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Should we Integrate Acupuncture into Western Medicine for Stroke Rehabilitation?

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1. Abstract

A research paper published in Journal of Neurology, Neurosurgery & Psychiatry in 2016 reported that among 2625 first-ever stroke patients, 21% survived to 15 years, by which time 14.3% and 15% still had moderate and severe disability, respectively, despite standard stroke rehabilitation [1]. Acupuncture is a common modality of treatment for stroke in China and is claimed to be effective. So, whether acupuncture can be integrated into the current Western stroke rehabilitation programme to further reduce post stroke disability becomes an important issue. This project is trying to answer this question.

First, I reviewed the literature for acupuncture's efficacy in stroke rehabilitation. Then, I surveyed how people in the UK viewed Traditional Chinese Medicine and acupuncture. Because even if acupuncture is effective for stroke rehabilitation, its application in the healthcare system in the UK depends on whether the public accepts it. Finally, through interviews I investigated why the integration of acupuncture into Western Medicine meets resistance in the UK.

In the literature review, three clinical trials were quoted, representing two studies with good design but opposite results and one study of fair quality with a positive result. It suggests that acupuncture may have an additional effect on motor recovery after stroke, and its integration into western stroke rehabilitation should be considered. However, most of the studies published are of poor to fair quality, so further randomised controlled studies are needed.

The survey reveals the public in the UK does not know very well about Traditional Chinese Medicine and acupuncture, and has seldomly used them. In addition to further clinical trials on acupuncture's efficacy, empowering the public with the knowledge of acupuncture in the UK is equally important.

The interview reveals that the main difficulty of integrating acupuncture into western stroke rehabilitation lies in whether western methodology should be used to assess acupuncture's efficacy.

In conclusion, acupuncture should be integrated into Western medicine for stroke rehabilitation provided its efficacy can be further proven. Without other convincing methodology than the evidence-based medicine, we should carry out more well designed, randomised controlled trials to prove its efficacy. To implement its integration into the public health care system for stroke rehabilitation, empowering the knowledge of acupuncture to the local population is equally important.

2. Introduction

In 2022, the Global Stroke Fact Sheet released that the risk of developing stroke has increased by 50% over the past 17 years, [2] making it one of the top two causes of death worldwide. Currently, it is estimated that 1 in 4 people will experience a stroke in their lifetime.

Despite continuous advancement in medical treatments for acute stroke, a significant number of survivors are left with disabilities which may permanently impair their activity of daily life and quality of life. This highlights the importance of stroke rehabilitation, which aims to reduce the patients' disability by facilitating motor recovery and adapt to the disability at a later stage.

Traditional Chinese Medicine (TCM) has been gaining popularity globally in recent years. There are many modalities of treatment in TCM, such as herbal medicine, cupping, and acupuncture. Among them, acupuncture stands out as the most popular. Compared to Western Medicine, TCM has different understandings of the cause of disease and its methods of treatment. So far researchers in the west have been trying to assess its efficacy using Western methodology, although TCM practitioners argue that Western methodology may not effectively evaluate TCM's efficacy.

Through this research, I wish to answer the question "Should we integrate Acupuncture into Western Medicine for stroke rehabilitation?" And, if we should, what are the existing problems and how we should proceed. This exploration may expand the range of rehabilitation options available to the patients for post-stroke recovery.

2.1. Definition of Stroke and its Classification

2.1.1. Definition of Stroke: The World Health Organization (WHO) defines stroke as "rapidly developing clinical signs of focal or global disturbance of cerebral function, with symptoms lasting 24 hours or longer or leading to death, with no apparent cause other than vascular origin" [3].

2.1.2. Stroke Classification: Stroke is mainly categorised into two types: Is chaemic and haemorrhagic. Ischaemic stroke is the more common type, accounting for approximately 85% of cases in the UK. The remaining 15% of strokes are known as haemorrhagic stroke [4].

