

Working Towards Clinical Excellence: The Source Point Clinic

Abstract

This article is a transcription of an interview with Graeme McCracken, the founder and clinical director of Source Point, a ground-breaking multi-bed clinic in Devon (UK) that provides patients with affordable and accessible acupuncture and Chinese medicine treatment, while providing practitioners with a good wage, fair working conditions and a nourishing, educational and supportive environment. According to the Source Point business model, care of the practitioner is seen to be just as important as care of the patient.

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Figure 1: Collaborative clinical working at Source Point

PD: Graeme, you've set up Source Point – a really interesting and different kind of multi-bed acupuncture clinic in Devon [Southwest England]. What was your motivation?

GM: Some of my first experiences of acupuncture were observing in a multi-bed setting – even before I actually started my formal study of acupuncture. Then during and after I completed my studies I spent some more time in multi-bed clinics in Hong Kong and shortly after that I volunteered for a couple of years at the Gateway Clinic in London.

PD: What kind of clinic is that?

GM: It's a National Health Service acupuncture and herbal medicine clinic, the only one of its kind, it was run from Lambeth Hospital at that time. It had nine beds with two or three practitioners working together at the same time. Treatment was free at the point of delivery and it was a really dynamic environment to learn in. It was where I really learnt how to be an acupuncturist. I had all the theory but it was the doing it – seeing lots of patients with a supportive team around me – that was transformative. It showed

me that many patients could be treated in a quick, efficient and effective manner and how a practitioner can also be supported and cared for within a team. It turned me on to the idea that acupuncture doesn't need to be an isolating profession where all the learning is done outside the treatment room. It can happen in the clinic – learning from exchange with others, guidance, discussions and short conversations. This was so valuable to me in the first few years of practice and continues to be now since its been replicated at Source Point.



Figure 2: Graeme McCracken at work in the Source Point clinic

PD: I would say that what novice practitioners most need – and often find hardest to get – is clinical experience. They simply don't get to see enough patients. So you don't get that much clinical experience under your belt, whereas when you work in a busy multi-bed clinic you get to see a whole lot more patients.

GM: Exactly. It generally seems to take four to six years to build up a busy clinic and by that time people who've been treating just a few patients a week or have been off doing other things to make money, may have forgotten much of the skill set they learned when studying. It doesn't help consolidate the learning. One of the advantages of the multi-bed model is that we can provide this for novice practitioners – they get priceless supervision, support and clinical experience, and in return the clinic gets support from them.

When we set up Source Point our vision was that it had to benefit the patient and the practitioner equally.

PD: Often when people discuss multi-bed clinics, they focus on the advantages for the patient - they can come more often, more easily afford treatment etc. But it seems like you are focusing as much or more on the benefits for the practitioner.

GM: Absolutely. When we set up Source Point our vision was that it had to benefit the patient and the practitioner equally. Our mission document states that the clinic is set up to offer the local community affordable and accessible acupuncture and other Chinese Medicine modalities, while providing the practitioner with a fair wage and fair working conditions within an educational and supportive environment. We felt that most existing multi-beds focused almost exclusively on the patient but there was a vacancy when it came to supporting the nourishment of the practitioner. We recognised that one major impediment to this was low or irregular income, presenting a real financial challenge. Many practitioners depend on support from partners or other work to supplement their practice. Acupuncture alone is not a realistic option in its own right for many practising it. So we're trying to provide a regular and reliable income to practitioners. That way you know that every week you're going to get a certain income you can rely on.

PD: How does that work in practice?

GM: Firstly, all payment for treatment goes direct to the clinic, not the practitioner. Actually this touches on another issue. Being paid directly by patients seems to create a different relationship. When I was in private practice I observed that I would often take on treatments and patients even when it would have been better for me not to, maybe because I was exhausted or was meant to be doing something else. But I agreed primarily because of the money. And I noticed that even when I was devising treatment plans and deciding how often patients needed to come back, however hard I tried to disassociate from it, the money element would creep in or at least be hovering in the background in some way. Under the system we have now, whether a practitioner sees two or 25 patients, they get the same income. So the income goes into the clinics coffers and the practitioner is paid from the pot.

