

School of Social Sciences Faculty of Media, Society and Culture

**Cultural constructions of illness : the client and
practitioner perspectives of traditional Chinese
medicine. Perth Western Australia**

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Degree of Doctor of Philosophy of the Curtin University of Technology**

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Declaration

This thesis contains no material, which has been accepted for the award of any other degree or diploma in any university.

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

Signature

P. Guere.....

Date

16/11/2010.....

Acknowledgements

In respect of Howard Becker and Arthur Kleinman, great creators of knowledge.

This thesis is dedicated to the memory of Dr William Wu (Doctor of Western medicine, an Oncology specialist and a Doctor of TCM) from Guangzhou Peoples Republic of China, a citizen of the Chinese community Perth, Western Australia. Dr Wu of Edith Cowan University Perth pioneered a program for TCM in 1990 for health graduates. He provided invaluable source material of case studies used for this thesis.

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Abstract

An increased use of Complementary and alternate health care practices (CAM) and under which TCM is found assumed, is found in overseas countries and has become increasingly popular among Australian consumer. There has been a considerably increase in the consumer use of TCM over the past decade, but little is understood on the practice of the clinical encounter in TCM explained from the context within a clinic in western society.

Investigation was made on how social and cultural processes have shaped people's acceptance of TCM as a form of complementary health. Drawing from an ethnographic focus, the study explores the practice of TCM in several clinic settings in Perth. Attention is paid to the ways in which notions of health and illness are constructed by clients and practitioners. This study examined the interactions found in the process of 'Kanbing' from a TCM practice in Perth, Western Australia in order to understand how health practices are shaped by cultural and social processes. From an anthropological perspective, the ethnography of this study was guided an extended contact with the everyday clinical context of TCM, facilitated through participant observation, interviews with clients and practitioners and case study analysis. Interviews revealed perspectives from clients of non-Asian backgrounds to record the lived experiences of the encounters between the practitioner and client of TCM in the clinic. Participant observation took place over a two year period from February 2002 to March 2003 with further follow up work in the field conducted at intervals throughout 2004 and 2006 to gain additional data.

The client centred interrelationships between practitioners of TCM, clients, and their perceptions, formed part of the interpretative process that informed the understanding of the cultural context from how an illness is described and explained through the process of Kanbing. My research was drawn from the reality of the encounter within the clinical context through participant observation within two western clinics of TCM. Thus the study makes a contribution to anthropology on the understanding of the structure and meaning found within the practice of traditional Chinese medicine in Australia.

GLOSSARY AND ABBREVIATIONS

Chinese words

Romanization of Chinese words generally follows the *Hanyu Pinyin* system when specific words are used that relate to a medical translation of Chinese words where appropriate. Throughout the text, 'Qi' is capitalized.

Ba Gang: the eight principles

Fu: an organ responsible for the reception of nutrients and to transmit and excrete waste material from the body.

Jingshen: mind and spirit

Kanbing: the process of looking at the illness and the interactions of assessment

Mai:pulse

Qi: the energy

Qing: emotion

Qing: emotion related disorder

Shenjing: nerves

Si Zhen: the four methods of diagnosis

Shen: spirit

Xue: blood

Zang Fu is the organ system of TCM

Zang: an organ responsible to manufacture, store essential substances namely Qi, blood and body fluid.

Zhenmai: examining mai

Zheng: classification of illness into a syndrome

Zhifa: prescribing treatment

Zhongyi: TCM practitioner

The Zang organs:

There are five solid zang organs; the heart, liver, spleen, lung, kidney.

Shen: kidney

Gan: liver

Pi: spleen

Xin: heart

Fei: lungs

Wei: stomach

The Fu organs:

There are six hollow fu organs; gallbladder, stomach, large intestine, small intestine, bladder and san jiao.

Pang Guang: bladder

Wei: stomach

Dan: gall bladder

Xiao Chang: small intestine

Da Chang: large intestine

Extraordinary fu organs are the brain, marrow, bones, vessels, gallbladder and uterus.

Traditional Medicine

These terms are extracted from a working definition of traditional medicine was provided by the WHO in the General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine (Appendix 1):

It is the sum total of the knowledge, skills, and practices based on the theories, beliefs and experiences indigenous to different culture, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. The terms complementary/alternative/non-conventional medicine are used interchangeably with traditional medicine in some countries (WHO, 2000, p. 1).

Traditional medicines are forms of medicine practised to some degree in all cultures and based on cultures that include African, Asian or Chinese medicine (Bannerman, Burton & Wen-Chieh, 1983, p. 9). Traditional medicine is the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (World Health Organisation, 2007).

Traditional Practitioners;

Traditional practitioners define life as, "... the union of body, senses, mind and souls," and, who describe health as, "... the blending of physical, mental, social, moral and spiritual welfare" (Bannerman et al., 1983, p. 9).

Traditional Chinese medicine (TCM)

As a system of traditional medicine, the practice of TCM includes:
Internal and external pharmacological therapy

- Chinese herbs, crude plant material
- herbal material includes the use of plant, animal and mineral substances – materia medica
- Acupuncture includes the use of traditional, laser or imbedded needles
- Chinese massage – Tuina
- Nutritional and lifestyle advice
- Breathing and movement exercise through Tai Qi or Qi Gong
- Specific techniques-
- Cupping, moxibustion, scraping techniques

A Practitioner of TCM

A practitioner of TCM is educated in the skills of this medicine is able to carry out most, if not all TCM techniques of Chinese medicine. Some practitioners choose to specialise in a particular field of the system. Chinese herbal medicine and acupuncture are common modalities selected to treat and prevent a wide range of symptoms.

TCM Practitioners in Australia

In Australia during the 19th century, Chinese immigrants who came to work in the Australian goldfields imported their knowledge of herbal medicine (Bensoussan & Myers, 1996). Loh (1985) says that in 1887 there were an estimated 50 Chinese herbal medical practitioners. From their report ‘The Practice of TCM’, Bensoussan & Myers (1996) estimated that there were approximately over 4,500 practitioners of TCM identified in NSW, Victoria, and Queensland. This included Western medical practitioners and other therapists who used any modality of TCM.

Complementary/Alternative Medicine (CAM)

The terms, “complementary medicine” or “alternative medicine” are used interchangeably with traditional medicine in some countries. These terms refer to a broad set of health care practices that are not part of that country’s own tradition and are integrated into the dominant health care system (World Health Organisation, 2007).

Definition of CAM

The terms complementary, alternative, non-conventional medicine are used interchangeably with traditional medicine in some countries (WHO, 2007, p. 1). Diverse groups of therapies that originated from different disciplines formed the body of CAM, known as non-conventional and not considered to be part of conventional medicine (House of Lords Sixth Report, 2000; National Center for Complementary and Alternative Medicine, [NCCAM] 2000).

Glossary of CAM terms is extracted from NCCAM (2000, p. 2)

CAM is a group of diverse medical and health care systems, practices and products that are not considered to be a part of conventional medicine. These include these five major domains extracted from NCCAM:

1. Traditional medicine systems

India's traditional Ayurvedic system based on the principle of restoring the innate harmony of the individual based on the Dosha's. Emphasis is placed on the body, mind and spirit. Other non-western systems embrace a similar belief and include Tibetan, traditional Chinese medicine and folk systems of health care. The dominant medical system practised in Europe from ancient Greece to the present era, was based on the belief that ill health resulted from an imbalance of the body's four humours (blood, phlegm, yellow and black bile).

ii. Mind-Body interventions

Mind body interventions use a variety of techniques to enhance the mind's capacity to affect bodily function and symptoms (NCCAM, CAM Basics, 2007). Early techniques of mind body medicine were developed by Dr Herbert Benson one of the first western physicians to bring a focus of spirituality into healing in the 1970's, who founded the Benson-Henry Institute of mind-body medicine. The practice of meditation, yoga, prayer, art, music and dance therapy are considered mind-body interventions. Associated with these interventions have been found evidence of biochemical connections and interactions between the neuropeptide and their receptor sites.

iii. Biologically based therapies.

Biologically based therapies are found in herbal medicine, special diets and food products. Herbs are defined as plants or plant products that produce or contain chemicals that act upon the body as a therapeutic intervention, to promote healing.

iv. Manipulative based therapies.

Chiropractic approaches to the spine, spinal network act to restore health and function to the body. Forms of massage that involve manipulation of soft tissues are also an example of this form.

v. Energy Therapies

Energy therapies are based on the activation of energy acting externally on the body to rebalance or reconnect the energy, an example is Qi Gong a component of TCM that combines movement, meditation and regulation of breathing to enhance the flow of vital energy of the body known as Qi.

NCCAM (2000, p. 2)

Allopathy

Allopathy is a descriptive name often given to orthodox medicine. Allopathy is the treatment of symptoms by opposites (Easthope, 1998, p. 268), similar to the principle of homeopathy.

Biomedicine

Western orthodox medicine is classified as biomedicine. Easthope defines biomedicine as, “the conventional medicine approach to medicine in Western societies. It seeks to diagnose and explain ill health in terms of malfunction of one of the body’s internal biological mechanisms” (1998, p. 270). Practitioners and clients using TCM in the thesis study refer to the context of biomedicine as ‘Western’ medicine, and hence this term is referred to in passages where there is context from interview transcripts from the research.

Conventional medicine

Conventional medicine is medicine that is practised by holders of M.D. medical doctor or D.O. (Doctor of Osteopathy) degrees and by their allied health professionals, such as physical therapists, psychologists and registered nurses. Some health care providers practice both CAM and conventional medicine (NCCAM, CAM Basics, 2007).

Non-Conventional medicine

The use of the term non-conventional rather than the term non-orthodox refers to all therapies and systems of health care that are considered not to be a part of orthodox health provision.

Orthodox medicine

Medical practices and institutions developed in Europe in the 19th and 20th centuries and are legally recognised by the state. Central to these practices is the teaching hospital, where all new doctors are induced into laboratory science, clinical practice, and allopathic biomedicine. These practices are now dominant in all parts of the world (Easthope, 1998, p. 268).

Therapeutic Goods Administration (TGA)

The TGA is the regulatory body for therapeutic goods including medicines, complementary medicine, medical devices, genetic technology and blood products in Australia. It is a division of the Australian Department of health and Ageing established under the Therapeutic Goods Act 1989. The TGA is responsible for conducting assessment and monitoring activities to ensure that therapeutic goods available in Australia are of an acceptable standard (Wikipedia, 2010).

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CHAPTER ONE

Background to the Study

“The social anthropologist aims at revealing the structural forms or patterns which lie behind the complexity and apparent confusion of actualities in the society” ...

(Evans-Pritchard, 1969, p. 123).

1.0 Introduction

Chinese traditional medicine has an ancient lineage of several thousand years, with the earliest known record of its use dating to 1800 BC (Pei, 1983). During the past several decades of the twentieth century, this form of traditional medicine has been found assumed under the auspices of complementary and alternative medicine as terms such as; “... complementary, alternative, non-conventional medicines are used interchangeably with traditional medicine in some countries” (WHO, 2007, p. 1). Diverse groups of therapies that originated from different disciplines form the body of CAM, known as non-conventional and not considered to be part of conventional medicine (House of Lords Sixth Report, 2000; National Center for Complementary and Alternative Medicine, [NCCAM] 2000).

Over the past several decades, social scientific interest has led to investigation of the increased use of complementary and alternative medicine (CAM) and traditional Chinese medicine (TCM) by consumers and medical practitioners throughout Western society. The question of whether the popularity in CAM use is associated with any transition in trends by consumers who seek out and choose non-conventional medicine is examined. The background of this chapter first provides a

review on the holistic health movement to which an association can be determined to have influenced the emergence of growth, in the public interest and consumer use of alternate health therapies. Characteristics that define non-conventional medicine, in association with the formation of categorisation by government bodies in the United Kingdom and the United States, are then examined. Explanation on the growth and trends in non-conventional medicine use by consumers to determine the key values that have impacted on the increased popularity of CAM and TCM usage is made.

A lack of research that distinguishes characteristics of TCM practice provided an opportunity for an ethnographic exploration from within a Western context to determine what is intrinsic to the cultural construction of TCM practice. The research purpose is positioned from the stance of providing an understanding of how TCM provides a social construct of illness and disease (Micozzi, 2002).

1.1 Background to the study

New scientific developments and technology during the first half of the twentieth century, contributed to the foundation of knowledge and the proliferation in the growth of biomedicine, conventional modern Western medicine. Conventional medicine is recognised to be the official medicine at a national level in all European Union countries and in modern Western society (Germov, 1998). As the dominant form of conventional health care, biomedicine is based on science, evidence based research and stringent ethical codes supported by an education system with rigorous principles, further discussed in Chapter Two.

In the latter half of the century the phenomenon of unconventional health care emerged from a plethora of different disciplines and backgrounds, with recognition of the unique therapeutic properties of each discipline accorded by categorisation, from a variety of ancient European Union, ethno-traditional, folk and popular medical practices. The Research Council for Complementary Medicine (RCCM) described unconventional medicine according to these principles which are noticeably varied:

Care is health and not disease oriented, it respects the autonomy of the patient, allows freedom of choice, promotes self treatment, encourages the patient to take on some individual responsibility for the outcome of the procedure and healing (2003, p. 2).

Beginning in the late 1970s and 1980s, consumers sought out different forms of healing resources as alternate methods to that of conventional medicine where self responsibility was assumed for the treatment of minor ailments, and hence the term ‘alternative medicine’ was applied to these different forms of care (Zollman & Vickers, 1999). The term complementary medicine has been used interchangeably to describe traditional medicine as an alternate form of medicine and refers to a broad set of health care practices that are not part of a country's own tradition or dominant health care system (Zhang, 2000). As a term, complementary and alternative medicine (CAM) was later applied in reference to a collection of therapeutic and diagnostic disciplines that lay outside of the recognised parameters of a conventional system of medicine (British Medical Association, 1993; House of Lords, 2000; Zollman & Vickers, 1999). Authorities now refer to these disciplines as CAM, to describe all forms of non-conventional medicine, which includes TCM (House of Lords, 2000; NCCAM, 2000; RCCM, 2003; RCCM, 2007; The Australasian Cochrane Collaboration, 2007). Non-conventional medicine use was approximated to be fifty percent of the population from many high income countries such as Canada, France, Germany, United Kingdom and the United States of America (World Health Organisation, 2005). The emergence of CAM is now described, beginning with the holistic health movement.

1.2 The holistic health movement

During the last decades of the twentieth century, what is known as the holistic health movement (Alster, 1989) rose from a scientific world that had evolved rapidly, but outside the framework of techno-medicine (Baer & Davis-Floyd, 2005). This movement was fuelled by a wide variety of non-allopathic practitioners and consumer activism. The Office of Alternative Medicine established in 1992 in the USA and in the United Kingdom (UK), The Research Council for Complementary Medicine (2000) sought to understand why public opinion favoured this new system of non-conventional health care identified as CAM.

Several conjectures may be made. Non-conventional medicine use may correlate with a fundamental pragmatism of patients who select health care on the premise of what they feel will be the most effective way to get better (Bensoussan, 1999). The selection of non-conventional medicine use also reflects consumer values on which a

holistic notion of importance is attached to care (Eastwood, 1998a) and which may be a plausible explanation for the appeal of CAM. Not to draw conclusion on what constitutes holism, a brief explanation is given for the purpose to illustrate how holism has emerged. Derived from the Greek word 'holos', the term holism, used in the mid 1920's, identified the concept of a whole, to describe a system of care that is directed through an ideology of health espoused through what is considered as a balanced integration between the mind, body and spirit (Barr, 1998). CAM therefore may purport to offer a focus that is holistic, but an argument is drawn from Zollman and Vickers (1999) who say, "... many conventional practitioners work in a holistic manner ... [this] relates to the outlook of the practitioner than to the type of medicine practised" (1999, p. 694).

Different interpretations may be found of ideologies that define holism, for example the American Medical Association defines holistic health as, '... a philosophy of medical care that emphasises personal responsibility and participation in one's own health care' (Barr, 1998). Holism is seen to treat the whole person (Zollman & Vickers, 1999). The approach from this perspective has an appeal engendered through an active participation, by consumers who attach value to personal responsibility in health decisions reflected through their response in the appeal of CAM. As a new form of health care it has been endorsed through an increased population of Australian consumers and general practitioners who have accepted and use CAM (Easthope, Beilby, Gill & Tranter, 1998; Easthope, Gill & Tranter, 2000; Eastwood, 2000b).

Social acceptance of new forms of care can in part be understood with reference to Chan and Chan (2000) who suggest, "... that modern medicine is progressing down a path of innate modernity" (p. 333). With contrasting backgrounds in medicine and education (Chan & Chan) postulate that health and illness is a social and cultural construction enforced by dominant attitudes. Such attitudes are found in a modernist world view reinforced through an enculturation that underpins social acceptability. Health seeking behaviour is constrained by dominant social 'mores' identified through behaviour patterns and cultural practices, which are an example of socially transmitted behaviour (Duncan-Mitchell, 1979).

It can be found from other sources that the dominant system of health, known as biomedicine (Friedson, 1994; Germov, 1998; Illich, 1976) evolved from class interests and has an underlying basis vested in interests, and dominant values which

are “created by historical evolution of societies” (Susser, Watson & Hopper, 1985, p. 137). Biomedicine originated during the nineteenth century to become the dominant form of health care and was widely accepted as the form of conventional medicine in modern Western society and in European Union countries (Germov, 1998). Dominant attitudes can change as Saks (1996) observed a decade ago, when the response of the British Medical Association moved from a hostile position of total exclusion of alternative medicine, to an idea of collaboration with non-medically qualified practitioners. This is evident in government led inquiry in the United Kingdom when a select committee was formed to report on CAM to the House of Lords (2000). Saks speculated a sway in attitude may have been politically motivated to strategically reduce any undermining threat to the dominance of biomedicine’s power by alternate medicine use. However, in the United States, Baer (2005) noted similar shifts in attitude that engendered acceptance of alternative medicine by the American Medical Association.

An integration of CAM regimes (Kaptchuk & Miller, 2005; Leach, 2006) found in the delivery of health care is approached by medical practitioners cautiously, but currently stands as reflection of a plurality (Leslie, 1980) which could nonetheless be beneficent for the purpose of alleviation of suffering in chronic illness. It brings out a focus on ethical implications for the manner in which the future relevance of health care is organised, to provide for the individualised health needs with physicians recognising that patients have the right of choice in their selection of health care (Kaptchuk & Miller, 2005; RCCM, 2003). This will be generated by a changing modern society where consumer rights, their associated health beliefs, will impact on decisions made for public health policy, services and health maintenance.

Public health and social literature proposes that beliefs, attitudes and values are independent constructs held by individuals (Cheek, Shoebridge, Willis & Zadooroznyj, 1999; Eastwood, 2000a; Germov, 1998; Green, Kreuter, Deeds & Partidge, 1980). The Health Belief Model (Rosenstock, 1966 in Waddell & Peterson, 1994) identified that social psychology involved decision making with a focus on motivation, beliefs and individual perceptions of health related behaviour. Behaviour can be predicted in terms of certain belief patterns, shaped by individual values and governed by the processes of socialisation (Green et al., 1980). Values ascribed to health attitudes on ‘ideal’ qualities, represent a collection of negative and positive beliefs. Ideal qualities, according to Dignan and Carr (1992), are influenced by four

major factors that shape access to health services; participation in health enhancing activity; individual perceptions of health belief that reinforce specific values, environmental modifying factors and the participation in health enhancing activity (Dignan & Carr, 1992; Green et al., 1980; Schreiber, 1991). Health beliefs and values influence how established forms of treatment are perceived and in particular, the promotion of self care is intrinsic to the practice of health promotion (Schreiber, 1991). Self care is reflected by "... the decisions taken and the practices adopted by an individual specifically for the preservation of [their] health" (Epp, 1990, p.7). Health practices have been identified as having characteristics expressed through cultural and social lens (Eisenberg & Kleinman, 1981; Lawrence & Weisz, 1999; Mahler, 1983; Mechanic, 1995; Susser et al., 1985). Systems of health care are expressed through social needs (Agdal, 2005; Kleinman, 1981; Kluckhohn & Murray, 1956; Mahler, 1983; Mechanic, 1995; Susser et al., 1985) that adjust by responding to modern social values.

Complex considerations in the advent of increased CAM use are expressed through societal values of individuality, the primacy of individual choice, personal experience and responsibility in health care (Easthope, 1998, Eastwood, 1998a). Former values, Chan and Chan (2000) say, are predicated on post-modern thought described as an epoch in time that has moved beyond modernism that sought to capture, define, understand and control knowledge. Postmodernism is associated with, "... values, a consciousness, procedures and the attitudes that reflect the status of contemporary Western civilisation" (Chan & Chan, 2000, p. 332). Attitudes that reflect such a contemporary modern society embrace individualism with respect for the rights and values of the individual, "... where fundamental meaning is no longer the privilege and responsibility of meta-narratives" (Shank, 2002, p. 159).

Contemporary social trends that have transformed Western modernity, Eastwood (2000a) refers to as post-modern trends, driven by choice and demand for options other than a dominant biomedical model. Eastwood suggested consumers required a health system that offered more holistic health provision, which CAM purports to provide and which incorporates the dimensions of mind-body-spirit expanded on in my research into Chinese medicine in Chapter Eight. Eastwood also argues that a post-modern trend "... has contributed to the relativism of knowledge which has resulted in the diminution of biomedical prestige and authority" (2000b, p. 136). The realm of medical knowledge held in control by medical authorities is now made

available publicly through freedom of access to health care information and through literary sources and the internet exchange (Marcinkiewicz & Mahboobi, 2009). This provides the patient with information on their condition and offers health promoting advice. Despite the inherent danger of information that could inaccurately depict a potentially threatening health problem, freedom of choice is found personified in an individualism posed by diverse cultural values.

A ramification exists that an associated increased consumer demand on alternate forms of health, is also suggestive of shift towards self responsibility and the control over ones choice in health care by opportunities made possible through government. For example, a 1994 legislation passed by the US Congress, "... permitted a wide access to dietary supplements without confirmation of their efficacy, and a concomitant loosening of legal restraints on alternative practices" (Chesney & Straus, 2004, p. 335). It is not surprising then that doctors have opted to become more receptive towards alternate health therapies and therefore increasingly competitive in their selection of modes of treatment in response to consumer demand (Chan & Chan, 2000; Leach, 2006; Rees & Weil, 2001; Veeramah & Holmes, 2000;).

Complex considerations, Eastwood (2000a) argues, is partly attributed to general practitioner and consumer driven use of alternative therapies, embedded in what are considered to be post-modern values, namely, "... spirituality, linked to spiritual traditions that are often non-Western values and practices" (p. 133). This is reinforced by what Coulter and Willis say, that "... all CAM groups subscribe to the recognition of spirituality through the recognition of 'vitalism', that living organisms are sustained by Qi, life force, yin-yang, prana, universal intelligence" (2004, p. 587). It may that the persuasive appeal of CAM is found to be linked to a user friendly person-centred approach that dispenses a blend of spirituality with various therapies, dietary supplements, and exercise regimes that become daily activities in an affirmation of wellbeing (Kaptchuk & Eisenberg, 1998). Complex interrelationships of factors that respond to the changing circumstances of health related values to some extent impact on future health policy.

Changing values are informed through considerations of socially diverse cultural health practices now found throughout modern Western societies. Constructions of how society views health and illness are to be found embedded in socially defined norms and beliefs of a particular culture (Stafford & Furze, 1997). Studies of Australian ethnic groups show decisions made on health policy are shaped by

cultural persuasions and ethnically based rules and frameworks (Easthope, 1998; Reid & Trompf, 1990). Diverse cultural values would determine the relevance of different forms of health care that were made accessible to the public (Chan & Chan, 2000). This has been found in the increased recognition placed on traditional health practices in the ethnically diverse American population (Chesney & Straus, 2004). The social relevance of medicine would then become less relevant if it did not enable new forms of health services to grow in response to consumer requirement reflected through the health needs and demands of ethnic populations (RCCM, 2003). The following section discusses the interest placed on those characteristics that distinguish CAM by government bodies in the UK, USA and in Australia.

1.3 Characteristic of non-conventional medicine

Many early sources attempted to define CAM, Ernst (1995) the first Professor of Complementary Medicine at Exeter University, the United Kingdom, gives this broad definition. CAM constitutes, "... the diagnosis, treatment and or/prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy or by diversifying the conceptual framework of medicine" (Ernst, 1995, p. 506). This definition does not help to understand why the alternate therapies offered by non-conventional practitioners would benefit the wellbeing of the patient. A contribution of defining CAM is offered by Bensoussan, "... complementary medicine should be defined as the therapeutic practices based on theory or explanatory mechanisms of action that do not conform to current medical thinking" (1999, p. 247). The approach offered by CAM is purported to espouse holism (Zollman & Vickers, 1999) and is found to be associated with groups of therapeutic and diagnostic disciplines that exist outside the parameters of conventional health practices.

CAM is identified as a modality that can be used by practitioners of both conventional and non-conventional medicine as a healing resource, contrary to it being an exclusive alternate commodity. This notion is borne out in contemporary medicinal discourse that describes CAM as non-conventional medicine being complementary and alternative to orthodox [Western] medicine (Fadlon, 2005). Confusion arises with terminology when the terms of complementary and alternative are used simultaneously as Fadlon points out, over the word 'alternative', when "...

the term ‘alternative’ carries the implication of one element replacing another” (2005, p. 1). Healing modalities from other disciplines can be incorporated into other systems of care for example when practitioners incorporate other system of care to provide an enhancement of healing (Baer & Davis-Floyd, 2005). An idealised notion of an incorporation of CAM or indeed as an integration into conventional health care is found in this encompassing definition by the Cochrane Collaboration;

as a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health systems of a particular society or culture in a given historical context (House of Lords, Sixth Report, 1.12, 2000)

In fact it is the capacity for a healing resource made available for the enhancement of the wellbeing of the patient in conjunction with conventional medicine. However a disparity remains in terms of what is widely acceptable to be offered to the public and that which is compatible with the ideals of conventional medicine. With such a plethora of therapies of CAM, a growing concern over these diverse practices has led to government inquiries in the UK, the USA and in Australia, on the nature of what constituted CAM, to review regulation and to initiate research on complementary and alternative medicine. In the UK, The Research Council for Complementary Medicine (RCCM) was established in 1982 with the main interest to conduct and promote research into CAM. Examining aspects of the protection and promotion of health, the results were to be disseminated to assist with the development of the National Strategy for Research and to facilitate legal reforms to present to the House of Lords Select Committee (2000). Reporting on the use of CAM by European doctors, Fisher & Ward (1994) pointed to the necessity of legal reforms to regulate the practice in Europe and to establish a better regulatory framework. A wide variance of regulation in CAM use was identified from one country to another, with some regulation in Germany and Scandinavian countries, while legal reforms were underway in the Netherlands and the United Kingdom initiated by reforms made in Parliament (House of Lords, 6th Report, 2000).

In the United States, Congress formally established the Office of Alternative Medicine (OAM) at the National Institute of Health in 1983. In 1998 Congress expanded the statutes, mandate and authority of the office by enacting legislation to create the National Center for Complementary and Alternative Medicine (NCCAM).

The US Government allocated \$117.7 million to NCCAM for research on CAM therapies with safety and efficacy research priorities (Chesney & Straus, 2004). NCCAM reported that an increased use of alternate therapies could in part be attributed to a frustration of modern Western medicine, not being able to meet expectations or the needs of people in the treatment of symptoms of chronic disease (Ernst, 1995). The RCCM points out that as a system of care, CAM provides an approach to health not based on a disease orientation, and the autonomy of the patient is respected. The freedom of choice is enabled through the promotion for self treatment and the self responsibility of the patient for the outcomes of the procedures and healing (RCCM, 2007).

Australian research initiatives to explain the alternative medicine use (Bensoussan & Lewith, 2004; Cohen & Willis, 2004; Eastwood, 2000a; Eastwood, 2000b; Siahpush, 1999) have shown an increased use of CAM by consumers and general practitioners with reasons not well understood in terms of why there is such popularity paid to alternate health care practice (Coulter & Willis, 2004, p. 587). CAM modalities are found to be used "... by women, people with higher education, those with an interest in the role of the mind in health or those with chronic illness" (Chesney & Straus, 2004, p. 335). In Australia, early studies of increased non-conventional medicine use, investigated cost factors and the socio-demographics of CAM users, which also included TCM (Begbie, Kerestes & Bell, 1996; MacLennan, Wilson, & Taylor, 1996; MacLennan, Wilson & Taylor, 2002).

The Australasian Cochrane Centre established in 1994 at Monash University funded by the Australian Commonwealth Department of Health and Ageing operates to apply a rigorous process to review randomised controlled trials across areas of health care and with CAM monitored under this provision. Consideration for public safety interests associated with the increased consumer use and awareness of CAM has prompted that standards of practice be regulated (Begbie et al., 1996; Bensoussan & Lewith, 2004; Coulter & Willis, 2004; Coyle & Smith, 2005; Llyod, Lupton, Weisner & Hasleton, 1993; Sawyer & Kassak, 1993; Siahpush, 1999a; Xue et al., 2005). Over the past decade, in view of the increased CAM usage, a regulation of CAM therapies was called for by researchers in Australia (Bensoussan & Myers, 1996; Khoury, 2000; Komesaroff, 1998; Meier & Rogers, 2006). Komesaroff (1998) appealed for a greater public protection and regulation of this sector through state legislation. Attached to this appeal was the recognition of increased claims on

Medicare made by general practitioners for services of acupuncture that had grown to nearly 50 percent in 12 years.

Explorations made to understand the epistemological dimensions of alternative medicine through research remains problematic as CAM treatments are often individually tailored to the patients needs (Bensoussan & Lewith, 2004). Kaptchuk and Eisenberg (1998) identified the difficulty of regulation was attributed to "... a disparity of beliefs and practices that vary considerably from one tradition to another and without any consistent body of knowledge" (p. 1061). The evidence of a wide variety of disciplines, beliefs and of therapeutic criteria, are found in the array of categories accorded into domains of therapies, that are classified according to the respective property of each therapy (The House of Lords 6th Report, 2000; NCCAM, 2000). NCCAM (2000) recognises that a major component of Chinese medicine lies within the domain of energy therapy and biologically based herbal remedies of non-conventional medicine.

1.4 Categorisation of CAM therapies

1) The United Kingdom

In the UK, an inquiry to debate the issues of CAM was organised through the House of Lords Select Committee on Science and Technology. Meeting on the 21st November (2000) the Select Committee, focused on issues arising from an increased use of CAM worldwide. These were; public health policy, regulation to protect the public, accumulation of evidence based research, adequacy of resource material for education purpose, standards for practitioner training and the prospects for National Health Service provision for these treatments. For the purpose of categorising the therapies, The House of Lords (2000) classified CAM into three broad groupings:

Group 1 Principle disciplines regulated by Acts of Parliament; Osteopathy and chiropractic. Others are acupuncture, herbal medicine and homeopathy.

Group 2 Therapies, which are used to complement conventional medicine including bodywork therapies, counselling, stress therapy, reflexology, and meditation hypnotherapy.

Group 3 Traditional medicine forms and alternative disciplines which lack any credible validity.

Efficacy of treatments from each of these broad categories were examined, with resultant NHS provision for therapies in Group 1 and with some for Group 2 (especially in the care of the terminally ill) being already available under GP guidance. Regulation of CAM was deemed a necessity, inordinate to the widespread use of CAM. A conclusion drawn from the issue of regulation was further development of regulatory structures and the prospect of research funding for Group 3 was considered mandatory. Concerns were raised that in the growing public interest on these therapies as the sole form of health intervention, a potential danger existed that patients could miss out on conventional medical diagnosis and treatment (XV1, Sixth Report, 2000). Summarised from the House of Lords Report, "... it would be useful to have more research on why the public are increasingly using CAM in their health care regimes" (Sixth Report 2000, Item 1.28, p.7).

2) The United States

Generic discussion of alternative medicine is problematic as Kaptchuk and Eisenberg (1998) point out, in terms of the variety of disparate beliefs and practices that form the body of knowledge of non-conventional medicine. In its inaugural 'Five Year Strategic Plan 2001 – 2005', NCCAM described CAM medicine as, "... those not presently considered an integral part of conventional medicine" (2000, p. 2). The plan drew a further distinction between CAM practices considered safe and effective and those which are not through evidence based research. CAM practice is divided into five major domains based on a mixture of conceptual and therapeutic criteria:

- i. Alternative medical systems that are based on the principle that health is achieved by restoring the innate harmony of the individual. It emphasises the equal importance of body, mind and spirit. Such systems are what since ancient Grecian times was a system of medical practice based on the restoration of ill health resulting from imbalance of the body's four humours (blood, phlegm, yellow and black bile).
- ii. Mind-body interventions, including the practice of meditation, hypnosis, prayer and forms of art, music and dance therapy.
- iii. Biologically based therapies such as herbal remedies, special diets and food products. Herbs are defined as plants or plant products.
- iv. Manipulative and body based methods, chiropractic approaches in which the spine is manipulated to restore health, and various forms of massage.
- v. Energy therapies based on the activation or generation of energy fields either originating in the body or acting externally on the body. A good example is Qi, a component of traditional Chinese medicine (NCCAM, 2000, p. 3).

NCCAM, in an amended Five Year Strategic Plan, examined the complementary and alternative healing practices from the context of science, education, and identified CAM researchers to be trained to provide for evidence based standards of science. Information from the Five Year Plan would be disseminated to the public and professional sectors to advise the context of the practice bases with views to regulation and further the expansion of evidence based research. A focus on investigation would enable explanation of future models of compatible integrated health care with conventional medicine (Executive Summary NCAAM, 2005-2009). Integration remains problematic due to a substantial variation (The House of Lords, (2000; NCCAM, 2000) in that the classifications of the practice contexts are disparate and lacks generic underpinning on the practice context. With many non-conventional therapies available that promote diverse beliefs, it is conceivable that considerable variation from one form to another (Kaptchuk & Eisenberg, 1998) would make general integration difficult. Selective therapies considered to be more mainstream by general practitioners, are reviewed in Chapter Two.

1.5 The growth of non-conventional medicine

1.5.1 Public expenditure

Non-conventional medicine use has increased markedly in Australia and overseas from 1990 onwards, evidenced through the increase in expenditure on these therapies, which research has identified, through the increased public and medical sectors, namely where CAM use was either an adjunct or a primary source of health intervention (Astin, 1998; Easthope, Gill & Tranter, 2000; Eastwood, 2000b; Eisenberg, Kessler, Foster, Norfolk, Calkins & Delblanco, 1993; Eisenberg et al., 1998; Siahpush, 1999a).

A national survey in the US in 1990 to 1997 (Eisenberg et al., 1998), examined the related expenditure of CAM use, through interviews on 1,539 adult participants in 1991 and 2,055 in 1997. A variety of CAM therapies such as herbal medicine, massage, megavitamins, self help groups, folk remedies and homeopathy of which an associated expenditure estimated to be \$21.2 billion in 1997. From this study it was found, that from 1990 onwards, alternative therapy use had increased from 33.8 percent to 42.1 percent in 1997. Over this period it was found that visits to alternate

practitioners increased from 42.1 million in 1990 to 629 million visits and these exceeded the total visits to all US primary health care physicians for that year of 1997, some 55 percent of respondents paid out of pocket expenses to access CAM (Eisenberg et al., 1998). Arguably this can be linked to the costs of public medicine which Di Stefano says is linked to accumulation of capital, “Western governments have acquiesced to a profoundly expensive medical system which a major drain on the public purse in all countries where it is a forms the dominant style of practice” (2000, p 92). Expensive health costs places pharmaceutical products out of reach for the vast majority of the world’s people. What is classified to be alternative therapies in the United States, “... constitutes primary health care for 80 percent of humans worldwide” (Micozzi, 2002, p. 400).

Consumers in the United States have paid considerable out of pocket expenses for complementary health services that are not covered by private health insurance, estimated to be at least \$12.2 billion annually (Barr, 1998). Private insurers in the U.S such as Blue Cross /Blue Shield reimbursed for acupuncture and others including Mutual of Omah, U.S. Health Care, and Blue Cross /Blue Shield of Washington and Alaska, America Western Life Insurance and Oxford Health Care have developed plans to cover CAM therapies. Alliances have been formed between networks of therapists with physicians to provide for a collaborative approach in health care. The outlay of money by consumers for therapies that operate in largely deregulated industry in the market economy remains a concern for public health and safe practice (RCCM, 2000). The industry is accessed from a variety of non-medical treatments facilitated through private outlets such as health clubs, beauty parlours, over the counter forms of medication in retail and health food outlets, natural therapy clinics, meditation centres and Chinese herbal shops.

Whilst it is clear that people should be free to make their own choice with respect to health care, the issue of the efficacy of the health practice, reveals that a gap exists in public health policy. Since the report by Barr, ongoing costs associated with the prolonged use of non-conventional therapies would eventually become a prohibitive factor for many evidenced through a decrease in the use of CAM (NCCAM, 2007). Results from a 2007 National Health Interview Survey of CAM use by Americans, reveals that approximately 38 percent of adults now used some form of CAM with cost to consumers of these therapies becoming a determining factor of their prolonged use (NCCAM, 2007).

To identify how the expenditure by consumers in the UK and the USA has increased (House of Lords, 2000; NCCAM, 2000) studies have focused on the consumer based access to CAM to find motivational factors that have led people to pay out for the health services of CAM therapists, in a largely self regulated industry. The House of Lords 6th Report (2000) noted the majority of CAM users were from the private sector, people often self referred without the approval of their doctor or the doctor's knowledge and were prepared to spend out of pocket money without private health reimbursement. In Australia a noticeable expenditure was found to be associated with the use of CAM therapies. On this expenditure, Lewith and Bensoussan say;

About half the population use complementary and alternative medicine (CAM), with an estimated 2.3 billion being spent on CAM in 2000; this was nearly four times the public contribution to all pharmaceuticals. Total CAM consultations in 2000 were estimated to cost \$616 million representing 1.9 million naturopathic and Western herbal medicine consultations in 2003. Similar patterns are seen in other developed countries (2004, p. 332).

Whilst expenditure, affordability and efficacy of these therapies remain considerations that ultimately affect CAM use, it appears that people are prepared to spend out on CAM therapies for an improvement in self care (Epp, 1990) supported in a number of studies (Berman, Singh, Lao, Singh, Ferentz, & Hartnoll, 2002; Berman & Chesney, 2005; Furnham & Vincent, 1995; Kelner & Wellman, 1997a). The use of CAM therapies has been found particularly helpful in patients who have cancer whom wish to improve their quality of life (Chrystal, Allan, Forgeson, Isaacs, 2003; Hlubocky, Retain, Wen & Daugherty, 2007; Kristoffersen, Fonnebo & Norheim, 2009). An estimated four in ten Americans wanted to try to improve their health with the use of acupuncture, chiropractic herbal medicine and homeopathy, the most widely used modalities (Barrett et al., 2003). The motivational factors of why people have chosen to use CAM therapies are viewed next.

1.5.2 Motivation of why people use CAM therapies

To explain what has motivated a significant number of people who use alternative medicine, three hypotheses were tested on randomly selected subjects from an adult

population of 1.035 adults (Astin, 1998). First, was an increased use of CAM related to dissatisfaction with conventional medicine; did the treatment offer more autonomy over health decisions; and second, was the use of CAM a reflection of a form of health care that expressed a compatibility with personal values and beliefs on health and illness? These predictors sought to distinguish an association of being ‘culturally creative’, a holistic philosophical approach to life and if ‘transformational healing’ was experienced from the use of CAM. From an overall response rate of 69 percent of respondents, the conclusion was drawn that any increase in CAM use was not a result of dissatisfaction with conventional medicine. However, Astin never asked this vital question in his survey, “... has conventional medicine worked for you?”, even though he sought to determine why people had turned to CAM use on which they are prepared to spend out considerable money (House of Lords 6th Report, 2000, 1.24.).

From another study in the United States, drawn from a sample of 31,044 adults aged eighteen years or older, it was found that 36 percent of that population had used some form of CAM in the previous twelve months (Barnes et al., 2002). Berman and Chesney (2005) drew conclusion from their study, an increased use was found to be associated with improved self care, that dietary supplements and other forms of self care, massage, mind-body approaches such as meditation, and energy interventions. Acupuncture and whole medicine systems (TCM) were the most commonly used form of CAM. The study concluded that with such a variety of different forms of CAM used, posed public concern for safety and effective practice and that a dissemination of information should be made available to the public and professional communities to allay concern.

Komesaroff made this point over a decade ago, that complementary therapies posed a potential risk to consumers based on a lack of clinical trials, especially in regard to TCM, which “... are in principle not susceptible to assessment using randomised trial design” (1998, p. 583). Policy that safeguards public health and a regulation of the CAM industry and development of research to measure outcome criteria of what has been effective in treatment, remain to a large extent unattended (Long, Mercer & Hughes, 2000). Chapter Nine provides a brief argument on evidences based outcome relevant to the recommendation made in the conclusion of this research. The broad public appeal of CAM requires a further examination on the notion of how consumer trends have found acceptance by consumers and

conventional health practitioners and importantly, why people are prepared to spend money often without medical rebates (Kaptchuk & Eisenberg, 1998).

1.5.3 International trends of CAM use

A broader set of cultural, political and institutional changes were seen to be related to the increased public interest in CAM health practices (Astin, 1998; Berman & Chesney, 2005; Eisenberg et al., 1998) and the acceptance of a wide range of therapies used by the public at an international level (Coulter & Willis, 2004; House of Lords, 2000; NCCAM, 2000; NCCAM, 2007). Healthy lifestyle factors have been attributed to CAM use (Furnham & Vincent, 1995), the motivation of use has been linked by others with the alleviation of chronic conditions and choice of multidimensional practitioners (Kelner & Wellman, 1997a). Increasingly references are made that CAM is used for the alleviation of chronic illness that did not respond well to biomedicine (Furnham & Vincent, 1995; House of Lords Report, 2000; NCCAM, 2007; Zhan, 2001). Other factors were linked to congruence with health belief values and some dissatisfaction of conventional medicine that contributed to the use of these therapies (Sirios & Gick, 2000).

In their study from the UK, (Furnham & Vincent, 1995) sought to determine why people visited conventional and/or complementary homeopath practitioners and if underlying values, such as a healthy lifestyle, governed the selection of choice of practitioners. From 256 subjects, four groups were formed from those who consulted with either a GP or one of the three CAM practitioners; osteopath, homeopath, or acupuncturist. A seven part questionnaire provided demographic data on; medical history, familiarisation with CAM therapies, health beliefs, life style, health locus of control, scientific health beliefs and perceptions of their consultation style. Conclusions were drawn from this study that people's values and perceptions were not a major factor in the choice of different medical practitioners, the most significant group to access CAM, were patients with a chronic medical history who sought out acupuncture for the relief of pain. People with chronic pain, were found to have the least satisfaction with their GPs, less confidence with conventional prescribed medication and were also the most concerned with the maintenance of a healthy lifestyle. Furnham and Vincent (1995) proposed that future studies should identify the differentiation on why people chose CAM, continued to use CAM and if

this was linked to a perceived failure of what biomedicine offered them to support their illnesses.

Motivation and coping styles were factored into a study (Furnham & Beard, 1995) to determine why people used CAM and understand why either a conventional or complementary practitioner was selected. A questionnaire was used to evaluate measure on specific areas of health belief, belief in a just world, coping style preferences when faced with a threatening situation and a measure of mental health. The three groups were compared for their differences in coping styles. The first used CAM medicine only, the second combined conventional with CAM, while the third used conventional medicine only. The study concluded there were no differences in coping style, health beliefs or mental health problems between the three groups. The results co-varied demographic factors. It was shown from the results that the complementary group yielded higher scores than the conventional medicine group with optimism towards their future health.

Motivation as a factor that contributed to decision making of CAM use has also been examined (Kelner & Wellman, 1997b; Sirios & Gick, 2000). Kelner & Wellman's early study from 1994-1995, drawn from a population of Canadian patients, divided 300 subjects into five groups and examined each on social and health characteristics that motivated their selection of health care. Each group was allocated a different kind of practitioner; general practitioner, acupuncturist, a Chinese doctor, naturopath and Reiki practitioner. Interviews on informants were conducted, using the Andersen Socio-Behavioural Model for analysis. The study revealed that some patients chose specific kinds of practitioners for particular problems, whilst others used a mixture of practitioners to treat a specific complaint and the type of practitioner choice was multidimensional. It also found that family physicians were consulted by almost all alternate health users, and there was no perceived disenchantment towards the type of practitioner, either conventional or those from an 'alternative ideology' of practice.

To distinguish between motivational factors, two different sets of factors were examined (Sirios & Gick, 2000) formed two separate groups of CAM users, to distinguish between frequency, the length of CAM use and, health beliefs that affected motivation. Both sets were found to have distinguishing factors that affected the decision to use CAM use with different predictors. Health-aware behaviours and dissatisfaction with conventional medicine were the best predictors on the overall use

of CAM. Conversely health problems and medical needs had little influence on why people chose to access CAM. Income was found to be the most significant discriminator linked to affordability, not to whether CAM was considered to be more or an equally effective treatment (Sirios & Gick, 2000).

Reporting on how CAM is generally used by the population, a National Health Survey conducted in the US in 2002 over a twelve month period, estimated that 62 percent of the population had used some form of complementary medicine (Barnes, Powell-Griner, McFann & Nahin, 2002). A higher than expected proportion of the population were found to use CAM in differing forms; the use of prayer (24 percent), deep breathing exercises (12 percent), meditation (8 percent), chiropractic care (7 percent), yoga (5 percent) massage (5 percent) and diet based therapies (4 percent). The survey found that, 54 percent of adults over 18 years were more likely to combine CAM with conventional medical treatments when it was thought these therapies would alleviate, chronic back pain, head or chest colds, neck pain or neck problems, joint pain, and anxiety or depression (Barnes et al., 2002). Turning now to explain patterns of use in Australian trends, of CAM use, the following section examines factors that identify how an increased consumer use is found to be associated with gender, and motivational factors namely associated with the enhancement of quality of life.

1.5.4 Trends in Australian CAM use

Public acceptance of CAM use in Australia is found documented in medical, public health and sociological studies over the past decade. Australians' increased CAM use was identified by GP's (MacLennan, Wilson and Taylor, 1996) in an early review in the Lancet. Studies on prevalence and cost of alternative medicine were conducted by interviews in South Australia on 3,004 persons aged fifteen years and over in 1993 (MacLennan et al., 1996). Specific features of why CAM was used were examined; the rates of use and types of alternative medicine and the therapists accessed. The analysis found: first, non-medically prescribed alternative medicines were used by 48 percent of the sample and CAM was also more likely to be used by peri-menopausal women on higher incomes. Second, women were more frequent users of iridologists, naturopaths and reflexology than men, and third a total of \$621

million dollars was outlaid on alternative medicines per annum with a further expenditure of \$309 million was spent on natural therapists per annum.

An expenditure and growth report on the CAM industry in Western Australia organised by the Department of Training and Employment in 2000, estimated that \$900 million dollars per year from 1995 onwards had been outlaid by consumers on alternative medicine which included natural therapies, relaxation therapy and massage therapy (Jones, 2000). Ashworth (2000) reported on a study by the Royal College of General Practitioners (Australia) that 45 percent of the population sought assistance from naturopaths and herbalists, whilst another 15 percent visit acupuncturists. The national expenditure for CAM was estimated to be \$2.3 billion dollars, outlaid on alternative therapies and practitioners in 2000, nearly four times the public contribution to all pharmaceuticals (Coulter & Willis, 2004).

From the increased national expenditure noted in 2000, MacLennan et al., (2002) repeated their 1993 study, to establish a profile of the consumers of CAM and their beliefs towards CAM therapies to determine if any changes had occurred in patterns of consumer consumption. Their study revealed consumers of CAM were more likely to be female, well educated, employed and with higher incomes, similarly identified by Chesney & Straus (2004) in the United States. Gender was found to be significant variable with females using more herbal medicines, aromatherapy oils, ginseng, and Chinese medicine than men. Furthermore many of these therapies were self prescribed, and the possibility these people were employed, had private health insurance that enabled them to access non-conventional medicine, naturopathy, homeopathy, acupuncture and remedial massage provided for by the ancillary benefits. The study concluded, with such variance in the use of therapies, safety regulation and standards similar to conventional medicine were deemed a necessity in view of a growing public demand for access to CAM and that safety and product information would promote a more professional practice standard (MacLennan et al., 2002).

Socio-demographic studies on population have assisted to identify by whom CAM is used (Lloyd, Lupton, Weisner & Hasleton, 1993). Examined were the characteristics of users of chiropractic and osteopathy therapies, their reasons for having sought this treatment and what role if any conventional medicine played in their decision to use CAM. A sample of 289 patients representing a cross sectional survey of patients from over eight Sydney practices, were studied. CAM use was

found to be positively related to income, with a generalised summary that these subjects came from a very select group with a narrow range of socioeconomic factors. However no income indicators were given to enable further speculation of whether affordability or even if gender was a factor attributed to the use of CAM (Lloyd et al., 1993). Gender as a determining factor was found to be associated with how people perceive the efficacy of therapies and of how CAM was accessed through a survey of Sawyer and Kassak (1993). Attitudes of new and current chiropractic patient's, towards the use of chiropractic care and whether patient characteristics were a good predictor of patient satisfaction were examined. From a self administered questionnaire on 507 participants, CAM use by patients was compared to conventional medicine. It was found that expectations of satisfaction with both forms of treatment were high and 22 percent of the population surveyed used chiropractic and dietary supplements. A conclusion was drawn that women were slightly more satisfied with chiropractic care than men, but were unable to determine why men were less satisfied with the chiropractic therapy or if more women than men sought this treatment.

These studies to some extent provide an insight into who uses CAM and for the purpose it is used often in place of conventional medicine, but do not explain the efficacy of any specific treatment with a variety of modalities used for consumer benefit that appears to be a superficial use for improved quality of life and enhancement of wellbeing. The focus of how CAM can be integrated into mainstream medicine is briefly examined.

1.5.5 CAM as an integrative medicine

CAM is characterised by a variable set of diagnostic and therapeutic modalities as non-conventional medicine, when these modalities are combined with conventional medicine, it is then described to be 'integrative medicine' (Caspi, Sechrest, Pitluk, Marshall, Bell & Nichter, 2003; Cohen, Penman, Pirota & Da Costa, 2005; Leach, 2006). Integrated forms of medicine, when both modalities of CAM and biomedicine are synergised, provide a holistic medium of health care. Di Stefano (2006) identified three key aspects that can be denoted to CAM; it complements conventional (orthodox) medicine, provides a more 'holistic' approach towards care and satisfies a demand by consumers on the conceptual understanding of health and illness.

It was thought earlier (Susser et al., 1985) the holistic movement was a paradigm shift that reflected a new form of integrative or 'social medicine'. Now a relevant association to this may be made that it reflects a new paradigm in the changing manner of how health care is accessed, based on the increasing evidence of a widespread demand and response by consumers and general practitioner who have adapted the use of CAM into their health care. The sustainability of a widespread integration of CAM remains a speculation until further investigation and evidence support a shift towards integrative medicine internationally (Leach, 2006). CAM has the potential to be used in the management of chronic disease and in preventive care to improve or maintain health (Coulter & Willis, 2004). The use of CAM to assist sufferers with chronic disease is acknowledged by social research that suggests that along with a growing recognition of CAM acknowledgement, biomedicine is not particularly effective in treating an array of chronic ailments (Baer, 2008).

Further research into new forms of medicine, incumbent social and ethical issues would need to demonstrate evidence, that CAM modalities have the potential for managing chronic illness, to assist in preventive care and thereby able to treat a wide variety of disorders (Bensoussan & Lewith, 2004). Any integrated approach could be restrictive, as McGuire (2002) points out, "... as there is an over emphasis on 'translating' CAM [TCM] and its effectiveness into Western medical terms" (p. 409), this applies to the value of CAM efficacy based on evidence based research. Notaries made on evidence based research whilst not dismissing the plausibility of justifying the efficacy of CAM, are urged by the increased consumer demand and the utilisation of a variety of non-conventional therapies, to address how these therapies can be integrated into conventional systems of medicine (Frenkel & Borkan, 2003). Lewith and Bensoussan (2004) determined that a selective incorporation of elements of complementary medicine would only be possible where options of these therapies are based on effectiveness, safety, convenience and cost.

In the UK, The House of Lords on the recommendation by Dr Dixon of the NHS Alliance, decided that CAM could be regulated under primary care, governed by existing statutory bodies of regulation. It was already made available through referral from doctors and allied health practitioners who operated in the field of primary health care (House of Lords, 2000) and seen to be assumed into existing secondary health care. First, manipulative therapies have been integrated into orthopaedic care. Second, acupuncture use was found in pain clinics. Third, acupuncture and

aromatherapy was noted to be in some obstetric and palliative care services. Fourth, homeopathy was already in place and provided in specialty homeopathic hospitals (House of Lords 6th Report, 2000). The management of ongoing chronic ailments might benefit from collaboration between conventional and non-conventional practitioners especially by consumers who wanted some autonomy and self responsibility on health options to enable them promote an enhanced quality of life. Such an approach could be facilitated through a plural or an integrated medical system which offers CAM and TCM interventions to clients and the integration of CAM with biomedicine (Leach, 2006). Different categorisations of CAM therapies recognise the place of TCM within the framework of CAM medicine (House of Lords, 2000; NCCAM, 2000). The following section briefly examines TCM.

1.6 Traditional Chinese medicine

Traditional Chinese medicine is a health system that has an extensive history of clinical experience (Giordano, Garcia & Strickland, 2004), and remains substantially different to Western conventional medicine, with linguistic differences and a logical sequence of ordering symptoms that varies considerably from Western medicine. Referral to TCM, in the United Kingdom through The House of Lords Report (2000), classified acupuncture under disciplines regulated by Acts of Parliament, thereby assigning official legitimacy to the practice of Chinese medicine. However any integration of TCM into mainstream medicine remains to be further addressed, Robson (2003) points out based on the principles of practice, safety and efficacy of TCM therapies. In Australia research towards that purpose has been attended by Bensoussan and Meyers (1996; 1997) with the proposal of 'Towards a Safer Choice'. TCM assumed under the auspices of CAM, has certain characteristics with forms of non-conventional medicine to some extent undermines this discipline, that should be a stand alone form of traditional medicine. Characteristics that identify TCM theory include a strong relationship between the environment and bodily function with the commencement of illness exhibited through an imbalanced energy in the body (Appendix 2). As a system of healing, TCM embraces the broad sense of constitution of physical balance as a foundation (Bensoussan & Myers, 1996; Giordano, Garcia & Strickland, 2004).

In Australia a review was made on the practice of TCM, initiated by the Victorian Department of Human Services in 1995. Bensoussan and Myers (1996) carried out the interim review for the Victorian Ministerial Advisory Committee (Appendix 3), into the standards of practice of TCM and of how it might be regulated, in regard to occupational regulation of TCM reported it would be dependent on identification of the specific problems that arose from the practice of TCM (Bensoussan & Meyers, 1996). Their tome reviewed TCM practices for the first time in Australia, culminated in the report entitled: *Towards a Safer Choice* (Doyle, 1998, p. 26). Acting on the report, the Victorian Ministerial Advisory made specific recommendations for the improvement of safety and for the regulation of acupuncture and Chinese herbal medicine. Resultant from this report the Victorian Government passed in May 2000 the Chinese Medicine Registration Act which required every practitioner of Chinese herbal medicine and acupuncture to be registered in Victoria (Khoury, 2000). The newfound recognition for TCM in Victoria, enhanced by a regulatory body has drawn attention to clinical competency as Parker (2003) with assessment based on the same rigorous validation of standards established by conventional medicine.

Official recognition of TCM through a registration of practitioners in Victoria has placed increased pressure on other states of Australia for conformity of regulation and the education of practitioners of TCM. In Perth TCM currently remains deregulated. The professional role of TCM practitioners in Australia has been defined through private accredited organizations (Australian Traditional Medicine Society, Australian Acupuncturists Association, and Australian Natural Therapists Association) that provide for membership on the basis of the hours of formal study undertaken and clinical coursework in practice. Self regulated organisations may have a code of ethics that govern certain practice, but lack stringency of a more credible registration body an example found in their review on standards of practice.

Bensoussan and Myers (1997) revealed there was an inadequacy of standards found in the training of primary TCM practitioners, and the Australian regulatory context was hindered by a lack of common definition in discussions of occupational regulation (10.4.1). With increased use of TCM, a more stringent surveillance of Chinese medicine providers and public education to protect against unauthorised Chinese medicine practice was recommended. Xue and colleagues (Xue et al., 2005) investigated public attitudes favouring TCM use in Melbourne and the impact of a statutory registration of practitioners. Drawn from a sample of 575 respondents, over

a 12 month period, they found that Chinese medicine was used by 30.9 percent and that 17 percent of the population had visited a Chinese medical practitioner at least once. Governments have a social and ethical obligation to respond to community needs in non-conventional medicine use (Coulter & Willis, 2004) and to provide information that will assist in the policy formation of regulatory frameworks to establish standards and conduct of safe practice. This raises the potential question of understanding how TCM is practised in the clinical setting, on how the assessment and diagnostic procedures are informed.

1.7 The research purpose

Cultural anthropology values the study of process over system in its empirical approach which this study will engage with to explain Kanbing. Attention will be paid to the social construct of illness and disease from the TCM perspective in the context of Western setting (Micozzi, 2002). Baer says, "... it is hoped that there is an interest by anthropologists beginning to conduct participant observation on CAM [TCM practice] more than they have to date" (2005, p. 356). Adler points to this particular initiative of research, "... we need to study the anthropology of complementary medicine and alternative medicine and integrative medicine as culture (2002, p. 412). Health and illness are a central concern of social science and related disciplines and, of particular significance to the research of the thesis, is the purpose to describe Kanbing within a Western clinic setting. In this research an ethnographic study described in Chapter Four, will be conducted with a focus directed on the characteristics of the TCM system through an analysis made on the clinical encounter known as 'Kanbing'.

The researcher acknowledges that important anthropological work has been carried out in China on 'Kanbing' (Farquar, 1994; Kleinman, 1997). The few ethnographic studies conducted in China (Farquar, 1994; Hsu, 1999) illustrate how TCM is practiced from within a traditional culture based on the Chinese idiom to describe this and a gap exists in current literature from within a western understanding. Peculiar to the review of literature is the notion that Klienman & Kleinman allude to; "Traditional Chinese medicine is equipped to see the links between social and bodily experience" (1994, p.707). This may be found to be formed from the clinical interaction [Kanbing], described to be the 'knowing practice' (Farquar, 1994) and the

'knowing doing' (Scheid, 2001) of clinical practice which requires further explanation and is the core purpose for this research on the tenets of the clinical interaction.

1.8 The research objective

The study investigates Kanbing through ethnographic exploration from field work by participant observation, exploration of case studies and from fieldwork based in two TCM clinics in Perth, Western Australia. Two questions are posed for the research:

1. How is the procedural encounter of the practitioner determined through the process of the client-practitioner interaction known as Kanbing?
2. What importance is attached to the clinical encounter of TCM from the perspectives of those clients who originate from non-Asian backgrounds?

Of core importance to the purpose of this thesis is that traditional Chinese medicine in the interpretation on the interaction is able to show there is a link between a person's social and physical experience of the illness experience (Kleinman & Kleinman, 1994; Unschuld, 1998). The first conjecture is that translation is made from narrative of the client that connects the emotional, physical and psychosocial wellbeing that is explained through an examination of the procedural phases of the assessment process and the diagnosis of the illness (Kleinman & Kleinman, 1994). The narrative of the illness experience and the repertoire of those interactions found in the clinic, are promoted through the narrative of the client's explanation through a sequence that identifies the chief complaint (Kleinman, 1988).

The second conjecture is that from the narrative and assessment process, a matrix is formed from which may be drawn an understanding of the clinical encounter [Kanbing] between practitioner and client experiencing TCM. The approach towards the diagnostic assessment guides the instrumental assessment of the procedure of performing a diagnosis but there remain tacit underpinnings to explain from this study that are translated through the interactive process of Kanbing. The social processes from which the study explains and interprets interactions between the client and practitioner forms an 'ecology of health' Micozzi (2002) that informs the explanation of the illness and the conceptual paradigm of TCM. Traditional Chinese

medicine, "... is like other cultural systems, it needs to be understood in terms of instrumental and symbolic activities" (Kleinman, 1981, p. 25).

1.9 Summary

The question of why TCM has gained increasingly popular use amongst consumers of health care is an important focus of this research as the dynamics of "... TCM is not considered as an alternative to Western medicine but as a medical system rooted in its cultural tradition" (Bensoussan & Myers, 1996, p.7). To gain insight into why people choose TCM and if there is a dissatisfaction towards conventional medicine, remains to be explained (Eastwood, 2000a; Eastwood, 2000b; Siahpush, 1999b; Veeramah & Holmes, 2000).

Medicine and illness are complex topics that are both embedded in socio-cultural contexts with different ways that approach the event of illness. Generally in the West medicine is viewed from a biomedical model that has a focus on dysfunction to explain illness and disease, traditional medicine views the body to be intrinsically linked to the social domain (RCCM, 2000). Anthropology can inform this understanding through the exploration of the process, as Micozzi (2002) points out that anthropology is a key to assists with understanding from the research exploration, an illness from a different cultural perspective. This understanding becomes "... a social science knowledge in the manner in which it constructs notions of health and normality" (Peterson, 1994, p.32).

Conclusions drawn from this research would assist with the development of future health policies that constitute a new framework for health and illness assessment. The information will make contribution to the knowledge base of social medicine for health professionals and academics working within the social context of multi-cultural backgrounds (Eisenberg & Kleinman, 1981). It is anticipated that the information from this study will help promote and enhance an understanding of the structure of healing found in the system of TCM.

1.10 Overview of the thesis Chapters

The literature reviewed in Chapter Two, is relevant to non-conventional medicine use and reveals that despite important work in conventional medicine on doctor-patient interactions, there are few studies available outside of China that explain Kanbing. A discussion of the medical anthropological perspective of traditional medicine is expounded on and the available literature on Kanbing examined. Chapter Three explains the initial-entry phase of the research, the philosophical basis of TCM theory and entry into the world of TCM that enabled this form of medicine to be understood from the context of the clinical reality experienced in China at the Guangzhou College of TCM in 1994. Chapter Four provides the methodology from the ethnographic focus selected for the purpose of the research. Chapter Five provides a description of the field setting and structured observation made on the role of the practitioner in the clinic.

Analysis from the ethnography is presented in Chapters Six, Seven, and Eight. Key elements revealed from the domains and taxonomy of the data (Spradley, 1980) described in Chapter Four, identify the practitioner's reference to the philosophy guiding their therapeutic role in the assessment process. Chapter Six describes explanation by the practitioner on the TCM assessment and diagnostic process in clinical practice. Expertise of interpreting symptomatology from illness description by the TCM practitioner is explored through the process of assessment and explained using the Explanatory Model described by Kleinman (1981). Exploration is made of the meanings that are attached to an illness as part of the unique expression of the client narration that informs the practitioner. Chapter Seven presents the perspectives from clients on their experience of TCM. Chapter Eight provides an in depth-analysis on meaning found in TCM attached to the diagnostic process, clinical transactions and interactions informed from a case study to determine how links are made in TCM during the process of assessment. It shows that transactions in the clinical experiences form a nexus between the discourse of the client and TCM theory. Chapter Nine summarises the studies main conclusions and discusses the importance of evidence based research and for integration of TCM within conventional medicine to serve the health needs of multicultural populations in Australia and overseas.

CHAPTER TWO

Contextual approaches of Biomedicine and TCM

Changes in perceptions of body, health and illness may be one factor enforcing that CAM is increasingly becoming a first-line intervention. Health authorities meet this challenge emphasising the regulation of CAM to safeguard patients but could also choose to focus on what clients define as their needs (Agdal, 2005, p. 67).

2.0 Introduction

This chapter examines the contextual approaches taken by two diverse health systems, biomedicine and TCM, that have evolved from different cultural traditions and with each having different orientations towards health and illness. The structure of each system is examined, to provide understanding of the assumptions and guiding principles that underpin each of these practice traditions. A focus is made on the doctor patient relationship in biomedicine and the process of Kanbing in TCM. Fundamental differences in biomedical and traditional health system are reviewed respectively on characteristics which underpin these practice traditions found in the separate sections of the review.

Section One, foregrounds the satisfaction associated with non-conventional medicine use to determine if broader trends have impacted on why there is an increased consumer demand for non-conventional medicine and TCM use. The main focus is taken on the contextual characteristics in the approach found within biomedicine specifically the values of the encounter of the doctor-patient relationship are examined to identify key values found to be associated with patient satisfaction.

Section Two explores from the perspective of anthropology, literature that describes how modern traditional Chinese medicine has evolved with examination made on the cultural construction of the clinical encounter ‘Kanbing’ found in TCM. Studies in anthropology have described the notion of Kanbing (Farquar, 1994) the interaction found in the clinical encounter, the transmission of information (Hsu, 1999) that informs the cultural construction of an illness, as the ‘knowing practice’ (Farquar, 1994) and the ‘knowing doing’ Scheid (2001).

Section One: Contexts of CAM use – Characteristics of Biomedicine

New forms of non-conventional medicine provide an opportunity for a ‘democratic contract’ between practitioner and client with the emphasis away from the traditional doctor-patient relationship, whereas the relationship with the CAM practitioner may be seen to offer a more conducive approach toward how the illness is explained in lay explanation (House of Lords 6th Report, 2000; RCCM, 2000). It has been argued that CAM research conducted across the United States, “... has revealed the incompleteness of a reductionist biomedical paradigm” (Adler, 2002, p. 412). This has dismissive overtones that the popularity of CAM is favoured over conventional medicine, because it is seen to be more natural, and offers a more personalised attention and time to consumers who use it (Bensoussan, 1999). Complementary therapies ‘seem to provide’ alleviation of symptoms for patients who have chosen to use treatments to assist their conditions which conventional medicine was unable to provide (Chan & Chan, 2000; House of Lords 6th Report, 2000; Vincent & Furnham, 1999). It can be argued that science has generally improved medicine, but evidence points to areas such as terminal illness and chronic pain (Chesney & Straus, 2004) where CAM provides what consumers seek out, the alleviation of suffering and enhanced wellbeing discussed in 2.1.1.

If CAM is able to promote wellbeing for consumers who have sought this form of health care out, it has bearing on the future consideration of how a health care should be organised, ‘... we should remember that the healthcare system is supposed to work for patients as well as doctors” (Brooks, 2004, p. 275). Biomedical parameters have been stretched according to Baer and Davis-Floyd (2005) who point out that in the late 1970’s biomedical practitioners began to adopt alternative therapies in response to the recognition of the limitations of the biomedical model. Health

authorities meet this challenge emphasising the regulation of CAM to safeguard patients but could also choose to focus on what clients define as their needs (Agdal, 2005, p. 67). However that which Adler (2002) referred to an 'incompleteness' in conventional medicine, requires a closer examination of the phenomenon of the popularity of CAM as a system of health care (Bensoussan, 1999; Chesney & Straus, 2004; Kaptchuk & Eisenberg, 1998).

Values ascribed to doctor-patient satisfaction in conventional are salient to an understanding of why there is an increased consumer use of CAM. Information from the House of Lords Sixth Report; based on research from the Consumers' Association, identified several reasons for a high patient satisfaction. Evidence was drawn that: overall patients appreciated the practitioner emphasis on overall wellbeing and that the consultation with the practitioner was longer which may have provided more satisfaction for patients. CAM practitioners have been found to have good communication skills which put people at ease, that listening techniques and an interest in the person's life, not just their physical health, contributed to higher levels of patient satisfaction (House of Lords 6th Report; 2000, [3.3]). A general patient dissatisfaction towards how biomedicine is practised was found in the response generated from the research that examined attributes in the doctor-patient relationship (House of Lords, 2000, [2.1.6]). These are probable explanations which may explain to some extent why a consumer shift is associated with an increased satisfaction found from the use of CAM (Veeramah & Holmes, 2000), but what if any efficacy has been derived from these non-conventional therapies that people choose to access?

Efficacy of conventional and CAM therapy was examined on a total of 216 patients who attended either an Outpatient's clinic in Britain, the British School of Osteopathy, an Acupuncture centre and the Royal Homeopathic Hospital. They were evaluated on four areas of major, minor, chronic and psychological illness (Vincent, Furnham & Willmore, 1995). Questionnaires from this survey covered four major areas of demographic information, experience of complementary medicine, a health locus of control scale and attitudinal variables, with ratings on the perceived efficacy of the treatment. Whilst no differences were found between the four groups, the health locus of control revealed an association of psychological factors affecting health beliefs with the concern about the harmful effects of conventional medicine. Results from studying these four groups revealed that beliefs in efficacy of the

treatment was related to psychological factors associated with illness, particularly amongst users of acupuncture who thought the therapy was able to cure minor and chronic illness. CAM use for the relief of chronic conditions has been recognised by others, which Baer (2008) argues, that there now exists a growing recognition that biomedicine is not particularly effective in treating an array of chronic complaints which motivate people to access CAM (Kaptchuk & Eisenberg, 1998; Kaptchuk, 2002).