Ischaemic stroke happens when a blood vessel supplying parts of the brain becomes blocked, typically from a piece of plaque or a blood clot, killing the brain cells [5].

Haemorrhagic stroke occurs when an artery in or around the brain suddenly ruptures, causing the brain to swell, increasing the pressure within the skull, which eventually kills the brain cells [6].

Initial treatment varies depending on whether the stroke is ischaemic or haemorrhagic, the areas involved, the time elapsed since the onset of stroke symptoms, and the patient's other medical conditions. Once acute phase is over, standard stroke rehabilitation starts regardless of haemorrhagic or ischemic stroke.

2.1.3. Stroke Rehabilitation: After the acute phase, stroke patients may still have paralysis or weakness in either one or both sides of the body [7]. Additionally, stroke survivors may struggle with understanding and forming sentences.

Rehabilitation becomes crucial in stroke recovery. Its primary objectives are to relieve the difficultness during the transition from hospital to home and reduce the risk of another stroke [8]. Recovery can span days, months, or even years.

There are three key types of rehabilitation therapy: speech, physical and occupational therapy.

2.1.4. Physiotherapy: Physical therapy uses exercises to help people regain motion and relearn coordination skills. According to one of the NINDS-supported stroke rehabilitation studies, both home physical therapy and locomotor training programmes using treadmill walking and body weight support improved to a similar extent [9,10].

2.1.5. Speech therapy: Speech therapy focuses on helping individuals who may have difficulty in understanding or producing speech. This form of therapy allows stroke survivors to relearn languages and speaking skills [11]. They also help to assess swallowing, which is often impaired during the stroke. Dysphagia is the major cause of aspiration pneumonia and death in the first two weeks following a stroke.

2.1.6. Occupational therapy: Occupational therapy targets to improve the activity of daily living. Occupational therapists also provide various aids and recommendations on wheelchairs, and training to enhance essential life skills. They also suggest modifications to the patient's home or workplaces environment to promote greater independence in their daily life [12].

2.2. Traditional Chinese Medicine: Acupuncture

2.2.1. Ancient Origin of Traditional Chinese Medicine and Acupuncture: The practice of TCM has a rich history that spans over 2500 years, with origins dating back to around 200 BCE in Asia. It is based on a belief known as yin and yang, a philosophical concept that centres on the idea of opposite yet interconnected forces. According to this philosophy, when the forces of yin and yang are balanced, one's body will remain healthy.

Practitioners of TCM also believe that there is a life force energy called Qi (pronounced "chee") within the body. The concept of Qi's flow channel had been documented as early as 100 BCE. If there is too much or too little Qi or if there is a blockage of the flow of Qi in one's body energy pathway, known as meridians, it can lead to sickness [13]. From the practitioners' point of view, they view the internal organs within the body as a complex interconnected system rather than individual structures. The ultimate goal of TCM treatment is to restore the equilibrium of yin and yang, ensuring the smooth flow of Qi throughout the body's systems.

Among the oldest practices within TCM, acupuncture has gained popularity worldwide since the 1970s. This technique is performed by the insertion of thin metallic needles into the skin through gentle and specific movements by either the practitioner's hands or electrical stimulation [14]. T4hese acupuncture points stimulate the central nervous system, causing chemicals to be released into the muscles, spinal cord and brain, thereby stimulating the natural healing mechanisms within the body.

2.2.2. Globalisation of Acupuncture: As acupuncture gradually proved their effectiveness, further investigations

were conducted to confirm its efficacy in managing pain and relieving headaches. Finally, in 1977, the National Institute of Health (NIH) consensus conference officially recognised the positive evidence on the effectiveness of acupuncture.

From the early discovery of acupuncture to its acceptance in Western countries, the field of acupuncture has continuously evolved and made more discoveries. It has progressively integrated with science to develop advanced techniques for patient care. In addition to traditional methods, such as scalp acupuncture [15], more new forms of acupuncture have been developed through the incorporation of modern science, such as electro acupuncture and laser acupuncture.

