Re-imagining Acupuncture Safety

a work in progress

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NO ONE WAY WORKS, it will take all of us
shoving at the thing from all sides
to bring it down.

-- Diane di Prima, Revolutionary Letter #8

“Prefigurative intervention” definition:

A disruption of space that images an alternative reality or utopia, at least temporarily. These actions give a glimpse of “the world that is possible” by modeling it, earnestly or in jest.

Prefigurative interventions are direct actions sited at the point of assumption — where beliefs are made and unmade, and the limits of the possible can be stretched.

http://beautifultrouble.org/tactic/prefigurative-intervention/

What I Learned about Safety from Two Pandemics

COVID-19

starting February 2020, I learned:

- What people want safety to be is often very different from what safety looks like in practice.
- There's a great temptation to relate to safety issues in ways that — ironically — make everyone less safe.
- Safety isn't something we can demand from the powers that be, it's something we have to create for each other incrementally — layer by imperfect layer.
- Safety is a collective project.

It’s the human condition…

- Safety practices have to take into account that often, the world and all the people in it are just bizarre. Unexpected things happen. Humans will do weird things, say weird things, think weird things.
- People will make mistakes. This might be the one thing you can count on.
- Safety isn’t about keeping all that stuff from happening, because you CAN’T. Safety is about what you do in the face of it.

For example, the week before my clinic shut down completely in March 2020, we had a staff person come to us and say, I'm really sorry, but I have to tell you I've had a sore throat for the last three days and I've been coming to work anyway -- I guess I was just in denial or something? I didn't want to bother you…

Fortunately this person didn’t actually have COVID, and hadn’t actually spread it to the rest of our staff and all our patients — but it was a great introduction to how navigating safety issues is, in part, about recognizing that you can’t *make* people behave the way you wish they would.

Qualities of effective safety practices (that COVID showed):

- they have a lot of overlap with good organization and good communication;
- they are realistic, which includes tolerating humans being human;
- they involve tolerating uncertainty — along with limited, ambiguous, and changing information.
- (Unfortunately that one's challenging, because humans tend to hate uncertainty in all its forms and try to get rid of it, instead of tolerating it.)
- Uncertainty isn't the same as being confused; good safety practices seek to clear up confusion.

COVID was my introduction to the concept of “the precautionary principle”.

…the precautionary principle (is) a form of pessimism that “seeks to ward off disaster by avoiding everything not known to be safe.” The opposite of the precautionary principle is something like epistemic optimism: We don’t know enough, and we should always try to learn more.

Derek Thompson https://www.theatlantic.com/ideas/archive/2021/04/end-hygiene-theater/618576/

But a problem with recognizing that we don’t know enough (about safety) and should always try to learn more? That requires tolerating uncertainty.

Because of uncertainty, “safe” vs. “unsafe” is often not a useful binary. There is no absolute safety. You can make things safer, if you work at it, but you’ll never make them completely safe. See also:

Harm Reduction

- “Harm reduction is the recognition that if there is an unmet and yet crucial human need, we cannot simply wish it away; we need to advise people on how to do what they seek to do more safely. Risk can never be completely eliminated; life requires more than futile attempts to bring risk down to zero. Pretending we can will away complexities and tradeoffs with absolutism is counterproductive...The better approach is encouraging risk reduction and layered mitigation—emphasizing that every little bit helps—while also recognizing that a risk-free life is neither possible nor desirable.” Zeynep Tufekci (my new favorite writer)

Harm Reduction

https://www.nytimes.com/2021/07/23/opinion/harm-reduction-covid.html

- a safety strategy devised by some of the world's most demonized individuals: people who inject drugs.
- In Rotterdam, the Netherlands, in 1981, a self-described "junkie union" led by Nico Adriaans distributed clean needles to fight hepatitis B, with government support.
- In Liverpool, England, in 1986, injectors and officials also came together to start needle exchanges and provide pharmaceutical heroin as a way to minimize risks from street drugs. To describe their philosophy, Russell Newcombe, a psychologist and drug user, labeled it "harm reduction" in 1987.
- Harm reduction allows nations to set policies that are both humane and effective by putting risks in context and centering the perspectives of those who are most affected.

