mee te maken. Het was niet die uitputting die ik vroeger had, maar op mijn werk vielen mijn ogen altijd dicht. Ik ben toen verschillende keren bij de dokter geweest, bloedanalyse enzo, maar er was niks te zien. Toen ben ik bij die acupuncturiste terecht gekomen. Met de bedoeling om die reflux op te lossen, maar eigenlijk is daar die vermoeidheid daar volledig mee weggegaan.” (user 6)

Primarily, the list of problems for which users consult an acupuncturist reflect all of the problems for which acupuncturists are regularly recommended, with a proven record for treating such disorders (migraines, etc.).

Acupuncture is also credited with acting on certain physiological or psycho-physiological mechanisms associated with ‘well-being’. It is by no means rare for patients suffering from serious illnesses to use it only for this aspect.

« Ma cousine a eu un cancer il y a deux ans, et elle a eu recours à l’acupuncture, mais en termes de bien-être, pas du tout de manière alternative, comme moi... » (user 1)

From the statements made by users, we can identify different types of acupuncture sessions: those that form part of a treatment for a one-off health problem, but do not produce their effect until after a certain time; and ‘wellness’ sessions generally aimed at releasing nervous or emotional tension which, according to users, have a virtually immediate effect.

We conclude that certain users use acupuncture according to a rationale that we referred to above as ‘exclusive’, i.e. they consult an acupuncturist for all health problems that affect them, including one-off and localisable physical problems for which they could see a traditional general practitioner. Others go to an acupuncturist selectively for general ill health for which they would not consult a traditional doctor who, according to them, would be restricted to an examination and treatment of the physical body.

- **We have identified two types of usage: exclusive and selective, which are associated with the complaints related by the users consulted.**
- **Usage of acupuncture for general ill health or stress, which takes the form of insomnia or tension.**
- **There appears to be a distinction between users that resort to acupuncture for a one-off localisable health problem, and those that seem to be motivated by a general malaise.**

3.3.3.4 Experience of treatments

The experiences of acupuncture treatments comprise a set of elements that recur in the descriptions given by users, which have been selected as key elements for a description of these treatments. The hearing that they are given, the pace and duration of the consultation, the subsequent relaxation, are all elements that make consultation with an acupuncturist a special moment, which cannot be compared with a traditional medical consultation.

Listening

First of all, the time devoted by practitioners to listening to patients is one of the elements most appreciated by users, unlike a consultation with a traditional doctor.

« Le fait de parler, bien sûr que c'est important, et un médecin normal, n'a pas le temps pour ça... Il a son cabinet qui est rempli de patients, et s'il vous consacre dix minutes, c'est déjà bien... » (user 4)

“De eerste keer als je gaat neemt die ook heel veel tijd om de diagnose te stellen. Dat is ook altijd een duurdere consultatie, want dat is ook altijd een uur, een uur en een half. Dat is vooral een vraaggesprek en die man gaf achteraf ook veel uitleg. Als je het wil. Dat is het ook altijd, als je wilt, dan kan je veel uitleg krijgen.” (user 7)

Users stress the importance of listening, a way of practicing medicine that makes them the focus of the consultation, giving them the impression of being treated individually.

« Elle prend le temps d'écouter, elle pose des questions, elle demande ce qui ne va pas... » (user 3)

Examination

Users are generally not surprised that their acupuncturists do not make a diagnosis, restricting themselves to identifying the part of the body where there is a problem – where energy is not circulating, according to some.

« Dans le cas d'une sinusite, par exemple, il dit simplement que le problème est au niveau du nez, il parle en termes de 'zones'. » (user 1)

« Il ne pose pas de diagnostic, il ouvre les portes, c'est tout... » (user 4)

“Die acupuncturiste heeft die vermoeidheid in mijn hoofd gezien. Ze zei direct, want ze doet een polsdiagnose, ze zei direct “moet je op verlof gaan ofzo?” Ik had niks gezegd van die vermoeidheid, want ik kwam voor die reflux. Ze zei dat mijn energie niet goed was.” (user 6)

The needles

The main element of treatment by acupuncture naturally consists of the use of the needles that practitioners insert into the bodies of their patients, at very precise points. When questioned on this subject, users unanimously state that insertion of the needles is not painful, although not particularly pleasant.

« On sent que l'on pique, mais cela ne fait pas mal, les aiguilles ne s'enfoncent pas très loin, ce n'est pas comme une piqûre... » (user 4).

“Ik heb ook eens van iemand gehoord die zei dat het altijd zo'n pijn deed als ze die naalden staken, maar bij mij doet dat geen pijn. Die van mij zegt ook altijd dat dat geen zeer mag doen. Als dat pijn doet, dat steekt hij de naalden anders.” (user 7)

The risk of contamination by unsterilized needles really does not seem to arise for users, who all stated that their practitioner used disposable needles.

« Il utilise des aiguilles qui sont sous vide, et lorsqu'il les enlève, il les jette dans une boîte scellée. Je remarque que ce sont à chaque fois des aiguilles propres. » (user 1)

« J'ai remarqué que c'étaient des aiguilles stérilisées, mais je n'ai pas cherché à le vérifier, je l'ai remarqué, c'est tout... » (user 4)

The needles are often inserted in a separate cabin, removed from the main consultation room. This form of spatial organisation of the medical practice allows the practitioner to take another patient during the time deemed necessary for the needles to have their effect. Once the needles are inserted, the patient must remain lying down and immobile for twenty or thirty minutes on average. This key element of an acupuncture session immediately gives it a different 'content', as well as a different 'form' compared with a traditional medical consultation.

For certain complaints, the practitioner heats the needles, which seems to have a specific function:

« Quand je suis à un niveau de fatigue extrême, elle chauffe ses aiguilles, pour essayer de restimuler le corps... » (user 3).

None of the users interviewed mentioned the use of specific instruments for electro-acupuncture, or moxa^d.

The corporeal experiences of the treatments

During the treatment, the practitioner sometimes plays gentle music, dims the lights and even burns incense in the cabins in order to create an atmosphere conducive to relaxation. This relaxing effect of an acupuncture session is much appreciated by users, who often find it the most pleasant aspect, considering that it acts on both the body and the mind.

« En général, je me sens plutôt détendu. Ce que j'aime beaucoup, c'est que l'acupuncteur peut avoir un impact corporel, mais qui peut avoir une répercussion sur la santé mentale. » (user 1)

« C'est certain que je paye aussi pour cet état là, pour ce moment accordé, et puis pour le bien-être qui vient après, et qui dure tout le restant de la journée, la soirée et la nuit aussi... » (user 3)

“Ik heb ook altijd het gevoel en dat is heel raar, dat ge daar echt loom en moe van wordt. Als ik naar huis kwam, had ik echt zin om in mijn zetel te kruipen en te slapen. Ook veel drinken om die afvalstoffen uit het lichaam te verwijderen.” (user 7)

“Ik werd heel rustig van acupunctuur. En de klachten gingen ook snel weg.” (user 8)

An acupuncture session produces an effect of relaxation and a sensation of well-being in users.

For some users, the acupuncture session sometimes produces 'emotional' experiences, similar to those that users of other wellness practices feel⁷⁶:

« J'étais sans doute dans une situation personnelle difficile, sans doute que j'avais besoin de cela... Il m'a installée sur une table haute, il a mis quelques aiguilles aux doigts, je crois sur la tête aussi, et j'ai eu beaucoup d'émotions, j'ai eu l'impression qu'il se passait quelque chose de particulier, quelque chose comme un gros chagrin qui sort... » (user 3).

« La première fois que j'y suis allée, c'était parce que je ne parvenais pas à reprendre le dessus, je ne dormais plus, je ne mangeais plus, et parfois je pleurais sans pouvoir m'arrêter... Elle m'a mis des aiguilles, et vingt minutes après elle est revenue, elle m'a demandé si cela allait mieux, je lui ai dit 'ouihhh', cela allait beaucoup mieux... » (user 2).

“De reflux niet, die was toen niet opgelost. Wel die vermoeidheid en ik had veel meer kracht.” (user 6)

The perception of these sensations of well-being shows that the effects felt during a session of acupuncture are not limited to physical effects, but also seem to affect the feelings and emotions of users.

^d moxibustion

The duration of the consultation and treatments

The duration of an acupuncture session, which can vary between a quarter of an hour and an hour, depends on both the type of complaint and the type of consultation. A first consultation may last as long as one hour, while a follow-up consultation can take only a quarter of an hour, which means that the time spent listening to the patient can also be reduced to a few minutes.

« La première fois, il faut dire le plus possible : les problèmes dont vous souffrez, ce qui vous amène... Cela dure entre une demi-heure et trois quarts d'heure. Pour les séances suivantes, bien sûr que l'on vous fait parler, mais beaucoup moins, parce qu'il a déjà la fiche... Cela dure moins longtemps, cela peut durer une demi-heure, mais cela peut aussi se réduire à un quart d'heure... » (user 4).

“De eerste keer heeft hij zo'n lang interview gedaan en ook alles opgeschreven en bijgehouden. De eerste behandeling was dan 5 minuutjes naalden steken en dan 20 minuutjes onder zo'n warme matras liggen met een dekentje over u. Dat ge ontspannen kunt liggen.” (user 7)

A treatment for a physical complaint is not usually limited to a single consultation, as is the case for 'wellness' sessions, but can be up to six sessions for the same complaint.

The perception of the physical effect of the treatment also occurs after a variable period: it may only appear after a few sessions...

« Je dirais que c'est au bout de la quatrième séance, que l'on commence à se sentir mieux... sauf pour la fois où je suis allée pour du stress, cette fois-là, je l'ai senti très vite, au bout de vingt minutes... » (user 4).

- **All of the elements of an acupuncture session (especially listening and the duration) make it feel radically different from a traditional medical consultation.**
- **There are different types of acupuncture sessions, and the content and form, duration and effect may vary dramatically.**
- **The effects felt are not only physical; they also sometimes have an emotional component.**
- **The corporeal experiences of users during acupuncture sessions vary depending on the type of complaint for which users consult an acupuncturist.**

3.3.3.5 The perception criteria for practitioners

Finding a good acupuncturist, or an effective one, is a problem often raised by users because there are no objective criteria for distinguishing between practitioners. We note that the criteria for satisfaction (or non-satisfaction) mentioned do not concern the treatment as such, but the quality of the relationship.

« La première consultation a eu une influence, peut-être pas forcément en termes d'efficacité, mais je dirais davantage en termes de contact avec la personne, car c'est quelque chose qui a son importance. Je trouvais que la personne en elle-même avait l'air efficace, performante... » (user 1)

« J'ai fait quatre acupuncteurs avant de tomber sur la personne qui me convenait. C'est le problème en médecine parallèle, c'est de trouver la personne avec qui le courant passe... Le premier, c'était un médecin qui s'occupait de trois patients en même temps, et avec qui on ne pouvait pas parler, qui mettait quelques aiguilles, et puis voilà... La personne que je consulte aujourd'hui, c'est deux patients à la fois, mais on peut quand même parler avec, tandis que l'autre non... » (user 4)

“Ik ben eens hier in de buurt naar een andere acupuncturist geweest, maar dat vond ik echt niet leuk. Die man die had hokjes, die stak de naalden en ging dan naar het volgende hokje. Dat was niks voor mij. Ik had toen ook gehoord van de andere acupuncturiste.” (user 6)

“Alles staat of valt of dat ze hun vak kennen en dan merkt ge dat wel. Het maakt niet uit of het een arts of niet-arts is, maar hij moet zijn vak kennen. Het moet wel iemand uit de paramedische sector zijn.” (user 7)

Both the personality of the practitioners and the manner in which they work comprise a set of elements that make up the necessarily subjective equation for users to assess them. The relational factors, expressed using the metaphor of the 'spark', remains rather vague in the descriptions of users, even though the use of such a metaphor betrays the idea that the therapist and the patient must be 'linked' by something that passes between them, with the 'current' generally flowing in one direction.

« Si ça ne marche pas, peut-être que le courant ne passe pas entre le médecin et moi... » (user 5).

Users consulting a doctor trained as an acupuncturist see this as an advantage, because the practitioner provides a dual vision. Doctor-acupuncturists are also perceived as offering a 'different' approach to traditional medicine, while providing a measure of guarantee in terms of medical knowledge and diagnostic ability.

« C'est quelqu'un qui est médecin généraliste à la base et qui est médecin-acupuncteur par ailleurs... cela permet d'avoir à la fois deux types de regard sur un problème... Je crois que je prends le fait qu'il soit médecin comme une garantie qu'il ait une vision plus globale... » (user 1)

« Cela me permet d'avoir quand même une écoute médicale qui est nécessaire... » (user 3)

"Die acupuncturiste is geen arts. Voor mij maakt dat persoonlijk niet uit. Zolang die maar goed opgeleid is. Integendeel, ik heb geen vertrouwen meer in artsen." (user 6)

"Ik ben al bij beiden geweest (arts en niet-arts) maar meestal bij kinesisten. Ik ben nog nooit bij iemand geweest die totaal geen medische of paramedische achtergrond heeft. Ik vind dat niet per se belangrijk, als de acupunctuur-opleiding maar goed is. Als daar maar genoeg medische vakken in zitten. » (user 8)

And where the practitioner is not only a doctor and acupuncturist, but also a homeopath or phytotherapist, users have the impression of being cared for using a more 'holistic' approach:

« Il y a quelques années, quelqu'un m'a parlé d'une autre acupunctrice phytothérapeute, que je vais toujours voir aujourd'hui... Elle fait parfois appel à ses facultés de phytothérapeute, elle m'a déjà donné un médicament qu'elle fabrique elle-même, c'était vraiment miraculeux... » (user 3).

« L'avantage du médecin acupuncteur que je vais voir, c'est qu'il est aussi homéopathe, donc il choisit selon le problème que j'ai... » (user 4).

"Wij hebben wel een alternatieve huisarts, die acupunctuur, kruiden en klassieke geneeskunde combineert." (user 8)

Users that have consulted a practitioner trained as a physiotherapist also state that they were very satisfied.

« J'ai aussi consulté un kiné qui faisait de l'acupuncture. C'était un flamand, à la frontière... Il avait suivi une formation en Chine et y retournait régulièrement. J'avais de très bons résultats, j'étais très contente, mais vu la distance, je n'ai pas continué chez lui... » (user 4)

All the users interviewed would also readily agree to consult an acupuncturist who was not a doctor, which shows that medical training is perceived as a plus, but it is not an absolute must for users.

« J'y vois l'avantage de quelqu'un qui fait un peu double emploi, mais s'il n'était pas médecin, je n'irais pas chez lui comme médecin traitant. Je pense que j'irais voir un médecin ordinaire et que j'irais voir par ailleurs un acupuncteur... » (user 1)

3.3.3.6 The perceived effectiveness of the treatments

The question of the effectiveness of acupuncture is omnipresent in the words of users, even though this effectiveness is felt rather than theorised or explained. We can tackle this question at two levels: firstly at a conceptual level (how it is explained), and then at an experiential level (how are treatments experienced).

Conceptual level

Users seem to accept quite easily the idea that there is no consensus on an explanation for the effectiveness of acupuncture.

« Ne me demandez pas comment il a fait, c'est une question d'énergie qui circule dans le corps.... C'est comme des portes que l'on ouvre ou que l'on referme... » (user 2).

« Je pense que c'est basé sur les méridiens... Mais les méridiens, ce n'est pas quelque chose de palpable, c'est un tracé d'énergie, on ne peut pas expliquer cela à un esprit cartésien. Il y a un circuit énergétique et il y a des portes. Si une porte est fermée, ben l'énergie, elle ne passe plus... Je ne sais pas comment, mais le fait est que ça marche... » (user 4).

“Ik heb ook het gevoel dat bij alternatieve geneeswijzen ook alles ineens behandeld wordt. Zij behandelen op alles, een klassieke geneesheer die behandelt bijvoorbeeld uw maag en ge ligt nog even gestrest en uw maag zal niet genezen. Ik heb jaren in een ziekenhuis gewerkt, ik ken alles van pillen. Placebo kan je wel zeggen, maar ik ben er zeker van dat die zaken helpen als het iemand is die zijn vak kent. Dat vind ik wel cruciaal.” (user 7)

“Ik heb er ook geen verklaring voor hoe het werkt, maar het werkt. Er zijn daar theorieën over dat dat een energetisch effect zou zijn. Is het placebo-effect, ik weet het niet. Ik heb daar geen verklaring voor. Ik ben daar nogal pragmatisch in, ik was blij dat mijn zoon zijn hoest voorbij was. Het lijkt absurd, maar er zijn veel dingen absurd en die we niet kunnen verklaren. Is dat placebo-effect of energetisch effect? Ik ben geen wetenschapper. Ik kan dus ook de reserves van de wetenschappers begrijpen, want er wordt inderdaad in die sector veel gespeculeerd, veel hypotheses heel snel als waarheid aangenomen.” (user 8)

The users therefore regurgitate the explanations that seem to have been given to them by the practitioners that they consult, which appear to be more metaphorical than medical. The mental images of ‘flows of energy’ and ‘gates’, used as synonyms for the concepts of ‘meridians’ and ‘acupuncture points’, nevertheless demonstrate an attempt at a conceptual translation to explain the effectiveness of acupuncture by referring to representations that are not, in themselves, particularly specific. These user statements also show that acupuncture certainly includes ‘beliefs’, which are expressed as if they are taken as true, and are not subjected to critical discussion.

Moreover, the desire to know a little more about how acupuncture works and its principles does not seem to be a concern of users: the patients that we met were not looking for more information on acupuncture, except perhaps about the indications for which they could consult an acupuncturist.

« Comment ça marche, pfff, ce n'est pas quelque chose qui m'intéresse particulièrement... » (user 4)

« Je n'en ai pas trop envie, ça reste quand même de l'ordre du mystère, de l'inexpliqué, tout en ayant des résultats concrets, comme tout ce qui relève du corps humain, il y a beaucoup de subjectivité » (user 3)

Similarly, the Chinese and the philosophical basis of acupuncture are virtually never mentioned by users, who see no link between the ‘mastery’ of acupuncture and the cultural origin of its practitioners:

« Je ne sais pas si l'acupuncteur que je consulte maintenant maîtrise mieux l'acupuncture parce qu'il est Coréen » (user 1).

Experiential level

All the users that we met said that they were satisfied with their acupuncture consultations, even when they mentioned cases where it did not prove more effective than other approaches.

This was particularly the case for a user who went to see an acupuncturist to help him (unsuccessfully) to give up smoking. The user attributes the failure of these multiple attempts to a personal defect, rather than to acupuncture.

This was also the case for a user that said that he had seen an acupuncturist for a problem of 'tension', but without results.

« J'ai essayé l'acupuncture pour un problème de nervosité, mais ça n'a pas donné... J'ai ensuite été chez une autre personne, mais ça n'a pas donné non plus... » (user 5).

There is also the case of a user that consulted a doctor-acupuncturist for migraine. Although the migraines did not disappear, she nevertheless said that she was very satisfied with the visits.

« Je suis retournée chez lui par après, mais pour autre chose, parce que mes migraines ne passaient pas. Ce sont des migraines liées au cycle menstruel, j'en ai toujours eu, depuis toute jeune, mais j'étais très contente de mes visites... » (user 3).

One user mentioned having been incorrectly 'pricked' by her acupuncturist during a session:

« La dernière fois que je suis allée voir mon acupuncteur, il m'a mal piquée, et je me suis endormie, car j'étais vraiment très fatiguée... et quand je me suis réveillée, je ne savais plus bouger... Bon, ce n'est pas grave, tu ne vas pas en mourir, mais on ne se sent pas bien après... » (user 2)

The general satisfaction of regular users of acupuncture could be said to be based on an entirely relative assessment of its effects. The overall assessment does not seem to be called into question by occasional 'failures' of acupuncture to make the complaints addressed to the practitioner disappear. The expected effectiveness of acupuncture sessions does not seem to be based on the disappearance of the symptoms or complaints that were the reason for the consultation, but on a general evaluation of the benefits of such sessions.

- **The assessment criteria employed by users to judge the effectiveness of a practitioner are rather vague, concerning mainly the quality of the relationship with the therapist.**
- **Users appreciate the fact that the acupuncturist that they consult is also a doctor, because this combines different skills and offers a 'dual vision'. However, the guarantee provided by medical training is not perceived as a criterion of effectiveness and satisfaction, or as a necessary condition.**
- **Users easily accept the existence of inexplicable elements surrounding the effects of acupuncture and show no particular desire to investigate further.**
- **Users take on board the explanations of the effects of acupuncture provided by their practitioners, without necessarily subjecting them to a critical assessment. Acupuncture also has a 'belief' component, which forms part of the specific experience of users.**
- **Generally speaking, users say that they are satisfied with their acupuncture sessions, even when the health 'problems' for which they consult them persist. The expected effectiveness is therefore not limited to the disappearance of the complaints addressed to the practitioner.**

3.3.4 The practitioners

Meetings with acupuncturists allowed us to gain a better understanding of why they turned to acupuncture and the training that they followed. In the individual interviews we also found out what they do, how they do it and, finally, their attitudes to the manner in which acupuncture is organised and regulated in Belgium today.

We met and interviewed 11 practitioners of acupuncture. They have medical (n = 6) or paramedical training: physiotherapists (n = 2), nurses (n = 2) or other (n = 1).

3.3.4.1 Practitioner profiles

Acupuncturists do not form a homogeneous professional group because of their different training, professional interests and their different concepts of acupuncture. These divergences, as we shall see in the following section, are reflected in the way in which they practice acupuncture during their consultations.

Training

The majority of the practitioners with medical training were trained in Belgium by the ABMA, which is not however the case of the 'pioneers', who were trained in China, Hong Kong or Formosa in the 1970s.

Because of the way in which training is organised and Belgian legislation, non-doctor practitioners followed theoretical training in Belgium and then went to China for practical training in acupuncture, because it is prohibited here.

Motivations

The motivations that prompt doctors or paramedics to learn acupuncture vary considerably. An early interest in oriental cultures or oriental medicine is often given as a key factor:

« J'ai suivi un parcours assez classique en médecine, que je pratique toujours, mais j'ai toujours eu un intérêt pour les médecines orientales... » (practitioner 2)

« Die interesse is er altijd al geweest. Ook ruimer dan acupunctuur, ik bedoel de Chinese cultuur. Ik ben vroeger naar China geweest. Dat is eerder een algemeen interessepunt, maar ook dat mijn vader met chronische rugpijnen, die nog heel beperkte mogelijkheden had voor medicatie, baat had met acupunctuur. » (practitioner 8)

Some state that they 'discovered' acupuncture by being treated themselves by an acupuncturist and had found it effective. They then followed training in this medicine in order to better *understand* and *master* acupuncture.

This initial interest was sometimes combined with coming up against certain limits in the practice of medicine and wanting to overcome them in order to offer *something else* to patients.

« J'en suis venu à l'acupuncture pour arriver à comprendre ce qui arrive au patient... Je suis arrivé à un moment dans une impasse dans le traitement des patients, pour lesquels j'ai cherché à proposer autre chose, pour arriver par un autre raisonnement au problème du patient » (practitioner 2).

Practitioners with medical training

The practitioners with medical training that we met mainly practiced a hybrid form of acupuncture, incorporating elements of biomedicine and traditional Chinese medicine, with a degree of hybridisation that varied from one practitioner to the next.

The degree of hybridisation could take the form of a varying combination of diagnostic techniques based on both conventional medicine and Chinese medicine, or at the level of the treatment: acupuncture can be combined with phytotherapy, homeopathy or the prescription of allopathic medicines.

« Si j'associe quelque chose à l'acupuncture, ce sont des plantes, des choses comme ça, pas de médicaments chimiques... Si vous venez chez moi, vous allez vous retrouver avec la valériane, par exemple, c'est quand même la médecine douce occidentale... » (practitioner 3)

Despite the fact that they practice acupuncture, doctor-acupuncturists still define themselves as belonging to the medical profession. They also adhere to the professional behaviour, language and standards of the medical world⁷⁵, while incorporating elements of acupuncture using procedures that vary from one professional to another.

First there are doctors that have incorporated a few elements of acupuncture into a practice that remains largely biomedical. For them, acupuncture is one more tool in their arsenal of therapies that they only use for certain patients and for certain indications (chronic pain, migraines, lumbago, etc.). It could be said that for these practitioners, acupuncture tends to become a medical specialisation that allows them to adapt their practice with regard to patients.

« J'ai des patients pour lesquels je ne fais que de la médecine générale, j'ai des patients avec qui je fais les deux, d'autres qui ne viennent me voir que comme acupuncteur et qui ne veulent rien d'autre... » (practitioner 3)

« Ik ben vooral huisarts en dan hangt het er een beetje vanaf hoeveel ze al geweest zijn, wat is hun klacht, hun voorkeur, dat speelt zeker mee. Heel concreet op vlak van hoofdpijn: is dat iemand die ouder is en de eerste klaagt over hoofdpijn, dan ik vooral vanuit het standpunt van de huisarts bekijken. Maar als dat gebeurd is, en die mensen zeggen dat ze niet graag medicatie hebben, dan stel ik meestal voor om een aantal sessies te doen. » (practitioner 8)

Other doctors always combine biomedicine and acupuncture for all patients that come to them.