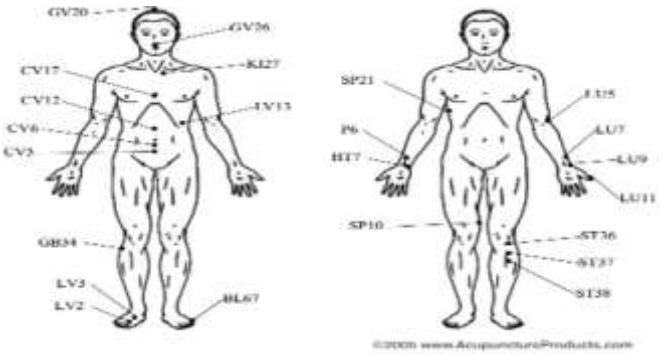
3. Literature Review

3.1. Study One: Effects of Acupuncture i6n Ischaemic Stroke Rehabilitation [1]

3.1.1. Study design: This study included a total of 497 patients between the age of 40 and 45, with a diagnosis of ischaemic stroke ranging from two weeks to twelve months after onset. They were randomised into 3 groups: Arm One (159 cases), Arm Two (173 cases) and the control group (165 cases). In the treatment Arm One and Arm Two, once daily acupuncture was given for two weeks in addition to conventional rehabilitation, compared to the control group who received conventional rehabilitation alone. The study was conducted in three centres over a span of 12 months from July 2016 to July 2017. The primary outcome measurement was NIHSS and the secondary outcome measurements were BI and MAS. They were assessed at baseline, week one and week two after enrolment by a blinded assessor.

3.1.2. Intervention: All patients received rehabilitation programmes. Both the treatment group and the control group followed the same basic treatment protocol, including medical and nursing care.

In the treatment arm, acupuncture was performed by [16] acupuncturists across three different hospitals. The acupoints were selected by experienced acupuncturists. In Arm One, the acupoints are: GV20; GV26; PC9; ST6; ST4; L115; L111: L14: GB30; GB31; GB34; and GB39. In Arm Two, the acupoints are GV20, L111; GB30; GB34; PC6; L110; SJ55; L14; ST36; SP6; ST41; and LR3. The frequency of acupuncture is daily, and its duration is two weeks [17].



3.1.3. Outcome measures: The outcome measurements used were National Health Stroke Scale (NIHSS), Barthel Index (BI,) and Modified Ashworth Scale (MAS) at baseline (T0), week 1 (T1), week 2 (T2), and follow-up (T3).

The primary outcome was measured by the NIHSS, ranging from 0 to 44 (1-4 = minor stroke; 5-15 = moderate stroke; 15-20 = moderate/severe stroke; and 21-44 = severe stroke).

The secondary outcome was measured by BI (0-100 points) and MAS.