Safety isn’t about right and wrong — that would be ethics or moral philosophy, which is different from safety. We would all like safety to be simple, but it isn’t —it’s complex (and fascinating!). For community acupuncturists, safety is largely about creating a container — and it’s always a work in progress.

Let’s talk about “hygiene theater”

(another concept that COVID introduced me to)

- Although scientists kept saying that COVID transmission via surfaces isn’t a thing, people kept ignoring them —
- in favor of doing as much performative cleaning as possible.
- Early in the pandemic, it was common to blame the spread of COVID in low income communities on individuals not washing their hands (subtext: poor people are ignorant and dirty, right?)
- Of course, the biggest factors in COVID spreading in low income communities — like more crowded housing and people working in jobs that didn’t allow for social distancing — weren’t actually under the control of individuals.

COVID transmission happens overwhelmingly via aerosols

but on some level, we just didn't want to hear it.

- Hygiene theater has lots of overlap with the idea that all forms of illness involve personal responsibility and that health is about the performance of certain individual virtues
- but the air is a collective resource that individuals don't have control over; it's really hard to take personal responsibility for your ventilation (particularly when you're poor).
- Ventilation is about structures, and it's easier to blame people for not washing their hands than it is to recognize that often, structures rather than individuals create unsafe conditions.

“Deep Cleaning Is Not a Victimless Crime”

https://www.theatlantic.com/ideas/archive/2021/04/end-hygiene-theater/618576/

- There’s an “opportunity cost” — performative cleaning takes resources away from more important things, including safety interventions that are actually effective.
- Performative cleaning muddies public health messaging by confusing people about what matters in terms of safety.
- And there’s an attention cost: worrying about the small stuff exhausts people from focusing on things that do matter…
- “When you ask more of people than what is needed, they grow tired of doing what actually matters,”says Julia Marcus, an epidemiologist at Harvard Medical School. (https://www.wired.com/story/its-time-to-talk-about-covid-19-and-surfaces-again/)

So what *does* actually matter in terms of safety? And how can we make more safety for ourselves and our patients? That got me thinking back to what I learned about safety from my first pandemic…

HIV/AIDS

- I worked at a grassroots AIDS service organization from 1989 through 1991 (when I left to go to acupuncture school).
- The organization included safer sex education outreach and a hotline, along with various forms of support (emotional, practical, legal, financial) for people with AIDS.
- The organization grew out of families and friends, mostly in the gay community, taking care of their loved ones at a time when the government and society as a whole truly didn’t care whether they lived or died.
- It was an example of marginalized people creating safety for each other when nobody else would. In hindsight it was a formative experience.

What I learned from the queer safer sex educators:

- Safety has a lot to do with communication and boundaries.
- Safety is impossible without self-care (you can't make yourself safer unless you believe you're worth taking care of).
- There is no right or wrong way to have consensual sex — there are safer ways and less safe ways, but no RIGHT way.
- Shaming doesn't make anybody safer; in fact it's likely to do the opposite, because…
- If you want to be safer in relationship to anything, you have to be prepared to discuss it in excruciating detail (very difficult to do if you're ashamed).

Anecdotal evidence based on my own social circle: people in sex-positive communities (queer, poly, kink, etc) had a relatively easier time navigating certain aspects of COVID, because they already had so much practice in talking about safety boundaries in excruciating detail.

It would be good if we all learned to talk about safety (in general) the way a lot of queer people have learned how to talk about sex. Talking about boundaries (in detail!) is uncomfortable — but it's a skill that can be learned. COVID showed how hard and how necessary this is.