« Je fais les deux, je fais toujours de la médecine générale... Parfois j'associe un traitement pharmaceutique pour accompagner... » (practitioner 1)

- **Practitioners with medical training almost never practice acupuncture exclusively.**
- **Practitioners with medical training tend to use acupuncture as a medical specialisation, i.e. as a complementary practice, for certain precise indications.**
- **The practice of acupuncture allows doctors to offer their patients a hybrid approach that remains largely conventional, but nevertheless *different*.**

Practitioners with no medical training

The non-doctor practitioners practicing acupuncture that we met were originally trained as physiotherapists or nurses. We find that these practitioners tend progressively to abandon their initial activity to focus totally on acupuncture.

For them, the virtually obligatory trip to China, which transpires from their descriptions as a sort of rite of passage, is also seen as a gauge of the seriousness of their training. The acupuncture that they practice often conforms more to what they learned in China (according to the principles of traditional Chinese medicine). They are opposed to the hybridisation of acupuncture, as the majority of doctors practice it today.

The type of training that they have received also influences the way in which they practice acupuncture. Although they admit that very few practitioners can master this technique to perform a diagnosis, the majority of them take the pulse of the patient, for example, because this is an element of the 'system' that they were taught. They also attach great importance to the contextual elements of the appearance of pain or the complaints brought to them by their patients, as they have been taught to do by Chinese medicine.

Just like practitioners with medical training, they incorporate some elements of their initial training into the practice of acupuncture. Physiotherapist-acupuncturists, trained to examine the musculoskeletal system, for example, make a diagnosis based on what they learned during their studies, but which they complement or refine, with reference to the way in which they were taught to make a diagnosis in Chinese medicine.

- **Practitioners with paramedical training tend progressively to abandon the exercise of their initial profession and practice only acupuncture.**
- **Because of the Belgian legislation that governs the art of healing, non-doctor practitioners have to be trained abroad, often in China.**
- **The training followed by non-doctor practitioners prompts them to practice and promote acupuncture that is more faithful to the practice of traditional Chinese medicine.**

3.3.4.2 *The indications and applications of acupuncture*

From the perspective of their professional practice, acupuncturists differed from their 'traditional' colleagues (doctors or physiotherapists) in that they used acupuncture either for local and acute problems, or for problems that they themselves described as 'complex'.

Local and acute problems

For a whole series of localised problems such as arthritis of the knee, lumbago, neck pain, etc., the form of the consultation is quite similar to that of a traditional doctor, with the difference that the treatment is with acupuncture.

Acupuncturists attribute acupuncture with three types of 'morphinic' effects: an analgesic effect, and anti-inflammatory effect and a relaxing effect. According to them, it is the combination of these three effects that produces the results that they present as semi-miraculous in the case of acute pain.

« Si ce sont des problèmes d'arthrose, par exemple, il n'y a pas grand chose à faire, à part placer les aiguilles là où il faut... » (practitioner 3)

« Avec quelqu'un qui a un infarctus du myocarde ou une appendicite, cela ne sert à rien de lui proposer une approche plus globale, le problème aigu est local... vous pouvez découper la personne en tranches pour de tels problèmes... » (practitioner 2)

« Pour un lumbago, par exemple, le patient ressort après vingt minutes en n'ayant plus rien, ils disent que c'est miraculeux. Je leur anesthésie complètement la zone, et donc la douleur part... » (practitioner 1)

Global problems

But for a series of 'complex' situations, acupuncture enables them to address the patient differently using what they refer to as a more 'global' approach.

« On s'intéresse plus à l'être humain, à sa complexité, il y a beaucoup d'anamnèse... Si la personne vient par exemple suite à un décès, ou s'ils se sentent stressés, anxieux, bon, là, si vous n'utilisez pas des points 'psy', vous allez vers l'échec... » (practitioner 3)

What the practitioner is saying here is that acupuncture allows him to deal with the mental distress or 'stress' of the patient. The following statements, by the same practitioner concerning his patients, confirm this idea:

« Vous avez des personnes qui ont fait le tour des médecins et des psychiatres, et qui sont déçus de la médecine classique qui se fout d'eux... alors, en une séance d'acupuncture, c'est incroyable le résultat, ils se sentent plus sereins, plus calmes... » (practitioner 3)

Acupuncture could therefore be seen as an equivalent to anxiolytics or anti-depressants, for instance, which other doctors would use to treat 'patients with complex pathologies',

The relaxing effect of an acupuncture session is unanimously recognised as one of the most common effects. Practitioners with medical training nevertheless try to do this without resorting to specific etiquette, making only limited use of the 'symbols' referring to the 'Chinese tradition'.

« *Moi je n'ai jamais voulu mettre le décorum chinois, je n'ai pas voulu mettre de musique non plus, même si je crois à la musicothérapie... J'ai un confrère qui s'habille tout à fait 'à la chinoise', lui est tout à fait 'yin et yang'... mais ça c'est l'effet surajouté placebo...* » (practitioner 1)

The relaxing effect is probably also linked to the manner in which an acupuncture session takes place, where the patient remains lying down for a period of twenty minutes without moving because needles are inserted at different points on the body. The indirect effect of the needles is therefore to oblige patients to remain in a position that helps them to relax.

The relaxing effect of acupuncture would explain its beneficial effect on patients suffering from light depression, feelings of malaise, etc.

« *Il y a des personnes qui se sentent très bien après une séance, vous voyez la vie en rose...* » (practitioner 1)

Beyond its strictly medical applications, the practitioners interviewed generally see acupuncture as an approach with a structure that enables them to better 'understand' their patients.

« *Je pose toujours des questions sur l'environnement relationnel du patient, sur leur profession, leur milieu familial, des choses que je trouve intéressantes... J'ai peut-être plus le temps de poser des questions au patient lorsqu'il est couché sur une table...* » (practitioner 4)

« *Hoeveel van die hoofdpijnen worden niet omschreven als spanningshoofdpijn? En wat is dat dan juist? En naargelang, en dat is misschien een meerwaarde van acupunctuur eens als ge de diagnoses spanningshoofdpijn hebt, kunt ge als huisarts met een aantal gesprekken die mensen verder helpen. Misschien is dat een tijdelijk probleem en is dat met pijnstillers en of ontstekingsremmers in orde, maar misschien ook niet. Misschien blijft dat duren en dan gaan die mensen ook verder zoeken.* » (practitioner 8)

The organisation of acupuncture sessions encourages dialogue between the therapist and the patient, which seems to be a desire often expressed by patients. The twenty minutes spent with the patient lying down could encourage dialogue between the patient and the therapist.

- **Practitioners with medical training use acupuncture to treat both acute and chronic pain, as well as complaints that they describe as 'complex'.**
- **The relaxing effect of a session is widely recognised as one of the main therapeutic benefits of acupuncture.**
- **The organisation of acupuncture sessions gives patients opportunities that are generally ignored in the traditional approach, enabling them to obtain a range of information on patients and their environment.**
- **Acupuncture is perceived as a 'global' medicine in the sense that it is interested in the relationship between the complaints of patients and the context in which they appear.**
- **For problems considered to be 'complex' by the practitioner, consultation is longer and more emphasis is placed on the relational dimension.**

3.3.4.3 Several different models of acupuncture

Although it is difficult to know precisely what practitioners do in practice in Belgium during consultations, not having observed them at first hand, it is nevertheless possible to identify at least the main outlines of the different models of their practices. There appears to be a distinction between two opposing views of acupuncture, both in terms of its practice and at the theoretical level of explaining its effects, which should be considered as two extreme models between which all the approaches encountered fall:

- Chinese-style acupuncture, which harks back to the Chinese ‘tradition’, philosophy and practice, as if they form an indivisible whole.
- Acupuncture that could be referred to as western-style, i.e. stripped of the majority, if not all, of its traditional references, reduced to its technical components and made to conform to a neurophysiological explanatory framework.

These two opposing views of acupuncture seem to relate to the two models of practices where the divergences seem to result from the initial training of the practitioner: the former is most frequently found among non-doctors than with training more in line with the style of acupuncture practices in China, while the latter is mainly found among practitioners with a medical training.

The western-style acupuncture practiced by the majority of practitioners with medical training was, to some extent, extracted and cut off from its traditional philosophical and explanatory framework and reduced to a medical technique. All of the acupuncturists with medical training displayed a degree of scepticism regarding the traditional Chinese philosophical system, showing a preference for a more ‘scientific’ and ‘rational’ explanation:

« Les chinois ont mis au point un système de réflexion, avec le yin et le yang et tout ça, qui n’est vraiment pas mal, mais avec lequel je ne suis pas tout à fait d’accord. J’ai appris tout cela, mais cela ne me sert à rien. Je préfère me référer à des approches raisonnées et reproductibles. » (practitioner 1)

« Je dis toujours à mes patients qu’il y a deux explications : l’explication traditionnelle, qui dit qu’il y a des blocages d’énergie, mais ça c’est pour les Chinois, moi je ne crois pas du tout à cette idée d’une circulation d’énergie dans les méridiens, pour moi il y a des explications neurophysiologiques... » (practitioner 4)

The effectiveness of acupuncture, and its morphinic^f effects (analgesic, anti-inflammatory and relaxing), is explained by reference to the role of ‘endorphin receptors’, which are stimulated by the needles inserted by the practitioner into the body of the patient.

« De nouvelles théories laissent entendre que l’on agit sur le système sympathique ou orthosympathique par des arcs réflexes, donc en piquant ces endroits là, vous libérez quelque chose qui va agir sur le système sympathique ou orthosympathique... » (practitioner 2)

The biomedical practitioners that believe this explanation nevertheless recognise that not all patients react in the same way to acupuncture treatments.

This differential response to acupuncture treatments is attributed partly to a neurophysiological problem, a lack of endorphin receptors in certain people, and partly to the existence of cultural models with attitudes and reactions to pain caused by illness and wounds.

« Vous avez des personnes méditerranéennes qui sont très sensibles à la douleur, et des Polonais, par exemple, qui résistent à la douleur d’une façon terrible... » (practitioner 1)

^e The idea that there is a form of acupuncture that conforms to the ‘tradition’ clearly poses a problem, because it is difficult to identify to which tradition it refers. As we shall see below, it indicates conforming to an approach, to a traditional manual, etc.

^f Not to be confused, strictly speaking, with the pharmacological effects of morphine.

As we can see, the concepts of *qi*, *yin* and *yang*, which form part of the conceptual arsenal of Chinese medicine, have given way, in the words of the practitioners of this model of acupuncture, to western concepts, sometimes going as far as denying the Chinese heritage of acupuncture.

« L'acupuncture est-elle chinoise ? Je n'en sais rien... Je crois que le système de points, pousser sur des points spécifiques du corps pour obtenir des réactions spécifiques, c'est plutôt universel... » (practitioner 2)

Similarly, the practitioners of this type of western-style acupuncture are never content to make a diagnosis based on taking the pulse of the patient or examining the tongue, as practitioners that follow the Chinese tradition do. They prefer to use the biomedical diagnostic methods, which they may complement or extend using the indications provided by this type of diagnosis, paying attention to certain contrasts inspired by Chinese medicine.

« La médecine chinoise est plus subjective. Si vous demandez à trois thérapeutes, vous aurez trois diagnostics différents, ce que vous avez beaucoup moins en médecine 'occidentale'... Mais quand on patauge un peu, quand on n'est pas vraiment sûrs d'un diagnostic, nous y ajoutons le diagnostic à la chinoise, et nous avons alors un complément que les autres médecins n'ont pas. (...) Je lui sers la main, je sens à la chinoise si sa main transpire, est sèche, s'il a du tonus, s'il tremble... Il ne sait pas que je l'analyse, c'est ça qui est important. » (practitioner 1)

« Je sais qu'il y a des acupuncteurs qui prennent le pouls, mais moi je ne le prends jamais, c'est tellement subjectif, que je préfère approfondir l'anamnèse en fonction de ce que je vois et de ce que je sens. On accorde beaucoup d'importance à des choses qui n'intéressent personne en médecine occidentale, comme par exemple lorsque une douleur s'aggrave quand il fait humide, cela veut dire quelque chose pour nous. » (practitioner 3)

« Nochtans zweer ik bij de oude Chinese geneeskunde, maar op het gebied van diagnosestelling, is dit voorbijgestreefd. (...) Me heeft die traditionele opleidingen, ik ben er een stuk voorstander van, maar het stukje diagnosestelling kan niet meet in deze tijd... we moeten het ook in onze tijd zien en niet in de tijd van 3000 jaar terug. » (practitioner 7)

Although, from a theoretical standpoint, there are some 360 acupuncture 'points', biomedical practitioners only use a small proportion of them. Some of them restrict themselves to the use of a small number of key 'points'.

« Je n'utilise pas tous les points, j'utilise au maximum de trente à cinquante points sur ceux qui existent, parce qu'il y a des points qui ont une efficacité moindre... » (practitioner 1)

« Il y en a 360, mais avec une soixantaine de points, vous pouvez faire de la très bonne acupuncture. Les autres points, ne sont pas vraiment importants. » (practitioner 3)

The justifications for the use of an acupuncture 'point' also diverge from those of the traditional practitioners, in the sense that the 'moderns' do not refer to 'tradition', but to empiricism, although they generally follow the indications in the translations of acupuncture manuals.

« C'est extrêmement difficile de justifier des indications pour certains points, mais les choisir d'après les conceptions philosophiques taoïstes, c'est complètement ridicule. » (practitioner 3)

« Au fond, ce sont des points que l'on a découvert par la tradition empirique, et que l'on essaie de justifier par des théories neurologiques, mais on ne connaît pas bien les mécanismes d'action pour raffiner le choix des points... » (practitioner 4)

The link that is made in this way between what is done and the 'points' and certain disorders nevertheless shows the 'magical residue' that even biomedicalised acupuncture has retained.

- **According to the conceptual framework that recommends using the biomedical model as a basis, not all patients react in the same way to acupuncture treatments due to the presence or absence of endorphin receptors.**
- **Many aspects of ‘traditional’ acupuncture have been abandoned by practitioners with medical training, who see acupuncture as one of many ‘medical techniques’, to be used for a limited number of disorders.**

3.3.4.4 Acupuncture in the health system

The situation of acupuncture in the health system has changed significantly since its appearance in Belgium in the 1960s. Following a period of probable mistrust, it now seems to be accepted to a degree by certain members of the medical profession as a valid ‘medical technique’, provided that it is practiced by doctors. According to the practitioners that we met, collaboration with non-doctor practitioners remains difficult.

« 15-20 jaar terug ging dat niet. Nu laat ons zeggen, zijn er een aantal artsen categoriek tegen. Er zijn een aantal die zeggen ‘laat ze maar doen’, en er zijn er ook een aantal die gewoon doorverwijzen. » (practitioner 7)

The appropriation of acupuncture by doctors could also be interpreted as an attempt to maintain their prerogative in the field of healthcare and to restrict access to it by other types of alternative therapy practitioners⁷³. Practitioners with biomedical training call for conditions that limit access to the professional exercise of acupuncture and are opposed to non-doctors practicing it.

« Si on veut faire de l’acupuncture, que l’on fasse les neuf années de médecine... Il faut un minimum de formation médicale, que l’art de guérir reste réservé aux médecins, et que l’on ne sorte pas de cela... » (practitioner 1).

« Il y a une école de kiné en Flandre, à Anvers, et qui cherche à former des kinés. Nous autres, sur le plan médical, nous sommes opposés à cela, parce que l’acupuncture, c’est de la médecine. C’est examiner quelqu’un, poser un diagnostic, et traiter quelqu’un... donc ça, c’est fondamentalement médical... » (practitioner 2)

« Je ne comprends pas comment l’on peut autoriser les kinés à faire cela aujourd’hui... » (practitioner 3)

Doctor-acupuncturists therefore criticise non-doctors for their lack of scientific and medical training:

« Ceux-là (les acupuncteurs kinésithérapeutes de formation) font beaucoup plus référence à la tradition chinoise, avec moins d’approche scientifique. » (practitioner 1)

The existence of certain ‘risks’ associated with acupuncture (pneumothorax, transmission of pathogenic agents, cardiac perforations, haemorrhages, paralysis, septicaemia, etc.) are also arguments put forward by practitioners (especially doctors) to limit its practice. Risks associated with a lack of medical or paramedical training are also mentioned, in particular the risk that a non-doctor practitioner could not identify a more serious health problem in a patient because it was masked by a collateral symptom.

« De vooropleiding heb je nodig om zaken uit te sluiten. Spijtig genoeg lopen er hier ook acupuncturisten rond die geen vooropleiding hebben gehad. Er zijn er niet veel, maar toch nog een paar. (...) Dan gaan de goeden he bekopen. Ik hoop dat het ministerie het kaf van het koren gaar scheiden. » (practitioner 7)

« (Aan de vraag : Kan een bakker studeren of uitoefenen ?) Nee, dat vind ik onbetrouwbaar. Tenzij hij dan eerst drie jaar verpleegkunde studeert of kinesist. En dat is bij ons ook een vereiste. » (practitioner 10)

However, the words of some practitioners with medical training are less radical, provided that the practitioner is given medical training:

« Maintenant, les kinésithérapeutes, ce sont quand même des praticiens qui sont reconnus, c'est une profession un peu particulière, dans le sens où ils traitent beaucoup de pathologies de l'appareil locomoteur... je dirais qu'il serait peut-être possible de trouver des accords, mais il faudrait qu'il y ait un encadrement. On pourrait envisager qu'un kiné fasse de l'acupuncture, mais sur prescription médicale ... » (practitioner 2)

« Ik heb het dan over kinesisten en niet over andere paramedici. Kinesisten die kennen het musculoskeletaal stelsel, vaak veel beter dan een huisarts en ik kan me voorstellen mits een goede opleiding op een veilige manier kinnen doen, maar wel voor de dingen die ze gewoon zijn om te behandelen. » (practitioner 8)

The idea of physiotherapists or other paramedical professionals practicing acupuncture limited to their respective fields of intervention (the musculo-skeletal system, for example) is also defended by non-doctor practitioners.

Where doctors and non-doctors diverge radically is with regard to the proposal to allow non-doctor practitioners to practice acupuncture 'on medical prescription'. For physiotherapists, for example, this would be a disguised attempt to prohibit them from practicing acupuncture, because of their mistrust of each other.

« Ce serait le plus sûr moyen d'interdire à des kinés de faire de l'acupuncture, parce que les médecins n'enverront jamais des patients à des kinés pour des séances d'acupuncture... » (practitioner 6)

Collaboration between practitioners with medical training and their conventional general practitioner colleagues seems quite good in the case of patients that they refer to each other.

« Bon, il y a des médecins qui n'y croient pas, mais je reçois assez bien de patients de trois médecins qui m'envoient des patients qu'ils n'ont pas réussi à guérir, essentiellement des cervicalgies de stress. (...) Je suis alors médecin spécialiste en acupuncture, je ne suis pas en concurrence... » (practitioner 3)

Practitioners with medical training say that half of their patients come to them on the recommendation of a colleague, such as a neurosurgeon. However, that does not seem to be the case for non-medical practitioners, who only occasionally receive patients for acupuncture on the recommendation of a general practitioner.

Another important observation is that, unlike other alternative medicines (osteopathy, homeopathy, etc.), acupuncture seems to be practiced less on small children. Neither parents nor practitioners like the idea of inserting needles, however fine they may be, into the bodies of young children. Acupuncture is therefore essentially a medicine for adults with chronic and complex health problems and stress-related problems.

- **Acupuncture today is considered by a part of the medical profession as a valid medical technique, provided it is practiced by doctors.**
- **The appropriation of acupuncture by doctors could also be interpreted as an attempt to maintain their prerogatives in the field of healthcare and to restrict access to it by the practitioners of other alternative therapies.**

4 THE PRACTICE

4.1 OBJECTIVE

The objective of the survey was to report on the practice of acupuncture in Belgium amongst practitioners affiliated with a professional organisation in Belgium.

4.2 METHODS

A quantitative web based survey was conducted amongst the members of the 4 recognised professional organisations.

The questionnaire was based on experiences from previous survey amongst osteopaths and chiropractic practitioners, examples from the literature and the results of our systematic review of the effectiveness of acupuncture.

The questionnaire was submitted to and discussed with representatives of the 4 professional organisations in a stakeholders meeting and adaptations were done following their remarks.

Persons who did not have no on line access were contacted with a paper version by mail.

The web survey used Modalisa (c) software, analysis was with EPIINFO (CDC Atlanta).

4.3 RESULTS

4.3.1 Response rate

329 persons answered the survey. The response rate per professional organisation is given below in table 1.

Table 1. Response rate per professional organisation

ABADIC	60/80	75%
EUFOM	67/100	67%
BAF	111/213	52%
UPMAB	91/200	46%
Total	329/593	55%

4.3.2 Baseline characteristics

Sample characteristics are presented in table 2.

Table 2. Age, sex and professional organization of the respondents (n= 329)

	Physicians		Others	
	Frequency	Percent	Frequency	Percent
Age (n=329)				
<30	0	0,0%	11	4,9%
>60	25	24,3%	25	11,1%
31-39	10	9,7%	68	30,1%
40-49	20	19,4%	75	33,2%
50-59	48	46,6%	47	20,8%
Total	103	100%	226	100%
Sex (n=325)				
Male	75	73,5%	133	59,6%
Female	27	26,5%	90	40,4%
Total	102	100,0%	223	100,0%
Professional organisation (n=317)				
ABADIC	3	3,3%	56	24,9%
ABADIC/BAF	0	0,0%	2	0,9%
BAF	7	7,6%	103	45,8%
BAF/EUFOM	0	0,0%	3	1,3%
EUFOM	3	3,3%	61	27,1%
UPMAB-BGA3	79	85,9%	0	0,0%
Total	92	100%	225	100%

4.3.3 Training

Only 4 respondents declared not having followed a training before their acupuncture training. Out of the 321 persons with a training "biography" the majority had a medical or paramedical training: 172 (53,6%) were kinesiherapists, 88 (27,1%) were general practitioners, 15 (5,0%) were medical doctor specialist (amongst them 6 anaesthetists), 36 (11,2%) were nurses, one midwife, 2 osteopaths and 7 had another training, of those one was a beauty specialist. There were no psychologists, pharmacists, veterinaries or dentists in the sample.

Table 3 Country and school where the training took place and if training was fulltime or part-time.

country of training(n=326).	Frequency	Percent
Only in Belgium	195	59,6%
Belgium and Asia	87	26,8%
Belgium and non Asian country	20	6,6%
Only in Asia	11	3,5%
Other countries europe	13	3,5%
Total	152	100,0%
Fulltime or partime (n=323)		
Partime	269	83,3%
Fulltime	54	16,7%
Total	323	100,0%
School in Belgium(n=360)		
Europe Shanghai College	58	17,6%
Jing Ming(Katho)	68	20,7%
OTCG	96	29,2%
ETTC	4	1,2%
ABMA-BVGA	84	25,5%
Dr Beyens	2	0,6%
Others	18	5,5%
Total	330	100,0%

Table 3 shows the country where the training took place and if training was fulltime or part-time. A majority got the training exclusively in Belgium. A minor part got the training in Belgium complemented with a training in Asia.

Amongst the people (n=131) who got a training abroad, 70 (53,4) got a training in China, 5 (3,8%)in another Asian country and 30 (22,9%) in Europe. Nanjing University was with 19 (27,1%) trainees the most frequent location in China.

Out of 324 respondents, 282 (87%) (5 no answers) follow one or another form of continuous education, 81 (24%) respondents mentioned that they were specialized in one or another topic, the most frequently mentioned specializations were auricular acupuncture (14 times), pain relief (12 times), electro-acupuncture (11 times) and pregnancy related problems (8 times).

4.3.4 Practice

The median time in practice was 9 years (no means are given as distribution was too skewed to the left), interquartile range 4 to 20, min 1 year and max 44,36% practices 5 years or less. One outlier (89 years) was excluded, 70 (21,2%) practices in group, the majority practices solo. Of those that practice in group, 46 (65,7%) associated with physiotherapists, 25 (35,7%) with osteopaths, 22 (31,4%) with fellow acupuncturists, 18 (25,7%) with a physician, 12 (17,1%) with a psychologist 10 (14,3%)with a dietician, 7 (10,0%) with logopedists and one dentist. Respondents could enter more than one answer.

Table 4 shows the place of practice and practice area. The large majority practices at home followed by a cabinet outside the house.

Table 4. Place of practice and practice area (more than one answer possible).

place of practice	Frequency	Percent
At home	241	73,30%
In a cabinet outside the house	116	35,30%
Hospital	11	3,30%
Policlinic outpatient department	6	1,80%
Rest house	1	0,30%
Patients house	28	8,50%
Else	2	0,60%
Total	405	100,0%
Province		
Antwerpen	48	14,7%
Oost Vlaanderen	53	16,2%
West Vlaanderen	35	10,7%
Limburg	23	7,0%
Vlaams Brabant	32	9,8%
Bruxelles/Brussel	44	13,5%
Brabant Wallon	15	4,6%
Luxembourg	6	1,8%
Namur	13	4,0%
Hainaut	22	6,7%
Liège	22	6,7%
More than one province	14	4,3%
Total	327	100,0%

Table 5 shows the types of practices that acupuncturists combine, and what kind of practices they use on the same patients.

Table 5. Types of practices that acupuncturists combine and kind of practices they use on the same patients.

type of practice :	Other practices done by acupuncturist		Do you combine this practice with acupuncture on the same patient?	
	Frequency (a)	Percent of total	Frequency	Percent of (a)
Classic medicine	95	28,9%	67	70,5%
homeopathy	35	10,6%	27	77,1%
nursing	25	7,6%	1	4,0%
kinesitherapy	138	41,9%	17	12,3%
oriental medicine	84	25,5%	65	77,4%
osteopath/chiropractic	46	14,0%	25	54,3%
Other	37	11,2%		

The median % of the time that a practitioner spends on acupuncture is 30% (no means are given as distribution was too skewed to the left), interquartile range 20% to 50%, min 0% and max 100%.

