sitivity to heat,[9,10] electrical resistance changes,[11–14] even *qi* sensations that the practitioner feels.[15] The finding of pressure pain at acupoints is only one of a number of possible reactions. It is a phenomenon that is dependent on the interests and experiences of the practitioner and not the nature of acupuncture points. The fact that acupuncture points show a range of nonpressure pain reactions is further evidence that acupuncture points are not trigger points since the latter must exhibit pressure pain as a defining feature.

Given that acupuncture's ideas developed more than 2000 years ago in a completely different culture with a very different conceptual map of the world and body and in a very different language, it is always a risky business casting modern ideas back onto the older ones. All the more so when the person doing this is not familiar with the origin language and historical basis and nature of those ideas. Yes, there is a superficial similarity,[16] yes some practitioners in the modern period seem to use them in superficially similar ways, but no, they are not nor could they ever be the same things. The parents of trigger point therapy summed it up appropriately: "Acupuncture points and trigger points are derived from vastly different concepts. The fact that a number of pain points overlap does not change that basic difference. The two terms should not be used interchangeably."[16]

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Live Harp Music Reduces Activity and Increases Weight Gain in Stable Premature Infants

Dear Editor:

Music enhances weight gain in premature infants on fixed feeding regimens.[1] To better understand the mechanism of this effect, we assessed the effects of live harp music on salivary cortisol (SC), heart rate variability (HRV), and activity in a pilot study of 8 stable premature infants.

All infants were at least 34 weeks gestation, had passed a newborn hearing screen, and had no medical conditions or medications affecting cortisol levels, cardiac function, activity, or caloric intake.

Infants were randomly assigned to usual care (4), quiet room (2), or harp music (2) for 45 minutes at the same time daily for 3 days. For the quiet room, infants were moved to a room used for transition to home where noise levels were approximately 30 decibels quieter than in our intermediate care nursery. For the harp music group, the infants were moved to the same room, but provided with 45 minutes of harp music, with volumes similar to those in usual care.

Outcomes were measured at the same time daily. SC was measured twice (before and after the intervention, approximately 1 hour apart). HRV was measured using a MiniMitter 2000 (MiniMitter Inc., Bend, OR) and calculated in standard fashion.[2] Activity was measured using a wristwatch actimeter (Actiwatch Model 64, Respironics Inc., Pittsburgh, PA), placed on the left lower leg.

This study was approved by the Institutional Review Board of the Wake Forest University School of Medicine.

At baseline, the 8 study infants had an average gestational age of 36.4 weeks and weight of 2279 grams, which was similar for all three groups. Weight gain during the study was greatest in the harp music infants (average gain of 19.1 g/kg-day), next highest in the quiet room infants (17.2 g/kg-day), and least in the usual care infants (13.3 g/kg-day) ($p < 0.05$). SC and HRV parameters were similar in all three groups; SC fell equally in all groups. Activity fell by approximately one order of magnitude in the 2 hours after the study intervention (from 5000 to 490 movements per hour, $p < 0.01$). This activity change was not observed in the other groups.

Music may enhance weight gain by decreasing activity and caloric expenditure. Although it is not possible to rule out effects of music on SC or HRV, these pilot data suggest that

larger studies should focus primarily on the effects of music on activity to promote weight gain in premature infants.

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Author Disclosure Statement

We do not have any commercial associations that might create a conflict of interest in connection with this paper.

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Knowledge and Attitudes of Lay Public, Pharmacists, and Physicians Toward the Use of Herbal Products in North Jordan

Dear Editor,

Herbal medicines (HMs) are promoted as "natural" and "safe," and they have been used for thousands of years without being subjected to the stringent standards of purity, efficacy and safety regulation applied to conventional drugs. Studies have shown that some HMs contain toxic metals and some may induce a wide range of adverse outcomes and drug interactions.[1] For instance, ginkgo (*Ginkgo biloba*), ginseng (*Panax* spp.), and royal jelly may interact with warfarin and cause an increase in bleeding time.[2] The prevalence of HM use has been reported at around 13% in UK[3], 27% in Canada,[4] and 70% in some developing countries.[5] In the United States, the prevalence of use varies from 12.9%[6] to 80.3%.[7] The prevalence in Jordan is unknown, although there are hundreds of herbalist shops selling more than 150 HMs, 27 of which were reported to be frequently prescribed.[8] The purpose of the present study was to determine the prevalence of HM use in Jordan, and to assess the awareness of the lay public, pharmacists, and physicians of the use of frequently prescribed herbs.

This descriptive study was conducted with a self-administered questionnaire given to 300 randomly selected members of the lay public, 300 pharmacists, and 72 physicians working in the private sector in Irbid, the main city in the north of Jordan (Table 1). SPSS (version 15) was used for data processing and analysis. Variables were described in terms of frequency distribution. Means and standard deviations were calculated for continuous variables.

Some 87.3% of the lay public, 84.7% of the pharmacists, and 66.7% of the physicians in the study acknowledged use of HMs for treatment of simple conditions. Most of those who used HMs (91.1% of the public, 95.5% of the pharmacists, and 87.9% of the physicians) believe that they got desirable effects following its use. The motives stated by the participants that led them to use HMs are shown in Table 2. Lay people learned about HMs from books/magazines (46.7%), friends and relatives (40%), herbalists (19.3%), and the Internet (5.3%). Only 21.3% of them sought information from physicians, and only 16% consulted a pharmacist. When physicians were asked about their feelings when consulted about HM use, 44.4% felt satisfied that the HM would have a positive effect, 25% were indifferent, and 30.6% had negative feelings toward HM use. When asked about their knowledge of the composition of HMs, 24.7% of the lay public, 60% of pharmacists, and 30.6% of physicians claimed that they had good knowledge. Some 25.3% of the public, 26.7% of pharmacists, and 52.8% of physicians thought that HMs may occasionally induce side effects. Regarding potential herb–drug interactions, most pharmacists (93.2%) and physicians (94.4%) believed that interactions could happen.

Our data show that HMs use is common in the north of Jordan and the prevalence rate is somewhat higher than that reported in other countries.[3–7] Additionally, this is one of very few studies that investigated the use of HMs among healthcare professionals (HCPs). Although some investigators have shown that the prevalence rate of HMs use is significantly high among well-educated individuals,[9] the reported use of HMs by Jordanian HCPs was significantly higher than that from other countries.[10] Although we did not investigate the characteristics of the members of the lay public who use HMs, the high prevalence rate of use (87.3%) may have no correlation with demographic factors. The essential motive for their widespread use was the belief that HMs are natural and, therefore, safe. We observed that relatives and friends encourage this belief; the use of HMs is usually recommended by elderly family members who know the Arabic names and the traditional indications for their use.

Most participants in this survey did not believe that HMs can have side-effects when used inappropriately. Further-

Table 1. Characteristics of Study Participants

	Total number	*Men*	*Women*	*Age (mean ± SD)*
Lay public	300	142	158	30.7 ± 10.9
Pharmacists	300	116	184	31.4 ± 8.9
Physicians	72	62	10	32.5 ± 10.9

SD, standard deviation.