Investigating patients' experiences of receiving acupuncture treatment in a multi-bed clinic: A case study of the Dragon Acupuncture Project, Brighton.

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Abstract

A case study conducted at the Dragon Acupuncture Clinic, Brighton, a non-PCT funded low-cost multi-bed acupuncture clinic, explored patients' positive and negative experiences of receiving acupuncture treatment in such a space. Questionnaires surveyed the demographic of DAP patients, attempted to quantify positive and negative experiences, and open-ended sections amassed richer, qualitative data. Semi-structured interviews explored topics raised in the literature search and the surveys in more detail. Results: The data revealed that reduced cost of treatment at the DAP means patients are benefiting from treatment who may otherwise not have been able to, or are having more frequent treatment. Some patients were concerned about talking openly to their practitioner in earshot of other people. Others were distracted by other people in the space, but many felt the space was relaxing. Although the practitioners at the DAP treat up to three patients per hour, few patients felt denied attention by their practitioner and many particularly liked having time in their treatment when their practitioner left them alone. Patients seeking treatment for complex or mental/emotional problems felt the limitations of the set-up of this type of clinic more than those seeking treatment for simple or musculo-skeletal problems. Many patients expressed enthusiasm about the 'community' ethos of the clinic. Conclusions: This model for the provision of cost-effective acupuncture treatment is effective and is benefiting patients. There are implications around confidentiality, and this model could be adapted to increase patient satisfaction in this area. More research is needed to quantify patient satisfaction with aspects of care in this type of clinic, and this could be used to instigate and monitor changes for better practice.

Introduction

Background to this study: Acupuncture treatment in the UK

Acupuncture treatment in the UK has most commonly been provided in private practice, whereby one practitioner treats one patient at a time in a private room, and often stays with the patient in that room throughout the whole treatment.

In China, cost- and patient-effective treatment models have evolved over time to the current fairly stable norm. These days, patients usually receive acupuncture treatment in large rooms with several beds – that is, a 'ward', just as medicine is provided in Western health services such as the NHS. This enables one doctor to treat several patients simultaneously. Acupuncture lends itself to this style of treatment, as needles often have to be left in the body for 10-20 minutes to take effect. During this time, as the patient rests, the doctor is free to treat another patient.

Recently, some practitioners/clinics have been adopting 'Chinese-style' models for the provision of acupuncture treatment in the UK. These may provide more cost-effective treatment and may allow the dissemination of the benefits of acupuncture and Chinese Medicine to a broader section of the population.

Multi-bed clinics in the UK

The Gateway Clinic, Lambeth, London

The Gateway Clinic (hereafter called the Gateway) was founded by John Tindall in 1990. It is funded by Lambeth, Southwark and Lewisham Primary Care Trust (PCT), and lies on the grounds of Lambeth Hospital. In 2004-5 the clinic received £94,000 of funding and treated over 400 patients per week (Thomson, 2005), which is a cost of £4.52 per patient per treatment. All patients must be referred by a GP within the local catchment area and can receive 12 treatments per referral. Patients with HIV and Hepatitis C are given priority, can jump the waiting list which is often several months, and can receive unlimited treatments.

The clinic consists of a large room with nine beds, some of which are separated by screens. Another large room serves as a waiting room, and a 'drop-in' ear-acupuncture clinic. There is a small room where patients can talk to their practitioner in private if necessary, although this is not encouraged. There is an office/staff room and a kitchen. The clinic employs several practitioners and is also popular for newly-qualified practitioners to intern. Each practitioner treats up to 3 patients per hour.

The Dragon Acupuncture Project, Brighton

The Dragon Acupuncture Project (hereafter called the DAP) was founded in 2003 by Nik Tilling and Calum Thomson, and is Britain's first well-established non-PCT funded multi-bed acupuncture clinic. Largely following the Gateway model, the practitioners each see up to 3 patients per hour. The DAP receives no funding, and charges patients

£12.50 per treatment (since Feb 2006, before that £10). Patient numbers have climbed steadily over time and the clinic now treats more than 100 patients per week. Patients self-refer and there is no upper limit to the number of treatments they may receive.

The clinic consists of a large room containing 5 beds, some of which are separated by screens. There is a waiting room and a room where patients can talk to their practitioner in private if necessary.

A small number of other multi-bed acupuncture clinics are appearing in England.

Literature review

Published debate concerning or challenging the norms of acupuncture provision in private practice in the UK is scanty. Giovanni Maciocia, in comparing practice in China and the UK, observed that, "You call weekly treatment proper treatment for here, but that's created by social circumstances. We're in private practice and people can't afford to come more often. If they could they would come every other day" (Kaptchuk et al, 1985). Cost effectiveness is a major issue for the wider dissemination of Chinese Medical practice in the UK, whether within the NHS or not. There is a body of work investigating the provision of cost effective CAM treatment in the NHS, largely sponsored by the Prince of Wales's Foundation for Integrated Health (FIH) (Smallwood, 2005; Halpern, (2001); Ong and Banks, (2003)), and the Gateway Clinic is praised for being effective in this area (Deadman, 2003). Rarely is the possibility mentioned of using this successful model more widely within or outside of the NHS, however. Halpern (2001) does not

describe the model by which Channel PCG provided "an acupuncture service that treated 768 patients per year at an average cost per patient of £11.43" (p16), and one can only assume it is not in one-to-one practice.

Halpern's study (2001) looked at PCG (Primary Care Group) plans for CAM services in the NHS around the time of the changeover of the last government and discovered that investment plans exhibit prejudice against CAM therapists. "To gain acceptance CAM therapists need to bridge the cultural divide between the populations of the typical GP practice and the parallel universe of the private CAM client base. This means demonstrating a willingness to tackle the problems that are PCG priorities such as deprivation and health inequalities. Some CAM therapists are already coming to terms with these issues. After years of being considered as fringe medicine, there is a danger that CAM services will have only succeeded in evolving into fringe healthcare. Based on the analysis of primary care investment plans, the future of NHS CAM services will depend ultimately on the ability and willingness of CAM therapists to tailor their services to meet the needs of the NHS" (p21). Evidently all services within the NHS must aim to be cost-effective, patient-effective and equitable. Some CAM practitioners who prefer to work outside of the NHS are also taking on these concerns. In either case, successful healthcare will surely aim to balance provision of best quality care for patients with financial concerns.

The exploration of patients' expectations and experiences and the development and use of patient satisfaction surveys is a relatively new and important field. Patients' reports have not traditionally affected healthcare provision. However, recent studies show the

dominance of patient satisfaction as a key indicator of service quality and the success or failure of improvement initiatives (Gourdjii (2003), Chin-hua (2003), Burney (2002)). The NHS Plan (Dep. Of Health, 2000) emphasized the importance of patient-centred care, and of the involvement of patients in consultation, planning and monitoring of change. The fact that patients and healthcare professionals often have different perceptions of what constitutes quality care is interesting and important to remember (Lynn, 1999; Turton, 1998). Chin-hua et al (2003) discuss the influence of patients' expectations on their satisfaction with care; expectations balance needs or desires and may be based on prior experience or idealism.

In the acupuncture field there is an ever-growing body of literature concerning treatment outcomes, sometimes measured by patient satisfaction. Fewer studies (eg, Xing, 2006; Peace, 2002) have investigated the expectations and satisfaction of acupuncture patients with aspects of care beyond the medical effectiveness of their treatment. Because multi-bed acupuncture clinics are a relatively new and rare phenomenon in the UK, it appears that no research has yet been undertaken concerning patients' experiences of receiving treatment in such spaces. Three articles exist describing the set-up and audit of the Gateway clinic (Deadman, 2003; Tindall, 1994, Joire, 2002); research is currently being undertaken there concerning medical outcomes; but no research exploring patients' needs, expectations or satisfaction has yet been conducted.

Xing and Long (2006) used non-qualitative postal questionnaires to measure patient satisfaction not just with treatment but other aspects of care at the student teaching clinic

at Salford Univeristy, and discovered, for example, that patients appreciated been listened to, were happy with the physical environment, and found the sessions relaxing and enjoyable. However, the authors felt that open-ended questionnaires would have revealed "important variations in perspective and meanings".

Peace and Manasse (2002) described the assessment process at the Cavendish Centre for Integrated Healthcare, a charitable centre in Sheffield offering limited sessions of complementary therapies including acupuncture to cancer patients. Patients were interviewed and completed an in-house designed initial questionnaire, detailing their hopes, needs and concerns around their illness and receiving treatment, then completed a follow-up questionnaire after their course of treatment. Results showed that concerns such as stress, depression and general coping strategies sometimes improved even when patients' physical well-being did not.

Various qualitative and quantitative methods have been used to research and explore patients' expectations, needs and satisfaction with services. Qualitative methods included open-ended questionnaires (eg, Bailey, 2005) and interviews (eg, Douglas and Douglas, 2003; Peace, 2002). Quantitative methods included questionnaires derived for example from on-line resources such as SEQUS software (eg, Burney et al, 2002; Goudji et al, 2003) or modified from resources like MYMOP (Measure Yourself Medical Outcome Profile) (Peace, 2002). Most studies included some demographic data.