A majority of 209 (63,9%) of respondents say they practice traditional Chinese acupuncture and 103 (31,5%) claim to practice both. Only a tiny minority of 15 (4,6%) claim to practice modern acupuncture.

Physicians state that they practice less 'pure' traditional and more mixed (See table 6).

The majority of 211 (64,7%) does less than 5 hours of practice a day, 89 (27,9%) does between 5-8h and a minority of 26 (8,0%) does more than 8 hours a day of practice. 4 did not provide an answer.

For a first consultation, 140 (42,9%) charges less than 35 euros, 165 (50,6%) charges between 35 and 50 euros and 21 (6,4%) charges more than 50 euro. For a follow up consultation, 202 (62,3%) charges less than 35 euros, 114 (35,2%) charges between 35 and 50 euros and 8 (2,5%) charges more than 50 euro.

Only 36 (11,2%) declares not to have a INAMI number, 103 (33,1%) has a number that is put asleep and 187 (56,5%) has an active INAMI number

Table 6. Proportion of physicians practicing modern, mixed or traditional acupuncture.

	Physicians		Non Physicians		All	
	n	%	n	%	n	%
modern	14	13,6	1	0,4	15	4,6
Mixed	50	48,5	53	23,7	103	31,5
Traditional	39	37,9	170	75,9	209	63,9
Total	103	100	224	100	327	100

4.3.5 Provider delay

When considered urgent, the patient can be seen on the same day in 63,3% of cases and in 83,7% in less than one day if the patient is a new case and seen on the same day in 70.5% of the cases and in 89,5% in less than one day if the patient is an old case. When not urgent, the median delay for new cases is 3 days (No means are given as distribution was too skewed to the left; interquartile range: 1 to 7; Min: 0; Max: 180) and 2 days (no means are given as distribution was too skewed to the left), interquartile range 1 to 4, min 0 and max 90 days for old cases.

4.3.6 Workload and profile of patients

Table 7 shows the number of patients seen per day, as well as the duration of a consultation and the proportion of patients coming for a new indication. The majority of physicians receives less than 5 patients a day and the majority of the consultations last between ½ and 1½ hour a day. Medical doctors tend to have a slightly higher proportion of consultation < 30 minutes (data not shown).

Table 7. Number of patients seen per day, the duration of a consultation and the proportion of patients coming for a new indication (n = 329).

number of patients a day	All cases (n = 318)		New cases (n = 326)	
	Frequency	%	Frequency	%
<5	185	58,2%	260	79,8%
6 to 10	90	28,3%	56	17,2%
>10	43	13,5%	10	3,1%
Total	318	100%	326	100%
Duration of a consultation	New consultation (n = 325)		follow up consultation (n = 326)	
	Frequency	%	Frequency	%
<30min	11	3,4%	28	8,6%
30min-1h/u	150	46,2%	252	77,1%
1h/u-1h/u30	151	46,5%	47	14,4%
>1h/u30	13	4,0%		
Total	325	100%	327	100%
Proportion of patients coming for a new indications (n = 306)				
	Frequency	%		
<25%	159	52,0%		
More or less 25%	70	22,9%		
More or less 50%	50	16,3%		
>50%	27	8,8%		
Total	306	100%		
on average, how many time a year do you see the same patient ? (n = 326)				
1 to 3	45	13,8%		
4 to 6	140	42,9%		
7 to 10	108	33,1%		
11 to 12	21	6,4%		
> 12	12	3,7%		
Total	326	100%		

Figure 1 and 2 show the proportion of patients consulting for therapeutic reasons and for preventive reasons, the majority of practitioners has around 10% of their patients coming preventively.

Figure 1. Distribution of practitioners by declared patients consulting for preventive reasons

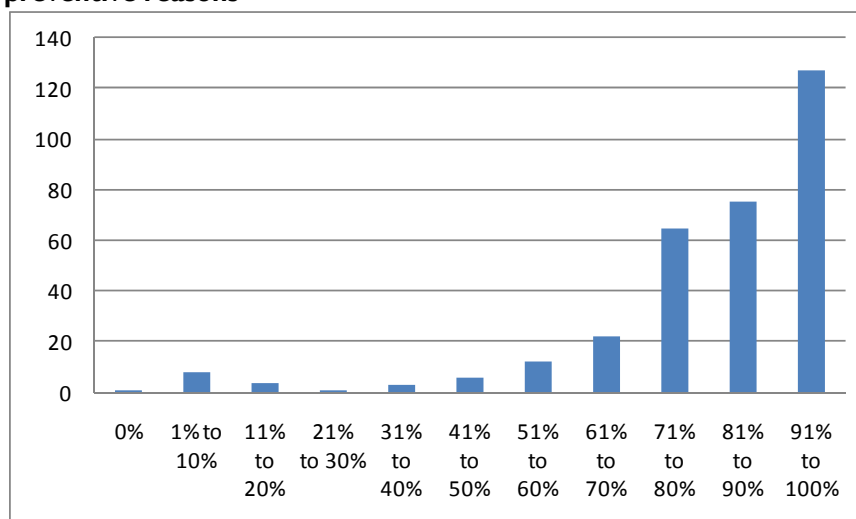
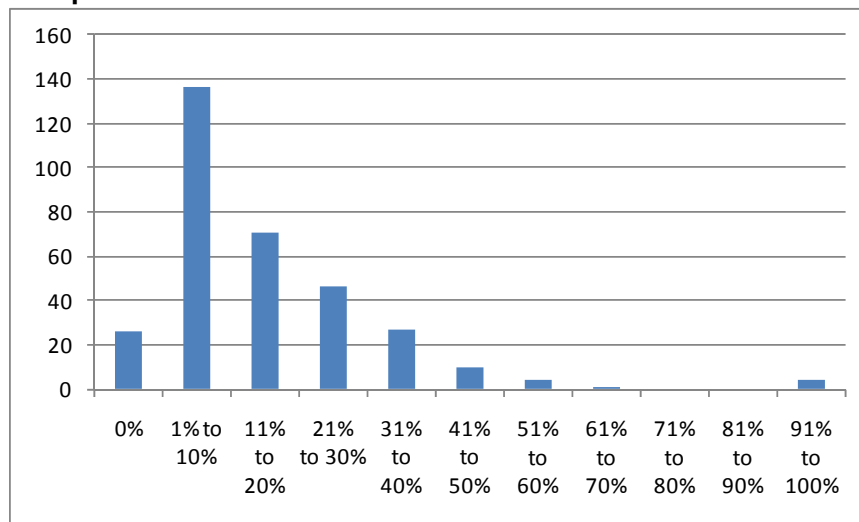


Figure 2. Distribution of practitioners by declared patients consulting for therapeutic reasons



Out of those who consult for preventive reasons, 80 (26,8%) practitioners state that patients come every month, 136 (45,5%) every 3 months and 83 (27,8%) state that they come once a year.

4.3.7 Patient referral:

Practitioners were asked to rank from 1 to 6 where most referrals came from. Most were referred by a relative/friend.

Table 8: Ranking of referrals of patients by practitioners from 1 to 6. (N = 329)

Ranking	1	%	2	%	3	%	4	%	5	%	6	%	total	average rank
referred by a friend or relation	189	59,4	59	19,3	28	9,4	15	5,6	7	3	4	2	302	1,68
website	59	18,5	93	30,4	45	15,1	35	13,2	21	9	12	6,1	265	2,63
referred by physician	23	7,2	48	15,7	70	23,5	41	15,4	48	20,6	40	20,6	270	3,6
referred by another conventional health care provi	9	2,8	34	11,1	51	17,1	72	27,1	48	20,6	20	10,3	234	3,75
referred by another non- conventional health care	6	1,8	27	8,8	39	13,1	55	20,7	44	18,8	32	16,4	203	3,98
not referred	24	7,5	36	11,8	50	16,8	29	10,9	49	21	39	20,1	227	3,7
doesn't know	3	0,9	5	1,6	12	4	14	5,2	8	3,4	35	18	77	4,61
others	5	1,5	3	0,9	2	0,6	4	1,5	8	3,4	12	6,1	34	4,26

4.3.8 Complaints for use of acupuncture

Table 9 shows the frequency of the complaints why patients consulting, ranked by importance (where often and very often was mentioned most). Neck pain, back pain and stress related conditions, including headache and insomnia, are the most frequent conditions. We did not see differences between MD's and others (data not shown).

Table 9. Frequency of the complaint for wich patients come consulting, ranked by importance (where often and very often was mentioned most)

Condition	Often or Very often		sometimes or rarely		never		Does not know the condition		No answer
	n	%	n	%	n	%	n	%	
neck pain	286	89,9%	22	6,9%	3	0,9%	7	2,2%	11
low back pain	285	89,6%	30	9,4%	3	0,9%	0	0,0%	11
headache	275	88,4%	26	8,4%	5	1,6%	5	1,6%	18
insomnia	273	84,8%	45	14,0%	3	0,9%	1	0,3%	7
stress related claim	257	82,4%	44	14,1%	7	2,2%	4	1,3%	17
depression and anxiety	233	73,3%	83	26,1%	2	0,6%	0	0,0%	11
gastrointestinal disorders	227	71,4%	80	25,2%	10	3,1%	1	0,3%	11
chronic fatigue syndrome	198	62,5%	105	33,1%	12	3,8%	2	0,6%	12
menopausal hot flushes	193	61,1%	105	33,2%	17	5,4%	1	0,3%	13
fibromyalgia	191	60,4%	113	35,8%	11	3,5%	1	0,3%	13
osteoarthritis	191	61,8%	99	32,0%	13	4,2%	6	1,9%	20
neuralgia	170	55,2%	118	38,3%	18	5,8%	2	0,6%	21
nausea and vomiting	160	51,1%	138	44,1%	15	4,8%	0	0,0%	16
allergy	156	49,2%	150	47,3%	11	3,5%	0	0,0%	12
dysmenorrhoea	155	50,5%	128	41,7%	23	7,5%	1	0,3%	22
fertility	137	43,9%	141	45,2%	34	10,9%	0	0,0%	17
colic pain	128	42,0%	142	46,6%	32	10,5%	3	1,0%	24
carpal tunnel	99	31,6%	188	60,1%	24	7,7%	2	0,6%	16
pregnancy	99	32,8%	139	46,0%	58	19,2%	6	2,0%	27
obesity	94	30,6%	170	55,4%	42	13,7%	1	0,3%	22
obstetrics	81	27,0%	148	49,3%	66	22,0%	5	1,7%	29
restless legs syndrome	79	25,8%	184	60,1%	40	13,1%	3	1,0%	23
addiction	76	25,6%	180	60,6%	31	10,4%	10	3,4%	32
spinal cord injury	75	25,0%	136	45,3%	88	29,3%	1	0,3%	29
hypertension	68	22,1%	189	61,4%	50	16,2%	1	0,3%	21
otolaryngology	61	20,3%	152	50,7%	75	25,0%	12	4,0%	29
dystonia	48	16,2%	158	53,2%	82	27,6%	9	3,0%	32
psoriasis	48	15,4%	190	60,9%	73	23,4%	1	0,3%	17
cancer side-effects	29	9,5%	197	64,6%	78	25,6%	1	0,3%	24
nocturnal enuresis	22	7,2%	180	59,2%	101	33,2%	1	0,3%	25
Parkinson's disease	19	6,2%	167	54,8%	118	38,7%	1	0,3%	24
stroke	15	5,1%	170	58,0%	97	33,1%	11	3,8%	36
Bell's palsy	13	4,6%	132	46,3%	110	38,6%	30	10,5%	44
glaucoma	7	2,3%	96	32,1%	194	64,9%	2	0,7%	30
dementia	5	1,7%	88	29,1%	206	68,2%	3	1,0%	27
epilepsy	5	1,7%	108	35,9%	187	62,1%	1	0,3%	28

4.3.9 Techniques used

Table 10 gives the frequency with which some of the techniques in acupuncture are used. Doctors tend to use slightly fewer techniques such as moxibustion, acupressure, auricular and electro-acupuncture, but differences are small (data not shown) .

Table 10 Frequency of techniques in acupuncture

Technique	Often or Very often		sometimes or rarely		never		Does not know the technique		No answer
	n	%	n	%	n	%	n	%	
needle acup	306	95,9%	9	2,8%	2	0,6%	2	0,6%	12
moxibustion	176	55,5%	117	36,9%	24	8,1%	0	0,0%	33
auricular	136	44,2%	148	48,1%	23	7,7%	1	0,3%	31
acupressure	71	23,9%	130	43,8%	94	31,8%	2	0,7%	33
tui na	48	16,2%	60	20,3%	175	62,1%	13	4,6%	47
craniopuncture	48	16,1%	113	37,9%	128	43,7%	9	3,1%	36
laser acup	39	13,1%	42	14,1%	213	69,2%	4	1,3%	21
other microsystems	23	8,2%	45	16,0%	191	59,9%	23	7,2%	10
shiatsu	17	5,7%	34	11,5%	231	77,8%	14	4,7%	32
ultrasound	10	3,4%	31	10,6%	241	80,9%	11	3,7%	31

4.4 DISCUSSION

The survey gives a description of the profile of acupuncturists that are affiliated to a professional organisation. We have no information about other non affiliated practitioners, their profile may be different as those professional organisations have a number of requirements concerning training and practice.

We have no data on the total number of practitioners of this therapy in Belgium nor on their characteristics. We are therefore not able to assess the representativeness or the expected sample, and moreover of the final sample.

The response rate was good compared to other similar surveys.

There are few differences between acupuncturist that are medical doctors and others, apart from the fact that their consultations are somewhat shorter, that they use slightly fewer techniques such as moxibustion, acupressure, auricular and electro-acupuncture, and that they identify themselves a bit less as purely traditional. Overall, differences are negligible. Both groups are consulted for similar complaints, mainly neck pain, back pain and stress related conditions. In this they show similarities with osteopaths.

5 ORGANISATIONAL AND LEGAL ASPECTS

5.1 BELGIAN AND EUROPEAN LEGAL FRAMEWORK

This chapter is common to the three reports on alternative medicines, as most of the issues are common to all non-conventional practices.

5.1.1 Introduction

This chapter provides details of the Belgian and European legal framework in which non-conventional practices may or may not be exercised.

Points 5.1.3 to 5.1.6 describe the Belgian legal context for both conventional and non-conventional practices. In addition to Royal Decree n° 78 (points 5.1.3.1 to 5.1.3.6), the 'Colla' law is also examined, paying special attention to the *ratio legis* (point 5.1.4.1) and the current situation (point 5.1.3.2). In point 5.1.5, the chapter analyses the interactions between Royal Decree n° 78 and the Colla law, as well as the consequences of exercising (non-)conventional healthcare (point 5.1.6). Finally, point 5.1.7 reviews the practice of non-conventional medicine in the European context. It also provides a brief overview of the legal context in the Netherlands, France and Great Britain.

5.1.2 Methodology

In this review of legislation, doctrine and jurisprudence, the Juridat and Jura databases and the official internet sites of the Belgian courts were consulted. Doctrine and jurisprudence, as published in the main legal reviews, such as *Revue de Droit de la Santé* and *Rechtskundig Weekblad*, were also consulted. As for unpublished jurisprudence, the parties concerned were contacted in order to consult the jurisprudence in question, as well as for consent to exploit it anonymously. Finally, the main reference works by experts in this field were also consulted.

5.1.3 The exercise of conventional healthcare in Belgium under the terms of Royal Decree no. 78

The description of the exercise of conventional healthcare is found mainly in Royal Decree no. 78 of 10 November 1967 concerning the exercise of the healthcare professions. For reasons of convenience, this Royal Decree will be referred to as 'Royal Decree no 78'.

5.1.3.1 *Exercise of the art of healing*

Royal Decree no. 78 makes a distinction between the art of healing and medicine. In the Royal Decree, the 'art of healing' extends to the medical arts, including dentistry, exercised on humans, the pharmaceutical arts in all their aspects (preventive or experimental), curative, continuous and palliative.⁷⁷ Doctors, dentists and pharmacists therefore practice the art of healing.

5.1.3.2 *The practice of medicine*

In the Royal Decree the practice of medicine refers to any act intended or presented as having the aim, with respect to humans, of examining the state of health, or identifying illnesses and disorders, making a diagnosis, setting up or carrying out the treatment of a pathological, physical or mental condition, real or assumed, or vaccination. In Belgium, the legislature has decided to give doctors a legal monopoly on medicine. Only persons satisfying the defined conditions, namely holders of a suitable diploma or with the approval of the Directorate General for the health professions of the federal public health service and registered in the order of doctors, can practice medicine. This monopoly is exclusive.

In other words, only doctors are authorised to practice medicine, to the exclusion of all others. There are only two exceptions to this rule: midwives and dentists, who are also authorised to practice medicine, each in their specific field. Moreover, this monopoly of doctors is also general in a way that each doctor is authorised to carry out all medical acts, whatever their (sub-)specialisation.⁷⁸

5.1.3.3 *The exercise of physiotherapy*

The exercise of physiotherapy is also subject to legal conditions, namely holding a certificate of recognition delivered by the Minister for Public Health and having a diploma approved by the Directorate General for the health professions of the federal public health service. The exercise of physiotherapy is not reserved exclusively for physiotherapists; it is also open to doctors (even with no specific recognition). Conversely, physiotherapists are not allowed to practice medicine. In addition, physiotherapists are not allowed to practice physiotherapy without a prescription from a doctor, failing which they could be found guilty of the illegal practice of medicine, provided that such practice took place on a regular basis.⁷⁸ The interpretation of a 'regular' basis is left to the discretion of the trial judge. Certain judges have already deemed that only two or three acts can be considered as 'regularly' (e.g. Cass., 20 September 1937, Ghent, 2 February 1965). It has also been judged that a regular basis should not be considered from a mathematical standpoint, but depends on the circumstances and specifics of each case. Acts are considered to be exercised on a regular basis when they are neither exceptional nor accidental (Corr. Namur, 13 October 1982).⁷⁸

5.1.3.4 *Exercise of the art of nursing*

The exercise of the art of nursing is also subject to several legal conditions, namely having the required certificate, having this certificate recognised and having obtained the approval of the Directorate General for the health professions of the federal public health service. In addition, the law has subdivided the acts that can only be carried out by nursing staff into acts A, B1, B2 and C.⁷⁸

5.1.3.5 *The exercise of the paramedical professions*

The exercise of paramedical professions is also governed by the law. Several Royal Decrees have described precisely the exercise of these professions, the professional certificates required, the mandatory qualifications, the list of acts and practices that can be carried out by the practitioners of these professions and their modalities. Under the law, the term 'paramedical professions' covers the following professions:

medical laboratory technician, logopaedist, occupational therapist, truss maker, orthotist, prosthetist, dietician, medical imagery technician, assistant pharmaceutical technician, orthopaedist and chiropodist. The practitioners of a paramedical profession must have a professional certificate approved by the Directorate General for the health professions of the federal public health service. When granting its approval, the commission registers the practitioner.⁷⁸

5.1.3.6 *Exercise of the profession of midwife*

In an exception to the monopoly on the exclusive practice of medicine granted to doctors, holders of a midwifery diploma are authorised to carry out the medical act of normal childbirth⁷⁸, provided that their certificate has been approved in advance by the competent medical commission. In addition, the law enumerates the activities that midwives can carry out alone, as well as the acts that they cannot perform.

Key messages: The exercise of conventional healthcare in Belgium under the terms of Royal Decree no. 78

- In Royal Decree no. 78, the ‘exercise of conventional healthcare’ refers to the exercise of the art of healing, medicine, physiotherapy, nursing, the paramedical professions and midwifery.
- Each of these forms of exercise of conventional healthcare is subject to specific conditions.

5.1.4 The exercise of non-conventional medicine in Belgium

5.1.4.1 *The Colla law*

The structure of the law

A big step towards recognition of the exercise of (certain forms of) non-conventional medicine was taken with the law of 29 April 1999 concerning non-conventional practices in the field of medicine, pharmaceuticals, physiotherapy, nursing and the paramedical professions (*Official Journal* of 24 June 1999). For convenience, this law will be referred to hereafter as the ‘Colla law’.

The Colla law is a brief framework law with only a small number of articles: article 1 (reference to article 78 of the Constitution), article 2 (definitions, establishment of chambers), article 3 (joint committee), article 4 (effects of certain Royal Decrees), article 5 (joint committee), article 6 (chambers), article 7 (procedure), article 8 (individual registration), articles 9 et 10 (duty of information), article 11 (penal provisions) and article 12 (entry into force of certain articles).

The rationale for the law

In view of the fact that a large number of people throughout the world were making extensively use of the services of certain non-conventional practices and that several European Union countries had already made moves to regulate such practices, a debate concerning the registration of non-conventional practices was urging. Because there was no specific regulation in Belgium, until that time anyone could practice various forms of treatment without any guarantees concerning quality or training. It was also believed that certain non-conventional practices were sufficiently substantiated to justify setting up a legal framework. The purpose of this framework was to define rules to guarantee that patients receive quality care. The result of this process is a dual registration system for both non-conventional practices and their practitioners. The framework law defines the basic conditions for setting up the two registration systems. The registration of a non-conventional practice has the effect of placing it within the legal framework of the Colla law, providing guarantees for patients.^{79 no. 1714/1} Individual registration guarantees to patients that the practitioner in question satisfies the general conditions applicable to the exercise of non-conventional practices and to the specific conditions applicable to individual registration. This mechanism gives patients the certainty that they are dealing with a competent practitioner. It is also important for the individual practitioners, who thereby ensure that their non-conventional practices are not branded the *illegal practice of medicine*, and can exercise them perfectly legally, provided that they comply with the rules in force.

Non-conventional practices

The Colla law defines non-conventional practices as the habitual practice of acts intended to improve and/or preserve human health, exercised according to the rules and conditions stipulated in this law. The law considers homeopathy, chiropractic, osteopathy and acupuncture to be practices that meet this definition. The law also stipulates that other practices may be considered as such in the future, provided that the King institutes chambers for this purpose.

The joint committee

The Colla law stipulates that a joint committee must be set up at the Ministry of Health, and that this committee will have to play a key role in the application of the law.

This joint committee is composed of several chambers. More specifically, the Colla law stipulates a chamber for each of the non-conventional practices, i.e. homeopathy, chiropractic, osteopathy and acupuncture.

Within six months after its constitution, the joint committee is required to formulate an advice on the general conditions applicable to the exercise of all non-conventional practices. This advice relates in particular to professional insurance and minimum coverage, membership of a recognised professional organisation, a registration system, an advertising system (enabling the general public to obtain information concerning registered practices and registered practitioners), and a list of acts not authorised for non-medical practitioners. The general conditions are determined by the King on the basis of this advice, by a decision deliberated in the Council of Ministers. Only when this advice has been formulated the law can be applied in practice.⁸⁰

In addition to the general conditions, the committee must also formulate an advice concerning the registration of non-conventional practices and the individual registration of practitioners.

The composition of the joint committee and the conditions under which they can issue an advice are defined by the law. Until today (end of 2010), these provisions have not yet been implemented.

The chambers for non-conventional practices

The Colla law introduces a chamber for each of the non-conventional practices that it recognises (homeopathy, chiropractic, osteopathy and acupuncture). Moreover, the King is authorised to establish additional chambers in the future for other non-conventional practices. He can proceed with the establishment of such chambers at his own initiative or at the request of the recognised professional organisations concerned. This refers to professional organisations of practitioners of a practice that could be considered for qualification as a non-conventional practice recognised by the King on the basis of the criteria defined by Him concerning the legal personality, the list of members, the commitment to participate in scientific research and an external evaluation.

The chambers have the task of issuing an advice during the registration of a non-conventional practice, as well as during the individual registration of one of its practitioners. Each chamber also defines the directives concerning the proper exercise of the practice in question and it advises the minister on the organisation of a peer review system and professional ethical rules.

The composition of the chambers and the voting procedures are defined by the law.

The procedure

Concerning the procedural modalities to be followed by the joint committee and the chambers, the Colla law stipulates only that it is up to the King to fix the other provisions concerning the organisation and working methods of the joint committee and the chambers, which has not been done to date.

The conditions of exercise for a registered non-conventional practice

As mentioned above, we must first wait for the advice of the joint committee concerning the general conditions applicable to the exercise of all non-conventional practices. Based on this advice, the King will then define the general conditions by a decision deliberated in the Council of Ministers. Only then the Colla law can be effectively applied.

In addition, *registration of individual practitioners* of registered non-conventional practices must be set up. Under the terms of the Colla law, no one can exercise one of the registered non-conventional practices or perform acts that form part of this practice without prior registration. Registration is granted by the minister, on the advice of the chamber concerned, provided that the applicant satisfies the general conditions and any conditions specific to the registered non-conventional practice. The Colla law defines the procedures to follow, but they have to be further executed by the King.

As for individual registration, the Colla law stipulates that it can be suspended or withdrawn, as a punishment for failure of the practitioner to comply with the provisions of the law or its executory decisions. Suspension (for a maximum period of one year) or withdrawal of individual registration is ordered by the minister at the proposal of the chamber concerned. Once again, the law defines a procedure that has yet to be implemented by the King (the law itself does not stipulate an appeal procedure).⁸¹

The Colla law also stipulates sanctions in the case of exercise of one of the non-conventional practices, or habitually dispensing treatments linked to such registered non-conventional practices, without being registered where registration has been suspended or withdrawn. These offences are punishable by a fine and/or a prison sentence.