Confession Time:

- I’m not a full-time safety geek, though sometimes I wish I were.
- My day job is being the executive director of an acupuncture school (the only accredited school that trains community acupuncturists).
- Because of my job, I already thought about acupuncture safety quite a bit, but since COVID, I’ve been thinking about it 1) very differently and 2) all the time.
- I’m frustrated with the acupuncture profession’s approach to safety.
- So I started a blog: https://acusafetynerd.com/

Quick diversion: before we get into what's wrong with safety in the acupuncture profession, let's talk about some things we've learned about safety as a result of practicing community acupuncture.

Social Safety

or, “the sense of feeling safe with other people”

- a concept that comes from Trauma Informed Care
- emerges in an environment that demonstrates trustworthiness, transparency and predictability
- “There are so many traumatized people that there will never be enough individual therapists to treat them. We must begin to create naturally occurring, healing environments that provide some of the corrective experiences that are vital for recovery.” Sandra L. Bloom, Creating Sanctuary

Social Safety

- is not just the absence of danger, but is a positive good that needs to be actively created and maintained
- is supported by collaboration and mutuality — true partnering and leveling of power differences between people offering care and people receiving care
- is enhanced by respect, compassion, acceptance and non-judgment
- “Our goal is to offer people as much acupuncture as they want, in support of whatever goals they have, so that they can use it in whatever way works best for them.” (from Working Class Acupuncture’s mission statement)

Subtle aspects of social safety

- “My favorite thing about this place isn’t even the acupuncture, it’s that I feel like I could never do anything wrong here” — regular patient of Working Class Acupuncture
- We recognize that both patients and staff contribute to social safety in the clinic in different ways, and we need everyone’s contributions.
- We recognize that patients can create social safety simply by their presence: people resting quietly sets the tone for other people to be able to relax.
- Social safety is an important ingredient in creating access to acupuncture.

Trauma Informed Care requires “abandoning the notion of trying to change people’s behavior by punishing, blaming or shaming them.”

https://acestoohigh.com/2017/10/01/wisconsin-aims-to-be-first-trauma-informed-state-seven-state-agencies-lead-the-way/

“Culture of Safety”

an occupational safety term for workplaces and organizations

- means a positive attitude toward safety; includes both positivity and proactivity
- people are comfortable talking about errors and “near misses” and even adverse events where harm occurs
- people communicate freely about safety issues and problems without fear of reprisal (or shaming)
- people share safety data and experiences without fear of reprisal (or shaming)
- it’s socially safe to talk about all aspects of safety; talking about safety makes us safer

I’ve been a licensed acupuncturist since 1994 and in my experience, the acupuncture profession does NOT have a culture of safety.

A big reason we don’t have a culture of safety is that we’ve chosen to politicize acupuncture safety. (Let’s just take a moment to remember how well it’s worked to politicize safety in relationship to COVID.)

Politicizing Acupuncture Safety

a weapon in the turf wars

- Licensed acupuncturists are most interested in acupuncture safety issues when they involve another profession, like physical therapists, using acupuncture needles.
- Exhibit A: the “Dry Needling Adverse Event Tracking System (DNAETS) Map” which lives on the website acupuncturesafety.org, and ONLY tracks adverse events connected to dry needling performed by non-L.Acs:
- “Dry needling is unsafe when performed by unqualified practitioners of acupuncture, such as physical therapists.”
- In other words, we believe it’s the L.Ac. qualification that creates patient safety, and patient safety is an argument we use to defend our turf.

We confuse total hours of acu training with acu safety training

(for political reasons, but the confusion is real)

- I didn’t realize how big an issue this was until I helped design a professional program to train acupuncturists and prepare them for licensure.
- The minimum number of hours for a Master’s level acupuncture program is 1905.
- Program standards include safety competencies, but most of the hours of entry-level acu training are not directly related to safety. I know this because I wrote the syllabi.
- The argument among L.Acs is that you need 2000 hours of professional graduate-level training to practice acupuncture safely — but that argument doesn’t make any sense if you look closely enough at the training itself.

For example, professional acupuncture programs must include 450 hours of biomedical clinical sciences. In many acupuncture schools, this means not only anatomy and physiology but also biology, microbiology, biochemistry, and physics. Science is neat but I promise you, these classes are not synonymous with acupuncture safety training.