Uptake of CAM services has been shown to be mostly among the middle class population (Peace, 2002; Zollman and Vickers, 1999), about 55-65% by women, and by patients with higher levels of education than those who access conventional care. Little research has been conducted into how ethnicity affects CAM uptake. These studies do not report how socio-economic class affects expectations of or satisfaction with care.

To some extent expectations and needs will be specific to the type of institution (CAM, NHS, private, etc) offering care and to the type of complaint being treated. However, Ong and Banks (2003) showed that patients expect "four major factors which impact on all healthcare interventions, whether orthodox or CAM: a comprehensive examination; a satisfactory diagnosis; effective treatment interventions; freedom from unwanted side-effects" (p14). Note that Ong and Banks do not include concerns beyond medical care here. Niles et al (1996) discovered that cardiac patients use six criteria to evaluate the quality of care they received in hospital, namely comfort, convenience, caring, communication, certainty, and cost. Chang (1997) prefers a "nine-dimension taxonomy" to describe how patients perceive nursing care. What is clear is that patients (and researchers) assess quality of care in different ways (Chang, 1997; Sitzia, 1997).

The literature demonstrates that certain needs, expectations and concerns are important to patients across the board. The physical environment in which patients receive care is a major concern (Douglas, 2005; Bailey, 2005), and has been shown to directly impact on healing and patient well-being (Hutton, 1995). Douglas and Douglas (2003) used qualitative semi-structured personal interviews to investigate patients' expectations and

attitudes to built hospital environments in Salford, "to determine factors that contributed to their experience within that environment." (p62). They discovered that a reduction in stress is a factor in patient recovery, that patients desire a pleasant, uncluttered and quiet physical environment and appreciate thoughtful design. Bailey et al (2005, p323) make the point that "While tangible components of service quality such as physical environment are among those most readily controllable, they also are among those least studied as attributes of patient satisfaction." The cleanliness of areas like washrooms is also important (Gourdjii et al, 2003). Patient satisfaction surveys in this area are starting to be used to arrive at optimally designed hospital environments (Douglas, 2005).

Studies (Bailey, 2005; Hale, 1996; Douglas, 2005) have shown that excess noise is stressful to patients. "Staff conversations and activity [are] among the most significant contributors to hospital noise levels and the contributor considered most disruptive by patients" (Bailey, 2005, p322). This will be relevant in multi-bed acupuncture spaces.

Privacy is a top priority for patients. Douglas and Douglas (2003) found privacy to be a main concern in hospital wards although patients did not all want single rooms to themselves as some preferred a higher level of social interaction. Some patients tailored their expectations, and felt that providing a single room for all patients was not financially realistic. Patients were shown to be more likely to withhold information when talking to clinical staff in curtained-off areas than in areas separated with solid walls (Barlas et al, 2001). This is relevant to clinics like the Gateway and DAP; but patients were also strongly positively affected by staff sensitivity to this issue (Bailey, 2005).

Indeed, sensitivity and professionalism of staff is universally shown to be important to patients. This includes the amount of time given for a consultation by doctors and CAM professionals: the fact that CAM consultations are often long and detailed, giving the patient sufficient time to feel 'heard', and that a good relationship between practitioner and patient is seen to be an essential part of the clinical process, are quoted as important reasons why patients' access CAM services (Ong and Banks, 2003). Practitioner empathy is central to providing high quality care; the practitioner should be constantly "attentive to new cues", that is, avoiding the "routinisation" of the healthcare encounter. Successful relationships aid healing, and the practitioner-patient relationship is most transformative and therapeutic when such skills as mindfulness, respect, active listening and sensitivity are utilized (Miller and Crabtree, 2005). Zollman and Vickers (1999) describe how patients' needs go beyond technically effective clinical care. Patients feel better when illness is explained in terms they can understand and that resonate with their experience, when their emotional, spiritual and existential concerns are attended to, and when they are encouraged to be involved in their own healing by being recommended lifestyle changes, etc. Although this article describes these things in relation to patients' positive reasons for choosing CAM, it states that these qualities should ideally exist too in conventional care. Ong and Banks (2003) suggest that integrating CAM into the NHS risks undermining "two of the most valued aspects of the CAM experience: the practitioner/patient relationship and time" (p15). Nursing care in NHS studies (Bailey, 2005; Douglas, 2005) is shown to be most important in influencing patient satisfaction, even when other factors such as physical environment are less than ideal, and that

sensitising staff to their impact on patients is an important part of training, morale and the provision of excellent care.

In conclusion, there is a wide body of literature investigating the needs, expectations, experiences and satisfaction of patients with many aspects of care in the NHS. This is the case because of recent political pressure for care to become patient-centred. There is a paucity of work of this sort in the field of acupuncture. Acupuncture/CAM has normally been provided in private clinics. This is beginning to change, partly due to the integration of CAM into the NHS. Despite the documented cost-effectiveness of multi-bed acupuncture clinics there has been no research to date looking at how provision of acupuncture in such clinics is perceived by patients.

Rationale for this study

This research falls against a background of imminent statutory regulation of the profession of Acupuncture and Chinese Medicine; of the greater integration of acupuncture and other CAM services into the NHS; and of a highly-educated population that is now much more willing and able to make choices about their own healthcare. Models of provision of acupuncture treatment have been adapted in some cases such as the Gateway and the DAP. As the provision of acupuncture and Chinese Medicine becomes accessible to the wider community, it is important to monitor the cost- and patient-effectiveness of different models. There is currently a paucity of such work in the field of acupuncture.

Aims and objectives

The aim of this research is to investigate patients' experiences, feelings and expectations about receiving acupuncture treatment in a multi-bed clinic, that is to say, in a room with several other people at one time. The objective of the research is to use patients' descriptions of their positive and negative experiences to aid reflective practice in multi-bed clinics, to begin to provide criteria by which patient satisfaction could be monitored and to aid the process of improvement of quality of care.

Research questions

What are patients' experiences of receiving acupuncture treatment in a multi-bed clinic? If patients have also received acupuncture in a private clinic, how do these experiences compare? Is a multi-bed clinic chosen only because of low-cost, or are there other positive aspects of being treated in such a space? Conversely, if patients chose a multi-bed clinic because of cost, do they feel they have to suffer any negative aspects of that type of space, and if so, what are they? What lessons can be learned from pioneering multi-bed acupuncture clinics, in order to help improve quality of care for future clinics of this kind?

Significance of this research

This research will, for the first time, examine the effectiveness of multi-bed acupuncture clinics from the patients' perspective. This treatment model has already been shown to be highly cost-effective to the NHS at the Gateway clinic (see above).

In the present healthcare climate, research that demonstrates a cost-effective and patient-effective model for the delivery of acupuncture treatment has the potential to aid the dissemination and benefits of Chinese Medicine throughout our community.

The author's position as researcher

From the outset, I wish to be clear about my position in this research project. I have built a good rapport with patients at the DAP in the 18 months I have worked there. I chose to conduct this research at the Project because it enabled me access to a large pool of subjects who were willing to aid my research process. Any effects of my position as researcher and DAP employee will be discussed later (see Discussion).

Methodology

Research design

The aim of this research is to investigate what experiences patients had when they received treatment at the DAP in a room with several other patients at the same time, and, if patients had also been previously treated privately, how these experiences compared and which were preferred.

The DAP was chosen as a case study because of the author's employment there. The author's good rapport with DAP patients meant they were willing to take place in research. Unfortunately, time constraints prevented other clinics such as the Gateway from being included in this research.

Questionnaires and semi-structured interviews were chosen as the most suitable methods to collect the data. These methods have been successfully used in many studies (eg: Douglas, 2003; Peace, 2002; Bailey, 2005). Neither MYMOP nor SEQUS were used as a basis for the questionnaire design, as they focus too clearly on medical outcomes and hospital environments.

The literature search revealed themes that were important to patients in the provision of good treatment, beyond effective medical outcomes. The most consistent and therefore important were: privacy, quality of the relationship between practitioner and patient, and a pleasant and stress-free environment. These themes were used to design an original

questionnaire which was partly open-ended. The questionnaire was checked by collegues at CICM and the DAP. (Questionnaire can be found in Appendix I.)

For each question (example: "Are there any (maybe unexpected) positive aspects you have discovered about having treatment with other people in the same room?"), a list of possible responses was offered. This method was chosen to make the questionnaire quick and easy to fill in. Each respondent could tick as many responses as applied to him or her in each case. For each appropriate question the respondent was invited to add any extra relevant information, allowing for the gathering of richer, qualitative data.

The initial survey asked for no demographic data apart from respondents' sex and age. This was later felt to be a serious omission and was collected in a second short survey.

The same basic a priori themes of privacy, quality of relationship between practitioner and patient, and physical environment shaped the semi-structured interviews. Each interview covered these topics; this increases the scope for comparability of responses between interviews. Interviewees were also encouraged to talk about other topics of personal interest, which may not have been previously identified by the literature or surveys, creating the possibility of richer data. This was important as pre-defining and prompting all the topics under discussion presupposes one knows what is important to interviewees: the literature has revealed that health-care providers often have different ideas of what constitutes good care than patients do.

First survey

The first survey took place in July 2005. Only patients over 18 years of age were chosen as this simplified ethical issues. Only patients who had already received at least two treatments at the clinic were chosen, so they had formed more than a first impression of the DAP. Participation in the survey was voluntary. A covering letter explained the reasons for the research and that patients' responses would be confidential. Patients were not asked to put their names on the questionnaires.