Obligations of the practitioners of a registered non-conventional practice

The Colla law imposes an *obligation of information* on all practitioners of a registered non-conventional practice.

This obligation first stipulates keeping a *record* for each patient. No specific sanction has been defined for failure to comply with this obligation, which does not mean that it could not justify the suspension or withdrawal of individual registration.⁸⁰

In accordance with the Colla law, a practitioner of a non-conventional practice may only provide a treatment for the patient after having received a *recent diagnosis* concerning the complaint, drawn up in writing by a doctor. This obligation only applies to practitioners who are not at the same time doctors. The patient is however allowed to refrain from a preceding doctor's consultation. In this case, the patient must confirm this decision in writing and this document must then be attached to the patient's record. Failure to respect this obligation may not only be punishable by withdrawal or suspension of individual registration, but also a sanction (in the form of a fine). Moreover, it emerges from preparatory parliamentary works that failure to respect this obligation by a non-doctor practitioner does not exonerate practitioners from their own responsibility. Non-conventional practitioners remain responsible for the indication of the treatment that they intend to undertake, without subsequently being able to evade responsibility under the sole pretext of an (erroneous) diagnosis of a doctor.^{82 no.}

1714/3

Another obligation for practitioners of a registered non-conventional practice is the *duty of care*. Under this obligation, the practitioner must take all necessary precautions to avoid the patient being deprived of conventional treatment. It emerges from preparatory parliamentary documents that this only concerns vital treatments for the patient. The practitioner must, for example, draw the attention of the patient to the need, where appropriate, to consult a doctor.^{82 no. 1714/3}

In the context of this duty of care, the practitioner of a non-conventional practice who is not a doctor is required to *inform* a doctor, at the doctor's request, of the evolution of the health of the patient. However, this exchange of information cannot take place without the consent of the patient. The practitioner can also supply or obtain information from another practitioner of a non-conventional practice. Finally, the Colla law also stipulates that doctors can also solicit at their own initiative information concerning the evolution of the health of their patients from a non-doctor practitioner of a registered non-conventional practice, but only in the interest of the patient and with the patient's consent. It should be noticed that the Colla law only refers to the *evolution of the health* of the patient, and not the treatment chosen.⁸⁰

The Colla law also mentions explicitly the applicability of article 458 of the criminal code (*professional secrecy*) to the non-doctor practitioners of a non-conventional practice.

The applicability of the Patients Rights Act of 22 August 2002 to practitioners of a non-conventional practice is examined in point 5.1.5.2.

5.1.4.2 *The Colla law today*

The choice of a framework law

During the elaboration of the Colla law, the legislature opted for a framework law. The purpose of this framework law is to offer patients various general guarantees before providing a more detailed formulation of the concrete conditions regarding training, assessment, ethics, practitioner registration, etc. Since it seemed neither possible nor desirable for the public authorities themselves to assume this task of detailed formulation, the legislature opted for a framework law, which mainly defines the procedure to follow. The key element of this framework law is the introduction of a joint committee, within which both traditional medicine and non-conventional practices are represented, which is tasked with determining which non-conventional practices are eligible for registration, and above all to define the conditions governing their exercise.⁸³

no. I-1310/3

Entry into force

As to the date on which the Colla law enters into force, a distinction must be made between articles 3, 8, 9, 10 and 11 and the other articles. Whereas articles 3 (joint committee), 8 (individual registration), 9 (obligations), 10 (relationship with Royal Decree no. 78) and 11 (penal provisions) will only enter into force six months after the first day of the month following the entry into force of the appointment of the members of the joint committee, the other articles have already been in force since 4 July 1999.

The implementing orders

More than ten years later, four implementing orders concerning the Colla law have been issued. They all relate to article 2, §1, 3°, namely the recognition of professional organisations.

The first implementing order is the Royal Decree of 4 July 2001 concerning the recognition of professional organisations of practitioners of a non-conventional practice or a practice that could be qualified as non-conventional (*Official Journal* of 19 January 2002).

This Royal Decree defines the conditions that a professional organisation must satisfy to obtain and retain recognition as a non-conventional practice. Recognition is granted by Royal Decree for a renewable period of six years. The procedure for the submission of a request for recognition is defined by the competent health minister. The minister defined these modalities in the ministerial order of 30 September 2002 defining the modalities for requesting recognition as a professional organisation of practitioners of a non-conventional practice or another practice that could be qualified as non-conventional (Belgian Official Journal of 5 December 2002).

The *second implementing order* is the Royal Decree of 10 February 2003 recognising professional organisations of practitioners of a non-conventional practice or a practice that could be qualified as non-conventional (*Official Journal* of 26 February 2003). Through this Royal Decree, ten professional organisations of practitioners of non-conventional practices or practices that could be qualified as non-conventional were recognised.

The *third implementing order* is the Royal Decree of 10 November 2005 recognising professional organisations of practitioners of a non-conventional practice or a practice that could be qualified as non-conventional (*Official Journal* of 9 December 2005). Through this Royal Decree, two new professional organisations were recognised.

The *fourth and last* implementing order is the Royal Decree of 6 April 2010 recognising professional organisations of practitioners of a non-conventional practice or a practice that could be qualified as non-conventional (Belgian Official Journal of 12 April 2010). Through this Royal Decree, nine professional organisations saw their recognition renewed and two new organisations of practitioners of a non-conventional practice were recognised.

The consequences of restricted execution

The Colla law cannot be applied at the moment because it has not been sufficiently executed.

The joint committee tasked with issuing an advice concerning the general conditions for the exercise of all non-conventional practices, their registration and conditions for individual registration not yet having been constituted, the committee has not yet started its work. One notable consequence of this situation is that the practitioners of non-conventional practices (such as osteopaths, chiropractors, acupuncturists and homeopaths) who are not doctors are not currently allowed to perform acts relating to medicine. If they do not comply with this prohibition, they become guilty of the illegal practice of medicine, which is punishable by the law. Certain professionals such as physiotherapists can however practice on medical prescription certain treatments that can be considered as alternative treatments.

Patients are also waiting for quality guarantees covering the exercise of non-conventional practices because, at the present time, practically anybody can exercise non-conventional practices without the benefit of any training.

The condemnation of the Belgian state

It is precisely because of this non-execution of the Colla law that the professional association *Le Registre des Ostéopathes de Belgique* summoned the Belgian state, in May 2008, before the Brussels court of first instance. On 22 January 2010, this court issued a judgement condemning the Belgian state. The court considered that the Belgian state was in default because of the non-execution of the Colla law within a reasonable period. This default results in prejudice to third parties, in particular professional associations, and compromises the honour and reputation of the professional organisation and its members. In this instance, there would have been no prejudice if the joint committee had been set up and if it had been in a position to carry out its task, in accordance with the Colla law.

Since damages in kind had been requested, the court sentenced the Belgian state to set up the joint committee as stipulated in the Colla law, in accordance with the legal provisions, on pain of being compelled to pay 5 000 euros per month of default after a period of three months following notification of the judgement. After June 2010, the state must pay a penalty of 5 000 euros a month to two associations of osteopaths.

A few remarks concerning the execution of the Colla law

There are a number of elements that make it difficult to implement the Colla law.

THE COMPOSITION OF THE JOINT COMMITTEE

The joint committee must be composed mainly of 'practitioners of a non-conventional practice' (art. 5). It is not stipulated in article 5 whether these members must be registered individually. Neither does the law provide a definition of a 'practitioner of a non-conventional practice'. As a result, it is not clear whether the law requires these practitioners to be registered for the composition of the first joint committee.

The law states that nobody can exercise a non-conventional practice without being registered (Art. 8 §1). In addition, the professional exercise of a non-conventional practice by a non-doctor is equivalent to the illegal practice of medicine, which is punishable (although recent jurisprudence tends to temper this position and certain non-conventional practices can be found in the practices legally authorised for physiotherapists on medical prescription)⁷⁷. If we keep to this interpretation that individual registration is not required to assemble the joint committee for the first time, it is possible that certain members of this committee would be guilty of the illegal practice of medicine. In order to comply with current legislation (the Colla law and Royal Decree no. 78) the joint committee could only be composed of doctors. This would go completely against the 'joint' character specified in the law. In addition, there remains the problem that doctors who also resort to non-conventional practices and sit on the joint committee as 'practitioners of a non-conventional practice', must also as doctors satisfy the conditions of the Colla law and therefore be registered individually.

If we consider that individual registration is necessary for constitution of the first joint committee, the problem arises that individual registration is only possible if the registration conditions are established by Royal Decree. This Royal Decree containing the registration conditions is solely possible following an advice of the joint committee. But the joint committee cannot be constituted as long as there are no (registered) practitioners of a non-conventional practice. Based on this interpretation, the law would have to be changed in order to break out of this vicious circle^{84, 85}. The composition of the joint committee without first amending the law involves a potential risk of a legal challenge to the composition of the joint committee (including all decisions taken by the joint committee that have legal consequences).

CONFIRMATION BY THE LAW OF THE ROYAL DECREE OF 6 APRIL RECOGNISING THE PROFESSIONAL ORGANISATIONS OF NON- CONVENTIONAL PRACTICES OR PRACTICES THAT COULD BE CONSIDERED FOR QUALIFICATION AS A NON-CONVENTIONAL PRACTICE

It would seem right and proper that a framework law should always be accompanied by long-term work on its implementation. The entry into force of the law always depends on the promulgation of numerous decrees. Moreover, several implementing orders must subsequently be approved by the parliament.

The Royal Decree of 6 April 2010 illustrates this, taking into account the recognition of professional associations for a non-conventional practice or a practice that could be considered for qualification as a non-conventional practice⁸⁶. Recognition of professional unions is necessary for the constitution of the joint committee. The law confirmed this Royal Decree on 19 November 2010.

According to the Colla law, the Royal Decree cannot enter into force unless it is ratified by the law within six months of its publication in the Belgian Official Journal.

In this particular case, the Royal Decree of 6 April 2010 was published in the Belgian Official Journal of 12 April 2010. This means that, in order to be applicable, it would have to be ratified by the Chamber and the Senate at the latest on 12 October 2010. Since ratification took place on 19 November 2010, it came too late.

It could be argued that the legislator cannot in principle commit its successors. Consequently, a new legislator must be able to decide to ratify this law after this period of six months. However, this reasoning raises the question of whether such a process complies with the principle of equality (articles 10 and 11 of the Constitution), a general principle that states that each citizen has (legally) the same rights and must be treated in the same way in the same situation. One might wonder whether the fact of changing the general rule with an individual legal application would prejudice the fact that each citizen, in the eyes of the state, has the right to the same application of the law. Indeed, by ratifying individual recognition of the professional associations after the period of six months, the legislator has departed from the general rule. The members of the professional association that will be recognised in the future therefore have no legal guarantee as to the delays in which their 'Royal Decree of recognition' would be confirmed by the law.

The consequence of late ratification is that the Royal Decree concerned cannot be executed and the legal effects cannot take place (such as the establishment of chambers).

One possible solution would be to publish the Royal Decree again and have it properly ratified within six months.

INTEGRATING LEGISLATION AND PRACTICE

Execution of the Colla law is also complicated by the fact that non-conventional practices have developed since 1999 and have enjoyed uninterrupted growth, which does not seem to be affected by the lack of development of the legal framework. Acupuncture is now taught in several faculties of medicine, the ULB offers a course in osteopathy, and various services are now reimbursed by the sickness funds in the context of complementary insurance. These developments should be analysed carefully before the implementation of the framework law⁸⁷. Legislation and practice are both evolving at their own pace, which complicates the legislative delay.

Neither is the execution of the law made any easier by the very different contexts of the various practices. For example, the law stipulates that half of the members of a chamber should be practitioners of the non-conventional practices concerned offered by a professional association. Where there are several professional associations, as is the case for osteopaths, the possibility of presenting a member should be offered to all the professional associations.

Key messages: the exercise of non-conventional medicine in Belgium

- **The Colla law of 29 April 1999 is a framework law that governs, through a limited number of articles, the exercise of non-conventional medicine in Belgium.**
- **The purpose of the Colla law is to set rules in order to guarantee quality care for patients. This guarantee is provided essentially by a dual registration system: registration of non-conventional practices and the individual registration of practitioners.**
- **The Colla law contains a description of a non-conventional practice and considers homeopathy, chiropractic, osteopathy and acupuncture as such.**
- **A joint committee must be constituted. This committee is called upon to play a key role in the execution of the Colla law. In particular, it is tasked with issuing an advice on the general conditions governing the exercise of all non-conventional practices and the conditions that practitioners of non-conventional practices must satisfy for individual registration.**
- **A chamber is constituted for each of the recognised non-conventional practices. These chambers issue advices during the registration of a non-conventional practice or an individual practitioner.**
- **The Colla law provides for sanctions in the case of failure to comply with certain rules.**
- **The practitioners of a registered non-conventional practice are subject to multiple obligations.**

5.1.5 The relationship between the Colla law and Royal Decree no. 78

5.1.5.1 *General*

Questions are being asked about the Colla law and its positioning in relation to Royal Decree no. 78.

A common denominator for the two texts is the similarity between the definitions of a non-conventional practice, namely 'the habitual practice of acts intended to improve and/or preserve human health, exercised according to the rules and conditions stipulated in this law' (Colla law) and 'the habitual performance by a person that does not satisfy all the conditions required by the first subparagraph of this paragraph of any act intended or presented as having the aim, with respect to humans, examining the state of health, or identifying illnesses and disorders, making a diagnosis, setting up or carrying out the treatment of a pathological, physical or mental condition, real or assumed, or vaccination', which is the definition of the (il)legal practice of medicine contained in Royal Decree no. 78. This definition is so broad that it also covers non-conventional practices⁸⁰.

In its advice concerning the bill for the proposed Colla law, the legislation section of the Council of State believed that the description of a non-conventional practice was so broad that it covered acts that, by virtue of the laws in force, must be considered as forming part of the practice of medicine so that these practices were also governed by Royal Decree no. 78. The Council of State also thought that the non-conventional character of practices is such that they are exercised in accordance with the rules and conditions stipulated in the Colla law, in such a way that the practitioner of such practices has the choice: either the acts in question are performed in accordance with the provisions of the Colla law, or in accordance with the provisions of Royal Decree no. 78. In the former case, the practitioner exercises a non-conventional practice, in the second a conventional practice. The Council of State considers that a strict distinction is therefore established between conventional practices and non-conventional practices⁸⁸ no. 1714/7.

This raises the question of whether it is possible for a person to exercise at the same time a conventional and a non-conventional practice. The Colla law does not exclude this possibility.

5.1.5.2 *In practice: the exercise of a non-conventional practice by a doctor*

According to the Colla law, any person who exercises one of the registered non-conventional practices or who performs regularly acts forming part of this practice, without being individually registered, is punishable. This raises the question of whether a doctor is required to obtain individual registration in order to be able to exercise a non-conventional practice.

According to the legislation section of the Council of State, doctors exercising a non-conventional practice have the choice, when they perform the acts in question, of complying with (1) the provisions of the Colla law or (2) the provisions of Royal Decree no. 78. In the former case they are exercising a non-conventional practice and in the latter a conventional practice⁸⁸ no. 1714/7.

A doctor can therefore exercise a registered non-conventional practice in accordance with the Colla law. In such a case, the doctor is clearly required to comply with the provisions of this law, and in particular the obligation of individual registration. If the doctor performs medical acts, he is also required to comply with the provisions of Royal Decree no. 78. This obligation is explicitly stipulated in the Colla law, which states that the provisions of Royal Decree no. 78 apply fully to the practitioners of registered non-conventional practices as mentioned in Royal Decree no. 78 in articles 2, 3, 21bis, 21quater and 22 (namely doctors, dentists, physiotherapists, nurses and paramedical personnel), provided that it concerns prerogatives granted to them by, or by virtue of, Royal Decree no. 78⁸⁰.

Incidentally, a doctor wishing to exercise a non-conventional practice can opt not to get registered. Non-conventional practices are also covered by the broad definition of medicine in Royal Decree no. 78. From a legal standpoint, this means that the respective doctor is not strictly exercising a registered non-conventional practice, because he does not comply with the requirements of the Colla law⁸⁰. In such a case doctors are nevertheless required to continue to take all normal precautions and refrain from performing medical acts for which they have insufficient knowledge⁸⁹.

Finally, doctors may also exercise a registered non-conventional practice that (hypothetically) does not involve the practice of medicine. In such a case, only the Colla law would apply and the doctor would be required to obtain individual registration. Since Royal Decree no. 78 does not apply in this scenario, the doctor would not be performing medical acts. It is probable that the King, on the basis of the Colla law and on the advice of the joint committee, would declare one or more of the provisions of Royal Decree no. 78 applicable, in particular to doctors for acts not forming part of their prerogatives in or by virtue of Royal Decree no. 78⁸⁰.

5.1.5.3 *In practice: the exercise of a non-conventional practice by a non-doctor*

Because of the broad definitions in the Colla law, certain acts classified exclusively as (conventional) medicine can now also be performed by non-doctors. Note however that this possibility is restricted to non-conventional practices, in accordance with the rules and conditions in force⁸⁹.

In principle, it was intended to remove non-conventional practices from the field of application of Royal Decree no. 78. The King would still have had the option of extending the sanctions stipulated in Royal Decree no. 78 in the case of the illegitimate exercise of a profession to the practitioners of non-conventional practices⁸⁰.

The Colla law also respects the monopoly of doctors, as seen in the obligation on non-doctors to obtain from their patients, in principle before the start of the non-conventional treatment, a recent written diagnosis concerning the symptoms, written by a doctor, on pain of being fined. Patients have the right not to consult a doctor in advance and to contact a non-doctor practitioner of a non-conventional practice directly. In this case, a written declaration by the patient must be attached to the record and the non-doctor practitioner will diagnose. In addition, practitioners of non-conventional practices are also required not to take into account the diagnosis of the doctor if they believe that this diagnosis is incorrect. They are not allowed to invoke the diagnosis of a doctor to escape their own responsibilities. Each intervening party will be deemed to be responsible for their share of the prejudice⁸⁹.

Key messages: the relationship between the Colla law and Royal Decree no. 78

- **The description of the practice of medicine in Royal Decree no. 78 is so broad that it also covers non-conventional practices.**
- **Doctors exercising a non-conventional practice have two options. They can choose to exercise a non-conventional practice, in which case they must comply with the provisions of the Colla law, or they can choose to exercise a conventional practice, in which case they must comply with the provisions of Royal Decree no. 78.**
- **In accordance with the Colla law, a practitioner of a non-conventional practice may only provide a treatment for the patient after having received a recent diagnosis concerning the complaint, drawn up in writing by a doctor (unless the patient decides not to consult a doctor in advance).**

5.1.6 The consequences of the (non-)conventional exercise of healthcare

5.1.6.1 *Performing a diagnosis*

In Belgium, only the holders of a doctor's diploma or a dentistry licence are authorised to perform a diagnosis and prescribe a treatment. They have systematic therapeutic and diagnostic freedom.⁷⁷ To make their diagnosis and choose the therapy they can therefore use the means that they deem suitable, including non-conventional practices. Practitioners that are not holders of such a diploma and perform diagnoses or choose therapies on a regular basis are then guilty of the illegal practice of medicine, which is punishable as a crime.

5.1.6.2 *The application of the law of 22 August 2002 concerning the rights of patients*

The law of 22 August 2002 concerning the rights of patients (hereafter the patients' rights act, published in the Belgian Official Journal on 26 September 2002), applies to all legal contractual and non-contractual relations under private and public law concerning healthcare dispensed to a patient by a professional practitioner.

The term 'professional practitioner' used in the patients' rights act refers to the practitioners mentioned in Royal Decree no. 78, as well as the professional practitioners of a non-conventional practice covered by the Colla law.

Although the patients' rights act clearly intends to apply to the practitioners of a non-conventional practice, this is never the case in practice. We have to wait for the entry into force of the Colla law for such practitioners to be also required to respect patients' rights under the terms of this law. In the absence of implementing orders, the main provisions of the Colla law have not yet entered into force. As soon as the key provisions of the Colla law enter effectively into force, the law of patients' rights will apply (automatically) to these professional practitioners. As a result, the practitioners of a non-conventional practice will also have to comply with the principles of the law of patients' rights, such as the right to the provision of quality services, to information on their state of health, to well-informed, free and prior consent, to refusal or retraction of such consent, to correctly updated individual records, to respect for privacy, etc.

5.1.6.3 *The application of the law concerning compensation for damages resulting from healthcare*

In its current form, the law of 31 March 2010 concerning compensation for damages resulting from healthcare (publication in the Belgian Official Journal of 2 April 2010) establishes the principle of compensation for prejudice resulting from the dispensation of healthcare and resulting from an act engaging the responsibility of a healthcare provider, or from a medical accident not engaging responsibility. In the latter case patients can obtain compensation from the medical accidents fund. The law provides for a series of exceptions, such as experiments or non-reimbursed aesthetic interventions. In some case the fund will not intervene further in the case of negligence on the part of the healthcare provider, for which the latter can be held responsible.

Under the law, the concept of 'healthcare' is understood in its broad sense. It is defined as the services dispensed by a healthcare provider in order to promote, determine, conserve, restore or improve the state of health of the patient or to provide end-of-life support. The definition of 'healthcare providers' is also very broad, including both professional practitioners and healthcare institutions. 'Professional practitioners' covers not only traditional professional practitioners (doctors, dentists, physiotherapists, pharmacists, etc.), but also the practitioners of non-conventional practices, but only as from the time the law enters into force.

5.1.6.4 Reimbursement of treatments

In Belgium, all persons are required to be insured for basic conventional healthcare. Patients that benefit from this conventional healthcare will be reimbursed (totally or partially) in principle in the form of an intervention by the compulsory health insurance. However, when a patient benefits from non-conventional healthcare, no such intervention occurs. In practice, when the non-conventional healthcare provider has an National Institute for Health and Disability Insurance (NIHDI) registration number, there may be some intervention by the compulsory healthcare insurance (for example a doctor who is also a homeopath and treats a patient can declare a consultation to the NIHDI)⁹⁰.

Patients are nevertheless at liberty to choose alternative treatments. Each individual has a free choice of therapy. However, the compulsory health insurance does not reimburse these alternative treatments. Some healthcare providers nevertheless offer reimbursement of certain alternative treatments via a complementary free insurance.

Because patients are increasingly resorting to non-conventional medicine, the sickness funds, in response to the demands of their members, are starting to reimburse (partially) certain forms of non-conventional medicine. As the sickness funds are free institutions, they can take decisions concerning complementary insurance without in principle having to request the consent of the state, apart from the sickness fund audit service. It is therefore possible for them to adapt their services to changes in the expectations of their members. In this case, such an adaptation has already taken place with the incorporation of certain non-conventional practices into general complementary insurance. The majority of the sickness funds limit such intervention to a number of non-conventional practices, with certain conditions attached to each of these practices (such as a ceiling on reimbursements)⁹⁰.

Detractors of this approach argue that by reimbursing alternative medicines the sickness funds and insurance companies are acting as trading companies, placing themselves above the law and giving a false signal to the public. Reimbursement of this type could induce patients to opt for non-regulated and non-recognised treatments, the usefulness of which is very limited and the risks far from negligible⁹¹.

The debate on the advisability of state and/or sickness fund intervention in alternative medicines was reignited in January 2004, after some thirty sceptics absorbed an overdose of homeopathy (30 ml of a dilution C30 (1 per 10⁶⁰ of snake venom, arsenic, belladonna, dog milk or extract of cockroach) in the University of Ghent. The purpose of this pretended suicide using a homeopathic product was to prove that homeopathic medicines do not contain active substances, as well as to challenge the sickness funds, which reimburse non-certified medicines on the basis of 'customer satisfaction' and not their 'proven effectiveness'.

5.1.6.5 Training

Acupuncture is now taught in certain faculties of medicine. The Brussels Free University introduced a full training course in osteopathy in 2006.

In Flanders it is possible to follow a training course in osteopathy in non-subsidised private institutes (such as the International Academy of Osteopathy (IAO) in Ghent, or the Flanders International College of Osteopathy (FICO) in Antwerp). Since the 2004-2005 academic year, the ULB has also offered training in osteopathy. This training is dispensed in the context of the *Institut des Sciences de la Motricité* (Institute of Motor Control Sciences) in the form of a complementary master's degree. This training is reserved for the holders of a diploma in motor control sciences, with a specialisation in osteopathy. It is dispensed by professors of the faculties of medicine and motor control sciences, as well as by osteopaths with a diploma (DO) for the practical exercises.

The training is subdivided into three years of baccalaureate, followed by two years of a master's, then a year of post-master's. This official university training, incidentally the first in Europe, could be offered thanks to the decree of 31 March 2004 of the French-speaking community defining higher education, favouring its integration into the European space for higher education and the refinancing of universities (Belgian Official Journal of 18 June 2004). This decree falls within the framework of the Bologna European reforms. Although it is possible to obtain a diploma in osteopathy from the ULB, nothing changes the fact that the exercise of this practice has not yet been recognised and that, in the strict sense, it could be seen as the illegal practice of medicine.

5.1.6.6 *Liability for the exercise of a non-conventional practice*

As long as the Colla law has not been executed, many questions continue to be asked concerning the resulting liability. We often wonder to what extent the practitioners of non-conventional practices have acted in the field of medical practices. This can be illustrated with examples.