Ditto for taiji, qigong, other classes in self-cultivation, and the study of classical texts: arguably valuable but not synonymous with acupuncture safety training. (Acupuncture safety is actually a pretty specific topic, with similarly specific competencies.)

Possibly as a result of politicizing acupuncture safety and confusing total acupuncture training hours with acupuncture safety training, the acupuncture profession suffers from…

General Negativity towards the Topic of Safety…

some common responses if you try to talk about safety with L.Acs:

- Acupuncture is so safe (when it's practiced by us) that there's nothing to talk about;
- Acupuncture safety is not a thing (unless it's about physical therapists "stealing our medicine", now that's a THING);
- If an L.Ac experiences an adverse event in their practice, it's because they did something wrong/chose the wrong points/aren't doing enough self-cultivation;
- Or the patient is lying.
- An adverse event in an L.Ac's practice is meaningful only if it lands a patient in the hospital (and maybe not even then).
- Talking about acupuncture safety makes us look bad. Stop it.

…which results in a lack of communication about safety

(not surprising given all the shaming)

- There are no real feedback loops in the acupuncture profession for safety data and communication, outside of the process of revising the Clean Needle Technique Manual (which L.Acs don't tend to look at anyway; the CNT manual is mostly for students).

- There's no socially safe place for acupuncturists to talk about safety issues that come up in their practices. If it's only undertrained, thieving physical therapists who are supposed to have safety problems with acupuncture, how can acupuncturists get support around safety?

- Who collects acupuncture safety data other than acupuncture malpractice insurance companies — who don't share it?

Not the NCCAOM!

for some reason I used to assume that the NCCAOM had a relationship to safety data…

- Possibly because of the NCCAOM mission statement: “To assure the safety and well-being of the public and to advance the professional practice of acupuncture and Oriental medicine by establishing and promoting national evidence-based standards of competence and credentialing.”
- But “evidence-based standards” doesn’t mean that the NCCAOM collects acupuncture safety data. It means they do a Job Task Analysis survey every seven years (and their JTA has a lot of problems with it, but I digress)
- The NCCAOM is in the certification business, not the safety business.
- This is another example of believing that a credential automatically equals safety, when the credential mostly isn’t about safety at all.

This seems like a good time to revisit the history of acupuncture regulation, legislation and credentialing to see how we got here. Although acupuncture regulation, legislation and credentialing is supposed to be all about public safety, it's mostly been about other things.
Like Orientalism.

Orientalism

“the white gaze”

- Scholar Edward Said, in his 1978 book of the same name, establishes Orientalism as a critical concept which describes the West’s (“occident”) contemptuous depiction of “the East” (“orient”)
- closely tied to Western imposition of imperial power over the East: imperialism and colonialism
- “is, rather than expresses, a certain will or intention to understand, in some cases to control, manipulate, even to incorporate, what is a manifestly different (or alternative and novel) world” (Said);
- results in the marginalization of the people of the East

Orientalism is always about power

- it often involves abstracting, reducing, and simplifying complex human realities to be more appealing to white audiences (thus more marketable)

- it's about fascination with ideas, culture, and objects which can be collected and consumed while simultaneously marginalizing humans (with whom the ideas and culture originated)

Acupuncture Licensure

(adapted from American Chinese Medicine, an ethnography by Tyler Phan, Ph.D)

- Chinese medicine in the US did not professionalize with its own licensure until the 1970s, where its legitimation is determined by mostly white Americans.

- Unlike the pioneers of Chinese medicine from the mid-19th and early 20th century who were all Chinese, the pioneers of its professionalization, Americanized Chinese Medicine, are primarily white Americans from the counterculture of the 1960s and 1970s.