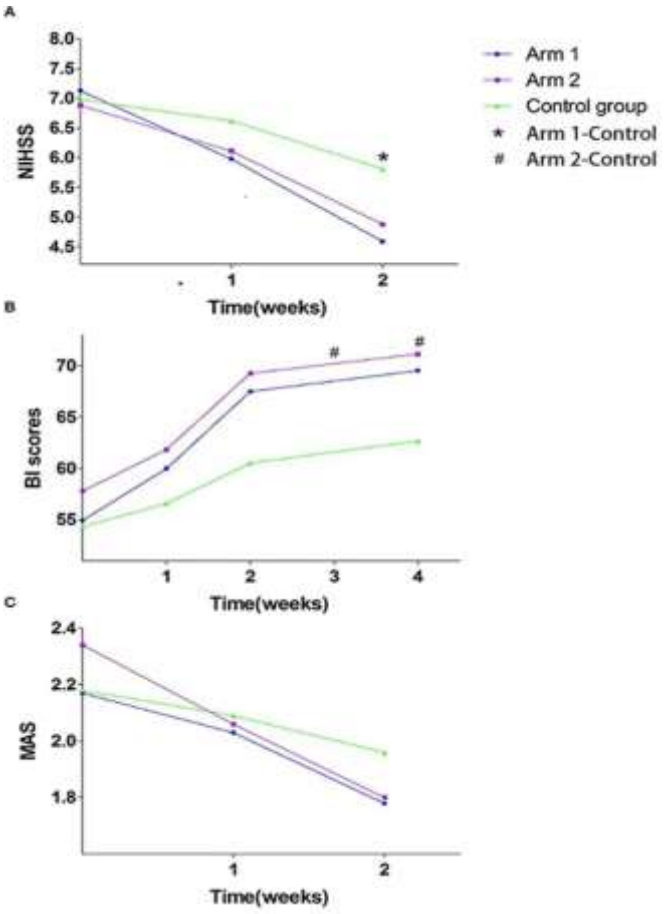
BI below 20 indicates that the patient's self-care ability is severely damaged, whereas a BI above 60 indicates that the patient can take care of himself.

The MAS determines the changes in muscle tone before and after treatments.

3.1.4. Results: As depicted in the figure, the NIHSS scores in Arm One, but not in Arm Two, showed a statistically reduction in week two, as compared to the control group.

Second, the BI scores in Arm Two, but not in Arm One, showed a statistically significant increase in week two, as compared to the control group.

Thirdly, there is no statistically significant difference in the MAS scores in week one and week two among the three groups.



3.1.5. Conclusion: According to the authors, the present study suggests that compared to conventional rehabilitation alone, acupuncture can further reduce the severity of neurological impairment and improve the activities of daily life after an ischaemic stroke.

3.1.6. Discussion: This is a properly designed prospective, randomised, single-blinded, controlled study, with sample size calculation, intention to treat, and well recognised measurement scales.

However, there is a lack of consistency in the treatment effect between the two treatment arms. The statistically significant

reduction in NIHSS score observed in Arm One was not seen in Arm Two, and the statistically significant improvement in BI score observed in Arm Two was again not seen in Arm One. NIHSS is a measurement of the severity of neurological impairment whereas BI is a measurement of the severity of impaired activity of daily living. They should, therefore, move in the same direction with corresponding improvements. The eight different acupoints in the two treatment arms do not seem to account for this discrepancy.

The following bias might be present. First, the enrolled patients have a wide variation in their duration of ischaemic stroke, so their potential and speed of recovery are different. Second, the rehabilitation treatment is up to the rehabilitation doctor to decide individually, who was not blinded.

Thirdly, there were as many as 16 acupuncturists taking part in this trial, who were not blinded. Although they followed the same acupoint protocol, bias could be still present due to different personal technique and interpersonal skills. If these three biases could have been controlled, the conclusion would be more convincing.

3.2. Study Two: Clinical Effects of Acupuncture for Stroke Patients Recovery [18]

3.2.1. Study design: This is a retroprospective, non-consecutive, case-controlled study. The data were collected between January 2019 and January 2021. It consists of 128 stroke inpatients, ranging from 41 to 73 years of age. 65 patients who received conventional physiotherapy and acupuncture were compared to 63 patients who received conventional physiotherapy alone for their FMS, MAS, BI, and NIHSS scores. The duration of treatment ranged from 12.7 to 28.3 days in the acupuncture and physiotherapy group and 9.7 to 26.8 days in the physiotherapy alone group.

3.2.2. Intervention: In the control group, patients received comprehensive physiotherapy according to the stage of the disease. They also received speech therapy and swallowing training. These sessions were given once a day, five to six days a week, with each session spanning 45 minutes to one hour.

In the intervention group, in addition to the comprehensive physiotherapy, they received acupuncture. The acupoints were selected based on the Brunnstrom stage of hemiplegia.