On 9 June 2009, the correctional court of Bruges had to judge a physiotherapist who practiced acupuncture. The Belgian Association of Acupuncturist (referred to as the *Association professionnelle des Médecins-Acupuncteurs de Belgique* in the judgement) had lodged a civil complaint concerning the alleged illegal practice of medicine/pharmacy. In its judgement, the president referred to a decree of the Court of Cassation of 20 June 1990, in which the court considered that the practice of acupuncture qualified as performing a medical act (see below). The president also considered that acupuncture formed part of non-conventional practices of medicine and that, in accordance with the Colla law, it did not fall within the scope of Royal Decree no. 78 in that it was exercised in accordance with the rules and conditions in the Colla law. Since the law had not yet come into force, an acupuncturist was not in a position to comply with these conditions, with the result that only doctors are authorised legally to perform acts that are considered by the Colla law as acts of a non-conventional practice. The acupuncturist in question was therefore found guilty of the illegal exercise of the profession. Nevertheless, the correctional court acquitted the acupuncturist in question. The president stressed that the use of non-conventional medicines was part of social reality, as confirmed by the Colla law and the attitude taken by several sickness funds. The president also pointed out the resulting contradiction between acupuncturists who had undergone serious training and were holders of an acupuncture diploma and members of a recognised professional organisation, but illegally practised medicine, and doctors who were authorised to perform acupuncture, in application of their therapeutic freedom, but did not have the benefit of training for this purpose. This situation prompted the president to take the following attitude: an acupuncturist could choose not to treat the patient that consulted him because of his competence in the field of acupuncture; in doing so, the acupuncturist would contravene his professional responsibility, which insists that the patient should be given the required assistance, thus committing an act punishable by law for omitting to assist a person in danger (article 422bis of the penal code). The obligation to provide quality care could oblige the acupuncturist to administer acupuncture treatment, while such treatment constitutes an offence against Royal Decree no. 78, based on the current situation. The court judged that for the accused there could be a *justifying emergency situation*, following the paradoxical finding where the accused contravened Royal Decree no. 78 (because of the absence of executory decisions) in order to preserve a greater legal value, namely the dispensation of quality care to patients. Meanwhile, the public ministry has appealed against this judgement. The judgement of the court of appeal was not known at the time of completing this study.

In another case, the Antwerp court of appeal confirmed on 25 June 2010 the acquittal of a defendant, for similar acts, pronounced by the correctional court of Turnhout on 13 February 2009. In this case it was a physiotherapist who, after having followed a training course in acupuncture, began to exercise this practice. He was also summonsed for the illegal practice of medicine, namely practicing acupuncture as a non-doctor. The president of the correctional court first stated that the accused exercised a completely separate medical profession as a physiotherapist, which authorised him to perform certain acts listed by the law without becoming guilty of the illegal practice of medicine. These include certain medical acts that can only be performed in consultation with the attending physician. The president went on to state that the exercise of acupuncture did not form part of the conventional practices referred to in Royal Decree no. 78, but fell into a legal void because of the non-execution of the Colla law. The president also pointed out that the law placed no explicit prohibition on physiotherapists practising acupuncture, and that it appeared that the legislator, through the Colla law, also intended to authorise physiotherapists to exercise non-conventional practices under certain conditions. The president also referred to the Royal Decree of 10 February 2003, concerning recognition of the professional association of acupuncturists. The fact that non-doctors are members of this association prompted the president to deem that this recognition by the public authorities should be considered as recognition of the legitimacy of the practice of acupuncture by non-doctors. The president also deemed that a physiotherapist who practiced acupuncture should comply, for this practice, with the restrictions and obligations applicable to a conventional practice, precisely because of the current legal void. Considering that the defendant had undergone serious training in acupuncture and that he was a member of a recognised professional association, and also considering that he had in this case provided proof of the fact that he had always acted in consultation with an attending physician, the president judged that the defendant, in the absence of legal execution conditions, had complied with all the currently applicable legal obligations for practicing acupuncture in the context of a medical profession, and that he had respected all the conditions and restrictions imposed on physiotherapists by Royal Decree no. 78. However, the president referred to an interpretation of the Court of Appeal in Ghent in its ruling of 28 June 2000, where a physiotherapist was judged guilty of the illegal practice of medicine when, on the basis of his knowledge of Chinese medicine and acupuncture, he made his own diagnosis and dispensed treatment on this basis. In the case brought before the Ghent court of appeal, the accused was declared guilty of the illegal practice of medicine, but was given a suspended sentence because of the serious training he had followed and the dilatory attitude of the legislator. (Ghent, 28 June 2000, T. Gez. 2001-02, 195).

Recent jurisprudence therefore does not automatically consider the exercise of a non-conventional practice without being a doctor as the illegal practice of medicine. It should however be noted that the courts do not generally give an acquittal, because there is no question in these cases of the illegal practice of medicine (which it is), but rather a 'bypass', such as the long-standing existence of a legal void, or the theory of justification by a state of necessity. It concerns legal concepts under ordinary penal law, which therefore have no fundamental link with Royal Decree no. 78.

On the other hand, the oldest jurisprudence takes this view. Note in particular the sentence of 14 September 1999 of a Chinese doctor by the court of first instance of Ghent, for the illegal practice of medicine and pharmacy. This practitioner was a Chinese doctor operating in Belgium and the Netherlands, practicing mainly acupuncture, phytotherapy and the administration of herbal remedies. Although he had been trained as a doctor in China, he had not obtained recognition of his diploma in Belgium because of the duration and complexity of the procedure. For this reason he was not authorised to perform in Belgium acts classified as medicine or pharmacy. In his defence, he invoked the argument that he was not practicing medicine.

This argument was dismissed because both doctrine and jurisprudence in Belgium consider the practice of acupuncture as forming part of medicine. In accordance with a decree of the Court of Cassation of 20 June 1990, Royal Decree no. 78 must not be interpreted in a restrictive sense and it also covers alternative medicine⁹². Although the Chinese doctor invoked the Colla law on the subject of acupuncture (not yet published at the time, but already promulgated and published by the King), the court judged that he could not invoke it because he was not registered as a practitioner of acupuncture. The same applies at the present time because of the absence of executory decisions relating to the Colla law.

The courts have also ruled on the responsibility of a homeopath who carried out this practice in the Netherlands where he treated Belgians. One of them brought this Belgian homeopath before the Belgian courts. Since the homeopathic treatment had been administered in the Netherlands, the case was governed by Dutch law. On 16 February 1998, the Antwerp court of appeal recognised the specificity of a homeopath in that a patient that chooses to contact such a non-conventional practitioner does so in full awareness and cannot expect the same criteria as a traditional doctor, and that the patient to some extent accepts the risk. This is not strictly speaking an acceptance of the risk, but a simple application of the rules of responsibility, namely checking the references of a normally prudent non-conventional homeopath placed in the same context⁹³.

In the 1980s a number of osteopaths were summonsed for the illegal practice of medicine. Most of them (mainly physiotherapists) were acquitted. An osteopath was however sentenced on 15 May 1985 by the court of first instance in Namur. Since the defendant did not have a medical diploma, the court tried to determine whether or not he had performed medical acts. To do this, the president made a comparison between (certain) osteopathic treatments and medicine and concluded that the acts performed on a regular basis by the accused should be considered as medical treatments. In this case, the defendant was sentenced for the illegal practice of medicine.

5.1.6.7 *Legislation concerning medicines*

To determine whether or not a product must be considered as a medicine, we have to examine its presentation and/or properties. When a product is presented as a medicine (even if it is not) or its composition corresponds to that of a medicine (in terms of function, content or properties), it is considered as a medicine. As a result, homeopathic medicines are also considered as medicines⁹⁴. Because of this qualification as medicines, they have to comply with multiple laws and implementing orders.

This means that a medicine can only be marketed after obtaining a marketing authorisation. This type of authorisation is delivered at national level (in Belgium by the competent minister at the end of a national procedure) or at European level (by the European Medicines Agency, at the end of a centralised or decentralised procedure, still referred to as mutual recognition). Special or simplified registration procedures have been set up for certain groups of medicines⁹⁵. These include homeopathic medicines for oral or external use, where no specific therapeutic indication is mentioned on the label or in the information concerning the medicine in question, and where its dilution level is such that the safety of the medicine is guaranteed⁹⁵. Homeopathic medicines that do not satisfy these conditions are subject to another procedure, through which the minister defines the special provisions relating to clinical and preclinical tests and assessments, in accordance with the principles and specificities of homeopathic medicine.

Key messages: The consequences of the (non-)conventional exercise of healthcare

- **Only the holders of a medical diploma or a dentistry licence are authorised to perform a diagnosis and prescribe a treatment.**
- **The law of 22 August 2002 concerning patients' rights will only apply to the exercise of non-conventional practices when the Colla law has been executed.**
- **The same applies to the application of the law of 31 March 2010 concerning compensation for damages resulting from healthcare.**
- **Certain sickness funds reimburse certain forms of alternative treatments.**
- **Although it is often a question of organised training, no non-conventional practice has been recognised to date, so the exercise of these practices can be considered as the illegal practice of medicine.**
- **Although many practitioners of a non-conventional practice have already been sentenced for the illegal practice of medicine, the courts seem increasingly disinclined to hand down sentences.**

5.1.7 The exercise of non-conventional medicine in the European context

5.1.7.1 Two concepts

Two concepts of healthcare coexist within the European Union⁹⁶.

According to the *first concept*, only doctors are authorised to practice medicine, with a few exceptions (this concept applies to Belgium). In the countries that have adopted this approach, the demand for non-conventional medicines is so high that some tolerance is shown.

The *second concept* is based on the reverse principle and considers that any person who so desires can practice medicine, with the exception of certain acts that can only be performed by doctors.

Because of the coexistence of these two conflicting concepts, the European parliament is often confronted with the case of healthcare practitioners that are officially recognised in their own country, but condemned in another country for the illegal practice of medicine. The divergences in status and recognition procedures for non-conventional medicines within the European Union contravene the principles of the free circulation of persons and freedom of establishment (as guaranteed by the treaty governing the functioning of the European Union). A resolution was finally adopted in 1997 concerning the status of non-conventional medicine (OJ no. C-182, 16 June 1997, 0067), in which the European parliament asks the Commission to pursue the recognition of non-conventional medicines. This resolution comes out in favour of the recognition of non-conventional medicine, provided that the results of the study permit. On 11 June 1999, the Council of Europe also published a resolution on this subject (not binding on Member States) in which it calls for Member States to harmonise their regulations⁹⁷.

'COST B4' was set up ("European Cooperation in the field of Science and Technology") to better consolidate the results of scientific studies of non-conventional medicines. This group has come to the conclusion that the key criterion for the choice of a therapy should be its effectiveness, attested preferably by double-blind randomised testing, while recommending also taking into account the satisfaction and welfare of the patient, for both conventional and non-conventional treatments. According to this group, the states should encourage studies of non-conventional treatments, while ensuring that such studies use rigorous methodologies⁹¹.

5.1.7.2 *Proof of clinical effectiveness*

In its report of 6 March 1997 on the status of non-conventional medicine, the European parliament deemed that it would be advisable to distinguish between the different non-conventional medicines. Clinical studies, an assessment of the results of treatments and other scientific or academic studies are required to analyse the facts and how they interrelate. According to the European parliament, this assessment should use methodologies suitable for the different medicines. However this approach tends to fall apart when their therapeutic effect cannot be certified by commonly accepted scientific methods. This is a somewhat controversial issue. It is therefore important to choose recognised methodologies and to define suitable validity criteria. Moreover, the European parliament is aware that it would be advisable to use a 'fluctuating range' of proofs and acceptability rather than a strict divide between scientific and non-scientific proof. Another element that needs to be considered is the fact that several non-conventional medicines already benefit from some form of official recognition in certain Member States and sometimes have a representative professional organisation at European level. Their effectiveness has been certified by various studies (limited scope), the results of which are generally convincing (for example chiropractic and homeopathy).

Key messages: the exercise of non-conventional medicine in the European context

- **Two concepts of healthcare coexist within the European Union.**
- **According to the first principle, only doctors are authorised to practice medicine.**
- **According to the second principle, any person who so desires can practice medicine, with the exception of certain acts, which are reserved for doctors.**
- **Proof of clinical effectiveness is important in order to distinguish between non-conventional practices.**

5.1.8 Conclusion concerning the Belgian and European legal framework

5.1.8.1 *The practice of conventional medicine in Belgium*

The practice of conventional medicine in Belgium is governed by Royal Decree no. 78. By the 'practice of medicine' the law means the medical art, medicine, physiotherapy, nursing, the paramedical professions and midwifery. Each of these professions is governed by specific criteria.

5.1.8.2 *The practice of non-conventional medicine in Belgium*

The law of 29 April 1999 concerning non-conventional practices in the field of medicine, pharmaceuticals, physiotherapy, nursing and the paramedical professions defines a framework for recognition of the practice of (certain forms) of non-conventional medicine. The Colla law considers the practice of homeopathy, chiropractic, osteopathy and acupuncture to be non-conventional practices. This list is not restrictive and other non-conventional practices could be added.

The purpose of the Colla law is to guarantee quality care for patients. This guarantee is provided by a dual registration system. Firstly, each of the non-conventional practices must be registered (which is only possible if certain criteria are satisfied) and secondly, each practitioner of these disciplines must also be registered (satisfying various conditions).

The joint committee instigated by the Colla law is called on to play a key role in this field, notably by giving an advice concerning the general conditions applicable to the exercise of non-conventional practices.

Since this joint committee has not yet been formed, it is not in a position to play this key role, so the law cannot be executed and is therefore not yet in force.

5.1.8.3 *The relationship between the Colla law and Royal Decree no. 78*

Royal Decree no. 78 provides such a broad description of the practice of medicine that it covers the exercise of non-conventional practices.

Practitioners of non-conventional practices who are also doctors have the choice of exercising a non-conventional practice or a conventional practice. In the former case, they must comply with the Colla law, and in the latter with the provisions of Royal Decree no. 78. However, practitioners of non-conventional practices who are not doctors can only perform these practices after having received a recent written diagnosis from a doctor concerning the complaint.

5.1.8.4 *The consequences of the (non-)conventional exercise of healthcare*

Only the holders of a medical diploma or a dentistry licence are authorised to perform a diagnosis and prescribe a treatment.

The provisions of the law of patients' rights of 22 August 2002 and the law on healthcare compensation of 31 March 2010 can only be applied to practitioners of non-conventional practices when the Colla law has come fully into force.

As long as the Colla law is not fully applied, the practice of non-conventional medicine, by a non-doctor therapist is qualified as the illegal practice of medicine. Several practitioners of non-conventional practices who are not doctors have already been sentenced for this reason. It should however be noted that jurisprudence is tending increasingly towards acquittal, provided that certain conditions are satisfied (such as adequate training) and in the light of the failure to execute the Colla law. In addition, certain medical treatments that can also be practiced as alternative therapies can also be practiced legally by certain professionals such as physiotherapists.

5.1.8.5 *The exercise of non-conventional medicine in the European context*

Two concepts of healthcare coexist within the European Union. According to the first principle, only doctors are authorised to practice medicine. According to the second principle, any person who so desires can practice medicine, with the exception of certain acts which are reserved for doctors.

5.2 THE SITUATION IN THE NETHERLANDS, FRANCE AND THE UNITED KINGDOM

This chapter is common to the three reports on alternative medicines, as most of the issues are common to all non-conventional practices.

5.2.1 Structure of the chapter

This chapter contains a brief presentation of the legal situation in the Netherlands, France and the United Kingdom.

5.2.2 Netherlands

5.2.2.1 *The legal situation*

In 1865 the Netherlands promulgated the *Wet op de Uitoefening der Geneeskunst* (law on the practice of medicine, hereafter referred to as 'WUG'), which introduced an examination prior to becoming a doctor. This law makes a distinction between conventional medicine and non-conventional medicine, making the practice of conventional medicine by unauthorised persons punishable. The Dutch legislation tolerates alternative therapists. In the Netherlands, 'alternative' medicine is the opposite of 'conventional' medicine.

This monopoly of doctors was amended in November 1993 by the *Wet Beroepen in de Individuele Gezondheidszorg* (law concerning the individual healthcare professions, hereafter referred to as 'BIG'). In principle this law authorises anyone to provide medical care, with the exception of certain acts that can only be performed by practitioners specially authorised for this purpose by the BIG law.

These are acts that entail a substantial risk for the health of the patient if they are not carried out by a competent therapist (particularly surgery, obstetrics and anaesthesia). However a diagnosis can be performed by anyone. The freedom to practice medicine is offset by a penal counterweight: any person that harm's the health of another is punishable under the BIG law.

5.2.2.2 *The BIG law*

The BIG law is partially a framework law. The main points governed by this law are registration of constitution and protection of certificates, the reserved acts (including the associated mission), disciplinary law and criminal law, specialities and the accreditation of foreign diplomas. Many of the modalities have to be finalised by 'general administration measures' (executory decisions), such as the training requirements, the fields of specialisation and the periodic registration system, as well as quality criteria. The legislation also entrusts a large number of issues to self-regulation by professional associations, within the framework defined by the law, such as the introduction of specialities⁹⁸. Because Dutch law has also opted (partially) for a framework law, its implementation is subject to executory decisions. In the Netherlands this approach has also been onerous and has also been staggered over several years.

The principle of the BIG law is based on the registration of professional certificates and training certificates, with a fundamental distinction between two categories. The first category is that of 'heavy regulation' (literal translation) and covers doctors, dentists, psychologists, psychotherapists, physiotherapists, obstetricians and nurses (article 3). For each of these professions, the BIG law governs the level of competence and the requirements in terms of training. The BIG law also contains provisions governing the introduction of specialities, in close consultation with the representative professional organisations. The second category is that of 'light regulation', which applies to the paramedical professions, based on the principle that training must satisfy quality criteria (article 34). Only people that have followed successfully the training imposed or recommended by the minister can use the certificate issued after such training⁹⁹.

The legal authorisation to hold a certificate protected by the law is granted via a substantive registration, which also acts as protection of the certificate under the 'heavy regulation' of the professions mentioned in article 3, and via protection of the training certificate under the 'light regulation' mentioned in article 34. The fact of having successfully completed the required training gives the right to inscription in the BIG register (comparable to the INAMI in Belgium) under the terms of article 3 or, for the protection of the training certificate, under article 34. Inscription in the article 3 register authorises the person that followed the training to hold the related certificate. The training certificate for the professions in article 34 is protected and can be used without prior registration. Non-registered persons are not authorised to hold the certificate. The illegitimate use of a protected certificate or a similar title is punishable by law⁹⁸.

A corollary of inscription in the BIG register is the authorisation to evolve independently in the field of reserved acts, provided that such acts are considered by the law to form part of the profession in question. Inscription is also equivalent to formal recognition of the competence of the person in the domain specific to the profession (or specialisation). The fields of competence are described for each group of professions, which gives particular importance to the issue of public information. The field of competence also intervenes in disciplinary law (which only applies to therapists registered in the context of article which does not allow the practitioners of an 'article 34' profession to evade the legal obligation to provide suitable care) and the penal provisions. The respective fields of competence of doctors, dentists, pharmacists and nurses are described briefly in the BIG law. For the other 'article 3' professions and for the 'article 34' professions, the field of competence is governed by the executory decisions, taking into account the fact that these fields are less fixed and more likely to evolve. The authorisation to perform reserved acts is the legal restriction in relation to the professional practice of competent persons. The competence to perform reserved acts can be used independently in practice, provided that the competence was acquired by experience. If a person is authorised, but not competent, to perform reserved acts, that person can give a prescription for the treatment.

Assessment of competence is entrusted to the practitioner of the profession in question, or to the professional association⁹⁸.

5.2.2.3 *Evaluation of the BIG law*

As for alternative medicine, Dutch legislation has adopted the principle of self-regulation for improving healthcare quality and public information by alternative practitioners. The practitioners of alternative medicine are not covered by the BIG law and have no official recognition. There is no registration mechanism for alternative medicines⁹³.

Because of the BIG law, the position in society of the associations representing alternative medicines has considerably changed in several ways, especially with the disappearance of the concept of the *unauthorised practice of medicine*. Moreover, the BIG law governs exclusively what the law terms 'qualified persons', tipping the scale too far in the direction of freedom of choice for citizens, to the detriment of safety. In addition, control by public bodies of non-conventional (alternative) practitioners is considered inadequate and the public ministry would not sufficiently pursue litigation. Other criticisms: the penal sanctions are considered to be too heavy, the plaintiff is not sufficiently protected and the quality of care is too dependent on the approach chosen by the professional association⁹⁸.

Many criticisms have also been levelled against the attitude of the public authorities, which are more or less neutral concerning alternative medicine. Some believe that the public authorities should draw up without delay a specific policy concerning the alternative professions mentioned in article 34. This would provide sufficient clarity in the meantime concerning the criteria to be used⁹⁸.

Key points: the situation in the Netherlands

- **In principle the BIG allows anyone to provide medical care, with the exception of certain 'reserved' acts that can only be performed by the professional practitioners authorised by the BIG law.**
- **The BIG law is partially a framework law which governs various important matters. Many other modalities are nevertheless left to self-regulation by the professional organisations.**
- **The BIG law is based on the principle of registration of professional certificates and training certificates, and makes a distinction between two categories, each subject to specific rules.**

5.2.3 France

5.2.3.1 *General*

As in Belgium, French law considers only qualified doctors that can practice medicine. As a result, the exercise of alternative treatments is reserved for doctors, which has led to a paradox in France, where certain doctors that only have a fragmentary knowledge of alternative treatments are authorised to use them, while these practices are prohibited for non-doctors that have followed proper training in alternative therapies. If this prohibition is flouted, non-doctors are open to litigation.⁹⁸

Notwithstanding these principles, France shows a degree of tolerance, as we shall see below.

5.2.3.2 *Homeopathy*

In France, homeopathic medicines obtained by medical prescription are reimbursed by the sickness fund, and have been since 1948. This is a peculiar situation in that homeopathy is not recognised by French law because it is not backed by any diploma¹⁰⁰ and the acts performed by homeopaths are not eligible for differentiated reimbursement⁹⁶.

5.2.3.3 *Osteopathy and chiropractic*

In March 2000, the minister Kouchner set up a commission tasked with drafting criteria for the official recognition of osteopathy and chiropractic. These criteria are found in article 75 of the law of 4 March 2002 concerning the rights of the sick and the quality of the health system. According to article 75 of this law, the use of an osteopath or a chiropractor is reserved for the holders of a diploma issued by establishments and institutes approved by the Ministry of Health, and according to the modalities fixed by decree. The programme and duration of such training (at least 3 520 hours), and the examinations that sanction them, are also fixed by a regulation.

An equivalent official qualification must be given to foreign diplomas, according to the modalities fixed by decree. Article 75 also stipulates that the practitioners of these disciplines are subject to an obligation of ongoing training, the modalities of which must also be defined by decree. The High Authority for Health (*Haute Autorité de Santé*) was given the task of drafting and validating the recommendations for good practices, as well as drawing up a list of good practices that should be taught by the training establishments and institutes. Article 75 also stipulates publication by decree of a list of acts that can be performed by osteopaths and chiropractors, as well as the conditions governing these practices. These practitioners can only perform therapeutic acts after inscription in the list.

Meanwhile, several executory decisions concerning osteopathy have been taken. These include decree 2007-435 of 25 March 2007 concerning the acts and conditions of exercise of osteopathy and various orders of 25 March 2007 concerning the practice of osteopathy in France. These provisions define the objectives of osteopathy, the manner of achieving these objectives and acts that are authorised or not. Only (1) doctors, midwives, masseur-physiotherapists and nurses with a university diploma (D.U.) or an interuniversity diploma (D.I.U.), (2) the holders of a diploma in osteopathy issued by a recognised establishment and (3) holders of an authorisation to practice osteopathy or use the title of osteopath issued by an authorised body, can use the title of practitioner of osteopathy. Osteopaths must also register their certificate. The training modalities and the approval of osteopathy institutes are governed by the orders of 25 March 2007.

The French universities offer two types of diploma: national diplomas that are subject to authorisation by the ministry, and diplomas delivered under the sole responsibility of the university independently and following approval by the board of directors. A university diploma (D.U.) where the university teaches the subject in question and the interuniversity diploma (D.I.U.) where several universities teach the same subject¹⁰⁰.

5.2.3.4 *Acupuncture*

Acupuncture has been recognised since 1950 by the *Académie de Médecine française*. It can be practiced legally, but only by doctors¹⁰⁰. When the intervention is on a medical prescription, it is even partially reimbursed by the social security. In France, acupuncturists are non-doctors and are not recognised. If they practice acupuncture, they may be found guilty of the illegal practice of medicine.

For several years there has been a D.I.U. in acupuncture for doctors. The teaching and good practices of acupuncture are regulated in this way. According to the *Ordre français des Médecins*, only doctors with a diploma in acupuncture can make use of this skill. Since November 2009, the faculty of medicine at Paris Sud XI has offered a D.U. in 'Oriental medical acupuncture'. This training is open to doctors, veterinarians and midwives.

5.2.3.5 *Reimbursement*

In France also, various sickness funds reimburse non-conventional practices. These reimbursements are often limited to a given number of sessions. In some cases reimbursement is offered as part of complementary insurance. Recognition of the diploma by the sickness fund is often one of the reimbursement conditions¹⁰⁰.

Key points: the situation in France

- **Only qualified doctors can practice medicine. The use of alternative therapies is restricted to doctors.**
- **Although homeopathy is not recognised by the law, homeopathic medicines are reimbursed by the sickness funds under certain conditions.**
- **France has already taken various initiatives for the recognition of osteopathy and chiropractic.**
- **In France, acupuncture is recognised by the Académie de Médecine and can be practiced legally by doctors.**

5.2.4 United Kingdom

5.2.4.1 *Common law versus self-regulation*

In British law, non-conventional medicines are referred to as complementary and alternative medicines (CAM).