60 questionnaires were handed out. Of these, 53 were returned. Most patients completed the questionnaires immediately at the DAP, and handed them back to the author personally; 8 took them away and returned them later. One questionnaire was incomplete, so was discarded. Therefore 52 questionnaires were analysed.

Interviews

At the end of each questionnaire, respondents were asked to indicate if they would be willing to be interviewed. 20 indicated affirmatively, and from these, 7 interviewees were chosen, not randomly, but intending to mirror the demographic of the DAP, by gender and age, as it had appeared in the first survey. This was important as it maximized scope for collecting data from varied perspectives across age and gender. Selection from available candidates was reasonably successful, and the following people were interviewed (names have been changed to protect identities):

- Rachel. Female, 36 years.
- Robin. Male, 35 years.
- Jules. Female, 58 years.
- Ali. Female, 30 years.
- Catherine. Female, 34 years.
- Jim. Male, 52 years.
- Sharon. Female, 39 years.

5 interviews were conducted in the homes of the interviewees, 1 in the author's home and one at the DAP 'out-of-hours'. The interviews were recorded and transcribed. Interviewees were assured that their identities would be kept secret. This was achieved by using false names on cassettes and transcripts from the outset. Tapes of the interviews were kept under lock and key, and were destroyed on completion of the research. Each interviewee signed a release form allowing verbatim quotes from their interview to be used.

Second survey

The second survey, collecting more detailed demographic information (sex, age, qualifications, income, ethnic group; occupation was not added as the census categories were felt to be hard to define and difficult to replicate) was conducted in February 2006. Where possible and appropriate (ethnic groups, qualifications) the categories used were similar or the same as those used in the most recent census, to allow for easy comparison with census results. (Questionnaire can be found in Appendix I.)

60 questionnaires were handed out to patients at the DAP. 57 were completed and placed in a 'ballot'-style box to maximize confidentiality (see discussion). When all the questionnaires were completed, the results were analysed and compared with the 2001 census results for Brighton and England.

Analysis of the qualitative data

The qualitative data was analysed manually by codes, with material pertinent to each code being extracted and placed into individual files. This process was first undertaken using the codes which had emerged from the literature. The data was then surveyed again and any other emerging codes were identified and the same process of collecting all relevant material into files was followed. As the data was collected, summaries of themes, stories and quotes were made, and then condensed. At each stage of this process, the reports of various themes were checked against the original transcripts to ensure they faithfully represented patients' experiences and concerns.

Computer packages were not used, as it was felt that they can remove the researcher from the material, such that nuances in the data might be missed. Also, the qualitative data was of a volume that allowed a manageable manual analysis.

Results

Graphical display of demographic data

Full 2001 census results can be accessed from **http://www.statistics.gov.uk/census/**

All percentages have been rounded to 1 decimal place

	DAP survey 1	DAP survey 2	DAP: average of 2 surveys	Census: Brighton and Hove	Census: England and Wales
Male %	34.6	26.3	30.5	47.7	48.5
Female %	65.4	73.6	69.5	52.2	51.5
Aged 18-30	19.2	22.8	21.0	15.4 (aged 18-29)	15.0
Aged 31-40	38.5	49.1	43.8	22.7 (aged 30-44)	22.6
Aged 41-50	15.4	17.5	16.5	17.6 (aged 45-59)	18.9
Aged 51-60	17.3	5.2	11.3		
Aged 61-70	5.8	3.5	4.6	4.8 (aged 60-64)	4.9
Aged 71-80	3.8	1.7	2.8	9.1 (aged 65-74)	8.4
Aged 80+	0	0	0	10.9 (aged 75+)	7.6

Fig 1. The above table compares sex and ages of DAP patients with census results from 2001 for Brighton and Hove (includes Worthing and Littlehampton) and England and Wales. The first DAP survey was carried out using the age categories listed on the left; only the second survey aimed to be comparable with census results. It was decided to leave the DAP age categories consistent, so they are not unfortunately directly comparable with the census results.

Qualifications attained (highest level)	DAP patients	2001 census results:	
		Brighton and Hove	England
No qualifications %	3.5	25.0	29.1
Level 1 %	1.7	16.1	16.6
Level 2 %	21.1	19.5	19.4
Level 3 %	7.0	9.8	8.3
Level 4 / 5 %	66.7	23.0	19.8

Fig 2. Table comparing qualifications attained by DAP patients, Brighton and Hove residents and nationally. Explanation of Levels 1 – 5 may be found in Appendix II.

Ethnic group	DAP patients	2001 Census: Brighton and Hove	2001 Census: England and Wales
White UK %	80.7	91.4	87.5
White other %	14.0	4.5	3.8
Black / Black UK %	0	0.5	2.2
Asian / Asian UK %	5.3	1.3	4.4
Chinese / Chinese UK %	0	0.4	0.4
Mixed race	0	1.4	1.3
Other	0	0.5	0.4

Fig 3. Table comparing the ethnic groups of DAP patients with Brighton and Hove and nationally.

Monthly income	DAP patients %
£ 0 – 500	24.6
£ 501 – 1000	21.0
£ 1001 – 1500	14.0
£ 1501 – 2000	17.5
£ 2001 – 3000	17.5
£ 3000+	5.2

Fig 4. Table showing the monthly income of DAP patients. There was no comparable data in the 2001 census. The Annual Survey of Hours and Earnings (ASHE, 2005) showed that median weekly pay for full-time employees in the UK was £431 (£471 for men; £372 for women), equivalent to £1868 per month.

Graphical display of quantitative survey data

Patients were invited to tick each statement that applied to them in the 'multiple-choice' style questions, so the overall total number of responses may exceed the number of questionnaire respondents (52) in any such question.

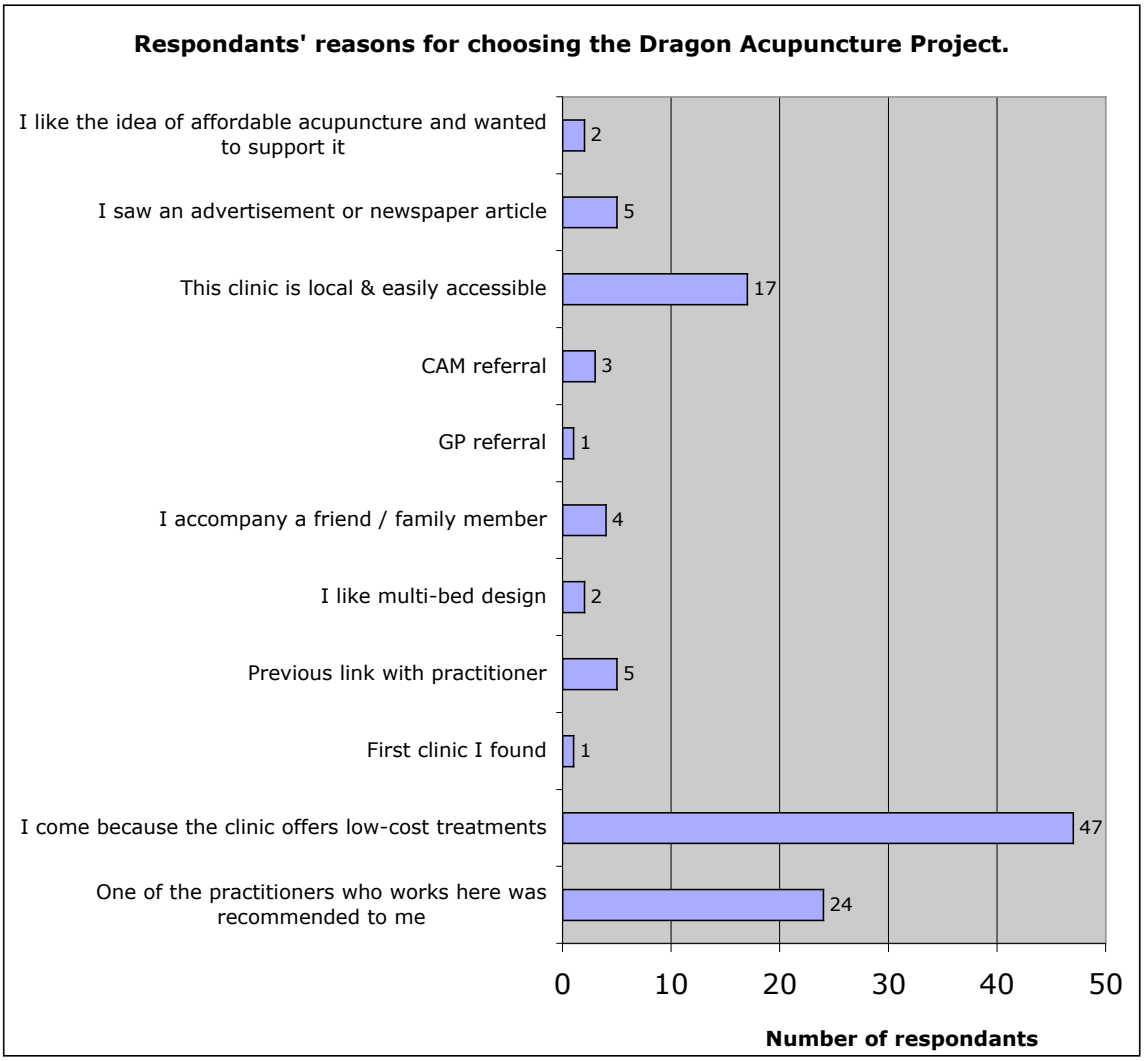

Fig 5. The above table shows that the low cost of treatment is important to a high number of DAP patients, while the multi-bed design is not, initially at least.