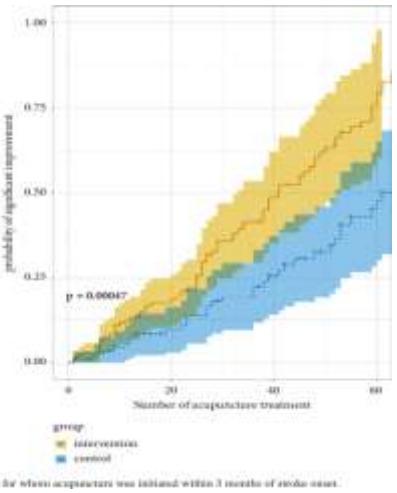
3.2.3. Outcome measures: The outcomes measures include the National Institutes of Health Stroke Scale (NIHSS) for the severity of neurological impairment, the Barthel Index (BI) Scale for the disability in activity of daily living, the Modified Ashworth Scale (MAS) for assessment of muscle tone, and the Fugl-Meyer Assessment of Physical Performance (FMA) for assessment of motor function.

3.2.3. Results: The greater increase in FMA score in the intervention group as compared to the control group ($p < 0.01$) suggests acupuncture improving motor function.

The great increase in MAS scores of the intervention group as compared to the control group ($p < 0.01$), suggesting greater reduction in muscle tone.

The number of patients with functional improvement as described by the physiotherapist is also greater in the intervention group than in the control group, as shown by the Kaplan- Meier Survival Curve.

Kaplan-Meier survival curve.



Kaplan–Meier curves of two groups comprised those for whom acupuncture was initiated within 3 months of stroke onset.

3.2.4. Conclusion: The study demonstrated that by adding acupuncture to conventional physiotherapy, there was more reduction in neurological impairment, lower muscle tone, better muscle power, and less disability in activity of daily living.

3.2.5. Discussion: This is a retrospective study on 128 stroke patients admitted over two years. As it is a retrospective study, patients were not able to be randomised or consecutively enrolled, both of which causes bias.

Secondly, in a retrospective study, where information is based on inpatient case notes, how could the investigator be certain that the physiotherapist who was assessing the patient did not know whether the patient was on acupuncture or not?

Thirdly, the author did not report when the outcome assessments were performed for the sample patients. Whether the patients in the two groups were assessed at the same interval, after admission and after stroke onset, is important.

3.3. Study Three: Does Acupuncture have Additional Value to Standard Post Stroke Motor Rehabilitation? [19]

3.3.1. Study design: A prospective, single-blinded, randomised controlled trial was carried out. 106 consecutive patients with moderate or severe functional impairment during days 3 to 15 after acute haemorrhagic or ischaemic stroke, were included in the study after informed consent.

Sample size calculation was performed assuming the FMAM median score change in the acupuncture arm should be 3 points more than that in the control arm to demonstrate that acupuncture produced additional motor improvement. Taking into consideration a 15% dropout rate, at least 47 patients in each arm were needed.

After inclusion, patients were stratified into group I, if admission BI was < 11, and group II, if admission BI was > 11. Stratification was used to avoid chance imbalance of severity of disability between the intervention arm and the control arm. Patients from group I and group II were then randomised to the intervention and control arm according to random permuted blocks of 4.

The total intervention duration was 10 weeks. All dropout cases were documented with reasons, and analysis was based

on intention to treat.

3.3.2. Intervention: For patients in the control group, they received standard treatments which included a total of 10 sessions of physiotherapy and occupational therapy per week, each lasting an hour.

Patients in the intervention group received the same standard treatments, with the addition of traditional Chinese acupuncture treatment. The selection of the main acupoints was based on the TCM theory.

3.3.3. Outcome measures: Outcome measures included Fugl-Meyer Assessment of Physical Performance (FMA), Barthel Index (BI), and Functional Independence Measure (FIM), respectively, at weeks 0, 5, 10, performed by blinded assessors.