In the United Kingdom, under Common Law (case law), any non-doctor can offer an alternative therapy, provided that he or she does not claim to be a doctor, does not practice a protected discipline (dentist, midwife or veterinarian for example) and does not prescribe medicines available exclusively by medical prescription¹⁰¹. These therapists cannot claim to be capable of curing certain diseases (such as cancer, tuberculosis or epilepsy) or advertise their services¹⁰². Nevertheless, they can treat these diseases.

Because the United Kingdom does not prohibit the practice of alternative medicines, there are only a few stipulations and obligations, so practitioners can make a personal choice and follow their own programme¹⁰¹.

Despite this context specific to the United Kingdom, there have been calls for regulation. The Health Act of 1999 stipulates that CAM practitioners could be regulated without having to undergo the long procedure of a parliamentary law, as was the case for osteopathy and chiropractic (see below). The majority of CAM practitioners nevertheless prefer self-regulation (freely consented) to legislation. This has also been widely opposed because of the great liberty offered by Common Law¹⁰².

In 2000, the House of Lords published a report on CAMs. In this report, CAMs are subdivided into three main groups, the first of which is professionally organised alternative practices. Acupuncture, chiropractic, osteopathy and homeopathy form part of this group¹⁰¹. The report also makes recommendations concerning training, research and development, the dissemination of information, etc.¹⁰².

5.2.4.2 *Osteopathy and chiropractic*

Despite Common Law in the United Kingdom, osteopathy and chiropractic have taken a different route. These two disciplines have undergone the lengthy journey towards self-regulation, after which they will benefit from a special legal status under new legislation.

Osteopathy was given legal status under the Osteopaths Act 1993. This act governs the practice of osteopathy in terms of the registration of accredited osteopaths, osteopathic training and the conditions governing the profession. The regulatory body set up under the law is the General Osteopathic Council.

Any person wishing to practice osteopathy in the United Kingdom must be registered by this body after following an approved training course.

Chiropractic is governed by the Chiropractors Act 1994. This law regulates chiropractic in terms of the registration of recognised chiropractors, chiropractic training and the conditions governing the profession. The regulatory body set up under the law is the General Osteopathic Council. Any person wishing to practice chiropractic in the United Kingdom must be registered by this body after following a recognised training course.

5.2.4.3 Homeopathy

Homeopathy was recognised in 1950 by the Faculty of Homeopathy Act. This 'Faculty' trains doctors, veterinarians, dentists and midwives in homeopathy and is officially recognised by the state as a homeopathy training institute¹⁰³.

No special registration applies to other homeopaths, i.e. practitioners who are not doctors, veterinarians, dentists or midwives. There are professional organisations of homeopaths, which require their members to be properly insured and to comply with the Code of Professional Ethics¹⁰⁴.

5.2.4.4 Acupuncture

The report published by the House of Lords in 2000 recommended that practitioners of phytotherapy and acupuncture should opt for statutory regulation in the same way as osteopathy and chiropractic¹⁰². Subsequently proposals along the lines of such regulation have been drawn up by the Department of Health. The main purpose of this regulation is to protect patients by setting criteria for training and competence. To date, these proposals have not been transposed into legislation.

5.2.4.5 Other CAM practices

As for other CAM practices, the British public authorities encourage practitioners to self-regulate and have no intention of intervening through legislation. The public authorities apply the principle that unregulated CAM practitioners must set the criteria and modalities for their practices. Nevertheless, there is a Complementary and Natural Healthcare Council, within which a register has been opened for the registration of practitioners that comply with certain standards, have followed some training and are adequately insured¹⁰⁵.

5.2.4.6 Reimbursement

As a general rule, the costs of non-conventional medicines are not reimbursed by the National Health Service¹⁰⁶. The United Kingdom is however the only country in Europe to have several public hospitals that offer (exclusively) alternative medicine services (Glasgow, London, Liverpool, Bristol and Tunbridge Wells)¹⁰⁴. These services are reimbursed by the National Health Service. Moreover, various individual insurance policies help to pay the cost of an alternative therapy, often on condition that the acts in question are performed by an accredited practitioner¹⁰⁶.

Key points: the situation in the United Kingdom

- **Under common law, any non-doctor can offer alternative therapies, provided that they do not claim to be a doctor and do not practice a protected discipline. Such persons are not allowed to claim that they can cure diseases. However, they can treat diseases.**
- **Osteopathy and chiropractic have been given legal status in law.**
- **Homeopathy has been recognised by the Faculty of Homeopathy Act. This faculty trains doctors, veterinarians, dentists and midwives in homeopathy.**
- **Acupuncture should also benefit from a legal status under the law, but this process has not yet been finalised.**
- **As for other alternative therapies, the public authorities recommend that practitioners should self-regulate their profession.**

5.2.5 Conclusion on the situation in the Netherlands, France and the United Kingdom

5.2.5.1 *The situation in the Netherlands*

In principle the BIG allows anyone to provide medical care, with the exception of certain 'reserved' acts that can only be performed by the professional practitioners authorised by the BIG law.

The BIG law is partially a framework law which governs various important points. Many other modalities are nevertheless left to self-regulation by the professional organisations. The BIG law is based on the principle of registration of professional certificates and training certificates, and makes a distinction between two categories, each subject to specific rules.

5.2.5.2 *The situation in France*

Only qualified doctors can practice medicine. The use of alternative therapies is restricted to doctors. France has already taken various initiatives for the recognition of osteopathy and chiropractic. In France, acupuncture is recognised by the *Académie de Médecine* and can be practiced legally by doctors.

5.2.5.3 *The situation in the United Kingdom*

Under common law, any non-doctor can offer alternative therapies, provided that they do not claim to be a doctor and do not practice a protected discipline. Such persons are not allowed to claim that they can cure diseases. However, they can treat diseases.

Osteopathy and chiropractic have been given legal status in law. Homeopathy has been recognised by the Faculty of Homeopathy Act. This faculty trains doctors, veterinarians, dentists and midwives in homeopathy. Acupuncture should also benefit from a legal status under the law, but this process has not yet been finalised. As for other alternative therapies, the public authorities recommend that practitioners should self-regulate their profession.

5.2.5.4 *Final observations*

The brief description of the approaches to the practice of non-conventional medicine in the Netherlands, France and the United Kingdom clearly illustrates the disparities in this field in Europe. Each Member State of the European Union has set up its own system, so the practice of non-conventional medicine is a long way from being governed by uniform regulations. This lack of harmony and uniformity, as well as the atypical situation in Belgium, makes it difficult for the Belgian legal framework to draw inspiration from the prevailing situation in the Netherlands, France and the United Kingdom.

5.3 ACUPUNCTURE TRAINING

5.3.1 Objectives

Acupuncture trainings play an important role in the actual practice of the non-conventional medicine in Belgium.

The different schools train the acupuncturist-to-be to a certificated therapist and their students spread their specific vision on acupuncture over Belgium. Besides the schools' impact on the student's vision, they play an indirect role in their close relationship to the professional unions.

In this chapter, the several schools in acupuncture will be described and their role in Belgian non-conventional medicine will be discussed. The three research questions of this section are:

- How is the training organised?
- Is there a quality control on the training?
- Is the acupuncturist able to diagnose and distinguish pathologies?

5.3.2 Methods

Information on the training was gathered during meetings at the KCE and by phone.

5.3.3 Results

5.3.3.1 *Brief presentation of the schools*

Europe Shanghai College was created in 1988. The training in acupuncture is organised in the sport centre of the University of Brussels (ULB) and is spread over 7 weekends per year. The basic education lasts for 3 years and is open for persons with a medical or paramedical training. This basic education is a prerequisite to the membership in professional union ABADIC. An optional fourth year as an advanced course aims at an equivalent title of a doctor of acupuncture. To achieve this title, the student has to pass an exam, organised by the Europe Shanghai College and under the supervision of the Chinese International Examination Centre for Acupuncture and Moxibustion. This Chinese centre is a recognised centre of the Chinese government and aims spreading a uniform (and Chinese) vision on acupuncture. Annually, a 2-weeks internship in several university hospitals of Shanghai is organised for the students. More information about the school can be found on its website: <http://www.escoftcm.com/>

Jing Ming was founded in 1979 and organises a 3 years-education in acupuncture. The training is organised in the infrastructure of the Katholieke Hogeschool Roeselare (KATHO). The courses are open for persons with a bachelor in paramedics or every other bachelor. The non-paramedical bachelors are allowed to follow the courses, but will not receive the certificate of an acupuncturist and will not be recognised by the professional unions. The first year consists of an introduction in the traditional Chinese medicine; the second and third year focus on acupuncture. Recently, the organisation (in 2010) changed its structure and its name as **Yin Tang**. The needed competences of the acupuncturist are described in a competence profile. The main competencies according to this profile are: knowledge about acupuncture, communication with patients and other health care providers, critical appraisal of the scientific literature and the competencies to handle with scientific methods. These competences fit within the main goals of the training in acupuncture, namely a critical scientific attitude, to handle with scientific methods, the integration of new knowledge, practical skills and the responsibility in the framework of a future position in the health system. These competencies are applied in the eight main courses of the training at the Yin Tang: the history of acupuncture and the traditional Chinese medicine, topography of the meridians and the acupuncture points, the basic concepts and regulation systems in the traditional Chinese medicine, the patterns of integration disturbances in the traditional Chinese Medicine, diagnostics (restricted to the traditional Chinese medicine), methods of treatment, planning of treatment, and skills of treatment. The competence profile is attached in appendix. More information about the school can be found on its website: <http://www.yingtang.org>

OTCG (Opleidingsinstituut voor Traditionele Chinese geneeswijzen) was founded in 1990 and is open for persons with a medical or paramedical training. The structure of the education in acupuncture is similar to the structure of the Jing Ming: a first year with the basics of traditional Chinese medicine and the second and the third year focused more closely on acupuncture. OTCG has build op a collaboration with the Karel de Grote Hogeschool: the lessons are organised in the infrastructure of this college and the college recognises the certificate. Like Yin Tang, OTCG developed also a competence profile. Acupuncture is defined as a preventive, curative and palliative therapy and the acupuncturist is a trained therapist in 11 domains of care, i.e. treatment, prevention, examination, training, inter (and multi)disciplinary collaboration, management, postgraduate training, information and advice, the development of the profession of the acupuncturist, the evaluation of practice and the provision of services. Next to these skills, also the attitudes are described, which are very similar to the attitudes of every health care provider. More information about the school can be found on its website: <http://www.otcg.be/>

ETTC (Enseignement des Thérapies Traditionnelles Chinoises) is the most recent training (2005) and can be seen as the French equivalent of the OTCG. The school is located in the infrastructure of the HENAM (Namur). The voluntary internship in China is organised in collaboration with the OTCG. More information about the school can be found on its website: <http://www.ettc-acu.be/>

ABMA–BVGA (Association Belge des Médecins Acupuncteurs –Belgische Vereniging van Geneesheren-Acupuncturisten) is founded in 1973 and is only open for persons with a medical training. More information about the school can be found on its website: <http://www.acupunctuur.be/>

The school of **Dr. Beyens** is a secession of the education at the ABMA. It is a private education and is concentrated in 12 weekends during 15 months. Dr. Beyens is a proponent of modern medical acupuncture, based on evidence-based medicine. More information about the school can be found on its website: <http://www.acupuncture-plus.eu/>

A third group of trainings are the schools which offer a broad scale of workshops and seminars for certificated acupuncturists. An example of this kind of training are the workshops and seminars organised by ICZO (Instituut voor Complementaire Zorg Opleidingen/Institute for Complementary Health Care Training). The school offers only trainings at certificated acupuncturists. Examples of a seminar is the internship at Malta for acupuncturists or the seminars about chronic fatigue syndrome. This school achieved the Q For label, representative for an evaluation of the quality of teachings and consultation organisations. More information about the school can be found on its website: <http://www.iczo.be>

5.3.3.2 *Organisation of the trainings*

The different schools are summarized in a descriptive table (see appendix), which allows to compare the different trainings and to distinguish the main differences between these trainings.

The **first concordance** between the different schools is the similar organisation of the courses. The courses are given during weekends (Friday to Saturday) (average of 7 weekends per year) during three academic years. The study load can vary from 60 to 72 study points. Only persons with a medical or paramedical training can enrol with the exception of the so-called free students, who can follow the courses but cannot achieve the certificate of acupuncturist. Some schools make the difference between persons with a paramedical or a medical training, but this difference is further described below.

The **second concordance** is the similarity in training cost. The lowest cost per year is offered at the Jing Ming (cost price for Yin Tang not yet known) (1390euro/year), the highest for the course of Dr. Beyens (2640euro/year) with an average of 1806 euro/year for all schools.

The **first main difference** in the structural organisation of the trainings is the (non)-accessibility of paramedics to all of the schools. The training at the ABMA and the school of Dr. Beyens is only reserved for physicians. At the other schools (OTCG, ETTC, Yin Tang, Europe Shanghai College) both physicians and paramedics, as defined in the Royal Decree 78, can enrol. Even the people with a non-medical preliminary training can follow the first year or even the whole course under the status of a free student with the big restriction of not achieving the degree of acupuncturist and never being allowed as a full member of a professional union. The difference in criteria to enrol reflects different views of the professional unions on the practice of acupuncture. More detailed information about the position of the professional unions can be found in the chapter on the professional unions of acupuncturists.

The **second main difference** is the (non) importance of an internship in hospitals in China. All the trainings organise compulsory practice lessons for their students, but not all of them organise also an internship. The medical schools (schools with access only for physicians) do not have any collaboration with a university (and his hospitals) in China. The other four schools (Europe Shanghai college, OTCG, ETTC and Yin tang) organise every year a two to three weeks internship in university hospitals in Shanghai

(Europe Shanghai College), in Nanjing (Yin Tang), in Beijing (OTCG) and in Shandong (ETTC). These internships are not mandatory for the students.

The main reason the schools organise these internships is to give the opportunity to the students to treat a high number of patients in a short period of time. Only the Europe Shanghai College emphasises the importance of the Chinese vision (Shanghai University) on the practice of acupuncture.

5.3.3.3 *Quality control*

Acupuncture is still a non-conventional medicine in Belgium, neither the profession nor the training are acknowledged. In order to increase the quality of their training, some schools collaborate with acknowledged colleges. Notwithstanding the involvement of these colleges, the collaboration is restricted to the use of the infrastructure and the recognition of the certificates by the colleges. It is a first step in the integration of the education of acupuncture in the acknowledged post graduate trainings. The OTCG has attained the quality label of ISO-norm 9001-2008. This label guarantees that the school has followed the imposed international standards for quality management and has become a certificate after an external audit. Still, this label is not a guarantee for the quality of the product (in this case the training in acupuncture) (source Wikipedia). The Europe Shanghai College improves the quality of the examination by following the standards of examination (the International Acupuncture Qualification Examination) set up by the Chinese International Examination Center for Acupuncture and Moxibustion. The centre aims setting up an international exam leading to a uniform vision on the practice of acupuncture. This vision is mainly influenced by the 5 biggest universities of China (of which the university of Shanghai, which collaborates also for its courses with the Europe Shanghai College). This centre is also acknowledged by the WFAS (World Federation of Acupuncture-Moxibustion Societies).

5.3.3.4 *Exclusion diagnosis*

The training in acupuncture is a postgraduate training, building further on the knowledge of the students on basic medical sciences, such as anatomy, physiology, physiopathology etc. In contrast to other (para)medical postgraduate trainings, the point of view of the conventional medicine is moved to the background and is replaced by the oriental point of view with their specific vocabulary. This shift could contain a potential danger for the paramedical trained acupuncturist in not timely recognizing the symptomatology of certain high-risk diseases, such as cardiovascular diseases and cancers. This different interpretation of symptoms can also discourage the communication between different (conventional and non-conventional) health care providers.

In order to found this hypothesis, we tried to compare the content of the trainings for the paramedical students on courses of physiopathology and symptomatology. The comparison was hindered by the different designation of the courses, the lack of information about the content of the courses and the lack of competencies in the research team to well understand the subtle differences between the courses.

5.3.4 Discussion

The aim of this chapter is to describe the different trainings in acupuncture in Belgium. Besides the more informative description of the schools, we compared and deduced the main concordances and differences between the schools. In this part we will try to explain our findings and explain them in comparison with other countries (where possible).

5.3.4.1 *Organisation of the trainings*

The differences in organisation of the trainings mainly reflect the different points of view on the practice of acupuncture: the physicians adhere to the inclusion of acupuncture in the medical practice in contrast to the paramedics who emphasise the complementary aspect of acupuncture in the entirety of the treatment of a patient without the need of a diagnosis by a conventional physician.

Other reasons for the nonaccessibility for paramedics is given by the representatives of the school and professional union: the danger of misdiagnosing symptoms and the danger linked to the use of needles (risk of pneumothorax for example).

Acupuncture is a treatment, inspired by the oriental interpretation of the functioning of the body. Nevertheless the pretraining in the conventional medicine, the student acupuncturists are encouraged to renunciate this basic knowledge and to turn over to the traditional Chinese medicine. The schism between the modern and traditional interpretation of acupuncture is mainly due to different visions on the role of acupuncture. The modern vision defends the incorporation of acupuncture as one of the therapy modalities in the conventional treatment of the complaint. This way, the diagnosis is set up with the principles of the conventional medicine. This is in contrast to the traditional vision, where the traditional Chinese diagnosis (such as palpation of the tongue and pulse) plays an important role.

We assume that the physician-acupuncturist seems to have a more modern approach due to their scientific education in the conventional medicine, which is based on the principles of evidence-based medicine. However, a more traditional approach is stated in the training of the physician-acupuncturists. This can be explained by the influence of the French School of acupuncture, which adhere to the traditional approach. This traditional approach is characterised by the emphasis on traditional semiology and oriental traditional nosology.

This French and Belgian approach is in contrast with the point of view of the British Medical Acupuncture Society¹⁰⁷. This society adhere the Western medical acupuncture, i.e. the use of acupuncture as a therapy in the treatment of specific clinical conditions following orthodox medical diagnosis by suitable trained practitioners (ref website). This therapy is applied using modern scientific principles rather than traditional theory. The society also mentions that the role of the traditional diagnosis is rather adjunct than an alternative for the orthodox medical diagnosis.

A possible point for confusion is the title of “doctor in acupuncture”. This kind of doctor does not correspond with the title of the conventional title of the physician, which could be confusing for the patient. He could consider the doctor in acupuncture on the same level of competencies as the conventional physician with a medical degree. Another name for the title, such as bachelor or master, could avoid this confusion and could facilitate the comparison with other (postgraduate) trainings.

5.3.4.2 *Quality Control*

The Belgian schools of education are regularly screened by an audit in order to monitor the quality of education. These committees consist of independent experts and their reports are made publicly. This quality control does not exist for the schools in acupuncture. As long as the profession and the education of acupuncture is not officially regulated, no officially and independent quality control can be obtained and everybody is free to set up his own school of acupuncture.

Some schools, like OTCG, Jing Ming and ETTC, have already set up a collaboration with a college. This collaboration consists in the use of infrastructure and the recognition of the certificate, but the supervision on the quality of education is very restricted. In which degree can a college organise a training of a not (yet) recognised medicine?

The Europe Shanghai College follows the guidelines of the Shanghai University, which can be seen as an indirect quality of control. The University is recognised by the Chinese government and has to comply with their educational quality standards. The quality control in Belgium consist mainly of the organisation of the international exam for the students at the Europe Shanghai College and the organisation of some courses given by Chinese teachers. The other schools, like the ABMA and the school of Dr. Beyens, have no external control of the quality of their education at all.

5.3.4.3 *Exclusion diagnosis*

The competence to diagnose a certain pathology is reserved to all persons with a medical degree (like defined in the Royal Decree 78). The role of the diagnosis is the main point of discussion between the different schools and professional unions. Can the traditional oriental diagnosis, as it is used in acupuncture, be seen as a orthodox medical diagnosis? If so, this would imply that non-physicians are breaking the law, as it is described in RD 78. However, the paramedical acupuncturists (acupuncturists with a paramedical training) counter this charge by describing the traditional oriental diagnosis as an energetic report, which is totally different from the orthodox medical diagnosis. This explains the little attention on the medical exclusion diagnosis and the medical pathologies in the courses for paramedical acupuncturists and the emphasis on the traditional theories on symptoms and pathologies. The analysis of the content of the courses is limited due to the lack of available competences and resources in this study. In order to found the hypothesis of a lack of medical knowledge in the acupuncture training, a more profound study has to be carried out on the quality of the different trainings in acupuncture.

A possible compromise between both point of views is to strongly advise the patient to see the physician for an exclusion diagnosis and to see the traditional oriental diagnosis as an complementary source of information.

Whether or not the paramedical acupuncturist has to work under prescription of a physician is a difficult question to solve. A more modern solution could be a kind of duty to report to the general practitioner, which will enhance the communication between all health care providers.

5.3.5 Conclusion

In Belgium, acupuncture training is a postgraduate training for medical and paramedically trained therapists.

The main difference between the schools is due to the different vision on acupuncture.

As it consists of a specific diagnosis and a treatment with needles, which penetrate the skin, it could be considered as a medical therapeutic modality provided by a physician.

The paramedically trained acupuncturists interpret the traditional oriental diagnosis as an energetic report and do not consider it as a part of the medical practice, but as a complementary therapy in the entity of the treatment of the patient.

The majority of schools adhere to the traditional approach of acupuncture.

Key messages

- **Structural organisation**

All the trainings are organised as weekend-trainings, spread over 2 to 3 years (except the school of Dr. Beyens, 1.5years). The traditional Chinese medicine is the main concept in the first year, the second and third year focus on acupuncture. Most of the schools teach the traditional vision on the Chinese acupuncture, except the school of Dr. Beyens, which is more oriented towards a modern, medical acupuncture.

The schools of paramedics annually organise internships in a Chinese university hospital, which give the opportunity to the student to treat a considerable number of patients on a short period of time.

- **(Non) accessibility for paramedics**

The formation at the ABMA and the school of Dr. Beyens is only accessible for physicians. The other schools (Europe Shanghai College, OTCG, ETTC and Yin Tang) are open for physicians and paramedics (physiotherapists, nurses, midwives).

- **Quality control**

In Belgium, there is no supervising commission monitoring the quality of the education in acupuncture. **ABADIC** is controlled by the Shanghai University and all the students have to pass an international examination with a jury of the Shanghai University. However, this quality control is restricted to the examination.

OTCG has obtained the **ISO-norm 9001-2008**, but this does not pertain to the content of the training.

Both **OTCG** as **Yin Tang** organise their trainings in collaboration with Belgian certificated colleges (**Karel de Grote Hogeschool**, **Katholieke Hogeschool Brugge-Oostende**). This collaboration is restricted to the use of infrastructure and the homologation of the certificate.

- **Diagnosis**

The training in acupuncture has shortcomings in courses in differential diagnosis and symptomatology (in the conventional medicine) for the non-physicians. This can lead to a potential risk of a missed diagnosis or the denial of a conventional treatment.

5.4 PROFESSIONAL ORGANISATIONS

5.4.1 Objective

The aim of this chapter is to describe the actual situation of the recognised professional unions in Belgium.

The research questions are:

- How are the professional unions organised?
- How do the professional unions view the profession and the acupuncture training?

5.4.2 Methods

The information about the professional organisations is gathered during meetings at the KCE and contact by phone with the professional unions.

5.4.3 Results

5.4.3.1 *The professional unions*

The most recent Royal decree (6th of April 2010) recognises four professional unions of acupuncturists: **ABADIC** (Association Belge des Acupuncteurs Diplômés de Chine), **EUFOM** (European Federation for Oriental Medicine), **BAF** (Belgian Acupunctors Federation) en **UPMAB-BGAB** (Union professionnelle des médecins acupuncteurs de Belgique - Beroepsvereniging van Geneesheren-Acupuncturisten van België).

The table in appendix summarizes the main characteristics of the professional unions.

ABADIC (Algemene Belgische Acupuncturistenvereniging Diploma China/L'Association Belge des Acupuncteurs Diplômés de Chine) was founded in 1986 and counts 80 members. It is the smallest professional union of all. All members have a basic training in medicine or paramedics and are certificated by the Europe Shanghai College. **ABADIC** is member of the World Federation of Acupuncture and Moxibustion Societies (WFAS).

BAF (Belgian Acupunctors Federation) was founded in 1982 and has 231 members. It is the biggest professional union of all. All members have a basic training in medicine or in paramedics. The professional union recognises all acupuncturists with a certificate of a Belgian school in acupuncture or a Chinese certificate acknowledged by one of the 5 universities of China. The professional union is a member of the World Federation of Chinese Medicine. The council of **BAF** has closed an agreement with the Red Cross concerning the permission of patients to donate blood after an acupuncture treatment. Before this agreement, those patients were not allowed to donate blood in order to reduce the risk of transmission of infectious diseases.

The use of sterile, disposable needles reduces this risk and made the agreement with the Red Cross possible. All members of BAF subscribe this agreement and use only the sterile, disposable needles.

EUFOM (European Federation for Oriental Medicine) was founded in 2002 and has 100 members. All members have a basic training in medicine or in paramedics and have obtained a certificate at a Belgian school of acupuncture. Eufom obtained the same agreement as BAF with the Red Cross concerning the use of disposable needles. The professional union is member of the European Coordinating Organization of Professional Associations (ETCAM).