2.1.1 Contexts of CAM use

Satisfaction from forms of medicine other than conventional medicine is found in sufferers of chronic disease who often turn to other forms of alternate medicine only after there has been an experience with long-term negative conditioning with mainstream medicine (Kaptchuk, 2002). Kaptchuk suggests that when "... patients choose alternative medicine, it may also potentiate a placebo response" (2002, p. 818), therefore a possible factor for the appeal of CAM use in chronic pain sufferers. The placebo effect Berman and Chesney report, refers "... to psychological or physiological changes associated with inert substances or control procedures" (2005, p. 574) and can be substantial in CAM interventions where manipulation of energy and therapeutic relationship is indeterminate and not scrutinised for efficacy as in conventional medicine. Sufferer's of pain, experience relief of symptoms in association with CAM use and an enhanced quality of life (Begbie, Kerestes & Bell, 1996; Chrystal, Allan, Forgeson & Isaacs, 2003; Hlubocky, Retain, Wen & Daugherty, 2007; Kristoffersen, Fonnebo & Norheim, 2009; Zhan, 20001). However, these studies do not explore the possibility of the placebo effect but examine the use of CAM in the alleviation of pain.

A demographic study that examined patients with cancer at the Royal North Shore Hospital and Port Macquarie Base Hospital (Begbie, Kerestes & Bell, 1996) found patient satisfaction with their use of CAM treatments. Patients from two population groups were surveyed to determine the patterns of alternative medicine use. Cost did not appear to be a major concern amongst CAM users with the median expenditure associated with alternate therapy use, estimated to be an outlay of \$530, with most patients reporting they had received value for money. The study drew three conclusions; first, a significant proportion of patients with cancer used one or more

forms of alternative therapy but the efficacy of these therapies was not evaluated. Second, younger ages and married status in females was found to be predominant and associated with non-conventional treatment. Third, the use of alternative therapy may reflect deficiencies in the conventional health care sector and dissatisfaction with existing health services in the provision of care and a desire for patients who sought to improve their quality of health.

Similar findings are brought out in the prevalence and patterns of CAM use in patients suffering from cancer from a New Zealand survey (Chrystal et al., 2003). A self administered questionnaire was distributed at the Mid-Central Regional Cancer Treatment Service to 350 outpatients who used CAM. They were asked to identify the types of therapies they used, the reasons for use, perceived effectiveness, safety and financial cost. From the response of 200 outpatients who completed the survey, 49 percent used vitamins, antioxidants, alternative diets and herbal therapies and stated that CAM was used to improve their quality of life. An important conclusion drawn by Chrystal et al., (2003), was that patient's who used CAM, may or may not consult with a specialist before that use. Such a lack of open communication of the use of non conventional medicine without the knowledge of their specialist may be seen by some as exerting control over one's health decisions. Conversely it constitutes a potentially risk taking behaviour especially when there are issues such as synergistic drug reactions involved with their biomedical care.

A desire for improvement in the quality of life was found to be associated with CAM use by others (Hlubocky, Retain, Wen & Daugherty, 2007; Kristoffersen et al., 2009). Hlubocky et al., (2007) examined motivating factors in decision making in patients with advanced cancer and the preference for CAM therapies, coupled with a desire to enhance quality of life and relieve symptoms of their illness. The Functional Assessment of Cancer Therapy-General instrument was used to assess quality of life, with univariate and multivariate analyses to assess differences between CAM users and non-users. From their analysis, Hlubocky et al., (2007) concluded that CAM use was more prevalent in patients who were likely to experience death within twelve months.

Quality of life improvement in patients suffering from cancer was also a factor that affected a decision to use CAM found from a Norwegian study (Kristoffersen et al., 2009). CAM therapies were more frequently used when the prognosis given to the patient by the physician was poor, then CAM was used as a form of self support,

this concurs with the research of Hlubocky et al., (2007). Kristofferson et al., (2009) concluded that further research was necessary to understand the frequency of CAM use as an improvement within a quality of life context. Terms of evidence of the effectiveness of the alternative therapy use in these circumstances (Barry, 2006) is not offered here as the broader ramifications for evidence based epistemology is addressed in Chapter Nine.

2.1.2 Contexts of TCM use

TCM studies in Taiwan from the past decade have explored attitudes towards TCM practice, found in the doctor-patient relationship and frequency of TCM use and the selection of therapies commonly used. A semi-structured focus group of twenty nine participants examined people's perception on the strengths and weaknesses between biomedicine and TCM therapies (Lam, 2001). From his study, Zhan (2001) identified that sufferer's who experienced chronic pain, resorted to TCM to enhance their quality of life. Herbal medicine and acupuncture, two main components of traditional Chinese medicine were used for chronic pain relief and symptom relief. Therapies were primarily used for conditions where biomedicine was less effective or ineffective in the treatment of allergy, pain syndrome and certain types of cancer.

The doctor patient relationship was examined in another study by Chin (2002) looked at the specific issue of informed consent and decision making. Chin's study examined aspects of bioethical practice with specific regard to the ancient Chinese Confucian cultural commitments. Chin noted that whilst this model will further develop in modern China, it will retain its Chinese character of moral integrity found in 'beneficence'. Reference is made to the decision based approach through the absolute autocracy of the doctor in the construct of doctor-patient relationship and how an ethical approach is considered to embrace the autonomy of the patient that incorporates patients' values and perspectives (Chin, 2002).

An increased use of TCM use was noticed in Taiwan from 1996 onwards with the frequency rates of use monitored from then until 2001 (Chen et al., 2007). Private TCM clinics provided most of the care (83 percent) followed by private hospitals (12 percent). Database sets were programmed to monitor the use of Chinese herbal therapy, acupuncture and manipulative therapy to analyse the use frequencies, the nature of the therapies used, the characteristics of TCM users and the disease

categories that were treated. The mean number of TCM users per annum was 5,733,602 with an increment of 1,671,476, nearly 30 percent of new users yearly. It was found that TCM use was gender weighted with higher use amongst females and an age distribution that peaked at around the mid-thirties. The study revealed the most common forms of TCM used were; herbal therapy was used by nearly eighty six percent of the population, followed by acupuncture, eleven percent and manipulative therapies, three percent. The ten most common forms of disease categories treated were respiratory, musculoskeletal and connective tissue, symptoms signs and ill defined conditions, injury and poisoning, digestive system disease, genitourinary system, skin and subcutaneous tissue, nervous system and sense organs, circulatory and endocrine, nutritional and metabolic disease and immunological disorders. Nearly sixty per cent of all subjects had used TCM over the six year period and that major disease categories recognised by Western medicine were also treated by TCM.

Overseas studies from Canada, have explored TCM use amongst older immigrants (Lai & Chappell, 2006). Satisfaction experienced by TCM users in an American clinic reported that patients enjoyed a close professional relationship with their Chinese medicine practitioner (Cassidy, 1998). In a mixed qualitative quantitative study of 460 participants in six acupuncture clinics from five States of America, Cassidy (1998) collected data and analysed handwritten stories collected from these participants. The analysis showed that respondents were highly satisfied with their Chinese medical care and that respondents felt their therapy had provided them with both physical and psychological relief. The study revealed that the participants were not familiar with the TCM as a health system, but understood that it was a form of 'holistic' health care, the ideology of which had drawn them to use TCM.

The integration of TCM with conventional medicine was examined from a study in Switzerland by Busato (2008) who evaluated TCM use versus conventional medicine in a Swiss primary care clinic. From a cross sectional study of 51 certificated TCM physicians and 71 conventional medicine physicians, and 2,530 adults, Busato found; patients who chose a conventional physician with additional certification in TCM had a higher chance of satisfaction with treatment than patients who chose a physician educated only in conventional medicine. Integration of TCM use in oncology patients has also been examined by Lee, Hlubocky, Stafford and Daugherty (2008). From their study of 95 oncologists where an integrated approach was made available as an

option to patients with cancer, they found that TCM popularity had grown amongst patients by eighty percent during active cancer treatment (Lee et al., 2008). However, four out of five oncologists felt their medical training was inadequate to prepare them to use TCM, but seventy eight percent felt they would continue to use TCM. In conclusion the use of non-conventional medicine was more frequently used when the prognosis given to the patient by the physician was poor (Lee et al., 2008). This concurs with other studies by Chrystal et al., (2003) and Hlubocky et al., (2007).

An Australian study in Adelaide (Coyle & Smith, 2005), examined the health status of one hundred and eighty women who underwent assisted reproductive technology, looked at the health status from a Western and TCM perspective. From a response of 98.3 percent who completed the questionnaire, TCM diagnosis was compared with Western diagnosis. It was revealed by Coyle and Smith a common diagnosis of TCM was a syndrome described as 'Kidney Yang deficiency' or, 'Qi and blood stagnation' found in fifty four percent of women by TCM practitioners. It seemed to be associated with stressors that contributed to an overall poor quality of life and the role that emotional dysfunction had on this. The survey concluded that emotional wellbeing and quality of life are important aspects of patient care that needs to be addressed in any clinical practice, conventional or non-conventional medicine. Coyle and Smith (2005) report what is described as a 'TCM syndrome' of a TCM diagnosis, has no comparable condition seen from a Western perspective. This is an important point for my research, as the contextual approach in TCM determines how a classification of syndrome is made from a collection of symptoms and is described from analysis of a case study to explain Kanbing in Chapter Eight.

A qualitative study on TCM use in Canada in cancer care explored the perspectives and experiences of the patient by Xu, Towers & Collet (2006) concluded the decision to use TCM was based on self help. Participants believed TCM to be an optimal therapy that was safe and effective, and highly valued that TCM was tailored to their specific needs and believed it was the basis of an optimal and safe treatment. In Switzerland, TCM use has been examined to determine the effectiveness and safety from an evaluation of forty three articles on 'gastrointestinal and liver' (Maxion-Bergemann, Bornhoft, Sonderegger, Renfer, Matthiessen & Wolf, 2006). From the articles surveyed, a comparison based on TCM diagnosis and a biomedical diagnosis, revealed that treatment based on a TCM diagnosis had improved the patients wellbeing overall. Comparisons of treatment by individual

medication (TCM) and standard medication (conventional medicine) showed a trend in favour of individual medication. The study reported that side effects can occur from the ingestion of herbal medicine, but that no severe effects had been registered in Switzerland (Maxion-Bergemann et al., 2006).

Studies have revealed (Cassidy, 1998; Coyle & Smith, 2005; Lai & Chappell 2006; Lee et al., 2008; Maxion-Bergemann et al., 2006; Xu, Towers & Collett, 2006) that there is an acceptance of TCM in Western countries particularly over the past decade with conventional practitioners of medicine prepared to research and report on the efficacy of this form of traditional medicine and for consumers to use TCM therapies. As a form of traditional medicine the systematic approach taken in the TCM diagnosis differs inordinately from that of biomedicine, which raises the issue of integration drawn in Chapter Nine. I now review how non-conventional medicine has been viewed by some general practitioners with reference made to the gate-keeping of CAM therapies and education.

2.1.3 General Practitioner (GP) interest in CAM

This section briefly looks at studies that show a general support by Australian GP's towards the development of education in CAM and the integration of CAM therapies by some conventional practitioners of medicine into their practices. Why there is an increased interest and support is revealed through research attended on GP's (Cohen, Penman, Pirotta, & Da Costa, 2005; Easthope, Gill & Tranter, 2000; Eastwood, 2000b; Hall & Giles-Corti, 2000).

Two surveys of Australian General Practitioners in Victoria and Tasmania in 1997 revealed that most doctors accepted acupuncture as a non-conventional therapy (Easthope et al., 2000). Doctors aged between thirty five and fifty four were more receptive towards and likely to use acupuncture. What has emerged from these studies is the support of CAM is reinforced through the GP acceptance of use and by the notion that it provides a more holistic form of health care (Easthope et al., 2000). From a sociological study attended by Eastwood (2000a) examined the demand for CAM to be multi-factorial in GP's and alternate health providers. Three provider groups were studied, general medical practitioners (N=17), alternative therapists (N=17) and a control group of GP's whose attitude towards the use of alternative therapies was unknown (N=10). Eastwood (2000a) found GP's use of CAM, had

increased in response to consumer demand for alternative medical forms; acupuncture, manipulation, hypnosis vitamin therapy and herbal treatment medicine.

The increased demand for CAM was driven by:

1) competition, for doctors to remain at the cutting edge of consumer demand for alternative therapies; 2) anti-drug consumerism, there was an increased resistance towards pharmaceuticals by patients; 3) consumer choice for patients exerting their right to choose options in health care; 4) criticism of the biomedical model with general practitioners criticising biomedicine for its bureaucratic, technological and dehumanising aspects (2000a, p. 142).

Eastwood (2000b) found from the survey, that GP's felt that short consultations were a product of the inheritance from the institutionalisation of the general practice conversely, they also considered that time intensive alternative treatments such as acupuncture, were too time consuming and as such financially unattractive. A major concern that emerged from Eastwood's study was that GP's identified with a career dissatisfaction borne out of 'six minute' medicine (Eastwood, 2000b). Eastwood's findings concur with Salgo (2006) professor at the Columbia University College of Physicians and Surgeons reported to the New York Times that, '... seven minute medicine' reduced the doctor-patient relationship to a financial concept in a business school term paper. The value attached to the initiation of care is an important consideration in patient care as a shorter contact time may be found to be depersonalised and does not enhance the development of a therapeutic relationship.

A survey of Australian General Practitioners by Cohen et al., (2005), revealed that CAM therapies were seen to have some value by GP's from a postal survey conducted through RMIT Victoria on a random population of 2,000 Australian GPs. Opinions towards CAM practice were examined. It was revealed that harmfulness, effectiveness of the therapies, current level of training and future interest in training, personal use and use in practice were a concern. Referral to CAM practitioners, appropriateness for GPs to practice CAM and for government regulation related to the increased patient demand for CAM were identified to be factors of interest in professional standards of conduct and public safety. The survey concluded non-medicinal therapies that included nutritional therapy and chiropractic therapy were acceptable to biomedical care and general practitioners viewed education in complementary medicine favourably (Cohen et al., 2005). However these figures should be interpreted with caution when taken into account the response rate of 33

percent of 2,000 GP's of this survey. An emphasis was placed on prioritising and providing funds for further research that investigated the potential harmful effects from CAM therapies through evidence based research.

Studies that explore GP use of CAM, emphasise that different ideologies reflect how useful CAM is perceived in treating patients (Cohen et al., 2005; Coulter & Willis, 2004; Cohen et al., 2005; Coyle & Smith, 2005; Easthope, Gill & Tranter, 2000; Hall & Giles-Corti, 2000). Reporting on influences of why patients used CAM from their study, Coulter & Willis (2004) identified several key factors; first, patients felt that they received greater individual attention from CAM practitioners, who accommodated their holistic values. Second, patients wanted to improve their health and quality of life, a key factor with those in particular who experienced chronic disease for which biomedicine was not able to always provide alleviation of discomfort in sufferers of chronic disease (Zhan, 2001) and in the symptoms experienced by those who have cancer (Chrystal et al., 2003; Hlubocky et al., 2007; Kristoffersen et al., 2009; Lee et al., 2008).

Australian general practitioners have been found to be accepting (Cohen et al., 2005; Easthope et al., 2000) towards some complementary therapies such as; acupuncture, massage, meditation, yoga, and hypnosis, chiropractic, Chinese herbal medicine, osteopathy, herbal medicine, naturopathy, and homeopathy. In this way GP's can act as agents of social change as they provide a gateway for consumers to access the use of some CAM therapies (Eastwood, 2000b). The Royal College of Physicians envisaged the gatekeeper role as the best route for CAM access on the NHS (House of Lords 6th Report, 2000, Ch. 9.32). Statistics from the Royal College of General Practitioners (Victorian Branch) identify use of alternative therapies, incorporating modalities such as relaxation, herbs, dietetics, homeopathy, manipulation and physical medicine reported on by Eastwood "doubled from 1992 from 2.000 to over 4.000 in 1996, with an estimated use CAM by one in six GP's" (2000b, p. 133). This is suggestive that GP's are already gatekeepers in this respect. If GP's act as gatekeepers for CAM, there remains the potential for schools of medicine to become involved with the inclusion of CAM incorporated within the curriculum.

A West Australian study (Hall & Giles-Corti, 2000) of four hundred GP's use of complementary therapies, showed there was a high level of interest and GP's advocated for regulation of the CAM sector and recommended that there be

provision for undergraduate and postgraduate education on CAM. However there still remains a resistance from medical authorities to the inclusion of CAM in medical training, Brooks (2004) points out, the innovation of teaching CAM familiarisation in Australian Medical Schools has been formerly met with some antipathy and “CAM may be taught as an independent elective, within another unit such as ‘society, health and health psychology’, or in the teaching of ethics” (Brooks, 2004, p. 275).

Overseas GP use of CAM and the evolvment of the public interest have made exertion on the influence of CAM education in medicine. A U.S. survey conducted in 1997 – 98 of 117 medical schools determined that 64 percent offered elective courses in alternative medicine with 68 percent of those being stand alone courses and 31 percent of required courses (Wetzel, Eisenberg & Kaptchuk, 1998). This prompted the formation of a Special Interest Group in Alternative and Complementary Medicine and the American Medical Association (AMA) to recognise the need for medical schools to respond to the growing interest in alternative health practices. Wetzel et al., (1998) commented that a “... daunting aspect of this situation is the sheer number of topics subsumed under the rubric of alternative medicine” (1998, p. 789). In the United Kingdom, it was shown that as far back as 1983, young doctors wanted training in CAM of these doctors twenty years on was conducted. Reilly who surveyed doctors on their attitudes to education commented on their interest;

It was found that from sixty two percent of returns conducted of all 3,727 general practitioners recently surveyed in Scotland, that only one in fifteen, think the current system allows for the delivery of any holistic care (Reilly, 2001, p. 408).

Considerable interest towards the use of CAM is apparent, but not all GPs favour what is considered to be unconventional medicine, whilst others favour what they consider to be an acceptable variety of therapies. In an explorative study of 295 physicians on their attitudes towards CAM use, physicians were asked about their knowledge of CAM use and if they had training in CAM (Berman et al., 2002). The results showed that over seventy percent of the doctors would consider the use of dietetics, exercise, behavioural medicine, counselling, psychotherapy and hypnotherapy as acceptable forms of medical practice. However some therapies; homeopathy, Native American Indian medicine and traditional oriental medicine, were not considered to be legitimate forms of practice. The study determined an

increased interest in some CAM therapies by GP's and the need for knowledge and training by physicians who wished to use CAM (Berman et al., 2002).

An exploration into the potential educational role on CAM within undergraduate medical education (UME) in Canada, suggested that with the development of courses in academic medical institutions the USA and Canada, there is the need to understand why CAM has become a cultural phenomena frequently termed integrative medicine (Adler, 2002). A working party for the National Vision for Complementary and Alternative Medicine in Undergraduate Medical Education, met to determine what can be taught in the curricula for undergraduate medical education (Verhoef, Epstein, Brundin-Mather, Boon & Jones, 2004). A concern is to understand whether CAM is a phenomena or a challenge to conventional medicine and this is argued by Leach, (2006) that "... future ramifications in the current system of health [that] will necessitate a major change in the current system of health care" (2006, p. 8) while others say this would redefine the boundaries of conventional practice (Giordano, Garcia, Boatwright & Klein, 2003).

The pursuit of a future integration will always produce resistance found in academics holding positions of power as departmental heads. Colquhoun (2007), professor of pharmacology at the University College London, sees that a current trend in CAM would lead to an erosion on the integrity of medical schools, "... if the trend persists, perhaps MIT [Massachusetts Institute of Technology] or Cal Tech will march in step with the medical schools and offer prizes for integrative alchemy of alternative engineering" (p. 335). Resistance is demonstrated by other academics in the United States who, also view that the creation of a curriculum for CAM would lead to an undermining of the normal scientific standards of evaluation in undergraduate medical education [UME] (Oppel, Beyerstein, Hoshizaki & Sutter, 2005). There are contentions to this; the administrative and educational characteristics of these courses and a need to have evidence based focus of CAM to distinguish what is useful from useless interventions.

Support from the Royal College of Physicians UK was engendered towards integrative medicine through Rees, former director of education and Weil, director and professor of medicine. Rees and Weil (2001) pointed out that such programs would "... offer fundamental changes in the way physicians are trained because integrated medicine is not just about teaching doctors to use herbs instead of drugs. It

is about restoring core values which have been eroded by social and economic forces” (2001, p. 120).

Integrated medicine then is about the patient and how they are valued within the context of the medical outcome. Contentions have been made that conventional medicine and its consumers, could benefit by incorporating into its provision a more holistic, empowering and accessible therapeutic approach (Barrett et al., 2003). The focus of biomedicine is approached from a stance assumed from a science based orientation. The following section now reviews the key characteristics that have shaped the contextual practice of biomedicine followed by an in-depth exploration on the attributes that are valued in the doctor-patient relationship.

2.1.4 Characteristics of the biomedical orientation

An expose is made to determine the nuances that have shaped the orientation of biomedicine as a disease model of health, which viewed from the perspective of social function provides meaning of cultural constructions to reveal there are limitations in this form of care as it currently exists (Adler, 2002; Becker, 1963; Edwards & Wilson, 1975; Ilich; 1976; Parsons, 1951). Biomedicine became the dominant form of recognised conventional health in the late nineteenth century (Easthope, 1998). The origin of biomedicine stems from a science based approach to explain the cause of illness usually to be associated with an underlying physical and pathological aetiology. Complex interplays between mind and body with the associated narrative to explain somatic illness can often be overlooked with deference paid to laboratory results of pathology of body fluids and blood. Mind-body dualism in Western culture had its origins in the Enlightenment, associated with Descartes work (1596 – 1650). This profound impact on philosophy subsequently contributed to the development of modern science and the creation of dualism separating the mind and body as distinct ontological realms (Audi, 2006, p. 196). There are two major considerations to consider in the orientation of biomedicine.

The first is the theory of dualism from which the approach taken in illness is through a biomedical focus is usually cast on aberrations of the physical body and measures these with scientific rigour whilst little attention is paid to the mind (Engel, 1979). Explanations for health are organised culturally and sociologically according

to the Western medical model with these three main elements that define the practice: it is biological in defining the disease process, mechanistic and science based (White, 1999). Cultural premises of conventional medicine are physician directed, specialist dominated and process oriented (Easthope, 1998; Good & Good, 1981) there is deconstruction of the body into parts from the perspective of a biomedical framework (Sharp; 2000; Turner, 1994). Consequently an emphasis of how health and illness are constructed is from reduction of physical matter to ontology of parts (Easthope, 1998; Germov, 1998; Porter, 2000). Disease pathophysiology is identified through the process of laboratory investigation, on the suspect pathogen with treatment focused on eliminating the pathogen. Under this model of medical thinking from the 19th century to recent times, the criticism of the tradition of biomedicine identifies a system of training doctors where emphasis is attached to laboratory science, clinical practice and allopathic medicine, other than the doctor-patient relationships (Germov, 1998). It is argued by some (Friedson, 1970; Willis, 1989) that healing an illness is not always based on the application of physical based scientific knowledge. Psychosocial factors were often seen as insignificant (Longino, 1997) whilst development of measurements to chart aberrations of the body's physiology has made marked progress (Porter, 2000).

Second, an understanding of the approach taken in biomedicine towards care is the way in which the biomedical model constructed the doctor-patient relationship. Parsons (1951) the leading figure in structural-functional sociology applied a medical construction on the patient physician-relationship and focused on how particular sub-systems are maintained in the integration of the wider social system. In terms of a social order of the 'sick role', function and order were maintained through a medical hierarchy in which the medical practitioner assumed control. To maintain this function and order required that a medical practitioner took control of the relationship, critics of the 'sick role' argue, this resulted in the diminution of the patient defined as a passive recipient of health care, who was subsequently disempowered (Edwards & Wilson, 1975). Disempowerment was applied through the social labelling of deviance to the perspective of illness with the sick person become a 'patient' and thus a passive recipient of health care (Goffman, 1971; Gove, 1975; Scheff, 1966). As a proponent of biomedicine, Longino argues, that a biomedical approach is predicated through these five doctrines:

- 1) Western medicine is based on a mind-body dualism, which is a barrier to an understanding of the psychosocial components of the connection between emotion, stress and an illness.
- 2) Through mechanical analogy doctors treat parts of the body separately. Medical students graduate without an integrated biomedical knowledge of understanding the human body as a whole.
- 3) Physical reductionism limits the dimension of social, psychological and behavioural dimensions in the search for cause and intervention.
- 4) A focus on imposing a 'sick role' onto patients with the expectation they follow the doctors orders to get well, disempowered the patient and denies them agency.
- 5) A specific aetiology that views each disease as having one cause pushes medical research for magic bullet cures (1997, p. 15).

These predications of the biomedical model were made by Longino (1997), based on his observations as a physician of medicine identified that specific negative components were found in biomedicine that de-emphasised 'holistic' attributes (Alster, 1989; Easthope, 1998; Eastwood, 2000b; Fadlon, 2005; Giordano, Garcia & Strickland, 2004; Rees & Weil, 2001). Kaptchuk and Eisenberg (1998) say that 'an appeal in healing' is linked with the practitioner-physician relationship. They reinforce this notion to argue that biomedicine is imbued with a 'sacred dimension', has a deep sense of core values, respects patients, renders service and seeks truth, and thus provides a holistic focus towards patient care. CAM is not the only form of health care that can purport to provide holistic notions of care. Conversely Berman (2001) identified medicine ought to re-examine the emphasis it placed on the importance of the integration of the mind, body and spirit and acknowledge the role of social, cultural and environmental influence, the power of self care and healing.

Biomedical practitioners use an esoteric knowledge that is dominated by patient charting (Donnelly, 1997; Donnelly, 1998; Hollenberg, 2005) rather than listening to the patient. Recent advancements have been engendered by undergraduate medical fraternities who have sought to establish improvement in the holistic quality of patient care advanced by the endorsement of change in the programs offered for medical degrees (AMC, 2000; Brooks, 2004). Such a step towards an enhancement of a holistic physician-patient approach in the future would also advance a collaborative partnership with practitioners of complementary and alternative medicine providing a more comprehensive approach to care (Leach, 2006) especially in the area of the doctor-patient relationship (Vincent & Furnham, 1999).

Programs that would provide future physician training that attached value to the doctor-patient relationship would have the potential to restore core values to medicine. Rees and Weil saw this to be a positive input as complementary medicine, "... views people as whole people with minds and spirits as well as bodies and includes these dimension into diagnosis and treatment" (2001, p. 119), which may act as a motivator for people to seek alternate forms of medicine use. Micozzi from his stance as physician and anthropologist argues, "... no one system of medicine alone can provide a formula that will offer effective medical care for the entire human family" (2002, p. 399) as in an eclectic health model dominated by consumerism, people seek out that which is most effective for their needs and, which provides satisfaction for them. The following section examines the attributes associated with the formation of a doctor-patient relationship.

2.1.5 The doctor-patient relationship in biomedicine

The primary emphasis of understanding the illness of a patient from biomedical discourse focuses on diagnosis, investigation, treatment and thereby the personal meaning of illness to second place (Brooks, 2004). It is argued (Vincent & Furnham, 1999) that emphasis is placed on the narrative, by CAM practitioners who routinely inquire about emotional issues, lifestyle and other personal information, with a focus on emotional factors, empathy, and perhaps this sensitivity, may be an important part of the appeal. A more holistic approach is seen to be taken towards patient care when the psychological and social issues are regarded to be important by a practitioner who is empathic towards the patient. The dialogue from the narrative entered into with the patient and the behavioural attributes of the practitioner, whether they are receptive and involve the patient in decision making, can improve the outcome for the patient regardless of whether the system of health is biomedicine or CAM oriented. What could emerge in the future might be a model in which the patient-practitioner encounter can be seen as a therapeutic process that involved participation in shared decision making through collaboration. How this can be better facilitated has the necessary component of the narrative foregrounding the illness experience explained in Chapter Eight.

Analysis of the narrative from the explanation of the clinical assessment forms a composite picture of the construction of illness which according to TCM theory is a

way that attaches an illness diagnosis without pathology. However the most intractable problems which are presented to a practitioner are often expressed as "... an 'illness without pathology', have a psychological or social basis of which the patient and (sometimes the doctor) may not be fully aware, or on which they may be unable to acknowledge" (House of Lords 6th Report, 2000, Ch. 3. p. 5). The narrative that forms the story of the patient informing the practitioner through discourse with the patient expressing how they feel should be enabled and attended by either a practitioner of CAM or conventional medicine and considered paramount to the analysis of the illness. From the attendance at what is being expressed through the narrative that informs the practitioner on the illness experience of the patient who reports to them the chief complaint (Donnelly, 1988; Longino, 1997).

To illustrate this, a case examination of an elderly bereaved man immobilised by osteoarthritis is made by students whose notions of proper practice had not been effective in their treating him. Longino explained to medical students "... it is artificial to stop at the boundaries of the body. There is a story here and none of you discovered it because you did not ask all of the right questions" (1997, p. 5). Whilst storytelling might permeate the clinical discussion, it is argued that it has no formal status for clinical reasoning, which could undermine the authenticity of the illness episode which is viewed from within a biomedical context (Mattingly, 1998). The literary phenomena of metaphor that guides the interpretive process in TCM would almost certainly be subjugated to a subjective experience or dismissed in clinical medical interpretation. Importance is however found attached, to the interpretive process of understanding narrative that informs what clinicians attend to (Montgomery-Hunter, 1991).

Physicians would argue they attend to narrative, eliciting and analysing stories that form part of their clinical investigation (Mattingly & Garro, 2000) as part of the primary scientific intervention within the process of medicine which requires specific skills and training (Monckton, 1997). Narrative found documented in medical records, usually amounts to very little and does not always adequately describe the person on important matters of what they understand and feel (Donnelly, 1988). He makes the suggestion that subjective experience including the relativity of symptoms were objectified or neglected on records with such accounts of symptoms made by the patient in consultation later reinterpreted by the medical students, who provided a more balanced and logical account of the patients account of their illness. However,

it is the narrative account as Hudson-Jones (1999) points out, that contributes to medical ethics through the content of what a person says, and is an important element for the acknowledgement of the illness experience being portrayed in that narrative to the practitioner. How this situation might be improved is found through the professionalism of the attending physician to ask the patient, what they feel, what they know about their situation and in manner of documenting the record, uses the patients own words to describe the experience (Donnelly, 1988; Dugdale, Siegler & Ruin, 2008).

Collaboration between the patient and physician necessitates that both parties are involved with shared information that involves how the narrative informs the decision making and negotiation through consensus in the preferred form of treatment (Charles, Gafni, & Whelan, 1997). This form of participation in communication (Bensing, van Dulmen & Tates, 2003) engaging both parties within the context of the medical encounter, involves the previous and future encounters of the consultative process. Participation also involves how well informed patients are and who may be more collaborative with the physician when they are able to describe their symptoms. The patient is then able to interact with the physician in a knowledgeable manner about their condition and consequent to this assume a greater responsibility toward their condition (Marcinkiewicz & Mahboobi, 2009).

Research by other academics in public health and medical practitioners has attempted to understand how the medical profession could improve standards of practice, by attending to the patient-physician interactions expose of narrative (Donnelly, 1997; Hudson-Jones, 2000; Kaplan, Gandek, Greenfield, Rogers & Ware, 1995; Kaplan, Greenfield, Gandek, Rogers & Ware 1996; Longino, 1997; Montgomery-Hunter, 1991; Murphy, 2001; Thom & Campbell, 1997; Wilson, 1999). The style of analytical and deductive process of general principles that guide a case as argued by Montgomery-Hunter (1991) might be 'abductive' rather than inductive as doctor's tack back and forth between interlocutions on the particular case and science based evidence. In doing so there is de-emphasis on the primacy of the event and information which may have had some impact on the diagnosis, which is displaced onto causality engendered through scientific investigation. Thus an emphasis on technology de-emphasised the immediacy of the doctor patient contact, with a focus directed away from the patient.

Factors that have been found to significantly improve the patient and physician relationship (Thom & Campbell, 1997) are the continuity of care and of having a 'usual' physician attend to a patient and was important in developing trust during the clinical encounters (Meyer, 2008). A key determinant in establishing a good physician and patient relationship was the development of trust in extended care. From a qualitative study at Stanford Department of Medicine, 29 participants ranging in age from 26 to 72 years were interviewed from four focus groups to explore patient's perceptions of trust (Thom & Campbell, 1997). Patients were interviewed on their self reported experiences with trust in a physician. The resulting consensus codes were then grouped into seven categories of physician behaviour; two of which were technical competence, five of which were interpersonal; understanding the patient, expressing caring, communicating clearly, building partnership/sharing power and respect for the patient. Two other categories were predisposing factors and structural staffing. The nine categories were analysed from the codex and conclusions were drawn from patients that the process of trust formation was essential in building and maintaining a good physician patient relationship (Thom & Campbell, 1997).

Drawn from the notion of repertoire that involved practitioner-patient behaviour, Kaplan et al., (1996) explored the characteristics of physicians' participatory decision-making styles. Trust was found to be a characteristic that determined the health outcome related to willingness to comply with medical advice or treatment and held as a value that facilitates effective communication between a physician and their patient. The practice procedure that governs the translation of this collaboration within the health environment looked at by Murphy (2001), sought to examine how patients experienced a biomedical practice how they responded to a changing health environment and the quality of relationship they had with their doctor. From a three-year longitudinal study on patients of primary care practitioners, eight measures on a Primary Care Assessment Survey (PCAS) measured relationship quality. These were (communication, interpersonal treatment, physician's knowledge of the patient, patient trust) and organizational features of care (financial access, organisational access, visit based continuity, integration of care). The results determined communication directly governed that the quality of physician-patient relationship and interpersonal treatment and trust were factors that generated positive health outcomes (Murphy, 2001).

Communication was measured on how thoroughly the primary physicians questioned a patient about their symptoms, the attention that was paid to what the patient said and the clarity of explanation given by the physician, their instructions, the advice given and help in making future decisions. The importance of trust, empathy and respect are reinforced through other studies (Blanchard & Lurie, 2004; Bendapudi, Berry, Frey, Turner & Rayburn, 2006; Keating, Gandhi, Orav, Bates & Ayanian, 2004; Larson & Yao, 2005; Li, 2006). Research has found trust to be a characteristic that seventy percent of patients associated with, who said they felt complete confidence and trust in their specialist physician. Meyers (2008) has put it, that the trust of a physician encourages participation for the patient to seek care and fosters the likelihood that they will seek follow up care. A central issue of trust is that strength and direction of the relationship between the interpersonal [the patient] and institutional trust, [the physician] (Meyers, 2008). The converse is found when less trust is associated with people whom they felt had talked down to them, not listened to them or had shown a lack of respect (Keating et. al., 2005).

Other research in the experience of the clinical encounter found associated negative associations with racial/ethnic disparities, and the perception of being spoken down, that reinforced a belief that the treatment was unfair when linked to race or how messages were communicated (Blanchard & Lurie, 2004; Keating et al., 2005). Blanchard & Lurie (2004) looked at how perceptions of health experiences were influenced over 6,722 adults conducted over an eight month period in 2001. Data was collected and then measured on a Health Care Quality Survey from which conclusions were drawn that negative perceptions can be associated with and have an influence on health care particularly, amongst racial and ethnic minorities. Cultural has been found as factor that influenced the quality of the medical encounter and interventions to reduce disparities found in communication of information (Keating et al., 2005) to ethnic minorities requires that governments should address cultural factors that affect the quality of the medical encounter (Naples-Springer, 2005).

A Committee on Quality of Health in America (2001) recommended that health care be based on characteristics; healing relationships, customisation based on the patients' needs, values and shared decision making. These values represent benchmarks in a standardisation for health care that would lead to an improved physician-patient relationship. The committee made the point that the majority of quality improvements are directed however towards more measurable objective

outcomes such as diagnostic testing, hospitalisations and escalating costs. Quality of caring as a characteristic of patient-physician interaction was investigated by researchers who conducted interviews on patients from over 192 Mayo clinics (Li, 2006). A list was compiled of behavioural attributes of what was considered to be seven ideal physician behaviours: empathy, humaneness, personal, forthright, respectful and thoroughness. Unsatisfactory care results when the benchmarks set by these standards for quality are not met, that leaves the patient to feel uncared for by their physician. Also that they have not been listened to, the consultation has been rushed, they have been inconvenienced, humiliated or that inadequate information has been given to them. The study concluded that the quality of care and the quality of caring are inseparable.

Reporting on behavioural attributes, Larson & Yao (2005) point out, empathy should characterise all health professions and that the healing relationship between physicians and patients remains essential to enhancing quality of care. Reports on ideal physician behaviours, have been examined by Bendapundi et al., (2006) who incorporated these ideal attributes into a survey for telephone interviews on a random sample of 192 patients from 14 different medical speciality services. Patients were asked to describe what they thought were the positive and negative experiences of the physician clinical encounter. The interviews identified the ideal qualities included a patient centred approach regardless of whether the service provided is conventional or non-conventional medical contexts.

2.1.6 Summary

From this review a change in the values ascribed to the patient-physician relationship have emerged with emphasis placed on satisfaction in patients predicated on a basis of trust and understanding between the physician and patient and the opportunity for the patient to become involved in the exchange of information, which generated effective communication. Developing trust was also recognised to reduce stress and facilitated the diagnostic process and also affected managerial decisions and fostered positive health outcomes (Hudson-Jones, 1999; Kaplan et al., 1995; Kaplan et al., 1996; Mattingly, 1998; Murphy, 2001; Thom & Campbell, 1997). Studies reveal the associated trends of CAM use overseas and in Australia, for chronic illness and of

the general practitioner interest with integration of selective CAM therapies into their practice.

The appeal of CAM is varied and reflects complex considerations that arise from the desire to enhancement of health and the promotion of quality of life which Zollman and Vickers (1999) say is found in a number of specific and non specific attributes that values the relationship with the practitioner, the ways in which illness is explained and the environment in which treatment is received. The RCCM, (2000) suggests there is a not a gap between unconventional medicine and conventional medicine in the medical concepts that govern healing, but in the reality of how an illness is perceived and the process of interpretation. Emphasis is a factor found in the creation of self responsibility that depends more on the therapeutic setting than on the therapeutic intervention. Primary care was found to be sustained through physician-patient relationships where interpersonal relationships correlated with patient satisfaction. Wellbeing was based on the importance attached to what patients identified with determined by factors of communication that identified with empathy, trust and collegiality (Blanchard & Lurie, 2004; Bendapudi et al., 2006; Keating et al., 2004; Larson & Yao, 2005; Li, 2006). Informed from the House of Lords Report (2000) by Dr Dixon of the NHS Alliance, on the delivery of CAM care, a bias can be found in the mechanism associated with the practice procedure, for example in primary care, there is an emphasis made on the relationship, between the recipient and practitioner,

The mode and transmission and practice of health delivery are contextually fashioned "... general care, primary care and complementary medicine are holistic from their focus" (House of Lords, 6th Report, 2000, 9.15). Forms of practice from perspectives of primary based and secondary care are different, self care is found to be associated with primary care, whereas secondary care provides a more interventionist biomedical focus. This association is important to traditional medicine in respect of the WHO (1983) Alma Ata, explained in the following section. It informs an understanding of traditional medicine found in the interaction in traditional Chinese medicine known as 'Kanbing', involves a therapeutic relationship established namely through the discourse between practitioner and client (client is the term used for the purpose of this study found in subsequent chapters).

Section Two – An anthropology of traditional Chinese medicine

An important approach to the study of non-Western conventional systems of medicine is found in medical anthropology. Anthropology and other social science disciplines have provided important conceptual and empirical observations on the limitations of the present dominant biomedical model (Micozzi, 2002). In particular, significant ethnographic research has been carried out on traditional Chinese medicine practices and the importance of the client practitioner relationship in understanding the illness experience. The premise of TCM is based on a notion of holism, with a process guided by a differential diagnostic system that links into patterns to form a composite picture of somatic illness (Ross, 1985). Such research has focused on the meaning of healing and social construction of health and illness (Unschuld, 1988).

2.2.1 Characteristics of traditional medicine

Medical anthropology literature shows a great variety of medicines are shaped by culture, history, experience, politics and economics (Eisenberg & Kleinman, 1981; Kleinman & Kleinman, 1994; Kleinman 1997; Kluckhohn & Murray, 1956; Lawrence & Weisz, 1999; Mahler, 1983; Mechanic, 1995; Susser et al., 1985; Unschuld, 1985). Brown (1995) suggests that social forces, class, race culture, ethnicity language and the institutional and professional structure shape the knowledge base of how illness is constructed. Anthropologists have attempted to explain from the reality of their field work how traditional medicine functions to determine the circumstances that have shaped the process of traditional medicine. Applied medical anthropology has contributed to the study of traditional medicine by revealing the cultural variability in health practices and providing an understanding of the relationship between attitudes that shape health beliefs and accepted treatments (Schreiber, 1991).

Traditional medical systems and practices are variously referred to as, indigenous, unorthodox, alternative, folk, and ethno-medicine and have often existed longer than bio-medical models of health and illness evolving over long periods of time in response to the needs of communities. Systems of traditional medicine can be distinguished by two broad streams. First, there are those systems often described as

‘folk’ systems, based on the notion of a supernatural power or powers which are the ultimate causal agent(s) of health and illness. Second are those systems in which the practitioners administer appropriate remedies based on the illness experience and self diagnosis made by the patient and recognised now as traditional medicine (Foster, 1983). There is overlap between these two streams in so far as they both understand illness as embedded within non-materialist frameworks of understanding and see healing as a socially and culturally constructed process rather than a largely or purely biologically based form of intervention. There is overlap between these two broad streams in so far as they both understand illness as embedded within non-materialist frameworks of understanding and see healing as a socially and culturally constructed process rather than a largely or purely biologically based form of intervention.

Traditional systems of health found in Tibetan and Chinese medicine are based on what may be described as a universal cosmology that has a spiritual underpinning. Spiritual and psychological phenomena of the dying state explained in Tibetan Buddhist medicine have been investigated (Evans-Wentz, 1960). Jung, pointing to the work of Evans-Wentz, comments that it offers insight into the metaphysical elements in Eastern thought. These views extend beyond the kind of explanation found in western thought (Jung in Evans-Wentz, 1960). Offering further insight into Tibetan medicine and psychiatry, Clifford (1986) an authority on Tibetan medical psychiatry, described the somatic phenomena of the external world affecting the inner stability of the mind. Tibetan medicine is described by Choedhak (1984) as a system of psycho-cosmo-physical healing. Taken from Indian Ayurvedic medicine, aspects of the humoral theory mean ‘subtle principles of life energies’ (Clifford, 1984). Based on the notion of gSo-ba Rig-pa, the science of healing tradition is formed around the humoral theory of wind/air (rlung, vayu), bile (mkhris, pitta) and phlegm (bad-kan, kapha). The principal idea is that these energies are in a state of balance. Clifford explains this as applied to “... balance within the body and between it and its corresponding aspects in the outer world” (1983, p. 90). Such notions consisting of a corresponding balance between the inner stability of one’s wellbeing and the external environment are discussed in more detail in Chapter Eight, drawing on the cosmology of the five element theory found in Chinese medicine previously described in Appendix 2. The understanding of healing encompasses a much broader universal structure in which the healer helps the patient to particularise a general cultural myth in how health is practiced and from which symbolic meaning is

attached to and used to explain healing (Dow, 1986). Traditional systems of healing pertain to this notion.

Cross-cultural variability in the meaning and practice of health care has been taken up by such bodies as the World Health Organisation (WHO) and as an agency of the United Nations, the WHO has responsibility for promoting international health matters. Earlier an endorsement by the International Conference on Primary Health Care proposed that health resources were inclusive of practitioners of traditional health and indigenous systems of health care to meet a goal known as 'Health for All by the Year 2000' (Mahler, 1983). In 1983, through the Declaration of Alma – Ata (May 1977, The Thirtieth World Health Assembly), the WHO endorsed the diverse needs of health care could be met through traditional health practitioners and that these be integrated with conventional health providers in response to the expressed cultural needs of the community.

A resolution 'WHO 30.49' promoted the development of training and research in traditional medicine (Zaman, 1983). Traditional medicine would be integrated through primary health care and could be facilitated through preventative health practices of primary health care. In traditional health systems, the role of traditional medicine practitioners plays a secondary role to the person seeking assistance (Foster, 1980) where therapeutic beliefs of health in traditional medicine are invested in the authority of the social groups or cultures using these medicine forms as an integral part of their health system (Leslie, 1983; Stoeckle & Barsky, 1981).

For decades the value of traditional forms of medicine has been overlooked in favour of the more scientific approach of bio-medicine within modern health systems. The professional socialisation of Western medicine was regarded as the 'dominant hegemony', and that other notions of health care and folk practitioners were unscientific (Kleinman, 1997). Leslie sees that traditional medicine is: "(1) dominated by modern medicine, (2) in practice the exclusive systems are pluralistic and, (3) the integrated systems exclude many aspects of traditional medicine" (1983, p. 316). These implications that described the previous typology of the acceptance of traditional medicine by conventional medicine encompass restrictions and impose limitation of its purpose.

Acceptance of non-conventional medicine into mainstream practice was supported by the World Health Organisation (WHO) expressed the belief in advocating for

traditional health practice to be included in government strategies. Mahler (1983) in support of the integration of traditional medicine advocated;

For far too long, systems of medicine and ‘modern’ medicine have gone their separate ways in mutual antipathy. Yet are not their goals identical - it improve the health of mankind and thereby the quality of life ... This is why the WHO has proposed that the great number of traditional healers who practised in virtual every country of the world should not be overlooked (p. 3).

Traditional systems of care are linked to social and cultural aspects of health being a “...unique blend of physical, mental, social, moral and spiritual welfare”, according to Bannerman, Burton & Wen-Chieh (1983, p. 9) and these characteristics of holistic care are seen to be offered by traditional health practitioners. From this has developed a system of health care that is approached ‘holistically’ (Stepan, 1983). The benefit of this could be applied across culture into Western medicine and a growing recognition has ensued, that an understanding of illness and disease requires a broadened cultural perspective to take into account other systems of health care (Kleinman, 1988; Kleinman & Kleinman, 1994; Leslie, 1983; Reid & Trompf, 1990, Stepan, 1983). A holistic understanding of healing encompasses a much broader universal structure in which the healer helps the patient to particularise a general cultural myth to which a symbol is attached to and which is used to explain healing (Dow, 1986) which my study explores. Traditional systems of healing pertain to this notion and of importance to the research, in understanding the explanation of TCM theory. An illustration of this is the work of Kleinman (1986) in his expository study of Neurasthenia in reference made to the cultural construction of illness attributed to the links between mind and body in TCM.

2.2.2 TCM as a system of health

Understanding how the processes of health practice are shaped has been assisted by medical anthropology (Pilch, 2000), with studies that have shown that cultural variability exists in health practices between the professional, folk and popular sectors of a health model framework (Agdal, 2005; Kleinman, 1981). Common features that are expressed namely through social and cultural dimensions are determined by values attributed to a health system (Evans-Pritchard, 1969; Joralemon, 1999; Schreiber, 1991). More diverse perceptions of health and illness

now influence individual behaviour related to beliefs, values of illness, health and disease risk (Agdal, 2005). To understand how health and illness are influenced by cultural determinants that shape health practice, I refer now to traditional systems of health found in Tibetan and Chinese medicine.

Traditional systems of health found in both Tibetan and Chinese medicine are based on what may be described as a universal cosmology that has a spiritual underpinning with an example found through the seminal work on the psychological phenomena of the dying state explained through Tibetan Buddhist medicine (Evans-Wentz, 1960). Jung commented on the work of Evans-Wentz, ‘that it offered insight into the metaphysical elements in Eastern thought with views that extend beyond the kind of rational explanation found in Western thought’ (Jung in Evans-Wentz, 1960). Offering this insight into Tibetan medicine and psychiatry, Clifford (1984) described the somatic phenomena of the external world affecting the inner stability of the mind. Tibetan medicine is described by Choedhak (1984) as a system of psycho-cosmic-physical healing. Taken from Indian ayurvedic medicine aspects of the humoral theory mean ‘subtle principles of life energies’, Karup (1983) identifies these are based on the notion of gSo-ba Rig-pa, the science of healing tradition is formed around the humoral theory of wind/air (*rlung, vayu*), bile (*mkhris, pitta*) and phlegm (*bad-kan, kapha*).

The principal idea is that these energies are in a state of balance. Clifford explains this as “... balance within the body and between it and its corresponding aspects in the outer world” (1984, p. 90). Such notions consisting of a corresponding balance between the inner stability of one’s wellbeing and the external environment are discussed in detail in Chapter Eight and draw on the cosmology of the Five Element theory found in Chinese medicine philosophy previously described (Chapter One).

Unschuld (1985) from his examination of illness on traditional Chinese concepts applied this understanding to explain the perspective of the circulatory theory described in the classic *Nei Jin Su Wen*. Unschuld concluded that disease is “... a socially determined product, a conceptual reshaping of the primary experience of illness” (1985, p. 19). The evolution of TCM practice has changed over the past two thousand years, yet Unschuld (1998) argues, it remains to a great degree faithful to the approaches formalised in traditional Chinese medical philosophy, which remain unchanged. Several scholars, (Hsu, 2009; Scheid, 2001; Unschuld, 1998), have pointed to the importance of historical studies in TCM in the Chinese context for the

understanding of modern practices of TCM in Western societies. The Chinese doctor ascertains pathological changes of various organs manifested in corresponding areas of the body through the four techniques of looking, listening, asking and palpating [Sizhen] (Rui-Juan, 1988; Zhan, 2001). Unschuld has drawn that further research is required to explain the practice of how TCM is translated in Western societies. Making this point he says;

a widely held view [perhaps erroneous] is that the traditional Chinese medicine that is currently practised in China as applied in the Western industrialised countries is a perfect reflection of the traditional Chinese medicine as practised in China for the past two thousand years (1998, p. 3).

Unschuld's comment refers to a contemporary TCM that emerged from the political and cultural changes in China toward the end of the Qing dynasty [1644-1912], (Yap & Cotterell, 1977; Zhan, 2001). During that period, Chinese intellectuals following the battles against the supremacy of European and Japanese powers were placed in a position of re-evaluating the former authority of the universality of traditional Chinese cultural principles in relation to medicine that now emerged as a science. Hence new words were admitted into the vocabulary that invoked an interlocution of science 'Sai Xiansheng' and democracy, 'De Xiansheng', as words symbolic of progress and prosperity (Zhan, 2001, p. 462). Conversely, during the 19th century, Western medicine was confronted with a flourishing system of indigenous health practice "... based on a cognitive foundation totally different from that of a modern scientific medicine" (Unschuld, 1992, in Leslie & Young, p. 45). These transitions occurring simultaneously in Western medicine and traditional Chinese medicine and led to the emergence of a plurality as Unschuld (1998) and (Scheid, 2001) describe from their explanation on how Chinese medicine has evolved.

In his analysis of Chinese medicine theory, Scheid described the development of plurality as an integrated form of Chinese and Western medicine (*zhongxiyi jiehe*) from the mid 1950's onwards, and was carried forward during the Cultural Revolution of 1966-1976 (p. 371). A third period is now described as an official plural health system of the so named three paths (*san tiao daolin*) policy that states that parity should exist between Chinese and Western medicine (Scheid, 2001). The emergence of plurality was described through three forms of medicine that are identified as; the new medicine 'Xinyi', the old form of medicine 'Jiuyi', and the national medicine, 'Guoyi' (Zhan, 2001).

Medical plurality is found in the development of the hybrid approach to modern TCM, from this ethnographic study of health care in rural Lijiang China. White (1998) argued that the Chinese state had formulated a hybrid practice of integrated Western and traditional medicine. White referred to the state and elite agencies shaped health policy to illustrate that local and rural peasant groups supported this form of medicine that evolved from a grass roots level of medicine in response to community needs. Collaborative practices of both medicines forms were analysed from the perspective of state policy and of how villagers engaged in the every day practice of this hybrid medicine form.

White (1998) described the hybrid system determining the 'biomedical' model under the disease model of health and illness, and 'holistic' under the provision of TCM. With the establishment of the Communist regime in China in 1948, plurality of Western medicine with TCM was promoted, creating a body of knowledge from traditional and Western clinical sciences for what is known as integrative medicine (Hui, Sampson & Beyerstein, 1997, Zhan, 2001). It was not until the late 1950's that as (Farquar 1994) described, traditional medicine acquired a professional legitimacy for the first time in history. During this period a style of traditional Chinese medicine emerged at the behest of Mao Tse Tung, wherein some therapies were selectively used and integrated into public health in China, with "a rejection of those [therapies] that were energetic and [of a] constitutional appreciation" (Giordano, Garcia & Strickland, 2004, p. 706).

TCM is now practised side by side with modern Western medicine, with many hospitals in China offering traditional Chinese medicine as their main branch discipline (Lu, 1994). However Zhan (2001) remains critical of the endeavour to separate out specific practices of TCM that distinguished it as being different for example; the practice of tuina [chinese massage], acupuncture and healing rituals founding Qi gong, which only served to diminish the legitimacy of TCM with Western medicine seen as being a superior form of medicine based on science.

2.2.3 Characteristics of TCM

The clinical frame of reference found in TCM is different to that of Western medical terminology (Giordano et al., 2004) and studies have identified the unique characteristics of TCM expressed as yin/yang, shen and the flow of qi (Connelly,

1979; Enquin, 1988a; Enquin, 1998b; Enquin, 1988c; Kaptchuk, 1983; Unschuld, 2003; Xinnong, 1987). These characteristics explored through research within the context of Chinese clinics have previously been elaborated upon in Chapter One (Farquar, 1994; Hsu, 1999; Hsu, 2001; Kleinman, 1986). Contemporary Chinese Traditional medicine is recognised through those characteristics that shape therapeutic practices, given to explain complex somatic patterns that exist in illness, that are irreducible to any one single causative [pathological] factor (Connelly, 1979; Enquin, 1988b; Farquar, 1994; Hsu, 1999; Hsu, 2001; Kaptchuk, 1983; Kaptchuk, 2000; Ross, 1985; Scheid, 2001; Xinnong, 1987; Zhang, 2007).

TCM is able to provide explanation on the energy imbalances of the body based on the philosophy that underpins the practice and the approaches taken by the clinical encounter which differ from the scientific based biomedical model (Kaptchuk, 1983). Bensoussan and Myers put it that, "... it is claimed that in TCM practice that disturbances to health are identifiable prior to manifestation of clinical symptoms" (1996, p. 6). This may be attributed to what Unschuld (1998) says, that TCM is able to provide explanation of physical and mental experiences of an illness. How an explanation is made is attributed to what Kleinman and Benson (2006) argue that TCM attaches importance on psychosocial stresses that characterised a person's life, are considered relevant to the practice of the clinician. It is accepted that some of the most intractable problems presented to doctors, are often expressed as 'illness without pathology', having a psychosocial or social basis of which the patient may not be fully aware, or be unable to acknowledge (House of Lords, 2000, 3.18).

In TCM symptoms and signs can only be understood from the terms of how it relates to the energy of the whole patient and extensive research undertaken in China provides examples of the aetiology, physiological dysfunction and pathophysiology identified through the TCM system of health care (Kleinman, 1986; Farquar, 1994; Unschuld, 1998) that have no known counterpart in Western medicine. Reference can be made to the complex nature of 'culture bound' or 'culture specific' syndromes (Kleinman, 1986). Culture specific syndromes suggest there is a connection between the psychosocial experience of illness that explains complex symbolic, social and individual interpretations. Areas that require investigation are the interwoven human-biological and socio-cultural networks of human response to illness in traditional Chinese medicine (Unschuld, 1985).

The symbolic interactions governing the processes of the clinical practice, provides an insight into how somatic symptoms are described and defined through the assessment and diagnosis through ethnographic exploration of the therapeutic role and the client practitioner interactions in the clinical practice of TCM. The Explanatory model provides a structure for exploring an illness episode through the clinical interactions in the clinic (Kleinman, 1981), and can be identified as themes uncovered through the process of the ethnographic gaze (Spradley, 1980). Interactions centred round the TCM assessment around the client centred narrative explanation of the illness is a crucial factor in the derivation of a diagnosis without the aid of laboratory investigations.

The social construction of an illness in TCM has several processes that guide the process of elicitation (Brown, 1995). Diagnostic explanations in TCM can be linked to a holistic framework of care that incorporates mind and body (Ferigno & Wang, 2000; Kleinman & Kleinman, 1994). This enables explanation to be made of somatic symptoms expressed by clients of TCM use. Traditional Chinese medical encounters explore clinical transactions (Dow, 1986; Kleinman, 1988; Moerman, 1983) of the illness experience to provide insight into the little understood system of symbolic interaction found in Kanbing.

Translation of the interactions and the variations found in the process of TCM can be explored through the practitioner client discourse (Kettler & Meja, 1984), relevant to the relationship of the clinical experience that forms part of the healing context between the practitioner and recipient (NCCAM, 2000). Ethno-medical studies provide accounts relevant to the sick person's own account of the reality of their illness experience (Kleinman, 1981; Kleinman, 1988; Kleinman & Kleinman, 1994; Worsley, 1970). Studies support that accounts of dialogue are embedded through culturally shaped experience of illness, of which a bio-medical approach can fall short of explanation (Fabrega, 1997; Turner, 1992).

The structure of healing in medicine stresses these culturally shaped experiences are formed between the cultural framework of the medicine, social organisations, and that "... social structures impact on the way that healers and patients respond to disease" (Joralemon, 1999, p.5). In Chapter Eight I draw on these contentions to explain the cultural construction of an illness through the contextual framework of Hierarchy of Living Systems (Dow, 1986), next I draw on the literature that looks at Kanbing.

2.2.4 Explaining the clinical encounter - Kanbing

Important contributions to the understanding of the practice of traditional Chinese medicine have been made (Farquar, 1994; Hsu, 1999; Hsu, 2001; Hsu, 2009; Scheid, 2003; Unschuld, 1985). The cultural emphasis given to understanding an illness described by Unschuld (1985; 2003), allows the focus of exploration to engage with the meaning attached to the illness in lay terms and onto which the interpretation is placed, which Traditional Chinese medicine is vested in interpretation (Enqin, 1988a) from which examine complex somatic symptoms are examined and are able to be described during the clinical encounter [Kanbing].

This process involves a collaborative approach to the clinical encounter means that "... when a patient explains their clinical signs [in TCM they] retain a sense of being the expert, the authority of best resort; on their illness" (Kleinman, 1981, p. 120). Kleinman's seminal work on TCM focused on '*Kanbing*', which according to Farquar (1994), is described as a particular way of 'looking at the illness disorder' by the practitioner as they engage with the client in interaction to discuss the chief complaint. Farquar (1994) also studied the application of the theory to the process of defining illness through detailed observation of Chinese clinical practice.

Farquar (1994) focused on the clinical encounter '*Kanbing*' in Chinese medicine and helped to explain concepts previously alien to Western understanding of TCM illness construction. Understanding is derived from the application of relationships between physiological systems expressed through Chinese traditional theory. The research draws on the analysis of the clinical encounter directly to the professional role enactment of the practitioner, however, and "... it does not explore the meaning of illness from the perspective of the patient" (Kleinman 1997, p. 214). During the process of the clinical encounter, the TCM practitioner seeks to elicit information that brings to light the hidden elements of the illness and transforms them into the TCM reality in the analysis made from the assessment. Zhang (2007), comments *Kanbing* is the interactive exchange between doctors and patients during the routine clinical process which through exchange seeks to trace and demonstrate how and 'at what point, various clinical discussions were made and therapeutic transformations achieved' (p. 9). Through the interactive clinical process [*Kanbing*], a cultural construction of an illness can be made that is not reliant on technology nor aided by

pathological investigation, but is based on the detailed description of an illness by the person to the practitioner and the assessment informed through the process of *Shizen*.

Hsu worked on an understanding of how information is transmitted. To illustrate how the cultural transmission of information is facilitated I draw on an ethnographic study in Yunnan Province China, of Hsu (1999), whose work looked at how information of Chinese medicine is understood and transmitted of. Guo (2002) supported Hsu's extensive ethnographic fieldwork saying, "... is timely and important to the study of Chinese medicine and practice in the West" (p. 250). Hsu specifically focused on Qi Gong practice, to show how Chinese medical knowledge is transmitted to practitioners who then elaborated on the 'clinical focus of pathophysiology' to explain disease.

A plural approach is therefore found in the manner of how Chinese medicine information is transmitted. Three modes of transmission of information are described by Hsu (1999), the first originates from medical background knowledge, second, that which is found in different social relationships, third, that which is imparted from the standardised transmission normally found in a classroom. The transmission of information in understanding illness from the perspective of TCM is explained like this by Hsu (2001). Hsu suggests the complex causality found in TCM involved an understanding of illness which is inductive and intuitive, rather than a logical deductive redaction when a biomedical doctor. Hsu makes this point to argue. A Western doctor "... would probably rather speak of an injury than long term contributing factors viewed as the causative aetiology and not a single incident" (p. 70). A biomedical perspective relies on the explanation of a disease on the basis of measurable biological parameters and the interpretative physician based dominance.

Zhang (2000) describes TCM and the illness experience as a set of heterogenous practices that are understood from an understanding of TCM practice that involves exploration shaped from a perspective of understanding the connection between Qi and consciousness (Zhang, 2000). This is not a simple process of understanding how Qi can be converted to a biological notion and for a cultural appreciation of this requires an appreciation of how of a cultural nuance remains deeply embedded in tradition (Mechanic, 1995). For example '*Ruing*' described in Tibetan medicine, is applied to "... a class of sickness that has collectively come to symbolise the suffering inherent in rapid social, economic and political change" (Janes, 1995, p. 6).

Kleinman (1986) similarly described collections of syndromes identified as the illness or ‘neurasthenia’, as a by product of the social suffering following the Chinese Cultural Revolution. Kleinman’s research on Chinese patients at Hunan Medical College explained ‘neurasthenia’ (*Shenjing Shuairuo*) as a schema of illness experience that extended beyond the immediate problem of the symptoms to that related directly to the then prevailing socio-cultural and political context. Somatic manifestations of illnesses among many Chinese were linked to tragedies and repressed anger at the political system under Mao’s Cultural Revolution (1966 – 1976).

Somatic factors that describe the emotional factors of illness with reference to *Qingzhi* disorder are described by Zhang (2007) who comments “... the way in which a *Qingzhi* disorder is conceptualised, experienced, diagnosed and treated remains remarkably Chinese. It is not culturally bound, but certainly permeated with culture...” (p.1). In Chinese medicine, the human body is described in abstract concepts that are expressed through the use of metaphor. An example of attaching descriptive language metaphorically to a body organ in this case the gallbladder is found in this earlier report by Enquin (1988a). Enquin says a function of “... the gallbladder seems to be an upright officer who is in charge of making a decision (1998a, p.114). The associated emotions of this organ are bravery and timidity and are illustrated through the work of Yu (2003) who draws on the example of the gallbladder being ‘a container of courage’, that is largely drawn from the earlier work of Enquin (1998a).

A social analysis of an illness Fadlon (2005) explained, may suggest that widely held view values are ascribed to symbolism and language, found in the encounter of symbolism attached to the function of metaphor in describing emotion on the function of organs in the body. Chapter Eight describes the function of the liver and the heart from the perspective of metaphor and emotion. Zhang drew from research on contemporary practice of traditional Chinese medicine in Beijing to identify, that “... face to face interaction is a strategy for understanding the clinical process” and “presents both the professional and patients perceptions and shows the role that the patient plays in both the diagnosis and the healing” (2007, p. 9). TCM research must explore the potential effects of the transmission of information, and ethnographic research can provide information that describes the social and cultural context of the process from which an interpretative and therapeutic encounter is informed. The

processing of information derived through these patient-practitioner relationships and the interpretation of these interactions should not be secondary to or as a side-line incidental to the research (House of Lords 6th Report, 2000, 3.18).

These studies provide some understanding of Kanbing from China (Farquar, 1994) and of how information is transmitted in Chinese thought (Hsu, 1999) and explain somatic factors associated with Qingzhi (Zhang, 2007). What they do not address is how the clinical interaction is linked with description of diagnostic content derived from the differentiation of symptoms to the narrative, that makes the connection with the Zang Fu Five element approach and which is translated through the interactive process [Kanbing]. Characteristics of an illness are processed through the identification of imbalances of yin and yang Qi, comprise a collection of symptoms that are formed through the understanding of TCM into a syndrome (Connelly, 1979; Enquin, 1988c; Lu; 1994; Ross, 1985; Xinnong, 1987). Explaining how a collection of symptom formed into a syndrome is one of the core tasks of cross-cultural healing in anthropology (Kleinman, 1988). Kanbing is based upon this premise: The clinical encounter begins when a suffering client comes to the practitioner who seeks information on how that client explains their illness.

The main criticisms from the available literature that inform the interactions found between clients and practitioners in TCM are;

- 1) The works of Farquar (1994), Hsu (1999), Hsu (2001) and Zhang (2007) are relevant to my study from the framework of a textual explanation of Kanbing and the transmission of information and (Kleinman, 1986; Kleinman, 1988) are drawn on to explain the role of emotions with reference to neurasthenia In Chapter Eight I argue that illness at an individual cellular level, is the result of the emotional context affected by the external world, as seen from the perspective of TCM and use case analysis to support this argument. However I extend to that an in-depth extrapolation of the interconnections found within the Five Element theory in Chapter Eight, Section 2, that illustrate the structure and process on an understanding of Kanbing practised in a Western clinic outside of China.
- 2) While these studies of Farquar (1994) and Zhang (2007), provide information on what they have attended in their research, the studies do not attend either to the perceptions of health and illness from practitioner client perspectives not are they

formed from information researched from a Western context on the experience of TCM.

3) Neither Farquar (1994) nor Zhang (2007), provide a hierarchical flow of the process of the interconnections that link the dimension of metaphor and narrative through the interconnections of the Zang and Fu organs based on the premise of the assessment procedure. From this perspective I explore the experience of illness expressed by the client and the meaning attached by the practitioner, as a form of mind-body connection with emphasis on the various cultural meanings attached to TCM theory described in Chapters Six and Eight of the thesis. In this way, it will necessarily be shown how practitioners act as interpreters of tacit information drawn from narrative and applied to TCM theory through the clinical process from their translation of client symptoms into a diagnosis.

4) On the study of *Knowing Practice* (Farquar, 1994), Kleinman makes this criticism, "... most of her scholarly material is textbook descriptions written by and for practitioners ... For illustration, the author returns from time to time to three paradigmatic textbook cases, ... she also draws upon much direct quotation from published texts (1997, p. 214). Kleinman says that the cases from Farquar's research that get attention are not derived from her participant observation.

5) From the literature surveyed, the process of the clinical interaction Kanbing (TCM) remains largely unexplained and, '... examination is made for what lies behind the complexity of these forms of medicine to reveal the attributes that are definitive to each' (Evans-Pritchard, 1969, p. 123) in this research.

2.2.5 Summary

This chapter has outlined the main types of research on CAM and TCM. It has shown that academic research in the United States on CAM use in several countries, including Europe, Britain and Australia, revealed that an increased use of CAM has occurred over the past decade (Astin, 1998; Berman & Chesney, 2005; Eisenberg, et al., 1998). People access CAM for a variety of reasons, including dissatisfaction with conventional medicine, changing personal beliefs about health care with an increased responsiveness to seek different therapies (Kerestes & Bell, 1996; Lloyd et al., 1993, MacLennan et al., 1993; MacLennan et al., 2000; Siapush, 1999a).

People who access CAM and conventional medicine already take an integrated approach to how they view health that can be suggested to provide a more holistic, empowering and accessible therapeutic approach. Conventional medicine could in fact build on integrating acceptable forms of CAM that would inform a better regulated and formal system of health (Barrett et al., 2003). A plural system of health care would ensue from an integration of the organisation and integration of elements of CAM structured into conventional medicine. Understanding how plural health systems can operate collaboratively is a future research consideration as Coulter and Willis (2004) suggest with consideration only if CAM therapies are committed to appropriate evidence based scientific scrutiny.

While studies demonstrate a growing interest in CAM as an alternate form of health provision, they have not addressed the interactions between physician and client. To understand the interwoven human-biological and socio-cultural networks of human response to illness (Adler, 2002; Eisenberg & Kleinman, 1981; Mechanic, 1995; Unschuld, 1988) requires a greater attention to the clinical encounter, client narratives of that encounter, and the meanings they attach to the illness experience (Good & Good, 1981; Jones, 2000; Kleinman, 1988; Mishler, 1984). Coulter and Willis (2004) suggest that CAM use raises issue for understanding the integrity and power of the therapeutic relationship between the practitioner and client. Their comments have implications in general for the patient-physician relationship to be understood in terms of the contractual nature and exchanges made during the process of interaction.