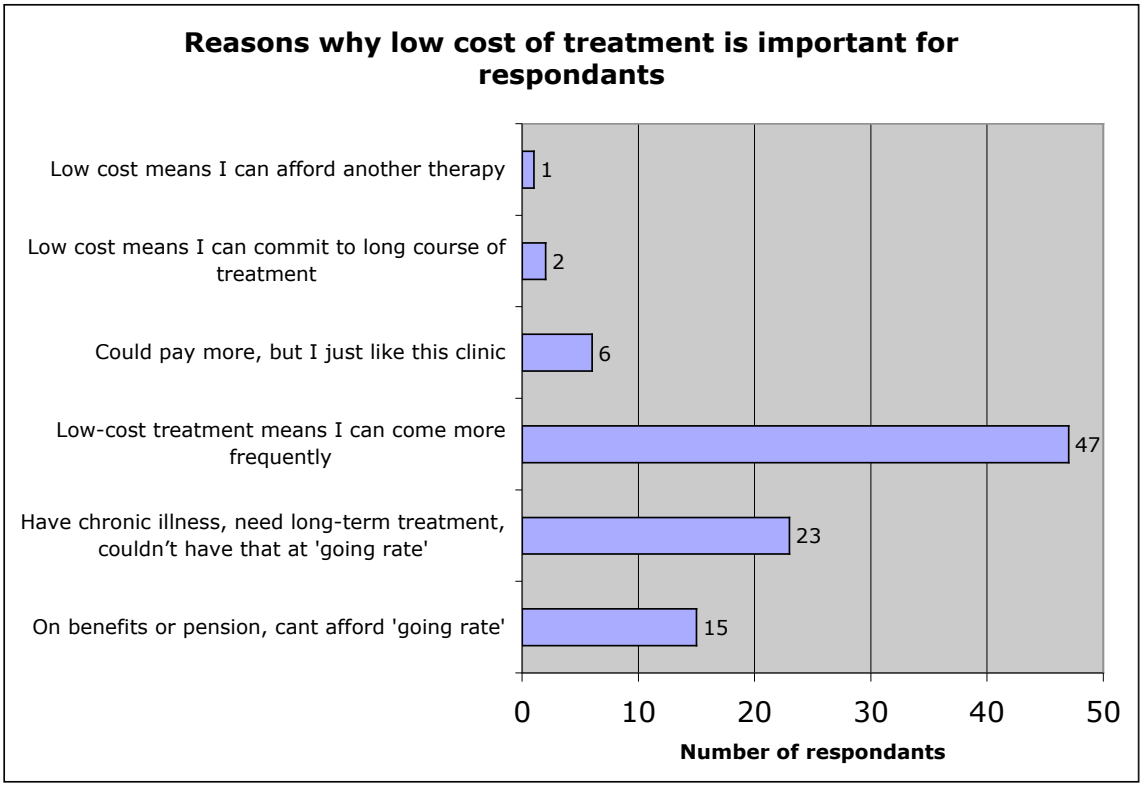

Fig 6. The above table shows that low treatment cost impacts on patients mainly by making treatment affordable at all and by making frequent treatment possible.

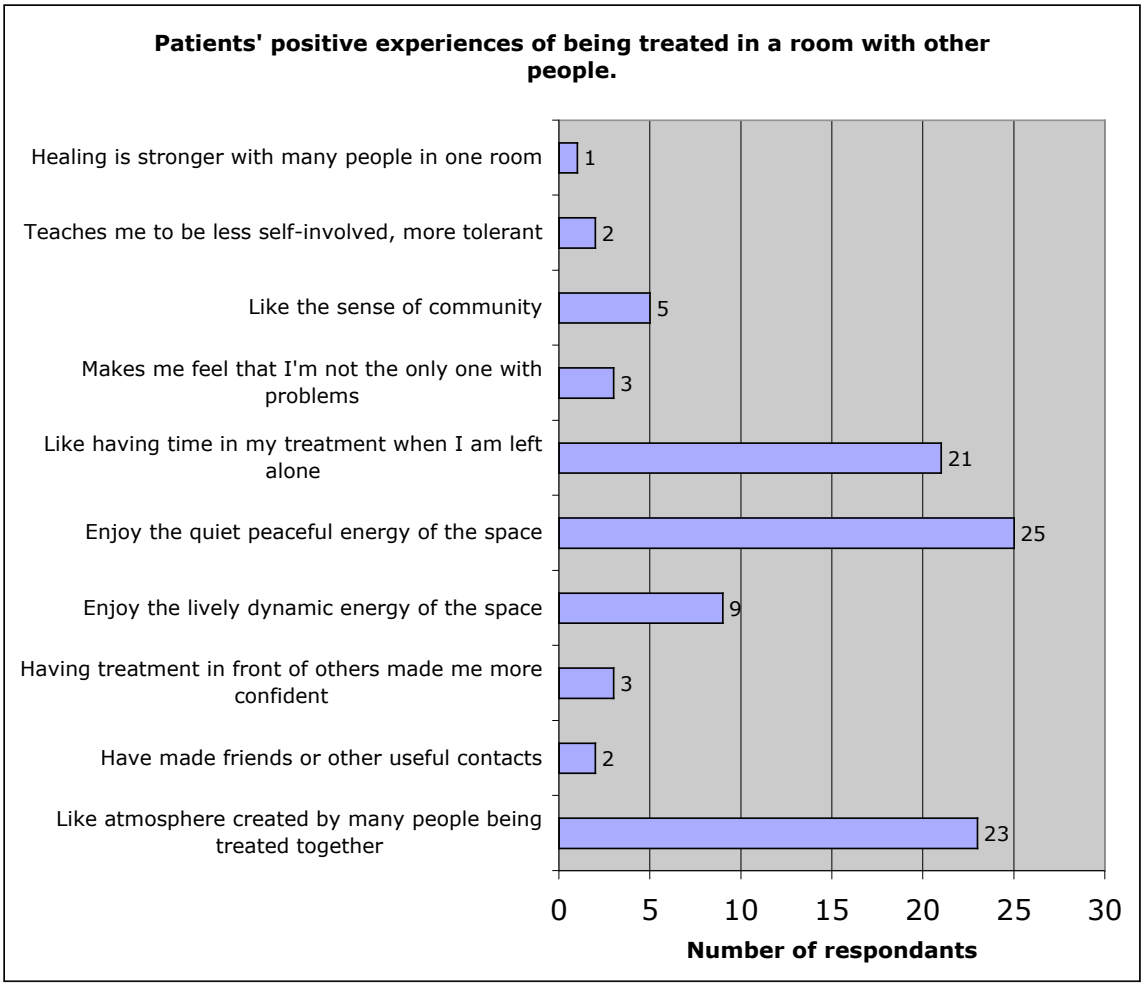

Fig 7. The top four themes in the above table were not suggested on the questionnaire (see Appendix I), but were added by patients themselves. The total number of 'positive experiences' recorded in this question is 94.