The **ABMA-BVGA** (Association Belge des Médecins Acupuncteurs –Belgische Vereniging van Geneesheren-Acupuncturisten) is a non-profit organization of which the professional union (**UPMAB-BGAB** (Union professionnelle des médecins acupuncteurs de Belgique - Beroepsvereniging van Geneesheren-Acupuncturisten van België)) is part of. This organization also organises the education for the physician-acupuncturists. The ABMA has 200 members.

Most of the professional unions are member of an European organisation, but the divergences in Belgium reflects the same divergences existing on European level, resulting in a broad amount of different European organisations.

5.4.3.2 *Point of view of the professional unions*

The professional unions make a difference between effective and honorary members. In the last case, therapists are inactive. All members subscribe to the deontological code of their professional union and are obliged to be covered by an insurance. The use of disposable needles is in general an accepted principle and the therapists who are still using non-disposable needles are rare.

ABADIC has a particular position in Belgium: the professional union takes distance from all European influences on acupuncture and only accepts the guidelines from the university of Shanghai.

EUFOM adheres to the more European approach of acupuncture, which mixes the conventional view on the physiology of pain with the view of the traditional Chinese medicine.

BAF can be considered as in between the Chinese and the European approach of acupuncture. The content of the courses is derived from the training in acupuncture in China, but the examination still happens in Belgium and is in accordance with the guidelines for examination of the Flemish community.

Both professional unions (BAF and EUFOM) have investigated an upcoming research-project in collaboration with the University of Brussels (Vrije Universiteit Brussel) on the mechanism of complex somatosensory stimulation and relaxation therapy in patients with chronic whiplash: the role of descending nociceptive inhibition and the autonomic nervous system. This project will start in the spring of 2011.

UPMAB represents the physicians, without making a difference between the more traditional oriented therapists and the more modern oriented therapists. The professional union defends the medical approach of acupuncture; both diagnosis and treatment are a part of the medical techniques and can only be performed by a medical schooled therapist. The diagnosis, as defined in the traditional Chinese medicine, is not rejected by the UPMAB but they recommend a critical approach of this traditional concept.

A weak point of a non-conventional medicine is the non-acceptance by the conventional medicine. Within the group of acupuncturists, communication is troubled between the physician-acupuncturists and the paramedical trained acupuncturists. Arguments put forward by the physician-acupuncturists aiming to restrict the practice of acupuncture to therapists with a medical degree are: the risk on side-effects due to the use of needles and the risk of a missed diagnosis and a delay in a conventional therapy. These arguments are objected by the paramedical acupuncturists by mentioning the lack of data concerning the number of harmful cases.

They also mention several solutions to avoid the risk of a missed diagnosis, like the referral letter, written by the general practitioner, or the duty to report to the general practitioner or to let sign an informed consent by the patient in which he confirms to be aware of the lack of medical diagnosis posed by the acupuncturist. This could enhance the communication between all health care providers.

5.4.4 Discussion

The different point of views on the practice of acupuncture between the different professional unions are due to the training of the therapists. Physicians consider acupuncture as a medical treatment, with the need of a medical diagnosis, whereas paramedics consider acupuncture as a complementary treatment with the diagnosis made by a physician. In fact, no real differences could be noticed between both point of views and the different approaches can be interpreted as a political strategy in defending his own profession against other professions.

Notwithstanding the similar points of view on acupuncture, a rupture is noticed between the professional unions of the physician-acupuncturists and the paramedical trained acupuncturists. This rupture is mainly caused by the prosecutions of the physicians against the non-physicians for the illegal practice of medicine. More detailed information about these prosecutions can be found in the chapter on the historical background.

The two main arguments brought in by the physician-acupuncturists to restrict the practice of acupuncture to the physicians is the potential risk of the use of needles and the risk for missing or a delayed posing of a medical diagnosis.

The risk of using needles to prick the acupuncture points is the same for both groups of therapists, but in case of emergency a physician has more competencies to cope the urgent problem. As discussed in the chapter on the evidence and the potential risks of acupuncture, no Belgian data are available and in the literature only rare cases are described. The risk of the use of needles exists, but can be considered as negligible.

The risk of a missed diagnosis is a more important problem. This need for medical diagnosis is mostly regulated by the medical prescription, in which the medical diagnosis is mentioned. Nowadays, the non-conventional medicines are not regulated and these therapists treat patients without the legal diversion to a physician. The paramedical trained acupuncturists try to avoid this problem by asking a referral letter at the general practitioner, in which the medical diagnosis is mentioned. However, this possible pathway of communication between the conventional physician and the non-conventional therapist depends on the goodwill of the patient (will he inform his physician?) and the goodwill of the physician (will he recognise this non-conventional medicine?). Also is this referral letter not yet a generally accepted way of working within the population of acupuncturists. The professional unions see this referral letter as a compromise between the non-communication and the medical prescription.

All the professional unions reject the idea of the medical prescription, mainly caused by the fear of dependence of the physicians. The dependency on the (non) recognition of acupuncture by the physicians could significantly decrease the number of patients. A solution to avoid the medical prescription is to let sign an informed consent by the patient, in which he declares to be informed not to have been posed a medical diagnosis by a physician. This solution is already described in the law Colla. Another possible solution could be the duty to report to the general practitioner, during or after the treatment, without involving the patient in this pathway of communication. The advantage of this duty to report is the formal communication between both health care providers, but this compulsory aspect could affect the trust relationship between physician and patient in case of which the patient does not want to inform his general practitioner or the general practitioner does not recognises this kind of therapy.

Another point of discussion is the risk of missing a medical diagnosis or obstructing a conventional, proven therapy. From the physician-acupuncturist we could expect the necessary knowledge to pose a diagnosis and to know all evidence-based therapies, but these competencies are not part of the basic training of a paramedical trained acupuncturist. This could be a potential danger.

This lack of knowledge advantages to restrict the practice of acupuncture to physicians or to recommend a communication pathway between the acupuncturist and the physician. Another possibility could be the determine the complaints in function of the basic training of the acupuncturist. For example, the physiotherapist-acupuncturist limits his practice to muscular-skeletal complaints.

This could be interpreted as a logical restriction, but leads to a breakdown of the acupuncture into different versions of this therapy. Also is the practice area of the actual physiotherapist broaden out to other complaints, such as pulmonary diseases and psychomotility. And could be stated that a restricted acupuncture for muscular-skeletal complaints for the physiotherapist-acupuncturists is not representatives for the actual competencies of the physiotherapist.

During the several meetings the discussion on the modern or traditional approach of acupuncture overruled all other discussions. Even at the end of the study the different point of views are not yet very clear. Within the group of physician-acupuncturists we see the more modern therapists and the more traditional therapists. We could state that the paramedical trained acupuncturists the more traditional approach of acupuncture adhere. The most modern approach of acupuncture, i.e. a limited number of points is considered as useful and the sham-therapy and placebo-effect are principal parts of the therapy, is yet a unexplored approach. This kind of acupuncture can be found in the UK¹⁴. This approach also rejects all the traditional aspects of the therapy, for example the theory of the meridians and the balance between the energy flows. This strongly reduced version of acupuncture raises the question of it still can be defined as acupuncture.

5.4.5 Conclusion

The description of the different professional unions clarifies the different visions of paramedical trained acupuncturists and physician-acupuncturists. Whereas the paramedical trained acupuncturists adhere the more traditional approach and the use of the traditional Chinese diagnosis, the physician-acupuncturists incorporate acupuncture as a therapy modality in their medical practice.

Key messages

- **There are four professional unions for acupuncturists: ABADIC, BAF, EUFOM and UPMAB-BGAB.**
- **Criteria for membership are: preliminary training as described in the Royal Decree 78, a certificate in acupuncture from a Belgian school of approved by one of the 5 Chinese Universities. Only UPMAB-BGAB is more restrictive and is only open to physicians, certificated by ABMA (strong link between professional union and school).**
- **All the professional unions are linked to a school.**
- **The professional unions for paramedically trained acupuncturists consider acupuncture as a complementary therapy, in combination with the conventional medicine. But they refuse to work under the prescription of the physician.**

Interpretations of acupuncture differ between unions: ABADIC claims the traditional vision on acupuncture, a vision based on a collaboration for the training with the Shanghai University.

BAF and EUFOM are more oriented towards Europe and strive for a European, more medical acupuncture.

UPMAB-BGAB is evolving towards a more traditional approach.

- **The professional unions (BAF and EUFOM) have an agreement with Red Cross on the use of sterile, disposable needles in all patients.**

6 GENERAL SYNTHESIS AND DISCUSSION

6.1 INTRODUCTION

6.1.1 Context

Acupuncture, chiropractic, osteopathy and homeopathy can be classified under the label of complementary and alternative medicines (CAM). In 2007 the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institute of Health (US) defined these medicines as a 'group of diverse medical and healthcare systems, practices and products that are not currently considered to be part of conventional medicine'. These therapies are referred to as 'complementary' where they are used jointly with conventional treatments, and as 'alternative' where they are used instead of conventional treatment.

The Belgian Minister for Public Health and Social Affairs has asked the Federal Healthcare Knowledge Centre (KCE) to describe the current situation of these practices in order to review or implement the law of 1999 (the so-called 'Colla law').

This alternative medicines project includes the publication of three reports. After a first report on chiropractic and osteopathy¹⁰⁸, this is the second one, devoted to acupuncture. A third report, on homeopathy, will be published later in 2011.

6.1.2 Objectives and methods

The report aims to respond to the following questions:

3. How effective is acupuncture? What are the benefits and harmful effects?
4. How can acupuncture be defined, and how is it used by the Belgian population?
5. What is the legal status of these medicines and how are they organised in Belgium?
6. How are the therapists trained?

In order to grasp these medicines in their complex and multidimensional nature, a range of methods were used:

- the medical literature was analysed to assess the clinical effectiveness and safety of the therapies under study;
- a telephone survey of the general population gave a view on the scale of the consumption of these therapies;
- a socio-anthropological interview-based survey gauged the perceptions of regular users and therapists;
- an online survey among practitioners describe their characteristics and those of their practices;
- a detailed analysis of the legal and organisational framework helped to understand the Colla law, the hold-ups and issues;
- consultation with the professional associations and experts gave an insight in how these professions are organised and how their practitioners are trained.

Together they draw a picture of the current state in Belgium but they cannot provide a complete answer to the initial research questions because of the limitations of each method and the resulting limitations of the material collected.

In order to give this general overview, we did a triangulation of the results of the different studies.

6.1.3 Limitations

Despite the range of methods that were mobilised, this study has several limitations; the most important are listed hereafter.

- The literature search was limited to a review of reviews, i.e. excluding findings from more recent primary studies. The quality of the reviews was variable, but above all, the studies included in the reviews were predominantly of low quality, and very little information on safety was found. Given the focus on systematic reviews, the literature study is biased towards subjects or studies for which a systematic review was published.
- The sociological part is exploratory, and the users survey, focuses on a small purposive sample of regular users, likely to be quite convinced of the value of the therapy and, hence, not representative of the entire user group, and certainly not representative of the whole population. The findings could nevertheless shed a light on the results of the population survey and give indications on the perception of acupuncture and the way consultations take place.
- Likewise, therapists who accepted an interview may not be representative of all therapists.
- The webbased survey among practitioners is only representative of the acupuncturists affiliated to a professional association, which is no prerequisite to practice. But, due to the lack of data on the total number and characteristics of acupuncturists in Belgium, we could not assess the representativeness of the respondents.

Yet, this is the first time a survey tries to draw a comprehensive picture of acupuncture in Belgium.

6.2 ACUPUNCTURE IN BELGIUM: USERS, PRACTITIONERS AND PRACTICES

6.2.1 Non-conventional medicines: an increasingly frequent use

The Belgian National Health Survey, carried out every four years by the Institute of Public Health, already highlighted the success of alternative (non-conventional) medicines among the population. In 2001, 11% of those interviewed had consulted an 'alternative therapist' during the past 12 months, and its rose to 12% in 2008¹⁰⁹.

In a KCE survey in 2009 on a representative sample of Belgian adults, one third of respondents had consulted an alternative therapist at least once during their life, and in the past 12 months 7% had consulted an osteopath, 6% a homeopath, 3% an acupuncturist and 2% a chiropractor. This represents by all means a substantial number of people.

6.2.2 Acupuncture in Belgium: general background

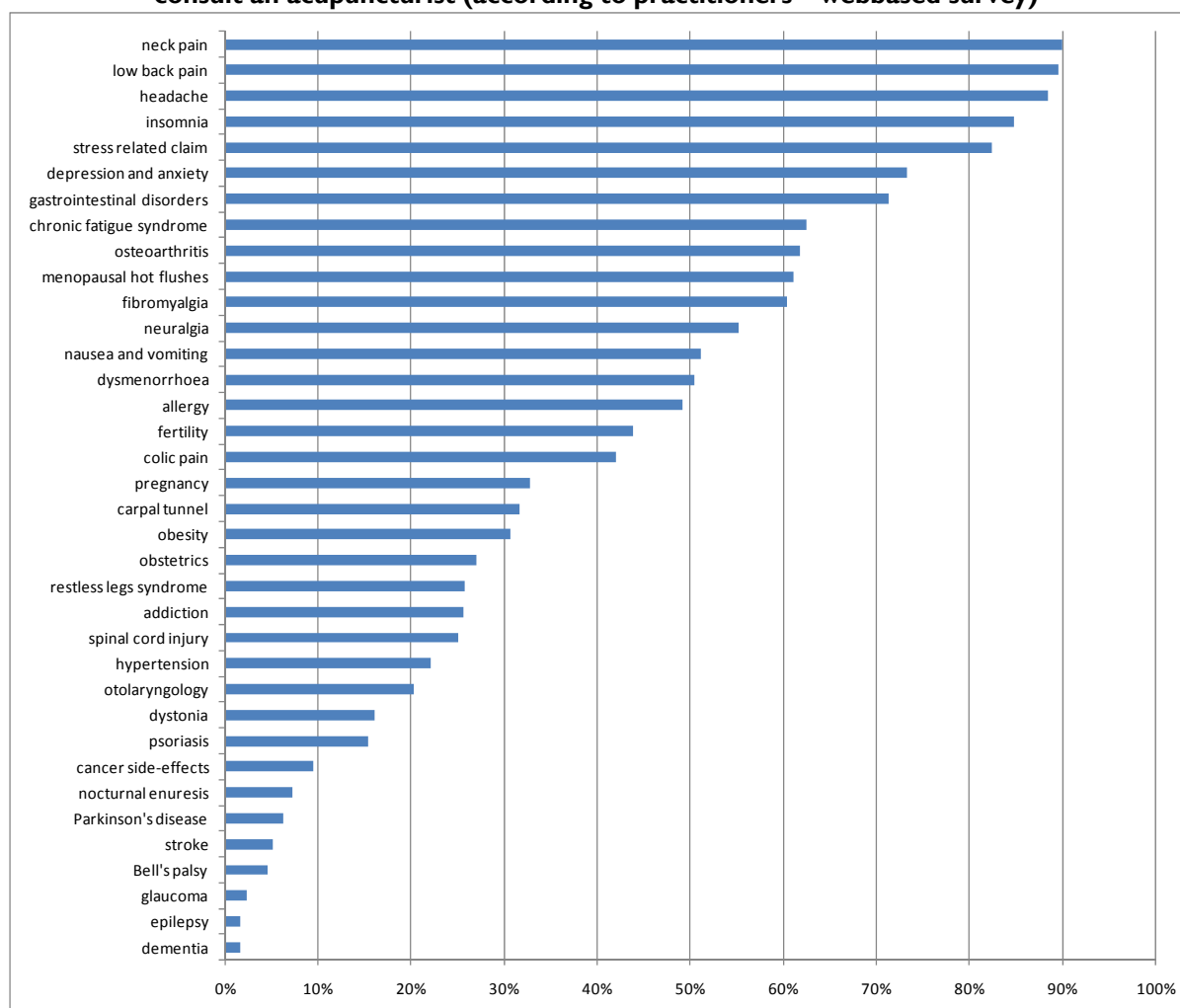
Acupuncture is a medicine of Chinese origin. It got established in Belgium during second half of the twentieth century. 'Western' acupuncture underwent many "translations", both in its content as in its form. The most radical transformations were observed during the 20th century. As doctors got interested in acupuncture and sought to explain its effects in a biomedical model, we saw the advent of a « scientific acupuncture ». Old concepts from Traditional Chinese Medicine (TCM) were gradually challenged by neurophysiological explanations (see below). The meridians, the *Qi*, the *yin* and the *yang*, and other concepts specific to the Chinese philosophical universe, were complemented by or replaced by biomedical concepts from neurology or reflexo-therapy. The strength of this relation to tradition or modernity (scientific acupuncture) partly depends on the acupuncturists' background education (medical or paramedical) (see below).

6.2.3 Who are the patients?

In our phone survey, 2.7% of the respondents had consulted an acupuncturist at least once in the last 12 months. The Belgian National Health Interview Survey had shown that the use of acupuncture remained stable between 1997 and 2008; they found a figure around 1.6%.

The main reason why people declared to seek help from an acupuncturist is low back pain. This was confirmed by the survey among acupuncturists and by interviews among regular users. Therapists also mentioned neck pain, and stress-related conditions, including headache and insomnia. Regular users also mention stress-related disorders as a predominant reason, but also wellness.

Figure 1: Frequency of the complaints for which patients often or very often consult an acupuncturist (according to practitioners – webbased survey)



According to our webbased survey among practitioners, most conditions for which acupuncturists are frequently consulted are chronic problems, for which conventional medicine has only symptomatic solutions to offer, and these solutions are generally either of limited effectiveness or bear a number of drawbacks, side-effects or risks. Moreover, many of the conditions also have a more or less outspoken psychosomatic component.

According to the acupuncturists, 10% of the patients consult for preventive purposes, with a majority doing so every 3 months on a regular basis.

Seventy three percent of the acupuncture users in the population survey consult several times per year. In 80% of the cases, this is combined with another non-conventional therapy. This is corroborated by the regular users who report concomitant use of e.g. homeopathy or osteopathy.

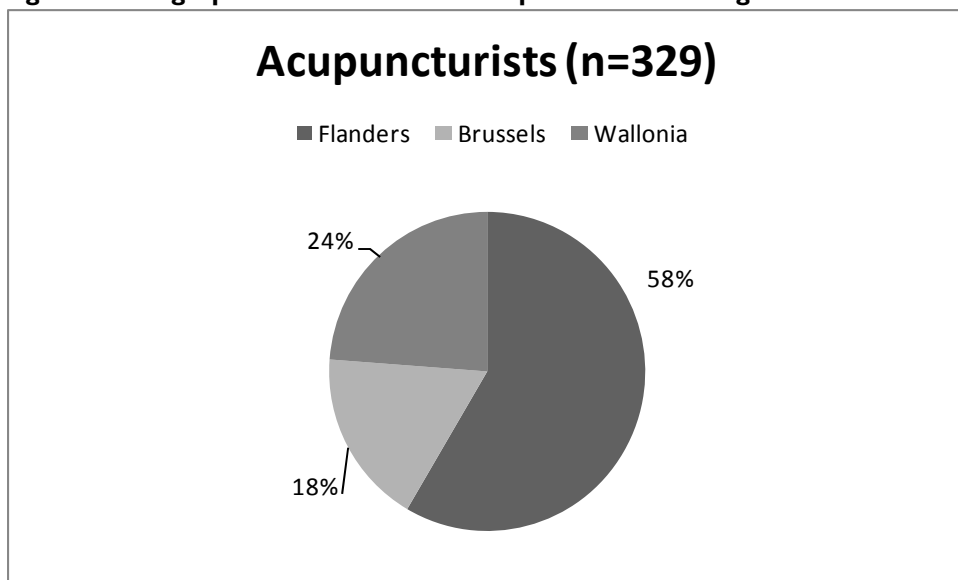
Acupuncturists declare to have a predominantly adult patient population, seeking their help for the above-mentioned reasons (musculoskeletal and stress-related complaints) as well for wellness or relaxation. Less than 20% of them take care of babies (0-36 months) and 30 to 40% treat children or adolescents, although our qualitative interviews reveal an aversion to prick children.

6.2.4 Who are the practitioners?

Today (early 2011), nearly 600 acupuncturists are affiliated to a professional association in Belgium. The majority (59%) is between 30-and 50-years-old, and almost two in three are men (64%). To a few exceptions they either are kinesitherapist, have a paramedical training (65%) or are medical doctors (32%, or 28% in our sample); amongst them a large majority are general practitioners. The median acupuncturist is in practice since 9 years.

Acupuncturists work mostly at home (73%) or in a separate private cabinet (35%). They are more numerous in Flanders (58%), than in Wallonia (24%) and Brussels (18%).

Figure 2: Geographical distribution of acupuncturists in Belgium



This geographical distribution is very similar to the one observed for osteopathy.

The majority of Belgian acupuncturists practice alone (79%), and, if not, they practice in group, mainly in combination with physiotherapists (kinesitherapists), osteopaths or other acupuncturists.

There are four professional associations of acupuncturists: ABADIC Belgian Association of Acupuncturists graduated from China, BAF (Belgian Acupunctors Federation), EUFOM (European Federation for Oriental Medicine) and UPMAB--BGAB (Union professionnelle des médecins acupuncteurs belges- Beroepsvereniging van Geneesheren-Acupuncturisten van België). They are all registered by the Colla Law, meaning that they fulfil the following criteria: they should have a list of members, agree to participate in scientific research and external evaluation, and have a corporate personality (rechtspersoonlijkheid/personalité juridique).

Criteria for membership to an association are: a primary training as described in the Royal Decree 78, a certificate in acupuncture from a Belgian school or a school homologated by one of the 5 Chinese Universities. Only UPMAB-BGAB is more restrictive and is only open to physicians, with an acupuncture certificate from one particular Belgian school (ABMA-BVGA- Association Belge des Médecins Acupuncteurs - Belgische Vereniging van Geneesheren-acupuncturisten- see below).

All the professional associations for paramedically trained acupuncturists view acupuncture as a complementary therapy, in combination with conventional medicine. However, they reject the obligation to work under prescription of a physician, which is interpreted as a lack of trust from the medical world.

This was not only emphasised by the representatives of the professional associations but also clearly appeared from the interviews with practitioners. Moreover, practitioners seem to engage into the study of a non-conventional medicine precisely in order to escape from the framework for conventional medicine.

Besides, they also fear income loss if they would become dependent on the prescription of the GP, as presumably only a minority of GP's will prescribe acupuncture.

ABADIC adheres to the traditional vision on acupuncture, as taught at the Shanghai University. BAF and EUFOM are more oriented towards a European, more medically oriented acupuncture (without rejecting the traditional concepts of acupuncture, though). Since several years, UPMAB-BGAB evolves towards a more traditional approach. Nevertheless, from our qualitative survey it appears that physician-acupuncturists present themselves in the first place as a physician.

6.2.5 The pathway of the Patient

6.2.5.1 *Initial access to the non-conventional medicine*

In general, patients use non-conventional medicines as a complement to conventional medicine, whilst not rejecting this last one. From our population phone survey, it appears that 87% of the respondents use both medicines, more often than not for the same medical reason. Eighty percent of acupuncture users also use other alternative medicines.

As for other forms of non-conventional medicine, the primary way to choose an acupuncturist is by mouth to ear referral. This is reported by users and stated by practitioners. A second entry point is via the Internet. We have no precise information how and where Internet is consulted but we know that every professional association publishes a list of their members' addresses on their website. Whilst internet is a modern tool to identify a therapist, the choice is no longer based on the reputation/fame of the practitioner, but only on the 'guarantee' offered by the mere affiliation to a professional association. Unfortunately, this referral modality was not proposed as a choice in the phone survey among general population; consequently, this result could not be corroborated.

According to the practitioners, patients can also be referred by a physician, showing that non-conventional therapies are sometimes used as a complement to a 'conventional' therapy.

Even if it is not possible to fully compare the results because of the different designs of the respective practitioner surveys, it seems that physician referral to an acupuncturist is much less frequent (7%) as compared to the referral to an osteopath (36%) or a chiropractor (42%)¹⁰. This could be linked to the higher proportion of physicians among acupuncturists, making direct access easier.

6.2.5.2 The consultation

First appointment

The first appointment is very prompt: the majority of acupuncturists are able to receive their patient the same day or the day after. When it is not urgent, the delay is 3 days in half of the cases.

Course of a consultation

An acupuncturist's consultation begins with a long anamnesis. Users seem to highly value the fact that they are listened to. Next, the therapist will examine the patient. A traditional acupuncturist will not establish a classic medical diagnosis but he/she will make an energetic report (the so-called energetic diagnosis) and identify the region of the body where the problem is situated and the points to prick. In 'traditional' acupuncture this energetic diagnosis plays an important role, and includes anamnesis, inspection and palpation (including pulse, tongue and audio-olfaction) and a differential diagnosis based on the traditional Chinese medicine references, leading to a traditional Chinese medicine diagnosis.

The treatment consists of the insertion of needles in the patient's body, at very precise points. This is not painful but sometimes unpleasant. The patient will lie down and stay immobile during 20 or 30 minutes. Disposable needles are used.

Other techniques are also used such as moxibustion (burning of dried moxa plant (*Artemisia sinensis*)), acupressure, etc (see further).

The body is believed to correct its own energy flow and balance after stimulation of acupuncture points and ill health is thought to reflect a disturbance of energy⁴.