Understanding practitioner relationship in non-conventional medicine attaches importance to how a process of treatment based on communication and of understanding the common problem of the illness goes beyond the scientific or medical interpretive of the disease process. Long et al., (2000) say the effect that a therapeutic relationship has on the healing relationship has been left unmeasured and argue that less attention has been given to measuring the subjective experience of therapy users. From the review of literature it can be concluded that there remains a gap in the understanding of the cultural context of TCM practice within Western society despite work attended to raising awareness of the practice issues of TCM (Bensoussan & Myers, 1996; Bensoussan & Lewith, 2004). Whilst CAM researchers have examined the subjective experience of therapy users they have left unstudied the interaction between therapist and therapy users (Long et al., 2000). This is

particularly the case of TCM use in Australia, how it is practised from an anthropological perspective provides explanation on why TCM has become a form of first line intervention sought after by consumers seeking out Chinese acupuncturists and herbalists or from a General Practitioner (GP) who have integrated TCM it into their practice (Chapter One, 1.3).

My research focuses on providing an explanation formed from the interaction of client and practitioner that requires to be understood "... in terms of instrumental and symbolic activities (Kleinman, 1981, p. 25). From within a Western context of understanding, explanation is made on how cultural constructs of an illness are described through the extension of metaphor and symbol attached to Chinese understandings of emotion and illness (Yu, 2003; Enquin, 1998a) which informs the process of the interaction Kanbing between the practitioner of TCM and the client, in the analysis of Chapter Eight.

CHAPTER THREE

The pre-entry encounter phase of TCM

This early experience ... enabled me to immerse myself in a Chinese community (Kleinman, 1981, p.17). and an appreciation of the exposure to Chinese philosophy and culture, gave insight into the foundation of TCM (Greene, 2010)

3.0 Pre-entry phase of the thesis development

This chapter provides an overview of the pre-entry phase of experience with the cultural encounter of Chinese medicine, which began in 1991 that influenced the phases of the inquiry to the current time during which I had exposure to the philosophy and the different traditions of this culture from the clinical practicum in Guangzhou. This led me to conduct the ethnographic research inquiry into TCM. Spradley (1980) suggests, "... living in another culture allows us to see alternative realities and modify our cultural theories of human behaviour" (1980, p. 16). Engagement for a brief time in an overseas Asian culture provided an experience that "... enabled me to immerse myself in a Chinese community" (Kleinman, 1981, p.17) and to explore facets of the clinical nature of TCM.

My professional life as an academic in health sciences led me to the path of research in this field when first becoming involved with collaboration through the School of Social Sciences to work on a program of stress management. My perceptions changed as I was inculcated into an exploration of alternate system of health care through the program. The relevant world taken for granted was challenged through a developing interest in Eastern philosophy. In 1990, I enrolled in an acupuncture course run by a university in Perth for allied health graduate and completed the

program in 1992. The course aimed to provide health graduates with information that would lead to the appreciation of the diagnostics techniques in the use of acupuncture and the philosophy of TCM from both a theoretical and practical perspective. The content of study included information on diagnostic procedures of TCM at a basic and intermediate level and an introduction to Mandarin. During the stage of advanced diagnostics, students practised the principles of treatment using acupuncture therapy under tuition and were then required to attend an intensive two-month practicum in Guangzhou China (Appendix 4).

A two-month intensive practicum in 1994 was held at Guangzhou Hospital of TCM for the students to gain further experience in acupuncture and Chinese massage (Appendix 5). Students at the college include undergraduates, postgraduates, and overseas foreign students. Since 1974 the college has taken students from more than 30 countries and mainly included students from Korea, Japan, West Germany, France, Britain, Australia, Africa, and India. Agreements for cooperation between American Colleges of Acupuncture, Colleges of TCM in Japan, Australia, Thailand and Singapore were made for students to study at Guangzhou. Following my practicum I received a certificate in advanced acupuncture, Chinese Medical Massage and Moxibustion by the College.

The experience from Guangzhou provided the necessary skills and length of study to gain accreditation with the Australian Traditional Medicine Society. Importantly, the practical experience facilitated an opportunity to document the daily experiences of a TCM clinical practice in Clinic No. 2 at Guangzhou College. During my time in China a log was completed of my practical experience in the field of TCM clinical practice. Doctor Wu, professor in TCM and Western medicine, found me to be sufficiently conversant with the principal points of acupuncture and knowledge of the treatment and permitted me to practise on patients in the clinic. This also included the practice of Chinese medical massage.

In 1995 I returned to China to Zhuhai to attend a multicultural health care and in a plenary session on complementary health presented a paper on Concepts of Traditional Health Practices. These steps in the study of TCM and my professional consolidation of information provided a foundation towards a focus on alternative forms of health care, with a specific interest in the practice of traditional Chinese medicine.

In this chapter the philosophy that underpins the understanding of TCM is now foreground followed by my observations made during the initial immersion into the clinical world of TCM in Guangzhou, China. To gain insight into the philosophy that shaped the culture of China, and read widely on the philosophy of Chinese civilisation shaped by two proponents, Confucius and Lao Tzu discussed now in the following section.

3.1 The philosophical basis of TCM

For the past several thousand years, TCM has been practised as a philosophical system of health care (Connelly, 1979; Enquin, 1988a; Enquin, 1988b, Enquin, 1988c; Xinnong, 1987). Health and illness are seen to result from complex interactions between the mind and body. Beginnings of the philosophy of TCM were thought to have originated during the time of the mythological 'Yellow Emperor', 2696 - 2598 BC (Veith, 1972). *The Huang Ti Nei Ching Su Wen* (The Yellow Emperor's Classic of Internal Medicine) consisted of Chinese technical, medical and philosophical terms, was first translated into English by Veith (1972) with a later translation by Unschuld (2003).

Since then traditional Chinese medicine 'is based on the Nei Jing' (Lu, 1994). According to TCM, the body is not separate from that of the mind or spiritual dimension of the individual and thus a holistic approach is taken in the recognition that mind, body and spirit are a corporate entity (Dalai Lama, 1997; Kaptchuk, 1983; Kleinman, 1981; Unschuld, 2003; Veith, 1972; Xinnong, 1987). Two thousand years ago, the Canons of Medicine explained the philosophy of TCM (Enquin, 1988a). Traditional Chinese medicine has now developed as a philosophy that identifies the counter-balanced energy of yin and yang and laws of nature as governing the universe.

The Zhou cultural period - was a period of rich cultural philosophy in Chinese history and paved the way for many subsequent Chinese civilisations. Of the 'Hundred Schools' said to have flourished in the eastern Chou (Zhou) era, Taoism along with Confucianism, survived the rule of the Ch'in dynasty (Rodzinski, 1984). For the purpose of understanding the formation of TCM philosophy, Confucianism and Taoism are briefly examined.

Confucius born around 551- 479 BC, was influential in founding a belief system around right relationships in politics and in ordinary family life (Herbert, 1992) this was a social system that exhibited high degrees of collective solidarity, with emphasis on filial piety in founding the respect for obedience (Soothill, 1945). Of equal importance in the contribution of Chinese philosophy, and reputed founder of Taoist philosophy, Lao Tzu, was born approximately 604 BC. The theory of the Tao is conjectured in the Nei Ching to explain 'the basis of the universe, the source of motion, rest and power and the interrelation of yin and yang within the human body (Unschuld, 2003; Veith, 1972). The thought applied to medicine was, that harmony between the yin and yang created health, whilst disharmony or over preponderance of one element instigated illness, disease and death and the concept of treating a disease based on the principle of harmony to eliminate excess and overcome deficiency is referred to in this way;

A cold disease should be treated by hot herbs, a hot disease by cold herbs, yin should be treated in a yang disease and yang should be treated in a yin disease (Lu, 1994, p. 10).

Harmony was also expressed through the world of nature and the natural elements. People who lived according to nature lived in a state of harmony with heaven and earth, yin and yang and the four seasons and were seen to promote wellbeing (Veith, 1972). The connections of the natural world that linked the Tao, Yin and Yang are components found in the theory of the Five Elements that are subdivided into water, fire, metal, wood and earth. Each element has a dependent and interdependent relationship with another. Veith (1972) from her translation made of the 'Nei Ching', explains the Five Elements like this;

Wood brought into contact with metal is felled; fire brought into contact with water is extinguished; earth brought into contact with wood is penetrated; metal brought into contact with fire is dissolved; water brought into contact with earth is halted (Veith, 1972, p. 19).

Distributed over the seasons of the natural world, an element specific to a particular season was exemplified in the theory of TCM. From the Nei Ching, the pulse diagnosis was developed and the Five Element theory that related to the Yin Yang takes into account the seasonal effect as well as the imbalances expressed as deficient or excess yin and yang of each element. For example, when a pulse is taken in the spring it is dominated by the element wood which belongs to the

liver. A pulse taken in the winter is dominated by the kidney, specific to the element water (Unschuld, 2003; Veith, 1972). Enquin describes the changing rhythm of the pulse to that of climate change, it is "... string like in spring, full in summer floating in autumn and sunken in winter" (1988a, p. 26).

The philosophy of the Nei Ching, Confucius and Lao Tze inform the reader of modern times, of how philosophy has shaped the practice of modern TCM, until the communists regarded Confucianism as an ideology of the upper class and Taoism as a philosophy was considered to be founded on superstition (Clayre, 1984). However these philosophies still remain integral to the modern traditional Chinese medicine theory.

1.3.1 Confucian philosophy

The Eastern Zhou period lasted from 770 - 221 BC. During this time Confucius had considerable impact on Chinese thought, particularly moral principles, ethics and correct conduct. Education was the means by which Confucius advocated equality in society (Soothill, 1945). The Doctrine of the 'Golden Mean' described by Confucius had a strong element of Taoism present in the principles describing mans nature. God given nature is called '*Tao*' (the way) and cultivating 'the way' flourished when the inner harmony is achieved. Confucianism was conspicuous as Parson's observed "... that it is almost purely an ethical doctrine, a collection of practical precepts without any metaphysical explanation" (1951, P. 546). Harmony was established through a set of moral and ethical codes for people to follow within a universe that constitutes an order in human society considered to be part of the microcosm of a universe ruled by heaven. Virtuous people become exemplary role models for the rest of society that Confucius described as virtue, when the possession of a state of perfect balance, inner peace and harmony was attained (Yu-Lan, 1989). Birdwhistell has drawn on the early writing of Li Yong a leading Confucian thinker, to examine the philosophy behind the Confucian approach towards Chinese medicine and explains the intent of teaching of illness like this;

Li said, "When the former sages advocated a way, it was to provide help according to the times just as when one is sick, the medicine that one takes varies according to the illness that one has (1995, p. 10).

Yu-Lan (1989) explains that when a state of balance and harmony ensue, one has wellbeing and good health. Health and illness were complex considerations that were not limited to the physiology of the human body and, were inclusive of physiological processes, psychological processes, social relationships, and cultural norms and meanings. Hence when disorder formed the pathology of a medical condition, it was referred to be a disruption of normal functions, found when there was opposition to harmony and balance in a person (Birdwhistell, 1995). This is claimed by Birdwhistell to be pragmatism in the context that from a theoretical framework, conclusions are drawn on how philosophical claims are justified by reference to analogy and metaphor.

In a conversation between the Duke Huan of Chi with the Duke Ai, it was said that, "... when ones virtue is excellent, any deficiency in bodily forms may be forgotten (1989, p. 87). Similarly an explanation of health offered by World Health Organisation in 1947, was "... health is a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity" (Alster, 1989, p. 77). In Chinese medicine, a state of wellbeing is found to be related to the harmony of energy of the yin and yang found in a balanced flow of Qi in the Zang Fu organs. Notions of peace and harmony were recurrent themes in Confucian writing and applied to specific values that governed the function of the state, family life and the wellbeing of the individual in society.

The essence of Confucianism was that correction is necessary to stabilise the moral order, if corruption exists in society, the state and in the individual (Birdwhistell, 1995). When a pathological situation was determined (*Bing*), the goal was to treat (*Zhi*) and to restore harmony (*He*) within the body. The recovery of health was the aim of the basic questions (*Suwen*) found in the 'Huangdi Neijing' (Veith, 1972). The harmonious functioning of the organs is analogised in TCM as Enquin (1988a) refers are made to be 'officers of the state' controlling specific functions throughout physiology of the body.

These functions are described by (Yu, 2003) metaphorically to attach understanding to the origin of TCM philosophy, an example is that of the gallbladder as a 'container of courage' (Yu, 2003). Enquin (1988a) described the gallbladder like this "... the gallbladder seems to be an upright officer, who is in charge of making decisions" (p. 114). When an imbalance persists in the harmony of the energy flow in the gallbladder, the function is then impaired. When there is disharmony within an

individual there is a need then to correct the imbalances, to promote harmony that has arisen from emotional imbalances of fear, anger, worry, grief and excessive joy (Ross, 1985). These imbalances lead to specific conditions within the body and promote the early stages of illness and hence the process of disease. Balance and harmony are the characteristics of the superior state in Confucianism and also govern the nature of physiological and psychological wellbeing.

1.3.2 Taoist philosophy

Chinese medical thinking shared important notions with other cultural thought, such as the arts of painting and calligraphy, astronomy and alchemy, and most fundamental, the concepts of Yin and Yang that were formed around concepts of energy “characterised by cyclical rhythm and phases that linked the phenomena of heaven and earth (the macrocosm) with those of the individual (the microcosm)” (Birdwhistell, 1995, p. 3). Founder of Taoism, Lao Tzu advocated that there were always two opposing aspects that occurred from within (Yin) and without (Yang). Ancient Taoism evolved from spirit worship of the yin. In a translation by Old (1894) of ‘The Tao-Teh-King of Lao-Tze’, in reference to the Tao, Old says the greatest virtue, is the origin of things that is like ‘a source of water’ which flows and is an ever-changing essence “... It has the virtue of adapting itself to its place it is virtuous like the heart being deep” (1894, p. 3). The changing aspect of nature is represented by the ancient Taoists who used the ‘*I Ching*’ to express both complementary and antagonistic principles of yin-yang in both creative and destructive arrangements. The system described by Legge (1973) is attributed to have eight basic triagrams, which form hexagrams, changing from yin and yang. Each figure of the hexagram according to Legge “... is assigned a certain attribute or quality heaven or the sky, water, fire, lightning, wind and wood” (1973, p. 11). The basis of the principle of the *I Ching* is that change is inevitable.

Nature is subject to ‘constant change’, within the external environment and also the physiological internal nature of the individual. Confucius perceived that each body is a microcosmic universe, and this cosmology in traditional Chinese medical thought has been illustrated by a number of writers (Baker, 1997; Connelly, 1979; Enqin, 1988a; Enqin, 1988b; Veith, 1972; Xinnong, 1987). Traditional Chinese medicine accords a cosmology that focused on how humans live in harmony with nature and

how change in that relationship impact upon individual wellness (Xinnong, 1987). An example is the pulse of life, an important diagnostic tool for traditional Chinese medicine.

TCM recognises the importance of "...‘*Tian Ren Xiang Ying*’..., the relative adaptation of the human body to the natural environment" (Enquin, 1988a, p. 32). Along with varying seasons, the times of the day are observed to have an influence on the condition of one’s health regulated by the pituitary and adrenal glands. This scientific basis for this is the homeostatic rhythm of the body governed by the pituitary bodies and adrenal gland that are seen in a state of constant flux of energy change regulated by the homeostasis of the body. The essence of Taoism is that attention needed to be made to the changing elements of the natural world to understand the flow of the Tao identified through the Five Element theory that governs the assessment and diagnostic process of TCM. Yin and Yang are the counterparts in a balanced state of harmony (Enquin, 1988b; Xinnong, 1987) and described by Maciocia, that:

Although yin and yang are opposite, they are also interdependent and cannot exist without the other ... they are in a constant state of dynamic balance, which is maintained by the continuous adjustment of the relative levels of yin and yang (2005, p. 5).

Whenever the energy flow is harmonious and flows freely without obstruction, health ensues. When a block or disturbance in the flow of energy occurs, distress or illness ensues. Hsu (1999) draws on the practice of Chinese medicine to describe the transmission of Qi and the interpretation of wellbeing the person, are dependent on the harmony of Qi as it flows through the body. Qi is the vital essence or life force of the body (Firebrace & Hill, 1988; Maciocia, 2005; Unschuld, 1998; Xinnong, 1987). Without Qi flowing harmoniously it may signal the start of a particular illness in the body. In Chinese medicine the body is composed of circuits of energy [meridians] and medical therapies are designed to clear or unblock energy imbalances.

The philosophical school known as the ‘Yin Yang’ School sometimes called the Naturalist School, developed the theory of yin and yang and the theory of the five elements (Maciocia, 2005). A unique cultural understanding is embedded in the philosophy of the Five Element theory that promotes harmony when there is imbalance or illness found in the body. The theory refers to the five elements found in the natural world described during the Zhou dynasty (Clayre, 1984, p. xi).

Explanation from the five element theory is illustrated through the phenomena of the natural world corresponding to wood, fire, earth, metal or water, which are engaged in cyclical patterns of energy change (Maciocia, 2005; Unschuld, 1998; Xinnong, 1987). Energy changes bring either states of harmony or disharmony, the outcome of our state of health depends on the interactions of these energies (Veith, 1972).

Chinese medicine also attached significance to the functions, interrelationships and patterns of emotional disharmony expressed through one's behaviour (Ross, 1985). The medicine is focused on the promotion of the restoration of harmony and balance of the energy throughout the body. The Qi being in a harmonious flow throughout the organs of the body remained a focus for the practitioner who initiated intervention aimed at the restoration of good health with the focus of healing formed from this holistic perspective rather than from a disease illness perspective. Concepts embedded in past Chinese philosophy, remain part of current practice of TCM and the format to detect forces of energy within the body are described through the Theory of the Five Elements used by the practitioner for their assessment (Connelly, 1979; Enquin, 1988c; Kaptchuk, 1983; Lu, 1994; Veith, 1972; Xinnong, 1987). This discussion has outlined TCM philosophy an understanding of which was a presupposition that enabled me to understand in depth TCM theory studied prior to my immersion into the clinical culture of Guangzhou China.

3.2 Cultural immersion

The insight into Chinese philosophy provides a theoretical stance but it is necessary to have some understanding of how the medical constructs of TCM and the manner in which clients are applied to describe and treat illnesses (Kleinman, 1981). To gain an in-depth of the principles of practice for a brief period of time I extended my knowledge of traditional Chinese medicine through education on TCM in the country of origin, the Peoples Republic of China, Guangzhou by attendance at a clinical practicum. From this experience I acquired an awareness of techniques involved in TCM. This led me to undertake further inquiry into this form of traditional medicine and left me open to enhance my knowledge of this different form of medicine and the manner in which it operated.

Engaging in research as an insider (Spradley, 1980; Denzin, 1989; Morse & Field, 1995; Burns, 1997) to some extent was facilitated by my prior engagement through

study and the clinical practicum experience in Guangzhou China. Active involvement in the practicum in the culture of the TCM clinic provided the opportunity to investigate TCM practice more deeply than would have otherwise been possible. It allowed me to immerse myself in the culture and gaze into an empirical world, which supposedly is hidden from the outside observer (Clough, 1992). From my experience in the clinic and from the opportunity to live as a student at the international student hotel I began to understand the importance of how health and illness were viewed from a different cultural context.

The two month clinical practicum experience was an intense time of action during which clinic time was measured in quantity each day with the break beginning at 8.00am until 12.30pm resuming at 2.00pm until 5.30 or 6.00pm each day (except Sunday), depending on the number of patients waiting for attention. During the time in the clinic I was the only foreign person from an Anglo-Saxon background. The journal that I kept of the fieldwork while in the clinic related to the treatments administered by myself under the guidance and direction of my interpreters, Dr Su Hai Ru and Dr Dai [pseudonyms]. In the journal I also documented details of different cultural expectations towards health as I had shown an ability to communicate in Mandarin, which I had learnt during the course. A gradual development of trust and mutual respect occurred between the people who accessed this clinic (Spradley, 1980). This may have been consequent to the fact that I was able to treat the same people on a regular basis as they came to the clinic thrice weekly and became familiar with me.

The pre-entry phase is an early important area to the development of the ethnographic research and provided a window (Shank, 2002) from which to view TCM, within the clinical reality from a clinic in China. Engagement with practical experiences studied through Guangzhou College of Traditional Chinese medicine assisted my research through the promotion of how TCM practice was understood. From this base of knowledge I became aware of instances of subjectivity based on cultural assumption of the practice of TCM that helped me to minimise any generalisations made in later observations of fieldwork in Perth. Claims attached to validity based on the admission of error, cannot be eliminated from scientific inquiry but can be minimised (Sacks, 2002) through extensive prior engagement that enabled a refinement of the social interpretation to develop.

3.2.1 Perth – initial contacts with Chinese culture

An interest in Chinese culture was facilitated by an association with the Chinese Friendship Society in Perth and insight the traditions of Chinese culture through links with a Chinese family who immigrated to Australia in 1988. Different cultural events such as Moon Cake Festival, Qing Ming and Chinese New Year have been celebrated and the cultural importance of each occasion explained. Participation in these social and cultural processes that involved witness to birth and death, were also shared along with the accompanying rituals as we engaged in those processes despite the difference of our cultural boundaries. Family members discussed the tragedy of the Cultural Revolution and their memories of pain, of the Cultural Revolution they had been sent to hillsides to tend to a farm, was shared with me. This information was related by ‘Y’ a former university lecturer and his wife, who had been a teacher, both young professionals and now in their ageing years. ‘Y’ described how the family had been forced to perform menial tasks, tending to chickens and pigs as a part of the Cultural Revolution thought reform.

3.2.2 China – immersion into Chinese culture Guangzhou

In 1994, I journeyed from from Beijing to Canton and on the flight noticed no other Caucasian person on the plane despite China had opened the doors to the world outside. On arrival in Guangzhou, it seemed that the people had flooded into the city from rural areas and were searching for new life, employment, as young people sought out modern western ways with an emphasis on consumerism and cheap labour with China foreground for the factory production of international conglomerates. On one occasion I witnessed the extreme poverty of the hundreds of homeless from the countryside, when I visited the rail station at Guandong, where people were crowded under the archways of the overpass near the station with their hand luggage.

At that same time commercialisation was in progress, Kentucky Fried Chicken had sourced an outlet and was opening its first shop along a main road in Beijing. Already in competition, there was an outlet for Wendy’s Burgers situated a short distance from a McDonalds located in Guangzhou, where I went with fellow students on several occasions after having tired of student food. Contrasts were observed along the main street. Western style commercial shops exhibited their latest fashions

from their windows and coexisted alongside herbal shops that exhibited their wares with snakes coiled in glass jars.

As I mingled in the crowds during my time spent in practicum at Guangzhou College of Traditional Chinese Medicine, contrasts were observed in that foreign landscape, as bike bells rang out and jostled with car horns added to the cacophony. Fumes belched from the heavy traffic and nearby industry, a reason why some pedestrians wore protective face masks against the heavy airborne dust. In China my main transportation was by bus or on occasion to hire a mini taxi. One day I rode about on buses that must have existed from the time of the Cultural Revolution, it had a folding canvas mid-section that linked the two parts of the bus together. Space was always at a premium and one stood shoulder to shoulder crammed in to wherever one could and as we journeyed along together, more people were crammed in. Any need for social distance was abandoned.

At the student hotel I had a room at the end of the complex on the tenth floor that overlooked a hillside, from my window could see a make shift camp that housed a number of people. Early each morning, I observed people around a camp fire. I often looked out and wondered why smoke would periodically rise from the hillside every



other day from different locations on the hillside. Why there was activity from different locations of smoke was revealed to me when one of the hotel assistants told me what it was. She pointed to her dictionary and then the hillside, and said “they are sleeping”. The hillside was the local cemetery.

Plate 1. Cemetery viewed from bedroom window

On *Qing Ming* Day, which occurred on the 26th March of that year, loud explosions came from the hillside. Processions of people wound their way up the hillside each day as they came to visit gravesites where paper money was burnt as offerings to the

ancestors and to sweep the grave sites. These celebrations lasted over the week as people came to the hillside to picnic, to light joss sticks and ignited fire crackers to ward off evil spirits. It was an interesting to observe from the top floor of the student hotel the processions each day as people came to honour their ancestors.

Guangzhou International Training Centre was established at Guangzhou College of TCM in 1956 and is now a University of TCM. This complex is set on 300,000 square metres of land (Appendix 4) within the complex there is a hospital for teaching, and an herbal pharmacy.



Plate 2. The Herbarium at Guangzhou

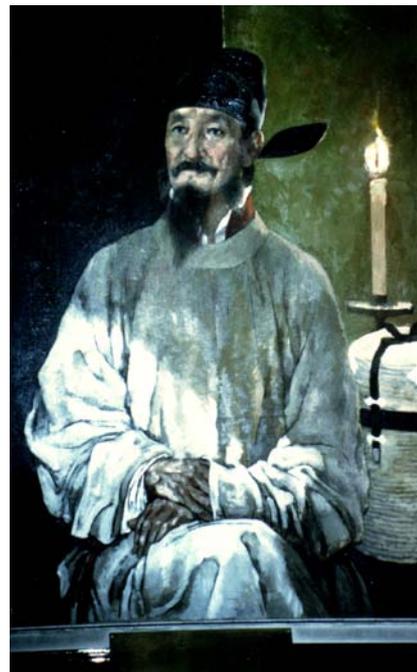


Plate 3. Portrait of Li Shizen

A herbarium is devoted to Li Shizhen (1518 – 1593) a physician and pharmacologist during the time of the Ming Dynasty [AD 1368 – 1644], he wrote the famous '*Compedium of Materie Medica*' which took twenty seven years to complete. Li's work revised and classified herbal substances. It lists 1,892 medicines and more than 10,000 prescriptions (Enquin, 1988a, p. 16). This compendium contributed to the early development of botanical medicine and pharmacology in China and remains important to the present day (Gao, 1997). Within the grounds of the complex at Guangzhou there was accommodation for doctors, students, an overseas student hotel, a student hotel, library and the main hospital site with several smaller

restaurant style places to eat. An open market area provided fresh food where fresh produce, vegetables, eggs, fish and pork could be purchased.



Plate 4. Open market in the grounds of the TCM complex

Security was a major consideration and the student accommodation which housed overseas students had iron grills on all of the windows even those on the tenth floor. The medical students building opposite the student hotel was occupied by young student's, their clothing was hung out each day out on the overhang where some space was available for the drying of their clothing.



Plate 5. Student washing on balconies

The daily routine of students began each morning with mealtime at the student cafeteria around 7.00 am. I queued along with other students who grasped their metal bowls into which a rice porridge or noodles were ladled out from huge steel vats. Students either stood hurriedly around eating or seemed to perch on uncomfortable bar stools before they exited the canteen to go to their classes for the day. My dining experience for the evening usually consisted of chopped fresh vegetables and cooked rice from a slow cooker purchased from a nearby 'Friendship' shop after abandoning the experience of the student cafeteria. In the compound students jostled shoulder to shoulder, those who were able to afford the luxury of bikes doubled their friends on the back as they made their way along the cobbled compound road. It was an atmosphere of purposefulness as we hurried together towards the hospital that loomed before us in the early morning light. Being early March and springtime, the humid weather was oppressive and the dust clung to the air from heavy traffic that surrounded the complex.

For a while I was the only overseas student present until two German doctors were in the clinic next door to me. Unfortunately we could not communicate, as they were unable to speak English and I was unable to speak German. Two young Chinese students from the college studying TCM spoke a little English and befriended me. In the evenings when I was free, these young student doctors along with some friends visited me to engage in conversational English and Cantonese. Such encounters provided me an opportunity to become further acquainted with the Chinese culture as these students brought their youthful enthusiasm with them as we sat and made the effort to mix an unusual combination of Chinese and English from translation dictionaries. In the clinic I was also reliant on my dictionary and would not have survived without it and the doctor 'Su' who interpreted for me. Fortunately there were two students from Australia, both Chinese who spoke English and a Japanese student who was also able to communicate in English with me.

3.3 My induction to clinic No.2.

Monday the fourteenth of March 1994, I met with Professor Chu and Daifu Bai in Clinic No 2. The previous evening I had arrived at Guangzhou College after I had travelled three hours by plane from Beijing following a conference. Patients queued outside the door of the clinic on large benches placed in the corridor of the hospital.

In the main teaching hospital for TCM there were a number of different clinics for acupuncture and massage. I was allocated Clinic no 2 with Dr 'Fu', and Professor 'Deng'.

I meet with many people, Professor Chu and Daifu Dai. Many people come to the clinic to be treated for cerebral palsy, rheumatoid arthritis, facial paralysis, infantile paralysis, migraine and muscular atrophy following stroke, spondylitis of the shoulder.
(13/3/1994)

The clinics operated Monday through to Saturday each Sunday we had time off. The atmosphere of the clinic was observed like this; there was a constant buzz of noise from the chatter of people who spoke Cantonese. Patients were observed to spit into spittoons outside the clinic door, the aroma of mugwort drifting in the air, which shrouded the clinic at times in a cloud of smoke and the crowded quarters, often overwhelmed me as I struggled for my 'personal space'.

My white crumpled coat which doctors wore, to some extent legitimised my 'being there' into the assimilation of the workplace and cultural ethics of Clinic No 2, which each student wore. Each morning I would tidy the bunks and replace the tops sheets and put a clean towel over the pillows. However I felt uncomfortable being the only Caucasian present and not able to speak Cantonese. The manner in which the daily routine was organised was comparable to that of any busy hospital outpatients department with patients who had frequent visits each week, and who waited on the wooden stools outside the clinic. Some men preferred to lean against the wall outside the clinic where they smoked while waiting their turn in the clinic. The therapies offered each day in the clinic as TCM were massage, cupping, acupressure and herbal therapy.

3.4 Activities that formed the culture of the clinic

My appreciation and understanding of Chinese culture was integral to the practice and philosophy of TCM and without such an appreciation, adjustment to the clinic routine would have been difficult. Through both active and complete participation I assimilated the cultural rules that governed the behaviour in the clinic around my learning experience of administering acupuncture to patients (Spradley 1980). In some situations I was involved directly with improving my acupuncture techniques

whilst observing others and at other times during the clinic routine I was fully immersed in the administration of therapies being given the opportunity to initiate cupping or needling techniques on patients. Explicit cultural rules (Spradley, 1980) of the clinic were numerous and included dimensions of acupuncture techniques that involving handling the needles differently to what I had been previously taught. For example, one had to grasp an assortment of needles in the crook of the small finger of the left hand. This was extremely difficult and one wonders how hygienic as a technique this was.

The acupuncture needles are tucked neatly into place in small tin containers after being sterilised by boiling technique. They are then transferred from the tin to the hand of each individual practitioner. The needles are then held by the practitioner, the correct way to hold them is to curl the little finger around them. (15/3/1994)

The students took some of the upkeep of the clinic to task each morning this included picking up needles from the floor that had fallen there after treatment when the practitioners were hurriedly organising other patients. The linen was changed on the bunks and records of the patient organised onto the desk. The needles were sanitised by a steam autoclave each morning prior to when the surgery opened, the needles were placed into a stainless steel container and then this was autoclaved. Disposable needles were not used. Patients were greeted as they entered the clinic and ushered to either a chair or a bunk.

Hindered by my inability to write Chinese characters I was unable to write on patient notes as did some of the other students but during this time I discussed the treatment with the interpreter assigned to me, which was either Dr Dai or Dr Su Hu Wren. Each day presented similar experiences, which enveloped me in the culture of the clinic. Each evening in the privacy of my room I tried to make a review of the day and the acupuncture points used for treatment of different conditions. The impact of immersion into this new culture was profound and clearly was a pre-entry experience that led me to conduct an ethnographic study at a later stage (Kleinman, 1988: Spradley, 1980).

Field notes and analysis on the treatments administered to patients provided insight into the practice found in the clinical routine. Discussions with my interpreter helped facilitate this experience, as I was able to discuss various patterns of treatment and the selection of therapies for different ailments. Despite many shortcomings of not

being able to communicate effectively through lack of knowledge of Cantonese my clinical practicum experience was enriched as a result of being accepted by the staff and patients in the clinic. The following field notes describe the experiences of the clinic and some daily activities whilst treatments were being carried out.

An interesting treatment in the massage clinic was identified by the doctor as ‘opening the Gate of Heaven’ a massage technique starting at the corner of the eyebrows working over through the earline over the point identified as Yangbai and around the midway point of the head, then to the back to Fengchi. The fingers are moved over the head following the Gall bladder meridian pathway. This was followed by lightly tapping over the scalp with the fingers (16/3/94).



Plate 6 and 7. Opening ‘the gate of heaven’ [TCM term]

On alternate days I visit the massage clinic in the afternoon to further develop my skills in the Chinese massage techniques. In the clinics there was a noticeable lack of technology and the primitive techniques of the clinic drew my attention to the lack of

technology. The bunks the patients rested on were narrow and crudely made up. In the clinic a desk and a few scattered chairs, the clinical books on acupuncture assorted on a bookcase and the needles that were recycled in their containers, set the atmosphere.

I attend massage clinic again and learn some new skills with Dr Su. The techniques are rolling shaking slapping etc. Then I attend to some cupping and massage of the shoulder under the guidance of Dr (21/3/94).

The main clinic room was small, less than three metres by two metres. This accommodated four bunks, three chairs and a desk that the doctor sat. In the corner of the room there was a sink for hygiene purposes.

The clinic is very small but a minimum of five patients are treated in here every 25-30 minutes. In regard to the practise of acupuncture I'm able to remember the main points despite not having time to revise them. As part of the diagnostic technique we examine slippery tongues revealed in people who are suffering from arthritis, as a stagnation of Qi.

The clinic was always full of people and therefore it was very difficult to move about as some of the patients sat on chairs as they waited to be treated in the clinic. The confined space led to accidents and from my field notes I illustrate how this crowded and confined space led to a very painful episode for one patient:

One day I inadvertently brushed my coat against the needles sticking out of a man's back. He was seated on a chair with his back arched out. There were no bunks left. He screamed at me in Cantonese.

The pain he experienced would have been intense as from the ends of each needle; 'mugwort' a herb was attached and burnt to allow the penetration of heat into the localised point at the needle insertion. Following that episode I was more careful regarding each step I took with caution in the limited space (Field Notes).

The sight of the mugwort burnt from the needles inserted into limbs at specific acupuncture sites was an overwhelming experience as I viewed a treatment which appeared to be alien to any experience in relation to my background in health care. Mugwort use is depicted in Plate 8.



Plate 8. – The use of mugwort attached to acupuncture needles.

The smell of mugwort burning was not unpleasant and the atmosphere appeared primitive as smoke drifted into the air from the needle. The use of mugwort is varied in that it can be used as an indirect application of the herbal moxa stick or insulated from the skin by a slice of ginger. In this case there is a direct application of herbal mixture attached to the needle head. The herb is burnt so that the needle is warmed and heat and from where the needle is inserted into the acupoint warmth is directed along the meridian pathway.

An example of a typical activity (Plate 9) as a patient is treated with acupuncture with a combination of moxa mugwort to the needle end. The scenery in the background shows older style ceramic power points to the right of the photo. It is possible the clinic had not been modernised since it was built in 1950. There is intense concentration on behalf of the acupuncturist as they insert precisely into the specific acupoint to be treated, the needle is inserted and Qi manipulated through the technique of needling. Certain steps are engaged with as the needle is inserted into the acupoint and the needle manipulated to promote the Qi to arrive at the point, hence stimulating the flow of energy. Yang Jizhou of the Ming Dynasty identified that twelve manipulations could be performed (Xinnong, 1987) important was the practitioner should be calm of mind and the point located accurately.



Plate 9. Acupuncture treatment for spondylitis of the shoulder

A patient who visited the clinic was a young girl who had a problem with a congenital muscular dystrophy of her limbs since birth. While her granddaughter was treated three times a week with acupuncture, her grandmother rolled her own cigarettes whilst waiting outside the clinic. The young girl had been treated with acupuncture over the past twelve months. During that time she had regained sufficient use of her limbs to walk normally and without assistance.



Plate 10. Granddaughter treated with acupuncture

The young girl had been treated with needles inserted to points on her head and to her lower limbs. Acupuncture was used to treat to lower arms and leg in Plate 12 and 13.



Plate 11. Acupuncture to lower arm. Plate 12. Acupuncture to lower leg

Points used for the treatment identified here are Hegu and Wenliu (Xi cleft point). Hegu is a Yuan primary point and can be used to treat for a variety of conditions one of which is facial paralysis the young girl had since birth and also a weakness and motor impairment of her upper limbs. Following acupuncture, she had demonstrated considerable improvement according to her doctor and after only three months of intensive acupuncture and massage therapy, and was able to walk unassisted for the first time in her life.

A young woman receives acupuncture treatment for lower back pain. Cupping had previously been applied seen as the red circular areas (Plate 13). Her back was massaged for twenty minutes after the cupping was applied and followed with acupuncture.



Plate 13. Needling to lower back points following cupping



Plate 14. Cupping to upper back and shoulders following massage

A man (Plate 14) attended for upper back and neck pain, was treated with cupping through the application of a heated cup to draw the circulation to the specific site of tenderness. A gauze swab soaked in spirit is lit, held by artery forceps and the flame lit cotton bud is inserted into the glass container then rapidly withdrawn. This creates a vacuum and the suction of the circular glass cup is applied to the affected area. Care is taken with insertion of needles to the abdominal area (Plate 15) to avoid trauma to and puncturing of internal organs especially around the liver area to the left. The man had come for treatment of hepatitis.

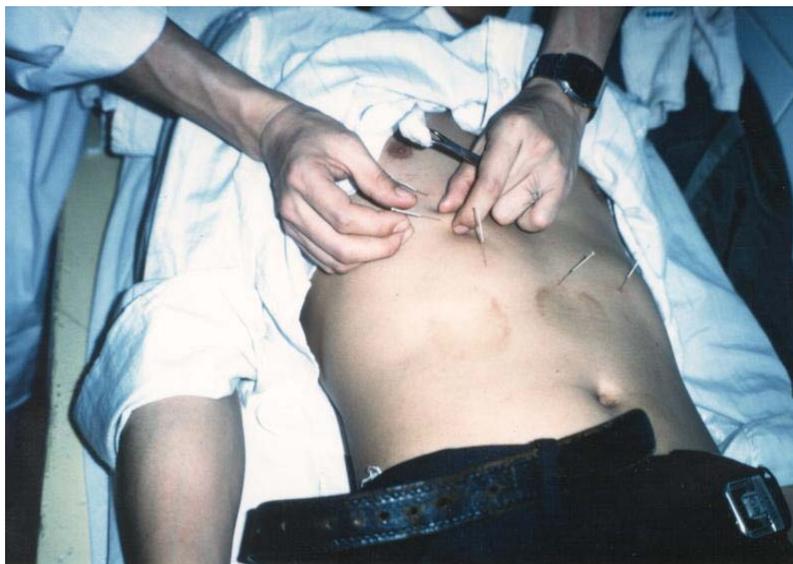


Plate 15. Acupuncture to the abdomen for treatment of hepatitis.

In the clinic at least at least fifty to sixty patients visited and were treated through traditional forms of TCM each morning. There were as many patients to be treated in the afternoon. Usually a session of acupuncture varied between twenty to thirty minutes depended on whether moxibustion was used in conjunction with acupuncture and followed by massage. During the time I had off between clinics, I returned to my room and reviewed the morning activities with other students who shared their understanding of acupuncture with me.

The massage clinic

To facilitate an understanding of Chinese massage I visited the massage clinics in the afternoon three times a week and was able to practise a variety of forms of massage known as *Tuina*. Treatments in the massage clinic were labour intensive and lasted from fifteen to thirty minutes. The dialogue between patient and practitioner was always accompanied by note taking, good eye contact and a noticeable minimal intrusiveness of any technology. The emphasis was on the exchange of hands on therapy where massage and acupuncture were concerned.

A form of therapy used was the application of traction by the use of a leather belt around the lower body of the person. Another form of treatment used as a form of massage was that of the use of acupressure which was used extensively for those who had experienced recent strokes. It was used as a form of rehabilitation and I was shown various forms of massage techniques explained to me as stretching, scraping and hacking. This form of acupressure is very different from that which I know of prior to this. My knowledge of acupressure was limited to an understanding this consisted of the application of direct pressure to a specific acupoint to promote the stimulation of Qi.

Chinese massage therapy was different to Western massage. Dr Du had said the underpinning belief was “no pain, no gain”. The massage was very vigorous and after I had experienced it first hand for a shoulder injury noticed it had stimulated the blood flow to the local area and relieved the pain. I held reservations about the intensity of the massage when local trauma to tissue already existed with evident bruising.

Many acupuncture treatments are followed through with cupping and then Chinese massage. That afternoon I visit the Massage clinic and watch Dr Wang who is the doctor in charge demonstrate his Tuina skills. Tuina is a name that identifies Chinese massage.

However in this situation he demonstrates a different form of massage and with fine balance he steps on back of a patient who has come in with dislocated vertebrae (18/3/94). This form of massage is supposed to relieve the pressure by stretching out vertebrae.



Plate 16. Walking Massage

The spine is stretched to relieve discomfort of the spinal vertebrae. The patient returned for treatment three times per week and I was able to observe the practitioner stepping over the back of his patient whilst supporting himself on a special rail. I was invited to perform this form of massage but felt it would be better to defer, as I did not have the experience and may have caused injury to the patient.

3.5 Reflecting on my experience

Acting as a participant student in the clinics I was given responsibility along with other students after we had completed the orientation to the clinic. Functioning to complete these tasks placed me in a position of trust with other health members including doctors and other foreign students. As a Western person exposed to the culture of this clinic appreciation of the activities observed each day enabled me to approach this ethnographic study with a stance that embraces the culture being observed through this window (Shank, 2002) which I felt had become transparent, and was not biased on racial differentiation or other distortions of opinion. The experience that I was immersed into was different to any previous experience and an effort was made by me to disengage from the obvious racial differences with my presence as a woman and the only Caucasian person in the clinic. I felt like I had become a member for a short time of Clinic No 2.

I was asked to identify specific points for treatment by Professor Chu for several new patients and felt they acknowledged some knowledge I had at this beginning level of entry in the study of TCM. An in-depth understanding takes TCM practitioners years of practice and study. More important to me was an appreciation of the culture which enhanced my knowledge of the philosophies that govern the practice of TCM. Of prime consideration was the unique meeting of cultures, in clinic No.2 in Guangzhou, China. Both professional and personal experiences seemed to be fused together as I emerged from the experience with TCM. The fieldwork provided a fertile ground for my future fieldwork and sharpened my methodological skills of observation and in note taking.

During the immersion into the clinical experience and observations on the interactions around me, awareness of the tacit rules that were an implicit part of the culture of the clinic was important to this cultural experience. This helped facilitate my perceptual skills through which as I was able to view how medical problems are managed in a different culture. People can be treated successfully and relieved of discomfort and chronic pain particularly from paralysed limbs following stroke and from arthritic problems, with massage and acupuncture. From observation on these interactions in the clinic I noticed how different practitioners administered a variety of forms of traditional Chinese medicine to patients. Chinese medicine involves the use of herbs, diet, massage, Qi Gong and acupuncture. Insight into the TCM medical

system and a network of friends and acquaintances developed from this exposure and provided a foundation for the later work of this research.

Human behaviour observed whilst in the clinic facilitated this ethnographic study “... you participate to some degree in the lives of the people you are studying” (Shank, 2002, p. 56). I felt this had in part already been accommodated for me through the cultural immersion. This is a subjective notation to illustrate how my immersion into the culture of the clinic was recognised by a patient at the clinic, who one day in her broken Cantonese-English said “she is just like one of us”. This anecdote reinforced for me how much these people had enhanced this clinical experience with their acceptance of me into the clinic at Guangzhou.

3.6 Summary

Insights that were gained from this pre-entry phase into the world and culture of TCM provided me with an emic point of view of the practice of TCM and the experience enabled me to view the process, the structure of how the social and philosophical construction of the TCM system of health care is different to that of Western medicine with which I was acquainted. Clinical insights and the qualifications gained in China facilitated my entry into the ‘field’ of a TCM clinic in Australia, something that is examined further and explored in this thesis.

To understand the nature of the philosophy that is embedded in TCM practice, led me to read widely on Buddhist and Taoist texts, and the information assisted with my background preparation from which the thesis evolved. It is imperative for ethnography that a study is not done for the sake of collecting cultural information from people merely to fill the bank of scientific knowledge (Spradley, 1980 p. 17). The undertaking of the study was to provide an explanation on Kanbing which remains to be attended from the context taken from a Western observational perspective other than within the country of its origin.

CHAPTER FOUR

Method of Data Collection and Analysis

In the context of culture, the study of patient and healers, and illness and healing, must therefore, start with an analysis of health care systems (Kleinman, 1981, p. 25).

4.0 Introduction

This study examines the interactions between client and practitioner within the context of the procedural process of consultation at several practices of Chinese traditional medicine in Perth, Western Australia in order to understand how health practices are shaped by cultural and social processes (Eisenberg & Kleinman, 1981; Kleinman, 1981). An ethnographic approach was taken to pay attention to the important contextual features of practitioner and client interaction found in a TCM clinic and to describe those through the Developmental Research Sequence (Spradley, 1980). The ethnographic exploration is formed in three major research phases and through the convention of the Developmental Research Sequence (DRS) (Spradley, 1980).

Access to fieldwork at the 'Hanyu' clinic in Perth's inner CBD, was facilitated by two practitioners. A second clinic, the 'Yin Min' clinic in a metropolitan suburb, provided an opportunity to study client's case histories with the clinic practitioner who provided translations on the formation of the differential diagnosis of illness from a TCM perspective.

4.1 The ethnography

The research is based on participant observation on TCM in two Perth clinics. It contributes to contemporary anthropology through its focus on the understanding of the structure, process and meaning in the practice of this form of medicine within a Western clinical context. An ethnographic approach was considered to be the most appropriate form of methodology to research culture bound health practices, in the social world of the TCM clinic. According to Evans-Pritchard, ethnography aims at "... revealing the structural forms or patterns which lie behind the complexity and apparent confusion ..." (1969, p. 123) within TCM. The World Health Organisation has commented that such studies based on qualitative techniques of inquiry, "... can provide baseline material from which further hypothesis can be generated and lead to future research" (World Health Organisation, 2000, p. 12).

Ethnography offered a naturalistic approach neither wholly predetermined nor tightly structured to assist in the understanding of how individuals construct social meaning attached to their perception of illness (Becker, 1963). The pre-entry exposure in China provided me basic skills from my participation in the culture of a non-Western clinic setting. This gave me a prior knowledge useful in studying TCM within a Western context. In particular it provided me with an understanding of the philosophy, terms and therapies used in TCM practice. The initial exposure to the culture of Chinese medicine was a necessary step towards becoming a participant observer, which allowed me to immerse myself in the reality of the TCM clinical world (Shank, 2002).

The ethnographic approach was guided by a necessity to enter into an extended contact with the everyday clinical reality of the world of TCM. From an 'insider' perspective, the cultural practices of TCM are inductively discovered within the cultural context and from an 'outsider' perspective (Field & Morse, 1985) different tactics were employed to conduct the research (see 4.2). Shank (2002) says that an ethnography benefits by trying to incorporate and coordinate both insider and outsider perspectives.

The ethnographic approach is based on the principle that human beings are culture-bearing agents embedded within social cultural framework that give meaning to their

actions from which interpretation can be made (Aarmond, 1982; Denzin, 1992; Fetterman, 1989; Geertz, 1988; Spradley, 1980). Through observing as systematically as possible the social cultural framework of the TCM clinic, the researcher is able to draw out these meanings as they relate to culturally defined notions of health and well-being (Kleinman, Das & Lock, 1997). The ethnographic approach is central to what Denzin (1991, p. 59) refers to: "... the production of cultural meaning, the textual analysis of these meanings, and the study of lived cultures and lived experiences". Each of these interrelated problems constitutes a distinct field of inquiry from which observations are made. In this study, all three fields are examined on those patterns of interrelationships: 1) within the clinic to describe the unique cultural context, 2) the traditional Chinese construction of an illness, 3) to find meaning in client and practitioner perspectives.

Understanding is drawn from the interpretation of the participant role of practitioners, from how they explained the clients encounter with illness with their use of TCM theory. This study draws on Farquar's work on traditional Chinese medicine (1994) which sought to understand the clinical encounter in TCM. These clinical encounters known as Kanbing constitute a field of inquiry into a lived clinical reality based on 'being there'. However Farquar has been criticized by Kleinman (1997) who points out that, "... we learn very little about particular practitioners, particular clients or particular encounters. Rather her concern is the ideal typical" (p. 214). Kleinman's criticism raises the possibility that participant observation can overlook the potential for exploration of the characteristics of particular practitioners and clients. This study will focus on those characteristics from within the clinical encounter.

4.2 The research phases of data collection

An ethnographic approach was facilitated by these three phases (Fig 4.1): 1) participant observation and formed the major component of research attended to examine the cultural setting, 2) focused interviews of a small representative group of clients who contributed their perspectives on TCM use, 3) Case study analyses provided examination on the structure of clinical encounter shaped by the structure of

the practice of TCM (Fig. 4.1). Case study analysis was facilitated through the Explanatory Model (Kleinman & Benson, 2006; Good & Good, 1981) with the exchange of information between the practitioner and the researcher on site.

These three ways research provided the base for my data collection to describe encounters between practitioners and clients. These strategies were used in a transparent a way as possible (Shank, 2002). Figure 4.1 summarises how the phases of research are developed. Phases one and two were structured according to the stages of the Developmental Research Sequence (DRS) (Spradley, 1980) described in sections 4.5, 4.6 and 4.8. Phase three included case study analysis. The routine of data collecting is described in 4.5.1.

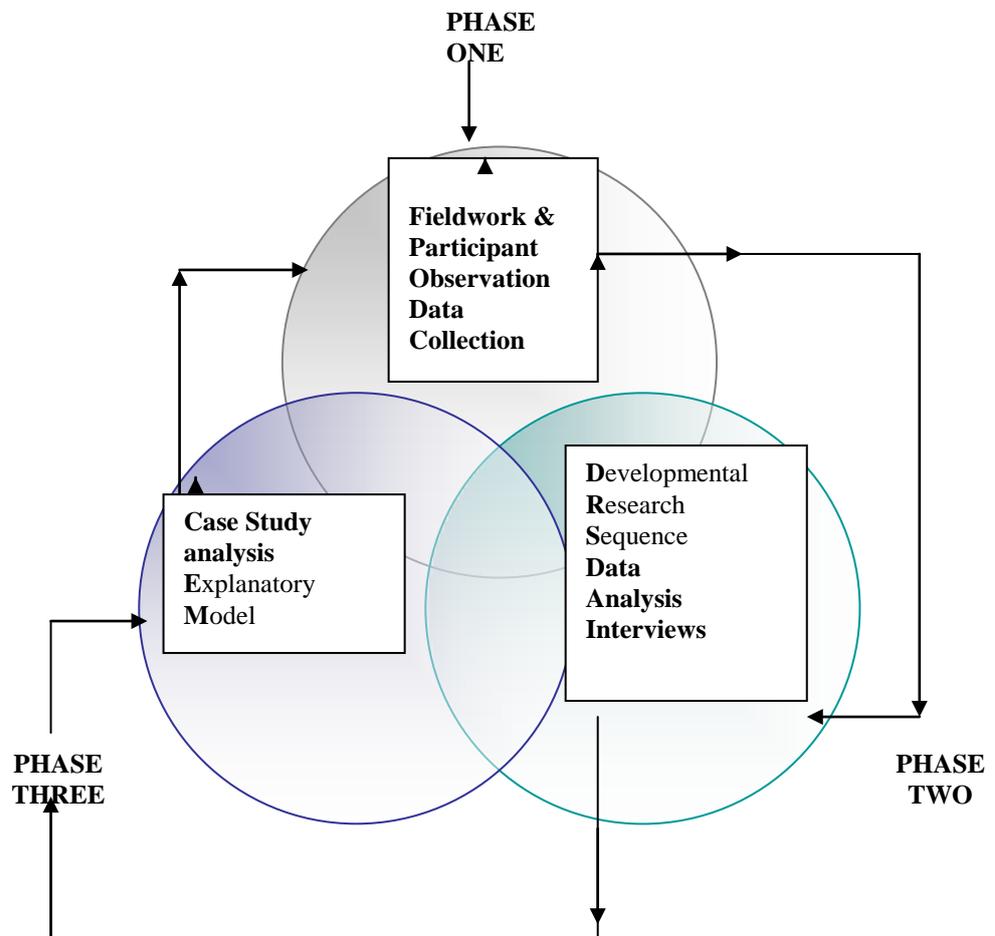


Figure 4. 1 The three phases of the research

In my role as researcher, observations were made on the daily flow of activities in the clinic to construct an image of these interactions in field notes (Spradley, 1980; Hammersley & Atkinson, 1995). Semi-structured interviews were employed on informants [clients of TCM] to reveal the ways in which TCM use was described, negotiated and understood. Attention was paid to differentiate characteristics of the assessment process from which interpretative analysis could be made on the collection of descriptive information describing the clinic in Chapter Five and in Chapter Six on diagnostic techniques. Thick description can be differentiated from thin description in that it gives the context of the act it traces, the intent and meaning behind the act (Shank, 2002). Interpretations that are made on each act of diagnostic assessment and the practitioner's notions of diagnosis are examples of such thick description. This is found in information presented from the textual arrangement, and, the reason behind each detail of the diagnosis, from which my interpretation was drawn (Geertz, 1973). Interpretations were made on the description of practitioners' perspectives of TCM theory and, are found in Chapter Five and Six. The basis underlying these descriptions provided by the informants was to reveal some of "... the culturally embedded norms which guide the actions of individuals in a specific culture" (Field & Morse, 1985, p. 22).

My involvement in the participation of active observation formed the primary data gathering mechanism with the immersion into the culture of traditional Chinese medicine (Hughes, 1992). I remained detached and objective in this role (Shank, 2002) and was cognisant to avoid 'going native' which I had assumed previously in China in my determined effort to fit in to the clinical world (Ellis, 1991). Going native can potentiate personal bias of what is observed. In order to provide a balance between the physical nature of participant observation and the potential of bias that could have an impact on the study, I focused on the strategy of writing field notes to provide material from which I could later draw on and consult with the practitioner about their translation of the activity. This had a stabilising effect of reviewing the information objectively to reduce what is known as the 'emotive function' of the message that can lead to the research being flawed (Ellis, 1991).

Error and bias can occur in any scientific study, the probability of using three strategies; focused interviews, participant observation and case study analysis, would each manage a different dimension of the clinical encounter of Kanbing were

employed to provide transparency (Shank, 2002) and to some extent negate distortion and bias of the data collected. Distortion can occur (Field & Morse, 1985) when the researcher becomes an ally of the informants that can lead to a failure to locate informant's views and ideas within a wider context of differential meanings. Distortion can also be found when the transcripts become the 'object of study' with emphasis placed on the codex. Shank, (2002) suggests that interpretation rigidly applied to each exact word spoken in transcripts can defeat the purpose the interview is intended for.

To ensure a full diversity of viewpoints and understandings were included in the study required me to engage in reflective practice in situ, in reading field notes, and, in reflective discussion with my supervisors. This was very helpful in overcoming an early tendency to be somewhat overly empathetic and sympathetic with Chinese cultural practises. Keeping field records also provided contextual information of the lived reality of the clinic, as Denzin puts it, "I was there, you can be too if you read what I write" (Denzin, 1991, p. 62).

4.3 Ethics Approval

Ethics approval from Curtin University's Human Research Ethics Committee at Curtin University (Appendix 6) was sought and obtained. The proposal was submitted to the practitioners for their agreement and consent to conduct the study, 'Practitioner Rights' (Appendix 7). Each client who contributed to the study was given a consent form that provided them with an explanation of the purpose of the study and an undertaking was given to protect their anonymity, 'Client Rights' (Appendix 8). Information was made available on the nature of the study with advice that withdrawal or retraction of information could be made at any time from the research, without recourse. Protection of identity through the use pseudonyms or code would supplant names so there would not be any identifiable detail of information recorded in the field notes or in the ethnography. Participants were advised the researcher would hold all data collected in a safe place for five years following the completion of the study and this information would remain confidential.

Photographs were taken of various aspects of the clinical practice, which has enriched the observational issues traditionally important for qualitative research

(Shank, 2002). Consent to take and use photographs were sought from clinical practitioners in China and Perth with the understanding that photographs would be used in future research (Field & Morse, 1985). Photographs were used to provide visual detail on the physical organisation of therapeutic practices and other spatially bounded features and activities. No photographs of clients were taken in Perth.

4.4 The research field

In seeking a suitable setting for the fieldwork, I interviewed established TCM practitioners in Perth, who were the gatekeepers who assisted me in gaining access to suitable sites. Selection of these practitioners was made on the basis they had membership with accredited TCM organisations, namely the Australian Traditional Medicine Society (ATMS), Acupuncture Association of Australia (AAA) and the Australian Chinese Medical Association, which govern the safe practice of TCM. There is no overall regulatory agency for TCM in the state of Perth. The three gatekeepers agreed to allow me to use their clinics as research sites. An agreement was negotiated with them following an explanation on the role of the researcher and the process of data collection from fieldwork.

A small 'convenience sample' of six informants (Field & Morse, 1985) were selected for focused interviews. These clients were selected by the TCM practitioner on the understanding that none of these people had used TCM prior to their treatment at the 'Hanyu' clinic. A degree of difficulty was encountered in the recruitment of these informants for interviews after their treatment, family and work pressures may have contributed to this. Clients were approached over several weeks by the practitioner to recruit volunteers and no particular selection pattern was favoured.

It is important to minimise potential bias in client selection in order to ensure a wide range of experiences can be observed (WHO, 2000, p. 13). However, the WHO states, "there are many situations where randomization can be impossible or unethical. The best way to solve this problem is probably by the proper selection of control treatments" (WHO, 2000, p. 14). The following guidelines were used to select the clients who were interested in participating in the study and that clients met the criteria:-

1. They had a minimum of four TCM sessions with an accredited practitioner.
2. They spoke English and were from a non-Asian background.
3. They were over the age of 18 years.
4. They were assured all information from the interviews would remain confidential and their identities protected at all times through the use of coding or pseudonyms.
5. They were given a copy of the client rights and made aware that they could retract any information they had given at any time and could withdraw from the study.

After lengthy consultations with the practitioner six clients agreed to discuss their experience of TCM. I met with each client at the clinic and they were informed of their 'Client Rights' (Eipper, 1996), and that interviews would be conducted at a suitable time for them (4.7). Focused interviews were later conducted with this small sample (Field & Morse, 1985) that provided the study with a source of information from which client perceptions could be examined. Initial verbal consent consisted of explanation of the research project and how they would be involved in providing their perceptions to the researcher through interviews conducted away from the clinic. Informants were given a written consent form and were assured confidentiality would be adhered to. Consent was understood to include the use of a transcript recorder which each informant was aware would be used for the purpose of recording interviews (4.7).

4.5 The first phase ——— **Engaging
in
Fieldwork &
Participant
Observation**

Fieldwork was undertaken from February 2002 to March 2003. Follow up work in the field was conducted at further intervals throughout 2004 and 2006 to gain additional data. The first phase of the research was through participant observation in the clinic. As data collection and analysis occurred simultaneously, the three phases overlapped.

As a form of study, participant observation provided a strategy to identify behaviours specific to the subculture of TCM practice (Marcus, 1986; Hammersley &

Atkinson, 1993). Four types of participant observation are described according to the level of involvement within the research setting (Gold, 1958). My research role involved 'observer as participant with a minimal participation in the work role' (Field & Morse, 1985; Gold, 1958; Shank, 2002). I entered the world of TCM without disclosure of my observational intentions (Gold, 1958). Shank specifies there are different observer types and says no one real person is an example of a "pure" observer category (2002, p. 21).

My research role was established with clients who were made aware of my presence as they entered the clinic. The herbalist Practitioner (2) greeted them and introduced me as a student before they proceeded into the consultation room with Practitioner (1). These gestures by the practitioners helped promote some trust with clients. Gaining entry into the community as a participant observer was contingent on this acceptance by clients and practitioners and on the understanding of the research objectives and concerns over confidentiality (Friedrichs & Ludtke, 1975; Morse & Field, 1985). In my situation I was both an 'outsider' who visited the clinic as a researcher and had 'insider' knowledge acquired from the working process of clinical practice of the TCM clinic in China (Spradley, 1980).

The commencement of data collection began with observations made within the consultation room of the clinic. I did not wish to be intrusive during the consultation so therefore positioned myself to the side of the office doorway and observed the interactions between Practitioner (1) with their clients and the interactions that occurred in the clinic throughout the day. An assessment room was adjacent to the main herbal store room so that entry by visitors to the clinic could also be observed. In the clinic I became familiar with clients and greeted them as they returned each day, others at variable times returning for repeat treatments during the week. This benefited the study as the informal interactions allowed a gradual familiarisation with the clients who were willing to volunteer information on the effects of the therapy they had previously received.

Structured observations formed the initial focus (Johnson, 1990) and first phase of assembling information began by ascertaining the environment and the physical boundaries and roles embedded in the detail of how the clinic functioned. This formed the beginning of analytic research in progress. A richer collection of information of the data gradually emerged providing contextual information from

which analysis could be commenced. The following domains were revealed in the chapter sections: practitioners in the clinic (4.3); people in the clinic (4.4); categories of activities (4.5); assessment (4.6); performing assessment (4.7); and differential diagnosis (4.8) described in Chapter Five that reveal the initial impressions of the practice encountered in the field setting.

The field work through the process of the DRS focused on the clinic operations, the practitioner role in assessment, diagnostic decisions and therapeutic care. At the end of each assessment of a client, I consulted with practitioners which further revealed the mechanics of clinical practice through this consultation (Hammersley & Atkinson, 1995; Marcus, 1986; Pelto & Pelto, 1978; Morse & Field, 1995). These consultations ensured the data collected and the meaning I had attached to these observations, were confirmed by the practitioners. In the consultation room practitioner and client interactions were observed and recorded. Commonalities of language specific to TCM were found to be used by the practitioner as they discussed with the client, the illness experience.

An 'insider' status helped me to understand the questions that were being asked by the practitioner as part of the assessment procedure. Observation made on the interchange between clients and practitioners began to reveal a pattern of therapeutic structure formed through the manner of the assessment process. During the process of assessment and interaction, attention was placed on "... narrative from healers and patients that serves to illuminate aspects of practice and experiences that surround illness but might not otherwise be recognised" (Mattingly & Garro, 2000, P. 5). A narrative is defined by Denzin (1989) as "... a story that tells a sequence of events" (1989, p. 37). The story and sequence of the illness events are significant for the narrator and the audience, and in this case the practitioner interprets the narrative after organising the information of the personal history into a sequence of interpretative stages through the process of Zheng described in Chapter Eight.

Observations made on the assessment procedure were followed up later in consultation with the practitioner who reviewed client records with me so that interpretation could be made from the information I had collected on the procedural interactions within the clinic (Mattingly, 1998). An understanding of the terminology embodied in the practice of TCM was facilitated by the practitioner who provided me with further their interpretations which they attached to the 'illness narrative' of the

clients during the procedure (Kleinman, 1989). The narrative was useful in allowing the tacit knowledge shaped by ‘Ba Gang’ and ‘Sizhen’ and organised into the stages of Zheng to be made explicit. It became clear that ‘tacit’ knowledge of TCM (Spradley, 1980) without a formal structure later revealed a systematic process enabled through the client centred approach that defines Kanbing.

4.5.1 The routine of data collection

The cyclical pattern of the DRS (Spradley, 1980) permitted return to the exploration of the wider context of the practice setting with continuation of fieldwork, conduct further observation, to interview, write, decode, translate and decode and analyse (Fig. 4.2).

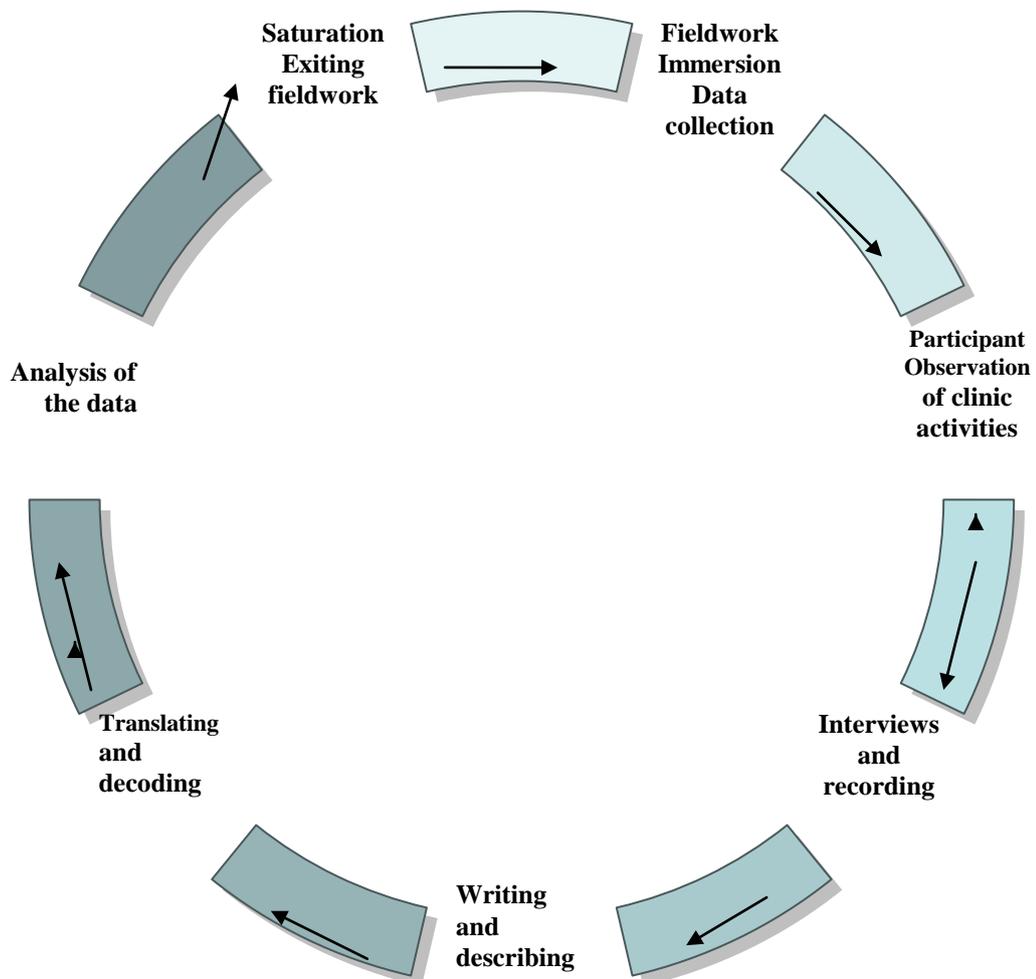


Fig. 4. 2 The cyclical experience of the DRS. (Adapted from Spradley, 1980).

DRS sequencing helped me to systematically explore the cultural perspective in a way that is workable and that allowed me to re-enter a particular aspect of data collection (Spradley, 1980). Analysing data was therefore ongoing and concurrent with data collection whilst in the field setting and involved the search for commonalities in the patterns of clinical activity and exceptions in the relationships of these recurrent activities and interactions between practitioner and clients.

Each entry into the field allowed opportunity for specific questions to be asked and, to make further observations from which the data was compiled then analysed. Working through these stages and from the field notes, assisted to discern and to confirm the patterns that emerged within the setting and the authenticity of the participant observation. The format of documenting field notes followed the principles suggested by Spradley (1980).

Field observations were initially recorded in notepad form and then written more fully as notes and arranged chronologically. Notes were made to capture the lived experience of the clinic, the people and the practitioner (Field & Morse, 1985). Transcribing these notes become imperative to ensure there was consistency in observations by using guidelines according to the convention of the DRS that helped identify patterns of interaction. To identify specific patterns of interaction observed from the clinic setting the notes were numerically coded and identified by date, time of day, chronologically arranged and a review conducted on these at the end of the day.

The clinic was open from 1000 to 1700 hours each day and during this time usually on a Tuesday, Thursday and Saturday I made notes of those interactions observed each day in the clinic. In the clinic under observation, two practitioners were usually present. One practitioner conducted client assessments while the other dispensed herbs. Prior to conducting an assessment the practitioner informed the client that I was there to observe the procedure and the client's consent was obtained. Field notes were then made of activities in the assessment room and in the waiting room. I did not participate in any of the clinics work practices and attempted to remain unobtrusive at all times (Agar, 1986; Hammersley & Atkinson, 1995; Marcus, 1986).

If a client did not wish me to sit in on the assessment I would go to the main herbal room to observe any interactions that took place there. Usually this consisted

of people who came in to purchase herbs over the counter. The herbalist would sell herbs and give informal advice on the various herbs. An example is when a client came in to ask for pain relief. The herbalist would ask ‘what kind of pain?’ or ‘what is your particular problem?’ and ‘why have you come to visit the clinic?’. The practitioner would then provide herbs made in capsule form. Herbs were dispensed after clients had been through the assessment consultation with the practitioner.