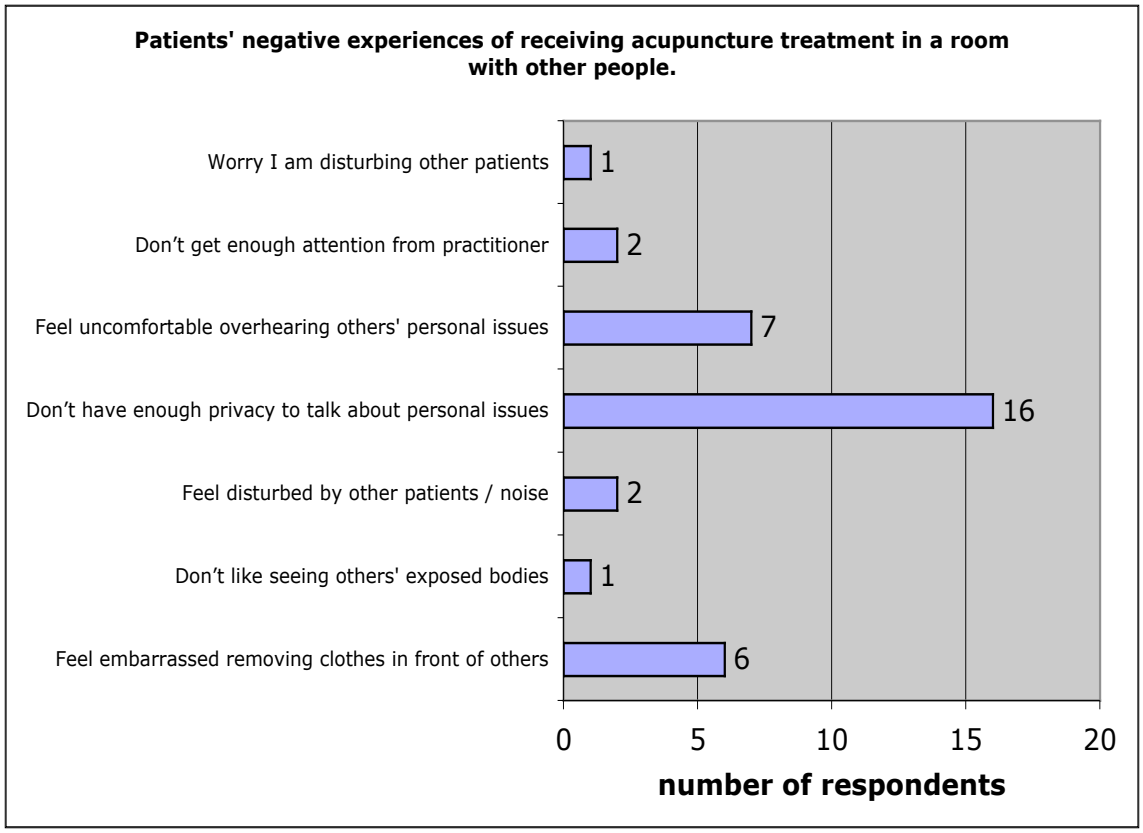

Fig 8. The above table shows that confidentiality is a concern for a significant proportion of DAP patients.

The total number of 'negative experiences' recorded in this question by patients is 35, compared with the total of 'positive experiences' being 94 (see Fig 7), which indicates that patients at the DAP are more likely to have (possibly unexpected) positive experiences than negative when being treated in this way.

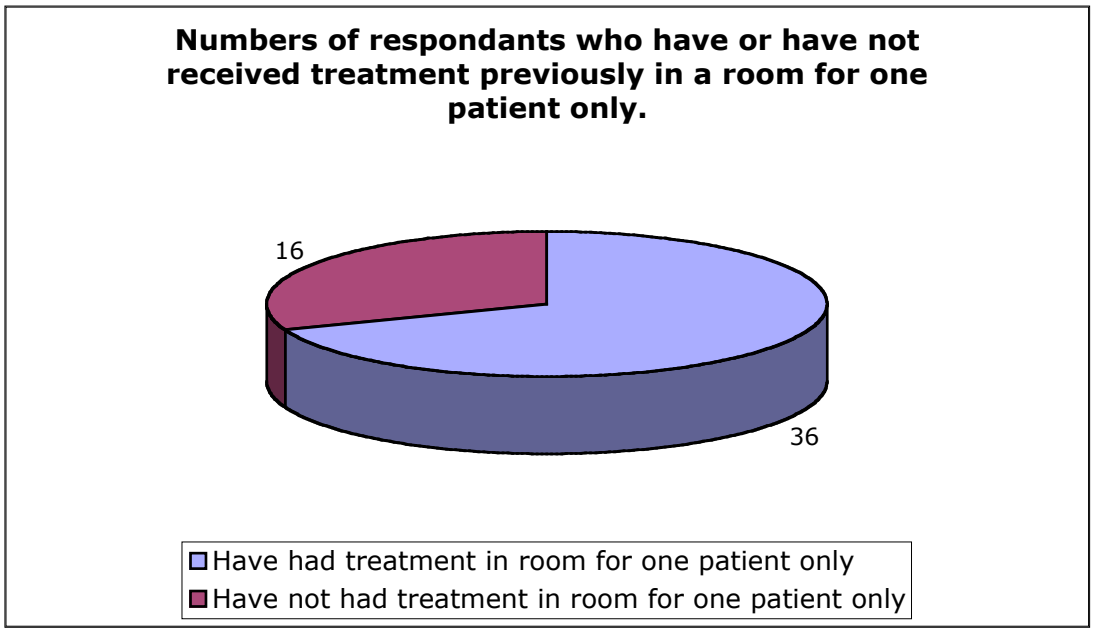

Fig 9. The above table shows the proportion of patients who had experienced private treatment in the past.

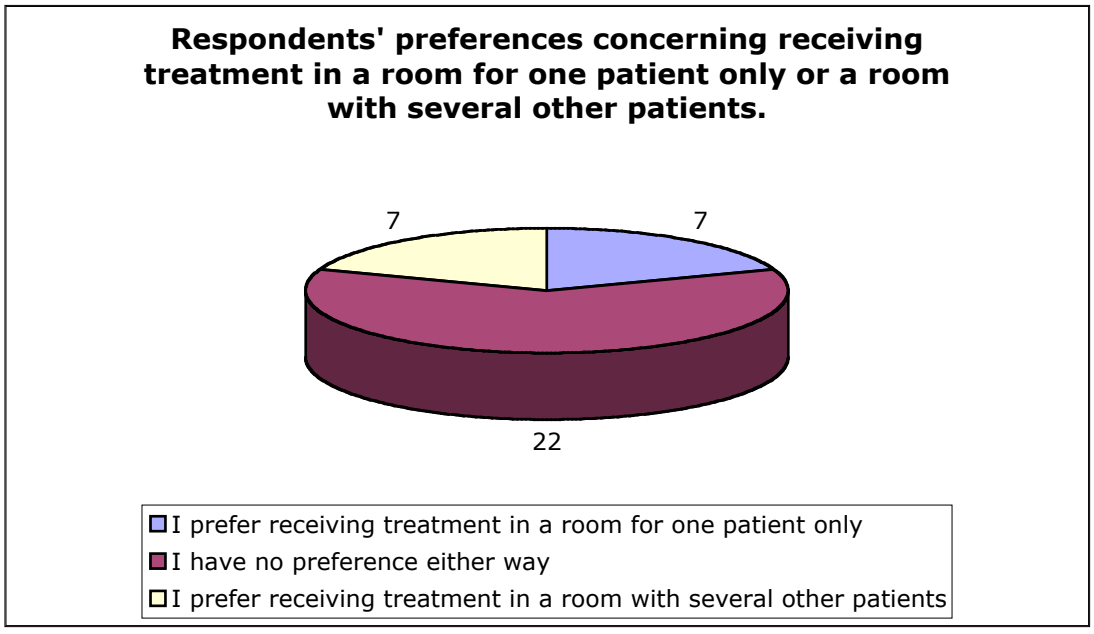

Fig 10. Of those 36 patients who had received private treatment in the past, the above table shows their preferences for different styles of acupuncture treatment.

Analysis of qualitative data

Privacy

Privacy matters to DAP patients in the areas of confidentiality, issues around removal of clothes, and awareness of the close proximity of other patients. 15 patients added extra statements on questionnaires on the subject of privacy, and of the 7 out of 52 questionnaire respondents who said they would prefer to have treatment in a private room, all gave privacy as their reason.

Confidentiality

Of the three themes mentioned above, confidentiality or, rather, having the confidence to speak without worrying about others overhearing, was most commonly mentioned by interviewees and questionnaire respondents alike.

Many patients had not experienced problems with confidentiality themselves, but significantly were still aware that the issue could be difficult for others. For example:

But I'm sure that a lot of people do need a lot more space, and they don't have the courage or the opportunity to say that without making it sound like a big deal, and possibly it's not a big deal anyway. (Alison)

Patients need different levels of privacy depending on their reason for seeking treatment. Robin felt less troubled talking within earshot of other patients when he was being treated for his back, than for a prostate problem. Two patients felt the clinic was best suited to

treating simple, physical problems for the same reason. A patient reported talking about sensitive issues "in a whisper". Others admit to feeling the lack of privacy, but variously report getting used to it, changing the focus of treatment "to health more than emotional issues", or rising to the challenge of this new experience of breaking down barriers.

I think it is positive to be seen in our conditions by others. It humanizes illness and distress and unifies us. (Male, 33)

Private space is available to talk in if patients need it. Being offered this space when she needed it enabled Catherine to feel safe and supported and she appreciated the sensitivity of her practitioner at this time. Jules also states that making patients feel safe and comfortable is of prime importance and is the job of the practitioner.

Rachel felt deprived of privacy when she encountered a work colleague she 'struggled with' who was also having treatment. Another patient (female, 35) worried that this could happen to her. Rachel also felt her privacy was compromised when another patient who had overheard her conversation wanted to talk with her after treatment.

I came out and this lady stopped me in the hallway… And that really took me off… I kind of really wondered where my privacy was. (Rachel)

Several patients, who may not have had confidentiality issues themselves, suggested that having a small room where one could talk privately before each treatment, or receive

treatment alone, would be beneficial, although, like others, Catherine is clear about the realities of providing low-cost treatment.

There's no way you would be able to offer a clinic at such low cost if you had individual treatment rooms. That's the compromise you have to make, to come. You have to weigh up the benefits. It's either that or no acupuncture. (Catherine)

Removal of clothes

Six out of the seven patients interviewed felt "completely comfortable" with their own and other's sometimes semi-clothed bodies in the project. They reasoned that past experiences (eg "being dragged to nudist beaches with my parents"), "just generally not being shy" and of being experienced body-workers themselves helped them feel comfortable. Jules emphasised that just because some people are comfortable, one must not assume all will be and that staff and patients alike must be sensitive to each other around this issue. Indeed, one body-sensitive patient cites possibly having to remove more clothes as a reason she might stop coming for treatment at the DAP.