The insertion of the needles can occur in a separate room, which allows the practitioner to treat several patients at the time. Music, subdued lighting or incense burning can be used to create an atmosphere favourable to relaxation, which is one of the main intended outcomes.

The practitioner can **combine several therapies** in the same patient, according to his initial or complementary training. 70% of physician acupuncturists combine conventional medicine with acupuncture, and 77% of all acupuncturists report combining acupuncture with homeopathy or oriental medicine. Kinesitherapists and paramedics do so less frequently, because it is not always deemed pertinent or because they have an agreement with the sickness funds to provide only one therapy a time. In contrast, physicians can combine acupuncture with conventional medicine, with reimbursement for both.

The qualitative survey among practitioners indicated that physician acupuncturists' practice varies between two extremes: from a largely biomedical approach integrating some elements of acupuncture as a treatment, based on a classical biomedical diagnosis, using only a small numbers of the 360 theoretical points, depending on patient or indication on the one hand, to a systematically combined practice for every patient on the other hand. The first model could be qualified as a 'modern acupuncture', advocating a critical view of the tradition and a more scientific or reasoned explanatory framework. The second model refers more to a 'traditional acupuncture', characterized by the traditional theories on acupuncture and the functioning of the body.

From the quantitative survey we estimate that 14% of physician acupuncturists present themselves as "western" or modern, 48% as hybrid or mixed and 38% as traditional or "Chinese style". Among non physician the figures are less than 1% modern, 24% hybrid and 75% traditional. These distinctions also reflect themselves in the discourse of the professional associations, as explained above.

Techniques used

Needle acupuncture is used by almost all acupuncturists. More than the half of them also use moxibustion. The third most used technique (often or very often by 44% of the therapists) is ear acupuncture. Acupressure and others point stimulation techniques are less often used. Less than one in four (22%) use Shiatsu (pressure) or ultrasound.

According to the acupuncturists we interviewed, they use this therapy for acute pain as it produces 3 types of presumed “morphinic” outcomes : analgesic, anti-inflammatory and relaxing.

Length of the consultations

The first consultation lasts between 30 minutes and one hour among almost half of the acupuncturists or between 1h and 1:30h among the other half. Subsequent consultations are shorter because the anamnesis goes less in depth, and take most of the time 30 minutes to one hour, time spent with the needles included.

Follow up

Forty three percent of the acupuncturist see their patients 4 to 6 times per year and one third of them up to 10 times. From the qualitative interviews we learned that this number of sessions is often judged necessary for curing a specific problem while ‘wellness sessions’ are rather punctual. Some patients use acupuncture preventively, consulting three or four times a year.

6.2.5.3 *Financial aspects*

The first consultation is more expensive than the subsequent ones: 43% of the practitioners charge less than 35 euros, but the others charge 35 and 50 euros, rarely more. Subsequent consultations are charged less than 35 euros by 62% of the therapists. Prices are on average lower than for chiropraxy or osteopathy.

The compulsory health insurance does not reimburse acupuncture as such. Nevertheless, if the treatment is administered by a physician, a ‘normal’ consultation can be charged and reimbursed.

In addition, the complementary insurance schemes of several sickness funds reimburse 10 to 12.5 euros, up to 5 times a year, for a non-conventional therapy consultation, in so far as the therapist is ‘recognised’. Unlike for osteopathy or chiropraxy, the schemes differ between sickness funds, and some restrict their intervention to treatment by a physician.

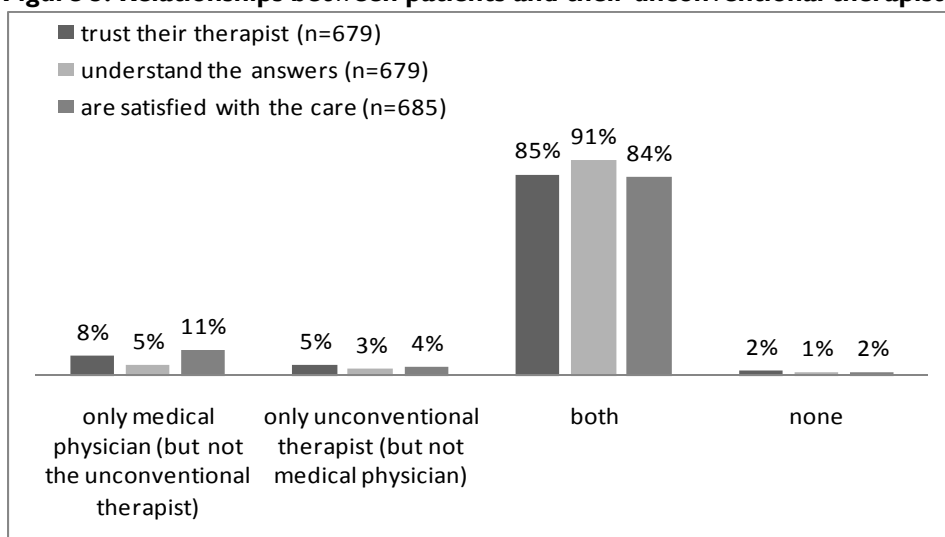
Private insurances can also occasionally intervene, depending on the cover, and in general also restricted to treatments under medical prescription.

Incidentally, a patient consulting a physician acupuncturist could benefit from a double reimbursement (regular consultation of a physician (compulsory health insurance), plus intervention for the acupuncture session (complementary or private scheme)).

Still, the major part of the cost is borne by the patient, and the telephone survey showed that 12% of the respondents would never consult a non-conventional practitioner because this is considered to be too expensive.

6.2.5.4 *Patient satisfaction*

Answers to phone survey showed that patients are satisfied with their non-conventional therapist (in general). They have confidence in him/her and think they understand well the information given. They are also satisfied with the treatment they have received. Their attitude towards the non-conventional therapists does not differ from the one towards their conventional physician: most patients are satisfied (in the broad sense) with the care they received.

Figure 3: Relationships between patients and their unconventional therapist

Regular users of acupuncture particularly appreciate the fact that their acupuncturist listens to them. This is enhanced by the fact that the patient is lying on a table during the insertion of the needles. They all describe a relaxation effect of the treatment, and this effect is clearly also aimed at by the therapists.

In the perception of the patients, acupuncture acts as well on their physical health as on their mental health and emotions. Several users relate the quality of the treatment to the quality of the relationship with their therapist. If this last one is not satisfactory, it could jeopardise the result of the treatment.

Table 1 : The consultation by an acupuncturist

Organisation of the practice	79% solo
Basic training of the acupuncturist	Medical doctor: 32% Physiotherapist (kine): 54% Nurse: 11% Other: 3%
Other activities	Acupuncture + medicine : 29% Acupuncture + kinesitherapy: 42%
Waiting time	The same day or the day after : 84% (new patients) and 89% (already known patient)
First consultation duration	46%: 30 minutes- 1 hour 30
Follow-up consultation duration	77%: < 1 hour
Number of patients per day	58%: <5
Main techniques used	Needle acupuncture : 96% Moxibustion : 55% Auricular: 44% Acupressure: 24%
Type of acupuncture	Classical: 64% Mixed: 31% Modern: 4%
Fees	35-50 €
Reimbursement by health insurances (compulsory, complementary or private)	Consultation by GP partially reimbursed by compulsory health insurance. Up to 5 session per year (any CAM, depending on the therapist's training or affiliation for some sickness funds)
Number of sessions per year	43% : 4-6 sessions 33%: 7-10 sessions

6.3 IS ACUPUNCTURE CLINICALLY EFFECTIVE?

6.3.1 Evidence in the scientific literature

We performed a literature search to document the effect of acupuncture for all conditions for which we could find at least one systematic review. We concentrated on reviews of randomised controlled trials. We included all interventions related to acupuncture, i.e. based on more or less the same concepts, including acupressure and electro-acupuncture.

Acupuncture is proven to reduce pain, although for most indications the clinical relevance can be questioned. For low back pain in particular, there is stronger evidence that the short term effect may be clinically relevant. In addition, sham acupuncture was shown to be effective in comparison with no acupuncture, indicating that the exact location of the needles is not important, which puts into question the underlying theories underpinning acupuncture.

Some studies show a significant effect on the success rate of vitro fertilisation: acupuncture would result in more pregnancies but also in more live births. In addition, the effect of acupuncture seems to be independent of the control group that was used, i.e. sham or no intervention. There is debate about the possible role of the placebo effect. Some argue that placebo effects are unlikely as the outcome (live birth) is not prone to subjectivity while others state that this cannot be excluded, e.g. because patients are more relaxed.

The placebo effect has indeed also its use, a.o. owing to the fact that, for indications like low back pain and neck pain, conventional medicine only proposes treatments of limited proven effectiveness. Consequently, patients do not obtain a satisfactory answer. In such circumstances the power of a placebo effect has been proven, in particular when the person has high expectations on the treatment.

For most other indications, the evidence in the literature is either inconclusive or absent, not in the least due to the overall poor quality of the published research.

Table 2: Summary of the efficacy of acupuncture for several conditions

Indication	Intervention	Compared to	Observed result	Outcome
Addiction				
Cocaine craving	Auricular acupuncture	Sham	Craving	One small study (n=30) shows an effect
Tobacco cessation	Ear acupressure	Advice	Cessation at 6 weeks	One outcome in one study (n=120)
Breast cancer				
Hot flushes as consequence of the treatment	Acupuncture	sham	Frequency of flushes	Small effect not sustained after the acupuncture was stopped.
Pain				
Pain relief	Acupuncture	Sham / No acupuncture	Pain relief	Effect
Tension-type headache	Acupuncture	<ul style="list-style-type: none"> • Routine care • sham 	Number of headache days	<ul style="list-style-type: none"> • Reduction • mixed results
Migraine	Acupuncture	Routine care/drug treatment	<ul style="list-style-type: none"> • Number of headache days • Migraine attacks • Headache intensity 	Reduction
Back pain	Acupuncture	Waiting list	Pain relief Functional status	Short term effect
Neck pain	Acupuncture	Multiple control groups	Pain intensity	Mixed results (immediately after treatment or short term)
Myofascial trigger point pain	Acupuncture	Standardized care / placebo	Pain intensity	Small clinically non significant effect
Knee osteoarthritis	Acupuncture	<ul style="list-style-type: none"> • Waiting list/usual care • Placebo 	<ul style="list-style-type: none"> • Pain • Pain and function 	<ul style="list-style-type: none"> • Effect • Clinically irrelevant short and long-term effect
Fertility and pregnancy				

Pain during labor	Acupuncture	Sham	Pain intensity	Mixed results (but methodological issues)
In-vitro fertilisation	Acupuncture	Sham/adjuvant	<ul style="list-style-type: none"> • Clinical pregnancies • Ongoing pregnancies • Live births 	Possibly an effect
Gastro-intestinal conditions				
Irritable bowel syndrome	<ul style="list-style-type: none"> • Acupuncture + psychotherapy • Acupuncture 	<ul style="list-style-type: none"> • Psychotherapy alone • Herbal therapy 	Improvement in symptoms	Short term effects
Postoperative nausea and vomiting	P6 Acupuncture	Sham	Number of patient suffering of vomiting	Effect
Chemotherapy induced nausea and vomiting	Acupuncture	Sham/placebo/usual care	Incidence of acute vomiting	Effect when compared with usual care but not when compared to sham

6.3.2 Patient point of view

While patients report to be satisfied, they often recognize that the treatment is not effective each time. They appreciate however the relaxation it procures, and they emphasise the role of the quality of the therapeutic relationship in the success of the treatment.

6.3.3 Which risks?

The literature does not provide much information. It appears that several minor adverse events could occur, depending on the indication or the technique (including sham therapy): haematomas, irritation, redness, sleepiness, pain, hypertension, bleeding, etc.

Risk of infectious diseases transmission, inherent to the use of needles, is not an issue anymore because practitioners use disposable needles. Besides, two professional associations (BAF and EUFOM) have concluded an agreement with the Belgian Red Cross about the use of sterile, disposable needles in all patients. Before this agreement, patients who had seen an acupuncturist were not allowed to donate blood.

In the interviews, the practitioners mentioned the following risks: pneumothorax, transmission of disease-causing agents, cardiac perforation, haemorrhage, paralysis, septicaemia.

We have no quantitative data on any of these adverse events.

6.4 TRAINING

From our qualitative interviews, we learned that the motivation to engage in a training in acupuncture often comes from an interest in oriental culture or medicine. A positive personal experience as a patient with this type of treatment could also be a motivation. And otherwise, they just are in search of other, additional ways to help their patients.

Acupuncturists are mainly trained in Belgium; in one third, this includes also courses abroad (33.4%) (in Asia for the most of them, sometimes with an internship), but most of the time, this is not the case (59.6%). It is a postgraduate training and, in more than 80% of our sample, given on a part-time basis, and spread over 2 or 3 years.

There are several schools in Belgium; only one school is reserved exclusively to physicians (ABMA-BVGA).

While the majority of the other schools are accessible to everybody, only medics and paramedics as defined in the Royal Decree 78 can obtain a degree of acupuncturist and claim full membership of a professional association. Nevertheless, the curriculum is focused on the traditional Chinese medicine and its particular symptomatology and diagnosis. The potential shortcomings in the field of the differential diagnosis and medical symptomatology could bear a potential risk for misdiagnosis or of a or of harmful delay in the initiation of an essential conventional treatment.

Only the Europe Shanghai College emphasises the importance of the Chinese culture for the practice of acupuncture. This school trained 18% of the acupuncturists who participated in our survey.

Today, no school is officially recognised. There are some instances of collaboration with a recognised educational institute, but this is restricted to the use of infrastructure and homologation of the certificate delivered.

Internship abroad (in practice in Asia) is necessary for non physicians because, as long as the Colla law is not implemented, they are not legally authorized to practice an alternative medicine, and, as a consequence, it is impossible to organize internship.

6.5 LEGAL FRAMEWORK

This chapter is common to the three reports on alternative medicines, as most of the issues are common to all non-conventional practices.

6.5.1 Background

During the 1990s, Europe acted as a catalyst in the development of new Belgian legislation concerning non-conventional medicines – at the initiative of a Belgian member of the European Parliament, P. Lannoye. In April 1994, he submitted a proposal to the European parliament ‘Committee on the Environment, Public Health and Consumer Protection’ concerning the status of non-conventional medicines. He called for non-conventional medical acts to be covered by national sickness insurance systems, the integration of complementary systems into the European Pharmacopeia, and a research budget for non-conventional medicines. It was not until three years later, on 29 May 1997, that a first resolution was proposed by the European parliament. The main thrust of this proposal was to encourage the Commission to undertake a recognition procedure for non-conventional medicines and to carry out studies of their safety, advisability, field of application and their complementary/alternative character. On 11 June 1999, it fell to the Council of Europe to adopt a resolution that called for the integration of non-conventional medicines at European level and governed access to these medicines for both practitioners and patients.

In response to this resolution, Belgium decided to amend its legislation. According to Article 2 of Royal Decree no. 78⁷⁷ performing a diagnosis and establishing the treatment of a physical or mental disorder are reserved for the holders of a medical diploma approved by the competent medical commission. Persons that habitually diagnose or organise treatment as described above, who are not doctors, are in principle guilty of the illegal practice of medicine. Osteopaths and chiropractors that perform these acts habitually and are not doctors are working illegally unless they carry out a medical treatment that falls within their specific legal competencies (for example, certain physiotherapy treatments on medical prescription). In this case, patients have no guarantee regulated by the authorities as to the quality of the care and safety.

On 29 April 1999, the Belgian parliament adopted a new law on the regulation of non-conventional medicines, known as the Colla law (after the name of the Minister for Health at the time, Marcel Colla).

6.5.2 The Colla law

The purpose of the Colla law is to guarantee that each patient receives quality care. This is ensured mainly by a dual registration system. Not only must non-conventional practices be registered (which is only possible if they satisfy certain conditions), but all practitioners must also be individually registered (for which they must also satisfy certain conditions). A key role is given to a joint commission, which must advise on the general conditions that apply to the exercise of all non-conventional practices and the conditions that practitioners of a non-conventional practice must satisfy to be registered individually.

However, since in early January 2011 this joint commission had still not been established, it cannot play its key role and consequently the law cannot be fully executed.

The law stipulates that half of the joint commission members should be proposed by the faculties of medicine, and the other half by practitioners of non-conventional medicines proposed by the chambers (art. 5).

One difficulty that arises is that article 5 does not specify whether practitioner-members of the joint commission must be registered individually. In addition, the law does not define what is meant by a 'practitioner of a non-conventional medicine'. As a result, it is not clear whether the law requires these practitioners to be registered for the composition of the first joint committee.

The law states that no one can exercise a non-conventional practice without being registered (Art. 8 §1). Moreover, the rule is that the professional exercise of a non-conventional practice by a non-doctor is tantamount to the illegal practice of medicine, which is a punishable offence, except for certain treatments that the law allows for certain professionals, such as physiotherapists⁷⁷. If we accept the interpretation that individual registration is necessary to assemble the joint commission for the first time, this raises a problem because it is this very joint commission that must give an opinion on the registration conditions^{84, 85}.

At the request of two associations representing osteopaths, the Brussels court of first instance ordered the Belgian state on 22 January 2010 to set up the joint commission. The government appealed but the judgement was for immediate execution. The Belgian state must therefore pay a fine of 5 000 euros a month as from June 2010.

The practitioner members of the joint commission must be appointed by the chambers, which must be established, with one chamber per non-conventional medicine referred to in the Colla law. These chambers are also constituted of representatives of the medical faculties and members appointed by recognised professional organisations. The composition of the joint commission requires prior recognition of the different professional associations by Royal Decree. The Royal Decree of 06 April 2010 recognising the professional organisations for non-conventional practices, or practices that may be considered for qualification as a non-conventional practice⁸⁶, confirmed the recognition of 13 professional associations that satisfy the recognition criteria.

For this decree to be properly executed, under the terms of the Colla law it must be approved by the Parliament within sixth month after its publication in the Belgian Official Journal. However, as the decree was published on 12 April 2010, it should have been confirmed by law at the latest on 12 October 2010; yet, the vote in the Chamber and the Senate to approve the draft law only took place in November¹¹¹. This decision therefore arrived too late. It could be argued that the decree cannot be executed and, consequently, that all subsequent stages, such as the appointment of the members of the chambers, cannot follow. A possible solution would be to republish the Royal Decree and, this time, approve it properly within six months of its publication.

Another interpretation is that the legislator can in principle not compel its successors to follow the former's decisions. As a result, a new legislator should be able to ratify the law after this period of six months. But, wouldn't changing the general rule with an individual legal application, prejudice the fact that each citizen has the same constitutional rights for the same application of the law in similar cases? Effectively, by ratifying the individual recognition of the professional associations beyond the period of six months, the legislator has departed from the general rule. The members of the professional association that will be recognised in the future therefore have no legal guarantee as to the delays in which their 'Royal Decree of recognition' would be confirmed by law.

6.5.3 Consequences of partial execution of the Colla law

As long as the Colla law is not fully in effect, the practice of a non-conventional medicine by a non-doctor is tantamount to the illegal practice of medicine. Several non-doctor practitioners of non-conventional practices have already been sentenced for this offence. We note however that jurisprudence tends increasingly towards acquittal, insofar as certain conditions (such as proper training) are satisfied and the Belgian state still fails to execute the Colla law. In addition, certain medical procedures that are also more or less in the realm of alternative therapists can be practiced legally by certain professionals such as physiotherapists.

This failure to execute fully the Colla law has as a consequence that any other law that may have an influence on the therapist-patient relationship does not apply. For example, the provisions of the patients' rights act of 22 August 2002 and the law of 31 March 2010 concerning compensation for damages resulting from healthcare can only be applied to the practitioners of a non-conventional medicine when the Colla law has been fully executed.

Two competing concepts of who can practice healthcare coexist within the European Union. According to the first one, in principle only doctors are authorised to practice medicine. Under the second one, any person who so desires can practice medicine, with the exception of certain acts that can only be performed by doctors.

Belgium falls into the first category because it restricts the practice of medicine to doctors, with the exception of certain treatments such as those provided by non-conventional medicines (once the Colla law will be executed).

7 CONCLUSION

Since its appearance in Belgium in the years 1960-70, the situation of acupuncture in the health system has gradually changed. After a period of marginality and mistrust, it seems today relatively well accepted by a certain number of members of the medical community, as a valid, complementary “medical technique”, albeit only in so far as it is practised by doctors.

Only limited scientific evidence of effectiveness

Overall, evidence of the effectiveness of acupuncture is quite limited and scarce. Only pain and maybe fertility seem to benefit from acupuncture, and the effects are difficult to distinguish from a placebo effect, due to the nature of the conditions for which acupuncture is used and difficulties in blinding the interventions. Applying a good placebo as such in acupuncture is a problem, hence the distinction with real acupuncture is by definition difficult.

In general, non-conventional therapists judge the effectiveness of their treatment on the basis based of their patients’ satisfaction. Our findings from the population survey and from the interviews of convinced users indicate that patient satisfaction is quite high, even if it seems more related to the quality of the therapeutic relationship and to the sensation of wellness that acupuncture procures, and not necessarily to the actual therapeutic outcome.

Execution of the Colla law

Even if their scientific basis is appallingly poor, these therapies encounter a considerable success, and they are not likely to disappear soon, nor is their prohibition realistic from a political point of view. This only adds to the urge to regulate their position in the health care system.

Generally speaking, the main issue for all four alternative medicines recognised by the Colla law, is the actual execution of the law.

The current situation is problematic for almost 70% of acupuncturists who are not trained as a medical doctor, and are therefore practicing illegally, even though the recent jurisprudence takes an attitude of tolerance.

Guaranteeing the safety of patients

Today, patients have no means to ascertain whether they are going to consult a health professional who can legally certify his competence or not. Moreover, they have no official guarantee of quality before undertaking a treatment. Likewise, the various provisions of the law on patient’s rights and the law on compensation for damages resulting from healthcare cannot be applied to the patients of non-physician practitioners as long as the Colla law has not been executed.

Hence, without official recognition of therapists or protection of the title of acupuncturist, patients have no objective guidance in their choice of a therapy or a particular therapist. Furthermore, since the surgeries of non-doctor therapists are mainly private, they are not backed by the confidence of an institution (medical centre, polyclinic, hospital, etc.) into which such practices would be integrated.

Supervising the training

To ensure patient safety, alternative practitioners must have a sound knowledge of semiology. This can be dispensed in different training courses leading to an acupuncturist qualification. Currently there is no external validation of the quality of the different training curricula offered in Belgium.

In order to remain coherent with the rest of the health system, the guarantees potentially offered by a better control of the training should go further than the mere aspects of safety and demonstrable effectiveness. A good number of the other practices currently used would still not be covered. This poses a problem for the Public Health authorities, which is still far from being resolved.

The question of (the recognition of) the training for established acupuncturists also remains unresolved.

Physician or non-physician ?

The practitioners having a medical training insist that access to the practice of acupuncture should be limited and they contest practice by non-physicians. They try to preserve their prerogatives in the domain, arguing that safety is at risk when non-physicians treat patients. In the absence of standards for training and access to practice, physicians provide more guarantees. Under the Colla law it could be possible to offer some guarantee on safety for patients by regulating access to the profession.

Increase financial accessibility ?

The financial accessibility of non-conventional medicines is linked to the price of the consultations. There is no control on the fees charged; for non-physician practitioners, there is no reimbursement by the compulsory health insurance, unless they fraudulently invoice services that are included in those they have access to on behalf on their INAMI/RIZIV recognition number (if any).

Given the limited evidence of a relative efficacy for some conditions, we cannot expect to devise meaningful information on cost effectiveness.

Many patients use relatively expensive medicines whereas the scientific evidence of their effectiveness lacks or is not very convincing. Even if these patients show a high level of satisfaction with these therapies, this is by no means a proof of effectiveness. Despite its valuation by users, acupuncture does not pass the test that is usually applied to judge the appropriateness of a reimbursement by the health insurance.

Allow reimbursement of acupuncture sessions by physicians ?

Currently, patients might have a financial advantage when they consult an acupuncturist who is also a physician because they could benefit from a double reimbursement of the session: once by the compulsory health insurance and once by their complementary insurance. One could ask whether the reimbursement of a consultation devoted to a non-conventional therapy, even when practiced by a physician, is not a misappropriation or an abusive use of public funds. It seems hard to justify the difference with, e.g. acupuncturists who are physiotherapist and who are obviously not allowed to use their INAMI/RIZIV registration number to give their patients a care attestation for reimbursement by health insurance, for essentially the same treatment. The different policies of the different sickness fund reinforce this inequality. Furthermore, we have no evidence that acupuncture would be more effective or efficient when practiced by a physician rather than by another therapist.

Work under prescription or not ?

The professional associations for kinesi therapists or paramedically trained acupuncturists see acupuncture as a complementary therapy, in combination with the conventional medicine. However, they reject the obligation to work under prescription of a physician, and they fear that their workload would decrease if a medical prescription is required.

The Royal Decree 78 states that a diagnosis can only be established by a therapist with a medical degree. All other therapists need the medical diagnosis, established by a physician, to initiate a treatment. Consequently, seen from this stance, it seems obvious that non-physician acupuncturist should work under prescription.

Solutions proposed by the acupuncturists themselves to avoid the need of a medical prescription are: to treat only after referral (letter) by a physician, rather than under prescription; to have a systematic informed consent by the patient (as foreseen in the Colla law) and/or to require systematic reporting to the referring practitioner or GP. Still, in view of the limited evidence, there is no justification whatsoever to be less restrictive towards non-physician acupuncturists than towards others (kinesi therapist or paramedical professions).

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