When it was not possible to directly observe a clinic interaction, as for example, if a client refused permission, I reviewed the clinical assessments made by the practitioner at the end of consultation. appointment with the client. At least seven to ten clients visited the clinic each day for a consultation. Some were repeat consultations to follow up with their treatments and the number of follow up visits made ranged from four to six over fortnightly or weekly intervals depending on the specific problem.

Following client consultations, I approached the practitioners when time permitted or at the end of the working day clinic to discuss specific features of the assessment technique and selection of treatment. The practitioners referred to the notes they had made, which were written in Mandarin. They would then go through the diagnosis with me and explain how they had made their observations. Physical observation of the client included inspecting the tongue, taking the pulses on both wrists before any notes were made on the client’s general condition. To differentiate between the entries of field notes and to separate direct quotes provided by the practitioner on their observations, commas and brackets were used in the field notes (Kirk & Miller 1986). For example differential diagnosis related to the theory of Yin and Yang was explained by the practitioner as:

- **“Yin and Yang”**,
- [when we study] [the basic] [theory]
- **“The symptoms”** [belong] [are caused] by
- [“hyperactivity”]
- **“Exhibit signs** “When [we find] [the symptoms”]
- **“Yang deficiency”** [deficiency of] [Yang”]
- **“hyperactivity of Yin”**

The process of recording the terms used such as ‘yin and yang’, ‘hyperactivity’, ‘yang deficiency’, ‘hyperactivity of yin’ ‘when we find’ and the meaning attached to these by the practitioner helped to identify the semantic relationships in domains in the diagnostic assessment. This is discussed further in Chapter Six. Memos made during the fieldwork were used to record thoughts and interpretations against the more detailed and explicit field notes. Memo’s also assisted with the follow up discussions with the practitioner for any detail I had not understood about a particular practice or treatment of TCM. An example of the notes I took is given below.

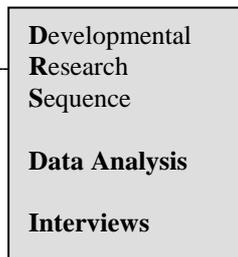
I observed Practitioner (1) commence a first assessment on a client at 11.30am. He took a sheet of paper which he placed in front of him on the desk and proceeded to ask the client questions related to their illness. He asks the client “do you prefer to drink hot or cold fluid”? As he listened to the client he made notes on the paper [the client history sheet that he had placed in front of him]. These notes were written in Mandarin. He then proceeded to make his assessment based on the method of Sizhen (Figure 4.7).

Why does he ask about whether they feel they [prefer to drink hot] or [cold fluid]” Why [does he then ask them] if they have [dizziness] and/or [insomnia]? What connection is he trying to make? What conclusion has he made from this information in his assessment? [Memo from the Hanyu clinic], how has he deduced what the person is suffering from after he has analysed these symptoms related to the condition. I would need to discuss these connections with the practitioner after the consultation ended.

In reference to my memo I verified my understanding of the assessment with the practitioner. For example, the practitioner informed me that if a person is experiencing inner cold they prefer warm fluids to drink. When the person experiences inner heat they prefer cold fluids. This applies to both acute onset illness and ongoing chronic conditions that the client may present with. Another example is when a person says they feel dizzy or suffer insomnia, which may be linked to a heart or liver ailment. Journal notes made of clinic encounters recorded of TCM practice in China helped me to reflect and to re-interpret TCM activities in the practice (Geertz, 1988; Strauss & Corbin, 1998).

Interpretations made from these journal notes and the bracketing assisted in the discovery of patterns that formed a composite picture of the life observed within the clinic (Hammersley & Atkinson, 1995; Spradley, 1980). These patterns provided interpretation from which I was able to “... make sense of the cultural practice that is part of the cultural plot” [of the TCM practice] (Lentricchia, 1990, p. 335). A basic understanding of how TCM was managed gradually emerged from the exposure to the clinical setting.

4.6 The second phase – Data analysis



The second phase consisted of data analysis. According to Evans-Pritchard (1969, p. 123) “... the analysis is made, not as an end – to resolve social life into isolated elements – but as a means – to bring out its essential unity by the subsequent integration of the abstractions reached by analysis... ”. The analysis of the information collected was done by utilising domain analysis, taxonomic analysis and componential analysis and the exploration of cultural themes:

1. Domain Analysis – making a domain analysis is the first type of ethnographic analysis (Spradley, 1980, p. 85). This involved the search for patterns in the practitioner’s conceptual framework and actual assessment practice from which a domain could be created. Recurrent patterns emerged as components of a domain. This helped show how the diagnostic encounter of TCM was shaped and was examined for different semantic relationships. These informed the initial basis of analysis with the object of inquiry being ‘Kanbing’.

2. Taxonomic Analysis showed the relationship among all the included terms in a domain to reveal subsets (assessment process) and the interrelationship to the

whole process (diagnosis). From this I identified distinctions in regard to the practice and organisation of TCM in the cultural context of this clinic.

3. Componential analysis involved a search for attributes that characterised the assessment and diagnostic structure found in traditional Chinese medicine and the meaning attached to these attributes by practitioners of TCM referred to in Chapter Six.

4. Cultural themes were revealed through the recognition of recurrent patterns in the domains and served to identify the subsystems of cultural meaning assigned to TCM in the clinical encounter of Kanbing.

4.6.1 Construction of a domain

The construction of a domain is the first step of the ethnographic analysis with the search for patterns that relate to the cultural behaviour of the clinic and the cultural knowledge embedded within the clinical practice. Domains were found through the DRS method in a search for terminology and patterns of meaning. Each included term was then examined for semantic relationships, similarities and variations to determine the inclusiveness to a domain.

In the construction of domain analysis I have used illustrations that portray specific domains constructed from the different categories of TCM practice observed within the clinic. Shank (2002, p. 142) points out, "... there has been a growing trend in qualitative research to move beyond a strict dependence on the written and spoken word as the primary source of data". A visual portrayal through these figures provides a clear illustration of domains that depict an accurate representation of the structural process of TCM assessment.

Domains related to a specific understanding of how TCM is organised, and explored from the information contained in the field notes of cover terms. This included terms such as, the kind of relationship that was intrinsic to the roles undertaken by the practitioner, the form this took, and examples of the diagnostic roles attributed to the work of the practitioner. This informed the study of the difference between concepts of expectation of the cultural role applied to the clinical practice of TCM and in that found within the interaction that formed the social

exchange (Spradley, 2000, p. 86). Notions of how the practitioner conducted a TCM practice are discussed more fully in Chapter Six and client notions in Chapter Seven.

In this example of a single semantic relationship, the ‘clinic’, was selected to uncover the relationship between the practitioner’s role and clinical practice (Table 4.1).

Table 4.1 The clinic

Relationship	Form	Example
A TCM practitioner	Functional	Practice ability
Is a kind of doctor	Authority on TCM	Clinical expertise
Has clinic people visit	Advice and treatment	Assessment procedures
Clients discuss illness	Assessment on information	Diagnosis made on client
Advises on treatment	Administration	Initiates treatment

Single semantic relationships are described, to identify different functions that the practitioner is involved with (Fig 4.6, 4.7, 4.8). Examples of domains that identify semantic relationships are:

1. Practitioners in the clinic (Fig. 4.3).
2. People in the clinic (Fig. 4.4).
3. Categories of activities in the clinic (Fig. 4.5).
4. Semantic relationships involved in the explanation of differential diagnosis, (Fig. 4.6; Fig. 4.7; Fig. 4.8).

Data was used to describe the patterns of behaviour and the circumstances under which particular interactions between client and practitioners occurred (Aarmond, 1989; Geertz, 1978; Morse & Field, 1995). Following this a preliminary analysis and interpretation of data produced information and led to further observation requiring detailed taxonomies of specific domains of clinic activities (Hammersley & Atkinson, 1995).

Data was used to form taxonomies from domains found in this social setting until data saturation was attained. This helped me to verify the consistency and the authenticity of patterns that emerged from the data and from this the formation of the domains described. Analyses of further domain terms were sorted into taxonomies. The taxonomy showed how the relationship among the included terms in a domain revealed subsets and interrelationships to the whole (Table 4.2). I was able to identify distinctions regarding the practice and organization of TCM in the social and cultural context of the clinical encounter from domains organised into subsets.

Domains were organised systematically for the exploration of semantic relationships between terms used by clients to describe illness and the clinic environment of the practitioner. These terms were then organised into subsets, each subset organised by relationships in description and variables of meaning.

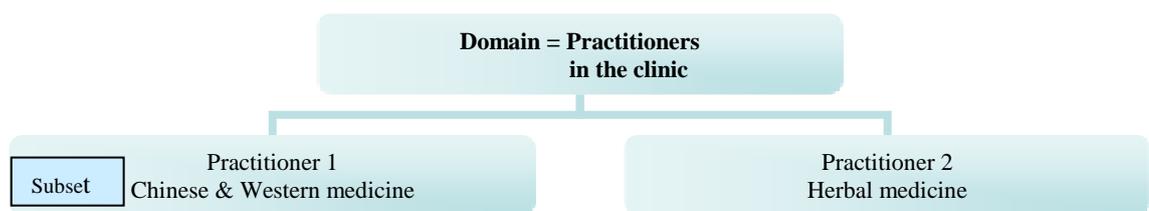


Figure 4.3 Domain – Practitioners in the clinic

An example of a domain identifying the subset of the practitioners provides an illustration of the qualifications of those involved in the practice of TCM at the clinic. Practitioner (1) had highly developed diagnostic skills from his past experience as a western medical heart specialist at Beijing Medical University. The partnership with practitioner (2) was a synergistic one where the skills of one enhanced those of the other (Fig.4.3) For example practitioner (2) was skilled as an herbalist whilst the other was skilled as both a practitioner of Western and Chinese medicine and able to perform complex diagnostic procedures.

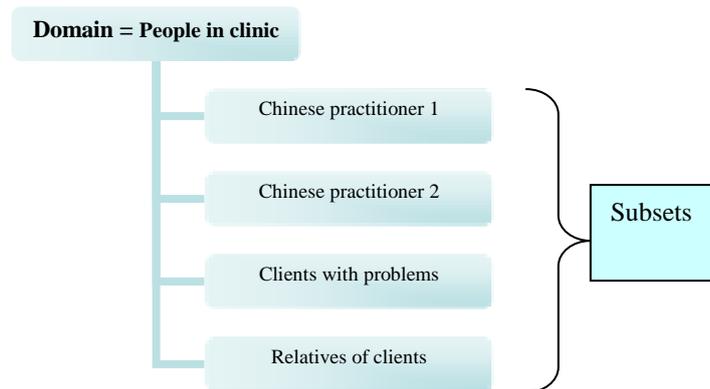


Figure 4.4 Domain – People in the clinic

The Domain ‘People in the Clinic’ (Figure 4.4) identified four subsets of people. A search was made from the recorded data for cultural meaning from which a domain could be created. Each domain was identified by three elements: a cover term, a semantic relationship and included terms that identified the symbology of TCM language. To identify a cover term in the data a single semantic term to pose the question in the interview was used. From observation attended in the clinic, specific recurrent daily activities were identified which formed part of the domain analysis of practitioner activities (Figure 4.5). An analysis of the cultural milieu within the clinic revealed cultural patterns of behaviour and formed the basis on which the categories of TCM practice were revealed.

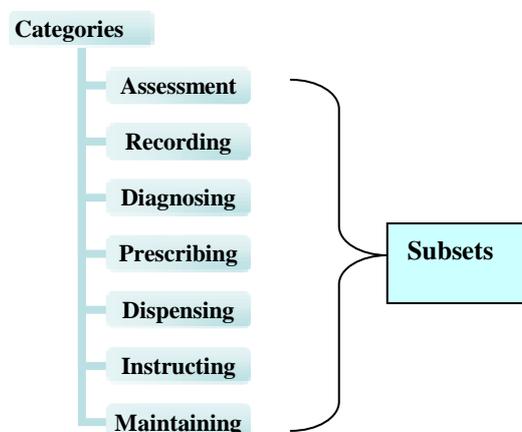


Figure 4.5 Domain – Categories of Activities

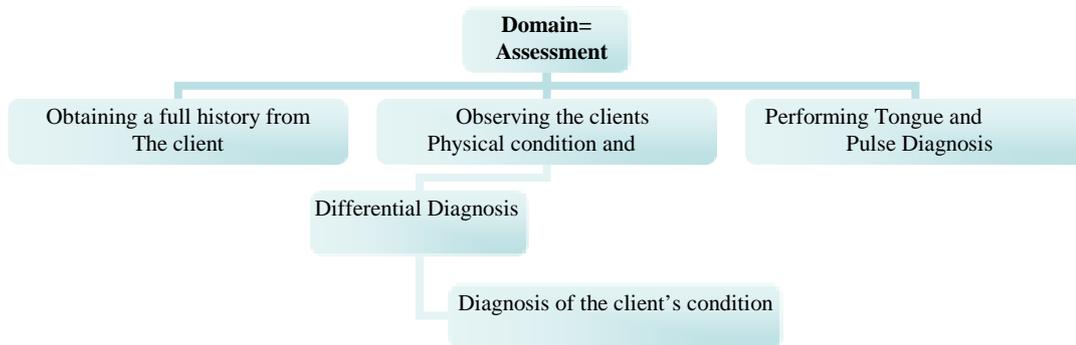


Figure 4.6 Domain – Assessment

Figure 4.6 identifies the domain of performing an assessment (see Chapter Five). Cultural patterns that were found to underlie the activities performed by the practitioners in the clinic formed a domain specific to the assessment of the client. The assessment was based on an analysis of the tongue and pulse diagnosis.

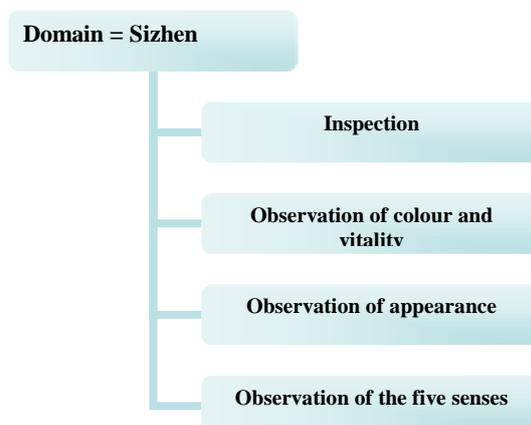


Figure 4.7 Domain – Performing Assessment (Sizhen)

The aspect of assessment known as *Sizhen* involves four methods of examination of the client, inspection, auscultation and olfaction and palpation. *Sizhen* provides the information upon which an analysis of the relevant signs and symptoms is derived. A connection is made between pathogenic factors and the vital energy and is then

summarised into *Zheng* meaning of a certain syndrome (Enquin, 1988b, p. 34). A further differentiation of the syndrome is made through domain *Ba Gang* (Figure 4.8).

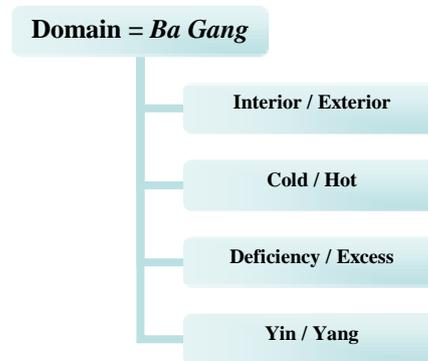


Figure 4.8 ‘Ba Gang’ – Differential diagnosis

‘*Ba Gang*’ enabled sub-systems to be formed: interior/exterior, cold/hot, deficiency/excess, Yin/Yang. These describe how the exploration of a specific syndrome is to be determined by the practitioner. As a system, *Ba Gang* provides a basis for the explanation of how the illness experience is described and formed through the identification of specific sub-systems. Description of differential diagnostic terms assisted the researcher to understand the meaning attached by practitioners to their process of an assessment. From what the informant says, patterns emerge “... that are meaningful to the native speaker” (Black, 1968, p. 432) which require interpretation by the researcher. Patterns are represented through the formation identified as subsets that revealed different themes of the assessment procedure.

4.6.2 Formation of Subsets

Thematic domains revealed the informant’s reality in the context of the social setting of the clinic (Burns, 1997; McKenzie, 1994; Morse, 1995; Pelto & Pelto, 1978). When a cover term was identified it was then determined to belong to one of the following domains; folk, analytic or mixed domains (Spradley, 1980). Thematic domains identified different semantic relationships. Patterns were organised into a

sub-system from which significant cultural language used by the practitioner can be found. Semantic relationships identify the assessment process for differential diagnosis (Black, 1968). A subset identified in Fig. 4.9 ascertains a differential diagnosis comprising of 'yin' and 'yang' energy, 'tongue' analysis and 'pulse' diagnosis.

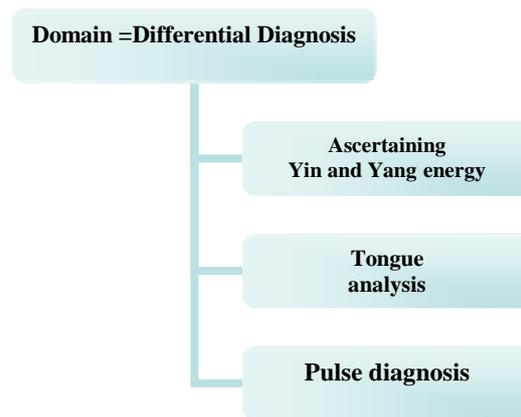


Figure 4.9 Folk Domain - a differential diagnosis

Differences in the folk domain identified concepts of cultural language (Black, 1968) applied to the practice of determining a differential diagnosis. Specific terminology characteristic of the TCM culture was repeatedly used by the practitioner in the formation of a diagnosis. Specific cover terms that formed subsets were then explored for meaning to examine semantic relationships. Criteria that identified specific folk domains were linked to terms such as Yin Yang, tongue analysis and pulse diagnosis, which comprise a differential diagnosis in TCM. Semantic terms are identified in Figure. 4.10.

When a cover term was identified it was determined to belong to one of the following domains: folk, analytic or mixed domains (Spradley, 1980). For example, practitioners drew on the Five Element theory, the Mother and Son relationships, and the Zang Fu organ tradition within TCM to form a differential diagnosis to explain an illness. The “real world of the clinical practice is to a large extent built up on the language habits of the group” [found in the clinical practice] Black, 1968, p. 42).

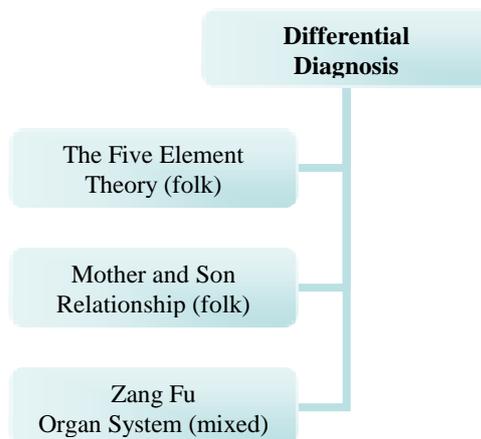


Figure 4.10 Domain – Elements of semantic relationships
 (To explain a Differential Diagnosis)

Another example of the semantic relationships used to explain differential diagnosis, are given (Fig. 4.11) and elaborated upon in Chapter Six.

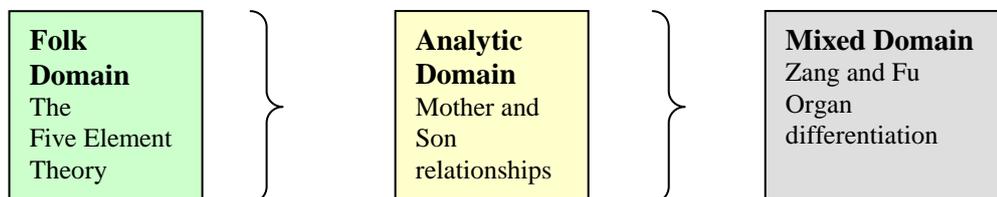


Figure 4.11 Domain – Semantic relationships (Spradley, 1980)

The theory of the Five Elements (**folk domain**) is linked to an inclusive symbolic understanding of Mother and Son relationships (**analytic domain**) within the Zang and Fu organ system of the body (**mixed domain**). To explain how a differentiation of a syndrome is formed see Chapter Eight. The detection of difference in explaining semantic relationships that form these folk, mixed and analytical domains was important to discover factors that might explain patterns governing how illness is explained through TCM by the practitioner and to clarify meaning and the value ascribed by TCM clients (Fetterman, 1989; Strauss & Corbin, 1998).

The data analysis revealed how meaning was assigned to TCM use by the practitioners and informants and is the subject of Chapters Five and Six. The DRS method provided the ethnographer with the opportunity to explore in depth aspects of TCM from the fieldwork observation. From observations of interactions in the clinic, meaning was found attached to the culturally constructed conventions of the clinical practice (Speziale & Carpenter, 2003). Uncovering conventions found within the practice procedures of TCM provides explanation of the significance of how culture and social processes shape the practice (Hammersley & Atkinson 1995). Thematic domains provided explanation from semantic relationships that determined the assessment, differential diagnosis and treatment offered in the clinic.

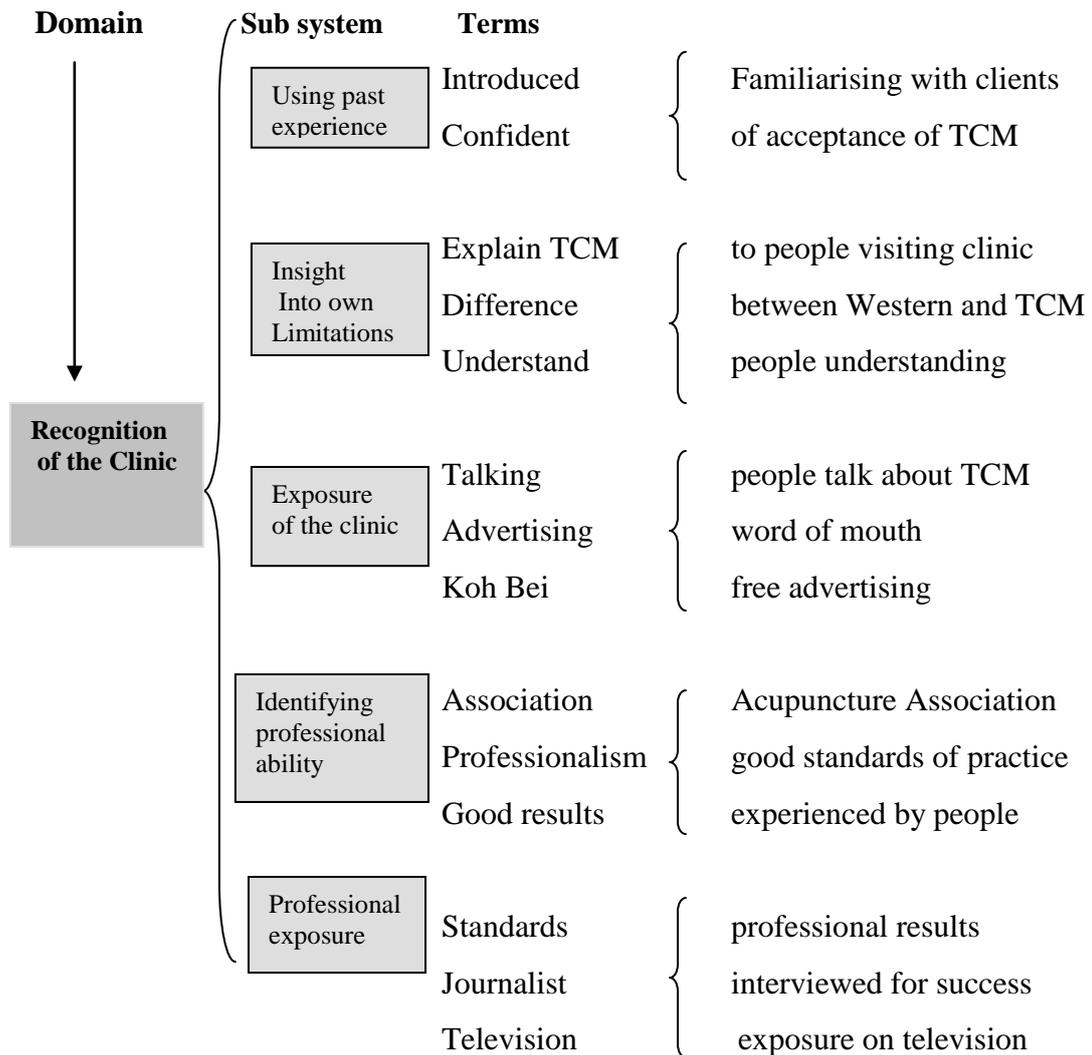
4.6.3 Taxonomic Analysis

From the construction of taxonomy, themes and sub-themes found in the data were revealed. Themes explained the diagnostic tradition, and the procedure of the assessment found in the clinical encounter. From these themes, the ethnographer was able to make distinctions regarding the organizational context of TCM of the clinical encounter explained in Chapter Five. The advantage of the use of taxonomy is that it approximates the cultural patterns observed. Spradley (1980) suggests that this is a way in which cultural patterns are revealed.

These patterns enable us to make sense of the world of TCM from which the observations of the clinic have been made. Analysis of these themes is generated from the interpretation of the general patterns found in the clinic. This is an 'inductive' construction in that it moves from a specific to a general understanding of the different subsystems.

Taxonomy are organised on the basis of a single semantic relationship (Spradley, 1980, p. 112) and may also be formed that relate to events rather than people (Shank, 2002) as illustrated in Table 4.1 which shows the relationships among all the included terms in a domain revealing subsets and interrelationships.

Table 4.1 Structure of Taxonomy – Domain: Recognition of TCM Clinic



Terms are used to assist identify the manner of the recognition of the clinic in Table 4.1. Taxonomy provides a framework to tease out and identify the use of sub-systems from terms, from which specific domains are revealed and propositions or induction can be made of the relationships (Strauss & Corbin, 1998, p.136). For example, the following illustration, ‘Recognition of the Clinic’, illustrates the relationship amongst all the included terms in a domain.

As the collection of data progressed it was important to integrate the symbolic links described in the rich text of TCM philosophy with the themes identified by the DRS. Chapter Eight examines how the data was used to identify specific elements

described through the diagnostic language of TCM. This second stage of the research also included the focused interviews with clients to elicit further data on their perspectives and reflections on the experience of TCM.

4.7 Client interviews

Focused interviews were conducted with six English-speaking clients from the ‘Hanyu’ clinic. Three were men and three women, whose ages ranged from 25 to 65. Although this was a small sample it provided information for the research to identify some key characteristics of TCM consumer use. These clients were approached after the initial consultation through the practitioner and a written consent was provided that detailed the conditions for the client involvement. Arrangements for follow up interviews were made whilst they were at the clinic with a preliminary discussion with each to establish a suitable venue where interviews could be conducted. Focus interviews were conducted away from the clinic where the clients felt more comfortable, usually in their own home. There was a minimum of six sessions and each session was taped and lasted between 45 to 60 minutes. Table 4.2 depicts the informant client profile.

Table 4.2 Client participant profile –

Client age	Male	Female
25 – 35	A1	
35 – 45	A3	B2
45 – 55	A5	B4
55 – 65		B6

Interviews were semi-structured with exploratory questions, which allowed respondents to speak freely about what mattered to them to them and their experiences with TCM (Spradley, 1980). The interviews consisted of a short list of questions with a specific focus. An attempt was made to ask “descriptive questions, structural questions and contrast questions” (Spradley, 1980, p. 123). It has been

argued that if questions are too short interviewees may sense an urgency to get through a list of questions and lose spontaneity in their responsiveness (Shank, 2002). Conversely, too few questions may let the interviewee take control and lead the process of the interview.

Spradley (1980) suggests that one way to proceed is to begin with a ‘grand tour’ question, which allows the interviewee to respond in an expansive and not too focused a manner. In this way the bias associated with a social acceptance response is minimalised. I followed this approach, beginning with a broad question on why clients were attracted to complementary health practice. For example one question was: “Why have you attended a complementary health practice?”

A contrast question and a descriptive question were used to elicit information about why clients used TCM as part of their health practice:

“In what way does the care differ to that of western medical practice?”
“What benefit (if any) do you feel you have derived from the therapy?”

The second and subsequent interviews then moved into a more specific focused on the benefits (if any) they felt they got from using TCM compared with their conventional medicine. These questions allowed opportunity for the interviewee to be reflective of their current practice as well as any other form of health care they had used.

“Is there any dimension of health care that you find satisfying?”
“Can you describe how?”

These questions sought to elicit specific information from the interviewee on areas of self responsibility in health care, communication of their health decisions to their GP, and how they were referred to the TCM clinic:

“How do you take responsibility to maintain your health?”
“Are you currently receiving any western medical care?”
“Have you discussed with your doctor that you are receiving TCM?”
“Tell me how you found or were referred to this clinic
“How have you found the treatment of this practitioner?”

Clients were given the opportunity to clarify any perceived misunderstanding, by recasting the question. Practitioners were interviewed in the clinic and were asked

about their notions of diagnosis and the philosophical basis that underlay TCM treatment. Exploration of meaning from the informants interviews on their perspective complemented the observations that I had made in the setting. Typed transcripts were made from each interview, analysed as described for domain formation (4.6.1) to reveal the meaning and importance that clients attached to the experience of TCM. Client perceptions of the clinical encounter and the interactions with the TCM practitioner are examined in Chapter Seven.

4.8 The Third Phase – Case studies

**Case Study
Analysis using
the Explanatory
Model**

The third phase involved the analysis of data from case studies described in Chapter Six and Eight. The case study involves a participatory relationship between the researcher and the informant (Shank, 2002). The rationale for the use of case study was to provide a broader analysis of the interaction between the practitioner and client to explain the detailed complexities of the process (Field & Morse, 1985). It allows for in depth exploration to be made, hence case studies were used as “... they are epistemologically in harmony with the readers experience and a natural basis for generalization” (Stake, 1978, p. 5).

To avoid over or unwarranted generalization, the research made examination of these case studies facilitated by the Explanatory Model (EM) and The Hierarchy of Living Systems (Dow, 1986) to explain in-depth, culture bound syndromes (Kleinman, 1988). This model provided a framework for analyses “... central to our appreciation of how illness is culturally constituted... the transactions present the cognitive basis of the illness experience’ (Kleinman, 1981, p. 120). In the case study analysis approach the task of explanation from moving from a cultural specific approach to one that is interpreted from a Western appreciation of the subject and found it necessary to control generalisations made on my interpretation. Shank suggests, “generalizability is often associated with a push to more breadth, as qualitative research is more concerned with depth” (2002, p. 94), hence it was

necessary to provide a mechanism that would facilitate for a structured analysis to be made.

Therefore an advantage of employing the Explanatory Model was it allowed a sort of mini-ethnography to be done as the model is characterized by a series of steps (Kleinman & Benson, 2006) that inform the cultural formulation of the illness. These steps are: 1) the social construct – the identity of the illness experience, 2) eliciting information by gathering relevant case data from the analysis, 3) evaluating the clients explanation of the illness narrative, 4) understanding the illness episode through psychosocial stress factors, 5) exploring the links between the symptoms and the culture of TCM, 6) treating the illness after identifying the pattern of disease. Thus from the in depth exploration, the case study was used to look at complex detail (Stake, 1995) of the interaction within the content of assessment and diagnosis of TCM.

4.8.1 Analysis of case studies

At the metropolitan ‘Yin Min’ clinic a review was made of twelve case studies of other clients was done with Practitioner Wong, who drew upon his medical records each time I visited the clinic. The review provided data for an evaluation of diagnostic foundations of TCM. This was guided by the Explanatory Model to provide analysis and interpretation of a differential diagnostic assessment. The interpretation from which the exploration is facilitated is through a ‘deconstruction’ of the diagnostic process information (Denzin, 1989). The features characterise deconstruction:

- 1) It lays bare prior conceptions of the phenomenon that has been observed defined or analysed; 2) a critical interpretation is made of data and analysis then offered; 3) the underlying theoretical model of action implied and used in prior study is critically examined; 4) preconceptions and biases that surround existing understanding are then presented (Denzin, 1989, p. 51)

Chapter Eight provides analysis of how a differential diagnostic was derived from the interpretation of somatic symptoms in the formation of a syndrome and examines the structure of the diagnostic technique in TCM from case study analysis (Stake,

1995). Information is used to examine concepts in the TCM diagnostic tradition and explain the nuances of cultural understanding of a specific illness.

The case study analysis provides a rich source of information from which the complexity of circumstances can be revealed from a single study (Stake, 1995). Shank makes the point that, “the case analysis by its nature turns us away from the typical to the unique” (2002, p. 53). How the illness of the person is described, involves the complex interpretation of behaviour, activities, and events that characterise the illness. Interpretative elements of TCM form a comprehensive pattern of assessment with idioms of language to express an illness episode and examination is made for what lies behind the complexity TCM, therefore to reveal in this research “... the attributes that are definitive” (Evans-Pritchard, 1969, p. 123)

4.9 Exiting fieldwork

The field was exited when no new material was forthcoming from the collection of data. Analysis continued using the transcripts and the material was continually reviewed. When themes from the data analysis made from observation and from interview transcripts revealed that the same patterns were revealed, the data collection phase of the study was drawn to closure (Shank, 2002).

4.10 Summary

This chapter has described the way in which the study was conducted and an ethnographic approach taken provided the method to make observation and engage in the clinic. The epistemology of TCM has many paradigms that interlink. Hence a number of different phases and approaches were taken in the ethnography: - Phase one (4.5) consisted of engagement in the field through participant observation described through the DRS (Spradley, 1980). Phase Two (4.6) data analysis and client interviews and domain construction were also described. Phase Three (4.8) explained the use of case studies and their analysis. It was shown that observational studies collected findings on the therapeutic or prophylactic treatments under routine conditions (WHO, 2000, p. 13) and on the nature of how the clinical aspect of TCM practice was managed.

As Spadley (1980) put it, ‘the world as it appears to us’ is never fully known, even when there is immersion into a particular culture to experience first hand the clinical

reality. However, close observations of the everyday workings of the practice and the on going interviews and conversations with clients and practitioners allowed for a deepening understanding of the varying ways in which client and practitioners viewed, understood and participated in the TCM experience. It allows the ethnographer to observe how human action is shaped and structured (Geertz, 1973) and to “unravel the ideological meanings that are coded into the taken-for granted meanings that circulate in every day life” (Denzin, 1991, p. 59). In the case of TCM these meanings are found embedded in the tacit forms of the TCM clinical practice that inform the interaction known as Kanbing supported by the processes of ‘Ba Gang’ and ‘Sizhen’.

CHAPTER FIVE

Description of the field setting

When a traditional Chinese doctor prescribes a specific herb, he's not attempting to correct a chemical abnormality, he's trying to restore the harmonious flow of Qi. (Eisenberg in Moyers, 1993 p. 260)

5.0 Introduction

This chapter examines the physical setting of the Hanyu clinic, the place of TCM in the local community, the people in the clinic and the daily management of the clinic activities. The Hanyu clinic was selected for the study as it has an established history of twenty years service provision of TCM, consumers in Perth. Access to the Hanyu herbal clinic enabled me to observe, gather data and provide further analysis of how the practice of TCM was conducted. I discussed with practitioners, the ways in which their assessment procedures were informed by the philosophy of TCM and how this was related to the information given by their clients. In this way I was able to examine how the assessment process is inextricably linked to the narrative of the client's condition and also to the practitioners understanding of the philosophy that underpins the process of TCM. Activities that form the procedural elements of the assessment of the practitioner's examination of the client are described and the formation of information from observations made by the practitioner.

5.1 Network of social access

The 'Hanyu' clinic located in the CBD of Perth forms the hub for many Asians and Europeans of diverse ethnic origins interested in using TCM and offers a unique facility for a range of local Chinese clients, clients from mixed Asian populations in Perth and for non-Asian clients mainly from Perth's suburbs. There is ease of access for cars and the terminus of the Perth Railway Station and Perth Busport are close by. The 'Hanyu' clinic provided a public service based on herbal therapies, acupuncture, Chinese massage and dietary supplements. In this setting I observed a range of clients, who came from all areas of Perth and even some from rural areas for consultations and, to purchase herbal products.

The 'Hanyu' clinic has an entry overlooking a main laneway which provides access to the area known as 'China Town' in Perth. Two large monumental lion heads guard the entrance to the laneway. Along this laneway were, garbage bins sometimes overflowing with refuse, a gaming house, a few small Asian restaurants and a large food hall. The herbal clinic shop is secured by a deadbolt and an alarm system as it is easily accessible located to the rear of the laneway. A side street off the laneway gives direct access to a main street, a very busy area during the day and Perth's main inner city night entertainment area. In the laneway outside the clinic, a placard announced the clinic open for business consultation time availability. A sign attached to the clinic wall advertises treatments for a diversity of conditions such as migraine, pain relief, hay fever, insomnia, menopause, bronchitis, skin problems, chronic fatigue, glandular fever, digestive problems, urinary tract infections, stress, sinus, depression, infertility, hypertension, impotence, weight loss, asthma, and period pain. Depicted in Figure 5.1 is the network of social accesses' to the clinic.

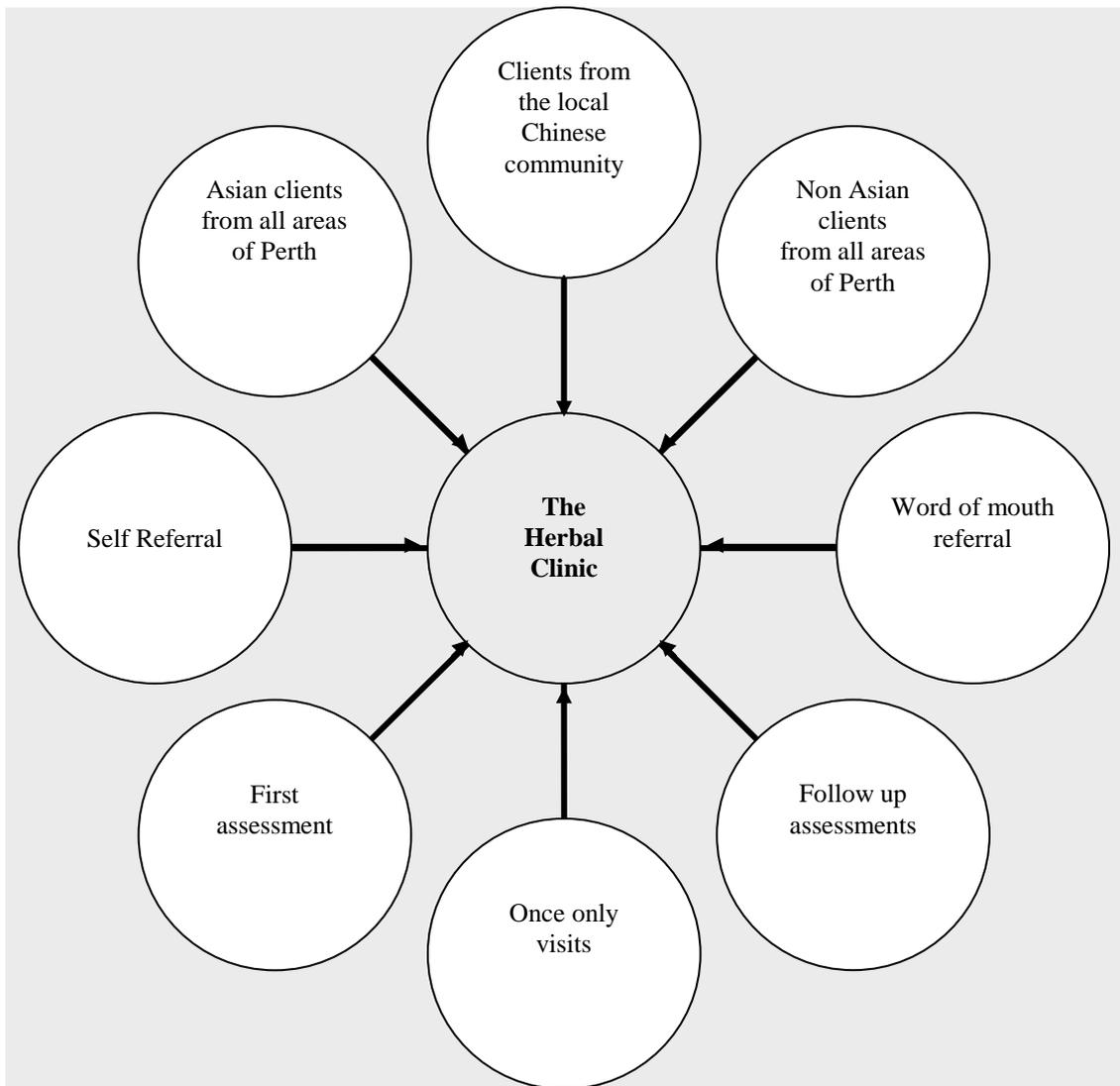


Figure 5.1 Network of social access to the clinic

5.2 Practitioners in the clinic - [Described as Domain (4.3)]

Structured observations were initially made on the clinic and the nature of what constituted the clinical practice each day. In the clinic there are two practitioners who operate this clinic, the main practitioner [referred to as Zeng], is a Chinese doctor qualified in Western medicine in China (as a cardiologist) and in traditional Chinese Medicine from the Beijing Medical University. With his partner [referred to as 'Rosli'], a Chinese herbalist from Beijing Chinese Traditional Medicine College, Zeng opened the clinic in Perth in 1985 after Zeng and Rosli migrated from Beijing. Zeng was the President of the Australian Traditional Chinese Medicine and

Acupuncture Association in 2005 - 2006. Both practitioners speak English and communicated well with their non-Asian clients. To find out more of how TCM has been accepted by the public of Perth, I began my field work by discussing with Zeng his understanding of the acceptance of TCM in Australia and in Perth.

5.3 Acceptance of TCM into the community of Perth –

[Described Taxonomy - Recognition of the TCM table 4.2]

Prior to the 1980's, TCM and other non-conventional medicine practices were regarded with suspicion by the medical profession and the public at large. For example, the 1974 Webb Report, initiated, by the Commonwealth Government to investigate the spread of alternate forms of medicine, claimed that naturopathy was a 'minor cult system, its practices of dubious value' (p. 234). However, the report did not condemn all alternative practices and considered that acupuncture had medical value and that practitioner's should be registered. Since that time there has been growing acceptance of TCM and from 2000 registration of TCM practitioners has been mandatory in Victoria. Zeng said that he had seen an increased growing acceptance of TCM:

Some Western people, there're interested in the Chinese medicine philosophy even though more and more people interested in Chinese culture. Some patients don't know. Explain to them they can understand. More and more people understand Chinese medicine etc. like the Chinese herbal shop 20 years ago just one in Perth, probably there are fifty [shops] now.

Zeng began his practice in Perth when there was limited awareness and knowledge of TCM and when few doctors with Western medical training provided support. Faced with this lack of awareness, support and in some instances opposition, Zeng's decision to pioneer TCM was a major task in a political social context where greater value and status was ascribed to Western medicine. Zeng said:

It's not difficult because I got confidence because TCM has been used for thousands of years in China. A few Western people now know the Chinese philosophy already - they talk about yin yang and the five elements.

Zeng was aware that the orthodox system of health care was vested in powerful professional bodies which set the professional standards governing medical practice and that there was considerable suspicion of TCM.

Commenting on the ways in which other health systems were viewed thirty years ago, Rosli the herbalist stated:

When we first came [to Australia] in 1983, they [the Western doctors] wouldn't even listen to anything about acupuncture, the doctor would just not listen that acupuncture was good for different things. And now of course acupuncture is widely used isn't it, even by the doctors, which is very interesting.

Zeng described how the Hanyu clinic gained acknowledgement in the local community with many clients coming as came as self referrals by word of mouth, and as referrals from Western medical practitioners. A major proportion of referrals were made by word of mouth as the practitioners had established reputations for their expertise in TCM throughout the local Chinese community. The clinic advertised through the Chinese business newspaper and in the Yellow Pages directory under the sections of herbalists and natural therapists. An example of such an increased acceptance of TCM is the establishment of registration in Victoria. However, while TCM's acceptance in Victoria was publicly recognised, in Perth there is no mandatory regulation. I asked Zeng if he felt the new registration in Victoria might be beneficial for TCM practice in Perth:

I don't know, but anyway in Western Australia, a few Chinese medical associations set up, for registration from government, they are starting to work already.

Zeng made this point to illustrate how he saw the public had become increasingly interested in TCM. He referred to how students from several primary and senior high schools visited the clinic regularly something unheard of twenty years ago. Students visited the Hanyu Herbal Clinic and also the adjoining Chinese Cultural Centre in the lane as part of their cultural awareness studies. Surrounded by boxes of herbs this group of over thirty students crouched on the floor listening attentively to the herbalist as she described the herbs, comparing herbs to parts of the human body by describing some as looking like arteries, veins and human lungs. The selection of

herbs was also identified by the herbalist to have characteristics based on parallel features of the human body, thus like treated like.



Plate 17. Students visiting clinic

Today in the clinic there was a group of 32 students from a College, in Perth. Their teachers have brought them to the Hanyu Herbal Clinic which was organised through the *Chuang Wah* Association of Perth. They are there to gain an appreciation of Chinese medicine and a different group of students will visit each week as part of their Integrated Cultural Studies for Year 8. During the visit the students asked many questions, the main focus related to the cost of herbs, their efficacy, methods of preparation and the most commonly used. [Field notes]

Rosli the Chinese herbalist explained concepts on TCM to the students, identifying that acupuncture and herbs treated common conditions differently. The students were inquisitive and questions such as the following:

- How much do the herbs cost?
- How long does it take the herbs to work?
- What are the most expensive herbs?
- How do you take them?
- Does it take long to cook them?
- Can you have the herbs delivered?
- What are the most common herbs used? (Field notes)

On other occasion I observed school students from a private Grammar school visiting the clinic and they continued to come each week for another month. These visits were a small part of the everyday activities of the clinic. A description of the clients and the clinic setting in China Town now follows.

5.4 People in the clinic - [Described as Domain (4.4)]

A population of about three thousand clients visit the clinic each year, and many return for follow up visits for ongoing treatment. People came for other conditions than those advertised such as for relief of symptoms of cancer, muscular problems, backache and sprains, chronic pain and relief from acute infection from influenza. Generally the people who come to see the practitioners are prescribed herbs that are customised to the needs of the clients. Over several months the average number of people who came was approximately ten to twelve a day both to be seen by Zeng for consultation and to purchase herbs over the counter. The ethnic mix of clients varied each day. In addition to the every day casual interactions I observed activities that governed the core practice of TCM in the management of client care. The physical dimensions of the clinic are now described.

5.5 The physical environment of the clinic

On entering the clinic from the laneway, the visitor enters the main waiting room, of approximately twenty square meters and is greeted by the herbalist in a white clinical coat. A phone rings intermittently with inquiries made by people wanting to make appointments to see either the herbalist or the practitioner. Clients are screened first by Rosli who asks why they have come to the clinic and then she ushers them into the clinical room if they are seeking a consultation. To purchase over-the-counter herbs, clients sit in the waiting room where the herbs are stored in large red drawers. In the clinic there are several large glass walls with a northerly aspect, which attracts the sun into the room. Directly to the right inside the entrance sits a large ceramic and rotund Buddha which the practitioner informed me was a 'medicine' Buddha. Incense sticks are lit early each morning as a prayer offering and the pungent odor of the sandalwood incense clings to the air. By the side of the Buddha there was a large

lucky plant which I was informed was positioned there to invite prosperity into the room.

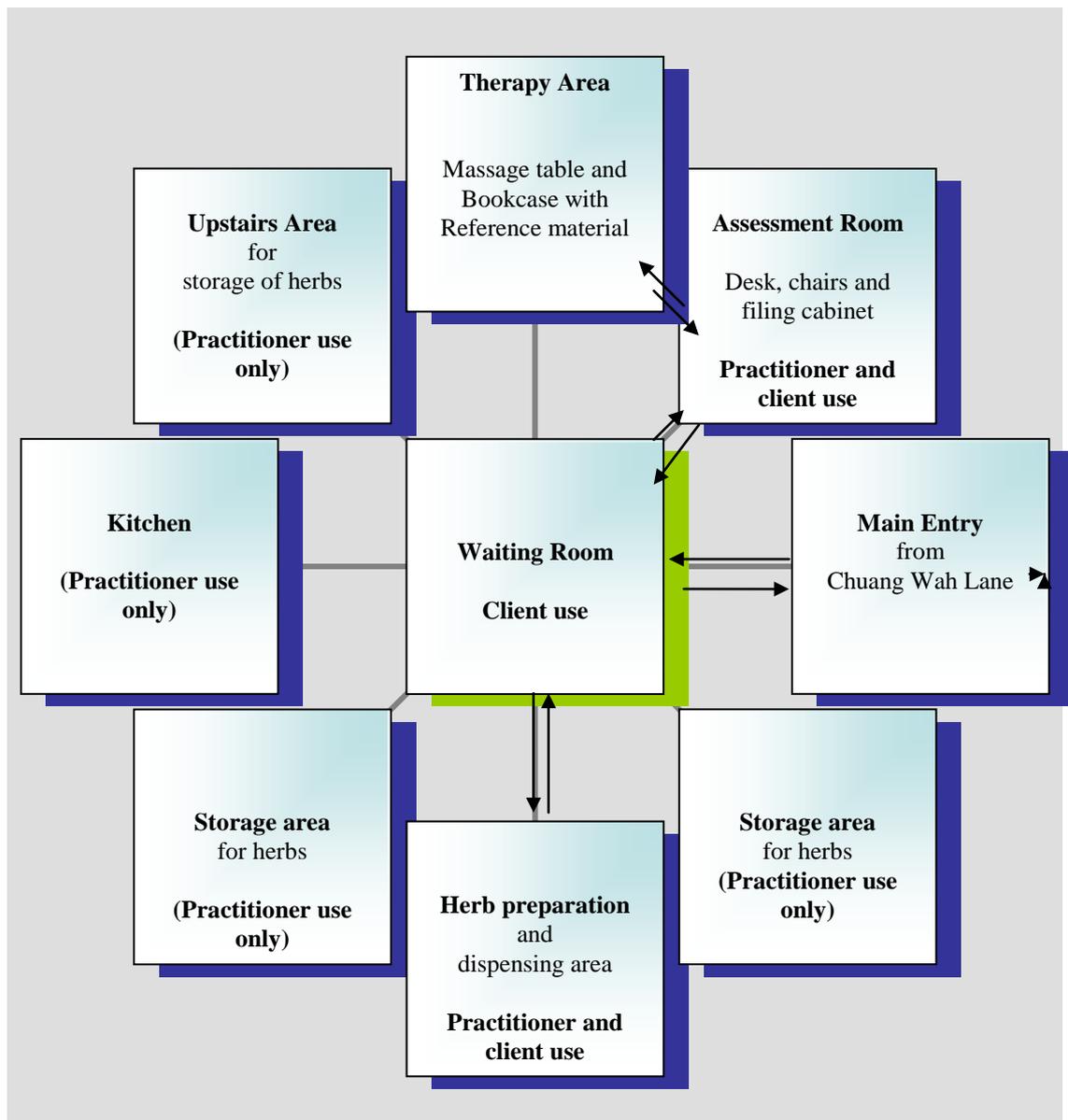


Figure 5.2 The 'Hanyu' Clinic (plan not to scale - Arrows depict flow of client traffic).

The clinic is divided into four large rooms. Three rooms are downstairs and divided into areas that provide for combined therapy and assessment, herbal storage, dispensing of herbs and a kitchen. The first room that leads from the entry into a waiting room is also part of the main clinic area where herbs are dispensed. There are four divisions in this large room, the waiting area, two herb storage areas and the

dispensing area. There is a kitchen at the rear of the waiting room and also a room which provides some storage for boxes of herbs for the use of the practitioner only.

5.5.1 Waiting room of the clinic

In the main waiting room there are two brown vinyl couches for clients to rest on as people wait for their appointments in an unhurried atmosphere. There is a noticeable but not unpleasant odor emitted from the many assortments of herbs. Nearby, on a bench lay a scattered assortment of older magazines and overhead fluorescent lighting provides good light. In the assessment room the lighting is more subdued and curtains pulled to provide privacy. The waiting room also houses the herbs in storage jars and on display under a glass counter pane. An assortment of jars, tin boxes and small cardboard containers of herbs for over the counter purchase are labeled in Chinese script.

5.5.2 Herb storage and dispensing

In an upstairs room there are dozens of cardboard containers of herbs stored to avoid lengthy delays as herbs are rail freighted to Perth from China via Sydney. Storing the herbs in a dry environment is required to avoid humidity which can cause mould. Downstairs, there are the large storage cupboards for the herbs which stretch from the floor to ceiling. An imposing steel chopper is fixed to the bench to cut up larger herbs when being dispensed with a bronze mortar and pestle nearby for herbs to be chopped into smaller portions or ground into powder form (Plate 20). Herbs are selected on the basis of the treatment of the different forms of syndrome and according to the four different properties of the herbs; these are cold, warm, hot and cool. These are denoted the different properties according to the effects of herbs observed by ancient Chinese botanists and herbalists.



Plate 18. Herb storage, mortar and pestle

The dispensation of the herbs are classified according to the eight methods of treatment: 1) inducing perspiration; 2) the method of clearing heat; 3) the method of inducing bowel movements; 4) the method of striking a balance and harmonizing; 5) the method of warming up coldness; 6) the method of tonification; 7) the method of eliminating; 8) The method of inducing vomiting (Lu, 1994). Herbs are weighed on a scale (Plate 22) and larger quantities of herbs are chopped into smaller portions (Plate 23), weighed, then placed on plain white paper (Plate 24) and secured with cello tape. Following the dispensing of these herbs they are bundled into a plastic bag and the herbalist describes how to prepare the herbs for consumption. A type written form in English describes the preparation of the herbs. Clients are also informed that if they had any worries they could ring and speak to the herbalist. An after hour's mobile phone number is provided on the clinic's business card.

Plate 19. Storage of herbs



Plate 20. Weighing of herbs



Plate 21. Chopping the herbs

Plate 22. Dispensing the herbs

5.5.3 The assessment room

The assessment room off the waiting area is four meters long by approximately three meters wide. Several charts written in Chinese calligraphy hang on the wall above the examination desk. Equipment in this room is sparse consisting of blood pressure gauge, acupuncture needles and glass containers for cupping. There is an examination table used for treating clients who come for acupuncture or Chinese massage. The assessment room also contains a desk with chairs on either side some note taking paper and a tiny pillow in the middle of the table used for taking the pulse.

Other furniture includes a bookcase with Chinese acupuncture journals and other books on herbs and acupuncture. To the left of the practitioner's desk is a filing cabinet for client records. A Therapeutic Goods and Services Certificate is displayed on the wall behind the desk and there is a Certificate of the Business Name, legally required to be displayed. Adjacent to this area a separate section is partitioned off by a wall divider to provide privacy for people having treatment.

A cupboard is used for the storage of acupuncture needles and glass cups used for cupping and a massage table covered by a white sheet fills the remainder of floor space. Between the space of the consultation room and the partitioned area there is a flip chart for informal teaching sessions for those interested to learn more about Chinese medicine. Zeng organizes sessions through a local natural therapy academy for interested students to visit. Several acupuncture anatomical charts on the wall depict acupoint locations on the surface of the human body.

5.6 Categories of activities – [described under Domain (4.5)]

Clients visiting the clinic for the first time are given a full assessment. Follow up visits consist of the practitioner reviewing their therapy for effectiveness. More generally the interchange within the clinic consists of clients visiting either for a primary assessment, which includes the client's history with a follow up needs assessment of an evaluation of treatment, and/or an over-the-counter purchase of herbal products. The herbalist instructed clients who visited the clinic with their purchase of over the counter herbal preparations and provided information to the many people who telephoned the practice to inquire about the herbs. More generally, the clinic activities related to the management of the client were as follows:

- 1). Recording - A history of the client's condition, a physical inspection of the client, of observations made of the client's health appearance and pulse taking, – palpation and tongue inspection.

- 2). Managing the therapeutic management selected for the client care and prescribed for one of the selected therapies. These included physical therapies, Chinese massage, moxibustion, acupuncture, herbal therapies

and a combination of both forms of therapy, with instructions on how to prepare the herbal tea.

3). Liaison with other health care professionals such as general practitioners of Western medicine, usually by letter of referral from several doctors who were treating their patients for symptoms of cancer. Follow up confirmation of the patient's progress was attended by Zeng by phone.

4). Maintaining records of visits and the treatments each time the client visits the clinic.

5). Initiating therapies that are written in Mandarin for specific forms of therapy for the practitioner's record.

6). Provision of a certificate for the client to claim on their private health insurance.

7). Stock taking of herbs in storage is attended to on a regular basis to ensure stock is reordered and adequate stocks maintained.

It was observed that these routine procedures are similar in character to what might be found in any Western medicine surgery. However, one of main activities of the interactions [*Kanbing*] observed in the clinic, the initial assessment process of the client has features specific to TCM and is described in detail in the next section and is expanded upon in Chapters Six and Eight.

5.7 Performing an assessment – [described under Domain (4.6) & (4.7)]

These initial observations made on the practitioner-client interactions formed an important component of the assessment process, I observed many such interactions and provide here a general description of the primary assessment. To understand the diagnostic process I asked the practitioner the basis upon which the assessment was made. He said they used the philosophy of the Five Element tradition and the Yin/Yang imbalance of the respective body organs as a framework for the assessment.

1) This is how the assessment procedure was shaped.

The primary assessment consists of an initial appointment, which is usually for thirty when the practitioner explores the client's history and conducts the assessment. History taking is based on interviewing the client and asking him/her to describe their symptoms. During this process the practitioner discusses with the client on a step-by-step basis what is happening to the client to identify the nature of any physical and emotional problems. The client is greeted by the practitioner who directs them to sit in the assessment room. There is a screen to the left of the room which provides privacy for those being treated with massage or acupuncture. A history sheet is the only document used to record essential information, which also serves to guide the assessment process (Appendix 9). No consent forms are used, consent being implied by attendance. Criteria that identify a specific medical problem are elicited from the client's remarks on their condition during the assessment consultation. Clients were asked probing questions about the nature, time and location of when they had experienced discomfort. The practitioner usually records the following information based on the procedure of assessment detail known as Sizhen [Domain 4.7] from which records are made from the following list (see Figure 5.3).

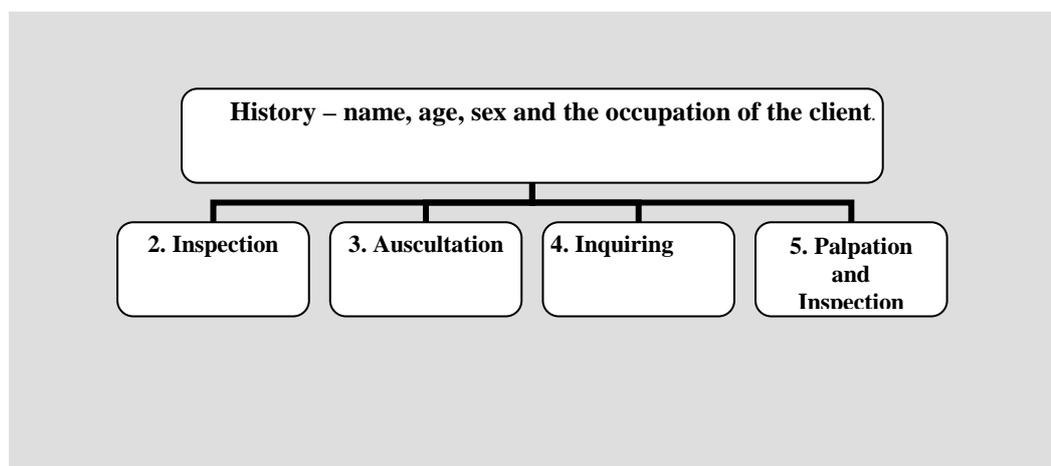


Figure 5.3 The assessment procedure of inspection and observation - *Sizhen*

The assessment procedure detail included:

1. History of client
2. Inspection for the vitality, colour of the face, tongue, tongue coating.
3. Auscultation and olfaction of the speech, breathing, cough any sputum and breathe odour.

4. Inquiring about type and frequency of pain and if it is relieved by any treatment.
5. Any insomnia headache, palpitation, chills, fevers, dizziness, appetite, thirst, perspiration on exertion or that occurs spontaneously without stressors.
6. Bowels, normality, whether there is frequency of constipation, diarrhoea, and if mucus or blood are present.
7. Urination, how often, any scalding, any discharge of menses, family
8. history of heart disease, diabetes. Any allergies, if conventional medications are used?
9. Palpation of the Pulse - Right wrist Cun Guan Chi, Left wrist Cun Guan Chi
10. Identification of Western medicine use from client's comments
11. TCM treatment recommended by the practitioner
12. Remarks that relate to features of the pulse
13. Practitioner's signature and date of visit.

Following these observations the practitioner made notes that were documented on the patients chart in Mandarin.



Notetaking following an assessment of a client

Plate 23. The assessment room

Specifically the practitioner's assessment of the client's history followed the steps below. During the assessment, I observed each practitioner make reference to the chief complaint or the underlying problem experienced by the client. The practitioner performing the assessment (either Zeng or Rosli) would ask the client directly beginning with: Why have you come to have treatment? What is your complaint?

From understanding why the person had come to the clinic, the practitioner then made notes after gaining an initial impression of the client's vitality from the colour of the face. Next an examination of the client's auscultation and olfactory functions were made, noting the vigour of the client's speech and respiration, identifying any breath odour and noting any sputum expectorated. Clients were then requested to display their tongue and the tongue and its coating were observed carefully. The client's description of their illness helped to identify the core or root of the problem. The practitioners listened to the client's description of his/her feelings about their bodily discomfort or other anxiety they may have experienced.

Client's perceptions of their illness were probed through questions about for example, any discomfort or pain experienced. Typical questions that were asked of each client were: - How have you experienced any discomfort? Do you have any pain? How frequently and at what time do you get pain? Do [you] have pain on urination? What is your urination like? How are your bowel movements, what is your mobility like, do you have any problem with digestion and if pain or discomfort is experienced?

These questions were not dissimilar to those a Western doctor would ask their patient and the direction of questions aimed at providing a base for a more detailed discussion of the client's illness based on the theoretical underpinnings of TCM from which interpretation is made. The practitioners pointed out that they needed the client's own description of the illness as they considered hearing the client's own views and experience of their illness as fundamental to the assessment. In addition the symptomatology of an illness can have different meaning and cultural connotations depending on the client's cultural and national background, and so they seek to translate concepts such as Qi and the idea of energy transfer through the body into the language of TCM.

2) Assessment formed around the philosophy of TCM

From this information, the practitioner is able to, analyse, interpret and construct an assessment which does not rely heavily on the use of modern technology. Analysing what in TCM is called the energy of the person was of particular importance in the assessment process. The practitioner explained to the client that listening to the

client's voice was necessary to determine the energy or Qi. Zeng explained it to me this way:

The energy of the voice is associated with lung, heart spleen and the kidney function. A normal voice reflects harmony of the internal organs. A talkative person accompanied by a loud voice indicates excess syndromes usually of heat, whilst a person who is quiet and has a feeble voice may be identified as having a deficient syndrome, usually a cold syndrome. Sudden hoarseness indicates an exhaustion of Qi.

Thus the practitioner was observed to listen attentively to the tone of the client's voice as they described their symptoms. According to the practitioner, the tone of the person's voice is important in diagnosing the inner state of their wellbeing and in identifying a specific organ that may be imbalanced. For example, a client that exhibits an imbalance of the element wood (which corresponds to the organs of liver and gallbladder) appears anxious, irritable and tense. Their tone of voice sounds as if they are shouting, their speech taking on a sharp controlling tone, and they may appear to have an aggressive manner.

A person who has a feeble voice may be identified by the practitioner to be experiencing a deficiency of Qi. They will appear lethargic and fatigued and slow in their movement. A state of fatigue and lack of energy are identified in TCM as a loss or block of the vital Qi flowing through the body. To illustrate this, the Zang Fu organs that correspond to different tones are depicted in Table 5.1. As these are culture specific and there is no other way to illustrate the propensity of these tones to the organs, I have provided an illustration an illustration adapted from a text source.

Table 5.1 Sound representing each organ (adapted from Xinnong, 1987, p. 20).

Zhang Fu organs	Emotion	Sound
Liver - Gallbladder	Anger	Shouting
Heart - Small intestine	Joy	Laughing
Spleen - Stomach	Worry	Sighing
Lung - Large Intestine	Grief	Weeping
Kidney - Bladder	Fear	Groaning

Intense listening is considered to be essential to pick up the tone of voice and, most importantly, the emotional state behind the voice which is linked to a specific organ. Symptoms that are understood symbolically in the Chinese system of thought related to states of energy are expressed as 'Qi'. Key words used to express this were described by Zeng:

The 'flow' of Qi, [we] identify the 'stagnation' of Qi or a 'blockage' of Qi

When asked if the Qi was important in the clinical assessment of the diagnosis, Zeng said:

Qi is the vitality of the person. Need to ask questions to make sure. Some pale colour of face, with other symptoms, breathlessness. Need other diagnosis to make sure.

This sense of life energy or Qi is the yin and yang energy that is within each individual and which functions to sustain life. The function of Qi was explained in detail and summarised by Zeng who put it like this:

- *Yuan Qi* - Qi that is primary it comes from the parents and is inherited.
- *Zong Qi* - Qi is formed from Qing Qi, from the lung and the Qi from food.
- *Wei Qi* - Qi that helps the immune function, to protect the body against any exogenous factors like infection.
- *Yin Qi* - Qi is derived from the energy of food essences – this is produced by the spleen and stomach and enters the circulation of the blood.

Qi is considered to permeate all parts of the human body and when the movement of Qi ceases then the vital activities of the human body are no longer operating (Xinnong, 1987). Assessing why Qi gives an indication of the energy state of the individual, Zeng made this analogy based on Western science and the understanding of adenosine diphosphate, ATP, an organic compound produced in cells from which energy is released:,

If there is no Qi [then] the patient's dead. It is like (A.T.P.) in biochemistry, that is power, the release of glycogen energy.

Zeng identified that Qi was an essential element to maintain life in all living creatures. Farquar (1994) an anthropologist who has worked on TCM in China, makes the comments that 'without Qi there would be no yin or yang, that Qi is the

cause, process and outcome of all activity in the cosmos' (p. 44). An impaired flow of Qi throughout the body can lead to disturbance of the mind and thereby cause the emotions to become imbalanced (Enquin, 1988b; Xinnong, 1987).

5.8 Transactions involved in the assessment

Symptoms described by the client are viewed by the TCM practitioner as related to a wider environment, the personal environment in which the person lives and their family and social networks. This whole person approach underpinned a symbolic understanding of the information and a shared responsibility in the communication procedure of the assessment. There was a strong sense of participation with the client and practitioner engaged in listening and responding to each other. For example, a person complaining of having a headache is listened to for cues that relate to wider psycho-social health issues, which are linked to their state of energy and how they have experienced the illness.

To detect underlying issues that might relate to psychosocial concerns, the practitioner asked probing questions about the client's family, social, work and physical environment to identify why headaches were being experienced. Underlying problems may relate to emotional disturbances experienced as insomnia, which can be traced to an emotional problem with roots in a wider system of social relations.

Zeng described it in this way:

First when the client comes in we ask them what's wrong with you, the main complaint. After that [we need] to have knowledge and clinic experience, ask them [about their] related [social/family environment] problems.

An example from the clinic is that of a client describing a headache. Below is a brief abstract of one client-practitioner encounter:

I have headaches which I cannot relieve with the medicine my doctor gives me. The practitioner asked me, when do you get your headache usually? In the morning or night, what time does the headache start?

The client responded:

I have headaches that start in the morning. Usually I wake up with a headache in the early hours of the morning usually after 1.00 am.

The practitioner then made notes on the onset of the headache and associated it with a dysfunction of the liver. This is classified according to the Zang Fu organs and the five-element theory occupying a time element of the twenty-four hour cycle. In TCM each two hour section of the cycle is governed by a specific organ and energy. Identifying related problems guide the assessment process as each symptom described is often connected to other symptoms. This forms part of what is meant by a 'holistic assessment' in TCM (Enquin, 1988a). As Zeng pointed out;

For instance when the client comes here, he says he got a sore throat, in that case only two days, so we quickly react to the cold he has.

We ask the client do you get fever, got blocked nose, any phlegm, colour, yellow or white, thick, thin, bowel movements, appetite, body aching.

Probably [this is] similar as in Western medicine – but we use totally different system from Western medicine.

Like wind exterior patient catch cold – the Chinese medicine divided into winds heat and wind cold. If heat we choose formula to remove wind and heat together.

Drawing on the Five Element theory, Yin Yang and, the Qi, the practitioner made their assessment of the client through detailed questioning and discussion, a process that involved the translation of client symptoms into the language of TCM and the re-description of the symptoms to the client.

5.9 Describing the practitioner skills

The skills of the practitioner are grounded in techniques that require a sound knowledge of the TCM philosophy and ability to translate client descriptions into symptom language through the process of Sizhen. In one case where the client had hypertension the initial interview began with the client providing a description of what they saw as the main symptom. For example, a person who complains of an aching limb will be asked further questions to determine if there is any other underlying symptomatology.