“the UCLA cohort”

mostly members of the UCLA psychology department

- Steven and Kathleen Rosenblatt, William Prensky, David Bresler, Elliot Greene, John Ottaviano, and Gene Bruno. The one non-white member of the group was their teacher James Tin Yau So. He joined the group on a special person’s visa from Hong Kong to accompany the UCLA cohort in the creation of the New England School of Acupuncture, the first acupuncture school in the US.

- Steven Rosenblatt, David Bresler, and William Prensky met when they worked together researching serotonin in animals at UCLA’s psychology department. They had a common interest in tai chi (taiji quan太極拳) and thought about introducing it to the department. In 1969, they practiced tai chi at Sunset Park in Los Angeles with their teacher Marshall Ho’o (1910-1993).

- The exact details on how the UCLA cohort began are uncertain, but all revolve around Marshall Ho’o and the local acupuncturist Dr. Ju Gim Shek (赵 金石), who the UCLA cohort referred to as “Dr. Kim.” One such account was in the late-1960s, Marshall Ho’o wanted to have a few of his non-Chinese practitioners perform tai chi for a Chinese New Year’s event in Los Angeles’ Chinatown and chose Steven Rosenblatt and William Prensky to perform. After the event, the local acupuncturist Ju Gim Shek invited them for tea, thus began their friendship. A little later, Ju Gim Shek would elect Rosenblatt to observe patients he was treating.

AB 1500, the first acupuncture law in the US

was a shameless power grab

- In 1972 Steven Rosenblatt and William Prensky allied with California legislator Gordon W. Duffy to establish AB1500, the first acupuncture bill in the United States.
- AB1500 stated that the practice of acupuncture was limited to unlicensed persons under the supervision of a licensed physician or surgeon in an approved medical school for the sole purpose of scientific research.
- The bill only benefited the UCLA cohort as they were the sole group aware of acupuncture who had resources and connections with a medical research facility.

Consequences of AB 1500

- immediately defined the practices of Asian American acupuncturists as illegal
- many Asian American acupuncturists were arrested for practicing medicine without a license
- The move to regulate acupuncture in the United States, as evident with California, was taken without consideration of the numerous Asian Americans who had already been practicing Chinese medicine years prior to the UCLA cohort.

Acupuncture schools and acupuncture licensing boards

the next projects of the UCLA cohort

- in 1975 they founded the school that would become the New England School of Acupuncture, the first accredited acupuncture school
- Later in 1975, Kathleen and Steven Rosenblatt founded the California Acupuncture College with Gene Bruno
- William Prensky and Steven Rosenblatt claimed to have influenced the ruling that caused Nevada to be the first state to license acupuncture in 1973
- Gene Bruno helped establish the licensing board in Oregon later in 1973 and also influenced the state of Washington’s acupuncture licensing board
- Prensky also worked on acupuncture licensing laws in New York

Next step: making a profession of “Oriental Medicine”

- Some of the professionalizing practitioners felt the term “acupuncture” was limited and did not encompass other healing modalities of Chinese medicine such as herbs, cupping, or gua sha (刮痧). As a result, some felt “Oriental medicine” was more inclusive.
- This title began to be used at the UCLA cohort’s California Acupuncture College (CAC) where they designated their graduates “Oriental Medicine Doctor” (O.M.D.).
- Later it was adopted on a national-level by the entirety of the profession where it was used in all of the national regulatory bodies as well as in many of the schools.

Making a profession: organizations

- The creation of the AAAOM (American Association of Acupuncture and Oriental Medicine) occurred in June 1981, when medical doctor Ralph Coan and professor Louis Gasper convened the first conference on the Chinese medicine profession at Los Angeles International University.

- In February 1982, three national regulatory bodies were created at the same time: the council for schools known then as the National Council of Acupuncture Schools and Colleges (NCASC, now **CCAHM)**, a commission to certify acupuncturists known at the time as the National Commission for the Certification of Acupuncturists (NCCA, now **NCCAOM)**, and an accreditation organization for schools known as National Accreditation Commission for Schools and Colleges of Acupuncture and Oriental Medicine (NACSCAOM, now **ACAHM**), which was recognized by the United States Department of Education in 1988.