PD: I don't quite understand that. If all the practitioners only see two patients there wouldn't be much of a pot.

GM: It's generally expected that a practitioner will treat three or four patients an hour as long as there are sufficient numbers of patients. We pay £17.50 an hour plus some holiday and sick pay, and practitioners are also paid for administration work and to attend courses and clinic meetings. Overall they get a steady but lower hourly wage than in a busy 'normal' clinic, but they still get paid the same when the clinic is quiet because we ensure that the clinic's income is greater than the payments given out to the practitioner. We keep a reserve. The plan is to increase the wage to £25 per hour as the clinic continues to grow, which we feel will reflect better the value of a clinical acupuncturist. It does beg the question though –

'What is an acupuncturist worth?' – something few seem to ask, or answer with any realism! Anyway, it is also worth considering that the Source Point acupuncturist is paid for the majority of work done in and out of clinic, which is not the case in one-to-one clinical practice where the acupuncturist can spend many hours on administration such as bookings, accounting, website development, clinical research and so on, for no extra remuneration. When this is taken into consideration I would think £17.50 per hour is equal to or possibly more than is received by the one-to-one acupuncturist charging 40 to 50 pounds per hour for all work done, especially when the clinic rent is taken into account.

PD: So the issue of taking on extra treatment when perhaps you shouldn't doesn't arise.

GM: Right. You go to the clinic on specific days and hours and commit to X amount of hours admin work and that's it. When I was in private practice I was more fluid, often to my own detriment.

PD: What if patients come in late in the day without having booked and want treatment?

GM: Unless it's an emergency they're asked to come back another time. However, we do run one extra bed for overflow when it's busy and usually fit people in without much bother; we also have a free drop-in auricular acupuncture service they can use.

PD: So you're looking after your practitioners better than people usually look after themselves in private practice.

GM: Well, we try to, though it is surprisingly difficult. We are a small social business, so it often feels like there is more work to be done than people to do it. We don't have it right yet, but we are moving in that direction and are aware of some of the pit falls and our current shortcomings. Basically in this model the care of the practitioner is equal to the care of the patient. Source Point strives to embody a yang sheng (養生) view, where nourishment of our workers is at the centre, so that care goes both ways. Some of the ways this is done is by providing a stable wage, holiday pay, weekly CPD, one paid formal CPD course a year, free acupuncture for all workers, a clear and structured time for treatment, and an employed administrator to take the burden off the clinicians. We are also working to create a culture of support and comradeship. The system would only fall down if we don't have enough patients, since our outgoings are fixed. If we were quiet for a long period we would have problems, although this hasn't happened to us yet, though we have had a few moments of panic and it could happen easily enough.

PD: Which is interesting in itself since you work in a remote part of England yet you have loads of patients. How many practitioners do you have?

GM: We have three - soon to be four - regular practitioners and two locums to cover them. But we only open at present for 12 hours a week; we have had to cut back due to staffing and location problems. We see around 40 to 60 patients per week, give or take, despite being in a rural location. I think there's a belief in the profession that there aren't enough patients - that too many practitioners are being trained for too few patients, but this isn't true. There are lots of people out there wanting acupuncture but it's just not a financial reality for them. So we have acupuncturists not receiving nourishment and support in their clinical practice – feeling isolated and not making enough money - and a lot of potential patients out there who want but can't afford acupuncture. I think our clinic - working in a low-income, sparsely-populated rural area - proves that. When we take our model into the city it will be exciting to see how many patients we get.

PD: So your ambition is to roll this model out more widely?