The practitioner sought to link the symptom to work or to the home environment in order to uncover an underlying pattern to the experienced symptom. When describing symptoms of pain, people often pointed to where they experienced pain. Responding

to body discomfort is part of identifying what is wrong, what the person expresses about what they have and can be understood to be self-diagnosing. The practitioner needs to be able to interpret from the information the client provides and from this derive a statement from the assessment. This information is then processed to form a differential diagnosis and the main diagnosis can then be made. The questioning by the practitioner provides the direction that drives the consultation to a conclusion. Zeng explained that:

Chinese medicine divides hypertension into 4 or 5 different types. They say – the more common type is hypertension of liver yang and deficiency of liver yin, too much yang, too less yin. How we know this type of hypertension caused by ... when we study the basic theory we know what symptoms belong and cause hyperactivity of yang and deficiency of yin.

For example, the person with hyperactivity of liver yang may describe symptoms of insomnia, dream disturbed sleep and mental restlessness. Zeng provides the translation into the symptomatology of TCM:

If people have an emotional problem they don't sleep well. This is wood produces fire. Liver has trouble can make fire very strong in the heart. When fire gets strong – interferes with the spirit, the spirit got trouble. In that case it [the spirit] gets insomnia.

Following this interpretation, which may identify an underlying emotional problem, the condition is explored by the practitioner. When the diagnosis is confirmed, treatment is initiated to restore harmony to the body system affected by imbalance of yin and yang (Xinnong, 1987), which has an effect on the flow of Qi and the circulation of blood. The first step in the treatment is to identify whether a yin or yang imbalance has occurred. This is done in the following way.

(1) Determining the flow of Qi [Described under Folk domain (4.9)] as tongue, pulse, yin & yang energy]

The practitioner examines the person to determine energies that are out of balance. The fundamental value of this form of assessment is to examine both the physiology and the wellbeing of the individual expressed as a balance or imbalance of energy of Qi flowing throughout the body. Therapeutic intervention is then aimed to restore

harmony and to strengthen the flow of Qi along the conduits or meridian networks of the body. A meridian pathway provides a continuous flow of interconnected energy and forms the basis of which the harmony and balance of the organs is maintained. TCM therapies aim to restore harmony and balance within the inter-connective network of meridians whether this is through acupuncture, providing herbal teas, or advice about exercise or massage. For example if the person is suffering from a 'wind cold' it is described as wind attacking the lungs. Warming herbs will be prescribed to drive out the cold and warm the channels which conduct the flow of Qi throughout the body. There is a continuum of the flow of Qi through out the twelve Zang Fu organs.

(2) Smelling

Body smells help indicate a specific imbalance and thus an organ dysfunction. The practitioner is able to detect differences in body odours representative of the Five Element Theory. An example of this is an earth imbalance of the stomach or spleen, where there is a very sweet or fragrant smell. Zeng explained that, an odour helps identify the organ with an imbalance of Qi present. Another example is where there is a fire imbalance associated with the heart or small intestine, which manifests as a distinctive scorched smell. An imbalance of the element metal represented by the lungs and large intestines is identified as being a rotten smell and a water imbalance of the kidneys and bladder is a strong acrid smell. The imbalance of wood identified through the organs of the liver and gall bladder emits a fetid odour.

(3) The tongue inspection

Performing the tongue inspection and pulse assessment helps to confirm and provide a differentiation of syndromes affecting body organs. These techniques of differentiation confirm pathological conditions according to the flow of Qi and blood. In essence the colour of the tongue reflects the state of interior organs and disease. The tongue proper or body of the tongue is divided into 5 regions. The middle section of the tongue represents the stomach, the back of the tongue the kidneys, the sides of the tongue, the liver and gallbladder and the tip of the tongue the lung and heart. Generally the tongue is observed for its colour: pale, red, yellow,

white, whether there are spots, if they are red or purple, if there are tooth marks at the side of the tongue and if it appears swollen.

Looking at the tongue provides a clear picture of the state of internal organs. The “... tongue is the mirror to the heart” (Xinnong, 1987, p. 27) reflecting the close physiological and pathological relationship and balance between organ and disorder. Each colour of the tongue represents a different problem. The tongue coating also identifies different systemic changes. The surface of the tongue is examined to reveal any changes in texture. For example a cracked tongue surface indicates internal heat and dryness and deficient yin, whilst a swollen tongue may indicate excess yin, deficient Qi and internal dampness. Internal dampness is related to situations where the client has a yin pathogenic factor and usually a disturbance of the spleen.

It is from the contextual elements found in the information provided from the client’s narrative and interpretations of these observations made by the practitioner, that a framework is formed to provide the basis from which a differential diagnosis is made found in the analysis in Chapter Six. An example given here is that of a client who has insomnia. Zeng described it this way:

For example some patients with insomnia get it because of hyperactivity of Yang. Or some people get phlegm from the fire usually in Chinese medicine calls it two types – excessive pattern and also deficient pattern.

Then we have a look at the tongue whether is white or red colour or slight red, dark red or purple colour and the tongue coating as well.

This example illustrates how a symptom and the signs observed through the tongue inspection are linked and it is in this way that the practitioner is able to assess the internal symptoms being experienced. Chinese medicine identifies areas on the tongue that relate to specific body organs, that is the tongue serves as a mirror of the internal organs. The channels of the heart, liver spleen, lung and kidney are directly linked to the body of the tongue. The tongue covering is sensitive to changes from these organs and reflects states of internal cold, damp, heat and stagnation of Qi. Thus the tongue and tongue coating provide a guide for making an assessment of the client’s condition.

Observing the clients tongue is a highly specialised practitioner skill which provides vital information about the state of the internal organs. It is a part of the education of TCM students who memorise more than one hundred tongue types (Eisenberg, 1993). Every variation and discolouration of the tongue corresponds to a specific problem of the internal organs. An example is a red tongue indicates a yang condition and a pale tongue a yin condition. Cracks in the tongue indicate dryness. Zeng explained it this way;

A swollen tongue that has tooth marks on the side may indicate a deficiency of Qi and internal dampness related to a condition of the spleen.

(4) The pulse assessment

In this part of the assessment, clients are asked if their pulse can be taken. The clients hand is placed on a small pillow for support and then the practitioner takes the pulse. Pulses are taken on both hands and at three different points on each. The practitioner examines by palpation the six pulses of each wrist expressed as the yin and yang pulses, which are related to each of the zang-fu organs to determine the flow of Qi energy. Rosli, the herbal practitioner said:

The approximate intervals of Cun, Guan and Chi, the pulses were reviewed on the left and right hand wrists of the client [Rosli].

The practitioner felt the pulse by placing fingers over the area of the wrist and in a smooth sequence of movement of the middle three fingers of her right hand felt along the areas of each wrist. Pulses are taken separately on each individual wrist at the three regions of Cun, Guan and Chi (Plate 26 and 27).



Taking the pulse of the right hand

Cun – Lung
Guan – Spleen
Chi – Kidney
(Yang)

Plate 24. Assessing the Right hand Pulse

With the right hand pulses, the practitioner regards any deep palpations as indicative of disorders of the lungs, spleen and circulation, and light palpations indicating, the colon, stomach and triple heater disorders.

The left hand pulses identify deep palpations with the heart, liver, kidney and with light palpations, the small intestine, gall bladder and bladder.



Taking the pulse of the left hand
at the positions of
Cun – Heart
Guan – Liver
Chi – Kidney
(yin)

Plate 25. Assessing the Left Hand Pulse

Rosli explained the unique features of pulse diagnosis;

The pulse taking purpose is different from Western medicine...the Chinese medicine divides pulse into six different problem ...and can give some indication what's wrong with patient's body. Because we look at correct one, the Chinese medicine has some holistic basis.

The pulse diagnosis is based on the 2nd century BC Chinese theory of vessels and blood is identified by TCM practitioners as one of the main traditional assessment tools. The Chinese have defined a system of abnormal pulses. Xiu describes that, “centuries of practice have allowed Chinese doctors to ascertain that pathological changes of various organs are manifested in certain corresponding areas of the body” (1988, p. 1758). The term ‘*Mai*’ in translation is sometimes referred to as a pulse (Hsu, 2001) and seventeen different abnormal pulses (*mai*) have been identified which according to Xinnong, are:-

1. Superficial pulse – (Fu mai);
2. deep pulse – (Chen Mai);
3. slow pulse – (Chi Mai);
4. rapid pulse – (Shu Mai);
5. Pulse of deficiency type –

(Xu mai); 6. pulse of excess type – (Shi Mai); 7. surging pulse – (Hong Mai); 8. thready pulse – (Xi Mai); 9. rolling pulse – (Hua Mai); 10. hesitant pulse – (Se Mai); 11. string taut – (Xuan mai); 12. tense pulse – (Jin Mai); 13. soft pulse – (Ru Mai); 14. weak pulse – (Ruo Mai); 15. abrupt pulse – (Cu Mai); 16. knotted pulse – (Jie Mai); 17. regularly intermittent – (dai mai) (1987, p. 269).

Some examples of the pathology of organs reflected in the pulse are that a wiry pulse indicates liver disease and a rough pulse indicates blood stasis or stagnation of the flow (Xinnong, 1987). Subtle energy changes of Qi imbalance are also felt in each of twelve pulses and energy blocks in the Zang Fu organs can be identified by taking the pulse. The pulse diagnosis confirms the state of flow of energy links between the Zang and Fu organs. Enquin (1988c) describes the main features of pulse taking as; the proper time, it is best for a pulse to be taken in the morning, the posture of the patient needs to be considered and for them to be sitting straight and the way of placing the fingers on the styloid process of the left and right hand.

Other elements of observation made during the assessment included inspection of the face, observing the complexion, the brightness of the eyes as in Chinese medicine it is thought that the flow of blood and vital energy are revealed in the face. A ruddy complexion reveals a state of health whereas a pale and lustreless complexion reveals there to be insufficient blood flow. Xiu explains that “a dark bluish green hue reveals circulatory stasis” (1988, p. 1757).

5.10 Important elements of interactions between practitioner and client

A summary follows of the important element’s that define the practitioner-client interaction. First, emphasis is found in elements that occur during the assessment when the client is given the opportunity to describe the symptoms of their illness and the relationship formed with the client. The initial consultation lasts for approximately thirty minutes with follow up consultation approximately fifteen to twenty minutes. In this way the practitioner and client build trust cooperatively in the shared experience of the interchange of information described in Chapter Two (doctor-patient relationship) and in the clients perspectives of the TCM encounter in Chapter Seven.

Second, another important element is the TCM practitioner's recognition of client's recounting of their symptoms in the understanding disease and illness. Time is spent discussing symptoms and how the client felt in relation to their illness. This attention to lay understandings helped facilitate the investigation into the client's wellbeing.

Third, from my observations the practitioner provided approximately 30 to 40 minutes for a consultation which gave the client the opportunity to discuss their symptoms in detail and to explore their symptoms with each assessment when they returned for follow up consultation. The practitioner in turn provided feedback to the client identifying why symptoms of ill health were being experienced. It was evident from my observations of the practitioner-client interchange that clients felt comfortable in discussing their problems as they gave intimate details of their lives.

Fourth, in making sense of an illness the practitioner seeks to provide an answer to questions: 'why do I have this illness' or 'why has it happened to me?' The clients were enabled to describe their illness symptoms upon which the practitioner drew on more contextual and emotional patterns that linked the emotional expressions drawn from the client recounting their illness experience and taken into account. If TCM is able to make meaning of an illness, (Kleinman & Kleinman 1994) a ramification exists that underpins this understanding. There are more complex considerations based on a philosophy embedded in the theory other than a simplistic nuance based solely on the production of client information. Complex considerations of the contextualisation involved in forming a diagnosis are elaborated on in Chapter Six.

Finally, the assessment was processed through the Yin Yang principle and the Five Element theory. These theories provided an opportunity to diagnose problems within the structure of the Zang Fu organ system without the support of laboratory tests. Reliance was placed upon skills of the practitioner to detect any imbalances of energy and discomfort that the client experienced. Treatment incorporates four strategies: "... to tone yang, to tone yin, to eliminate excess yin and to eliminate excess yang" (Maciocia, 2005, p. 7). Following the assessment, the practitioner prescribes herbs and to assist in adjusting the energy of yin and yang by 'making yin stabilised and

yang well preserved'. Restoration of the flow of Qi is focused on the balance between the yin and yang energies of the body organs to be treated by the herbs.

5.11 Summary

This chapter has described the initial structured observations that were made in the field. The network of social accesses, the practitioners in the clinic, the people in the clinic, and the acceptance of TCM into the Perth community form a profile of the field and the people involved in the clinic. Observing the daily activities of practitioners, clients, general features of the clinical encounter are formed around the assessment procedure. The process of assessment was observed and specific skills of the practitioner performing the procedure are described with reference to the theory of traditional Chinese medicine. This is discussed further in Chapter Six. Elements that form the basis of the interaction are noted. Reference was made to the beginning of the differential diagnosis, which is based on understanding of the philosophy of the Five Element theory and Yin/Yang imbalances of the respective body organs.

CHAPTER SIX

Practitioner Perspectives of the Clinical Encounter

“...a good physician who has mastered the technique of diagnosis will examine the patient’s color and take his pulse and will classify all symptoms into yin and yang as the first step in making diagnosis”
(The Yellow Emperor’s Classic of Internal Medicine cited in Lu, 1994, p.10)

6.0 Introduction

The emphasis on treating the whole body is purported to be the basis of how the process of TCM is practiced. This assumption is examined in this chapter to explain from information provided through interviews with the two practitioners at the Hanyu clinic, who from their insight explain how they initiate intervention from a holistic perspective which they see to be explained through the philosophy that underpins TCM theory. The process of examining the client is enabled through the process of interaction known as ‘Kanbing’. First, reference is made by the first practitioner from the ‘Hanyu’ clinic on how he attended the clinical process drawn from the principles of *Ba Gang* and the four diagnostic methods of *Sizhen*. Principles of the clinical process are described in his transmission to me of the understanding on how the clinical practice is shaped by TCM theory.

Second, an exploration is made through a deconstruction of the clinical process from a case study and interviews conducted with the practitioner at the ‘Yin Min’ clinic a suburban clinic of TCM.

6.1 Explaining the clinical process in TCM

To provide insight into the clinical process of TCM the practitioner drew on the understanding of an ancient Chinese philosophy that guided the clinical practice to explain to me how he understood Chinese traditional medicine, found within those concepts. Traditionally a practitioner of Chinese medicine was regarded as a physician who practised health maintenance and was paid to keep the person well as it was thought that prevention was viewed as being more desirable than of providing a cure for illness. The energy of the body was considered to be important and to be associated with an interconnectedness of the energy flow from organ to organ by the meridian pathway system found in TCM. These interconnections formed the basis upon which the practitioner attended to treat imbalances between the Zang Fu organs of the body.

In TCM the organs of the body "... are described for their function rather than for their location and structure, and the theory of the cosmogony, the continuous interaction of yin and yang, the four seasons and the five elements" (Veith, 1972, p. 30). This notion is analysed in detail in Chapter Eight where there is explanation made on the interconnection between the organs, the corresponding five element theory, the emotional factor of each associated element and the flow of Qi, that connects the organs as a whole. These following descriptions illustrate how an illness is interpreted by the practitioner and practitioner Zeng explained this interconnectedness of the body organs, that a connection is generated in the following way:

Because Chinese medicine looks at correct ...has a holistic focus, let me give you an example. The ear gets disorder or some problem. The Chinese medicine they think the problem caused must be from the kidney – because in Chinese medicine they say kidney has orifice opening into ear, liver into nail, spleen into mouth, heart into tongue.

He illustrated this further by referring to the relationship between asthma and the bodily organs that are affected by the condition:

Aetiology, they think is from external factors such as wind cold, summer heat. Some factors like Qi stagnation. If the asthma turns into a chronic disease in that case not only attacks the lung but even attacks the kidney, kidney attacks spleen. In that case how to explain the relationship in lung and kidney, lung and spleen? Can we use the five element theory to explain the relationship – [yes, as] they [the five elements] promote and counteract each other.

Using words to describe factors such as ‘wind cold’ ‘summer heat’ Qi stagnation, the attack of one organ upon another, such explanation lacks any scientific or plausible explanation from how conventional medicine is interpreted. Yet TCM theory focuses on the synchronistic occurrence of natural phenomena (Ross, 1985) and applied principles of treatment from a holistic perspective based on the notion of an underlying order that exists within the natural world. Kaptchuk (1998) describes the process of diagnosing an illness in TCM, as a network that has a web with no weaver except in the translation of how the phenomena are ordered. The phenomena found within the natural universal laws which underpin TCM theory, and central to the Five Element theory, provide the explanatory framework of the TCM system.

Zeng stressed the importance of the examination made on the total physiology of the patient rather than reducing the diagnosis to a focus on the diseased organ and gave the example of a smoker with emphysema to illustrate his point. He suggested that a Western medical approach explained emphysema as due to a diminished capacity of the alveoli brought about by the exchange of blood gases and reduced oxygenation. In contrast he provided this account of how he approached the diagnosis giving the following example of how the assessment linked with the formation of the diagnosis and was asked to explain how he could make a diagnosis from the assessment process and made this comment:

We put the main complaints and the history of present disease and check the tongue body, coating and the pulse, [then] put [these] together to analyse that from Chinese medicine theory we say ‘Ba Gang’, is the 8 principles to differentiate, then make diagnosis. ‘Sizhen’, is the 4 diagnostic methods. The five elements are used for diagnosis and treatment as well.

Therefore he identified that there is a ‘process’ that is linked the pathology of symptoms found in an illness to the TCM diagnosis, that allows for the detection of a pathological disturbance within the organs of the body without the aid of laboratory tests. How the pathology or pathogenic factors are identified as being a cause of disease such as epidemic, internal injury caused by disturbance of the seven emotions, improper diet, maladjustment of work and rest and surgical trauma can be tracked through what the Chinese medicine system refers to as Sizhen is now described.

6.2 Sizhen – the process of a systematic assessment

6.2.2 The examination – Sizhen

Zeng explained that ‘*Sizhen*’ comprised the clinical features of examining their client; questioning, inspection, palpation and pulse assessment are conducted and this systematic assessment governs the construction of a diagnosis. Thus a complex framework of interconnected information is assembled from the client-practitioner interaction known as Kanbing, through which the interconnections are made between factors to explain an illness. Kaptchuk (2000) puts it like this:

‘... that instead of a biomedicine perspective of explaining why x is causing y, in Chinese medicine the focus is explaining the relationship between x and y’ (p. 4).

The notion of explaining X number of signs that are observable are turned into symptoms as a causation factor in an illness, which then becomes a progressive process of Sizhen, from which the organisation of symptoms are assembled into what is known as ‘syndrome’. Thus TCM looks at the root cause of the illness (Scheid, 2001). Farquar (1994) reinforces this notion by suggesting that biomedicine treated the surface manifestations of illness while, “Chinese medicine excels at ‘treating the root of a problem’ even though it may take some time, *zhongyi zhi ben, xiyi shi biao*” (p. 137). It is the complete integration of these methods that forms the basis of the TCM diagnostic process which will be analysed in the case study analysis (6.5). Zeng explained that Chinese theory is an essential to guide the diagnosis and the intervention that follows specific to the nature of the problem.

After [we examine the patient] to make diagnosis we still follow Chinese medicine theory, choose related formulas (herbs) or acupuncture points.

When questioned how a decision was made to use either the herbs or acupuncture Zeng informed me that the depended on the kind of disease that was present whether it was simple or complex and replied:

For patients when we need acupuncture or herbs or both, usually this first depends on whether – we use acupuncture all the time usually for some simple diseases. Sometimes doctors use herbs –

most times only use herbs – some complex diseases use only acupuncture or herbs.

I asked Zeng to explain how the treatment was strengthened by using acupuncture and herbs together. He replied:

Not stronger, but more effective. This also depends on what the Chinese doctor what they use most of the time. The second time depends on the patient's condition.

Zeng gave me this example of what he referred to as the principle consideration in treatment and drawing on the example of 'wind heat' he explained this is how he would choose a prescription:

Using the formula called *Qiao San* to drive out the heat and to remove wind. This formula has been used for several hundred years. Yin flower *Qiao* another herb – these are the main ingredient and choose the formula but different patients get different constitutions so the basic formula we choose also needs modification – either take out some herbs. For acupuncture points we choose the same.

Herbs or acupuncture treatments were based on the premise that a balance must be achieved between the notion of promoting and acting upon to strengthen the Qi or to diminish hyperactivity. With the combines use of acupuncture points the treatment can be strengthened according to the individual constitution of the patient. I now explain therapeutic care and make reference to examples that the practitioner discussed to illustrate the basis on which a decision to initiate care is made.

To explain how therapeutic care is prescribed based on the assessment, Zeng provided an example of a client who in this example experienced a 'headache'. Even a headache has a complex consideration that necessitates that the correct identification is made to determine what kind of headache the person has. The practitioner explained the classification of the headache was determined by the time the headache commenced, which is linked to the five element and yin/yang theory to identify differences according to the interactive elements of different body organs. Zeng expressed it this way:

A headache commencing at 7pm at night would be treated differently from that of a headache commencing at say 2am in the morning. According to reason we use different formula herbs to treat the root not just the symptom, so the reason for the disease is

also different, that's why we need to use different formula for some disease for different patient.

Zeng further explained that, the hours between 5pm-7pm correspond with the organ the kidney and of the element water whereas the time between 1am-3am corresponds to the liver and the element wood.

The information that he identified implies the headache requires different formulas related to several factors. If say the headache is caused by an exogenous or external factor, then pathogenic wind disturb the meridian flow of Qi. Another reason may be if there is an internal disturbance of Qi (endogenous) and is due to abnormal flow of liver yang and a deficiency of Qi and blood. Herbs that are used to treat a headache will differ according to the diagnosis of whether the headache is caused by wind pathogens in the meridians which conduct the Qi, whether it is a headache due to the surge of liver yang rising or if the headache is caused by deficient Qi and blood flow.

This is elaborated on by Rosli the Chinese herbalist;

The treatment of a liver problem where there may be too much heat is treated by herbs that can cleanse, whereas the headache that occurs in the early morning is probably related to a lack of energy and therefore a low Qi. Herbs are given that will to promote energy or the flow of Qi.

Therefore it can be stressed that the individualised nature of the treatment is implemented on the premise of the exact nature of the problem of the imbalance of Qi, found to be either deficient or in excess in the energy system of the body. Alleviation of the headache comes through the identification of the underlying cause caused by an imbalance, in Qi and or blood flow. Treatment then is based on what is identified a correction of the imbalance of yin and yang energy within the Zang Fu organ system that has contributed to the headache.

Rosli based on her expertise of herbal medicine informed me the treatment selection for a headache was like this;

Some herbs can settle down yang – subdue the yin, so in that case we have some herbs for yang and some for yin. There was a difference in taking into consideration that the constitution of the body type of the individual. For certain disease in different patients the reason for the disease is the same but the constitution is different. That's why we need to use different formula for some diseases for different patients.

Then an allusion was made to how the constitution of the individual which Chinese medicine takes into consideration when initiating treatment and Rosli referred to Western medicine to support her statement which in one respect is true, but also is a bias in how she considered the stance assumed of Western medicine.

Somebody who is thin has got a different body type to somebody who is fat. So you have to take that into consideration whereas in Western medicine, if you're fat or thin it doesn't make any difference, [the Western doctor] doesn't [usually] look at body type. In Western medicine if you have a problem – he just gives you a prescription for Panadol but doesn't look at the body type. So somebody who is thin has got a different body type to somebody who is fat.

Interestingly the point reinforced by this practitioner that the Chinese factored into the assessment of the individual the difference in body type to treat the condition and to provide a different herbal formula individually tailored for each person. The treatment that might be effective for one person will not be for another based on their constitution. To illustrate how this application is based, Zeng gave a different example of how the treatment works with reference to the example of hypertension:

How do we use the theory of yin and yang in directing the patient's assessment? Five elements same – we still say – some examples are easier to understand and one form of hypertension is the hyperactivity of yang and deficiency of yin. The liver belongs to wood. Kidney belongs to water. So there is '*Yuan Qi*' deficiency of kidney yin and hyperactivity of kidney yang.

Zeng elaborated on how the five element theory formed the basis for the TCM assessment to show it is important how each organ inter-promotes the function of other organs in reference to the five element theory.

The water couldn't nourish the wood so cause yin/yang couldn't balance. To nourish the yin settle down the yang control the wood. They say some herbs nourish the yin – the water gets enough. Some herbs subdue the yang and liver yang to control the wood. This is the five elements how to use them in TCM theory.

When asked why there was such a focus on the importance of how each organ inter-promoted the function of the other, he explained that this was based on the holistic focus of TCM that the body was treated as a whole. What did he mean by whole and how could this be understood? Zeng stated:

The mind and body are treated as a separate entity [in Western medicine] but they need to work together. The Chinese medicine have some holistic – let me give you some example, the ear gets disorder or some problem. The Chinese medicine thinks the problem must be caused from kidney – because in Chinese medicine they say kidney has orifice opening into ear, liver – nails, spleen –mouth, heart, and the tongue.

The illustration that he gave when he referred to these organs of the body did not provide a very clear picture of what is meant by his notion of ‘whole’ and the idea that TCM viewed the organs of the body as a composite whole needed further exploration. So Zeng turned to the explanation in the following way. He discusses what he considers the relationship between an emotional disturbance and the interactions of the organs with each other.

The organs - Also they restrict each other as well like the water and earth belong to kidney and spleen. They are easy to understand when we get angry. Emotional upset that means damage the wood, damage the liver in that case we feel distension in the stomach area, we have burping and no appetite, poor appetite usually belongs to the spleen and stomach function and is not straight away from the liver. It is known as ‘*Wu Ko Pei Tu*’.

In this example he provides a clearer perspective of how TCM approaches a somatic connection between the illness, the organ and the emotional factor that has caused the problem. He explained that the assessment of the client is made on how the inter-relationship of the Zang organs and Qi are understood like this:

The examination for the client assessment begins with a diagnosis based on the Law of the Five Elements and identifying the flow of Qi. According to the reason we use different formula in herbs to treat the root not just the symptoms. It’s also a very complex form of medicine – a total way of looking at why you have a particular problem so that is only why I brought [sic] the term ‘holistic’.

To clarify what is meant by holistic Zeng drew from the example of insomnia which from a Western perspective might be thought to be associated with worry that cause a person to be unsettled and hence to experience disturbed patterns of sleep.

There are these examples why person might not sleep at night: anxiety and overwork [damages heart and spleen], congenital

deficiency of yin [kidney] emotional depression causing stagnant Qi [liver]. Irregular consumption of food and alcohol [spleen and stomach] you look at the interaction of all the organs in the body, the whole picture [sic] not just one organ.

With reference made to these associated factors, a more complex picture evolved of what might cause this problem. Zeng made the connections of the body organs to a specific problem, insomnia, but argued that other environmental factors can contribute to this condition like overwork, strain that affects the flow of the kidney yin Qi. He considered other factors as well that might cause harm within the body such as the consumption of food and alcohol. Zeng argued that as a practitioner he perceived that TCM was based on a complex approach that viewed the assessment of a client holistically.

6.2.3 Classification of symptoms

All factors have to be taken into consideration as the example that he referred to insomnia, has connection to a number of factors related to the dysfunction of the heart, the spleen, liver and kidney that contribute to this condition. Blood is circulated from the heart, stored in the liver and the essence is stored by the kidney and when these factors are in harmony, then the heart and mind is peaceful. When there is the prevalence of emotional disturbance and other mental conditions these contribute to damage the function of the connections between these vital organs of the heart, spleen, liver and kidney and is the link that interconnects with somatic manifestations thereof an illness.

The examination that forms part of the client assessment begins with a diagnosis based on the Law of the Five Elements and the identification of the flow of Qi. Energy or Qi undergoes cyclic transformations throughout its journey in the body system of Zang Fu organs along the different meridian pathways. The Five Element theory refers to elements in the natural world corresponded to wood, fire, earth, metal or water that is engaged in cyclical patterns of energy change. These five elements of change are constant and interactive thus created inter-dependency in the function from one organ to another. Zeng referred to the condition of asthma and described it this way:

Etiology - they think from external factors such as wind cold, summer heat. Some factors like Qi stagnation. Also if the asthma turns into chronic disease in that case not only attacks the lung, but even attacks the kidney, and spleen. Can use Five Element [theory] to explain the relationship – they promote each other and counteract each other.

Five Elements are used for diagnosis and treatment as well. For this relationship such as lungs and kidney, is difficult to explain. If we use Chinese medicine theory particularly the Five Elements is easier and reasonable [to describe the relationship between the lung, kidney and spleen].

Zeng also explained how the Five Element theory is used to describe the relationships between the associated organs, related to the Chinese notion of what the practitioner identifies as ‘we think the relationship is like Mother and son’. He described this relationship by saying:

So when you look at the relationship of the Five Elements, you have the Mother/son relationship of the internal organs – so that you have counteracting to each other and inter-promoting effect of the mother son. The five elements gets close relationship also each element belong to an organ e.g.; Heart – Fire; Lung – Metal; Spleen – Earth; Kidney – Water; Liver – Wood.

Within the Five Element theory the element that generates is called ‘Mother’ and that which is generated is called ‘Son’. Hence the generating and being generated is known as ‘mother and son’. In order to understand how this concept of an interconnection is made and how it becomes an approach to consider the ‘whole’, I wanted to understand what is meant by how the organs of the body form a relationship as described previously by Zeng. He put it like this:

We think relationship like mother and son. The promoting function of the organs means there is growth, this refers to the ‘*son*’ being the organ that is promoted and the ‘*mother*’ the one who promotes this growth. Each organ inter-promotes with each element being the son of the element that promotes it and the mother of the organ it promotes.

This explanation lacked any substantial definition therefore I referred to a text on Chinese tradition to understand more of how Zeng explained it. In Chinese thought governed by tradition, the mother gained a superior position through giving birth to a son, who when older found in the mother an ally with a sympathetic ear when times

with his father or even with his wife were difficult (Clayre, 1984). Thus in Chinese medicine this allegory draws on the impact of the mother-son relationship to describe conditions where there is an inter-promotion of the five elements known as the mother-son relationship. It is also regarded to be an inter-controlling relationship.

When an abnormality is found within the function of the inter-promoting function of the organs, it is then referred to as the ‘over acting’ or ‘counteracting’ in such a way that an excessive element has a detrimental impact on the other, explained as the son affecting the mother or the mother affecting the son. Confucian philosophy placed emphasis on the notion of ‘filial piety’ found in Book 11 on Concerning Government in an old translation of The Analects translated by Soothill.

It is said, “When Ming 1 Tzu asked what filial duty meant, the master answered: ‘It is not being disobedient’ ” (Soothill, 1945, p. 9). A domineering mother or a rebellious son would have a damaging affect on the harmony of the relationship. Zeng informed me the five element theory is used to explain the concept of energy imbalance with each organ viewed independently and also interdependently. He explained it through a main schema that illustrates the interactions that occur between the five Zang organs which he understood to be the main form of promoting functions of the Zang organ system.

Within the Five Elements wood generates fire, fire generates earth, earth generates metal, metal generates water and water generates wood

According to Zeng this function through an inter-promoting, interacting, an over acting and mutual cooperation that generates or impedes the flow of Qi through the organs, if a dysfunction is found in the son organ, the mother organ should be strengthened; if there is a hyper-function found in the mother organ, the son organ should also be treated (Connelly, 1979; Enquin, 1988; Lu, 1994; Xinnong, 1987). This inter-promoting function between organs was then described by Zeng as:

The relationship you get promoting and confirm each other. How to understand that? If they say the wood produces fire, fire can be controlled by water – how to understand.

If people have emotional problem don’t sleep well. This is wood produces fire. Liver has trouble can make fire very strong in the heart. When fire gets strong – interferes with the spirit, the spirit got trouble in that case [you] get insomnia.

Referring to the example of emotional anxiety, it can be explained like this, ‘when the heart (son) affects the liver (mother) and if the heart blood is deficient will then in turn lead to a blood deficiency that will affect the liver storage of blood (Maciocia, 2005, p. 27). Over the duration of time deficient blood in the liver (child) will affect the kidneys (mother). TCM derives a diagnosis by an examination of the flow of Qi found through the whole body. The energy of the individual Zang and Fu organs is expressed as a yin or yang energy and each organ is represented by 1) one of the five element factors of nature; 2) attached to the Five Element theory; 3) the Qi of Yin-Yang of each organ. While these three elements are considered in making a diagnosis, they cannot be separated from the totality of the human organism (Connelly, 1979; Enquin, 1988; Xinnong, 1987) and an important emotional component in this theory that links the organ to the corresponding emotional state described in Chapter Eight.

Links between mind and body are expressed through the symbology of the body organs as representative of the five elements with the energy of each organ dependent on the other, in balance and harmony. The flow of Qi is described by the philosopher Lao Tzu (in Connelly, 1979) “... my body is in accord with my mind, my mind with my energies, my energies with my spirit” (p. 15) when harmony is absent, illness is thought to occur. This notion of harmony of mind and body is less evident in Western medicine and aberrations found in the physical pathology of the body are analysed biologically using laboratory sampling and investigations to confirm the etiology of disease. Diagnostic labeling is then applied to a particular symptom or experience of illness. TCM considers that not all aberrations of symptoms associated with an illness can be identified with a diagnosis based purely on the analysis of physical symptoms through scientific investigation (Kaptchuk, 1983).

An example of an approach taken in TCM is now given to illustrate the element wood represented the liver. First, Zeng reinforced his philosophy of TCM and said:

The theory of TCM is different from Western medicine ... the 5 elements is used for diagnosis and treatment as well. If we use Chinese medicine theory particularly the Five Element theory is easier and reasonable.

Zeng then continued with this description between the five elements and the TCM Zang Fu organs:

There is example, can tell that Chinese medicine always follows the theory - is holistic. So your eyes got trouble from liver - red colour, discharging, we say too much heat of liver we use the herbs to clear heat from the liver.

How this is explained is relevant to the function of the liver regulated through the flow of vital energy [Qi] and the flow of blood. The regulation of Qi has 3 aspects; to regulate the mind and mood, promote digestion and absorption and to keep Qi and blood flow regular. Zeng illustrated it like this:

When we get angry, emotional upset that means damage the wood, damage the liver in that case we feel distension in the stomach area, burping (and have) no appetite.

In other words, when the function of the liver is normal, a person's mental and physical action is balanced. If an imbalance exists then symptoms that relate to either hyperactivity or hypoactivity will ensue. Zeng refers to belching and poor appetite and indigestion as a lack of coordination between the liver, stomach and spleen:

Poor appetite usually belongs to the spleen and stomach function, not straight away from the liver *Wu Ko Pei Tu*. The wood attacks the function of the spleen and the stomach. The wood attacks the earth. Western medicine, - use some medicine for this maybe no result - maybe get temporary result. No cure. If Chinese medicine, use 5 elements theory we know the original reason is from the liver.

The free flow of Qi to promote the function of the liver is referred to by Ross (1985), who describes the function it like this: when it [Qi] is obstructed in any way it gives rise to excessive or inappropriate reactions on behalf of the person. Zeng described further how an abnormal pathology of the eye is also linked to a dysfunction of the liver.

On examination the eyes can reflect pathological changes within the liver. This is illustrated when the sclera is yellow - this indicates jaundice and redness of the eye, belongs to the inflammation.

The minor pathology changes [of the internal organ states] can be found through observing eye. An example is of dryness of the eyes, usually explained as a deficiency of liver-yin in TCM.

Zeng then explained that conjunctiva of the eye is an example of how deficient liver yin from heat present in the liver channel explains the condition:

So your eyes get trouble from liver. When eyes have infection – red colour, discharging we say too much heat of liver.

He elaborated on this by reference to the mother-son relationship with reference to the transmission of Qi to illustrate that an over-reaction and counteraction occur, when a liver condition is transmitted to another organ. For example when transmitted to the spleen [wood overacting on earth], the heart [the disorder of the mother affected the son], the kidney disorder of the son affected the mother. These differences that determine the pathology of the Zang Fu organs, is an important function of *Sizhen* (the four methods of diagnosis) in the process of information drawn from the client based on examination of the systems of the body that is governed by the mind-body-spirit concept found in TCM. These integrative elements of mind-body-spirit are considered in the assessment of when a diagnosis is derived (Connelly, 1979; Enquin, 1988; Xinnong, 1987) and a further analysis of this concept is made in Chapter Eight.

Classification – of energy imbalance

6.3 The differential diagnosis – Ba Gang

From the assessment performed through the process of *Sizhen*, a differentiation is made of an illness syndrome by the practitioner based upon these following ‘eight’ principles (*Ba Gang*):

Exterior and Interior
Cold and Heat
Deficiency and Excess
Yin and Yang

The occurrence of any disease is due to the relative imbalance of yin and yang. Yang in excess makes yin suffer and yin in excess makes yang suffer, “...the root cause for the occurrence and development of disease is imbalance” (Xinnong, 1987, p. 16). Yin and yang are considered to be the general principle for the differentiation of syndromes caused an imbalance of energy. Within this context yin is treated for yang problems and yang is treated for yin problems and when there is imbalance such as

excess or a hyperactivity of each element due to a deficiency of the other, treatment is directed to strengthen the deficiency and control the excess. Zeng explained;

That by regulating the flow of Qi in its distribution along the varying acupoint's of the meridian - by means of inserting a needle to stimulate the normal flow of Qi or by pressure applied to specific points, a balanced flow of Qi will return.

This is illustrated as a principle of treatment: "To adjust yin and yang, [makes] 'yin stabilised and yang well' and restoring harmony between them" (Xinnong, 1987, p.16). When elements of yin or yang are deficient then the deficient Qi is strengthened or control of any excess is diminished. In order to relieve deficiency and reduce excess, the flow of Qi is regulated to maintain a homeostatic equilibrium through the therapeutic intervention based on herbal formulae or the selection of specific acu-points found throughout the meridian complex of the body. It is when the body's resistance against disease is strengthened, that pathogenic factors are thereby eliminated from the body and the body's natural immunity is reinforced.

TCM stresses that many chronic musculo-skeletal diseases are related to blockages of Qi, which relate to poor blood supply as Qi is the commander of the blood and assists to propel and transport blood throughout the body (Enquin 1988b). From a TCM perspective the breakdown of health relates to pathogenic factors that have a disturbing effect on the physiology where the body function has reached exhaustion. This is evidenced in later phases of illness through organic dysfunction. Pathogenic elements referred to in TCM, are the predecessors of the onset of disease.

The TCM practitioner draws on *Ba Gang* to perform what is referred to as a differential diagnosis which is based on the differentiation between the signs, symptoms and formation of syndrome. From the identification of specific characteristics of the illness into a syndrome, an accurate diagnosis is derived. Disease is essentially different to syndrome, in that disease pathologically affects specific organs, which become dysfunctional while a syndrome is a manifestation of imbalance of Qi in a specific organ or organs (Enquin, 1988; Lu 1994; Xinnong, 1987). Disease causation is traced back to the problem or energy blockage within the Zang Fu organ system that caused the physical discomfort of pain related to the poor flow of blood as well as deficient energy of Qi. The cyclical transformation of energy

refers to the interactions within the Five Element theory explained previously. Zeng based his diagnosis and explanation of the energy of Qi flowing throughout the body linked to the Five Element theory:

When you look at the philosophy of the Five elements, you have the Mother/Son relationship of the internal organs – so that you have counteracting and inter-promoting of the Mother/Son.

The emphasis is on therapeutic treatment after the differentiation of a syndrome has been ascertained, with the aim to correct the flow of Qi, restore harmony and balance and the approach taken by TCM that regards that disease occurs from the following two aspects: "... the deficiency of the vital Qi or the dysfunction of the human body and the pathological damage to the body ..." (Enquin, 1988a, p. 46).

The analysis of disease from a deficient Qi or pathology provides a framework from which the determination of syndrome is made from the differential diagnosis. It is supported through the Five Element theory of the Zang Fu organs. Earth represents the stomach and spleen organs. It may be reinforced to generate metal [strengthens the function of the spleen to benefit the lungs]. Water is replenished to nourish wood [nourishes the essence of the kidneys to benefit the liver] which supports earth to restrict wood [supplements the function of the spleen to treat hyperactivity of the liver] and strengthens water to control fire [replenishes the essence of the kidney to treat hyperactivity of the heart] (Enquin, 1988, p. 62). This has been explained as the interdependent, the inter-promoting and controlling function that each Zang Fu organ has over the other, illustrated through the connection between heart, lung and spleen and the effect on deficient Qi controlled by the inter-promoted effect in the circulation of the blood flow. It is inextricably linked to Kanbing, as the practitioner forges a link from the client's narrative through that of the symbolic language (Kirmayer, 2004) of the five elements, linked to each of the five emotions. In the following section of 6.4 an analysis is made on the formation of a differential diagnosis from the context of TCM practice.

6.4 A case analysis – Analysis on the structure of a diagnosis

In the following section I examine a case study from the Yin Min clinic. Practitioner ‘Wong’ after migrating to Western Australia from China, opened a private herbal clinic in 1990. The Yin Min herbal clinic practice was located in a metropolitan suburb and was very accessible, with a public transport, a bus route running from the northern suburbs into the city and established parking directly outside. Although a smaller clinic than the Hanyu, it was kept constantly busy with people and it was observed on several occasions that at least six clients would be seen in the waiting area at any one time. Appointments were necessary and were booked in advance.

A room at the front of the house had been converted from a lounge room into a waiting area for consultation adjacent to an adjoining practice room that had two surgical beds for clients having acupuncture treatment. Herbal supplies were stored on an enclosed back veranda of the house. The main form of therapy this practitioner offered was acupuncture, supplemented by herbal therapy. Observation of the practitioners acupuncture techniques were followed with a detailed discussion on each case helped to identify how diagnostic procedures such as pulse and tongue formed the assessment. Information from these discussions was used to uncover the application of TCM theory relevant to each case and involved questioning the practitioner about the cultural understanding applied to the diagnostic procedure that guided the practice.

I make analysis on the key stages of the practitioner’s diagnostic assessment facilitated through a mini-ethnographic explanation to provide a critical examination deconstructed through the Explanatory Model framework (Kleinman & Benson, 2006). Kleinman (1981) suggests, “... explanatory frames take into account illness issues to a greater degree than does the biomedical perspective” (p.73). The analysis of the approach taken in understanding an illness is described by Ross (1985) like this:

Western thinking tends to be reductive and analytical, separating the parts of the phenomenon from each other, in order to study each part in isolation. Chinese thinking tends to be intuitive and synthetic, grouping phenomena into patterns of functional interrelationships (p. 62).

Ross has drawn that the analytic approach taken in Chinese thought differs to that of the logical reduction taken in a science based approach, therefore it difficult to place in

context how a cultural analysis can be understood and explained from within the realm of a scientific based tradition. Explanation that considers relevant cultural factors to determine illness is contextualized within the Explanatory Model (Good & Good, 1981; Kleinman & Benson, 2006). Deconstruction as Denzin (1989) describes, has features of critical interpretation, observations and analysis offered on how phenomenon have been defined, observed and analysed. In this context the deconstruction is made on the practitioner interpretations from the process of assessment to derive a diagnosis.

‘Janet’ experienced the traditional Chinese medicine condition of ‘Wind Cold’ the explanation of which is drawn from the practitioner theoretical explanation of their assessment. Wind cold is a cultural prescription based on the patient who informed the practitioner about ‘their illness’ that is not structured in terms of a biomedical illness (Pfifferling, 1981). The case study from the Yin Min clinic [pseudonym-Wong], progresses through an extensive analysis of the illness, through the following five stages that I have used as an explanatory framework to guide the process from the illness narrative and the environmental stressors that have impacted on this illness.

To provide analysis on the procedure of assessment, I approach this deconstruction of the assessment contextualized within the case analysis. Cultural assumptions may hinder a practical understanding of what an illness episode is therefore the practitioner’s interpretations are described as he informed me from discussions that we engaged with on the case study. To elicit material (Pfifferling, 1981) suggests a set of questioning frames enables the provider to approach the patient’s explanation, in this situation I provide analysis on how the practitioner provides explanation and predicate that on the five stages I set out hereunder.

First, to explain the phases of assessment, these five stages from the Cultural or Explanatory Model (Kleinman, 1981) guide the deconstruction of the case analysis to illustrate how the practitioner derived the subsequent diagnosis, they are:-

- (1). Aetiology and the onset of an illness and its origin
- (2). Time and cause of symptom onset
- (3). Pathophysiology
- (4). Course of the sickness (acute, chronic, impairment)
- (5). Treatment

Second, I apply each stage of the assessment based on the Explanatory Model used as a framework to link them with these steps, that Practitioner Wong identified that formed the basis of how the primary assessment is conducted:- 1) inquiring 2) forming a differential diagnosis, 3) differentiation of syndromes, 4) differentiation of specific syndromes and 5) the derivation of diagnosis.

6.4.1 Step 1). Inquiring

The first step in inquiring is to understand the aetiology and the onset of the illness through the process known as Ba Gang and Sizhen. In this step the practitioner is placing the array of context described to him into signs and symptoms that fit his understanding of TCM theory. This includes filtering perceptions through cultural screens to be able to process the information into the terminology that attaches meaning to these symptoms described.

Janet had symptoms of cold for over one year and had come to the TCM clinic for treatment of her breathlessness and coldness of the extremities of her hands and feet.

The practitioner asked questions integral to the process of assessing Janet's current condition and Janet's past history is described. The practitioner exploration identified the chief complaint through symptoms present in the client's current illness. The client's past history was also evaluated followed by pulse and tongue diagnosis. A differential diagnosis of Zang Fu organs and diagnosis was based on explanation of the Five Element theory and the flow of Qi throughout the meridian network. Thus the critical distinction here is the move from what has previously described as a biomedical condition in now translated into the phenomena of a cultural construction of an illness in TCM terms.

(1) The Aetiology – the chief complaint

As the practitioner continues to endorse from the symptoms what he perceives into TCM terminology, he attends to underpin what is known as the 'chief complaint'. From the understanding I have, the investigation by the practitioner is processed from

information based on observation previously made at the Hanyu clinic these are tacit rules that guide the process of listening, smelling and inquiring through what is referred to as the four methods or '*Sizhen*' (Enquin, 1988, Farquar, 1994; Lu, 1994). How these methods contribute to an explanation of the causation, location of a disease and Qi imbalance is through the formation of a collectively summarised symptoms of the illness, known as *Zheng* from which a categorisation of these collective symptoms are then formed into a syndrome, '*Zheng*'.

Janet's symptoms which were explained to the practitioner were described by him as:

She has breathlessness, difficulty breathing and palpitations, dizziness, requires oxygen, medications for hypotension. She always felt cold inside and she preferred to drink hot fluids.

Other symptoms included poor appetite. On inspection the practitioner noticed she had abdominal distension and also an oedema of her ankles. His observations are based on visual acuity and his knowledge of TCM theory rather than any laboratory investigation. They are also filtered through explicit cultural semantic references to folk terms used to analyse the illness [described as Domain 4.9] before it is structured into TCM metaphor and theory. Chapter Eight provides an extended analysis of metaphor in the interconnections made between the theory and the language of TCM, with specific reference made to the interaction.

(2) Time and cause of symptom onset – The second question

To determine when Janet's problem first arose, in order to identify the time and course of onset of the illness, the client had informed the practitioner she had previously been physically fit with no undue stressors in life. Janet informed the practitioner that she became sick one year ago with a cold that lasted for 10 days. During this time she experienced chills, fever and noticed her muscles were sore. During this time she suffered from a headache, which after ten days became worse and began to experience shortness of breath, Janet then collapsed and was admitted to hospital and diagnosed with pneumonia.

(3) Pathophysiology – The third question

The next step involved the practitioner distinguishing the pathophysiology that Janet presented from her narrative on her past events to the present stage of her illness. Janet told Practitioner Wong, she had previously visited a Western medical practitioner and from a diagnosis of a chest x ray, she was informed she had intra-peritoneal fluid and had an enlarged heart with fluid on the right side of her chest at the time of her collapse. After the hospitalisation her condition improved but her physical constitution remained weak. Towards the end of the year she said she had been admitted once again to hospital with a viral infection. After her second hospitalisation she decided to visit a practitioner of Chinese medicine. When she attended the Yin Min clinic, Wong observed that her main symptoms were cold feet and hands, abdominal distension and cyanosis of the face around her mouth and lips. He then went through the stages of his examination and examined her tongue and then took her pulse.

- On examination the tongue proper diagnosis showed slight red colour and a slight white coating. The tongue was moist and pale with blue spots at the end.
- The pulse – the sensation of the pulse felt was deep, weak and hesitant.

How the possible causes for the illness are identified is found through their link to six exogenous factors or the 'Six Forms of Qi'. Under normal circumstances the six forms of Qi do not cause pathological changes in the body. All six forms of wind, cold, summer, heat, damp and dryness/fire that affect the body invade from the exterior to the interior via the portals of the body such as the skin, mouth, and nose, similarly as in Western medicine. Another term that is used in understanding and deriving a diagnosis is that of seasonal disturbance. Wong referred to it this way:

Janet's illness occurred in October, during the spring season. The Qi predominant in spring relates to understanding the elements of nature that affect her illness.

Wong's differentiation of external Qi was based on the four seasons, which he now explained to me:

‘Wind’ is the predominant Qi of Spring therefore the body may be easily invaded, especially after work when the body is perspiring or when sleeping.

‘Cold’ is the predominant Qi of the winter, but if the body is perspiring and exposed to cold without adequate clothing, this can give rise to the invasion of the pathogenic cold.

(4) The course of the illness – The fourth question

How serious the illness is can be related once again to what TCM considers to be pathogenic factors, I wondered how one can distinguish whether the condition is acute, chronic or if there is impairment based on this notion of pathogen. Wong put it like this to explain how Janet’s illness had progressed:

Janet’s course of the illness [is] as a result of the invasion of the body by wind and cold. Wind cold is a yin pathogenic factor it debilitates the Yang Qi of the body and thereby retards the yang warming function of the body. Janet experienced cold limbs and cold pain in the abdominal region caused by stagnation of Qi and blood.

The pathogenic Qi comes into conflict with the anti-pathogenic Qi resulting in the disharmony of the yin and yang balance of the body. In turn this causes disturbance to the Zang Fu organs and meridians, derangement of Qi and blood and an abnormal ascending and descending function of Qi.

This is said to be a situation of a hyperactivity of the pathogenic Qi that has caused a ‘syndrome of excess type’. It is called a “disharmonial function activity of Qi” (Enquin, 1988a, p.174). Deficiency of Qi can be identified in disease resulted from a prolonged weakness of body constitution, poor function of the Zhang Fu organ and deficiency of Qi blood and body fluid. Wong explained the lungs are the regulators of the life force – Qi:

The cycle of energy begins in the lungs, governing Qi and interacts with the heart in maintaining the rhythm of the pulmonary and cellular respiration. The lungs are responsible for making the energy descend and for distributing the Qi to all parts of the body.

The lungs function to transmit air to and from the body and as part of the function to be open to the external environment, are subject to attack from pathogenic factors.

Wong now provided a discernment to elaborate on how he differentiated the pathogenic factors attacking the body and described these links made between lungs and heart and the heart and spleen:

i. Lungs and heart – during the development of febrile diseases the pathogenic factors in the lung may invade the heart directly and described like this:

An invasion of the pericardium of pathogenic factors through contrary pathway, by the connection between heart and the lungs.

ii. Heart and Spleen – pathologically the heart and spleen often affect each other. The deficiency of the blood source due to deficient spleen Qi may result in consumption of heart blood, the heart dominates the blood and the spleen controls the blood. Wong said:

Long term illnesses diminish spleen Qi causing dysfunction of the heart propelling force of the Yang Qi leading to deficiency of spleen Qi. The spleen depends on the controlling force of the Yang Qi to fulfil its role of transportation and transformation.

The formation of Qi that governs the flow of the heart blood relies on the normal function of the spleen and in TCM. In TCM the main functions of the spleen are to transport, distribute and transform nutrients and to promote the metabolism of water.

6.4.2 Step 2). Forming a differential diagnosis

The practitioner then formed a differential diagnosis through the identification of key elements that guide the final diagnosis that he makes based on a differential diagnosis. When asked how he based this differential diagnosis on the assessment of the symptoms expressed by Janet, he described that these four elements were possible attributions to her illness:-

1. Deficient Heart Yang Qi.

Deficient Xin Qi, deprives the blood of warmth and gives rise to retardation of blood circulation. The symptoms that relate to this deficiency from the case history are described as;

Janet is experiencing chills, cold limbs, cyanosis of lips and dark purplish tongue.

2. Invasion of the Lung by Wind Cold.

When invasion of the lung by wind cold occurs it affects the lung in its function of dispersing and descending. Since the lung is related to the body surface, the skin:

The wind cold has the effect of causing a disharmony of *Yin Qi* and *Wei Qi* therefore Janet experiences the sensation of feeling chills, of having a fever and an aching body.

3. Deficiency of Qi of the Lung

Deficient Fei Qi gives rise to cold limbs, blue complexion, pale tongue with thin coating, a weak pulse of deficiency type.

4. Deficiency of Spleen Yang Qi

Deficient Pi Qi may be due to an initial dysfunction where heart blood is consumed and spleen Qi weakened.

Janet appears to be very pale and has experienced a coldness of her limbs.

6.4.3 Step 3). Differentiation of a Syndrome

This is how a differential diagnosis is now conducted from each stage of the assessment made so far, from which a differentiation is now made of the syndrome carried out in accordance to the Meridian Theory. Wong went on to say;

Initially pathogenic wind cold has invaded Janet's body through the Taiyin meridian of the hand. In the primary stage there is obstruction of the Wei Yang from dispersing Qi resulting in fever and chills. In the secondary stage affecting the Shaoyin Meridian of the hand, pathological changes of the heart and kidney are experienced.

When the hand Shaoyin meridian is affected there is systematic weakness, as evident in Janet's situation as she has had exposure to cold for ten days. This is attributed to what the practitioner explained as the following;

Hypofunction of the heart and spleen occurs which manifests as a deficiency of yang leading to excess of yin. Cold is a pathogenic factor that consumes the Yang Qi of the body.

From this explanation of the identifying features of the illness the practitioner is then able to make a differential diagnosis based on the pathological changes viewed from TCM theory.

6.4.4 Step 4). Differentiation of Specific Syndromes

Differentiation of specific syndromes in TCM is an essential part of the analysis and forms a categorization of the different pathological changes of Qi and blood into syndromes (Xinnong, 1987). Wong described these four types of syndromes:

1. syndrome of deficiency of Qi
2. a syndrome of sinking Qi
3. a syndrome of stagnation of Qi when it does not flow
4. a syndrome of perversion of Qi when it is twisted

This differentiation of Qi dysfunction forms the pathological basis for the wellbeing of the organs. Qi flows via the twelve meridian pathways throughout the body and interconnects with each Zang Fu organ. It is the function of the Qi to promote growth and development in the body, to govern the physiological activity of the blood and to disperse body fluids. This function is governed by Ying Qi that circulates in the blood vessels and is a constituent of blood. Other functions relate to the maintenance of body warmth, to defend the body against pathogens and to provide nourishment (Xinnong, 1987). From the perspectives of the practitioner's, diagnosis is constructed through a primary assessment and secondary assessment:

The primary assessment – identified that Janet has wind cold initial invasion attacking lung Qi that affects the heart yang Qi and causes blood stagnation.

The secondary assessment – determined Janet has Spleen Yang Qi deficiency

6.4.5 Step 5) Derivation of the diagnosis

This is based on the differentiation of dysfunction in the five elements. It involves determining the primary and secondary organs of involvement in the disease process which the practitioner described as:

- **Primary** – ‘Pathogenic Wind Cold attacking the Lung Qi’ counteracting to the heart producing damage to yang Qi and blood stagnation.

- **Secondary** – ‘Spleen Yang deficiency due to damage of the heart’s inter-promoting function to the spleen’.

(5) The treatment - The fifth question

Here the practitioner explained the course of the therapy. A correct therapeutic method considers the differential diagnosis of symptoms and signs or ‘*Shi Zeng*’ (Enquin, 1988). The description provided from the case analysis derives from the philosophy of a practitioner is grounded in the traditional philosophical practice of TCM and will be referred to again when consideration is made on the interventions based on either herbal medicine, acupuncture or a combination of these methods. Janet’s case analysis identifies the process of diagnostic consideration. The interaction between Zang and Fu organs provides a complex system of interaction in the diagnosis not found in Western medicine. To reiterate this, Wong said;

The yin and yang and five elements all of these are basic theory in Chinese medicine. Also that theory is thousands of years old – they give direction for [my] treatment and diagnosis.

The traditional diagnosis and differentiation was based on the information given and then related to the five elements and the interactions with the corresponding organs of the body. The chief complaint of breathlessness for one year accompanied by coldness of the extremities (hands and feet) is referred to in the differentiation of Qi in the Zang Fu organ system. On the basis of his assessment a documentary record is made that covered the complete psycho-social history of the person assessed. This included the personal history, inspection of the appearance of the individual, their bodily functions, appetite, pulse palpation and a full investigation of the client’s specific problem. Enquin (1988c) suggests that TCM approaches this form of a holistic assessment by;

...taking the body as a whole in observing diseases has two implications on the one hand, the human body should be taken as an organic whole whilst special attention is paid to the interrelation and interaction between local pathological change and the maladjustment of the whole body... (1988c, p. 10).

Notions that underpin a holistic approach to assessment are elaborated on in the analysis of the case study in Chapter Eight.

6.5 Summary

These clinical accounts provided by the two practitioners Zeng and Wong, with a short contribution made by the herbalist Rosli provide an understanding on the steps applied by the TCM practitioners of how their approach towards the construction of illness is taken in TCM. Analysis of how an illness is culturally described is found in the exploration of the case study related to the syndrome of 'wind cold'. The explanatory model provided a framework on which the method of diagnostic tradition in TCM is revealed. Through the translation of signs and symptoms of health and illness made by the practitioner a diagnosis is formed. The reality of the illness experience is examined through the mechanical constructs of Sizhen that formed the diagnosis and through which the narrative is explained through the theory of TCM.

Analysis of the stages of the assessment were examined to show how links are made through the steps of the assessment found in the interrelation and interaction that exist between pathological changes seen as a maladjustment of the body in response to the flow of Qi. Through the interactive process with the client, the practitioner formed a link between the client's narrative to that of the symbolic language (Kirmayer, 2004) of the Five Element theory and Yin Yang drawn from the theory of TCM that are found embedded in the process of Sizhen and Ba Gang, to inform the diagnosis of the somatic aspect of the client's illness (Connelly, 1979; Dew, 2006; Farquar, 1994; Ferigno & Wang, 2000; Hsu, 2001; Kirmayer, 2004; Ross, 1985; Yu, 2003; Zhang 2007) in Chapter Eight. In Chapter Seven, I examine TCM from the perspective of the client on the treatment of TCM.

CHAPTER SEVEN

Client Perspectives of their Clinical Encounter

Professional socialisation of modern health professionals causes them to regard their own notions as rational and to consider those of patients, the lay public and other professional and folk practitioners as irrational and unscientific
(Kleinman, 1981, p. 56).

7.0 Introduction

This chapter examines the client perceptions of their TCM encounter. It seeks to understand why clients who sought TCM treatment for the first time had chosen this type of medicine. My research intent was to interview clients treated by TCM for the first time and to examine how clients perceived the practitioner response to their illness and if there were elements of that encounter they considered were not beneficial. Often during the interview clients provided unsolicited comparisons between TCM treatment and their experience with the conventional medical system. These comparisons can prove useful in drawing conclusions about the relative merit of the two systems as seen through the eyes of client's. The observations made and interview data recorded, formed the basis for a domain analysis which identifies the responses of a mixed group of male and female informants. Seven domains were identified: 1) side effects attributed to

pharmacological use; 2) experiences with conventional medicine; 3) the clinical encounter of TCM; 4) personalisation of the TCM interaction; 5) the individualised treatment of TCM; 6) effects of TCM therapy; 7) client concerns about TCM. An example of how the interviewing took place is provided below. Thus, in the case of reasons for using TCM, several questions were put to each client at the time of the interview that began with;

‘Why have you attended a complementary health practice?’

This was followed up with questions designed to elicit any contrasts they saw between TCM and conventional medicine. These questions were:

‘In what way does the care differ to that of western medical practice?’

‘What benefit (if any) do you feel you have derived from the therapy?’

The interview then focused on a more specific exploration of what benefits they had obtained from TCM, if they communicated this to their doctors and how they viewed the clinic and practitioner. Examples of questions were:

‘Is there any dimension of the health care that you find satisfying?’

‘Can you describe how?’

‘How do you take responsibility to maintain your health?’

‘Are you currently receiving any western medical care?’

‘Have you discussed with your doctor that you are receiving TCM

‘Tell me how you were referred to this clinic and how you found this practitioner?’

Domains helped to reveal characteristics unique to the system of TCM health provision as perceived by these clients and what they considered to be a beneficial impact on their wellbeing following the use of TCM therapeutics. A more detailed discussion of these seven domains is now provided.

7.1 Main reason for TCM use

An initial response revealed clients chose to access TCM was what they perceived to be the various inadequacies arising from their encounters with Western medical practitioners. All six clients interviewed expressed what they felt as dissatisfaction with conventional medicine and the negative effect of prescribed medication use

that had led them to seek out an alternative form of care through TCM. It might be argued TCM was sought to enhance their health or assist with the recovery from of an illness, which others have considered to be the persuasive appeal of alternate medicine (Coulter & Willis, 2004; Kaptchuk, 1998). However, this could be suggestive of general consumer patterns that reflect sociological trends in use rather than of any bias towards a form of care that is borne out of dissatisfaction with conventional health care (Astin, 1998; Baer, 2005; Barnes et al., 2002; Siahpush, 1999a).

Client's responses to their use of conventional medicine, which they referred to as negative side effects, included a range of side effects from allergic responses to an exacerbation of the symptoms of conditions being treated. An allergic response to the medication prescribed by her doctor was described by (B2) in the following was:

B2. I'm so allergic to all sorts of medication that they gave me, because I've got a health problem myself with lupus ever since I got married in 1963. And then nobody could help me except by giving me cortisone. And I, because I've got a nursing background, I don't like cortisone and I can see what damage it can do. So I turned to alternatives to find something better than the prescribed medicine by the doctors.

Another informant mentioned two factors that had led her to choose alternate health care. The first was a perceived lack of efficacy of the prescribed medication for the relief of chronic pain;

B 4.I kept getting refluxes, you know like I used to get the pain up here on the right hand side, it used to go from here under my ribs, up my shoulder blade like that and so I went to the doctor at Vic Park and he said 'well you know you may have gall bladder trouble, you may have that and it may have to come out' so they had an ultrasound on my liver and gall bladder. Well I have a fatty liver.

The client was reluctant to admit the need for other investigations as she had begun to lose trust in conventional medical procedures. Second, she attributed unpleasant side effects when her blood pressure increased to the Western medication.

B4.The blood pressure went up. It was two hundred and something over ninety-five, something like that. This arm just sort of dead ached, like a toothache. The whole arm dead ached all

day. I really wasn't sleeping well, I wasn't feeling well, and so that's why I really went to the [TCM] doctor.

Another client commented on what he felt was the inadequacy of the medication, as he felt worse after using them:

A3. Because I've told him before, I can't take these medications and yet there are lots of different types you can try. I've tried lots of them and nothing suits me, makes me sick and stressed and headaches and dizziness, you know. I mean you can't put up with this sort of thing.

This client (B6) stated she felt she had not been involved in the consultative process on the choice of cardiac medications and that the medications she used made her feel sick and she experienced shortness of breath. The client said she felt she could no longer take them due to these side effects.

B6. The last interview was with my heart specialist because I had a heart attack a few years ago. And he prescribed all sorts of things to slow the heart down. They made me so sick and I couldn't touch them, couldn't even dress myself without huffing and puffing and all sorts of things. Quite dreadful! So I gave it all up.

Client (A5) had been taking long term prescribed medication and found that he was developing side effects from their use. He also felt that his illness had ill defined symptoms, he had some problem with his liver, and that these issues were not being attended to by his regular physician who continued to prescribe anti-inflammatory medication over a nine year period.

A5. I've been on anti-inflammatory drugs for 9 years. Last year I started to develop some problems with my liver but then I started to take 'Pepcidine' about 2 years ago because it was giving my insides a hard time. And probably some of the later model anti-inflammatory drugs, are not supposed to affect the stomach (and they did) would take me another week to alleviate the effects of stopping when they caused problems to the point of becoming terrified of stopping them despite the side effects they had.

As a result of taking these medications over an extended period of time, he experienced unpleasant side effects and anxiety when he ceased taking them.

Client A1 had a chronic condition for which he was prescribed Naprosyn by his general practitioner and thereafter he experienced gastric reflux, pain and headaches. He described how his pain levels increased;

A1. In January my legs were aching again. I was taking Naprosyn 1 gram per day. Then after leaving off I used to get terrible headaches. If I stopped taking the Naprosyn for more than 2 days I just literally locked up completely and then I'd start to fall apart and as I started to fall apart I'd just be in a huge amount of pain, my arms, legs, hands, ankles and feet. Everything would start aching tremendously.

Negative experiences attributed to the use of prescribed medications and the unpleasant side effects, was a major reason in deciding to access non-conventional medicine and also the notion of relief from chronic pain that was not addressed by conventional medicine. Other issues on the general experience of conventional medicine that these clients were concerned with had prompted consideration towards TCM as a health options are now discussed in detail.

7.2 Experience with conventional medicine

Clients expressed a more general concern about their experiences of conventional medicine, pointing particularly to the corporate control of health, its link to technology and the disempowering effects of such control on their ability to assume responsibility for their own care. Factors clients identified with as sources of concern for them were: corporate health linked with technology, disempowerment which disabled them from assuming self responsibility and self care in improved quality of health (Epp, 1990).

7.2.1 Corporate health care

Reporting on why they had attended a complementary health practice, several clients commented they felt the focus of Western medicine had altered, with smaller GP clinics often being incorporated into larger corporate health system and that the provision of medical services had become an industry that was now engineered toward profit. What concerned them the most was the corporatised

medicine exacerbated the growing impersonal approach taken by Western medical practitioners in their dealings with clients where the emphasis was on making money for the practice and an over emphasis on pathology investigations. Two male clients felt this was governed by the concern among doctors of the possibility of accusations of malpractice, which led them to be overly cautious in their practice and their greater reliance on laboratory investigations to confirm diagnosis of particular conditions.

For example, client A1 commented:

A1. How many alternate practitioners, acupuncturists Chinese doctors etc. ... how many of them are refusing business? It's like this western capitalist dollar versus truly wanting to cure people. It's disgusting but that's the way it is.

From another perspective of 'cure and fix', perceived to be an aspect of biomedicine, client A5 illustrated how doctors were focused on the monetary aspect of the service:

A5. The Chinese doctor would be happy [for their clients] if you could fix yourself. Whereas a western doctor would feel, oh they need me to cure (them). Preventions better than cure! I mean, I wonder how ... we would be in a lot better state if they [western doctors] were paid to keep us healthy enough.

The way I see it doctors are going on strike and not operating because of their insurance premiums ...because doctors are getting sued. If the doctor wasn't centred on the dollar then, why does this become an issue? They should be out there doing their job to the best of their ability. Why would getting sued be entering their heads? Their not prepared to take people in case they make a mistake and get sued. And I don't think that's the way to work.

These clients contrasted the profit oriented approach in Western medicine with the approach taken in TCM. TCM was seen as being there to help and to heal people and little mention was made of money. However, their views ignored the fact that clients pay handsomely for herbs in a situation where there was often no direct reimbursement, unlike that of bulkbilling in a medical practice.

In contrast to the two examples above, clients recognised that TCM also functioned for profit and had to be run as a business, but that what was of greater importance

to them was they felt they had paid for a valued service to access a health care alternative of their choice. Clients with private medical coverage were later subsidised, but for those without private coverage, accessing TCM was expensive and probably restricted the range of persons able to seek out TCM support. For example this client said:

B4. There are Medicare rebates but ... only on his visits... you can get a medical rebate on the visit... not on the herbs.

Private health insurance offers rebates for the service of the consultation, but not for the herbs in her situation. People who had private cover were able to continue with the treatments over time but for others the cost of herbs became a prohibitive factor.

Another client (A3) referred to doctors he knew who had established waiting lists for new patients, had turned some away telling them they would be contacted when a vacancy existed. The client interpreted this as a device to reduce threats of malpractice. He went on to say:

A3. And they are refusing treatment of people because they don't want to get sued because it will come out of their pockets and their insurance companies and it's just wrong. And they've taken an oath to help those people ... okay they took an oath to help you ... but hey they [the patient receiving Western medicine] might sue me so I'm not prepared to help you now ... it's just incredulous.

I think if the dollar factor were taken out of it ... the problem wouldn't be there.