Several patients suggested on their questionnaires that having screens in the space would make patients feel more comfortable if they had to remove clothes. (At the time of the first survey, the DAP had no screens.) Two interviewees discussed how screens can create a compromise between having the space be totally open and using individual treatment rooms, making this treatment model viable.

Awareness of other patients in the space

Patients have varying reactions to overhearing other's personal conversations. Some patients empathise…

When I hear others talking about personal issues, I worry that they must feel confined or exposed. (Female, 29)

… while others feel the effects on themselves.

Straining to hear other people's sensitive and personal issues is a bit distracting. (Female, 64)

Several patients made the point that being distracted by others during treatment makes it harder for them "to relax and let go". Four patients said that "switching off" or "going in to a meditative state" is an important part of acupuncture treatment and that is difficult in the DAP. Jim experienced being disturbed by another patient's distress, and Robin felt irritated by a patient's very vocal reaction to needling. For example, Catherine felt her "energy being drawn to other people and their stuff" and found this negatively impacting on her treatment.

I think to be honest if I was in a room completely by myself and I was able to shut myself down, I would gain more benefit from the treatment. (Catherine)

There is an awareness amongst patients that acupuncture treatment can bring up difficult feelings. Some patients felt that "having treatment in a room with lots of people feels more supportive", but others felt the lack of privacy most acutely at these times.

It's very vulnerable. I guess I didn't realize how vulnerable acupuncture was 'cause I'd never experienced it before… I know that day I was very aware of people being around me and I just wanted to get out. If I could have disappeared that's exactly what I wanted. (Rachel)

Abuses of dignity

Sharon alone raised another point. Having experienced an abuse of dignity when she was being treated in private practice in the past, she felt safer and more comfortable being treated in a room where there were several other people at all times, "because the chances of these kinds of abuses happening is so much reduced".

Practitioner availability and rapport

No patient felt that they had received inferior treatment because of reduced practitioner time, but there is a sense among patients that this type of clinic lends itself to certain types of treatment, namely simple or physical problems that require less intense patient-practitioner involvement. Patients having treatment for mental-emotional complaints demanded more time and sensitivity from their practitioner than those being treated for physical complaints. On one hand, these patients were more likely to express dissatisfaction with the amount of contact they had with their practitioner, but on the

other they expressed gratitude at being able to access acupuncture at all as they felt this had not been possible elsewhere.

Two interviewees told how they now chose to be treated at private clinics. For example:

I wanted to go more into my emotional stuff… I've got a rapport with my new practitioner that goes deeper than I could have got… not with the practitioners, but at that clinic. It's difficult to say, but it's the environment. (Robin)

Jules is happy with the amount of time she has with her practitioner, but qualifies this with the fact that acupuncture is not her only therapy and that she "knows [her] body so well". She is happy with the exchange of less practitioner time for affordable treatment, and feels that patients need to be pragmatic about how the Project works and realistic about their own needs.

And I have an understanding of why it is that I get the time I do… how it comes to be accessible because of that format, and it's such an efficient use of time. But I think you've got to realize that if you could do with more personal attention, or you're very vulnerable, or you're not comfortable with other people in that space, then it is one-on-one you need, and then you've just got to pay for it.

Alison feels that the amount of time provided for each treatment necessarily creates upper limits on practitioner/patient rapport, although she describes modifying her expectations, which she sees is…

…part of the deal, with the low cost, and there are times when I'd like more time, obviously… but you kind of expect it because you're not paying that amount of money, so there's going to be less time.

Sharon is aware of the time constraints, and of "…feeling guilty about taking up too much of their time if you feel like you're running over", but is grateful for the service the DAP provides, and has also modified her expectations to fit the model. The result of this is, therefore, a feeling of having enough time with her practitioner.

Alison, like several others, sees being left alone by her practitioner during her treatment as a positive aspect of this treatment model. Several patients who had been treated privately report feeling compelled to chat with their practitioners and this negatively impacting on their treatment. They feel that treatment at the DAP is "less intense", allowing for deeper relaxation.

The physical environment

Several patients did have comments to make about noise. For example, Alison felt that most of the clinic's noise came from having the initial talk between patient and practitioner in the main treatment room, and thought it would be ideal to do that in

another space. This is important to her as "… seeing everybody else makes me feel a bit more excitable, whereas what I need is to be quiet." She is aware that, unfortunately, extra rooms are not available at this location at present.

Catherine also feels reducing chatter in the treatment room would positively impact on her treatment. However, she justifies the noise in the space as being part of the "whole package" and diverts the conversation to the fact that the clinic is in a "great location".

Patients are less tolerant of chatter which is not related to treatment. Jules felt that the space can get overly 'lively' if patients who are friends are treated at the same time. She thought a certain amount of noise was okay, but that patients need to keep noise to an 'appropriate' level so treatments are not hindered. Sharon states:

Again I think it's something you learn to do is to talk in quite a low voice, like in a hospital ward. But sometimes when I've overheard people's very loud conversations, not their confidential ones, but their other ones, I've found it a bit disturbing to my peace of mind.

Robin felt disturbed by practitioners 'talking shop' in earshot of patients, which he felt added to the noise levels of the clinic, and was 'inappropriate'. Beyond this, he described the DAP as "never overly noisy. It was a calm place to go to."

Two patients commented that the central location is invaluable. However, "in summer it's either very hot or very noisy" (Sharon) as the clinic is next to the main road. Jim doesn't seem to want to make a serious issue out of this, though, and contradicts himself:

It doesn't bother me. Ideally it would be a nice quiet place, but I like the buzz. It is a bit noisy and it does get hot in the summer.

At the end of the survey, patients were asked what changes they might make to make the DAP a "more comfortable or successful treatment space" and most of the responses concerned the physical environment of the clinic, in such ways as wanting screens or more space between beds, a larger and more comfortable waiting area, double glazing to keep out the traffic noise and ventilation to keep the heat down in summer and help cope with the 'overpowering' moxa.

A sense of community

A positive sense of community was commented on by a significant number of patients. Alison commented:

But actually one thing I do get from the Dragon Project, which I think is really important, is a sense of community, which is why I like going and which I don't think you get anywhere else, and I think people are really lacking that in this day and age. Even if you don't know people you see the same faces every week. And it's

across the ages too, it's not just young people or old people, there's a complete mix. I think that's really essential.

11 out of 14 respondents who added extra comments to the survey question "Are there any (maybe unexpected) positive aspects you have discovered about having treatment with other people in the same room?" referred to the community ethos of the DAP. For example:

I like the sense of 'oneness' with my fellow humans it seems to impart. (Male, 47)

It makes treatment less isolating, puts my own treatment into perspective. Makes me feel less precious and self-involved. (Male, 47)

Some patients, particularly those with long-term illness, simply appreciated the social aspect of the project and enjoy the "friendliness of the clinic with people chatting and enjoying each others' company, it seems". (Female, 70)

I like people, that's why I like the Dragon Acupuncture Clinic really. (Alison)

One patient compared the "sense of ordinariness rather than privilege and luxury" that the clinic creates, to the NHS "in its positive aspects". (Female, 41)

There is a political/ideological appreciation of treatment being made available to a wider section of the community. Three patients referred to this when they added extra comments in response to the question "Why did you choose this clinic?" For example:

I like the idea of a cooperative venture that aims to make acupuncture affordable to all – not just middle class people with plenty of disposable income. (Female, 50)

Some patients have a sense of 'feeling involved' in a worthwhile venture, and are making an ideological gesture by supporting the clinic.

There's a kind of collective feel about getting treatment in a room with other people. And it is that sense of… that it's a clinic that's dedicated to the welfare of a wider community, in the same way that a doctor's surgery is, you kind of feel a part of something bigger. (Sharon)

Other patients simply expressed gratitude that they were able to have regular treatment.

…there's an appreciation for the work the Project has achieved and I have a lot of gratitude. **(Jules)**

Discussion

Discussion of results

Demographics, cost of treatment and income of patients

The patients who seek treatment at the DAP match the typical pattern for CAM users, in that they are predominantly female and highly educated in comparison with the national average. However, the data show that approximately 60% of DAP patients earn below the national monthly average. The high level of graduates at the DAP (66.7% compared with a national average of 19.8%) indicates that most DAP patients are likely to be 'middle class'. CAM uptake is shown to be highest among middle and upper socio-economic groups. So, the DAP seems to provide the well-educated and lower-paid with the independent acupuncture treatment they desire. The implication of this may be that, even when (CAM/) acupuncture treatment is provided at low-cost, it is still accessed by predominantly middle-class patients, perpetuating its status as a 'niche' service.

Low cost of treatment is significant to a high proportion of DAP patients, either in giving those on low incomes or benefits access to treatment at all, or in permitting patients to access treatment at the frequency they feel is necessary but which they would otherwise be unable to afford. In this way, the DAP can be said to be successful in offering a patient-centred service that aims to provide for optimal treatment intervention.

The fact that 5.2% of DAP patients earn more than £3000 per month would suggest that low-cost of treatment is not a concern to all DAP patients.