For BI, we used the version described by Wade and Collin in 1988, which has a total BI score of 20. The severity of disability is classified as mild (BI>15), moderate to severe (5 < BI < 15), and very severe (BI </= 5).

FIM is a more comprehensive assessment of disability. We used the modified version of NIHSS, which is composed of 13 items with each item scoring 0 to 2 or 0 to 3, with a maximum score of 31.

The primary endpoints were the Foetal Movement Acceleration Measurement (FMAM) median scores at 10 weeks and FMAM median score change over time.

Secondary endpoints were Focal Muscular Atrophy (FMA), Functional Independence Measure (FIM), and BI median scores at 10 weeks and FMA, FIM, and BI median score changes over time.

3.3.4. Results: A total of 106 Chinese patients were enrolled at days 3 to 15 after acute stroke. 31 patients each were randomised to group IA and group IB, and 22 patients were each randomised to group IIA and IIB.

14 patients dropped out during the trial, accounting for a 13% dropout rate. There was no statistical difference in dropouts between the 2 arms.

No differences were seen between the intervention arm and the control arm in either group I or group II, when comparing impairment scores FMAM and FMA, or disability scores of FIM-c, FIM-m, FIM, and BI at 10 weeks.

The median score changes of FMAM, FMA, FIM-c, FIM-m, FIM and BI over 10 weeks from baseline did not show statistical difference between the 2 arms. In fact, both arms showed similar improvements in motor impairment and disability, and the improvement was faster in the first 5 weeks.

3.3.5. Conclusion: Based on the findings of this trial, it was concluded that the addition of traditional Chinese manual acupuncture on the body with standard therapy treatments has no additional value to standard post stroke motor rehabilitation.

3.3.6. Discussion: This is a clinical trial of acupuncture on stroke rehabilitation with a negative result.

Although the study has strictly followed the principles of Evidence Based Medicine (EBM), it is still not a double-blinded trial, and the sample size remains small. Besides, there are many different combinations of acupoints nowadays; the negative result of this study should be treated with caution.

4. Survey

4.1. Purpose

This survey aimed to investigate the preference and experience of individuals across the Asian and Western societies regarding the use of Traditional Chinese Medicine (TCM) and Western Medicine (WM).

4.2. Design

The survey was a cross-sectional study, using a self-administered online questionnaire. It covers seven questions, namely:

1. Where are you from?
2. How well do you know TCM?
3. Have you ever used TCM?
4. If yes, what did you use?
5. How well do you know WM?
6. Have you ever used WM?
7. Which one do you use if you are ill?

The survey intends to answer the following questions:

1. Is there a difference in choosing the treatment modalities of TCM and WM between Asian society and the Western society?
2. Which treatment modality, TCM or WM, is more popular in Asian and Western societies?
3. Whether acupuncture is a common therapy for those who choose TCM treatment?

The survey could give us an insight into whether advocating integration of acupuncture into Western Medicine for stroke rehabilitation is feasible and practical.

4.3. Data collection

Data collection took place over a five-week period and was conducted online using a secure survey platform, Google Forms. Participants were recruited through convenient sampling methods, primarily through personnel networks and social media. Informed consent was obtained from all the participants before the survey.

Data collection took place over a five-week period and was conducted online using a secure survey platform, Google Forms. Participants were recruited through convenient sampling methods, primarily through personnel networks and social media. Informed consent was obtained from all the participants before the survey.

4.4. Results

This sample consisted of 123 participants, with approximately 60 respondents from the Asian society, mainly from Hong Kong and Singapore, and 63 respondents from the Western society, mainly from the UK.

Data analysis involved the use of statistical software to calculate the data, including percentages, for various survey questions.

The details of the results are expressed in the following table.