His comments revealed that whilst he was disgruntled with western medicine it may also be considered atypical. It is known that medical practitioners have high insurance premiums to cover for malpractice. The point not justified from his stance towards Western doctors was that new patients were possibly not taken by doctors who had over subscribed practices and who were being accountable by their refusal to take further referrals.

Corporate profit, waiting lists for services informed these clients who failed to see that CAM and TCM practitioners were also profit oriented as they also are required to cover expenses to make a profitable living from their service. An

attraction of TCM was the availability of the practitioner and the opportunity to access a health service of their choice.

7.2.2 Technology

Clients also expressed concern that western medicine had become too technological, that this was linked to their perceptions that doctors gave less attention to personal understanding and support and that consultation times were subsequently reduced. For example, one client commented on the difference in the underlying philosophy of the two medical systems and what he considered the technocratic Western approach;

A5. With technology then and this form of medicine (TCM) there is a bit of a difference in that one's based on the natural world, the other is based on the scientific world. The scientific world has too much artificial technology. The production of chemicals and things to make chemical compounds to combat the naturally occurring sickness it doesn't make sense to me.

Other clients considered that the technology and, computerisation in Western were intrusive factors which created a barrier between the person and the practitioner. One client compared the new system with what she considered the older medical style practice where she felt she had been listened to:

B2. I think that probably that for the younger doctors the technology is an advantage, but to the older doctors, their old way is very satisfactory. We had a family doctor at the 'Parkview' medical centre who when you went to see her was like 'sit down, tell me what's wrong and you went through a thorough check out. She was very busy but still gave you time, but now when you come over here to see the doctors, its like they'd sit back and its hmm, hmm, they're just writing in their notes on the computer and then just give you 'hmm', 'hmm'.

In this client's case her frustration was compounded by her GP's failure to solve her problems and so she had sought help elsewhere;

B2. We [(B2) and her husband] don't have a lot of confidence in western doctors, because we haven't had much result from them. But we take a lot of alternative medicines and find that we get more satisfaction than we do from going to a doctor. The doctor is really our last resort.

The comment illustrates how people can approach the general practitioner as ‘... our last resort’ and to try different alternate approaches towards their health care. When asked why she did not have confidence in Western doctors, she stated:

B2. Well basically because they don’t seem to be very interested in what you’re saying to them. It’s not easy to just ring up and say that you’re sick you need to see your doctor, where you can’t see your doctor, would you like to see another one?

And to add to the confusion when I went to get a repeat of my prescription ...when I got home I had a totally different script for a totally different person. You know because they haven’t even got the computer down pat so that it works for them.

The above comment suggests that the increasing use of technology and the declining continuity of treatment are linked. Patients who see their doctor or practitioner over a period of time form a therapeutic relationship with the practitioner built on trust and collaboration that is engendered through effective communication. Trust is a factor that facilitates the diagnostic process and positive health outcomes and is built over time (Hudson-Jones, 1999; Kaplan et al., 1995; Kaplan et al., 1996; Mattingly, 1998; Murphy, 2001; Thom & Campbell, 1997). Part of that trust involves talking directly and literally face to face with the doctor.

Client (B4) stated that while her doctor had talked to her, he had not looked at her directly, but instead focused mainly on the computer. Another client referred to the general business management of medical practices which had become corporative and increasingly depersonalised. The client expressed her disapproval of a medical practice with large numbers of doctors which resulted in a decline in personal contact.

B4. Yes, all the doctors from this area have now gone to the E... V.. P... And right there are so many doctors there. And I believe that the interest in my personal wellbeing is not there.

These comments related more widely to studies which show that having continuity of care through a ‘usual’ doctor who attends to a patient is important in developing trust during the clinical encounter and this rapport established through regular communication had declined (Thom & Campbell, 1997). My own research

suggests that a lack of interaction in communication and a personal involvement was a central factor in shaping client decisions to seek out alternate health care.

Client (B6) was a business woman, who had frequently traveled overseas on trips with her husband and had made several visits to London to a Harley Street heart surgeon expecting to get his expert opinion and advice. She explained that she had travelled thousands of miles to get there:

B6. You go over there and see him and he would hover over there and listen to your heart, you undress and hop onto the couch and he doesn't talk to you but listens to your heart.

Describing her cardiologist, she felt there was a lack of rapport when talking to him, saying,

I have a heart specialist; who you would think has a stone face.

To B6, the specialist was not supportive of her involvement when she offered information to him on what she was experiencing. She perceived her specialist's inability to interact with her with his focus directed onto his blood pressure equipment in the consultation, was a key reason she eventually sought out a practitioner of TCM. However, she recognised that 'doctors cannot fix everything' and that there are personality factors which shape clinical encounters (Kubacki, 2003) regardless of the practitioner's medical specialisation. One client complained about reliance on the use of pharmacology, technology and repeat hospitalisation;

A1. It solved the symptoms I had but it wasn't solving the problem. That was the headache I had and it was creating more problems by trying to fix it with a pill. I grew up very unhealthy. I spent as much time in hospital as out of it. Over the last seven years, [since taking herbs] I wiped my dependency on medical practitioners.

Another client (A5) insisted that conventional practitioners rely too heavily on technology and have a negative mindset towards alternative health practitioners;

A5. Oh yes, we've got a microscope so we know what's going on, whereas 'those guys' [practitioners of TCM] don't have a microscope and don't know what's going on. They work in primitive conditions [that are unassisted by modern technology].

These comments provide support to the argument that conventional practitioners with a background in biomedicine, rely more heavily on the regime of laboratory testing and scientific scrutiny. It has been argued that healing an illness is not always based on the application of physical based scientific knowledge (Agdal, 2005; Baer, 2005; Friedson, 1970; Germov, 1998; Kirmayer, 2004; Willis, 1989) but requires greater focus on the way the person experiences the illness and an emphasis on the client's narrative account of those experiences (Bensing et al, 2003; Kleinman, 1988; Montgomery-Hunter, 1991; Napoles-Springer, 2005). However the distinction between a technologised conventional medicine and a narrative focused non-conventional medicine can be found in the approaches taken in the investigation and interpretation of how an illness is diagnosed.

In TCM the focus is found to be derived from the interaction 'Kanbing', from the way the person describes the illness experience and explored through the analytical process that evaluates the narrative. TCM diagnostic techniques of 'Sizhen' and 'Ba Gang' evaluate the pathology of the symptoms to form from symptoms a categorisation of a specific syndrome. It can be said that the practitioner of TCM is less dependent on technology, and relies more on observational skills and the narration accounts of clients than on technology. This requires further investigation in particular more detailed ethnographic research on client centred approaches throughout conventional and non-conventional health practices.

7.2.3 Disempowerment

Several clients expressed their concerns that conventional medicine was both depersonalised and disempowering in the sense they felt they had not played an active role in the clinical encounter. While the use of technology can be advantageous in providing rapid results that communicate changing perspectives of a patient's condition, the converse can be that it alienates the patient where attention is paid to the efficiency of service with less attention paid on the personal interaction. It can occur where the person feels their views have not been attended to over technological mediation of their condition and was expressed by several clients who felt the encounter with conventional medicine did not process according to how they perceived it should. For example (B2) said:

B2. Oh well, blood pressure! Take a tablet! That's not the answer in my opinion!

My opinion is why I have got it in the first place?

I know why I got it in the first place, because I'm overweight. And I know that we have a history of being overweight in our family right back from my grandmother.

We have all followed in the genes of our grandmother, who never ate fast foods. Who cooked all her own meals [without purchasing processed foods] and who grew all her own vegies in their garden! We have a history of obesity right back from there, you know, which has followed on through our entire family.

This client thought the doctor should tell her more about her condition during the encounter. Instead, she was told to take a tablet with little explanation other than was in the found in the packaging that supplied consumer advice on adverse affects of this medication. In her view this amounted to neglecting the genetic component of the high blood pressure and the fact that it remained elevated despite her best efforts through attention to diet and exercise. B6 described her lack of rapport and disappointment with her London specialist after journeying from Australia to be attended by him. She remarked;

B6. The other thing he might say is 'Oh, it [her heart] still sounds the same as last time'. And what I thought was he's seen hundreds of customers since he last saw me how could he have remembered what my heart sounded like? Well you wonder!

To (B6) such treatment amounted to a failure to be listened to when she asked questions, put more broadly, she considered the treatment as a failure to meet normative benchmarks, leaving the patient feeling uncared for (Li, 2006). B6 told me that she had actually felt worse after the encounter with her specialist.

B6. Talking about this heart specialist, one day I had this pain I said to him because I did not know what was happening. All this ... every now and then I would get this sharp pain. I said why do I get this sharp pain?

Did you know what he answered me? He said, 'why do people get headaches'? I was so depressed after that I thought to

myself this is not on. That man thinks I'm neurotic - maybe by having this pain! I was feeling heavy and more depressed.

The client sought both reassurance and an explanation for her pain but was met with a perfunctory response. A possible added dimension to B6's experience was her Anglo-Indian background and the sense she was being spoken down to (Blanchard & Lurie, 2004). Several studies emphasise that a successful therapeutic encounter between the patient and doctor is founded upon a relationship that incorporates trust. Other studies have argued that a successful therapeutic encounter between the patient and doctor is founded upon a therapeutic relationship that incorporates a number of elements of these being trust (Keating et al., 2004) empathy and a respectful encounter with the patient (Bendapudi et al., 2006; Li, 2006). The patient is in an unequal and vulnerable relationship with her doctor and for clients in this study, they wanted an opportunity to be heard.

The healing context that is part of the professional socialisation in Western medicine does not attach as great an importance onto the transactions between the expression of the narrative informed by the client as does traditional medicine (Kleinman, 1981). For example, this male client referred to his doctor saying; 'Well, basically they don't seem to be interested in what you're saying to them' (A5). Another client (B4) offered this generalised view about Western medical practice:

B4. Yes, well they're not writing a script, they're just writing in their notes and then just give you um, you know like, take your blood pressure and the blood pressure thing doesn't fit properly. And I think it isn't good enough, it isn't good enough.

The expression of her dissatisfaction was attached to what she felt had been not listened to her. However this client qualified her view when speaking of her husband's treatment.

B4. She [the doctor] explained to Colin what cholesterol was all about and why it was there. Well [the doctor] she was very good. She just put different views through and she gave him the time and with me. Before she would write out the prescriptions she thoroughly went through what I was and what I wasn't.

The client's comment points to the conventional doctor who in this context had not provided time in the consultation on a particular problem. Others criticised organisational pressure to get patients treated as quickly as possible. B2 offered this insight:

B2. The pressure of time that doctors operated under to see their patients ensure that scripts were written up and given out to their patients was limiting.

There was little time for any feedback in response to our questions.

These comments find support in work on other conventional practices where the practice manager ensures the doctor gets through a maximum number of patients in a minimal time frame (Eastwood, 2000a; RCCM, 2003; Salgo, 2006). In the RCCM study, it was the chance to spend longer with the doctor that led to patients' choice to seek complementary medicine. The amount of time allowed in consultation was given as a reason for choosing complementary medicine especially when the problem was chronic and patients had the time to be able to express their symptoms to their practitioner (RCCM, 2003). Several clients suggested that in conventional medical practices, time is restricted to a brief interchange, provided there are no disruptions from phone calls or other distractions, before a prescription or a referral for a laboratory test are written and given to the patient;

A1. Western medicine (practitioners) takes tests – they go by the tests. So they don't go by ...they don't talk to the person! They take liver function tests if you're complaining of whatever.

As referred to earlier, not all clients interviewed were dismissive of conventional medical practice. Some considered that when they visited their 'family doctor' with whom they were familiar there was adequate personal support. These were general practitioners who practised independently or with one or two others in the community and who were not in corporate based medical practices. This suggests that an important factor in client satisfaction is the continuity of treatment in a familiar environment, such as that provided by family doctors in the past. Thus, one client said:

Western medical doctors in corporate health practices had become more remote from the clients and unlike TCM, did not provide a supportive environment (A5).

Charles et al., (1997) have argued that among the key factors shaping an effective clinical encounter that the doctor and patient must share information and reach consensus on what should be preferred treatment. Several studies have also commented on the importance of the allocation of sufficient time during a consultation and that doctor's value what the clients had to contribute to their own assessment (Bensing et al., 2003; Brown, 1995; Donnelly, 1997; Hudson-Jones, 1999).

7.2.4 Self Responsibility in medical care

Clients emphasized the importance of self responsibility in seeking medical advice, and suggested that many people did not have the knowledge to see beyond conventional medical support. Clients expressed this in different ways and two male informants referred to socialisation into accepting Western medical systems and practices. One related this to the socialisation of people from an early age to visit a doctor if became sick.

A5. I think through no fault of their own [people's] they're very limited from the point of view that whilst ever people are sick they go to a doctor. Throughout their childhood this is instilled into them. So whilst ultimately they have total autonomy in their decision-making their upbringing and their surroundings don't really allow it. They are not prepared for the unknown, stopping them from going to an alternate medical practitioner or a naturopath of whatever they like.

The other client had experienced ill health as a child and had drifted from conventional medicine to non-conventional health practices. His negative comments were directed at conventional care which he thought focused pharmacy based chemicals produced through a laboratory. His comments pointed to conventional health care as being bio-technical with a focus on the chemical repair of a disease.

A5. For the first six years of my life I spent as much time inside of hospital as out of it. When you are sick that's what

you do ... go to hospital. The doctor is expected to know what's wrong and to fix us...we expect the doctor to be able to do it with some chemicals that someone in a laboratory created. I feel there are many expectations there. For our practitioner of medicine to tell us what is wrong. Over the last seven years I've [almost] wiped my dependency on medical practitioners – for the [remaining] 5%, I'll go to a doctor if I need a doctor's certificate.

What these clients saw as a pattern of behaviour instilled in people from birth, some researchers refer to people being socialised to have trust and respect for the 'expert advice' given by a medical practitioner (Blanchard & Lurie, 2004; Keating et al., 2004). If there is a problem, they expect the doctor to know what is wrong and to fix it. Another client (A1) said it was expected that the "doctor is educated to know what to do". Client B4 expressed how her concern over the doctor's control. She referred to:

B4. A terror of always having to rely on doctors to get that script with them in control of it and I never want to be controlled by a doctor.

This desire to not be controlled was expressed in different ways by clients. For example, assuming self-responsibility over health, with an emphasis on changing the concepts of health, lifestyle and managing symptoms of ill health was another mentioned by several. characteristic shared by all clients. A5 and A3 described how they viewed the clinical reality of the TCM treatment and said that they felt it was up to the individual and the emphasis of care should not be focused on expecting the practitioner to fix the problem.

A5. I think it is really up to your self mostly. Some people will only listen to their doctors, which I think is a bit stupid, because if the doctors can't fix you, you can't keep listening to them all the time, taking their treatment.

A3. You can't, you just have to look for an alternative. It's really up to yourself and if you feel the doctors not helping you why keep on going? So I really think it's up to the person.

Other clients referred to healthy lifestyle changes, with exercise and walking as ways of ensuring that maintaining one's health was as much an individual

responsibility as well as seeking alternate ways to improve their health. For example (B4) told me:

B4. I try to maintain a health diet ... I'm not as healthy as I need to be but I know I should be ... I know how healthy I should eat, I know I shouldn't be a recreational smoker all that sort of stuff ... I try to maintain a little bit of grip I don't want to do too much on my Dad's side of the family totally jam packed with heart disease and heart failure. I've gone and had the ECG, the testing of all the cholesterol readings and all that sort of stuff and I'm sure I'm not going to fall over and die. Reasonably healthy yes! Yes I think its up to myself to keep myself well in many ways, because the doctor can't be with you all the time, they can't feel how you feel, they don't know what to do with you from day to day, what you eat and what you do. So I think it's up to the individual to monitor him or her self.

Many clients who visited the clinic purchased over the counter herbs following a brief discussion with the herbalist for advice on self medication use of herbs for minor complaints such as headache, providing relief from colds, assisting with weight loss and other problems that might benefit from this use.

7.3 The clinical encounter of TCM

Clients' desires to have autonomy, to make decisions on what health care to choose. They saw change in how conventional medicine was practised, the impersonal nature of attention to the patient and the effect of technology on the consultation experience, these were important factors that shaped people's decision to access other forms of alternate health care. In addition clients were attracted to what they considered to be the observational skills of the TCM practitioner which contrasted with the pathology approach of conventional medicine.

The observational skills found in TCM, the tongue and pulse diagnosis provide an approach to the diagnostic process that is a unique form of observational pathology, the process of which explores signs and symptoms that are classified into syndromes in Chapter Six and Eight. This is illustrated by B4 from her comment about the inspection made by the TCM practitioner when he examined her tongue.

For this client, the tongue diagnosis was an important feature of the assessment encounter, in that the practitioner allowed the client to see the change herself:

B4. Show me your tongue, oh your tongue” but you could see it yourself, you know the coating that you have on your tongue. After you take the herbs you’ve got no coating.

This ‘see for your-self’ approach was central to the practitioner’s treatment that encouraged clients to make their own observations after taking the herbs. She noted:

B4.It does the whole colour of your tongue changes. So that’s just one thing you notice yourself.

This contrast between dependency on technology and the skills of visual observation of the TCM practitioner was also made by A3. It appears the actual physical face to face contact helped to make this client more confident of their treatment and he made this point:

A3. I find that the Chinese doctor, his diagnosis is a visual inspection and he’ll read the colour of your tongue ... and I mean the diagnosis when I first sat down in front of Zeng he looked at me and made notes for six or seven minutes. Just looked at me and made notes. Then he got me to poke my tongue out several times, observed my tongue and came to the conclusion for his diagnosis.

In contrast this client pointed out that his conventional doctor relied heavily on pharmaceutical preparations to treat his symptoms, saying:

A3. But it’s ... you know your Western doctor wants to know what he can get out of his Mims book (pharmacy).

This client (A3) went on to say explain that a Western doctor has dissected the body [when they study anatomy] and that Zhang who also has a background in Western medicine as well as TCM, had studied similarly. He commented:

A3. He’s done all of that in China as so have many other practitioners of TCM who have studied both Western and Chinese medicine.

At the beginning of the consultation, the TCM practitioner usually asked why the person had come to see them. This drew a variety of responses from the clients who told the practitioner they experienced ‘various conditions’ including what they

described as insomnia, depression, asthma, migraine, arthritis, diabetes, high blood pressure, infertility, diarrhoea and obesity. The ability of clients to attach a label to their symptoms (Kleinman, 1981) has been strengthened in recent years with the easy access to internet information on health and illness (Marcinkiewicz & Mahboobi, 2000).

7.3.1 Personalisation of the interaction

Clients considered they received a more personalised service from their TCM practitioner. However the extent to which this is intrinsic to TCM is debatable. It can be argued that given the small number of clients who visit a TCM practice (an average of ten consultations per day), there is adequate time to allow for more personalised interchanges and a patient centred approach to the consultation. In addition other studies suggest that both conventional and complementary medical practitioners subscribe to ideal interpersonal treatment within a patient centred approach, even if they cannot always provide it (Kaptchuk & Eisenberg, 1998).

Bendapundi et al., (2006) have shown that where personalised treatment is provided, as most common is in found in primary care, it nurtures the interchange of the interpersonal relationship and correlated with patient satisfaction and their wellbeing (Murphy, 2001). One client (A5) associated this with two factors time and attitude and commented:

A5. They [TCM practitioners] seem to have more time, they seem to have more care, and they listen. A [western] doctor seems a bit righteous in his own way.

Oh they [Western doctor] definitely don't want to explain things. The alternative medicine [practitioner] will, they will explain things totally. But the doctor will prescribe you a tablet and say well you take this, blah, blah blah. Half the time they don't realize they are just clutching at straws and say, 'Oh, that's going well at the moment, here's some medication for it'.

Clients considered that the quality of communication exchange on information during assessment and treatment in TCM made them feel they were being treated as a whole person rather than as a bearer of separate symptoms to be treated. They stated that the practitioner responded with interpretations of their illness experience

which made them feel they were being listened. The extra time given to them played an important role in client perceptions of their satisfaction with the clinical experience. Also there was greater continuity of treatment in that clients were more likely to see the same practitioner at each consultation rather than shifted about from doctor to doctor.

An aspect of TCM noted by clients was that TCM practitioners were less depersonalised than Western medical practitioners. Clients tended to see the same doctor on different visits compared with western practice where they were sometimes allocated to another doctor rather than the particular doctor they had seen earlier and in whom they had placed their trust. Developing a rapport with their doctor, respect for the individual and the attention paid to personal details are discussed here.

For example, B4 commented on this when she was unable to access her regular doctor.

B4. ...last time when I had to go and get my blood pressure tablets again, the doctor that I have been seeing wasn't there.

Basically because it's not easy to just ring up and say you're sick, you need to see your doctor, well you can't see your doctor, he's away. Would you like to see another one?

One client (A1) thought conventional doctors were not as respectful to clients as they should be and sometimes were complacent:

A1. Well I think the true feeling of the human being is not there as it used to be.

A1. I think sometimes the doctors do get a little bit of complacency about them, which I expect if you've got a problem then they are more thorough.

However, another client (B2) thought that if the problem was serious, then much greater attention was provided by the doctor. In the case of TCM, she stated her practitioner took notice of all ailments, including minor ones, and that she was able to talk with him freely on all matters:

B2. He's very good with you and you can ask him all sorts of questions. He will look inside your eyes and take the pulse.

There was qualified agreement among clients that the practitioner took into account more than their physical condition when making an assessment. For example, some were asked where they lived or worked and the significance of their family relationships and why they had sought out TCM. Importantly, the practitioner's attention was focused onto the client's particular illness, through the assessment procedure. (A5) said he thought the TCM practitioner took an interest in examining the appearance of the eyes and the tongue;

A5. The eyes and the colour of your tongue, mostly! They are more in touch with your body naturally.

This reference to being more natural was related to the almost complete absence in the practices studied of sophisticated technology in conducting an assessment. The only Western technology evident was the equipment used to monitor client's blood pressure something that was noted more favorably by some clients. For example, the client (A1) referred to the lack of technology use in the TCM practice, saying;

A1. The main difference is the simple diagnostic processes they carry out ...that would have to be the biggest main difference.

The following client (A3) also made a similar observation;

A3. The body actions give away how you feel as well. Unfortunately most doctors don't even talk to you. Western medicine practitioners take tests i.e. cholesterol; whatever you need more or less tests. They go by tests. So they don't go by ... talking to the person.

This positive view was not held by all clients. For example, client B4 said:

B4. He [the Chinese practitioner] has no qualms about telling you that you go to your [medical doctor] to have tests that I can't do for you. But, then he's just fobbing you off [for] the tests that he should be doing as well.

Despite some differences in views on the TCM practice, all clients affirmed they felt comfortable discussing their particular problems with the TCM practitioner. Clients provided the practitioner with intimate details of their lives, considered that they were given feedback they felt able to comprehend and that they were involved in a collaborative effort with the practitioner to achieve an effective therapy.

It can be suggested 'the voice of the patients life-world' contrasts with the 'voice of medicine' where the health professional controls the patient and minimizes their capacity to express their own views and thought. Porter (2000) describes this voice of medicine as a purposive rationality that directs the manner in which western medicine is organized (Donnelly, 1979). It is guided by a science based tradition which gives greater authority and legitimacy to the acceptance of the professional opinion of the doctor's voice, than that of the patient. In unconventional medicine, the narrative and the understanding the patient has of their illness, are important considerations (Blanchard & Lurie, 2004; Donnelly, 1997; Hudson-Jones, 1999; Montgomery-Hunter, 1991).

These observations on collaboration, empowerment, feedback and greater personalisation, generally support the notion described in the broader literature that an unhurried atmosphere assists in the cementing of the relationship of practitioner to client and helps to facilitate healing. Trust is held as a value that facilitates effective communication between doctor and patient and enhances the patients confidence in the decision making process related to willingness to comply with medical advice or treatment. (Charles et al., 1997; Kaplan et al., 1996; Murphy, 2001; Thom & Campbell, 1997)

7.3.2 The individualised therapeutic treatment

Clients perceived that the attention paid by the practitioner was based on several factors; the time spent listening to them, prescribed treatment based on their assessment, usually herbs and that each prescription was customised according to individual need (RCCM, 2000; Xu, Towers & Collet, 2006). One client (B6) indicated that pharmaceuticals prescribed for other health problems did not take into account her current condition thereby having a negative impact on the efficacy of the treatment. She referred to a friend of her husband who had diabetes to illustrate this point, suggesting that individual differences should be taken into consideration especially when the person has an underlying medical condition that could necessitate a different strength or formula used in the medication.

B6. Well for the first time in many, many years, my husband for the first time got a cold and went to the doctor. And

anybody that had a cold had the same medication. Now you know he isn't the same as my friend with full blown diabetes.

One client (B3) made a further suggestion that patent medications that were dispensed in pharmacies and hence when a medication was prescribed it was a standardised response and that a person might have an underlying illness that would impact on the current treatment being prescribed. For example, this client (A3) suggested:

A3. Everybody is getting the same medication [in western medicine]. Well everyone's not the same. Everybody's constitution is not the same. What might be good for me might not be good for you, what might be good for you isn't good for me. So they don't [general practitioners] do anything to make it different.

In contrast, TCM prescriptions are based on the particular diagnosis of the energy imbalances of the body (Eisenberg, 1993; Ernst, 1995) and that selected herbs or acupuncture were used for each individual based on identifying the specific nature of the condition. These herbs were then prepared by the client at home for consumption. The preparing for the herbs for administration was either given as a verbal or written instruction by the herbalist at the time of dispensation.

In reporting on how these herbs were prepared, client B2 said;

B2. Oh no, no they're not a problem, just shove them all into a pot, put them and boil them like hell for two minutes and then just turn down to low and let them cook out. So it wasn't a problem. I just had a pot and I just had a strainer – it ruined the pot and it ruined the strainer and it ruined the jug thing, it absolutely discoloured everything.

I recall that in the dispensing area of the clinic specific instructions were provided to clients by their practitioners. They were to boil the herbs and then allow them to simmer so that there was approximately one cup of fluid left after straining them. The herbs could be re-boiled again that evening and then discarded. When discussing her preparation of the herbs she informed me;

B2. And like I said, I used to 'shove them all into the pot', cook them down and make the two lots so the next mornings I would put aside and away we would go. I wouldn't boil them up again, which you're supposed to do. I just did it in one hit.

This example suggests that some clients are unaware of how to use the herbs properly despite the advice given by the herbalist during consultation. Although both practitioners had considerable experience, pre-packaged medications purchased over the counter or the herbs dispensed were a cause of concern amongst clients as the information was written in Chinese which meant the client was unsure of the contents. Commenting on the use of herbs, this client (A1) suggested;

A1. I've had some of the medicines I used to take for the bronchitis and what not were the worst things I've tasted in my life. So it's not different getting that medicine [Chinese herbs] and stewing (it) in a pot.

One of the clients commented on sending her friend "round to the herbalist" and commented that it had been an unsuccessful encounter due to the bitter taste of the herbs, which he described as foul and said;

B6. I think ultimately he didn't like the tea because it was so bitter ... and he didn't go back. I haven't spoken to him since. I suppose there are ways around it like taking herbal pills instead.

Then client (B6) described her experience of the tea as 'very bitter, it's horrible, rank and some of it gets worse'. She opted to take herbal capsules instead. I discussed with her the disadvantages of the herbs and she suggested one of the problems was the appearance of the herbs.

B6. I think a lot has got to do with appearances, you know like when you look at the concoction of herbs that you've got, dumped on a bit of paper, it looks like something you collected as a kid out of the garden. It's a pity they can't slice the herbs up because people go on what a thing looks like.

I made the suggestion that they do have pills but she replied;

B6. Pills yes, they've got those but the herbal tea is the foulest thing I've ever taste [sic].

Another client (B2) commented that her herbs tasted sweet;

B2. Ours sort of had a dried sultana of some sort and was sweetened up, so they weren't bitter they were nice.

These observations suggest that clients were not always diligent in following the guidelines given to them by the practitioner guidelines dismissing the information given to them on the herbal preparation and that some were put off by the taste of the herbs they used.

In summary, this section focused on how clients perceived the individualised nature of TCM with the main focus on how prescription herbs were prescribed and dispensed. It was also observed that in TCM there were also standardised pills that were sold over the counter and in a way is no different to pharmacy driven medication use. However the effects from the use of herbs, was found to be more beneficial than that of conventional medicine use, which is elaborated on next.

7.3.3 Effects of the TCM therapy

After having TCM treatment, clients perceived they had benefited from using herbs. Positive affirmations of their treatment were expressed in the following comments. This client (B2) said:

B2. Well, because I get satisfaction from it. I feel well again. Like going back years, I got this sore throat and nobody could find out what it was and the doctors were saying it was tonsillitis. It wasn't you know and it went on and on and I couldn't talk and I didn't know what the hell it was. I had to go to for my back. I said to him, this is driving me crazy and it's making me feel so ill. So he said I'll give you some relief. They weren't vitamins they were a homeopathic herbal remedy. Well it was some drop that I put under my tongue and wow, it all cleared up.

Another client (A1) offered this comment to illustrate how he experienced relief after taking herbs that were patented in a tablet form.

A1. I've had a lot of aches and pains which he gave me tablets for which were absolutely brilliant, like after two tablets I had no aches and pains. No, it was because of my aches and he gave me a tablet and fair dinkum in one dose all my aches and pains went. That's why I went to him because of my aching bones and legs.

Describing his relief from arthritic pain after taking herbal tablets this client pointed out;

A3. Take for example when I've gone to see the Chinese herbalist with my lower back pain, the root of the problem is my back and how it's situated. He can do Chinese massage on it and make it feel better – but I've seen my circulation being the problem – blockages through my body and he needs to draw from this otherwise he's putting bandaids on. I could have acupuncture to take the pain away, it will take the pain away for a short while but unless the circulation is improved it's still going to be the same.

He recognised there are limitations to such treatment in saying that he experienced only temporary relief. Then with the pain returning, he was dependent on taking herbs for pain relief, which would eventually become too expensive to maintain. Another client (B6) who used herbal tablets to control high blood pressure told me;

B6. I'm only taking ... herbal pill [for] 'high blood pressure' tablets. But now I find that I can function properly; my blood pressure is under control. I used to have really high blood pressure. What else can you ask for?

The following client (A5) found that the herbs helped alleviate another condition as well as the original one, as the herbs correct the imbalances of the flow of Qi throughout the body which is often the case with Chinese medicine when somatic factors are considered in the diagnosis.

A5. Basically I've stopped aching. There have been little side effects from taking the herbs. I used to catch colds quite badly and some of the herbs I first took unblocked my nose and got rid of that.

I was more alert as I was fairly tired all the time, just the last few months I've felt tired again so it's great really to get the fatigue lifted. The most noticeable change would have been the muscles.

The efficacy of the therapy related to a number of variables ranging from reduction of symptoms of some physical ailment to a client's expression of feeling more comfortable after receiving treatment and is attributed to the philosophy of TCM which seeks to establish the flow of energy and correct imbalances that exist through the organ system of the body (Eisenberg, 1993; Ernst, 1995; Kaptchuk & Eisenberg, 1998). Efficacy in TCM is considered to have been achieved when the

clients say it has been of benefit to them and that they experienced wellbeing following their therapeutic course. Therefore when the circulation of the energy has improved, blood will flow more smoothly, which alleviated the discomfort from chronic pain (Baer, 2008; Kaptchuk, 2002; Lu, 1994; Zhan, 2001). Not all clients identified with this with only one client, (A3), who drew attention to the flow of energy, saying he felt the uniqueness of TCM was related to the release of blocked energy through the body. He made this observation;

A3. If you went along to a Chinese doctor and started to talk about Qi and energy blocks they would lead on because they know about energy. One of the best ways to become aware of an energy block is to have some acupuncture and when the needle hits an energy block you know about it. It's a pain that a whole world of its own. And they will know where the energy blocks are.

He said there is a block you need to improve this and that within yourself and this will eliminate those energy blocks. Each time the acupuncture is done the needle goes to a different level, it's not just flowing this way but it's flowing internally as well, that way. The energy blocks are felt as pain but not in the muscle but in energy.

Reference to Qi as the energy form within the body has been identified clearly by this client in reference to 'energy blocks' experienced in his body with the client remarking on the flow of energy following treatment. Even more interesting is the comment that 'energy blocks are felt as pain but not in the muscle but in energy'. When energy is unblocked there is a relief of symptoms, but this does not make sense in conventional health care. He made a further suggestion based on his understanding of the internal healing process as being like this;

A3. [It is] Based on the Qi and that is what Western medicine can't explain. Acupuncture is another form of using the Qi. That's how he healed my neck. A Chinese doctor can do what a Western doctor cannot do.

However other clients did not appear to have this level of understanding. All clients interviewed had experienced some form of chronic illness or disability and had been previously treated by their Western doctors. Some clients saw value in both systems of health care and continued to visit their specialists or GP's whilst accessing TCM. For example one client (B6) continued with her visits to her heart

specialist while taking the Chinese herbs at the same time without her doctor knowing. She told me how she had ceased to take her Western cholesterol medicine and was taking only the Chinese herbs. She went to see her doctor who checked her for her cholesterol.

B6. I was so nervous because I didn't take his medicine for a whole year. But he said come see me, so I went and got my cholesterol blood check. When it was ready I came back to him I was more nervous I really was.

Then he said "Oh it's great, it's wonderful, your cholesterol is 3.5" I said that's great.

I was happy. So I breathed a sigh of relief.

Now by just controlling [blood pressure] my health with natural things, I take 1 tablet morning and night with the herbal capsules and the CoQ10 capsule (because that strengthens the heart) I don't need to take all those terrible things (Western medicine for cholesterol) that make me sick and feel like an invalid.

When I asked her if she told her GP that she was no longer taking the medicine for her cholesterol, she informed me;

B6. No, I never told him. I thought to myself God if I tell him he would hit the roof.

A disclosure of any medication use should be part of the collaboration between doctors and patients (Pappas & Perlman, 2004); and went on to say that she might have to tell him next time of her use of TCM. Previously she had told her doctor she was unable to take conventional medicine due to the side effects. 'I've tried lots of them and nothing suits me, they make me dizzy and stressed and to suffer from headaches and dizziness'. She continued to use TCM and to visit her doctor of western medicine to access the ongoing pathology for which her cholesterol levels could be monitored.

7.4 Client concerns of TCM

While for the most part, TCM users were satisfied with the treatment they received, they did have some concerns, one such concern was the cost of herbs. One woman who had a problem with her pregnancy had to have special herbs that cost

seventeen dollars per packet per day for seven days and was prepared to pay this without questioning if the herbs would be effective or if they contained harmful substances. Reports on herb-induced aconite poisoning are rare, with estimated 4-5 cases per population million (Bensoussan & Myers, 1996) and in Sweden a study on use of herbs revealed that although side effects can occur from herb ingestion, no severe effects had been registered (Maxion-Bergemann et al., 2006).

Some clients were happy to take herbs if they got results, despite their high costs but others found cost outweighed the benefits obtained and eventually became prohibitive. For example client (B2) and her husband who were on pensions said;

B2. We did it for three months and it was costing us \$10 per day. So virtually it was costing us \$210 per week.

Another client (B4) said that cost was a prohibitive factor for her in taking herbs over a protracted period of time with the cost of her herbs being ten dollars a packet per day for seven days. For example:

B4. We had to use two packets a day, it was a dose in the morning and a dose at night and then we had to have tablets as well which cost twenty five dollars a packet and my husband had to take two in the morning and two at night. Mine cost twenty five dollars as well as my husbands which also cost twenty five dollars.

The cost factor added up over a period of time and one client said it cost \$2,000 in medication for a ten week course. Even those with private insurance, such costs were too high as the rebate was on the consultation and not the cost of the herbs. B6 commented:

B6. You can't get a medical rebate on the herb you can only get a medical rebate on the visit. And the visits for the consultation are twenty five dollars.

This client commented that her TCM practitioner told her she would only need to take the medication for three months and then for two weeks every three months as a maintenance medication. She pointed out that her practitioner had no way of checking whether three months of therapy had modified her cholesterol level as any laboratory testing procedure was not available and she would still need to go to her Western doctor to have cholesterol checked;

B6. ...if the practitioner of TCM was going to program it, then he should be able to test it himself.

She felt that her treatment was still dependent on Western medical science to provide evidence of the effectiveness of her therapy despite there being a notable change in the measure of her cholesterol levels. A negative comment came from another client (B4) who was concerned about the therapy. She had aches and pains and said that the tablets she had been given “were absolutely marvellous”. But then she began to have symptoms which were adverse.

B4. He said to me this is what I think is happening to you. He was prepared to listen to me and each day he would call us and make sure the herbs were alright for us. I took these tablets for only two weeks and that’s when my ankles started to swell and he said you’d better stop taking those tablets because I think your heart may fail. And I think you’d better go to your doctor because I think you need to have some tests. He was the one that said to me I have to go to the doctor, to go and have tests.

Ironically, she had first decided to access TCM because of the adverse effects of her western medicine and now she was experiencing side effects from taking herbal products. Other complaints were made about the use of herbs, where they were imported from, the kinds of herbs that were being used and their possible side effects. The following client (A3) identified the side effects experienced from herbs as a valid concern in view of the self regulation of TCM in Western Australia. [Recommendation on the wider regulation of TCM, are made in Chapter Nine].

A3. You know like, the only thing that I’ve really got a problem with, they give you all these herbs, they don’t tell you what the herbs are, so now if you go to the doctors and you say, he says are you taking anything else and you say, yes I’ve been to a herbalist and I’m taking some herbs or something like that, they will say, well what herbs? No because they’re not telling you, you know and if you like, ginseng or something like that might have a reaction to the tablets that you’re taking.

Another (B4) referred to the need for herbs to be standardised in Australia as they are in China. However she informed me that she felt her treatment was safe, as practitioners can not ‘sell them without any [herbal] medical knowledge’ and felt safe as the practitioner she attended was trained in Beijing and qualified to practise in herbal medicine.

B4. That's the only problem I've got with them, is the fact that they'll give you tablets but they don't tell you what's in them. I mean by law, I mean they're not allowed to come into the country until they've been tested. They can't just put them on the shelf and sell them without the medical knowledge?

The concerns raised by the clients were legitimate in view of the fact that future practise of Chinese medicine under a registration act would ensure safe practice issues on the practice intervention, the administration procedures, storage and prescribing of herbs. Another issue, on the safety of these products, the imports had been passed through quarantine and the Therapeutic Goods Administration for imported herbal products. However the preparation of herbal products [capsules] produced on site would need to meet requirements under the Commonwealth Therapeutic Goods Administration (TGA). Capsule forms for ingestion of some herbs were made in the back kitchen on a wooden table, under crude conditions. Acceptability of these prepacked capsules made available to the public was not a product that TGA would not be aware of.

Any adverse effect of herb use was not an issue raised at the time of consultation with the catch cry heard from the herbalist; 'the herbs are good, the herbs are good for you'. It would have been useful for clients that information was made available to describe the property of the herbs and to alert clients to the possibility of adverse reactions. A factor to be accounted for is the synergistic affects of some herbs that might occur when conventional medicine use is used in combination.

7.5 Summary

This chapter has examined client perspectives of their clinical experience with TCM revealed through six major domains. Clients reflected back to their experience of conventional medicine to explain their conversion towards TCM in explaining their shift to TCM. In particular importance was domain four related to clients' perceptions that they felt listened to when they described their symptoms to the practitioner. Clients considered that they were given the opportunity to discuss the nature of their illness, which allowed them to build a rapport with the practitioner. Other positive aspects of the clinical encounter included the herbal therapy prescribed for the specific

needs of the client and the benefit derived from the therapy. Several clients raised concerns about the safety of the herbs they were using and also the costs of herbs, which affected their willingness to continue with TCM.

On efficacy of treatment, client perceptions were mostly positive on the relief of their symptoms and clients generally reported satisfaction with their treatment. None of the clients had previous experience with TCM. Only one client had any understanding of Chinese words, such as 'Qi, Yin and Yang'. Clients identified their TCM clinical experience to be less hurried, more personal and less invasive technologically. While the sample size is too small to generalise on the clinical experience of TCM, the evidence presented suggests that the nature of interaction between client and practitioner differs between the two systems of medicine and that central to the process of healing, is the perception by clients that there is an interchange that occurs between client and practitioner that facilitates this.

An important question raised by the discussion is the extent to which perception of the value of TCM is a product of the intrinsic nature of the treatment provided or as a result of a range of extrinsic factors such as the demand for services and its effects on the consultation times. A factor much more difficult to determine is the nature of the therapeutic impact of the relationship on the healing of the illness, and of how medicine is practiced. Bensoussan and Lewith say this raises;

very important issues for medical practice, not the least the sanctity, integrity and power of the therapeutic relationship. As patients become more educated, vocal and vociferous, the medical profession can no longer just be the 'possessor of knowledge' but must also provide interpretation and wise counsel (2004, p. 586).

CHAPTER EIGHT

Kanbing - Analysis of the clinical encounter

The social anthropologist seeks to show how some characteristics of an institution or a set of ideas peculiar to a given society, how some are common to all societies, and yet others are found in all human societies. The characteristics he looks for are of a functional order (Evans-Pritchard, 1969, p.123).

8.0 Introduction

In this chapter analysis is made on an illness episode to illustrate how the elements of the clinical encounter involve the use of metaphorical construct in the explanation of an illness from the perspective of TCM. In previous chapters, reference was made to Qi, Yin, Yang, and the Five Element Theory and, of how those aspects of TCM philosophy support the assessment and diagnosis process. I observed the functional order of the process of interaction (Evans-Pritchard, 1969) described as Kanbing, followed up with in-depth discussions with practitioners and exploration made on interactions between the practitioner and client informed through a case study. To show how the interpretation is found embedded in the philosophy of TCM, I provide my interpretation and analysis of Kanbing.

There is an importance attached to this interpretation of Kanbing as it illustrates the progressive reasoning formed through the process of the client practitioner interaction towards an understanding of the somatisation of an illness, unlike that of Biomedicine. To provide an in-depth extrapolation on the analysis of constituents that determine Kanbing, the chapter is organised into three sections. First, the theoretical construct is illustrated with the formation of 'syndrome' identification.

Second, a case history from fieldwork at the Yin Min clinic provides the foundation for an examination of the process. Analysis is made on the illness narration of the client and interpretation by the practitioner and examined through a four stage process within the clinical context (Dow, 1986; Kleinman, 1988; Moerman, 1983).

Third, I examine the translation that has been made by the practitioner on the client's illness that identifies specific syndromes to illustrate how a syndrome is culturally differentiated building on the work of Kleinman (1988). It is determined that somatic interpretation of TCM theory evolves from a uniquely expressed use of symbolic language. A system of thought is applied to Chinese medicine that has evolved from Taoist and Confucian philosophy (Birdwhistell, 1995) and is found expressed as balance and harmony within Yin Yang, underpinned by the Five Element theory (Connelly, 1979; Ferigno & Wang, 2000, Kleinman & Kleinman, 1994; Maciocia, 2005; Pilch, 2000; Ross, 1985; Zhang 2007). In the analysis I show that interconnections are made through terms such as Mother-Son relationship drawn from Chinese notions of kinship to make understandable the cultural notions of illness informed through a systematic decoding of the somatisation through Kanbing. This is drawn from the five major Zang organs, and the five emotional expressions found within metaphor informed through the five elements drawn from the natural world. Fourth, the chapter concludes with a broader conceptual discussion of the importance of the role played by Qi to illustrate the link between the mind and body, the somatic physiology of the five major organs and of the spirit (*Shen*) that governs the emotions in TCM thought.

Section One

8.1.1 Characteristics of the theoretical construct of Kanbing

Kanbing plays a central role in facilitating the clinical encounter of the assessment process (Kleinman, 1981; Farquar, 1994) and refers to a process of inquiry through consultation. The object of the clinical encounter is to examine the clinical reality of the interchange between the client and the practitioner (Kleinman, 1981; Farquar, 1994) and Zhang (2007) refers to this as the clinical process of "looking at illness" (p. 4). How this 'looking at the illness' occurs, is through the formal process of '*Bian*

Zheng' through which analysis is made of the relevant information, signs and symptoms collected through the four method of diagnosis, listening, smelling, inquiring, pulse and palpation informed through the theory of TCM (Enquin, 1988a).

Narrative plays a crucial part in the assessment phase, even though people may differ in respect of their illness reports, on how they express their anxiety about their symptoms that achieve meaning in relationship to physiological states interpreted to be specific organ symptoms. The task of the practitioner during the clinical encounter of Kanbing, is to decode these by relating symptoms to their biological referents (Good & Good, 1981) drawn from the illness narrative and symptomatology. This encounter involves the practitioner paying close attention to words that are used by the client to convey implicit references to such elements as the psyche, heart, mind, consciousness, vitality, soul or spirit from a TCM perspective. It enables the practitioner to then provide interpretation on this narration based on the principles of TCM philosophy and observations are made from the assessment that are translated by the practitioner into the language of the "... relationship of the mind and body governed by the flux of Qi, Yin Yang, and the Five Element theory" (Zhang, 2007, p. 4).

8.1.2 Culture bound syndromes explained through TCM

TCM assessment considers that signs and symptoms of an illness that arise independently from behaviour or have a psychological meaning that is translated (Good & Good, 1981) by the practitioner into a syndrome formation. Three important stages illustrate this. First, explanation of the illness through the use of metaphorical constructs to create symbolic connection and translation. Second, application of symbolism to pathological change informed through TCM theory in the construction of the diagnostic process. Third, identification of the mind and body link in relation to the translational processes of the organ ecology, explained through the interconnections of the Zang and Fu organs and the flow of Qi. These TCM physiologies identify how an illness reality is constructed from the narrative and through the interpretative skills of the practitioner as a culture bound syndrome (sections 8.2.5 – 8.3.5).

Physiological attributes of symptoms are classified as specific syndromes to form what can be described as culture bound syndromes expressed through the conceptual

framework of TCM (Dow 1986; Good & Good, 1981; Kirmayer, 2004; Kleinman 1988; Moerman 1983). TCM provides a casual explanation of the link between the physical and mental realm of an illness, that Kleinman and Kleinman say, is “the equivalent in social theory of a ‘mystical leap’ in psychosomatic medicine, between the mind and body, processed by connections made between the symbolic, the social and the individual” (1994, p.708). Birdwhistell similarly puts it, that a “... physiological alchemy found in the expression of early Chinese thought, [is] exemplified through the Zhou philosophers who used metaphorical terms to make connections in illness and medicine which was extended into physiological-political correlations” (1995, p. 3).

Pathology is identified from those connections made between the substrata of social, political and physiological to the expression of individual somatic illness that lacks any Western science based rational explanation. However, for TCM to progress the level of discussion of TCM has to be raised to a rational explanation of the physiology represented by scientific theory (Zhan, 2001). Yet, arguably natural elements found in TCM philosophy, Yin Yang, Qi, the Five Elements representative of the nature, explain the nature of an illness that are culturally fashioned notions. Hence the attendance is made in the analysis to understand how a cultural construct informs an illness episode.

To explore notions of culture bound syndromes, I first refer to Nichter (1994), who suggests that tension borne out of wider upheaval of the social or natural environment can be mitigated through the transformational process of healing. An important example of tension found within the social environment in the understanding of illness is illustrated in reference to the anguish experienced by individuals during the Chinese Cultural Revolution. Schwarz similarly described tension as a feeling, “arising out of memory” and explains that “... according to ancient psychology, human nature is usually in balance in a tranquil state whereas the disturbance of harmony is created by grief and sorrow” (1997, p. 122). Suffering arising from tension and grief are causative factors that lead to a loss of inner balance or calm, which Schwarz described as a ‘tidal flow of heart’s blood’ (*xin xue lai chao*) is unleashed a metaphor for the phenomenology of social catastrophe that have impacted on the physical and mental substrata of the individual, commensurate with the onset of illness.

Socio-somatic processes impact on every day living and social relations, to some extent affects blood pressure, heart rate and respiration, that may contribute to the development of illness and disease. A cumulative progression of causative factors develops over an extended period of time to be revealed as somatic manifestations of illness in TCM. Derivation of the assessment procedure in TCM considers the dialectical categories of the socio-somatic processes, the social relationships that ground health and illness within the phenomenological constraints of time, place and phase of lifespan (Kleinman & Kleinman, 1994) and, in this respect characterise the contextual nuances of TCM as a different form of medicine to that of biomedicine.

8.1.3 The body ecology

Phenomenology of time, place and phase can be understood if reference is made to Dow's Hierarchical Framework of Living Systems (Dow, 1986) from which I postulate that, a 'culture bound syndrome' can be revealed through the connections made between different levels of substrata. From this framework, it a structure of an interwoven description of environment, human biological and socio-cultural traditions, that form connections to link the illness experience with the description of the manifestation of symptoms.

Connections found between that of the strata of the natural, individual environment and the cellular level of the organism explain how collections of symptoms are translated by the practitioner into what is described as a syndrome (Ferigno & Wang, 2000). The information processed during Kanbing provides a special semiotic system from which meaning is derived from the interpretation of the illness, to develop a differentiation of symptoms into a syndrome. With the changes found at a cellular level, it may be that the body becomes a bearer of meaning pertained to by Connerton as performative memory;

... the body ecologic is like the body politics, interwoven with the environment, so that body and environment cannot be dealt with as separate entities (1992, p. 352).

Illness can be found to be interwoven within the broader environment explained through family and social relationships, relates to the wider environment of society (Kleinman, 1988) which TCM theory draws in the explanation from the function of the human body. Somatic physiology is formed upon metaphorical constructs that lie

beyond the boundary of the physical body and described as the body ecology (Hsu, 1999, p. 110) where the notion of illness is found interspersed throughout the system of the body. This interspersion is found represented as disharmony in the flow of Qi, through obstruction or due to the stagnation of Qi flow. Even changes in the atmosphere such as cold, dry, damp and wind, can be associated with excessive Qi in the environment that affects the emotional state or the five directions ‘Wu Wei’ described in TCM. Wu Wei is expressed in the person through the emotions of joy, anger, worry, sorrow and fear (Xinnong, 19887; Hsu, 1999) and is elaborated on in section 8.3.3.

These external and individual environments cause catharsis, impacting somatically on a cellular level and autonomic arousal (Dow, 1986; Kirmayer, 2004), to explain this reference is made to the heart (*xin*), which in TCM is said to be ‘the monarch of all organs (Enquin, 1988a, p. 74). The heart in TCM governs the balanced emotional state of the mind, Ross conjectures “... the heart or *xin* is the seat of consciousness, rather than the brain in Western medicine” (1985, p. 123). The essential functions of the heart (*xin*) are; to control blood (*xue*), in the flow through the vessels (*xue mai*) and to house the spirit (*shen*). The pulse referred to as *mai*, reflects the state of whether Qi is sufficient or not which is reflected through the vitality or energy found in the body. Zhang points out that Qi, ‘... vitality is manifest through the functional activities of mind and body and suggests a dynamic inseparable relationship in the lived world of the mind and body’ (2007, p. 6).

8.1.4 Somatisation of an illness

A somatisation of illness found in the organisation of the individual body ecology can be related to the broader context of society and environment illustrated by Kirmayer (2004) from his theory of a Hierarchy of Healing Mechanisms. He proposed structural levels of organisation similarly to Dow (1986) to stress the import of how changing environmental relationships affect the individual. Kirmayer’s hierarchy consists of society, community, the family, the individual and regresses to the physiological cognitive function of the individual though the limbic system and brainstem that regulate the autonomic arousal in response to pain. Mediating instrumental responses are represented by the law and order of collective community support in each of the individual’s response to insight in social

conditioning and catharsis. Dow’s Hierarchy of Living Systems provides a conceptual framework, on which the somatic manifestations caused by events in the person’s external environment can be contextualised with links made to those occurring within the organ ecology at an individual level, with the resultant effects occurring at a cellular level (see Table 8.1).

Table 8.1 Hierarchy of Living Systems

(Adapted from Dow, 1986, p. 61)

Environment	System
Natural environment	Social
Individual environment	The self
Body	Somatic
Cells	Molecular

The example of ‘Neurasthenia’ explains how a syndrome is formed from TCM translation to be a specific ‘culture bound syndrome’ (Kleinman, 1989) and describes how substrata of environment are analogised through TCM theory to provide a contextual framework between social, individual environment and the cellular body illustrated to be as a ‘Hierarchy of Living Systems’ (Dow, 1986). Kleinman (1986) traced how collections of illness symptoms were categorised as a syndrome in TCM. He linked the political and social turmoil that occurred in China during the Chinese Cultural Revolution as having an impact on people’s health in its aftermath. Kleinman revealed the link between the self and social environment to the cellular environment to put it that “... in every culture, illness, and the responses to it, individuals experiencing it and treating it, the social institutions relating to it are systematically interconnected” (1981, p.24). Such a stance assumes that the somatisation of illness extends beyond the individual self and is found embedded within the natural and social environments that are provided in the expose of the case study analysis.

8.1.5 Differentiation of Syndromes

The link to neurasthenia, shows how the manifestation of symptoms such as a lack of energy, fatigue, weakness, headaches and anxiety, become an emotion related disorder known as ‘*qingzhi bing*’ (Zhang, 2007). *Qingzhi bing* is characterised by a decrease in the vital energy of Qi (*qinzhi bing*) and produce change in the Zang Fu organ system through the dysfunctional flow of Qi. The somatic emotion related ‘*qingzhi*’ disorders, encountered in today’s modern clinics in China continue to reflect the political and social upheavals in contemporary Chinese society (Zhang, 2007). It was determined by Kleinman (1986) that neurasthenia was identified to be a collection of syndromes differentiated into four complex groups that apply to the systems of: *wei, qi, ying and xue*.

The differentiation of each is through ‘Ba Gang’ to determine whether a condition has excess or deficiency, interior or exterior, cold or heat, yin and yang and the location of the illness in each assessment made by a TCM practitioner (Enquin, 1988a). Examples of four different syndromes (Kleinman) identify that diagnostic differentiation of each and found to be representative of neurasthenia. Each syndrome exhibits a pattern specific to an excess or deficient flow of energy:

- 1). Liver-kidney yin deficiency (*Gang Sheng Yin Xu*) – chief symptoms are dizziness, distended feeling in the head, blurred vision, tinnitus, bitter taste, insomnia, rapid or faint weak pulse.
- 2). Heart-kidney disharmony (*Xin Sheng Bu Jiao*) – due to pathogenic abnormalities in the physiological relationship of the heart yang and kidney yin. Symptoms are insomnia, frequent dreams, palpitations etc.
- 3). Heart-spleen weakness (*Xin Pi Liang Xu*) – amnesia, insomnia, frequent dreams, reduced appetite, loose stools, fatigue and weakness are experienced
- 4) Liver-stomach disharmony (*Gan Wei Huo Wang*) – irregular consumption of food causes fire to be present in the stomach and emotional distress with predominance of anger and anxiety [found in the case study] (1986, p. 23).

Discerning the nature of a syndrome such as ‘*Gang Sheng Yin Xu*’ provides the determination of the treatment (*Zhifa*) for the specific symptoms. For example, neurasthenia results from depression of vital energy in the liver that is experienced as somatic emotional symptoms with chest discomfort, depression, anxiety, irritability, anorexia and abdominal distension. From the combination of these symptoms explanation in TCM there is recognition that illness has a psychosomatic origin

(Kleinman, 1988) and is 'culturally fashioned'. Focus is directed onto the individual and external events that characterise neurasthenia. In TCM illness expressed through characteristics of symptoms are categorised and distinguished as the four specific syndromes. Significantly Kleinman's study of neurasthenia found that the complaint persisted after therapeutic levels of antidepressant and anti-anxiety medications were given. Improvement was found only after in patients "... who resolved a major family or work problem" (1989, p. 8). Implicit in this finding, is that rather than a chemical based intervention, improvement was conversely linked to the effect the environment had on the individual's wellbeing, particularly that which initiated change at a cellular level. The effect of an illness at a bio-cellular level has its origin in a complex interplay of considerations, and put by Kleinman and Kleinman, "... traditional Chinese medicine is equipped to see the links between social and bodily experience" (1994, p. 707) revealed through the Kanbing.

8.1.6 The clinical encounter - Kanbing

In TCM a subjective step by step process guides the functional order of the assessment made by the practitioner beginning with an interpretation made of the client narrative of the manifestation of clinical symptom experience. The social construction of diagnosis and illness are a central organised theme guided through the phases of Zheng throughout the encounter known as '*Bing*', which the practitioner makes a translation from. The practitioner's translation is acted upon by culture-specific symbols generalised by cultural myth in TCM. Clients are supported by the practitioner to describe the illness experience in lay terms which then is conceptualised through the framework of the TCM, enabled through each of the phase of the clinical encounter of Kanbing (Figure 8.1). Observations are made by the practitioner [*Zeng*] of the client's behaviour and emotion as they express their illness symptoms and assess the information in terms of the four methods [*Sizhen*] and the eight principles [*Ba Gang*] identified in Chapter Four. I illustrate how the interactions of Kanbing are formed through the four diagnostic method and Ba Gang to determine the stage of syndrome formation.

Characteristics of an illness are processed through the identification of imbalances of Yin Yang Qi, to comprise a collection of symptoms formed through the clinical understanding of TCM into a syndrome (Connelly, 1979; Enquin, 1988a; Lu; 1994;

Ross, 1985; Xinnong, 1987). Questions and observations, particularly the inspection of the tongue and pulse diagnosis are used to elicit clinical detail to inform the assessment.

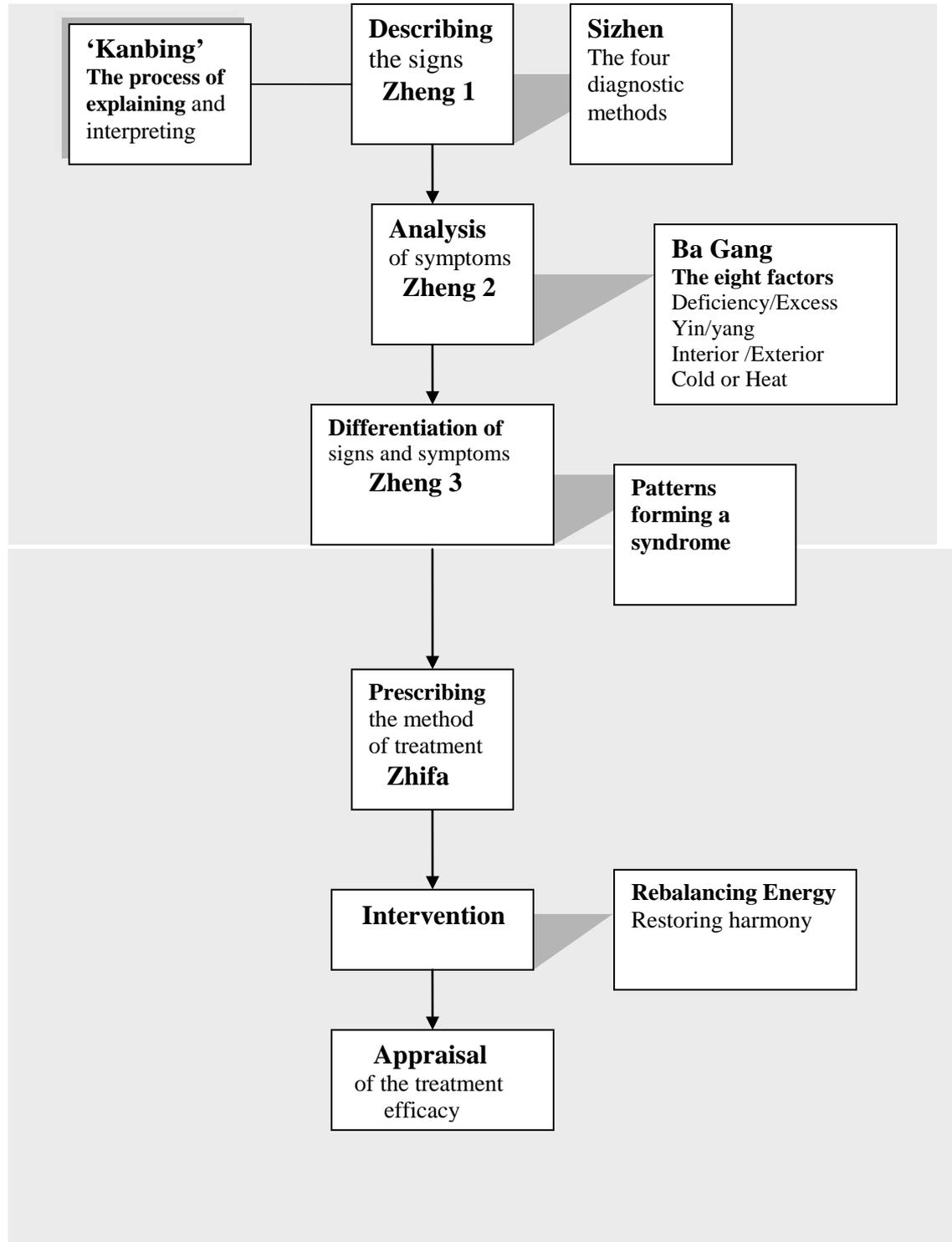


Figure 8.1 Phases of Kanbing - the clinical encounter
(Adapted from Farquar, 1994, p. 55).

Kanbing as a process is informed, through reference to the stages of Zheng distinguished by the narration of the illness, the causation of the illness and the determination of the chief characteristics of the illness (Hsu, 2001).

Section 2

8.2.1 Explaining the illness experience

As described by Blumer (1969), three premises promote an understanding of the interactive process; symbols have attached meanings, meaning is derived from the social interaction of shared meaning and is modified through the interpretive process. Based on these three premises on how meaning is attached to different forms of illness by the practitioner found embedded in the explanation of the TCM philosophy.

The practitioner makes their observation on the client's behaviour and emotion through the stages of [*Zheng*] as they express their illness symptoms to assess the narration using the four methods [*Sizhen*] and the eight principles [*Ba Gang*] identified in Chapter Four. Questions and observations, particularly the inspection of the tongue and pulse diagnosis are used to elicit clinical detail to inform the assessment. Assessments conducted with client's revealed explicit information about their TCM encounters that link the clients' narrative of the illness experience coupled with the interpretative skills of the practitioner to form a structure on which the process of assessment and diagnosis of TCM is made. Such an approach of the interpretation is expressed by what Ferigno and Wang (2000) have to say:

“... to view Chinese medical ideas or the ways in which the mindful body is enacted in clinical discourse is to experience Chinese medical knowledge” (p. 133).

Explanations on the 'mindful body' (Ferigno & Wang, 2000) in Chinese medical knowledge is found in the emotional experiences expressed by the client in the narrative (Pilch, 2000). Exploration of the subjective information of the client is fostered from a stance where the practitioner works with the client and is not restricted by dominant medical discourse (Donnelly, 1998; Germov, 1998). To illustrate this, analysis is now made on a case study from my fieldwork at the Yin

Min clinic with secondary literature included to provide theoretical explanation to the conceptualisation of the characteristics of the illness. The case analysis is based on the concept of *verstehen*, first that the illness reality is considered to be fundamentally semantic' and second meaning is drawn from a client centred approach 'recognises all clinical transactions to be fundamentally hermeneutic or interpretive (Good & Good, 198, p. 167), such an approach forms the crux of the interpretive nature of Kanbing.

8.2.2 A case analysis – 'Nicole'

Nicole is a woman in her early forties who holds a responsible position in a nursing facility where she works as the clinical nurse on night shift. When Nicole arrived in the consultation room at the clinic her facial appearance was haggard with a drooping right eyelid and a sagging lip on the right side of her face. Nicole had experienced the condition for the past few weeks and had seen her local doctor but felt she had not received any benefit from the treatment given. Her condition appeared suddenly during her nights off duty two weeks prior which interfered with her role as she was unable to read the charts correctly when administering medications to the residents. With a flushed face, a right eye lacrimation, nasal discharge and constant pain, Nicole had the appearance of a person in distress. In desperation Nicole had sought out the TCM practitioner for advice in the hope it would provide alleviation from the facial pain she was experiencing. At the assessment interview, Nicole began by saying to her practitioner:

"I have been to see my GP and he diagnosed that I have Bell's Palsy".

The TCM practitioner then commenced an assessment focusing on the background history to the onset of her problem. Below is an edited account of the clinical encounter and the history and clinical observations made by the practitioner.

Practitioner. "When did your problem start"?

Client. "It happened during the night I woke up like this, my face was all distorted to one side. And it is very painful".

Practitioner. "How long have you had the symptoms for now"?

Client. “For two weeks now. My doctor has informed me, I will have this for six months. I’m also finding it too difficult to work as I’m unable to see properly and cannot read. It is interfering with my work as I cannot read the labels on the medication packets”.

Practitioner. “Have you experienced any emotional distress recently”?

Client. “My husband has had to go back up North to work and that leaves me alone to manage with our house that is being re-built plus I am also coping with the stresses of working night shifts”.

Practitioner. “Have you been exposed to any drafts, have you been sitting or sleeping where there is cold air on you”?

Client. “No, but I have not been able to sleep much during the day”.

Practitioner. “Have you been eating any spicy food”?

Client. “No, I don’t like spicy food”.

Practitioner. “Have your meals been regular or irregular”?

Client. “They haven’t been regular as I have not felt like eating much since my husband went away to work and do not like cooking for myself much. Also when you work nights, you tend to pick at things more”.

Practitioner. “You mention you have pain. Can you please describe the pain to me - is it dull, sharp or throbbing”?

Client. “It is very sharp and feels like a knife cutting in the side of the face down from the eyes to my mouth. It isn’t there all the time but when it is, the pain is excruciating. I have been going to work, but I can’t work like this, as I can’t read even with my glasses on. And I have to see to be able to put out my pills when I give out medications where I work on the night shift as a nurse. I can’t read the information on the charts now”.

Practitioner. “Let me see your tongue please”.

The practitioner sought to identify the locality of the discomfort, whether it is relieved by heat or cold, relieved by change in position and if it is seasonal and sought to identify other problems linked to external social environmental factors.

First – the practitioner noted the tongue coating as; ‘the tongue proper is red with a little yellow coating’. The practitioner on viewing Nicole’s tongue stated that the red tongue body indicated that she had an ‘excessive heat syndrome’ and the yellow coating indicated the presence of ‘mild heat’. According to the practitioner, if the

tongue is dark yellow it indicates intense heat while the normal tongue is a pink red in colour. When heat is present the Qi and blood flows more rapidly filling the small vessels of the tongue to produce a bright red colour. After examining her tongue the practitioner asked to take her pulse.

Second – the pulse was taken on both wrists and then notes made of the observation. The practitioner then sought to link the reading of the pulse to Nicole’s comments on her feelings of anxiety. It was noted her pulse is ‘taut’. A taut pulse is felt as a tight string is indicative of diseases of the gall bladder and liver and according to TCM, the pulse exhibits as taut when there is liver dysfunction. A function of the liver is to govern the flow of Qi and disturbance of the activity of the flow of Qi is indicated by a taut pulse, a key diagnostic sign. When disturbance to the flow of Qi occurs, the diagnostic sign of liver fire and the hyperactivity of liver yang Qi are recognised.

Observations during the assessment. Nicole’s became very agitated. In making his assessment, the practitioner drew attention and referred to the importance of the interpretive signs based on TCM understanding. These are explained through [Zheng1] an imbalance is found between her emotional state and the flow of Qi. After examining the various signs and symptoms through the four methods [Sizhen], the practitioner linked the observable signs of the vitality of the Qi with the client’s description of her symptoms [Zheng2]. From the interview, a composite analysis began to emerge that involved a classification of these symptoms into a pattern of collective signs to form a syndrome differentiation [Zheng3]. The practitioner provided this summation of Nicole’s illness to me in the following way based on his tacit explanation. However, what is the relationship between these particular expressions of client distress that he determines are grounded in the personal and social context from which he elicits meaning in her physiology? He describes these conditions:

1) Aetiology – Her facial palsy is known as *Gan Wei Ho Wang*

The deviation of the eye and the mouth is caused by facial paralysis.

2) Time and onset of symptoms

It can occur in patients at any age. Nicole woke up to find she developed a facial paralysis overnight.

3) Pathophysiology

The main reason for the paralysis of the eye and mouth is the surge of fire from the liver and the pathogenic involvement of the stomach from a poor diet and from the mental state of anxiety.

4) Course of the illness

Usually there is incomplete closure of the eye on the affected side, and also there is sharp pain and it may be accompanied by headache.

5) Treatment

The focus of treatment is to provide a differentiation [described in chapter seven] to identify the aetiology. Treatment emphasises correcting the flow of energy to the affected area. That is to facilitate the flow of Qi via the meridian pathways rather than the focus of alleviating the pain. Once energy flow to the area is corrected pain will not be experienced.

Based on the practitioner's identification of the above factors a method of treatment [*Bian Zheng Lunzhi*] or [*Zheng zhi*], was then selected (Farquhar, 1994). The practitioner wrote the prescription [*Fang*] based on a selection of herbs according to the characteristics of the illness as a homeopathic image of the particularities of the illness episode (Farquhar, 1994). In TCM, importance is attached to seemingly unrelated elements can be revealed as emotional distress or imbalance in the mind and body harmony which may relate to the person's family, social or work environment. The manner in which a person behaves, their speech and body language; provide signs for the interpretative evaluation of the practitioner of the illness source. Interactions with clients and the narrative of their illness disclosure are identified by the four stages in the process of that encounter that are integral to the cultural construction of the illness, the role of diagnosis, the controversial element of the diagnosis in the social construction of the condition which is explained through the analysis of Zheng.