Given that the first step toward the professionalization and regulation of acupuncture involved driving underground those people who had actually been practicing the medicine in their own communities, how much information about safety (based on real world practices) could have informed subsequent acupuncture regulation?

It’s striking to what degree the structures of the acupuncture profession were created by (white) people who had very little experience with the actual practice of acupuncture. This is not a situation conducive to promoting safety — this new acupuncture profession has arguably been lucky that acupuncture is naturally as safe as it is. What’s really suffered has been ACCESS.

Oh, here’s a fun exercise, let’s look at a law

the acupuncture law for Oregon

- Found here: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=3898

- Definition: ”Acupuncture” means an Oriental health care practice used to promote health and to treat neurological, organic or functional disorders by the stimulation of specific points on the surface of the body by the insertion of needles. "Acupuncture" includes the treatment method of moxibustion, as well as the use of electrical, thermal, mechanical or magnetic devices, with or without needles, to stimulate acupuncture points and acupuncture meridians and to induce acupuncture anesthesia or analgesia.

an application of this law for POCA Tech students

- Since "Acupuncture" includes… the use of electrical, thermal, mechanical or magnetic devices, with or without needles, to stimulate acupuncture points …”
- This means that POCA Tech students cannot legally apply ear seeds on anyone without a clinical supervisor (5 years experience as a licensed acupuncturist, registered with the Oregon Medical Board) being present.
- For public safety reasons, of course.
- Wouldn’t you like to see all of the safety data about adverse events involving ear seeds applied by unsupervised acupuncture students (or laypeople)? Me too!
- According to the CNT Manual, 7th edition, “There are no common Adverse Events associated with the use of ear seeds/vaccaria.” (pg 63)

- “When you ask more of people than what is needed, they grow tired of doing what actually matters,”says Julia Marcus, an epidemiologist at Harvard Medical School.

- https://www.wired.com/story/its-time-to-talk-about-covid-19-and-surfaces-again/

And while we're on the topic of ears, let's not forget how the acupuncture profession has used public safety as an argument against NADA and other instances of laypeople practicing auricular acupuncture. Many LAcs oppose recognition of "acu detox specialists" in any form. It doesn't matter that NADA has an excellent safety record.

There’s a dynamic, nuanced relationship between safety and access (this plays out in community acupuncture all the time) but at the level of the acupuncture profession, “safety” is used rhetorically/politically MAINLY to limit access to treatment, including in ways that disproportionately impact marginalized communities.

To recap what I learned about safety from two pandemics: safety is a complex, collective enterprise, not a weapon. Nothing good comes from using it as a weapon.

the acu profession's version of hygiene theater

is unfortunately the dominant approach to acu safety

- obsession with credentials and training hours as opposed to actual safety competencies
- focus on "individual responsibility" instead of larger systems and structures
- not interested in safety data except as a weapon against "outsiders"
- often performative
- ignoring what actually makes safety practices effective — COMMUNICATION, data collection, and being open to always learning more…
- in favor of what doesn't work — shaming, blaming, and politicization.

There is no “right way” to practice acupuncture. There are safer and less safe ways. Practicing acupuncture according to, say, TCM is not inherently safer than practicing it according to any other theoretical paradigm.

One good way (I think) to interrupt the use of safety as a weapon to limit access/fight turf wars, is to take safety seriously, as a positive goal worth pursuing in its own right, and give it the attention it deserves.

At this moment in time, I don’t know if it’s possible to de-regulate acupuncture in the US or to fix the many problems we have with legislation and credentialing. They are deeply embedded.

Though it’s worth remembering this excellent quote by Ursula K. LeGuin about things that seem like they will never change:

“We live in capitalism. Its power seems inescapable. So did the divine right of kings. Any human power can be resisted and changed by human beings. Resistance and change often begin in art, and very often in our art, the art of words.”

Ursula K. LeGuin

I do know that it IS possible -- and healthy for us -- to change the way that we RELATE to the regulation, legislation and credentialing of acupuncture, and relating differently to safety is a crucial aspect of that.