Questions		**Asian Society**	**Western**	**Society**	**Others**	**No. responded** 123
1. Where are you from?						
Respondents No.		60		59	4	
Percentage		48.80%		48%	3.20%	
2. Do you know TCM well?						60+63
Very well	Respondents No.	6		1		
Percentage		10%		1.60%		
Fairly	Respondents No.	25		7		
Percentage		41.70%		11.10%		
Not well	Respondents No.	29		55		
Percentage		**48.30%**		**87.30%**		
3. Ever used TCM?						60+63
Yes	Respondents No.	39		7		
Percentage		65%		11.10%		
No	Respondents No.	21		56		
Percentage		**35%**		**88.90%**		
4.If yes, what did you use?						38+11
Acupuncture	Respondents No.	8		0		
Percentage		**21%**		**0%**		
Herbal Medicine	Respondents No.	20		2		
Percentage		53%		18%		
Other unclassified	Respondents No.	10		9		
Percentage		26%		82%		
5. Do you know WM well?						60+63
Very Well	Respondents No.	14		16		
Percentage		23.30%		25.40%		
Fairly	Respondents No.	39		28		
Percentage		65%		44.40%		
Not Well	Respondents No.	7		19		
Percentage		11.70%		30.20%		
6. Ever used WM?						60+63
Yes	Respondents No.	57		46		
Percentage		95%		73%		
No	Respondents No.	3		17		
Percentage		**5%**		**27%**		
7. Which to use if ill?						60+63
TCM	Respondents No.	1		0		
Percentage		**1.66%**		**0%**		
WM	Respondents No.	31		55		
Percentage		**52%**		**87.30%**		
Both	Respondents No.	28		8		
Percentage		46.66%		12.70%		

Table Survey Results

4.5. Findings

A significant difference was found between the Asian population and the Western population in their understanding and choosing of TCM. While 48.3% of Asian respondents do not know well about TCM, as high as 87.3% of Western respondents know little about TCM. In addition, while 35% of Asian respondents have never used TCM, as high as 88.9% of Western respondents have never used TCM. These data suggest that as compared to the Asian population, most of the Western population neither know nor use TCM.

Second finding is WM is still the treatment of choice in both societies, as only 11.7% and 5% of Asian respondents do not know WM well and never used WM, respectively. In contrast, 52% of the Asian population and 87.3% of the Western population will use WM alone in case they fall ill.

The third finding is among the various modalities of TCM, only 21% of the Asian population and none of the Western population have chosen acupuncture.

The fourth finding is as compared to using TCM alone, there are 46.66% and 12.7% of the Asian and Western population, respectively, who choose a combination of WM and TCM, when they fall ill.

4.6. Discussion

This is a cross sectional study of a small sample size. Due to limited resources, the survey was primarily distributed to individuals within the researcher's personal network and social circles in Hong Kong, Singapore, and Liverpool. This recruitment strategy may introduce selection bias, as the respondents may share similar characteristics, viewpoints, and backgrounds. Consequently, the survey may not fully reflect the views of a wider population.

This survey highlights that it will be a great challenge if we wish to push for integration of TCM with WM in a Western population.

On the other hand, the data shows there is still 12.7% of the Western population who wish to use combination therapy when they become ill. If more well designed randomised controlled trials of acupuncture on stroke rehabilitation could prove its effect, its integration into WM is likely to be welcomed in the Western population.

5. Interviews

5.1. Purpose

To understand how the acupuncturists and Western trained doctors look at the issue of whether acupuncture can be integrated into western stroke rehabilitation, interviews with both parties were conducted. It aims to gather their views on the issue of integration, its benefits, and potential difficulties. Through these interviews the researchers could also have better ideas how to design related clinical trials in the future.
It is noteworthy that some of these interviews were originally conducted in Chinese and subsequently translated into English by the author.

5.2. Interview with a western medicine practitioner

A GMC registered senior geriatrician from Hong Kong was interviewed. He acknowledges the rich history of TCM suggests that certain TCM treatments, like acupuncture, may hold promise for stroke rehabilitation.