8.2.3 The four stages of Zheng

Four stages of Zheng guide the illness construction of TCM and from my observations on the practitioner were centred on tacit transactions performed in the clinic that imported a therapeutic healing relationship. To provide a depiction of these transactions it can be argued similarly to Dow (1986) that the illness experience is generalised accordingly with culture specific symbols in a theoretical synthesis of

healing. When the suffering client comes to the practitioner their illness is interpreted in terms of cultural myth, the practitioner attaches emotions to transactional symbols and the transactional symbols help the patient to transact his or her emotions through the exchange of information in Kanbing. I explore each stage of Zheng, which I link to the manipulation of information by the practitioner as they create a contextual cultural construction embedded in TCM language culture and notions of symbol. To do this reference is drawn on how this is attended by:

- (1) Creating the symbolic bridge between sign and syndrome through metaphorical language**
- (2) Relating the illness experience to the mythic symbols in TCM**
- (3) Identifying the transactional symbols that focus on the link between emotions and somatic symptoms**
- (4) The treatment initiation of the specific therapeutic intervention**

Each stage of Zheng provides formal identification given in the explanation of TCM.

Stage 1 [Zheng 1] – Creating the symbolic bridge between sign and syndrome

In this stage client symptoms are translated into the metaphorical language of TCM. Links are made by the practitioner between the symbolic dimensions of theory and the elements of TCM. Interpreting how the person feels, the practitioner creates a bridge by constructing a clinical picture informed through the Five Element theory that link the specific organ dysfunction to the emotional experience of distress expressed by the client. By distinguishing patterns of a disease, the collection of signs (*Zheng*), are processed by the practitioner (Farquar, 1994). This pathology of symptoms and the consequent syndrome occurs when an imbalanced state of hyperactive liver yang is linked to the stomach and the kidney yin fails to put out the fire. The practitioner explained this as an ‘excess yang and deficient yin’.

Nicole exhibited emotional tension and this distress, according to the practitioner, ‘indicates an emotional imbalance causing her liver to be hyperactive’. Her condition is exacerbated by her poor diet. Pathogenic heat attacks the stomach illustrated through the Five Element theory which identifies Qi as being imbalanced in the liver and stomach (Figure 8.2). The distress caused by her family situation is exhibited as

anger. Nicole sees her family as a casual agent of her distress. Nicole, referring to her illness told the practitioner,

“I feel worn out”, “I’m listless”, “I’m run down”, “I have no energy”.

The practitioner translation of this was expressed as:

“The client (Nicole) has ‘yang which is in excess’ or ‘there is Yin deficiency’, ‘the flow of Qi is stagnant’”.

From these words used by Nicole to express how she feel that she is tired, run down, has no energy, the practitioner makes translation and connection with TCM theory (Figure 8.2) via theory of the Five Element theory from which a diagnosis is constructed.



Figure 8.2 Client narrative connected to practitioner translation.

Kleinman suggests the primary ground for diagnosis and provision of care is founded upon the patient’s discourse. “Listen to the patient, he [she] is telling you the diagnosis” (1988, p. 130). The practitioner has attached importance to these mind-body somatic connections expressed through the interconnections of Zang Fu organs and the five elements which were associated with the harmonious function of Qi (*Qi hua*). The maintaining functions of the Qi are that of ascending, descending, entering and exiting in promoting physiological activities of the Zang Fu organ system as well as the bowels, channels, collaterals and tissues.

To explain the function of Qi, a brief summary illustrates the flow of the disharmony of Qi in Nicole's physiology. The role of emotional distress engendered by the illness is illustrated by Nicole's behaviour when observed by her practitioner as being tense and erratic. In Nicole's situation, the main physical manifestation of the pathology is the paralysis that affects her face. The practitioner identified that the element of excessive fire (which is one cause for facial paralysis) and disharmony of the liver and stomach were linked to her emotional distress and characteristics of the normal function of the liver – distinguished by growth, which 'dislikes being anxious' (Xinnong, 1987). When these functions are imbalanced the person will experience anxiety, depression, belching, sighing, distension and stuffy sensations in the chest and hypochondria (Xinnong, 1987). Function and dysfunction of the flow of liver Qi form a source of vital energy from which these interpretations can be made:

- 1) When there is dysfunction of the flow of Qi emotional changes occur and leads to the stagnation of Qi flow. Symptoms of depression, paranoia or weeping are experienced, [Nicole has experienced depression and disturbed sleep] this is an indication she has hyperactivity of liver Qi.
- 2) Liver dysfunction can have a harmful effect on the spleen and stomach resulting in indigestion. [Nicole has not been eating well since her husband's absence]. This is known as an 'attack of the stomach by liver Qi'. When Qi flow is poor, stomach distension and irritability will be experienced. Abdominal distension and diarrhoea can also occur, and is referred to as a 'disharmony of the liver and spleen'.
- 3) The liver controls the maintenance of the tendons and nails. When there is insufficient Qi, 'tendons are deprived of nourishment which causes contracture and weakness, and can cause poor mobility'.
- 4) Eye function is governed by the liver and eyes that demonstrate normal function are clear and bright. With poor Qi circulation they will be dry, red and painful [Nicole has painful and red eyes].

Pathogenic changes will occur when any of the seven emotions affect the corresponding organ and thus cause illness, importance is placed on the interconnections of the Zang Fu body organs and their interconnections with emotional and cognitive states (Ross, 1985; Enquin, 1988b). This is expanded upon in section 8.3.3.

Stage 2 [Zheng 2] – Relating syndromes to the metaphor of TCM

To derive a syndrome from the pathology of the clinical signs, the process of the four methods of Sizhen, is attended by the practitioner, from which differentiation of the signs and symptoms denote the presence of illness experienced by Nicole. These are; 1) eye disease; 2) hypertension; 3) neurosis.

The form of syndrome is metaphorically constructed through the Five Element theory as each specific syndrome has unique characteristics that identify the pathological changes that have taken place between the Zang-Fu organs of the body. For example, the nature of the specific syndrome attributed to Nicole's facial paralysis has to be differentiated from these syndromes, the practitioner identified as:

(1) Bing Yin

When the onset of paralysis is sudden this is caused by the invasion of the meridians of the body on the face by wind cold (*Bing Yin*). This acts to cause contraction of the meridians impairing the circulation of Qi and consequently the flow of blood.

(2) Gan Wei Huo Wang

A second cause is when there is excessive fire of the liver and stomach, which rises to 'attack the face' (*Gan Wei Huo Wang*). The irregular consumption of food causes the fire to be present in the stomach. This is exacerbated by emotional disharmony such as anger or in this case, the absence of Nicole's husband, the irritation of having to fend for herself in his absence and a sense of frustration which can all contribute to disharmony of the liver causing the Gan fire to arise.

(3) Yin Xu Huo Wang

Deficiency of yin and excessive fire (*Yin Xu Huo Wang*)

In this situation the water of the kidney yin fails to control the upward surge of fire. The meridians are affected as the fire flares up along the pathway to reach the face where it shows as a red flush.

The Syndrome determination - From the assessment made on Nicole, the practitioner from the signs and symptoms identified, interpreted her illness as 'an attack on the face' or *Gan Wei Huo Wang*, there is excessive liver fire attacking the face. According to the practitioner, these signs and symptoms are;

1. In the region of the head – headache is often a symptom, tinnitus and even deafness may be experienced
2. A disturbance of emotions – Nicole is tense and anxious. Her speech is rapid and loud.
3. Liver and Stomach involvement of fire present – this will produce a bitter taste in the mouth, nausea and pain in the hypochondrium area.
4. When full fire is present the person will experience thirst and crave cold drinks.
5. The person will experience constipation.
6. On facial inspection, the eyes will be very red.
7. The person experiences insomnia and is unable to sleep
8. The pulse will be thin and wiry
9. The tongue is red with a thick yellow coat

Stage 3 [Zheng 3] – The transactional symbols

Somatic symptoms are explained through these transactional symbols which relate to manifestations of imbalance of yin and yang energy in Nicole's body. Observable patterns of behaviour are exhibited by restlessness in her demeanour, and conveyed by erratic gestures made as she expressed herself when talking to the practitioner. There is rigidity in her vocal expression which has a high pitch and her speech is rapid and clipped. The practitioner takes into consideration that Nicole's behaviour is characteristic of an anxious person who is erratic, imbalanced and very tense. Somatically, various interpretations can then be made in regard to observations on these interactions and her body imagery.

Nicole's body type in TCM is described by the practitioner as a 'deficient yin type' as she is thin and inclined to emotional excitability, such a person is considered to be irritable, excitable, restless and hypersensitive (Ross, 1985). The practitioner sees Nicole's own state of emotional disharmony has contributed to and exacerbated her current situation, worrying to excess over the building of a new home, dealing with her husband's absence and her frustrated desire to conceive despite being on an IVF program. Her emotional excitability's is considered to have affected the balance of Qi flowing to her heart with an excess of liver Qi impairment of the liver function.

The practitioner discusses with Nicole the need for her to rest when acute pain is experienced as if she continues to work and remains in a hyper-aroused state her condition will be exacerbated and her treatment compromised and that 'the fire' in the liver and stomach will not settle. She has been working despite her condition and the practitioner advises her to reduce any fatty and spicy food in the diet, to avoid

alcohol. Being a health worker Nicole has felt anxious that it will be difficult for her to be replaced on her shift and has not taken sick leave.

Stage 4 [Zheng zhi] – intervention and treatment

When a differentiation of the syndrome is made treatment (*zhifa*) is then prescribed in which the liver and stomach will be treated to reduce the fire in the liver. In cases of neurosis, the focus of therapy is aimed at creating balance and harmony involves reducing the liver fire, to pacify and disperse heat and nourish the heart. Nicole's treatment involved the selection of different acupuncture points to her face and also to her upper hand. Two weeks after commencing acupuncture therapy Nicole's symptoms had disappeared and she no longer experienced the excruciating facial pain. There is a transformation of the psychophysiological process into a meaningful experience with the affirmation of healing (Kleinman, 1988, p. 134) when the client says their symptoms have been relieved and they no longer experience insomnia, heat in the head region and tension within the body.

From the practitioner's perspective, his treatment considered the mind-body connection to explain her illness and therapy was initiated to bring about change to the balance of the energy within her body. This provided the relief from her symptoms that Nicole sought. Nicole's case analysis illustrates that relevant aspects of social and family and social commitments required scrutiny by the practitioner. Each stage of the encounter of the diagnosis formation is guided by the diagnostic methods (*Sizhen*) and the eight factors (*Ba Gang*), in the formation of syndrome and selection of treatment based on the appropriate therapy.

8.2.4 Cultural construction of an illness

Argument that supports the premise attached to the combined processes of the specific elements informed by Kanbing, were described previously in 8.2.2 and 8.2.3. A detailed illustration based on the exchange of the illness narrative of Nicole and the presentation of the illness identifies how the cultural construct of an illness is informed through the processes of the assessment (Figure 8.3).

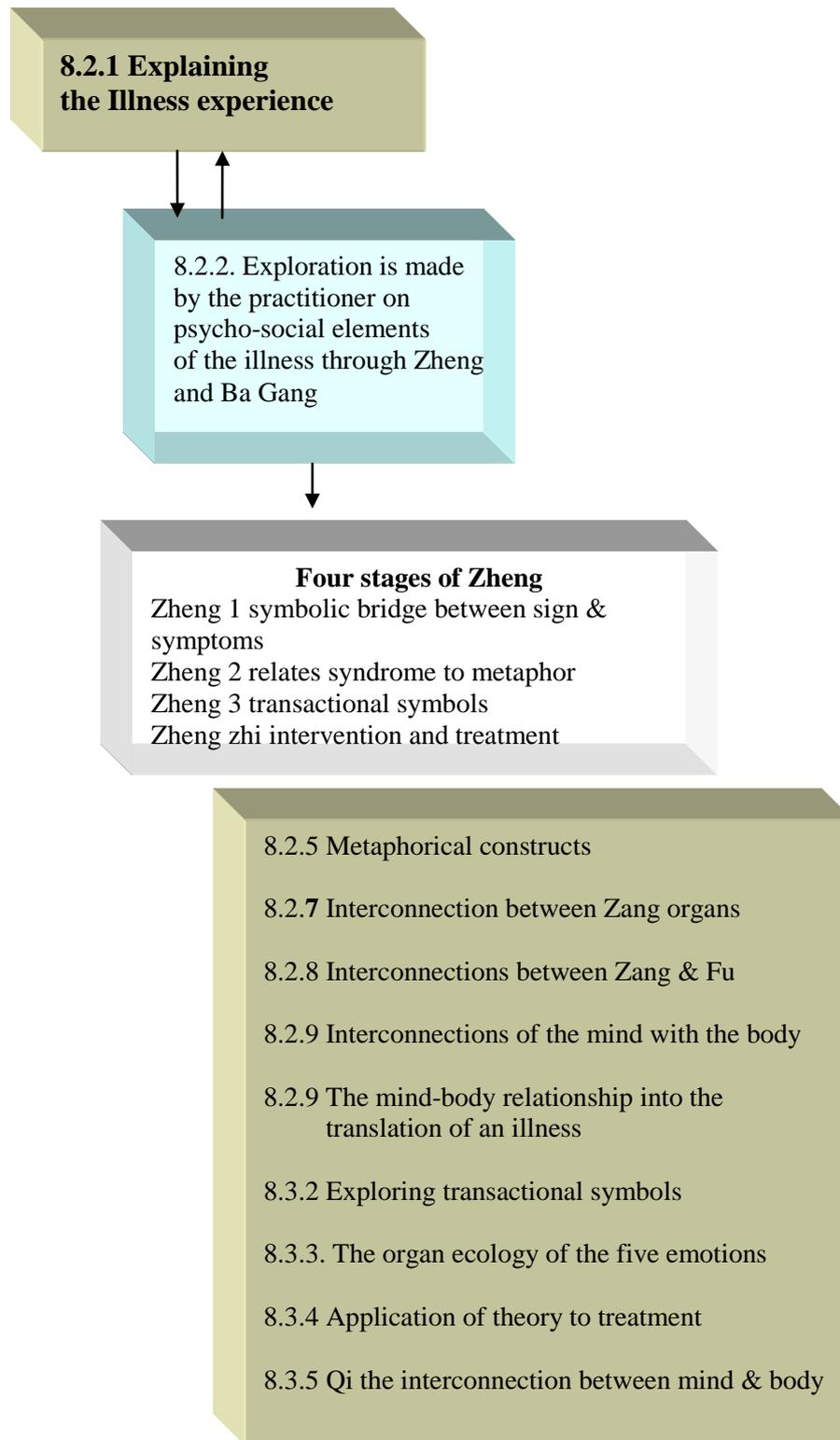


Figure 8.3 Sequence of a cultural construction of an illness.

In Kanbing transactions provide a form from which metaphorical construct is derived from symbolic connection and interconnections between organs, organ ecology and the nature of Qi. These are reframed as a process that involves explaining the schema of both mind and body (Longino, 1997), through the organ ecology representative of the five elements and the five emotions according to the stages of symbolic healing postulated by Dow (1986). From the clinical encounter, the information exchanged between the client and practitioner, the analysis is postulated on the premises to explain how Kanbing searches for meaning in the examination of the whole person. I show that interconnections are made between the metaphorical constructs that inform the illness (8.2.5), the symbolic connections found in the transaction (8.2.6), the interconnections made between the Zang organs (8.2.7), the Zang-Fu organs (8.2.8) and between the mind and the body (8.2.9).

8.2.5 Metaphorical constructs to create symbolic connections

The clinic interaction in TCM provided an opportunity for the client to form part of the search for an explanation of the illness reality (Good & Good, 1981). Metaphor and symbolic language are used by the practitioner who describes the nature of the interconnectedness of organs with specific elements of wood, fire, water, earth and air (Enquin, 1988a; Xinnong, 1987).

First, metaphor provides a format for the projection from which the bodily experience of the client is grounded in the process of sensory-affective imagery (Kirmayer, 2004). A person may come in to the clinic and complain of a backache and after discussion with their practitioner suggestion is made by the practitioner that provides a metaphorical reinterpretation of the illness to imbue meaning to explain that a specific meridian has ‘been attacked’ by wind cold or dampness.

Metaphor to suggest a meridian has ‘been attacked’, is described through the language unique to TCM, that ‘... the meridian pathway is blocked and thus the flow of Qi is impaired’. In describing how the flow of Qi is impaired, the practitioner discusses the ‘stagnation of Qi’ is brought about by ‘damp’ and suggests a therapy which involves ‘heating the meridian’ to ‘remove the cold and damp’. This diagnosis is based on a description of natural phenomena understood from the Five Element theory (Enquin, 1988a; Xinnong, 1987).

Chinese medicine imparts the cultural use of metaphor to body function and dysfunction (Yu, 2003). Yu gives the function of the gallbladder as an example with the association made between the gallbladder and a person who exhibits courage. Metaphorically a man without a gallbladder is a man without courage and by nature is indecisive, irresolute and with undesirable personal qualities (Yu, 2003). Yu's comment illustrates the semiotic notion that illness has somatic meaning expressed through metaphor in his example to promote courage and decisiveness (Enquin, 1988b).

Meaning is attributed to the function of the liver that is seen to regulate mind and mood, promote digestion and absorption and is the gatekeeper of Qi. Metaphor is found in the expression that 'tears are the fluid of the liver' (Enquin, 1988b). Eyes are the 'vital gate', a reference to the ending of the Taiyan channel at the point known as Zhiyin, the term vital gate recognises the importance of the kidney Yang, and is explained through this allegorical description that "the vital gate is both the root of the inborn Qi and the house of water and fire" (Enquin, 1988a, p.110).

With reference to Nicole, her symptom of lacrimation relates to the emotional imbalance of her liver Qi, and is manifested as fluid, in TCM thought. Allusions made to specific functions reinforce the notion that illness has a somatic meaning informed by symbolic connections through the use of metaphor.

Second, untangling the metaphors used to define illness is guided by TCM philosophy through a hermeneutic process that provides interpretative description to assist with the explanation an illness experience (Good & Good (1981). There is a symbolic exchange that Dow (1986, p. 56) suggests forms the interactive process of healing. It is not simply that the healer heals but that transactions between sick people are critical as the healer manipulates symbols to help the patient incorporate his or her own emotions into the transaction.

The patient is partner to the derivation of meaning from their experience of the illness reality and, is included in the translation of events by the practitioner. Felton (1993) makes this point that "... we have to talk about the patient as an active, vital participant in healing" (p. 225). In TCM, that therapeutic participation is engendered through the process of the interaction. Exchanges that are encountered in Kanbing between the healer and the recipient, even to the purpose of tongue and pulse examination, inextricably link the practitioner to a therapeutic role in the healing encounter.

Transactions and interactions between the sick person and healer that guide the exploration of symbolism in TCM language and the use of metaphors form a specific interpretative schema used by the practitioner. Dow (1986) argues that experience of healers and healed are generalised with culture specific symbols in cultural myth. Symbolic transactions (Kirmayer, 2004) occur between practitioner and the client, to link relevant interrelated internal factors at a cellular level and somatic symptoms and external factors such as the environment to the meaning found in the illness.

8.2.6 Symbolic connection in transaction

I now examine the symbolic forms expressed as words and phrases that play an important role in the transaction of the encounter. When clients describe specific dysfunctions of the body, these form part of the symbolic transaction engendered by the practitioner, (Dow, 1986) symbols "... become an intrinsic focus between the healer and the recipient" (Pilch, 2000, p. 30). Patterns of information can be identified describing the illness experience, which is textured according to the narrative embedded within the specific cultural context described by TCM.

The Five Element theory interwoven with elements of the natural world forms the diagnostic framework for the traditional healer (Maciocia, 2005; Xinnong, 1987). The Zang-Fu organs of the body are each associated with its own pulse, taste, colour, time of day, season, odour, sound, body orifice and pathway where the 'Qi' energy flows from and connects to other organs (Connelly, 1797; Enquin, 1988a; Lu, 1994; Xinnong, 1987). Symbolism expressed through the Five Element theory forms a guide for the practitioner of TCM to classify phenomena described by the ill person. Illness is therefore explained by both the physiological and pathological changes attributed to the inter-promoting and interacting relationships within the organs of the body determined through the flow of Qi energy.

In determining Nicole's illness, the four syndromes of *Wei*, *Qi*, *Ying* and *Xue* systems provide a means of differentiating pathological conditions and connect to the eight principles of interior and exterior, excess or deficiency, cold or heat, yin and yang, the flow of Qi and blood (xue) transmitted by the meridians and collateral systems. Diagnosis is based on the physical examination of the Qi or energy found through the interconnections found through the relationship of the organs. An example of this is the mother and son relationship to describe organ function based

on the Chinese tradition of the mother giving birth to male offspring to continue the family lineage (Clayre, 1984; Dow, 1986).

Links are identified through the organ relationships based on inter-promoting growth around the construct of the five elements known as a ‘mother-son’ relationship. Every organ is linked to an element of the natural world. Each element is a ‘son’ of the element that promotes it and the ‘mother’ of the one, it promotes. A normal relationship is explained as an interacting relationship – when wood acts on earth, earth acts on water, fire acts on metal and metal acts on wood (Connelly, 1979; Dow, 1986).

Specific terms are used to describe other effects of the Qi [energy] flow that links and supports each organ with terms such as, ‘inter-promoting’ or ‘inter-controlling’, ‘overacting and counteracting’ (Xinnong, 1987). Each of the elements takes on the role of “... being acted upon (under control) or (the controller) acting upon” (Xinnong, 1987, p. 21). Interacting relationships are known as ‘inter-controlling’ and along with ‘inter-promoting’ aspects to fulfil a co-operative and opposing role within the energy cycle of the five elements related to each organ. Harmony and balance promote and ensure normal growth and development.

Dysfunctions occur in the harmony and balance between the Qi flowing from one organ to another when there is an over acting or counteracting disorder of ‘the mother affecting the son’ or ‘the son affecting the mother’ (Xinnong, 1987). Counteracting energy means the energy flows in a converse and imbalanced way. Relevant to the physiology of the body the counteracting effect causes imbalance in the energy of the Qi. The element wood may counteract on metal and this would suggest there is an imbalance in the organs said to be deficient in metal Qi or an excess of the wood Qi (Xinnong, 1987).

An example from the *Nei Ching* (18) describes how an organic dysfunction is distinguished, when wood is brought into contact with metal it [the wood] is felled, fire extinguishes water, earth is penetrated by wood, metal can be liquefied by fire and water can be contained by earth (Veith, 1972). Wood is a symbol of the liver, metal (lungs), fire (heart), earth (spleen) and water (kidneys). Contextual imagery of nature forms a nexus between the client’s secular explanation of the illness, the practitioner’s interpretation of this through the Eight Principles (*Ba Gang*) and the disorder of the internal *Zang-Fu* organ identified within the theory of the five elements and from this nexus the practitioner attaches an illness diagnosis.

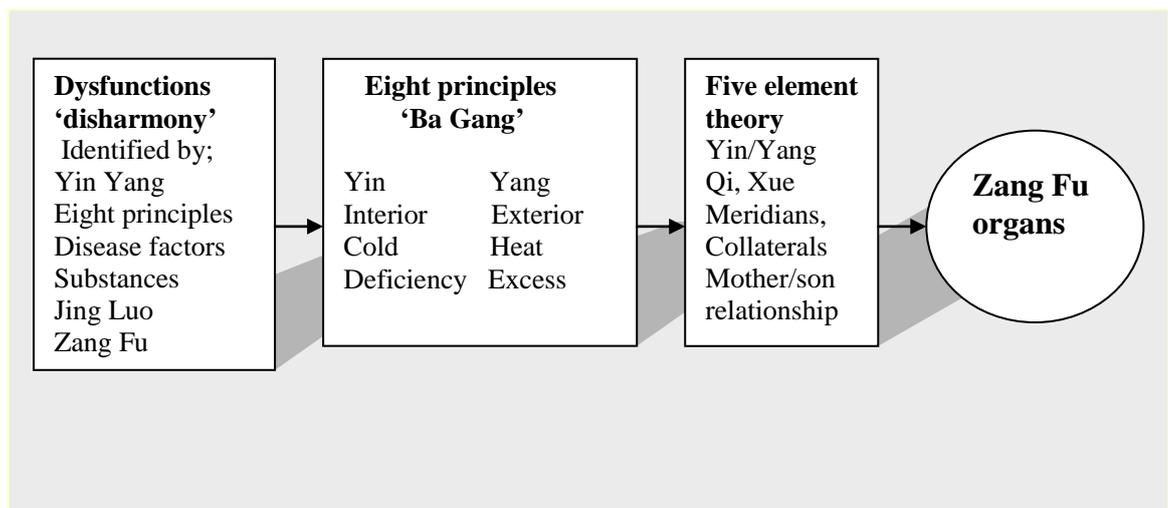


Figure 8.4 Connection of dysfunction to Zang Fu organs.

8.2.7 Interconnections between the major Zang organs

To illustrate the pathological interconnections between the major Zang organs, I now refer to the functions of the liver and heart, and the liver and stomach as these are the major Zang organs regarded to be dysfunctional that generate the pathology of Nicole’s facial paralysis. First, in the case of the liver and heart, the liver is specifically related to the function of the heart and to that of the lung (Xinnong, 1987). The heart and liver ensure the blood circulates freely, the heart controls the circulation and the liver stores it (Maciocia, 2005). There is a physiological interdependency and the potential for a pathological influence of one organ on the other. Physiologically the liver co-operates by ensuring that the flow of energy is unhampered to ensure that blood and Qi flow freely (Enquin, 1988a). If liver function is impaired stagnation of the liver, Qi hinders both the flow of Qi and blood. This is illustrated in Figure 8.5.

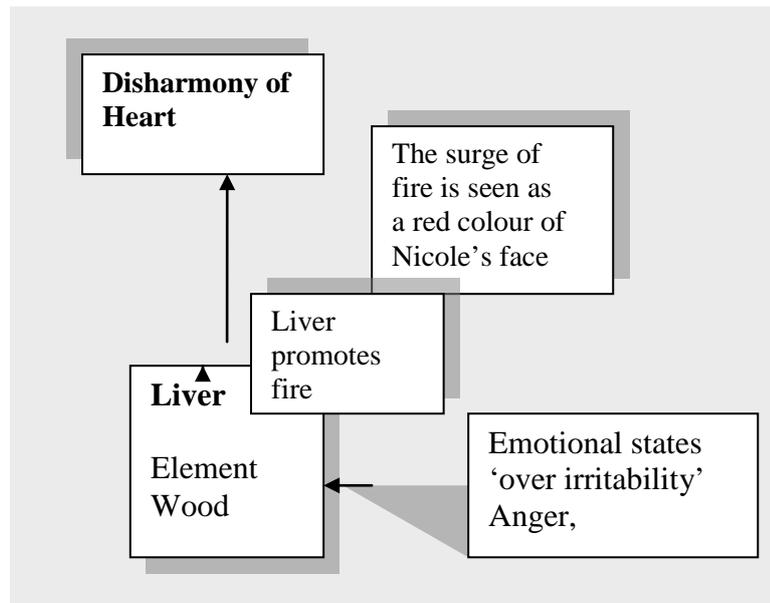


Figure 8.5 Hyperactivity of liver yang disturbing heart.

If there is a deficiency of blood from the heart then a deficiency of liver blood also occurs. The presenting symptoms are:

‘Palpitations, insomnia, dream disturbed sleep and pale complexion. The person may also experience dizziness, blurred and impaired vision’ (Xinnong, 1987).

The liver and stomach are expressed as a syndrome *gan wei bu he*, and is often due to the overactivity of emotional states, mental depression or exhaustion. Irregular food intake injures the *Wei Qi* or stomach Qi and the dysfunction of the liver Qi in promoting the flow of Qi produces mental irritability. The person will experience belching and distension of the stomach and will be anxious and tense.

8.2.8 Interconnections between the Zang and Fu organs

Nicole’s example illustrates the interconnections between the liver (zang organ) and gall bladder (fu organ), explained here in reference to the case analysis. Physiologically the gall bladder is attached to the liver and connected through meridian channels and acts as a conduit along which the Qi flows (Xinnong, 1987). Both organs act interdependently but can be pathologically affected by each other. If

there is too much liver fire and gall bladder fire Nicole will experience a bitter taste in the mouth and have dryness in the throat and be irritable.

A core task of TCM clinical practice is to affirm the client's emotional and physical experience of illness, initially the TCM practitioner directs the focus from his/her perspective to juxtapose the illness experience of the patient, relating divergent perspective with their environment and cultural settings to assess the illness episode (Kleinman, 1989). From the practitioner's perspective an order of the sequence is necessary to reach the core of the TCM theory. This enables the practitioner to identify and determine the connections between signs of the illness and the effect on the organ or organs to differentiate the symptoms into what was described earlier as a 'syndrome'.

In understanding the social and personal meaning attached to this illness [experienced by Nicole] the client is assisted to create meaning out of the chaos of their daily lives. Client's voice in lay terms what they are experiencing within their body state of somatic conditions. There is anticipation of having sought assistance they will gain relief for symptoms that cause their distress. In TCM this provides an entry for an understanding of the mind-body dimensions explained through the symbolic language of TCM interpreted by the practitioner. Somatic imbalance can be linked by observation to the pathology of the illness as Qi that is "considered to be the manifestation of the mind and which state can be observed in the glitter of the eyes" (Maciocia, 2005, p. 41).

8.2.9 The inter-connection of the mind with the body

Nicole's illness provides an example of the role played by the element wood from the Five Element theory. The Zang-Fu organs of the liver and gall bladder are represented by the element wood. The links between the emotional disturbances that affect Nicole are from the imbalance in this element creating a disharmony between the flow of Qi and blood. TCM involves specific forms of identification found during the assessment procedure where the practitioner deciphers and translates client symptoms into the language of TCM (Connelly, 1979; Enquin, 1988b; Lu, 1994; Ross, 1985; Xinnong, 1987).

A symbolic bridge is then created between personal, social and cultural meanings attached to an understanding of the Five Element theory to explain organ interaction.

In Nicole's case she has an imbalance of Qi related to the upsurge of liver yang. The liver is represented as wood, as a tree regulates the flow of sap which is transformed from water and nutrition from the soil, the liver stores and regulates the flow of blood (Xinnong, 1987). When the function of the flow of blood and the vital energy or Qi is normal, the body's mental activities will be balanced and the person relaxed and at ease. Emotional disturbance leads to turmoil and agitation that causes the flow of Qi to be disrupted. Referring to each of the emotions and their symptoms of imbalance, several conditions are expressed through Nicole's symptoms, poor appetite, sore eyes, disturbed sleep patterns and she is tense and anxious.

The practitioner listening to the symptoms being described relates these in terms of a metaphor as, 'archetypal element of wood'. Wood is the element representative of the liver, emotional wellbeing occurs when the liver function is maintained normally, the flow of Qi is harmonious and the mind is relaxed. Connelly (1979) remarks that "... as a tree flourishes so too does the liver Qi or energy of the person" (p. 24). Trees have roots, which ground them to ensure they continue to grow and tap into water, which nourishes them, a person who describes themselves as ungrounded will be put off balance easily, manifested by feelings of dizziness and vertigo that relate to a lack of balance and coordination.

If the person is off balance they may also experience spinal problems because their trunk is out of alignment. The practitioner drawing on his/her understanding of the flow of Qi detects and interprets subtle energy imbalances (Kaptchuk, 1987). A subsequent diagnosis and evaluation of the overall physiology and wellbeing are based on observing and interpreting the body as a whole (Ferigno & Wang, 2000; Kleinman & Kleinman, 1994).

As the discussion has shown, in TCM clinical practice emotional meanings attached to an illness experience play a central role and generally symbolic meaning can be found in emotions such as grief and sorrow when the body is in a state of imbalance (Schwarcz in Kleinman, Das & Lock, 1997). Chinese medicine attaches significance to the functions, interrelationships and patterns of emotional disharmony expressed in behaviour (Ross, 1985) and attributed to the emotional imbalance has affected Nicole's health examined in the following section. I now move from the case analysis to expound on the notion of element of Qi in TCM before concluding in Section 3 to look at the mind-body relationship in the translation of illness.

Section 3

8.3.1 The mind-body relationship in the translation of an illness

The previous discussion mentioned the central importance of the mind-body relationship in TCM the next task is to provide a broader discussion of this relationship as it is understood in Western medicine by medical and biomedical practitioners who have examined mind-body relations (Benson, 1979; Moyers, 1993; Pert & Ruff, 1993; Pert, 2000). In TCM the role of Qi in the mind-body connection has been examined and explained through Kanbing (Connelly, 1975; Enquin, 1988b; Ferigno & Wang, 2000; Firebrace & Hill, 1988; Gilbert, 2003; Hsu, 1999; Maciocia, 1989; Ross, 1985; Unschuld, 2003; Zhang, 2007).

The practitioner's use of the vocabulary illustrates that words and phrases act as key elements in the cultural construction of illness. For example specific words and phrases such as: 'like mother-son relationship', 'mother failing to nourish child' 'the heart houses the mind', 'blazing Gan fire', 'invasion of wind cold', and 'dysfunction of the liver in maintaining the free flow of Qi', provide insight into the specific cultural context in which TCM is practiced. Other words are used metaphorically to convey a sense of the complexities of the relationship between mind-body: heart [*xin*], mind [*shen*], consciousness, vitality [*qi*], soul or spirit [*shen*] (Ferigno & Wang, 2000).

Environmental change inevitably affects the nervous system of the body and this has an effect on the heart (*xin*) which seen from the perspective of TCM, controls the mental and emotional activities and connects with the spirit and emotion governed by the mind. Maciocia (2005) argues that Chinese language expresses concepts embedded in the culture, for example, "*Jing-Shen* means mind or consciousness, showing the interaction of the body and mind" (p. 17). Particular importance is attached to understanding of the vocabulary of words and phrases that are used to construct imagery of the mind-body relationship, with such words to describe experiences when it is said, we have a 'broken heart' or have 'gut feelings' (Kabat-Zinn, 1993). Lo (2001) suggests that language used to illustrate metaphorical constructs in TCM, are linked to wider cultural constructs such as empire, architecture and the geography of China. Words are used to describe animals, plants,

water and valleys, buildings and astronomy (Xinnong, 1987). The assembly of these words is applied to the identification of specific points throughout the meridian system. Ferigno and Wang argue this vocabulary of words, phrases and metaphor:

... take practitioners to other levels of meaning, furthermore what can be perceived, as an inherent weakness of language can be seen from another perspective to contain other layers of meaning eminently suited to seeing and knowing body-mind (2000, p. 34)

How this occurs in TCM might be understood by exploring the mind-body relationship described this way by Maciocia (2005) who refers to the heart governing the blood, whilst the liver stores blood. The heart houses the mind and the liver connects with the soul. Connections that inform Qi are found through the mind-body relationship and can be explained with reference to the somatic nervous system, the neuropeptides (Pert, 2000) and a shared substrate (Hsu, 1999) found in the overall function of the physiology of the body expressed as links to the five emotions, the five elements of nature, found in the Five Element theory. Adler (1993) describes the link between mind and body like this, "... the mind and the body – that's the same thing. They're inseparable" (p. 245) and Felton (1993) says, "I tend not to separate brain and mind because I think ultimately they're one and the same" (p. 237).

An understanding on the mind-body relationship has been enhanced through neuroscience by Pert (1993; 2000) who extensively researched the interface of pharmacology and neuroscience. In 1974, Pert discovered the opiate receptor, the cellular bonding site for endorphins in the brain and this provided a scientific understanding of the mind and body communications that are initiated through emotion. On the physiological and psychological correlation of intracellular molecular biology, Pert concluded that a biochemical connection links the mind and body.

Opiate receptors and peptide receptors Pert said, "... were identified as providing a connection between brain and body parts and that neuropeptides are the 'biochemical units of emotion' " (2000, p. 181). According to Pert, the emotional state connects to the psychological reactions and the release of specific peptides attaching to specific receptor sites that are found in the immune system. These neuropeptides form a connection of an extra-energy level between the mind and physical body that is not yet fully understood.

Qi [in TCM] is an example an extra-energy level and important to an understanding the nature of TCM, to ratify this assertion reference is made to Moyers (1993) who with a research team of scientists, psychologists, neurologists and immunologists travelled to China to examine the TCM approach to medicine and the central role played by Qi. From this fieldwork a series of interviews developed around the concept of Qi that were shaped by two important questions. First, how do thoughts and feelings influence health? Second, how is healing related to the mind? To find if there was an association between thought, health and mind, Moyers posed this question to the team, 'if Qi is anything like adrenaline?' Eisenberg, an Associate Professor at Harvard Medical School, replied:

It goes beyond any one chemical. Your mind governs your energy. The question is how do you translate that into Western scientific terms? We invented the notion that biology and physics, psychology and psychiatry are separate. But if we want to deal with health and we're looking only at the chemistry, we have an imperfect glimpse (1993, p. 310).

To explain this I refer to Scheid, who writes that blood, (*xue*) in Chinese medicine, denotes a form of several energies in the body, "is more analogous to the western medicine thought than Qi, where no counterpart exists in the world of biomedicine" (2001, p. 380). If this is understood in the context of TCM thought there is no counterpart yet understood in western scientific thought, then the function of Qi recognised in TCM plays a function that would be difficult to approximate in evidence based research. Qi is an example of an extra-energy level that has an impact on the balance of emotional states and physical wellbeing of the body as it is found throughout the body. Hsu (1999) also makes this point on the unique property of Qi:

'Qi' is varied in its qualities according to its location and that disharmony of the dynamics of Qi is responsible for disorders in the body. ...The wellbeing of a person depended on the harmony of the chorus of Qi in different locations, inside and outside the body (p. 82).

Here Hsu draws on the analogy that balance of Qi is expressed as a harmony between the external and internal environment. The organs of the body each have their own different form of Qi, therefore when Qi is in disharmony in one area it will affect the overall state or flux of Qi elsewhere (Hsu, 1999, p. 82). Accordingly when the flow of Qi is obstructed or uneven, the balance of emotional stability is disturbed. The person may respond with excessive or inappropriate reactions resulting in disharmony with self and others (Ross, 1985).

8.3.2 Exploring transactional processes of the organ ecology

In TCM each aspect of the body is regulated and governed as a microcosm and the ecology found between the Zang Fu organs. This microcosm is recognised as being an organic whole, closely aligned and susceptible to the influences of the natural world (Enquin, 1988). The unity within the body is expressed as the viscera, bowels, tissues and other organs each having special but interconnected functions (Xinnong, 1987). Hsu (1999) suggests that this provides an ecologic notion of the body she illustrates as a concept of mutuality between the macrocosm and microcosm and the continuity of the internal and external aspects of the physical body. Hsu suggests "... is a shared substrate [of] Qi. The shared substrate of Qi, permeates the external environment" (1999, p. 82).

Referring to the case of Nicole who has experienced anxiety, there is a state of imbalance within the complex connections of the Zang organs where the Qi does not flow rhythmically according to the cycle of meridian transportation, Qi becomes stagnated and the energy to a particular organ is blocked. The flow of Qi through the meridian pathways becomes impeded and this causes blockage or stagnation. The following section explores the connections that are made between the organs and the emotions.

8.3.3 The organ ecology of the emotions

To understand the meaning of the client's behaviour from significant experiences in their life, the practitioner elicits information that constructs meaning from the socio-somatic attributes recognised in the illness. A focus is directed to the interpretation of how the person feels. The practitioner creates what may be hypothesised to be a symbolic bridge expressed as metaphor through the dialect of five major emotions linked by the Five Element theory. Metaphorical interpretation is given to explain the somatic representation represented by the emotion linked to a specific organ dysfunction (Dow 1986; Moerman 1983; Kleinman, 1988). Gilbert (2005) weaves these socio-somatic processes of everyday life through which social relations, affect blood pressure, heart rate and respiration. Gilbert also perceives how social loss and demoralisation can contribute to illness and disease (Kleinman, 1997; Nichter, 1997; Schwartz, 1994).

Seen from this perspective, TCM interweaves those aspects of the environment which form an ecology in which the human body resides. Hsu (1999) calls this ‘the body ecologic’, acting as a constitution of mutual resonance that occurs between the macrocosm and microcosm, between the inside and outside of the physical body. It manifests as both pathological and somatic change that interrelate and are concurrent with the individual’s emotional state. Ferigno and Wang (2000) suggest that from a “Chinese medical perspective the mind and body are seen as unified, together informing the human condition” (p. 134). Specific energy or Qi found in each zang body organ is found representative of the following five emotional states that somatic imbalances are able to be linked to:

1) Fear – Shen Qi is associated with the function of the kidneys. Fear occurs when a person is distressed and may exhibit a temporary loss of control of their ability to retain urine. The somatic activity of the kidney when fright occurs causes the flow of *Shen Qi* to be interrupted.

2) Anger – Gan Qi or Liver Qi governs the storage, the regulation of the flow of energy and blood, and the liver stores and regulates blood to keep the *Gan Qi* flowing smoothly. A person exhibiting a violent outburst of emotion speaks aggressively or shouts, who has a florid face and shakes or tremble with rage, has a dysfunction of Gan Qi.

3) Joy – associated with the heart. Excessive joy can impair the heart and cause a dysfunction with the liver. Chinese medicine sees an association similar to the mood swings categorised in Western medicine as a Bi-polar disorder. The Qi of the heart is (*Xin Qi*) with the main function to circulate the blood. TCM views heart activity as controlled by higher mental function and conscious thought. Such a person is vigorous and has a sound mind.

4) Worry – is associated with the spleen. There is depressed function of the transportation of food essences from the stomach in a person who worries and is pessimistic. The Qi of the spleen (*Pi Qi*) is responsible for the production of blood and Qi and any dysfunction in transportation and transformation causes a deficiency of both.

5) Grief – is associated with the wellbeing of the lungs. A person who has experienced loss and grief will suffer from the stagnation of Qi and respiratory function may affect the lung (*Fei Qi*). The lungs are responsible for inspiration that

forms *Zong Qi* and expiration and it promotes the warming activity of the body with a second function attributed to the lung of regulation of the flow of Qi in the inspiration and expiration function.

Enquin (1988b) says that although there are ‘five’ emotions, pathogenic characteristics can be associated with other emotional factors of excessive rage and sorrow that will affect the heart Qi. For example Xinnong says, “... deficiency of the heart Qi will cause ceaseless laughing” (p. 30). Xinnong describes manic depressive disorder as characterised by melancholy, dejection, reticence and incoherent speech, while a manic disorder is distinguished by shouting, restlessness and violent behaviour (1987, p. 421).

Drawing once again to the case analysis of Nicole, three emotional factors are exhibited through her behaviour. First, fear that she will have a permanent paralysis and her anxiety caused by being unable to perform at her workplace. Second, she is angry at having to work and organise the building of a new home, her anger is expressed through the upsurge of the liver yang. Third, she worries when on her own without the support of her partner. In the clinical encounter the practitioner sought out characteristics that may indicate there to be an emotional disturbance that is linked to a specific pathology of the organ function. Nicole has an imbalance of energy between her liver and stomach that creates a disharmony of her heart Qi. It is explained by Maciocia as:

The mind and emotion mutually support each other, therefore a weak heart and a [low] mind may lead to depression and anxiety while constrained emotions can lead to a weakening of the mind and lowered vitality (1989, p. 106).

The heart and liver are the two organs considered responsible for ensuring there is a balance in the harmonious flow of emotions throughout the body. How a person perceives their world creates either balance or an imbalance of thought. The practitioner is able to determine disturbances that arise from imbalances of emotional states that arise from disharmony between the heart and the liver to create imbalance (Ross, 1985). TCM takes into account culture specific syndromes that relate to specific somatic health problems embedded within a particular cultural consciousness with earlier reference made to the syndrome of ‘neurasthenia’.

To explain what is meant by cultural consciousness, TCM refers to the spirit or *shen* that resides in the heart and that a lack of joy is associated with deficiency of *shen*. Grief and worry injure *shen* that has an effect on the ability of the Qi to flow freely. When an imbalance occurs and disturbs the spirit the person experiences restlessness, insomnia and disturbed sleep. If the liver or Gan Qi becomes involved as in the case study of Nicole in 8.3, ‘there may be feelings of restlessness, anxiety and panic’ (Ross, 1985, p. 124). Certain manifestations of illness such as depression or the blocked flow of energy may be comprehended as different diseases in different societies (Unschuld, 1985). Viewed from a western context, this might be described as clinical depression (American Psychiatric Association, 2000).

When modern psychology was introduced to China, the concept (*qing zhi*) was used to explain “... illness such as stagnation of sadness and worries (*youyu*) was used to translate the Western concept of depression” (Zhang, 2007, p. 90). However, in Chinese there is no known word for depression other than the word for sadness (*yiyu*) which has the word ‘*yu*’ in its translation and ‘*yu zheng*’ includes a group of illnesses and patterns of syndrome (Zhang, 2007). These have their origin in the Chinese concept of ‘*qingzhi bu shu*’ or blocked emotions with the cause attributed to an impeded Qi mechanism (*qiji yuzhi*).

A TCM practitioner who diagnoses a dysfunction of ‘*Shen*’ focuses on the restoration of harmony between the kidneys and the heart. Kidneys store water and are associated with the emotion fear, and feelings of arousal and anxiety. The heart is associated with the element fire and the emotion joy, when a disorder exists there is lack of control of mental and emotional activity as “... the heart is the ruler of all the organs and the seat of the spirit (Firebrace & Hill, 1988, p. 63).

In uncontrolled emotional activity brought about through surges in emotion that impact on the heart, there needs to be restoration to tranquillity (Firebrace & Hill, 1988). Conversely the circulation of blood can be influenced by emotion. A dimension of health recognised in TCM, ascribes importance to the energy pathway or meridian flow of Qi found in each organ throughout the body. Hence the therapy is initiated to promote harmony and balance of the flow of energy between the major organs. The practitioner seeks to uncover facts that are relevant to the illness, first focuses to identify links that explain somatic symptoms.

8.3.4 Applying theory to the diagnosis and treatment

TCM theory is linked to clinical practice through data collected using the diagnostic methods of Shizhen and Ba Gang, includes assessment, observation, questioning listening, pulse and tongue diagnosis through the four stages of Zheng. These methods determined how pathological change of the body is based on the law of the five element theory (Xinnong, 1987). The human body is considered to be an organic whole, thus when one organ of the body experiences a dysfunction, it may also impact on other organs and tissues through transmission.

Transmission involves disorders of ‘the mother affecting son’ and ‘the son affecting the mother’ (Xinnong, 1987). An example is when a disease of the stomach is transmitted to the liver, known as earth counteracting on wood. Theories based on the concepts of overacting and counteracting help explain the cultural construction of an illness in TCM. From the assessment made on Nicole, the practitioner drew on TCM theory to explain her somatic symptoms; the flushed face and excessive lacrimation fluid from her right eye and a runny nose. This analysis phase before a syndrome is identified is formed around meaning attached to the theory of the five elements, which her practitioner described;

‘... this situation is one of having an imbalance of kidney yin with an excess of liver yang Qi and stomach yang Qi’.

The redness of the eyes is found to be associated with heat and discharge from the eyes linked to both wind and heat (Ross, 1985) and fire quenched through the element water of the kidney yin. If there is insufficiency of the kidney yin, water fails to control the fire. Figure 8.6 shows the complex interplay between the organ physiology and the pathological relationships between the organs of the body.

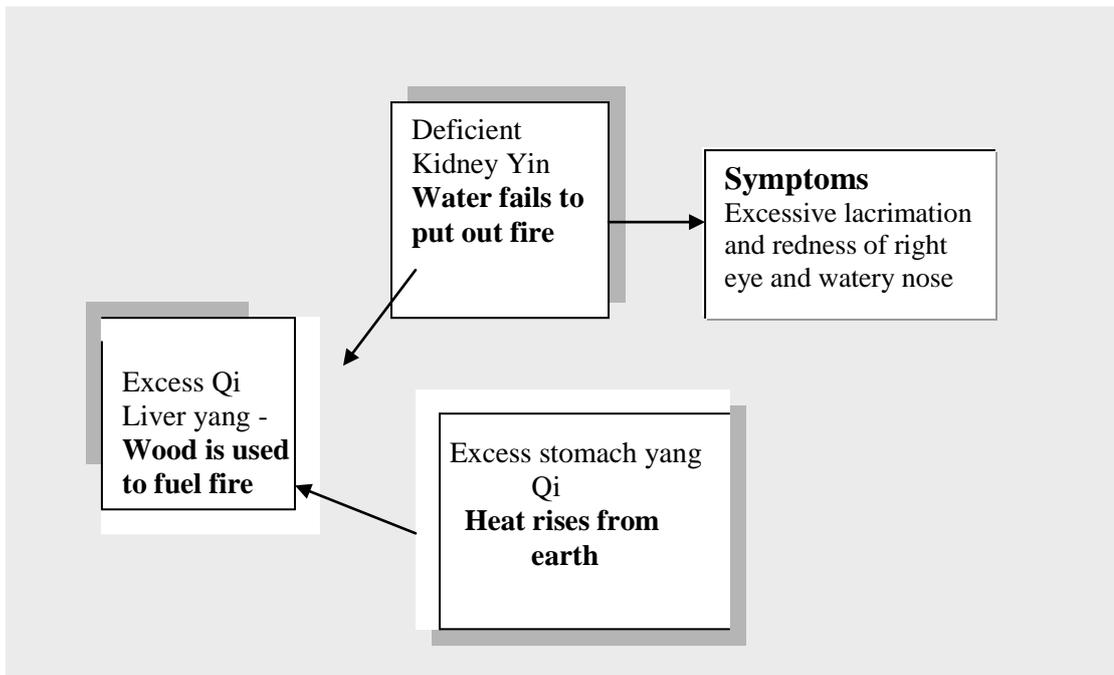


Figure 8.6 Liver and stomach counteracting.

As a result of the excess liver and stomach yang Qi, the fire flares up (Fig 8.6). The interpretation of the cause of this illness derives from ancient texts as in the ‘Plain Questions’ sections of Huangdi’s Internal Classic where he writes;

When the Qi of a given element is in excess, it will overact on the acted element and counteract on the acting element. When Qi of a given element is in deficiency it will be attacked by the acting element and counteracted by the acting element (Xinnong, 1987, p. 21).

The approach to reveal the mind-body connection illustrated through Nicole’s illness of facial paralysis is linked to the five emotions and imbalanced flow of Qi. A TCM diagnostic approach is based on a central notion in Chinese medicine where the body is viewed as an organic ‘whole’ interpreted to be a mind-body understanding. In Kanbing there is an interwoven connection that ‘looks at the illness’ (Farquar, 1994), by the practitioner who “weaves the central components that contribute to the individual’s experience and in doing so ‘honour’s’ that weaving as a sum greater than the individual parts” (Gilbert, 2003, p. 564). Eisenberg (1993) puts it that in traditional Chinese medicine thought, there is an understanding on the relationship between the mind and the body explored through the practitioner-client interactions known as Kanbing. I present these inter-connections as illustrated in Figure 8.7.

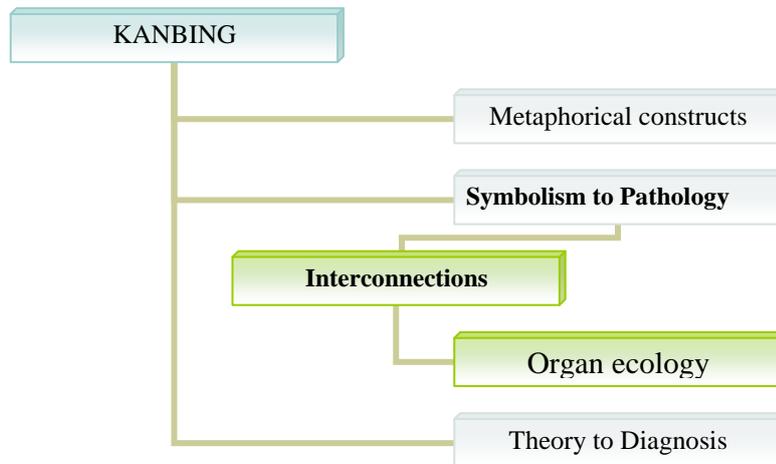


Figure 8.7 Analysis of Kanbing.

A holistic focus of attending to practitioner client interaction is found in Kanbing through the dexterous weaving of connected information extracted through tacit processes that explore and reveal all facets of a person’s life. This promotes a form of medicine that encompasses an examination of the whole, a view shared by others (Enquin, 1988a; Kaptchuk, 1983; Kleinman & Kleinman, 1994; Lu, 1994; Maciocia, 2005; Xinnong, 1988).

8.3.5 Qi – the interconnection between mind and body

The notion of a spiritual element in TCM has in the past been met with scepticism by Western medical practitioners. Chinese philosophy since the beginning of early Taoist philosophy linked nature and human adaptation to the elements ‘thus giving a spiritual basis to the theory of TCM medicine’ (Enquin, 1988, p. 32). The concept of balance and harmony of the flow of energy in the body is described by Lao Tzu (cited in Connelly, 1975, p. 15), ‘... my body is in accord with my mind, my mind with my energies, my energies with my spirit’. It provides a basis for harmony

between the mind and body that is not generally recognised in the practice of biomedicine. However understandings of mind and body in Western medicine were pioneered by Benson (1975). In 1998, The Harvard Medical School formed an association with the Mind/Body Medical Institute founded and directed by Benson an Associate Professor in Medicine at Harvard. Benson, Corliss and Cowley (2004) say the work of the Mind Body Medical Institute:

‘is based on the inseparable connection between the mind and body – the complicated interactions that take place among thoughts, the body, and the outside world’ (Newsweek, September 27).

Advancements in mind-body medicine have also been made by Pelletier (1993) who holds a chair at the Department of Psychiatry at the University of California, School of Medicine. These advances by Western doctors have determined that links are formed between the mind and body. Kleinman and Kleinman (1994) suggest TCM as a form of medicine, enables ‘links between the social and bodily experience’ (p. 707) explained by referring to the role of Qi and emotion.

Energy expressed as Qi, constantly flows throughout the body (Figure 8.8) to link the emotional states that adapt to the counterbalance of the changing dynamics of Yin and yang balance in the zang fu organs. Qi is in a constant state of flux and interconnections made between Qi, the mental state and the organs of the body as it nourishes and enables blood (*xue*) to be propelled through the vessels, the flow of Qi being affected by the energy of Shen. When there is loss of energy or a block to the flow of energy, “devitalisation is understood to affect the body-self and the network of connections, the microcosmic local world and the macrocosmic society” (Kleinman & Kleinman, 1994, p. 14)

The practitioner is able to detect and describe patterns of human illness from how Qi is manifest as a loss of energy or as an energy block, described in the discussion earlier on neurasthenia. TCM sees a correspondence exists between environmental processes and mind-body interactions through the interactions and transactions link disease manifestation through the phases of Kanbing. In Chinese medicine the flow of Qi might be expressed and associated with the sense of pain and discomfort, shen, mental activity, feeling states or one’s sense of the spiritual (Ferigno & Wang, 2000). The discourse surrounding ‘Yin’, ‘Yang’, ‘Shen’, ‘Qi’ and ‘Xu’, provides a way of to translate and interpret health and illness from a TCM perspective. Internal states of dysfunction in the physiology of the body can occur in relation to external events and

this may then cause disharmony to the internal state of balance explained through the cultural construction of TCM. This is illustrated by Rose (1999) who describing the concept of Qi disharmony. He writes that when he visited Chengdu, Dr Chen suddenly began to speak to him;

The evil Qi, Dr Chen announced, 'has invaded the network vessels. It must be driven out. There are 'six evil Qi' that circulate in the world. Now we have an abundance of two of them: the damp and the summer heat. That old woman that was here an hour ago [had] dampness and heat obstructing the lower burner.

We have to drive out the 'evil Qi'. That's why we use the rhubarb root along with wild chrysanthemum flowers: it will also cool her down. We help the upright Qi and drive out the evil Qi. Then she will feel comfortable and the aching in her legs will be gone. You have to know when to treat the inside and when to treat the outside (p. 81).

Dr Chen refers to the 'evil Qi' that needs to be driven out through the use of rhubarb root and wild chrysanthemum flowers. How this might act to eliminate the problem the woman has in her 'lower burner' defies logical interpretation from the approach of Western medicine. It must be examined through the precepts that inform notions of traditional Chinese medical views of health and disease embedded in the philosophy expressed through the five elements of wind, fire, earth, metal and water. An understanding of the Five Element theory is given by Unschuld, drawing on the *Nei Jing* [*Su Wen* 19]:

evil Qi of wind cold starts in the skin where it can be eliminated through sweating and ending in the heart. Hence wind cold is said to pass from the lung [metal] to the liver [wood] from there to the spleen [soil] which transmits to the kidney [water] before it ends in the heart [fire] (Unschuld, 2003, p. 173).

The five elements of nature express transformational stages within an illness in the body and with the use of an appropriate therapy, at any of the stages of heart, liver, spleen, kidney except the lung, can inhibit the transmission of the disease. When the 'evil' Qi has invaded the bone and marrow, the disease cannot be healed [*Su Wen* 16]. The description above of the variables of cold, dry, damp and wind [*wu wei*] excess Qi affecting the emotions of joy, anger, worry, sorrow and fear [five impulses], links the 'analogous processes in heaven (*tian*) and man (*ren*) the macrocosm and microcosm of the body ecologic (Hsu, 1999, p. 110). Such a representation of the organs of the body where each possesses a different Yin or

Yang energy is a way of viewing the body as a unified system of correlations of five elements, five emotions and the organ viscera working in synergy (Enquin, 1988).

A symbiotic relationship exists between mind and body, the way in which human life unfolds (Rose, 1999) is a dynamic process wherein a synergistic effect is found throughout the organism, the consequent equilibrium being that of a state of balance of Yin and Yang Qi (Maciocia, 2005). A description of the changing state of Qi within the body becomes a way to understand the mind-body connectedness wherein a balanced flow of Qi, is consequential to the experience of wellbeing. The mind-body association found in Chinese medicine presents difficulties to those associated with a western conventional medicine approach as Eisenberg (1993) points out;

The difficulty in looking at Chinese medicine is that it's like going to medical school within the confines of a theological seminary. In the West we separate religion and medicine. In Chinese medicine, the medical masters were also the spiritual leaders. They never split the two (p. 297).

Mindful-body awareness is found to be enacted through discourse in the assessment interwoven with a description of how much discomfort a person is experiencing. Ferigno and Wang (2000) argue that in Kanbing, the practitioner listens and gives credence to how a client describes their experiences they experience and is a way of understanding that person's state of being. Chinese medicine attaches meaning through Zheng, to descriptions of symptoms and varying somatic states. The way in which a disorder is conceptualised, explained, diagnosed and treated remains "... remarkably Chinese. It is not culturally bound but [is] certainly permeated with culture" (Zhang, 2007, p. 1). This is evident in interconnections found between the body ecologic that Hsu writes of through an understanding of responses to illness found within the Kanbing process that 'looks at illness' (Farquar, 1994). I have provided my examination and analysis of the interactive processes revealed in sections 8.2.3 to 8.3.5 of this chapter. The link between the mind and body is expressed through the symbology of the body organs, each representative of different elements of nature and the flow of Qi, which I illustrate in Fig 8.8.

Chinese medicine is uniquely different to conventional medicine as it articulates a language which incorporates a symbolism in Chinese terminology of words such as 'Qi' or energy, Yin/Yang to generate a unique conceptual model. This approach is provided through Kanbing that establishes the interpretation made on states of wellbeing or illness. Dialogue serves to establish this connection between what

people say they feel physically and what they are experiencing emotionally (Pert, 1999; Pert, 2000).

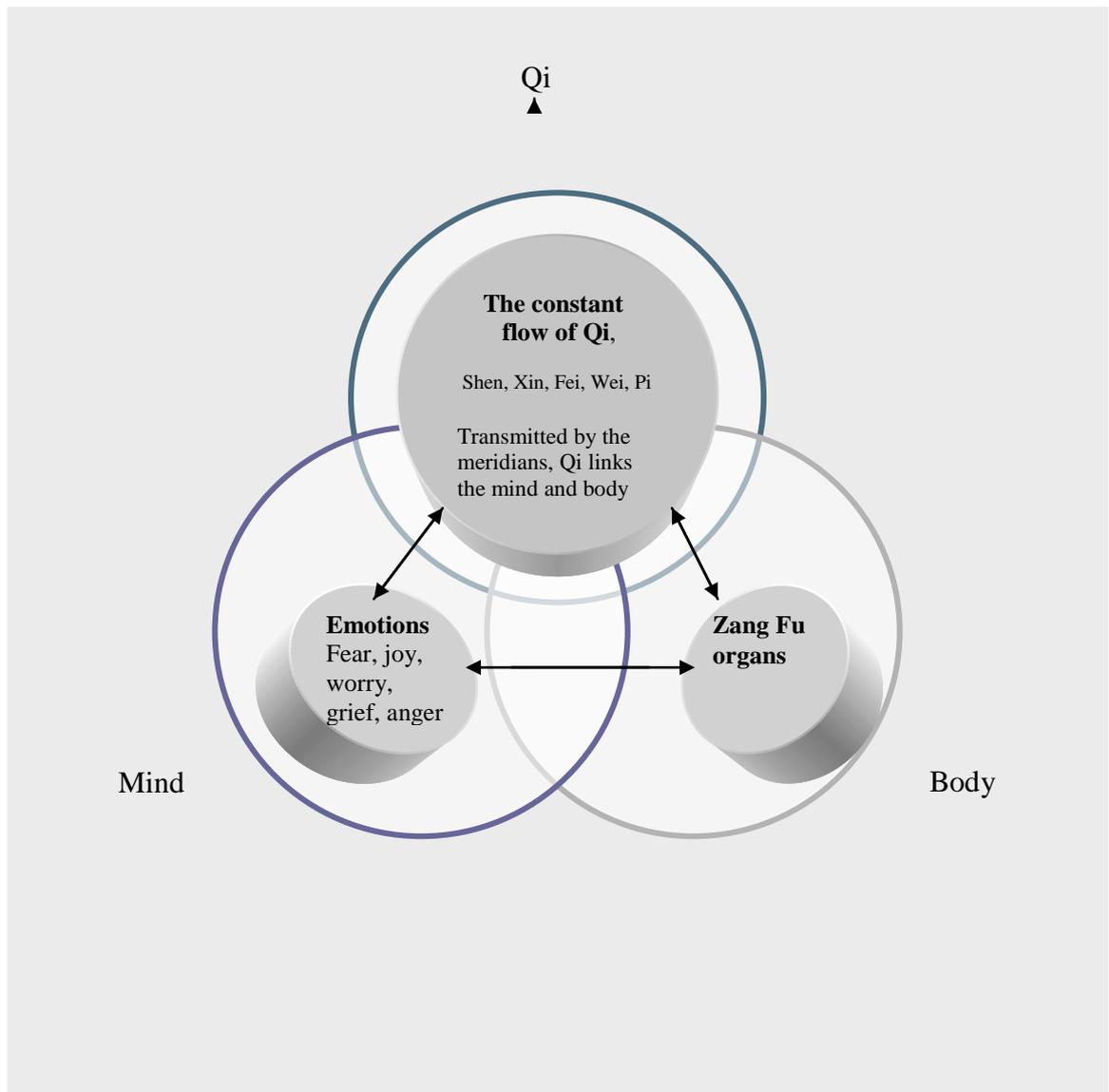


Figure 8.8 A model of internal synergy.

From a neurobiological perspective, emotions are believed to have a deep physiological impact on the body and somatisation of the physiological experiences, are integral in the symbolic exchange in the therapeutic context in TCM (Kirmayer, 2004). This notion is supported by Kleinman that, "... the somatisation of the illness demonstrates the vital links between illness and treatment aspects of cultural therapeutic systems" (1988, p. 119). Kleinman and Kleinman (1994) say that Chinese

medicine is “equipped to see the integration between social and bodily experience” (p. 707), this assertion is based on the governing factor that links are able to be made between the physical, the social and the emotional dimension in describing illness.

8.4 Summary

The case analysis of Nicole, narrative, clinical assessment and the practitioner’s diagnostic skills applied through the four methods of diagnosis (*Sizhen*) are all informed through Kanbing. Kleinman (1989) puts it, “... the structure reveals the relationship of the interaction between patient and healer, illness and healing and the cultural context (p. 120) through interconnections. Interconnections between the individual and external environment are illustrated in the hierarchical structure (Dow, 1986). A symbolic aspect of healing found in transactional processes (Kirmayer, 2004) says involves a transformation from sickness to wholeness through ‘culturally salient metaphorical actions’ (p. 33). In TCM importance was given to the centrality of the metaphorical construction and somatic connections of the mind-body dimension of the illness.

Crucial to this chapter was analysis to show how Kanbing informs the cultural construction of an illness through the clinical interaction. The example of the case study of Nicole is suggestive that the nature of the clinical exchange and the interchanges that occur, are vital in the construction of an assessment and diagnosis during the therapeutic clinical encounter. Kanbing promotes an understanding of the symbols used in the schemata for diagnostic explanations (Pilch, 2000) intrinsic to the role in partnership formed through transactions to guide the healer and the recipient, the narrative and symptoms that relate to the illness experience. It has been argued that TCM paid critical attention to the analysis on the differentiation of specific syndromes and symbolic interpretations made by the practitioner to determine the level of intervention required. Qi imbalances in the zang-fu organ system and the effect on emotional imbalances that impact on these organs have been noted. Disruption to Qi flow has been associated to be a contributing factor of somatic disturbance with emotions of grief and sorrow expressed through symbolic meaning in TCM thought (Schwarcz, 1997). Focus on mind and body interactions

provides detection of the manifestation of somatic imbalances determined by the energy of Qi.

Pervasive elements that formed complex interplay during the assessment of the client-practitioner interactions assist in understanding how a cultural construction in TCM is facilitated through transactional symbol and metaphor. The interactions in Kanbing stressed the interconnection of the mind and body, where the links of that process are facilitated through the tacit understanding of the practitioner from the interpretation of the client's narrative are rendered into a cultural explanation of an illness. The interactive process between client and practitioner in Kanbing form an essential element in what is seen as a humanistic model of health (Baer & Davis-Floyd, 2005).

CHAPTER NINE

Conclusion and recommendations

9.0 Introduction

Examination has been made in this thesis on the structure of TCM through an ethnography study in several clinics of TCM in Perth to explain commonly occurring patterns of interaction between practitioners and clients integral to the process known as Kanbing. Chapter One outlined the purpose of the study and focused on the development of the holistic health movement. The evolvment and trends associated with the surge in consumer use of CAM and international interest in non-conventional medicine under which TCM is found to be often assumed, was foreground. Chapter Two examined literature on attributes of CAM, biomedicine and TCM. Public health literature was reviewed on the doctor-patient relationship and included a brief anthropology of traditional Chinese medicine. Chapter Three, explained how philosophy has shaped Chinese traditional medicine thought and describes the pre-entry into the clinical field of ethnography through the practical experience in Guangzhou China as a social and cultural pre-encounter with TCM.

Chapter Four discussed the methodology through which examination would be made on the cultural encounter of TCM in a non-Chinese setting. Chapter Five

described the field of study in Perth. Perspectives of the practitioner were explored in Chapters Six to provide an in depth analysis on the organisation of TCM practice focusing on the explanation of the process of diagnosis. Chapter Seven provided analysis of client perspectives of the experience of the TCM clinical encounter. Chapter Eight examined the symbolic language of TCM, drawn from an extended case study.

9.1 Key findings from the clinical encounter

Explanation of the clinical encounter and the formation of the symptoms of an illness into a syndrome illustrate how the cultural construction of an illness is processed as a core task of cross-cultural anthropology (Kleinman, 1988). The explanation of how an illness is culturally constructed is drawn in TCM from the interactive process of Kanbing. It is based upon this premise: the clinical encounter begins when a suffering client, comes to the practitioner who seeks to elicit information on their encounter with an illness. Chapter Five to Chapter Eight provided a contextual analytical insight into the practice and healing experience drawn from the clinical encounter from TCM practitioners and clients.

Chapter Five – in this chapter it is identified how the practitioner’s skills are grounded in the knowledge of TCM philosophy from the translation made from the clients’ narrative. It was argued that the practitioner’s skills consist of their ability to link the client’s description of symptoms to the somatic imbalances within their individual and external environments, drawn specifically on the notion of flows and the activity of Qi linked by the Five Element Theory.

To understand the dynamics of the clinical encounter, it was also argued that attention is given by the practitioner to understand the client’s illness experience which is a crucial element of Kanbing. Various diagnostic techniques used by the practitioner were attributed to be stages that informed the nature of the interactions found in Kanbing. These included ‘Sizhen’, the four methods of examination describing illness symptoms and ‘Ba Gang’ from which a differential diagnosis classification of a cultural construction of symptoms to form a syndrome processed through the analytic framework of Zheng.