GM: We've found a system that works – one that's scalable. With that said the whole thing is an experiment and therefore is in unknown territory and could fall apart at any time. What we need to make this work is courage people with passion, that's what is so great with what is happening in the States with the POCA (Peoples Organisation of Community Acupuncture) movement. They see the problems within the profession and are getting to grips with making changes to address it. Source Point is not interested in creating a franchise or getting rich out of this - we just want to help others create a practice that meets their own needs and those of their patients. At the same time, it's useful to pool resources. The idea we're looking at now is to set up a central hub – a Charity or Community Interest Company – which owns all the systems it's taken Source Point over four years to develop and myself 15 plus years to ponder. These include clinical methods, paperwork, data crunching systems, accounting, legal structures, the website etc. We hope new and existing clinics will decide to become members of the hub. Everything they need - including administrative and fund-raising support - comes from the hub and some income goes back from the clinics to support the hub. So instead of each clinic employing an administrator or paying for business development, the hub's resources will finance this. In the future we hope to be able to offer low interest loans or grants to support new clinics to start up and thrive in their early years – one of the hardest things for new practitioners and clinics.

PD: I don't understand how this model helps with the financial costs of setting up a clinic.

GM: Well it takes a lot of the work, costs and problems out. Like sorting out paperwork, websites, making flyers, signage; getting an external profile, accounting and data collection systems, digital booking systems, clinical systems ... Normally someone has to do all this and either an external person is employed and has to be paid, or else the practitioner will do it unpaid – often with little or no experience of doing anything like this before.

The other way that we hope to support new practitioners is by always having an experienced - 10 years plus - acupuncturist to work alongside them. In this way it is not one, two or more new practitioners fumbling around in the dark together; sure, this can work, but it's not as good as having someone who has seen it before and can support and guide, especially when it comes to utilising different techniques, prognosis and managing patient expectations. We are looking to create clinical teams that are supported by a network of other clinics and a central hub - we are stronger together – for both new and experienced practitioners can bring their strengths and weakness to this sort of environment.

The patient is told that their case (like that of all new patients) will be discussed at our weekly clinical meeting ...

PD: So to sum up, what you're saying is ... practitioners come out of college with very limited clinical experience, facing the challenge of setting up a business (which they probably also have no experience of doing), struggle to get patients and therefore income and clinical experience, struggle with issues of confidence and clinical knowledge, face doubts about their skills, and more. It's an enormous emotional, practical and financial challenge and as a result many give up after a short while. They also feel isolated from each other and may feel they're in a competitive relationship rather than a mutually supportive one. So your model seeks to address all these problems.

GM: Exactly! And even to go beyond that. We aim to improve on the conventional one-to-one clinical system by pooling experience to improving diagnosis, clinical methods, outcomes and so on ... Let's take the example of someone who comes to us with a complaint, say, 'I've got a bad knee, I've had it a couple of years, I can't really walk any more, I'm putting on weight and it's causing me to get depressed.' We do a full case history and then formulate a treatment plan as a response to the patient. For example, 'We think we can help, we anticipate it will take six twice

weekly treatments to get an initial change and in that time we anticipate you'll have less pain, and that the pain will be less diffuse and more focused on the medial side of the knee where the origin seems to be. You'll be starting to move more and this will help with losing the weight. In three weeks time on your sixth treatment we'll review your progress and see where to go from there.'

So we've offered a treatment plan, a prognosis and a time frame. The patient is told that their case (like that of all new patients) will be discussed at our weekly clinical meeting and the prognosis and treatment plan might be adjusted as a result of this discussion. The person who did the intake presents the case at the meeting, we discuss the case, see if there is any further information we need to gather and then decide whether we think the diagnosis and prognosis are correct, appropriate and realistic, and if we feel they aren't, we'll change them and inform the patient about the change. One thing we've discovered is that less experienced practitioners generally err on the side of caution, rather than excessive optimism, when giving a prognosis. So this might be changed, and the patient informed, as a result of the collective second opinion at the clinical meeting.

PD: Has it ever happened that a less experienced practitioner gives a prognosis but after discussion in the clinical meeting it's decided that acupuncture probably can't help at all?

GM: Yes. To carry on with the knee problem as an example, we might decide we can't help and need to refer the patient back to their GP for orthopaedic assessment. But at the same time we might also suggest that acupuncture can help with their associated exhaustion, stress, distension and weight gain. Or sometimes we simply say we don't know if treatment can help or not – it's up to the patient if they want to try. But even though we can find the process challenging, we believe that establishing a clear diagnosis and prognosis is vital.