If the regulation, legislation and credentialing of acupuncture were dramatically re-organized to reflect better priorities (like access), it would REQUIRE that we have a different relationship to safety.

And that different relationship to safety is something we can work on right now, regardless of whether any other changes are currently possible or accessible to us. So…

Let me tell you about our AERD!
No, wait, come back…

What's an AERD?

Adverse Events Reporting Database

- An AERD is a way to collect safety data. Reports of adverse events can be made anonymously and voluntarily by anyone (patients and providers).
- We made one for acupuncture in 2018. See: https://acupunctureconsumersafety.net/index.html
- A major goal of our database is to support a culture of safety in the practice of acupuncture. Part of creating a culture of safety is making it easier and more comfortable for both practitioners and patients to communicate about safety issues. We believe that better, more cooperative communication around even minor "adverse events" can help prevent, and/or improve the management of, adverse events in general.

A common reaction to our AERD, particularly within the acupuncture profession, is “what on earth is the point of this exercise?” (with a side order of “stop it, you’re making us look bad”)…

So let’s talk about what our AERD is good for, in practical terms. But I also want to be clear, right out of the gate, that it might be helpful to think of our AERD as a form of prefigurative intervention:

a disruption of space;
a direct action sited at the point of assumption — where the limits of the possible can be stretched;
a way of modeling a relationship to acupuncture that's based on being serious about safety (as opposed to being based on Orientalism and turf warfare) and is designed to include, rather than marginalize, people.

Who’s been using our AERD

we have just under 200 responses

- 88% are from acupuncturists, mostly community acupuncturists
- 6% are from acupuncture students (POCA Tech interns)
- 5% are from patients

our AERD has been hugely helpful for POCA Tech

(can't imagine having an acupuncture school without one!)

- recognizes common adverse events and errors that the CNT manual doesn't list (particularly adverse events related to trauma triggers), and helps put those events and errors in context
- provides lots of real world examples of how communication impacts safety practice
- trains students to document safety incidents as a matter of routine (our EHR has a button that says "report an adverse event" that takes students straight to the AERD)
- creates a context in which students relate to safety issues without shaming or politicization (safety incidents happen, they don't mean you're a bad practitioner)

Acu Safety Nerd blog as extension of the AERD

also extremely helpful for the school

- blogging about AERD data has modestly increased reporting
- blogging about safety issues/incidents that have come up in clinics where students intern or observe has been a way to use those experiences as teaching tools
- as well as modeling communication and reflection about safety issues
- setting a tone of curiosity and openness around safety
- for example: https://acusafetynerd.com/anatomy-of-a-safety-incident-4-part-1 and https://acusafetynerd.com/anatomy-of-a-safety-incident-part-2
- and also: https://acusafetynerd.com/pneumothoraxes-and-a-culture-of-safety

AERD as prefigurative intervention

maybe not what AERDs are outside of the acupuncture world, but hey, it's what we need

- creates a feedback loop for acupuncture safety information; when information circulates, so does authority and power
- requires trust and transparency to use and also (we hope) creates more trust and transparency
- allows us to act as if safety practice and regulation/legislation/credentialing are not the same thing (they're really not!)
- allows us to act as if safety is a collective project, something that practitioners and patients make for each other, as opposed to something we demand from external sources or a weapon to be used against outsiders

The AERD is a way for us to encourage and participate in a culture of safety, even if nobody else in the acupuncture profession is interested. That’s empowering, and it’s MUCH better to be empowered than disempowered when it comes to safety.

How would acupuncture education and practice be different

if we gave safety the attention it deserves?

- It would be easier to incorporate public health perspectives like trauma informed care and harm reduction
- It would be easier to face our legacy of Orientalism/structural racism and work on repairs
- It would be easier to prioritize access
- It would create a healthier, saner, more supportive environment both for students and for working practitioners

When it comes to safety, “every little bit helps” (Zeynep Tufekci)

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