However, one of the key concerns is on the quality of data available to evaluate the effectiveness of acupuncture in combination with Western stroke rehabilitation protocol. Western medicine typically uses observational studies, which involve large patient cohorts. Treatments are initiated and the progress is monitored. Its efficacy is evaluated through statistical analysis. However, when it comes to acupuncture treatments, the available data often lacks the depth and consistency needed for an analysis.

Nonetheless, it's important to acknowledge that there is some evidence, often based on case studies, suggesting that acupuncture can benefit stroke rehabilitation. The challenge is to validate these claims through more scientific research on integrating acupuncture into Western stroke rehabilitation.

As a medical professional himself, his primary objective is to enhance the well-being of his patients. He is open to exploring treatment options that can optimise the patient's recovery.

In conclusion, he believes that we should remain open to the possibility that acupuncture could play a valuable role in stroke rehabilitation. At the same time, we should acknowledge the importance of scientific studies to prove acupuncture's efficacy for stroke rehabilitation.

5.3. Interview with an acupuncturist

A UK registered acupuncturist was interviewed. She believes that acupuncture holds a distinct place within healthcare practice. In her opinion, while Western medicine undoubtedly plays an important role in managing infections and acute conditions, its effects decrease overtime. This is where acupuncture shows its advantage, offering sustainable wellness.

Acupuncture operates on the principle of harmonising the body's energy channels.It enhances the body's own potential for self-healing. It also serves as a diagnostic tool, able to identify which energy channels have been out of balance by presenting symptoms.

Acupuncture is a highly personalised treatment in healthcare. Acupuncturists meticulously tailor treatments to the patients, based on which energy channels are imbalanced.

She went on to list some illnesses that acupuncture helps. For example, acupuncture can aid in fertility, offering hope to those who wish to conceive. Acupuncture has also brought relief to individuals suffering from vertigo, often with remarkable relief after just a few sessions. Its potential to reconnect disrupted neurological pathways makes acupuncture a good tool for stroke rehabilitation.

Regarding one of the principles of therapy in Western Medicine, namely the repeatability of therapeutic effect, she admits that the effectiveness of acupuncture is somewhat variable, depending on the individual's responsiveness and the complexity of one's body.

Finally, she noted an encouraging trend that some acupuncturists have been working with the National Health Service (NHS), offering integrated medical care, despite various remaining hurdles and funding issues.

Looking forward, she believes that public perception, with some individuals remaining sceptical about acupuncture, and financial constraints may hinder the integration of acupuncture with Western medicine. To promote greater awareness and acceptance, it is essential to engage in dialogues, encouraging individuals to consider diverse treatment options, including acupuncture, especially in cases where Western medicine may fall short.

6. Conclusion

The literature review suggests that acupuncture may have additional benefit to standard stroke rehabilitation, so it should be integrated into Western Medicine, provided its efficacy can be further confirmed. Without other convincing methodology than the evidence-based medicine, we should carry out more well designed, randomised controlled trials to prove its efficacy.

The survey shows the public in the UK does not know much of TCM and has seldomly used it. Even those who have used TCM, seldomly choose acupuncture. Therefore, if we wish to integrate acupuncture into stroke rehabilitation in the UK, more promotion and education are needed before we can persuade the health care provider to fund this initiative.

The interview part well illustrates the difference on how to move forward between western medical practitioners and acupuncturists. The former believes "we should acknowledge the importance of scientific studies to prove acupuncture's efficacy for stroke rehabilitation", whereas the latter believes "it is essential to engage in dialogues, encouraging individuals to consider diverse treatment options". Both comments are constructive, and based on non-maleficence and beneficence, continuing well designed acupuncture clinical trials on stroke rehabilitation while allowing selected stable stroke patients choose acupuncture with informed consent appears to be the way forward.

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