Discussion of themes revealed in the data

The literature review revealed that privacy and confidentiality, quality and sensitivity of the patient-practitioner relationship and time available during treatment, and the provision of a pleasant and quiet physical environment were perceived by NHS patients (and CAM where the research was available) to be most important in the provision of high-quality care (beyond effective medical outcome, which is not included in the scope of this research). These themes were investigated in the survey and interviews. The data collected in this case-study also revealed that patients considered the 'community' aspect of the DAP to be highly significant. These themes will now be discussed separately.

Privacy

Privacy is a major concern for NHS in-patients, but they also value social contact. A concern that is particularly relevant to multi-bed acupuncture clinics is that NHS patients have been shown to withhold information when they think other people can overhear, although this is positively affected by staff sensitivity. Patients adapt their expectations of levels of privacy because of awareness of costs and past experiences.

Privacy is a top concern for DAP patients too, although in different ways to those investigated in the literature. This is obviously because of the DAP being a non-NHS, independent out-patient clinic where patients stay for a maximum of 1-2 hours. This is

the first research into the implications of privacy and confidentiality in multi-bed acupuncture spaces. The survey clearly shows that confidentiality is the single most common concern that caused patients to report a 'negative experience'.

Some interviewees had not experienced any problems with confidentiality, but were mostly being treated for straightforward physical complaints. As patients required more emotional support or had to reveal very personal information, the implications of being treated in close proximity to other patients became more evident. This shows that both patients and practitioners need to be realistic about the limitations of confidentiality in this type of clinic. How to deal with this – provision of private spaces, for example – is up to each clinic. Patients should be made well aware of the set-up of the multi-bed clinic before they commence treatment, as this will constitute an aspect of informed consent.

The literature did not show that revealing their bodies is a main concern of NHS patients, presumably because sufficient screens are always available to preserve dignity. Screens were not available at the DAP at the time of the data collection, and this is one example of this research succeeding in its aim of facilitating reflection and promoting better practice: it quickly became clear that providing screens at the DAP would dramatically increase patients' sense of dignity, safety and feeling cared for. Screens are now available.

NHS patients were not shown to be sensitive to overhearing other patients' personal conversations, but this was a concern to many at the DAP. This may be due to a

perception among CAM users that part of successful treatment is quiet 'me' time, creating an expectation that this will be provided. It is interesting that patients have not modified this particular expectation, where they have modified others. A certain level of distraction in such a clinic is inevitable. Staff and patients alike should be sensitive to this issue and to the needs of other patients.

Practitioner availability and rapport

The literature demonstrates that a good relationship between practitioner and patient is one of the most important factors in patient satisfaction. A perceived good consultation/treatment is of sufficient length, more than just 'routine', with good communication skills and empathy from the practitioner. General sensitivity of practitioners and staff to the needs of the patient is as important as these other factors. Some patients chose to use CAM as they desire longer treatment times than they could have with a conventional medical practitioner. This is pertinent to the DAP treatment model, where practitioners are treating up to three patients per hour.

This research revealed that DAP patients seeking treatment for complex or mental/emotional complaints sometimes required more time and deeper rapport from their practitioners than those seeking treatment for more straightforward complaints. This is to be expected. An unexpected result is that over 40% of questionnaire respondents stated that being left alone during treatment is a positive and desirable aspect of receiving treatment at the DAP. This is backed up by about the same proportion of interviewees, some of whom feel that having a practitioner around throughout private sessions

negatively impacted on those treatments as it prevented relaxation. This may come as a surprise to CAM professionals who fear reducing contact time in treatments if their practice were to be integrated into the NHS, for example. The DAP patient still receives an initial consultation of about one hour, which enables them to feel 'heard' by their practitioner. Also the fact that patients can book longer sessions with practitioners if they need to is a strength of an independent clinic; although patients would pay more, they are empowered in that they can shape their treatment encounters.

Patients at the DAP appreciated sensitivity of practitioners around issues such as confidentiality and removal of clothes. From the data collected it is not possible to conclude whether or not sensitivity of staff was more important than any other factor in DAP patients' satisfaction with their care.

Physical environment of the clinic

The available literature showed that patients value receiving treatment in a stress-free, pleasant, clean and quiet physical environment, although little research has been carried out in this field, especially concerning acupuncture rather than NHS patients.

It is clear that a comfortable and pleasant space where patients feel secure is just as important to DAP patients as those in the literature. Robin's comments about practitioners 'talking shop' echo findings in the literature that staff conversations are very obtrusive to patients. Having areas that are clearly defined as being staff or patient spaces seem to help everyone feel secure.

Noise in the treatment space is definitely important to DAP patients. External noise such as traffic is disturbing. Other patients' conversations, whether personal or general, are significant contributors to noise in a space such as the DAP. Patients' reactions to this have been discussed earlier in this section in 'Privacy – Awareness of others in the space'.

A sense of community

This theme did not arise in the literature search. Perhaps this is because patients' no longer appreciate the marvel of the NHS as a provider of free healthcare to the whole community, but instead have high expectations of that care and often low satisfaction. Neither did this theme arise in CAM-oriented research as so much CAM provision is still in private practice and no research of this kind yet exists.

Few survey respondents specifically chose to be treated at the DAP because they desired a multi-bed space; this may be because many patients are unaware of the clinic design until they make enquiries and it is explained to them. However, some patients said that the ethos of the clinic had *become* a positive reason for them to be treated there and the large number of extra comments about the community feel of the clinic, its 'friendliness', the importance of its social aspect to those who are chronically ill, and the positive atmosphere created when several patients are treated together, shows how important this issue is to DAP patients. Interviewees echoed that feeling a part of 'something bigger' and less elitist was important to them. It would appear that some DAP patients feel

somewhat deprived of a sense of community in their daily lives and enjoy getting that from the clinic.

How do patients rationalise their beliefs and arguments?

It is possible that the novelty of this type of clinic and the appreciation of its ethos or ideology is used by patients as a way to rationalise lowering expectations of aspects of treatment such as privacy. Similarly many patients feel a lot of gratitude for being able to access acupuncture treatment at affordable prices, and may therefore be willing to accept lower standards of care than at private clinics. Perhaps if this type of treatment were available to all free of charge, expectations would rise and satisfaction would fall.

Preferences for treatment methods

The proportions of patients preferring private treatment and those preferring to receive treatment in a multi-bed clinic were identical in this study. All survey respondents who would prefer to be treated in a one-to-one clinic cited some aspect of privacy as their reason. Those who preferred treatment DAP-style cited the sense of community they enjoy there and not having to chat with a practitioner all through a private treatment. Those who had no preference all stated in one way or another that it is receiving good treatment that is important, not the set-up of the clinic.

Reflection on the research methods

The use of questionnaires and semi-structured interviews is felt to have been successful in collecting appropriate data to answer the research questions and thereby meeting the aim of the research to explore patients' positive and negative experiences of receiving acupuncture treatment in a multi-bed clinic. The qualitative data in particular was useful, as it is here that respondents seemed to truly express themselves, producing rich data that allowed themes to emerge beyond those found in the literature.

The use of more than one data collection method, or triangulation, may go some way to enhancing the validity of these results, as results arrived at from one method of data collection can be corroborated, or not, by data collected by the other method. In this study, the data collected from the questionnaires, which provided space for the addition of qualitative answers, were generally corroborated by the interviews, so neither one is considered here to have been more or less reliable.

How might the data have been affected by the methods of collection?

Collecting qualitative data necessarily involves the researcher in the research process and disallows disinterested observation. The data in this study may have been affected by the close working relationships the author built up with some patients over time, both as researcher and as employee of the DAP. Whether being interviewed or completing questionnaires, patients may have held back full and truthful opinions, either because of a desire to please, or for fear that their future treatments may be negatively affected if they were to criticize the DAP.

A process of learning occurred for the author concerning assurance of anonymity for patients taking part in the research. After completing the first survey questionnaires, which purported to be anonymous, patients were asked to hand them to the author, and it would have been obvious to these patients that their responses could have been glanced over immediately, therefore they could rightly have feared their anonymity was not protected. This was not a satisfactory state of affairs, so for the second survey completed questionnaires (also anonymous) were placed into a 'ballot box'. This was a much safer method of protecting anonymity.

The positive aspect of having good rapport with DAP patients resulted in patients being willing to be interviewed and in very high returns of completed questionnaires, namely 86.7% for the first survey and 95% for the second survey.

Sample used in the research

To date, the DAP has treated about 550 patients. Each survey 60 questionnaires were handed out and nearly all were returned (see above). Therefore each survey assessed about 10% of *all* DAP patients and a much higher proportion of patients seeking treatment at those times. It is felt that this sample size was large enough to be representative of DAP patients in general by age and gender.

It is obviously less than ideal that a second survey was conducted to collect information omitted in the first, because the sample was not identical for both surveys. It was useful to be able to average two amounts of data concerning gender and age of DAP patients. It

is impossible to determine here the exact implications of having two sample groups; for example, it is not possible to know if the proportion of graduates in the second survey is the same or different to the proportion of graduates in the first survey. The author relied on the fact that a large enough sample size was used both times to be able to generalise from each to DAP patients generally.

How much can this sample be generalised to the population as a whole?