From then on, the practitioner who does the initial intake will see the patient the first two or three sessions then a different clinician will see them as a matter of principle in order to get another 'second opinion' (the first being in the clinical meeting). This brings up another point, as introducing a different clinician at an early stage of treatment disperses both patient and practitioner dependency issues. We often think about a patient being dependent on their practitioner, not a good thing in our opinion, but I've observed that by sharing patients, we have done away with feelings of 'I have failed' if the patient does not get better, or 'I am a great acupuncturist' when they do. As it's a collective approach to treatment, there is very little 'I' in it - an interesting side effect. But going back to second opinions, the thing is that they go on all the time, as practitioners often informally discuss the

progress of the patients, there is also formal rolling second opinion systems in place to support both acupuncturist and patient. This all provides a real opportunity for the profession to move on from the guarded and isolating position of 'this is my diagnosis and treatment and I'm sure it's right'. It encourages us to be more open.

We've found this is a really valuable learning process. Some practitioners use superficial needling, for example, and some use deep needling and they can observe each others' clinical results and reassess their own (often fondly-held) opinions.



Figure 3: Clare Mulligan treating at Source Point

PD: How often are the clinical meetings?

GM: Two hours, once a week. Whenever possible all practitioners attend in person or online. And all are paid for attending - the same as the clinical rate.

We start the meeting by checking in on how each practitioner is doing that day. The reason for this is that we've observed that a clinical meeting can be a vulnerable place for a practitioner since they're putting themselves in a situation where they can easily feel exposed or judged. So we check in to find out how everyone's feeling and what's been going on in their lives. For example if I've been arguing with my wife for the past three days, people might understand why I'm seeming a bit irritable or defensive.

We then do 'point of the week' where one practitioner brings a point to discuss. We look it up in the books, locate it and discuss our own experience of using it. We may needle it and talk about different ways of utilising it – needling, rice grain moxibustion, bleeding etc.

We then have a 'clinical gem of the week' slot, which is open to any observation one of us wants to share. It might be theoretical or diagnostic, a way of treating, a needling technique, a particular patient someone has learned from or an article which has just been read...

PD: And presumably if people have been away on courses they feed back to the group ...

GM: yes. Then we go on to discuss every new patient, case by case, starting with age, appearance, way of moving, a sense of them as people, their symptoms and so on. We look over the diagnosis, treatment plan, treatment principle, prognosis and suggestions for points that should be included in every treatment – usually just a couple of points – to instil a kind of regular shape to the treatment, whoever gives it. We look at what happened during the first treatment and make suggestions about future visits.

Then we discuss upcoming reviews. For example, in the case of a person who is down to have six initial treatments for their knee pain, we discuss the case after the fifth treatment. We consider their progress and whether they might be due for discharge or a second course of treatment. Of course we always give patients the option to continue treatment for associated or underlying problems, even if their main problem is resolved. For example we might explain how that knee disorder was caused by an underlying Spleen or kidney deficiency which might also be causing other symptoms and which can be treated. Or we might suggest the patient goes into a maintenance programme - to be seen again in a few weeks for a 'top up'. But of course not every patient has the desire to deal with their deeper disharmonies, some just want their symptoms fixed, which is fine - it's their choice at the end of the day and we make sure we clearly give them that choice.

PD: Are there any special challenges you've found in working with this model?

GM: All models have challenges and we have two main difficulties: one is staffing the clinic and the second is practitioners with different styles of acupuncture.

When I set up Source Point I did not expect to have trouble finding acupuncturists to work there, for me it seemed to make a lot of sense – regular pay, working with others, being part of a dynamic and supportive clinical environment ... But for unknown reasons we have really struggled to find acupuncturists who are interested in working with us, and it really is working with us as we are a workers co-op so all workers own and have an equal say over the business. When we have advertised we have sometimes had zero, one or two responses, which has meant we have had to limit the days we can open and have not been able to grow the team. When we started I thought we would be able to find lots of people who are passionate about community acupuncture and social business. I did not realise then how naive this was. This has been very frustrating and has definitely stifled our growth. One of the reasons could be that we are quite rural, though to be honest, it seems to me that

the education most acupuncturists receive is a big part of this too. What the colleges give their students does not feed into a radical rethinking of the provision of Chinese Medicine. It's stuck in a one-to-one practice model, with stand-alone practitioners who are not educated in or encouraged towards group practice. This seems to lead to a profession with a distorted sense of self-worth. Even relatively new graduates with little experience seem to have been taught that they can command a wage equal to or more than an experienced physiotherapist or even doctors with nine years plus education ... I would like to see colleges cultivating a desire in their graduates to get stuck in to clinical practice and learn the medicine rather than limit their experience by demanding unrealistically high fees.

Rather than reducing the medicine to a few fragments, we can actually embrace the whole body of Chinese medicine and create a kind of clinical excellence that isn't possible in isolation.

PD: And your second challenge of acupuncture styles?

GM: Well, we communicate in terms of eight principle and zangfu differentiation because it's the one language we all share. Outside that we try to understand what each practitioner is trying to do with the styles and methods they have learned. I have a limited understanding of the 'CF' in five element acupuncture. It's not what I use but I know enough to be able to translate it back into the modalities I do use. But it's tricky. If a practitioner comes in with a very strong five element or other background and someone else is using zangfu differentiation, there may be a big difference in how they treat. This can be very challenging but it can also be very educational. For example, if a five element practitioner achieves a significant clinical result, it makes me look more openly at what they are doing. On the other hand, if someone has piriformis syndrome and a practitioner goes in with really deep needling into the piriformis plus ashi points, and they have really good results, the person who's doing five element or superficial Japanese needling, well their ears prick up also and they pay attention. So by an osmotic process we're developing a clinical style solidly based on treatment outcome. For me that's been a completely unexpected consequence of this way of working and it's fantastic learning for everyone involved, as well as the best outcome for patients.

PD: It does require practitioners to model flexibility, tolerance, letting go of tightly held belief systems – which can be difficult but rewarding.

GM: Yes, difficult! I've struggled with it, because like most people, a lot of the time I believe that I'm right. So it's been a great learning for me to be open to modalities I've judged negatively in the past and stay open to what works. We've had a few practitioners who haven't been able to do that successfully. They've been too embedded in their belief system or unable to be open to learning from others. It can also cause problems if the patient feels they're getting inconsistent treatment and crossed messages. We all have to be careful not to suggest to patients that we are doing something special or different from and better than other practitioners. We have to be committed to not putting each other down or our self up, but to support the clinic as a whole.

PD: So in this process of developing a clinical style that comes from co-operation and mutual observation, have you observed any special characteristic that are evolving? For example stronger rather than milder treatment, or more rather than fewer needles.

GM: I think the main result has been the development of a truly pragmatic approach. We are only concerned with positive outcomes. We recognise the need for light superficial needling with thinner gauged needles for deficient conditions, but at the same time there's no shying away from very strong needling - seven or nine cun needles, deep muscle releasing, very strong stimulation, not worrying if the patient experiences very dynamic deqi. We move qi where it needs to be moved, and nurture and encourage it where it needs to be nourished, it all depends on the patient. The important thing is that we are willing to learn the skills to do what needs to be done for the best outcome. It feels like a very clinical based approach founded on what works for the individual. For me this is Chinese medicine at it best: alive, adaptive, responsive, a collective approach supported by other clinicians. We are cultivating a fresh and flexible style based on and growing from the fertile soil of the classics. We have no interest in dead wood dogma for the sake of so called theoretical purity.

PD: My impression is that most acupuncturists trained in the West lean towards the more mild, supportive style of needling. It must be quite a steep learning curve for new practitioners, having to learn these stronger needling techniques.

GM: It's a real challenge – using thicker, longer needles, inducing strong deqi down the channel, causing muscles to jump and patients to break out into a sweat – this kind of needling is not often shown and taught in Western colleges. But most respect the results when they get a chance to see it in action and learn from it. It means we all end up with a broader skill set and more options.