The demographic data showed that DAP patients are predominantly female and middle class – a common demographic for CAM users; but also relatively low-paid, which is less common. The opinions given by DAP patients must therefore be judged as being true for that particular demographic. However, the concerns of DAP patients about issues like privacy, confidentiality, good rapport with practitioners, sensitivity of staff to their needs, and the physical environment in which they receive their care, were very concordant with those raised by other CAM and NHS patients in previous research. This gives some evidence therefore that the data collected in this study may be generaliseable to the general population.

Has this research been transformative?

One of the objectives of this research was to aid in reflective practice at the DAP. The research met this objective and has been a valuable learning tool. For example, practitioners at the DAP now understand better that they and patients may have different ideas of what constitutes good care and that asking patients what they want is the only way of truly finding out. Provision of privacy and confidentiality has improved by the

provision of screens which were repeatedly requested in the questionnaires, and by ensuring that patients are aware they can request private talking-space at any time.

Implications for practice of acupuncture

This research shows that the DAP is successful in providing acupuncture treatment at affordable prices to patients who may not otherwise be able to access such a service at all or with sufficient frequency. Also, the service is accessed by those on higher incomes. Patients report more positive than negative experiences of receiving acupuncture in such a setting and are very supportive of the ethos of the clinic. The author believes this research shows that, although there are certain implications of practicing in this way, this is a model of practice worth pursuing for the provision of acupuncture treatment.

Conclusions

The data from this case-study demonstrated that:

- DAP patients match the typical demographic of those who access CAM services in that they are predominantly female, predominatly of middle socio-economic, and are highly educated. However, a high proportion of DAP patients earn less than the national average.
- DAP patients share similar concerns to those shown to be important to NHS and non-NHS patients alike in previous research, such as privacy, confidentiality, the desire for a calm and pleasant physical environment, and a good relationship and treatment encounter with a sensitive and competent practitioner.
- The most pertinent of these concerns to many DAP patients was confidentiality, or the willingness to talk about sensitive or personal issues when others may overhear. This concern was the most likely to result in patients reporting a negative experience of receiving treatment in a multi-bed clinic. Sensitivity of staff to this issue is very much appreciated by patients, and it would appear that the availability of some private space where patients can talk confidentially is an essential component in providing patients with a sense of security and of being well cared-for.
- In this type of treatment space, providing screens between beds is important in helping patients feel secure and cared-for, especially when they have to remove clothes.

- Decreased contact time between patients and practitioners was far less of a concern than confidentiality. Indeed, being left alone by the practitioner for a time during treatment was seen to be a positive aspect of receiving treatment in the DAP by many patients.
- Many patients were very attracted to the 'community' ethos and the social aspect that the DAP provided and this had become a positive reason for being treated at the clinic.
- Patients preferences for receiving treatment in a private or multi-bed clinic were split exactly 50/50. Those preferring one-to-one treatment cited greater privacy as their reason; those preferring treatment at the DAP preferred a 'less-intense' treatment where their practitioners left them alone, and valued the community feel of the clinic; those who had no preference made the point that good quality acupuncture treatment is more important than the clinic set-up.
- The author feels that this model of treatment serves a wide section of the community successfully, and deserves to be pursued as a way to disseminate the benefits of acupuncture treatment. Arguably, this type of clinic is better geared towards the treatment of simple or physical complaints. However, creative and careful adaptation of this model should mean that more complex or mental/emotional complaints can be treated just as well, and that a section of patients in need can also receive the care they seek.
- This exploratory research now sets the path for more in-depth investigation into patient satisfaction with this type of clinic; this could be used as a way to arrive at and monitor changes for better practice. Research into successful and manageable

ways of increasing patients' confidentiality would be useful. Also, research into how such a clinic would fare in a non-middle class area would be helpful in planning future multi-bed clinics, and thereby continuing to disseminate the practice and benefits of acupuncture to ever wider sections of the community.

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Appendix I

First survey questionnaire

Survey of patients' experiences of receiving acupuncture treatment in different environments.

Please answer the questions below. Your answers will be completely confidential.

1. Are you male or female? (Please circle answer)

2. How old are you? …….years.

3. Why do you come to this particular clinic? Please tick as many answers as apply to you, and add more if you wish at the end.

- ❑ One of the practitioners who work here was recommended to me.
- ❑ I come because the clinic offers low-cost treatments.
- ❑ This was the first clinic I came across when looking for treatment.
- ❑ I have been treated by one of the practitioners at another clinic previously.
- ❑ I particularly like the idea of being treated in a multi-bed space.
- ❑ I accompany a partner, spouse, friend etc.
- ❑ I was referred here by my GP.
- ❑ I was referred here by another alternative or complementary health practitioner.
- ❑ I have a chronic illness and couldn't afford to have treatment 'at the going rate' on a long-term basis.
- ❑ I come here because I live locally and this particular clinic is easily accessible.
- ❑ Other……
  ……
  ……

4. In what way, if at all, is the low cost treatment important to you in choosing this clinic? Please tick only the answers that apply to you, and add more if you wish.

- ❑ I am on benefits or a pension and find it very hard to pay 'the going rate' for complimentary treatment such as acupuncture.

- ❑ Having treatment at low cost means I can afford to come more frequently, eg weekly, than I might otherwise be able.
- ❑ I could comfortably afford to go to a one-to-one clinic, but I like this particular clinic and choose to be treated here.
- ❑ Other……

  ……

  ……

5. Are there any (maybe unexpected) positive aspects you have discovered about having treatment with other people in the same room? Please tick only the answers that apply to you, and add more if you wish.

- ❑ I like the atmosphere created when many people receive treatment together.
- ❑ I have made friends or useful contacts with other patients.
- ❑ Having treatments in front of others has made me more confident in myself or about my body.
- ❑ I enjoy the lively, dynamic energy of this space.
- ❑ I enjoy the quiet, peaceful energy of this space.
- ❑ I like having time in my treatment when my practitioner leaves me alone.
- ❑ Other……

  ……

  ……

6. Are there any (maybe unexpected) negative aspects you have discovered about having treatment with other people in the same room? Please tick only the answers that apply to you, and add more if you wish.

- ❑ I feel embarrassed removing my clothes in front of other patients.
- ❑ I don't like having to see other patients' exposed bodies.
- ❑ During treatment I feel disturbed by the other patients close by.
- ❑ I don't have enough privacy to talk about sensitive or personal issues.
- ❑ I don't like overhearing others talking about sensitive or personal issues.
- ❑ I don't get enough attention from my practitioner because he is busy with other patients.

- Other……..……

  ……

  ……

8. Have you ever received acupuncture treatment in a room for one patient only?

- Yes
- No

9. If 'yes', how do you feel about receiving acupuncture treatment in a room with several patients compared to a room for one patient only?

- Overall, I prefer receiving acupuncture treatment in a room with several patients.
- Overall, I don't have a preference either way.
- Overall, I prefer receiving acupuncture treatment in a room for one patient only.

Please give reasons for your answer to question 9.

……

……

……

10. If you could suggest one change to this clinic to make it a more comfortable or successful treatment space in your opinion, what would it be?

……

……

……

……

……

11. Would you be willing to be interviewed about this subject?

- Yes
- No

Second Survey questionnaire

I am in the third year of an Acupuncture degree course. For my research dissertation, I am studying patients' experiences of receiving acupuncture in a multi-bed clinic like the Dragon Acupuncture Project. Some of you have already kindly completed a questionnaire for me.

Thank you for taking the time to answer these questions. Your responses to this set of questions will enable me to build an accurate picture of the backgrounds of people who use the Dragon Acupuncture Project. This may tell us how more clinics like the Dragon Project could succeed in other parts of the country.

I am aware that some of this information is sensitive in nature. Please be assured that your responses will be anonymous and completely confidential.

1. Are you… male or female ? (please circle)

2. How old are you? 18 – 30 31 – 40 41 – 50 51 – 60 61 – 70 71 – 80 >80

3. What qualifications have you gained? (Please tick the appropriate box(es)

- ❑ No qualifications
- ❑ At least 1 O level / GSCE / NVQ level 1 / Foundation GNVQ
- ❑ At least 5 O levels / GCSEs / CSEs / School certificate / at least 1 A level / NVQ level 2 / Intermediate GNVQ
- ❑ At least 2 A levels / at least 4 AS levels / Higher school certificate / NVQ level 3 / Advanced GNVQ
- ❑ First degree / higher degree / NVQ levels 4 or 5 / HNC / HND

4. What is your monthly income?……

6. What is your ethnic group? Please tick the appropriate box

- ❑ White UK
- ❑ White other
- ❑ Black / Black UK
- ❑ Asian / Asian UK
- ❑ Chinese / Chinese UK
- ❑ Mixed

Other, please specify……

Appendix II

2001 Census categories for qualifications achieved (to highest level):

Level 1 = at least 1 O level / at least 1 GCSE / NVQ level 1 / Foundation GNVQ

Level 2 = at least 5 O levels / at least 5 GCSEs / at least 5 CSEs / School Certificate / at least 1 A level / NVQ level 2 / Intermediate GNVQ

Level 3 = at least 2 A levels / at least 4 AS levels / Higher School Certificate / NVQ level 3 / Advanced GNVQ

Level 4 / 5 = first degree / higher degree / NVQ levels 4 or 5 / HNC / HND