There has been some resistance in including this type of treatment and some are reluctant to do so, but the proof is in the pudding. People see the way that a strong treatment has been given the week before and hear from the patient that they've had a pain-free week, whereas previous milder treatments may have made no or little difference. You have to be very blinkered not to take that on board. That's the advantage of this kind of setting – we can learn literally in the flesh, it's not an ethereal concept, it is the 'practise' of medicine.

PD: *How easy do you think it would be for other clinics – especially multi-beds - to adopt some of your ways of working?*

GM: I think every clinic can change something, us included! For example even in multi-bed clinics, practitioners often use their own needles and other supplies, treat patients individually, and may barely talk to other practitioners, let alone have structured clinical meeting or space for reflection. This way of working doesn't fix the kind of problems I've identified, and some of these can be changed fairly easily. But it can feel daunting to try and change everything and it may well not be necessary to do so.

Another issue is that some multi-bed clinics - for example in the US – seem to have stripped Chinese medicine down to its bare bones to make it more accessible – reducing the range of needling (maybe no local and adjacent needling for example), numbers of points used, associated techniques such as moxibustion, etc. Part of my reason for creating this kind of clinic is that I feel that we can make a model that's just as accessible for everyone, but rather than reducing the medicine to a few fragments, we can actually embrace the whole body of Chinese medicine and create a kind of clinical excellence that isn't possible in isolation - a Chinese medicine that is rich and supportive in all of its traditions and growing through its clinical roots rather than just its theoretical context.

PD: *So does that mean you use techniques such as moxibustion and cupping in the clinic?*

GM: Yes. We have to work quickly though. To take moxibustion as an example, I'll decide very early in the interview if I want to use it, and I'll start applying moxa while I carry on asking any other questions I need to ask. We also incorporate cupping, electro-acupuncture, gua sha and bleeding into our treatments. There is also herbal treatment available, which we find indispensable in treating many conditions, deficiencies in particular.

PD: *Do you provide opportunities for students to come and observe?*

GM: Yes we're very keen on students coming. We offer

this for a small donation on the same sliding scale as our treatments. We usually ask them to come for a minimum of four to six hours and part of the deal is that they have to receive a treatment. That means they get the full experience of what we're offering - from both the blunt and the sharp end. They really have an opportunity to learn something special because we're getting clinical results that I've never seen in private practice. I don't know why it is exactly. It could be needle retention – we leave them in for 40 minutes. Or maybe it's the group environment - the 'qi field' - which generates a stimulating and healing force. We're getting some astonishing outcomes – people cancelling knee operations after a few treatments, people being able to walk down the street after being immobilised with massive pain, life long migraines abated and more importantly remaining migraine free, women conceiving after just a couple of visits following years of trying and a variety of different treatments, to mention but a few. I don't think we're better than anyone else. I just think we're getting to grips with what the healing process requires.

That's the advantage of this kind of setting – we can learn literally in the flesh, it's not an ethereal concept, it is the 'practise' of medicine.

Source Point Community Acupuncture Clinic is located in the village of Moretonhampstead, on the edge of Dartmoor National Park, in the county of Devon, UK. The current staff team is Graeme McCracken, Pippa Brown, Sarah Green and Clare Mulligan. For more information see www.sourcepoint.org.uk or email info@sourcepoint.org.uk.

Graeme McCracken is an acupuncturist, tui na practitioner and Chinese dietary therapist. He began his Chinese Medicine journey in 1998, and has studied in Hong Kong, London, New York and China. Over the past 18 years Graeme has experienced a variety of clinical environments, from the National Health Service to the elite clinics of London. Now as co-founder and Director of Source Point Community Health he strives to make Chinese Medicine possible for both those who give and receive it. Graeme also lectures on multi-bed acupuncture, Chinese dietary therapy, Chinese medicine theory and clinical practice. Graeme can be contacted at: Graeme@sourcepoint.org.uk

Peter Deadman has worked in the field of 'alternative' healthcare for over forty years. He recently published 'Live Well, Live Long' about the Chinese yangsheng (nourishment of life) tradition.