Chapter Six – provided an in-depth discussion with practitioners to explain their understanding of illness pathophysiology. Central to the practitioners understanding

of cultural pathophysiology of TCM, was the therapeutic emphasis on the flow of Qi, the restoration of harmony and balance within the Zang Fu organ system in TCM. It was shown the complexity of the practice, the analysis of the assessment embedded in cultural values are typified through TCM philosophy. Metaphorical language was found to be used by the practitioner that formed an interpretative basis of an illness episode to describe somatic manifestations, unlike that found in conventional medicine. An extended deconstruction of the process a differential diagnosis was then made that looked at the interpretation of an illness from a case study analysis.

Chapter Seven - interviews on the client understanding and experiences of TCM are revealed from non-Asian clients, and the importance attached to the quality of time the practitioner gave them during the consultation. Related to this were the opinions of clients who considered that TCM treatments were more personal and individualised compared with the more corporate management found in the biomedical system of care. Kanbing involves a collaborative approach to the clinical encounter, "... when a patient explains their clinical signs they retain a sense of being the expert, the authority of best resort; on their illness" (Kleinman, 1981, p. 120). Clients found there to be more autonomy in their sharing of information with the practitioner of TCM.

Clients reported that the TCM practitioners provided them with extended time to discuss their conditions, which assisted establish rapport and helped to built trust in their interaction. Drawn from the client's perspectives, it was also reported they felt to have exercised greater personal responsibility when they managed their own health needs through their access of TCM. While some clients felt they had benefited from TCM, there was concern expressed over the cost of herbs and the biological properties of the herbs they ingested that was not disclosed to them. An important point made by some clients reporting on the assessment interview from their experience with Western medicine, was a reliance on technology rather than the more personalised exchange of information they perceived to be found in TCM.

Dissatisfaction was expressed towards conventional doctors of medicine who did not pay attention to what they [the patient] said about how they understood their own illness. While some dissatisfaction with medical practitioners played a role that encouraged clients to seek TCM, it was not conclusive. Clients were aware that conventional medicine practice was itself varied and felt that if necessary they would use both systems of care, to improve their health status. One aspect of TCM use

raises the issue of responsibility in the failure of clients to report on the use of non-conventional medicine to their Western doctors.

Chapter Eight provided a detailed analysis of assessment and differential diagnosis from a case study that explored TCM philosophy and practice with particular importance placed on elements that comprise Kanbing in the explanation of the nature of an illness episode. Links were made by the practitioner to explain the body as a corporeal entity, where the physiological symptoms were linked to the emotional state of the client through metaphor used by the practitioner from the language of TCM. Insight was derived from the clinical descriptions through the focus of the four interpretative frames or stages of Zheng.

9.2 Discussion on key findings

1) Somatic meaning attached to the illness

From my research I have found that in TCM, there is an involvement of a complex interaction that directs the assessment and diagnosis process. The explanatory model was applied to the case analysis in Chapter Six to help deconstruct the components from the interpretation of the cultural construction of illness from which somatic meaning was attached by the practitioners. It is from the perspective of a contextual whole that considers the seven emotions, the five major organs and the Five Element theory, that in TCM the physical and psychological factors of illness are expressed to be a 'somatic illness'.

First, illness is described according to changes within the internal and external environment. Having the time available for an extended consultation was an important consideration and was perceived to facilitate a personalised approach with the TCM practitioner. This enabled careful conclusions to be drawn from the practitioner who took into account social issues during the assessment which in instances may be a contributory factor to the illness. In contrast Western medicine diagnostic methods are often quick and straightforward (Eastwood, 2000a; Salgo, 2006) and are not always inclusive or sensitive to the broader context of the social environment inhabited by the ill person (Longino, 1997). In TCM, attention was found to be paid to the adaptability in the clients changing life's circumstances that is linked to the life style factors of the individual and the somatisation of their illness

experience (Dow, 1986; Kleinman & Kleinman, 1994). The integrative process encompasses aspects of connections described as the flow of energy or Qi between the Zang Fu organs and emotional state (Zhang, 2007). Necessary to this clinical process was the recognition given by practitioners to the inclusiveness of the external, the social and the internal environment of the physiology that linked the body with the mind (Kabat-Zinn, 1993; Pert, 2000).

Second, somatic interpretation is attached by practitioners to the illness experience described by clients. Interpretation of meaning is found within the five elements in TCM theory, expressed as metaphor, that provide the link between the mind and body (Ferigno & Wang, 2000; Yu, 2003). When a client described somatic manifestation of the illness experience, attention was then focused onto the meaning of the symptom through the focus of TCM. From my observations the practitioner in the interpretative phase of the assessment diagnosed an illness from their observations made on the client and from the client's explanation. There was a complex pattern of interplay between interconnections of the mind and body described through the consultative dialogue of the client and practitioner, emerged as a narrative based interaction.

2) A narrative based interaction

A core finding of the clinical encounter was that clients were enabled to describe their illness in detail to the practitioner and simple lay language was used by the practitioner in feedback to clients. Clients found this assisted with their acceptance of TCM treatment which was very different to that found within a usual context of conventional medicine. Client explanations of the illness reality transformed into a diagnosis by the practitioner was reliant on the interpretive skills of the practitioner to restore the balance of health and wellbeing (Kleinman, 1988). An important consideration for the study was that an atypical group of clients, from non-Asian backgrounds, who had not experienced TCM previously, were used as informants.

The case analysis showed the central importance of the description narrative process involved in the consultation process that provided the practitioner with information considered to be significant. The Explanatory Model (Good & Good, 1981; Kleinman & Benson, 2006) provided information on the practitioners commonly held views about the diagnostic procedure. Clinical interpretation was

shown to be embedded in complex TCM symptomatology. To contextualise these, metaphor was drawn from traditional Chinese medicine to affirm the patient's somatic expression of their illness experience, elaborated upon in Chapter Eight.

From client perspectives on TCM it was pointed out that a 'client oriented approach' of collaboration was of greater value to them than an orientation that focused on a disease orientation. Understanding the information embedded in the client's history required practitioners to have acute observational and interpretive skills. Interpretation is vested in the attached meaning of symptoms explored through the process of differential diagnosis from which the promotion of symbolic language is used in the schemata for diagnostic explanations formed the framework of TCM theory. Responding to clients needs, the practitioners drew on the understanding of the client's life background, family and social circumstances, relationships and emotions of the client expressed through characteristics of the person's behaviour and appearance. This more holistic approach allowed the client to be a part of a collaborative approach. Collaborative partnerships that incorporate a whole system approach towards health promote an element that supports a therapeutic relationship, are a crucial element to the healing process (Good & Good, 1981; Pilch, 2000).

Policy developments to incorporate CAM and TCM with conventional medicine would encourage a more comprehensive approach to health care (Rees & Weil, 2001). It is important that the development of a more integrative medicine in public health involves both clients and potential users of CAM [TCM] in the policy formation and implementation process (Caspi et al., 2003). Future development of multidisciplinary health care delivery should also be consistent with approaches in the regulatory framework of the public health system (Giordano et al., 2004; Robotin & Penman, 2006).

Information from this research could be used for a larger quantitative demographic exploration of TCM and conventional medicine consumers. Research on patient-centred approaches to health care, with comparison on differences in the practice of each medicine form would enable further examination of the complex interplays found in the therapeutic relationship. One tentative conclusion that can be drawn here is that the philosophical value and meaning of TCM cannot be fully explained through the notions of a Western medical and scientific approach. Conventional and non conventional medicine differs towards their respective approaches in health care.

9.3 Broader Implications of this study

(1) Efficacy of CAM and evidence based research

A major challenge for the future prospects of teaching TCM in medical faculties is for research on efficacy clinical trials that are rigorous and parallel in quality to that found in conventional medicine (Hensley & Gibson, 1998; Opiel et al., 2005). Commenting on a systematic review of Chinese herbal medicine undertaken, Hensley and Gibson (1998) say these trials were insufficiently rigorous to establish conclusions on the efficacy of the herbal products. Further investigation on therapies of TCM would necessitate double-blind "... randomised controlled clinical trial the 'gold standard' in science based laboratories" (WHO, 2000, P. 53) It may be that measuring the efficacy of treatment might be fraught with ethical difficulty, especially if TCM were monitored on chronic ailments and measured on double blind trials with placebo administration. The mechanisms of effect based on the energy principles of the harmonious flow of Qi intrinsic to TCM, may make scientific plausibility in monitoring the efficacy of therapy difficult, but not impossible. Bensoussan (1999) noted that some consumers may in fact be less convinced with clinical trials applied to a new drug than they might otherwise be, to a herbal product, the efficacy of which has been well documented in classical medical literature.

Opiel et al., (2005) in a strong criticism of CAM, pointed out that even if certain therapies were shown to be efficacious, this would not vindicate a whole field of practices that defy the well established tenets of physics, chemistry and biology. A consideration should be that any outcome from research that generated an improved understanding of the beneficial efficacy of CAM treatments would assist promote that a more integrative approach to be taken with CAM therapies (Wetzel et al., 1998). The problem lies with the diverse range of these therapies as defined by the categories by NCAAM and the House of Lords Report. Vincent and Furnham (1999) point to "... the assessment of non-specific placebo factors, being the role of beliefs about health and medicine and the relationship between patients and complementary practitioners" (Vincent & Furnham, 1999, p.170).

Recent advances in biomedicine have been based on clinical research and pharmaceutical trials but these trials based on providing best evidence fail to explain any paradigm shift in medical understanding. Chan and Chan say, "... the

determination of best evidence requires the consideration of not what is best evidence but how is best evidence determined” (2000, p. 332). Best evidence can be flawed if it is only based on the research model within the dominant medical value system. This system favours well funded large trials reviewed by physicians, epidemiologists and other experts, not research on understanding how effective a complementary therapy is. Research on CAM in Australia CAM has not been identified as a priority by major funding organisations such as the Australian Research Council and the National Health Medical Research Council. This has resulted in a sparse funding for evidence based research resulting in too few studies that support the efficacy of CAM and has led to a lack of development of appropriate research skills in complementary medicine (Bensoussan & Lewith, 2004).

Walach (2009) identifies that a presupposition accompanies conventional medicine as ‘evidence based’, whilst CAM is not. He argued that validity of evidence based research is made on the premise of an active treatment and a non-active or placebo treatment. A CAM placebo might have potential be more effective than a conventional supposedly evidence based treatment. Walach suggests that a broader issue is for research to work on producing methodological data to compare CAM efficacy with conventional medicine but not exclusively an evidenced based debate. The focus on explaining how a medicine is scientifically effective is an attribute of biomedicine that does not help in understanding other elements that contribute towards patient satisfaction either in their decision to use of conventional or CAM medicine. Efficacy in biomedical terms would not bear the same contingency in a health care (CAM/TCM) that incorporates the notion of healing through energy systems and mind-body medicine.

(2) Consumer choice in collaborative health practice

The thesis has shown that researchers and medical practitioners have viewed health and illness from different perspectives that are shaped by varying cultural and health beliefs. From the perspective of health behaviour, a limitation of the biomedical model of medicine may be a failure to meet the requirements of immigrants by forms of traditional health which may be more culturally relevant to them (Reid & Trompf, 1990). Another challenge to the conventional system of health is evident in the criticism of consumers wanting autonomy to access services other than those

provided by biomedical health practices (Friedson; 1970; Germov; 1998; Willis; 1989). Studies have suggested a general increased interest in alternative medicine use is at least, partly related to consumer dissatisfaction with conventional medicine (Easthope et al., 2000; Eastwood, 2000b; Porter, 1998; Siahpush, 1999a). Consumers have a right to make decisions and to seek alternate [paths] of healing, other than a system of health that has focused on a paradigm of illness (Easthope, 1998). Values that are congruent with assuming self responsibility examined by Barrett (2003) suggested that an increased CAM use in Americans is synonymous with individual responsibility to improve health and/or combat illness with a redefinition of responsibility that focuses on the individual (Caspi et al., 2003).

Whilst there is increased recognition and acceptance of complementary health therapies by the public, the current provision of non-conventional medicine is culturally and politically determined (Leckridge, 2004). Agdal (2005) suggests this relates to change in societal perceptions of health as a factor that has led to an increase in CAM now increasingly used as a first line intervention. Baer (2005) has shown that it was in the early 1970's that different forms of non-conventional medicine began to appear. It is now possible that therapies included within biomedicine will create a new paradigm or health system identified as 'integrative' that meets the demands for a holistic focus in health provision.

Asserting that CAM can be assumed to be a new paradigm, in sociological terms (Coulter & Willis, 2004) implies that the knowledge base and efficacy of CAM are 'commensurable' with biomedicine, which from the perspective of rigorous evidence based research would founder. The potential for a health paradigm that reflects consumer demands and possible integration would be tenured on conditions of assimilation suggested by Baer that "... the less holistic therapies that can meet the rigors of randomised trials, will be adopted by biomedicine" (2005, p. 352)

(3) Education for practitioners of TCM

With Chinese medicine integrated into the health system, illustrated by the recognition of TCM through the State Government of Victoria with the registration of practitioners, considerable responsibility rests with academic institutions in the development and implementation of educational curricula and research programs (Giordano, Garcia, Boatwright & Klein, 2003; Giordano et al., 2004). Academic

competency would be enhanced through partnership at universities where access for coursework in human science laboratories could be facilitated. TCM popularity has placed pressure on practitioner education and for the provision of safe standard of TCM. Specialised education is necessary to understand the perceptions of individuals accessing alternate forms of health care as TCM. This suggests a need for improved education, research and professional regulation to guide future TCM practice (Komesaroff, 1989). Since their report, Bensoussan and Myers (1997) say, an increased recognition for education on TCM has led to the development of programs in Australian universities. An increased scholarly, policy interest in the practice and the public use of TCM has seen traditional Chinese medicine courses offered at undergraduate and postgraduate levels within Australia and overseas universities.

In their position statement, the Australian Medical Council (2000) endorsed their position in a the review of the status of CAM in Australia, determining that at least 16 degree courses were on offer at university level, but not within medical faculties, usually expertise in CAM had to be imported into the medical school from outside the university. It was pointed out by Lewith and Bensoussan (2004), that universities in Australia offering major training programs for CAM, TCM and chiropractic study were not attached to medical schools, and a responsibility rested on these institutions to develop academic and clinical teaching programs to a competency level of safe practice (AHMC, 2000). Ten private colleges offer courses and all but three colleges have courses accredited by State-based education systems of their equivalents [8.4.2] (Bensoussan & Myers, 1996).

Degree programs range from traditional Chinese medicine now at bachelor, post-graduate and a masters degree with facilities for doctoral research in TCM offered in NSW, through the Sydney Institute of TCM, University of New England, University of Technology Sydney, the University of Western Sydney. Victoria offers TCM at the Royal Melbourne Institute of Technology, Southern School of Natural Therapies and at the Victoria University. At a national level centres have advanced the integration of health care at Queensland University and at Monash University Melbourne, Centre of Complementary Medicine. In Western Australia, CAM and TCM programs are offered through the Perth Academy of Natural Therapies and the Institute of Holistic Health, Jandakot.

The Australian Medical Council Berman (2001) noted, acknowledged the role of social, cultural and environmental influences in self-care and healing of various

complementary therapies that included TCM. Emerging from these studies (Coulter & Willis, 2005; Khoury, 2000; Parker, 2003; Xue et al., 2005) ensues responsible planning for further investigation and the creation of an established data base for the provision of an emerging field of morbidity associated with an increased use of TCM (Meier & Rogers, 2006). Methods for testing and reporting data reliability would be maintained from TCM clinic audits and the reasons for encounters with TCM to provide for credibility of the practice and through further research, delineations on ethical and legal implications.

Recommendations made from these data bases would provide advancement of TCM within the Australia community and future regulation with such progress attracting subsidy for research on evidence based efficacy. Improved funding availability would be imperative for research on the social and ethical issues of TCM use, especially where there is the potential to manage chronic illness and provide improved preventative care (Bensoussan & Lewith, 2004; Baer, 2008). Commonwealth funding agencies such as the National Health Medical Research Council have hitherto been reticent to provide funds for research in areas that are outside of orthodox medicine. Funding remains scarce as Bensoussan and Lewith reported, that only "... \$850,000 of about \$1 billion of National Health and Medical Research Council funding has allocated to CAM research in Australia since 2001" (2004, p. 331). Future research funding generation will be incumbent on collaborative, dialogue and support between mainstream practitioners and non-orthodox providers to guide and support research development throughout Australia (Robotin & Penman, 2006).

(4) Integrative medicine

Modern Western medicine seems to be at a crossroads, with a new form of medicine identified as integrative medicine including TCM, being incorporated into established health care systems (House of Lords, 2000; NCCAM, 2000). My study has shown that TCM clients experienced a greater attentiveness to their illness experience with practitioners of TCM than they had with Western conventional practitioners. This may indicate that for future consideration there is a need for a more hybrid approach to medicine. Such an approach would incorporate an integration of different forms of medical understandings and practices.

However, this would involve a system that fostered double standards for validating conventional and non-conventional treatment as it ignores the epistemological beliefs and practices that exist between these different forms of medicine (Kaptchuk & Miller, 2005). Given growing consumer demands on CAM and TCM and integration would be a responsible way of responding to consumer expectations and needs (Frenkel & Borkan, 2003; Germov, 1998; Leckridge, 2004; Reilly, 2001). In 2002 in the USA the White House provided policy recommendations for administration and the legislation of CAM Appendix 10). In the UK, HRH Prince Charles founder of the Foundation for Integrated Medicine (UK) commented, "... there is a need for further changes in the way medicine is taught, practised and researched" (2001, p. 181). A degree of integration has commenced in this past decade through much of the United States, in Canada, Europe and in Australia (Barret, 2003).

Scientific advancements in biomedicine have revealed that cash strapped health systems in the USA and in Australia are increasingly reliant on scientific based technology to produce results especially in the standardised pharmaceutical industry spawned by evidence based research and funding. Lock suggests a widely shared belief particularly relevant to the scientific progress that "development of new technologies, will lead to a global utopia of health" (2002, p. 240). Future diversity in health care systems may ensue if there is a state of compromise between pluralism, linked to the uses of traditional forms of medicine with respect for contrasts in systems of health care, harmonisation fostered and engendered through the World Health Organisation. Pluralism invites collaboration between care providers and recognises the autonomy of the choice freedom of medical options available to the patient (Kaptchuk & Miller, 2005).

Leslie, with an interest in medical pluralism made this suggestion, "... that one of the ideals of biomedical practice was to transform the local medical systems everywhere so that they would become part of an international standardised medical system pursuing the rational and laudable goals of biomedicine" (1980. p. 191). In respect of Leslie, the advent of CAM had only barely emerged at that time when he made his observation. Two decades later Straus (2000) Director of NCCAM made this observation;

As CAM interventions are incorporated into conventional [orthodox] medical education and practice, the exclusionary terms, 'complementary and alternative medicine' will be superseded by the more inclusive, 'integrative medicine' (preface).

A more inclusive form of medicine does not necessarily guarantee a complete integration of one medicine form into another as Hollenberg (2005) argues, that when efforts are made to integrate CAM with biomedicine, dominant biomedical patterns of professional interaction continue to exist. How this might be overcome is through the education within medicinal schools on CAM. From a qualitative study from which a conceptual model of integrative medicine might be developed, practitioners were interviewed on attitudes towards the integration into conventional health care (Hsiao et al., 2006). Four key domains were identified; attitudes, knowledge, referral and practice. Dual trained practitioners such as physician acupuncturists, advocated an open minded approach towards other healing traditions. This supports the notion of an integrated medicine that operates for the benefit of the client (Leckridge, 2004). Magnussen (2006) explored how the integration of alternative medicine in public health care was offered to the public in Britain Royal London Homeopathic Hospital. His work focused on how acupuncture and homeopathy were introduced and offered to the patients through a collaborative and a consultative approach. Similarly Leach sees such an approach to be "... collaborative where the professional is able to work with the patient in a respectful manner to better meet the needs of the patient and community" (2006, p. 1).

Medical schools view the acquiescence of knowledge on CAM is becoming problematic (Coulter & Willis, 2004, p. 587) with such diverse practices that characterise therapies from reflexology to whole medical systems, as in traditional Chinese medicine. Baer suggests that ultimately the creation of an authentically holistic, pluralistic and integrative medical system, would involve the transcendence of social and political stratification in capitalist societies. It could be argued the future concerns of integration have to some extent have already been mediated by the recognition and adoption of physicians and allied health, with creation of the Australasian Integrative Medical Association (Baer, 2008).

9.4 Future research implications

Integration of non-conventional forms of medicine raises ramifications on future policy on health provision and strategic planning, creating opportunity and an obligation for further scientific study and evaluation. Achievement of these goals would be required to be brought about through a sustained commitment to research exploring non-

conventional health practices and the need for public protection from harm. NCCAM identified commitment to a strategic plan which embraces ethical, legal and social implications of an integrated medicine (Strategic Plan, 2005-2009). The plan identified there main goals that supported: mind-body medicine, biologically based practices, manipulative and body based practices; energy medicine, whole medical systems, international health research and health services research.

A key area of future health research may be how TCM and Western medicine can complement the respective attributes of each system in the approach towards health care. One way would be a systematic comparison of what constituted successful therapeutic encounters between physician/practitioner and patient/client in both forms of medicine. Future research to explore the value of an improved collaboration between clients and practitioners may be a way to respond to consumer expectations while at the same time ensuring that standards of safety and adherence to a professional code of ethics is maintained.

However research on the efficacy of treatments and of how the integration of TCM within Western medicine might be advanced, requires exploration on the placebo effect in healing. Disparity exists however in the way in TCM recognises the mind-body link and views the mechanism of how energy is transported in the human organism, differently to that of Western medicine (Micozzi, 2002). Walach (2009) has argued that the efficiency of the evidence based approach in validating CAM, leaves much to be desired between what can be considered sham and active treatment. TCM efficacy requires further ascertainment and sponsored evidence based research (Bensoussan & Lewith, 2004). Rigorous research would inevitably find a regulatory approach to a registry was necessary for TCM practitioners in all Australian states, with a commitment to the future vision of a monitoring system on safe practice, morbidity and of clinical research to draw conclusion on the efficacy of treatments in consumers who use this form of medicine for chronic symptom relief.

9.5 Summary

As a health care system, TCM is able to provide aspects of meaning formed through the narrative of the assessment and attached to cultural constructs embedded in the concepts of Chinese philosophy. Thus a link is formed between health, wellbeing and culture. It is expressed like this by Kleinman;

The health care system, like other cultural systems integrates the health related components of society. Patients and healers are basic components of such system and thus are embedded in specific configurations of cultural meanings and social relationships. They cannot be understood apart from this context (1981, p. 24).

Cultural construction of health and illness are found to be embedded in those attributes guided by a philosophy that has shaped traditional Chinese medicine which has pervaded for several thousand years which lies beyond the recent emergence of CAM in the latter half of the twentieth century. In respect of TCM, the contribution made in the recognition and explanation of somatic manifestation of an illness is unique and can only be understood from the cultural context in which this form of traditional medicine is practised. A client centred approach is the foundation for the practitioner-client interaction of Kanbing in TCM. It contributes to a greater sensitivity and acceptance on the part of clients where importance is attached to the narrative. Consideration is made on the mind-body connection in the formation of the cultural construct of an illness in TCM which is representative of a humanistic model of health care (Baer & Davis-Floyd, 2005).

References

- Aarmodt, A. M. (1989). Ethnography and epistemology generating nursing knowledge. In J. Morse (Ed.), *Qualitative Nursing Research: A Contemporary Dialogue*. Maryland: Aspen Publication.
- Adler, S. R. (2002). Integrative medicine and culture: toward an anthropology of CAM. *Medical Anthropology Quarterly*, 16(4), 412 - 414.
- Agdal, R. (2005). Diverse and changing perceptions of the body. Communicating illness, health, and risk in an age of medical pluralism. *Journal of Alternative and Complementary Medicine*, 11(Supp 1), 67-76.
- Agar, M.H. (1986). *Speaking of Ethnography*. *Qualitative Research Methods Series* 2. Newbury Park: Sage Publications.
- Alster, K. (1989). *The Holistic Health Movement*. Alabama, USA: University of Alabama Press.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental DSM IV-TR*. (4th ed. pp. 345-428), Washington, DC: Office of Publishing Operations, American Psychiatric Association.
- Ashworth, K. (2000, June 2). Editorial; Half the ailing seek alternative cures. *The West Australian*, p. 5.
- Astin, J. A. (1998). Why patients use alternative medicine: results of a national study. *Journal of American Medical Association*, 279(19), 1548 - 1533.
- Audi, R. (Ed.), (2006). *The Cambridge Dictionary of Philosophy*. Cambridge: Cambridge University Press.

- Australian Medical Council (2000). *Undergraduate Medical Education and Unorthodox Medical Practice*. AMC Position Statement. amcATamc.org.au
- Baker, I. A. (1997). *The Tibetan Art of Healing*. London: Thames and Hudson Ltd.
- Bannerman, R. Burton, J., & Wen-Chieh, C. (Eds.). (1983). *Traditional Medicine and Health Care Coverage*. Geneva: World Health Organisation.
- Baer, H. A. (2005a). Social scientific and historical studies of complementary medicine and alternative medicine in Anglophone countries: a multi book review. *Medical Anthropology Quarterly*, 19(3), 350 - 356.
- Baer, H.A. (2005b). Trends in religious healing and end the integration of biomedicine and complementary and alternative medicine in the United States and around the globe. *Medical Anthropology Quarter*, 19(4), 437- 442.
- Baer, H.A., & Davis-Floyd, R. (2005). *Alternative Health Care*. Sage Encyclopaedia of Anthropology Sage Publications.
- Baer, H. A. (2008b). The emergence of integrative medicine in Australia; The growing interest of biomedicine and nursing in complementary medicine in a southern developed society. *Medical Anthropology Quarterly*, 22(1), 52-66.
- Barnes, P., Powell-Griner, E., McFann, K., & Nahin, R. L. (2002). Complementary and alternative medicine use amongst adults: United States. *Seminars in Integrative Medicine*, 2(2), 54-71.
- Barr, B. (1998). The effect of holism on the health care system. *Hospital Material Management Quarterly*, 20(1), 70-81.
- Barry, C.A. (2005). The role of evidence in alternative medicine: Contrasting biomedical and anthropological approaches. *Social Sciences & Medicine* 62(11), 2646-2657.

Barrett, B. (2003). Alternative, complementary, and conventional medicine: is integration upon us? *Altern Complement Med*, 9(3), 417-427. (Accessed October 28, 2009).

<http://www.liebertonline.com/doi/abs/10.1089/107555307655516>

Barrett, B., Marchand, L., Sceder, J., Maberry, R., Applebaum, D., Rakel, D., & Rabago, D. (2003). *Altern Complement Med*, 9(6), 937-947. (Accessed January 28, 2009).

<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?itool=abstraction>

Barry, A. C. (2006). The role of evidence in alternative medicine: Contrasting biomedical and anthropological approaches. *Social Science and Medicine*, 16(11), 2646-2657. (Accessed November 12, 2009).

<http://www.sciencedirect.com.dbgw.lis.curtin.edu.a/science>

Becker, H. (1963). *Outsiders: Studies in the Sociology of Deviance*. New York: Free Press.

Begbie, S.D., Kerestes, Z.L., & Bell, D.R. (1996). Patterns of alternative medicine use by cancer patients. *The Medical Journal of Australia*, 165(10), 545- 548.

Bendapudi, N.M., Berry, L., Frey, K.A., Turner Parish, J., & Rayburn, W. L. (2006). Patient's perspectives in ideal physician's behaviours. *Mayo Clinic Proceedings*. 81:338-334. (Accessed October 31, 2009).

<http://www.Mayoclinicproceedings.com/content/81/3/338.abstract>

Bensing, J., van Dulmen, S., & Tates, K. (2003). Communication in context: new directions in communication research. *Patient Education*, May; 50(1), 27-32.

Benson, H. (1975). *The Relaxation Response*. New York: W.M. Morrow.

- Benson, H., Corliss, J., & Cowley, G. (2004). *What is mind body medicine? The Mind Body Medical Institute*. Newsweek Sep 27. (Accessed May, 20, 2009). <http://www.nbmi.org/basics/>
- Bensoussan, A., & Myers, S.P. (1996). *Traditional Chinese Medicine: Research Review*. Interim Report. Submitted to the Public Health Branch Victorian Department of Human Services.
- Bensoussan, A., & Myers, S.P. (1997). *Towards a Safer Choice: the Practice of Traditional Chinese Medicine in Australia*. Sydney: Faculty of Health, University of Western Sydney.
- Bensoussan, A. (1999). Complementary medicine – where lies its appeal? *The Medical Journal of Australia*, 170, 247-248. (Accessed 6 September 6, 2009). <http://www.mja.com.au/public/issues/mara5/bensoussan/>
- Bensoussan, A., & Lewith, G.T. (2004). Complementary medicine research in Australia: a strategy for the future. *The Medical Journal of Australia*, 181(6), 331-333. (Accessed January 28, 2009). http://www.mja.com.au/public/issues/181_06_200904/ben10060_fn
- Berman, B.M. (2001). Complementary medicine and medical education. *British Medical Journal*, 322(7279), 121-122.
- Berman, B.M., Singh, B.K., Lao, L., Singh, B.B., Ferentz, K.S., & Hartnoll, S.M. (2002). *Med. Anthropology Quarterly*, 16(4), 398-403
- Berman, J., & Chesney, M.A. (2005). Complementary and alternative medicine in 2006: optimising the dose of intervention. *The Medical Journal of Australia*, 183(11/12), 574-575.
- Birdwhistell, A. D. (1995). Medicine and history as theoretical tools in a Confucian pragmatism. *Philosophy East and West*, 45(1), 1-28.

- Black, M. (1968). Linguistic relativity: the views of Benjamin Lee Whorf. In R.A. Manners & D. Kaplan (Eds.), *Theory in Anthropology, a Sourcebook* (pp. 432-437). London: Routledge & Kegan Paul.
- Blanchard, J., & Lurie, N. (2004). Respect: patient reports of disrespect in the health care setting and its impact on care. *Journal of Family Practitioners*, 53(9), 721-30. (Accessed October 31, 2009).
<http://www.ncbi.nlm.nih.gov/pubmed/15353162>
- Blumer, H. (1969). *Symbolic Interactionism. Perspective and Method*. Englewood Cliffs, New Jersey: Prentice Hall.
- British Medical Association. (1993). *Complementary Medicines: New Approaches to Good Practice*. Oxford, UK; Oxford University Press.
- Brooks, P.M. (2004). Undergraduate teaching in complementary medicine. *The Medical Journal of Australia*, 18(5), 275. (Accessed January 30, 2006).
http://www..mja.com.au?public/issues/181_05_060904?bro10359_fm
- Brown, P. (1995). Naming and framing: the social construction of diagnosis and illness. *Journal of Health and Social Behaviour*, 35(extra issue), 34-52. (Accessed November 19, 2009).
<http://F/social%20construction%20of%2>
- Burns, R.B. (1997). *Introduction to Research Methods*. (2nd ed.). Melbourne: Addison-Wesley Longman.
- Busato, A. (2008). Patient satisfaction with traditional Chinese medicine. *Complementary Therapies in Medicine*, 16(6), 350-358.

- Caspi, O., Sechrest, L., Pitluk, H.C., Marshall, C.L., Bell, I.R., & Nichter, M. (2003). On the definition of complementary and integrative medicine: social megostereotypes vs. the patient's perspectives. *Alter Ther Health Med*, 9(6), 58-62. (Accessed January 28, 2009).
<http://ncbi.nlm.gov/entrez/query.fcgi>
- Cassidy, C.M. (1998). A survey of primary care physician's perceptions of their patient's use of complementary medicine. *Complementary Therapies in Medicine*, 11(4), 254-260.
- Chan, J.J., & Chan, J.E. (2000). Medicine for the millennium: the challenge of postmodernism. *The Medical Journal of Australia*, April 3(172), 332-334.
- Charles, C., Gafni, A., & Whelan, T. (1997). Shared decision making in the clinical encounter: What does it mean (or it takes at least two to tango). *Social Science and Medicine*, 44,(5), 681-692. Accessed December 6, 2007, from: link
 Doi:10.1016/s0277-9536(96)00221-
- Cheek, J., Shoebridge, J., Willis, E., & Zadooroznyj, M. (1999). *Society and Health. Social Theory for Health Workers*. South Melbourne: Addison Wesley Longman Australia Pty Limited.
- Chen, F.P., Chen, T.J., Kung, Y.Y., Chen, Y.C. Chou, L.F., Chen, F.J., & Hwang, S.J. (2007). Use frequency of traditional Chinese medicine in Taiwan. *BMC Health Services Research*, 7:26doi:10.1186/1472-6963-7-26. (Accessed May 2, 2009). <http://www.biomedcentral.com/1472-6963/7/26>
- Chesney, M.A., & Straus, S.E. (2004). Complementary and alternative medicine: the convergence of public interest and science in the United States. *The Medical Journal of Australia*, 181(6), 335-336. (Accessed January 28, 2009).
http://www.mja.com.au/public/issues/181_06_2009004/che10109_fni

- Chin, J.J. (2002). Doctor-patient relationships: from medical paternalism to enhanced autonomy. *Singapore Med Journal*, 43(3), 152-155.
- Choedhak, Tenzin (1984). Tibetan medical centre, Dharmasala. In T. Clifford, *Tibetan Buddhist Medicine and Psychiatry* (Covernote). York Beach, ME: Samuel Weiser, Inc.
- Chrystal, K., Allan, S., Forgeson, G., & Isaacs, R. (2003). The use of complementary and alternative medicine by cancer patients in a New Zealand regional cancer treatment centre. *N Z Med J*, 116(1168), 296.
- Clayre, A. (1984). *The Heart of the Dragon*. Glasgow: William Collins Sons & Co.
- Clifford, T. (1984). *Tibetan Buddhist Medicine and Psychiatry*. York Beach, ME: Samuel Weiser, Inc.
- Clough, P.T. (1992). *The End(s) of Ethnography From Realism to Social Crititicism*. Newbury Park: Sage Publications.
- Cohen, M.M., Penman, S., Pirotta, M., & Da Costa, C. (2005). The integration of complementary therapies in Australian general practice. *Journal of Alternative and Complementary Medicine*, Dec 11(6), 995 – 1004. (Accessed January 28, 2009).
<http://www.ncbi.nih.gov/entrez/query.fcgi?itool=abstractplus>
- Colquhoun, D. (2007). What to do about CAM? *British Medical Journal*, October, pp 335-736. (Accessed October 7, 2009).
<http://www.bmj.comdbgw.lis.curtin.edu.au/cgi/content/full>
- Connelly, D. M. (1979). *Traditional Acupuncture: The Law of the Five Elements*. Columbia, Maryland: The Centre for Traditional Acupuncture, Inc.

- Connerton, P. (1992). *How Societies Remember*. Cambridge: Cambridge University Press.
- Coulter, I. D., & Willis, E. M. (2004). The rise and rise of complementary and alternative medicine: A sociological perspective. *The Medical Journal of Australia*, 180(11), 587-589.
- Coyle, M., & Smith, C. (2005). A survey comparing TCM diagnosis, health status and medical diagnosis in women undergoing assisted reproduction. *Acupuncture Med*, 23(2), 62-9. (Accessed November 17, 2009).
<http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd>
- Dalai Lama Message (1997). *The Buddha's Art of Healing*. (Accessed May 16, 2007).
<http://www.tibetmedicine.org/hhdl.htm>.
- Denzin, N. K. (1989). *Interpretative Interactionism: Applied Social Research Methods*. (Vol. 2). United States of America: Sage Publications.
- Denzin, N. (1991). Representing lived Experiences in Ethnographic Texts. In N. K. Denzin (Ed.), *Studies in Symbolic Interaction* (pp. 59-69). Vol 12. London, England: JAI PRESS INC.
- Denzin, N. K. (1992). *Symbolic Interactionism and Cultural Studies. The Politics of Interpretation*. Cambridge, Massachusetts: Blackwell Publishers.
- Dew, K. (2005). Documentary analysis in CAM research: Part 2. *Complementary Therapies in Medicine*, 13(4), 297-302.
- Dignan, M.B., & Carr, P.A. (1992). *Program Planning for Health Education and Promotion*. (2nd ed.) Philadelphia: Lea & Febriger.

- Di Stefano. (2000). American Capital and the reign of Biomedicine. *Journal of the Australian Traditional Medicine Society*, September 6(3), 89-92.
- Di Stefano, V. (2006). *Holism and Complementary Medicine*. Melbourne: Allen and Unwin.
- Dixon, M. (2000). NHS Alliance Report to the House of Lords (Item 9.15). House of Lords (2000). *Science and Technology Sixth Report. Complementary and Alternative Medicine*. The Select Committee to Report Science and Technology. (Accessed June 12, 2000).
<http://www.publications.parliament.uk/pa/ld199900>
- Donnelly, W. J. (1997). The language of medical case histories. *Annals of Internal Medicine*, 127(11), 1045-1048. (Accessed September 6, 2009).
<http://annals.org/cgi/content/full/127/11/1045>
- Donnelly, W.J. (1998). Righting the medical record: Transforming chronicle into story. *JAMA*, (260), 823-825. (Accessed September 6, 2009).
<http://jama.ama-assn.org/cgi/content/abstract/260/6823>
- Dow, J. (1986). Universal aspects of symbolic healing; A theoretical thesis. *American Anthropologist*, 88(1), 56-69.
- Downer, S.M., Cody, M.M., McCluskey, P., Wilson, P.D., Arnott, S.J., Lister, T.A., & Slevin, M.L. (1994). Pursuit and practice of complementary therapies by cancer patients receiving conventional therapies. *British Medical Journal*, 309 (6947), 86-9.
- Doyle, R. (1998). *Report on Options for Regulation of Practitioners*. Victorian Ministerial Advisory Committee on Traditional Chinese Medicine. Victoria: Victorian Government Department of Human Services.

- Dugdale, L.S., Siegler, M., & Ruin, D. (2008). Medical professionalism and the doctor-patient relationship. *Perspectives Biological Medicine Autumn*;51(4), 547-553. (Accessed March 14, 2010).
<http://www.ncbi.nlm.nih.gov/pubmed/18997357>
- Duncan-Mitchell, G. (1979). *A New Dictionary of Sociology*. London: Routledge & Kegan Paul.
- Easthope, G. (1998). Alternative medicine. In J. Germov. (Ed.), *Second Opinion: An Introduction to Health Sociology* (pp. 267-280). Melbourne: Oxford University Press.
- Easthope, G., J.J. Beilby, G.F. Gill., & Tranter, B. K. (1998). Acupuncture in Australian General Practice. *The Medical Journal of Australia*, 169(4), 197-200.
- Easthope, G., Gill, G., & Tranter, B. (2000). Normal medical practice of referring patients for complementary therapies. *Journal of Complementary Therapy Medicine*, 8(4), 226-33.
- Eastwood, H.L. (2000a). Complementary therapies: the appeal to general practitioners. *The Medical Journal of Australia*, 173(2), 95-8.
- Eastwood, H. L. (2000b). Why are Australian GPs using alternative medicine? Postmodernism, consumerism and the shift towards holistic health. *Journal of Sociology*, 36(2), 133-156.
- Edwards, A., & Wilson, P. (Eds.). (1975). *Social Deviance in Australia*. Melbourne: Cheshire Publishing Pty Ltd.
- Eipper, C. (1996). Ethnography, testimony, trust and authority. *Anthropology*, 19(1), 15 -20.

- Eisenberg, L., & Kleinman, A. (1981). *The Relevance of Social Science for Medicine*. Dordrecht: D. Reidel Publishing Company.
- Eisenberg, D.M. (1993). The mystery of Chi. In B. Moyers. *Healing and the Mind*. (pp. 257-314). New York: Doubleday Publishing Group.
- Eisenberg, D.M., Kessler, R.C., Foster, C., Norfolk, F.E., Calkins, D.R., & Delbanco, T.L. (1993). Unconventional medicine in the United States. Prevalence, costs and patterns of use. *New England Journal of Medicine*, 328(4), 246-52.
- Eisenberg, D. M., Davis, R. B., Ettner, S. L. Appel, S., Wilkey, S., Van Rompay, M., & Kessler, R. C. (1998). Trends in alternative medicine use in the United States, 1990 –1997: Results of a follow up national survey. *JAMA*, 280(18), 1569 - 75.
- Ellis, C. (1991). Emotional Sociology. In N.K. Denzin (Ed.), *Studies in Symbolic Interaction, Volume 12* (pp. 123-145). Vol 12. London, England: JAI PRESS INC.
- Engel, G. L. (1979). The need for a new medical model: a challenge for Biomedicine. A Challenge for Biomedicine. *Science*, 196, 129-136.
- Enqin, Z. (Ed.), (1988a). *Basic Theory of traditional Chinese Medicine (I)*. Shanghai: Shanghai Publishing House of Shanghai College of TCM.
- Enqin, Z. (Ed.), (1988b). *Basic Theory of Traditional Chinese Medicine (II)*. Shanghai: Shanghai Publishing House of Shanghai College of TCM.
- Enqin, Z. (Ed.), (1988c). *Diagnostics of Traditional Chinese Medicine*. Shanghai Publishing House of Shanghai College of TCM.
- Epp, J. (1990). *Achieving Health for All: A Framework for Health Promotion*. Minister of National Health and Welfare, Ottawa.

- Ernst, E. (1995). Complementary medicine – A definition. *British Journal of General Practice*, 45(5), 506.
- Ernst, E. (2003). Obstacles to research in complementary and alternative medicine. *The Medical Journal of Australia*, 179(6), 279-280.
- Evans-Pritchard. E.E. (1969). *Social Anthropology*. London: Cohen & West LTD.
- Evans-Wentz, W.Y. (1960). *The Tibetan Book of the Dead*. London: Oxford University Press.
- Executive Summary (2005). *Investing in Research. Expanding Horizons of Health Care*. National Center for Complementary Medicine. (Accessed December 11, 2009).
<http://nccam.nih.gov/about/plans/2005/page4.htm>
- Fabrega, H. (1997). Earliest phases in the evolution of sickness and healing. *Medical Anthropology Quarterly*, 11(1), 26-55.
- Fadlon, J. (2005). *Negotiating the Holistic Turn*. New York: Suny Press.
- Farquhar, J. (1994). *Knowing Practice: The Clinical Encounter of Chinese Medicine*. USA: Westview Press, Inc.
- Felton, D. (1993). The brain and the immune system. In B. Moyers. *Healing and the Mind*. (pp. 213-237). New York: Doubleday Publishing Group.
- Ferigno, P., & Wang, D.Y. (2000). The mindful – body in Chinese medicine. *Journal of the Australian Traditional Medicine Society*, 6(4), 133-136.
- Fetterman, D.M. (1989). *Ethnography Step by Step*. Newbury Park: Sage.

- Field, P.A., & Morse, J.M. (1985). *Nursing Research the Application of Qualitative Approaches*. Rockville, MD: Aspen.
- Fisher, P., & Ward, A. (1994). Complementary medicine in Europe. *British Medical Journal*, 58(3), 216-20.
- Firebrace, P., & Hill, S. (1988). *New Ways to Health A Guide to Acupuncture*. Hong Kong: Hamlyn Publishing Company.
- Foster, G.M. (1983). An introduction to ethno medicine. In R. Bannerman., J, Burton. & C, Wen-Chieh. (Eds.), *Traditional Medicine and Health Care Coverage* (pp. 17-24). Geneva: World Health Organisation.
- Frenkel, M., & Borkan, M. (2003). An approach for integrating complementary-alternative medicine into primary care. *Fam Pract*, 20(3), 324-332. (Accessed January 28, 2009).
<http://www.ncbi.nlm.gov/entrez/query.fcgi?itool=abstraction>
- Friedson, E. (1970). *Profession of Medicine*. New York: Harper and Row.
- Friedrichs, J., & Ludtke, H. (1975). *Participant Observation Theory and Practice*. England: Saxon House.
- Furnham, A., & Beard, R. (1995). Health, just world beliefs and coping style preferences in patients of complementary and orthodox medicine. *Social Science and Medicine*, 40(10), 1425-32.
- Furnham, A., & Vincent, C. (1995). Value differences in orthodox and complementary medicine patients. *Complementary Therapies in Medicine*, 3 (2), 65-9.
- Gao, Dui. (1997). *Chinese Medicine*. London: Coulton Books Ltd.

- Geertz, C. (1973). *The Interpretation of Culture. Selected Essays in Interpretive Anthropology*. New York: Basic Books, Inc.
- Geertz, C. (1988). *Works and Lives. The Anthropologist as an Author*. Cambridge: Polity Press.
- Germov, J. (1998). *A Second Opinion. An Introduction to Health Sociology*. (230-248). Melbourne: Oxford University Press.
- Gilbert, M. D. (2003) Weaving medicine back together: mind body medicine in the twenty first century. *The Journal of Alternative and Complementary Medicine*, 9(4), 563-570.
- Giordano, J., Garcia, M., Boatwright, D., & Klein, K. (2003). Complementary and alternative medicine in mainstream public health: a role for research in fostering integration. *The Journal of Alternative and Complementary Medicine*, 9(3), 441-445. (Accessed October 13, 2009).
<http://www.liebertonline.com/doi/abs/10.1090/acm.2004>.
- Giordano, J., Garcia, M., & Strickland, G. (2004). Integrating Chinese traditional medicine into a U.S. Public Health paradigm. *The Journal of Alternative and Complementary Medicine*, 10(4), 706-710. (Accessed October 13, 2009).
<http://www.liebertonline.com/doi/abs/10.1089/acm.2004.10.706>
- Goffman, E. (1971). *The Presentation of Self in Everyday Life*. London: Pelican Books.
- Good, B. J., & Delvecchio Good, M. J. (1981). The meaning of symptoms: A cultural hermeneutic model for clinical practice. In L. Eisenberg & A. Kleinman (Eds.), *The Relevance of Social Science for Medicine* (pp. 165-195). Dordrecht, Holland: D. Reidel Publishing Company.
- Gold, R.L. (1958). Roles in sociological observation. *Social Forces*, (36), 217-223.

- Gove, W. (1975). Labelling and mental illness: a critique. In W. Gove. (Ed.), *The Labelling of Deviance* (pp. 33 - 81). London: Sage.
- Green, L., Kreuter, M., Deeds, S., & Partridge, K. (1980). *Health Education: A Diagnostic Approach*. United States of America: Mayfield Publishing Co.
- Guo, Zibin (2002). The transmission of Chinese medicine. *Medical Anthropology Quarterly*, 16(2), 250.
- Hall, K., & Giles-Corti, B. (2000). Complementary therapies and general practitioners. A survey of Perth GPs. *Australian Family Physician*, 29(6), 602-6.
- Hammersley, M., & Atkinson, P. (1995). *Ethnography Principles in Practice* (2nd ed.) London: Routledge.
- Hensley, M.J., & P.G. Gibson. (1998). Promoting evidence – based alternative medicine. *The Medical Journal of Australia*, 169(11-12), 573-574.
(Accessed May 18, 2001).
<http://www.mja.com.au>.
- Herbert, E. (1992). *A Confucian Notebook*. London: John Murray.
- Hlubocky, F.J. Retain, M.J., Wen, M., & Daugherty, C.K. (2007). Complementary and alternative medicine among advanced cancer patients enrolled on phase I trials: a study of prognosis, quality of life and preferences for decision making. *J Clin Oncol*, 25(5), 548-54.
- Hollenberg, D. (2005). Uncharted ground: Patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care settings. *Social Science and Medicine* 62(3), 731-744.

House of Lords (2000). *Science and Technology Sixth Report. Complementary and Alternative Medicine*. The Select Committee to Report Science and Technology. (Accessed June 12, 2000).

<http://www.publications.parliament.uk/pa/ld199900>

HRH Prince Charles. (2001). The best of both worlds. *British Medical Journal*, 322 (7279), 181-182.

Hsiao, A., Ryan, G., Hays, R., Coulter, I., Andersen, R., & Wenger, N. (2006). Variations in provider conceptions of integrative medicine. *Soc Sci Med*, 62 (12), 2973-2987. (Accessed January 28, 2009).

<http://www.nih.ncbi.nih.gov/entrez/query.fcgi?itool=abstract>

Hsu, E. (1999) *The Transmission of Chinese Medicine* Cambridge: Cambridge University Press.

Hsu, E. (2001). *Innovation in Chinese Medicine* (Needham Research Institute Studies). Cambridge: Cambridge University Press.

Hsu, E. (2009). The History of Chinese Medicine in the People's Republic of China and its Globalization. *ORA Journal Article18T08:43:12* (Accessed May 16, 2007).

<http://ora.ouls.ox.ac.uk/objects/uuid%3A3f2090-abc-4aff-a086-7>

Hudson-Jones, A. (1999). Narrative in Medical Ethics. *British Medical Journal*, 3 (18), 253-56.

Hughes, C. C. (1992). 'Ethnography' what's in a word? Process? Product? Promise? *Qualitative Health Research*, 2(4), 439-50.

Hui, K.K., Sampson, W., & Beyerstein, B. (1997). Is there a role for traditional Chinese medicine. *JAMA*, 277(9), 714.

- Hunter, K.M. (1991). *Doctors Stories – The Narrative Structure of Medical Knowledge*. Princeton New Jersey: Princeton University Press.
- Illich, I. (1976). *Limits to Medicine*. London: Marion Boyars Publishers Ltd.
- Janes, C.R. (1995). The transformation of Tibetan medicine. *Medical Anthropology Quarterly*, 9(1), 6-39.
- Johnson, J. C. (1990). *Selecting Ethnographic Informants*. Newbury Park: Sage.
- Jones, P. J. (2000). *Vocational Education and Training opportunities within the WA Complementary Therapies Industry*. Draft Report for Western Australian Department of Training and Employment. East Perth: Western Australian.
- Joralemon, D. (1999). *Exploring Medical Anthropology*. United States of America: Allwyn & Bacon.
- Jung, C. (1960). Commentary. In W.Y. Evans-Wentz. *The Tibetan Book of the Dead*. London: Oxford University Press.
- Kabat-Zinn, J. (1993). Meditation. In B. Moyers. (Ed.), *Healing and the Mind* (pp. 115-143). New York: Doubleday Publishing Group.
- Kaplan, S., Gandek, B., Greenfield, S., Rogers, W., & Ware, J. E. (1995). Patient and visit characteristics related to physicians participatory decision making style. *Medical Care*, 33(12), 1176-1187. (Accessed September 6, 2009).
<http://links.jstor.org/sici?sici=0025-7079%28199512%2933%3A1...>
- Kaplan, S., Greenfield, S., Gandek, B., Rogers, W., & Ware, J.E. (1996). Characteristics of physicians with participatory decision making styles. *Annals of Internal Medicine*, 124(5), 497-504.

- Kaptchuk, T. J. (1983). *Chinese Medicine: The Web that has no Weaver*. London: Rider.
- Kaptchuk, T.J., & Eisenberg, D.M. (1998). The persuasive appeal of alternative medicine. *Annals of Internal Medicine*, 129(12), 1061-1065.
- Kaptchuk, T. J. (2000). *The Web that has no Weaver: Understanding Chinese Medicine*. USA: McGraw Hill Professional.
- Kaptchuk, T.J. (2002). The Placebo effect in alternative medicine: can the performance of a healing ritual have clinical significance? *Annals of Internal Medicine*, 136(11), 817-25. (Accessed 28 January 28, 2009).
<http://ncbi.nlm.gov/sites/entrez?Db=pubmed&Cmd>
- Kaptchuk, T.J., & Miller, F.G. (2005). Viewpoint: what is the best and most ethical model for the relationship between mainstream and alternative medicine; opposition, integration or pluralism? *Academic Medicine*, 80(3), 286-290. (Accessed October 28, 2009).
<http://www.ncbi.nlm.nih.gov/sites/entrez?>
- Karup, P.N.V. (1983). Ayurveda. In R. Bannerman., J. Burton., & C, Wen-Chieh. (Eds.), *Traditional Medicine Health Care Coverage* (pp. 50-58). Geneva: World Health Organisation.
- Keating, N., Gandhi, T., Orav, J., Bates, D., & Ayanian, J. (2004). Patient characteristics and experiences associated with trust in specialist physicians. *Arch Intern Med*, 164(9), 1015-1020. (Accessed October 31, 2009).
<http://archinte.ama-assn.org/cgi/content/abstract/164/9/1015>
- Kelner, M., & Wellman, B. (1997a). Health care and consumer choice: medical and alternative therapies. *Social Science & Medicine*, 45(2), 203-12.

- Kelner, M., & Wellman, B. (1997b). Who seeks alternative health care? A profile of users of five modes of treatment. *The Journal of Alternative and Complementary Medicine*, 3(2), 127-40.
- Kettler, D., & Meja, V. (1984). *Key Sociologists. Karl Mannheim*. London: Tavistock.
- Khoury, R. (2000). Victoria Passes Chinese Medicine Registration Act. *Journal of the Australian Traditional Medicine Society*, 6(2), 51-53.
- Kickbusch, I. (1989). Approaches to an ecological base for public health. *Health Promotion*, 4(4), 265-8.
- Kirk, J., & Miller, M. L. (1986). Reliability and Validity in Qualitative Research. Qualitative Research Methods Series 1. Newbury Park: Sage Publications.
- Kirmayer, L. (2004). The cultural diversity of healing: meaning, metaphor and mechanism. *British Medical Bulletin* 1(69), 33-48.
- Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural systems. *Social Science and Medicine*, (12), 85-93.
- Kleinman, A. (1981). *Patients and Healers in the Context of Culture*. Berkley, California: University of California Press.
- Kleinman, A. (1986). *Social Origins of Distress and Disease. Depression, Neurasthenia and Pain in Modern China*. New Haven & London: Yale University Press.
- Kleinman, A. (1988). *The Illness Narratives: Suffering, Healing and the Human Condition*. United States of America: Basic Books, Inc., Publishers.

- Kleinman, A., & Kleinman, J. (1994). How bodies remember: social memory and bodily experience of criticism, resistance and delegitimation following China's Cultural Revolution. *New Literary History*, 25(3), 707-17.
- Kleinman, A. (1997). *Writing at the Margin – Discourse between Anthropology and Medicine*. California: University of California Press, Columbia and Princeton.
- Kleinman, A., Das, V., & Lock, M. (Eds.). (1997). *Social Suffering*. Berkley, California: University of California.
- Kleinman, A. & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLoS Med*3(10): e 294, [do:10.371/journal.pmed.0030294](https://doi.org/10.1371/journal.pmed.0030294). (Accessed October 26, 2009).
<http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed>
- Kluckhohn, C., & Murray, H. A. (1956). *Personality in Nature, Society and Culture* (2nd ed.) New York: Alfred A. Knopf, Inc.
- Komesaroff, P.A. (1998). Use of complementary medicines: scientific and ethical issues. *The Medical Journal of Australia*, 169(4), 180-182. (Accessed October 22, 2006).
<http://www.mja.com.au/public/issues/aug17komsrof/komsrof.html>
- Kristoffersen, A.E., Fonnebo, V., & Norheim, A. J. (2009). Do cancer patients with a poor prognosis use complementary and alternative medicine more than others? *J Altern Complement Med* 15(1), 35-40.
- Kubacki, A. (2003). What's important in the doctor patient relationship? Letters to the Editor. *Journal of the Royal Society of Medicine*, June; (96), 314.

- Lam, T.P. (2001). Strengths and weaknesses of traditional Chinese medicine and western medicine in the eyes of some Hong Kong Chinese. *Journal of Epidemiology and Community Health* 55(10),762-765.
- Larson, E.B., & Yao, X. (2005). Clinical empathy as emotional labour in the patient physician relationship. *JAMA*, 293(9), 1100-1106. (Accessed October 31, 2009).
<http://jama.ama-assn.org/cgi/content/abstract/293/91100>
- Lai, D., & Chappell, N. (2006). *Use of Traditional Chinese Medicine by Older Chinese Immigrants in Canada*. Oxford: Oxford University Press.
- Lawrence, C., & Weisz, G. (Eds.). (1999). *Greater than the Parts: Holism in Biomedicine*, (pp. 1920-1950). New York: Oxford University Press.
- Leach, M. J. (2006). Integrative health care: A need for change? *Journal of Complementary Medicine*, 3(1), 1-11.
- Lechridge, B. (2004). The future of complementary and alternative medicine-models of integration. *J Altern Complement Med*, 10(2), 413-416. (Accessed January 28, 2009).
<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?itool=abstractplus>
- Lee, R.T., Hlubocky, F.J., Stafford, R.S., & Daugherty, C.K. (2008). An international pilot study of oncology physicians' opinions and practices on complementary and alternative medicine (CAM). *Integr Cancer Ther*, June, 7(2), 70-75.
- Legge, J. (1973). *The I Ching*. New York: Causeway Books.
- Lentricchia, F. (1990). In place of an after word. In F. Lentricchia & T, McLaughlin (Eds.), *Critical Terms for Literary Theory*, (pp. 321-338). Chicago: University of Chicago Press.

- Leslie, C. M. (1983). Policy options regulating the practice of traditional medicine. In R. Bannerman., J. Burton., & C. Wen-Chieh. (Eds.), *Traditional Medicine and Health Care Coverage* (pp. 314-317). Geneva: World Health Organisation.
- Leslie, C. (1980). Medical pluralism in world perspective. *Social Science and Medicine*, 14B, 191-196.
- Lewith, G.T., & Bensoussan, A. (2004). Complementary and alternative medicine with a difference. *The Medical Journal of Australia*, 180(11), 585-586. (Accessed August 30, 2006).
http://www.mja.com.au/public/issues/180_11_070604/lew10237_fm
- Li, J. T.C. (2006). The quality of caring. *Mayo Clinic Proceedings*, 81(3), 294-296. (Accessed October 31, 2009).
<http://www.mayoclinicproceedings.com/content/81/3/294.full>
- Lloyd, P., Lupton, D., Weisner, D., & Hasleton, S. (1993). Choosing alternative therapy: an exploratory study of socio-demographic characteristics and motives of patients resident in Sydney. *Australian Journal of Public Health*, 17(2), 135-44.
- Lo, V. (2001). The influence of writing life culture on the development of Western Han amoxxa therapy. In E. Hsu (Ed.), *Innovation in Chinese Medicine*. Cambridge: Cambridge University Press.
- Lock, M. (2002). Utopia of health eugenics. In M. Nichter. & M, Lock. (Eds.), *New Horizons in Medical Anthropology: Essays in Honour of Charles Leslie*. (pp. 240-266). London: Routledge.
- Long, A.F., Mercer, G., & Hughes, K. (2000). Developing a tool to measure holistic practice: a missing dimension in outcomes measurement within complementary therapies. *Complementary Therapies in Medicine*, 8(1), 26-31.

- Longino, C. F. (1997). Beyond the body: an emerging medical paradigm. *American Demographics*, 19(12), 14-17.
- Lu, H. C. (1994). *Chinese Natural Cures*. New York: Black Dog & Leventhal Publishers, Inc.
- MacKenzie-Cook, P. (2006). Challenging the new orthodoxy in integrative medicine. *J Altern Complement Med*, 12(7), 679-683.
- McGuire, M. M. (2002). Not all alternatives are complementary. *Medical Anthropology Quarterly*, 16(4), 409.
- McKenzie, A. E. (1994). Evaluating ethnography: considerations for analysis. *Journal of Advanced Nursing*, (19), 774 –781.
- MacLennan, A.H., Wilson, D.H., & Taylor, A.W. (1996). Prevalence and cost of alternative medicine in Australia. *The Lancet*, 347(9001), 569-73.
- MacLennan, A. H., Wilson, D.H., & Taylor, A.W. (2002). The escalating costs of alternative medicine. *Public Medicine*, 35(2), 166-73.
- Maciocia, G. (2005). *The Foundations of Chinese Medicine: A Comprehensive text for Acupuncturists and Herbalists*. New York: Churchill Livingstone, Elsevier.
- Magnussen, F. (2006). *A medical anthropological look at complementary medicine in public health care*. Universitetet I OSLO. (Accessed October 26, 2009).
<http://www.duo.uio.no/sok/work.html>
- Mahler, H. (1983). Foreword. In R. Bannerman., J. Burton., & C. Wen-Chieh. (Eds.), *Traditional Medicine and Health Care Coverage* (pp. 7-8). Geneva: World Health Organisation.

- Marcinkiewicz, M., & Mahboobi, H. (2009). The impact of the internet on the Doctor-patient relationship. *AMJ*, 1(5)1-6. Doi. 4066/AMJ.2009.69.
- Marcus, G. E. (1986) Contemporary problems of ethnography in the modern world system. In. J. Clifford & G. E. Marcus (Eds.), *Writing Culture the Poetics and Politics of Ethnography*. Berkley: University of California Press.
- Mattingly, E. (1998). In search of the good: narrative reasoning in clinical practice. *Medical Journal of Anthropology Quarterly*, 12(3), 273-297.
- Mattingly, C., & Garro, L.C. (2000). *Narrative and the Cultural Construction of Illness and Healing*. Los Angeles: University of California Press.
- Maxion-Bergemann, S., Bornhoft, G., Sonderegger, E., Renfer, A., Matthiessen, P., & Wolf, U. (2006). Traditional Chinese medicine (phytotherapy): Health Technology Assessment Report – selected aspects. *Forsch Komplement Med*, 13(2), 30-41. (Accessed November 17, 2009).
<http://ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=Sho>
- Mechanic, D. (1995). Emerging trends in the application of the social sciences to health and medicine. *Social Science and Medicine*, 40(11), 1491-1497.
- Meier, P., & Rogers, C. (2006). Reporting traditional Chinese medicine morbidity – A University of Technology Sydney report with an emphasis on developing standards for testing and reporting data. *J Altern Complement Med*, 12(6), 529-534. (Accessed November 17, 2009)
<http://ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=Sho>
- Meyer, S.B. (2008). Do your patients trust you?: a sociological understanding of the implications of patient mistrust in health care professionals. *Australian Medical Journal* 1(1). (Accessed April 14, 2010)
<http://www.amj.net.au/index.php?journal=AMJ&page=article&op5B5>

- Micozzi, M. (2002). Culture, anthropology and the return of complementary medicine. *Medical Anthropology Quarterly, Dec. 16*(4), 398-403.
- Millar, W.J. (1997). Use of alternative health care by Canadians. *Canadian Journal of Public Health, 88*(3), 154-8.
- Moerman, D. (1983). Anthropology of symbolic healing. *Current Anthropology, 20*, 59-80.
- Monckton, J. (1997). The task of medicine. *Report of a seminar working group debate held in Munich in 1997*. RCCM. (Accessed November 12, 2000).
<http://www.rcm.org.uk/costtask.htm>
- Montgomery-Hunter, K. (1991). *Doctors Stories - The Narrative Structure*. Princeton, New Jersey; Princeton University Press.
- Morse, J. M., & Field, P. A. (1995). *Qualitative Research Methods for Health Professionals* (2nd ed.). Thousand Oaks, California: Sage Publications.
- Morse, J.M. (1995). *Qualitative Nursing Research a Contemporary Dialogue*. Maryland: Aspen.
- Moyers, B. (1993). *Healing and the Mind*. Doubleday: New York.
- Murphy, J. (2001). The quality of physician-patient relationships. *Journal of Family Practice, 50*(2), 123- 129.
- Napoles-Springer, A. (2005). Patient's perceptions of cultural factors affecting the quality of their medical encounters. *Health Expectations, March; 8*(1), 4-17.

- National Center for Complementary and Alternative Medicine. (2000). *Expanding Horizons of Health Care Five Year Strategic Plan 2001 – 2005*. Director. S.E. Strauss. Silver Spring, USA: NCCAM Clearinghouse. (Accessed October 12, 2001). <http://nccam.nih.gov/nccam/fcp/clearinghouse>.
- National Center for Complementary and Alternative medicine (2007). *CAM Basics. What is CAM?* (Accessed December 1, 2007). <http://nccam.nih.gov/health/whatisacam/>
- National Institute of Health and Alternative Medicine (1992). *Expanding Horizons Report to the National Institute of Health on Alternative Medical Systems in the United States*. Washington, DC: Government Printing In B. Barr. (1998) The Effect of Holism on the Health Care System. *Hospital Material Management Quarterly, August 1998, 20(1)*, 70-81.
- Nichter, M. (Ed.), (1992). Ethno medicine: diverse trends, common linkages. In M. Nichter (Ed.), *Anthropological Approaches to the Study of Ethno medicine*. United States of America: Gordon & Breach Science Publishers.
- Old, W. R. (1894). *The Book of The Path of Virtue: A Version of The Tao-Teh-King of Lao-Tze*. Madras: Minerva Press Broadway.
- Oppel, L., Beyerstein, B., Hoshizaki, D., & Sutter, M. (2005). Still concerned about CAM in undergraduate medical education. *Can Fam Physician, 51(8)*, 1069-1070.
- Papas, S., & Periman, A. (2004). Complementary and alternative medicine. The importance of the doctor-patient communication. *Medical Clinics of North America, January; 86(1)*, 1-10.
- Parker, M. (2003). Chinese Dragon or toothless tiger? Regulating the professional competence of traditional Chinese medicine practitioners. *J Law Med. 10(3)*, 285-95.

- Parsons, T. (1951). *The Social System*. Free Press: New York.
- Pei, W. (1983). Traditional Chinese medicine. In R. Bannerman, J. Burton & C. Wen Chieh (Eds.), *Traditional Medicine and Health Care Coverage* (pp. 68-81). Geneva: World Health Organisation.
- Pelto, P.J., & G.H. Pelto. (1978). *Anthropological Research. The Structure of Inquiry* (2nd ed.) Cambridge: Cambridge University Press.
- Pelletier, K. (1993). Between mind and body: stress emotions and health. In D. Goleman & J. Gurin. (Eds.), *Mind-Body Medicine*. (pp. 18-38). Yonkers, New York: Consumer Report Books.
- Pert, C. (1993). The chemical communicators. In B. Moyers (Ed.), *Healing and the Mind*. (pp. 177-193). New York: Doubleday Publishing Group.
- Pert, C. (1999). *Molecules of Emotion. The Science behind Mind-Body Medicine*. New York: Simon & Schuster.
- Pert, C. (2000). *Your Body is Your Subconscious Mind*. Boulder: Sounds True Inc.
- Peterson, A. R. (1994). *In a Critical Condition: Health and Power Relations in Australia*. North Sydney: Allen & Unwin.
- Pfifferling, J.H. (1981). A cultural prescription for medico centrism. In L. Eisenberg & A. Kleinman (Eds.), *The Relevance of Social Science for Medicine* (pp.197-207). Dordrecht, Holland: D. Reidel Publishing Company.
- Phalen, K. F. (1998). *Integrative Medicine*. Boston: Journey Editions.
- Pilch, J.J. (2000). *Healing in the New Testament: Insights from Medical Anthropology*. (p. 19-36). Minneapolis: Fortress Press.

- Porter, S. (2000). *Social Theory and Nursing Practice*. Melbourne: Macmillan.
- Rees, L., & Weil, A. (2001). Integrated medicine. *British Medical Journal*, 322 (7279), 119-120.
- Reid, J., & Trompf, P. (1990). *The Health of Immigrant Australia*. Sydney: Harcourt Brace & Jovanovich.
- Reilly, D. (2001). Enhancing human healing. *British Medical Journal*, 322(7279), 120-122.
- Reilly, D. (2002) If CAM rose from the ashes of western holism, what now? *Medical Anthropology Quarterly*, 16(4), 408-409.
- Robotin, M., & Penman, A. (2006). Integrating complementary therapies into mainstream cancer care; which way forward? *Med J Aust*, 185(7), 377-379.
- Robson, T. (2003). *Introduction to Complementary Medicine*. Melbourne: Allen and Unwin.
- Rodzinski, W. (1984). *The Walled Kingdom. A History of China from Antiquity to Present*. New York: Free Press.
- Rose, K. (1999). Have no twisty thoughts. *Parabola, Winter* (24), 81-86.
- Ross, J. (1985). *Zang Fu The Organ System of Traditional Chinese Medicine* (2nd ed.). Edinburgh: Churchill Livingstone.
- Saks, M. (1996). From quackery to complementary medicine: the shifting boundaries between orthodox and unorthodox medical knowledge. In U Sharma & S. Cant (Eds.), *Complementary Medical Knowledge*. London: Free Association Books (1996).

- Sacks, O. (1990). *The man who mistook his wife for a hat, and other clinical tales*. New York: Quality Paper Back Club.
- Said, H. M. (1983). The Unani system of health and medicare. In R. Bannerman., J, Burton. & C, Wen-Chieh. (Eds.), *Traditional Medicine Health Care Coverage* (pp. 61-67). Geneva: World Health Organisation.
- Salgo, P. (2006). The Doctor will see you for exactly Seven Minutes. *The New York Times*. March 22nd. (Accessed April 14, 2010).
<http://www.nytimes.com/2006/03/22/opinion/22salgo.html>
- Sawyer, M.G., and Kassak, K. (1993). Patient satisfaction with chiropractic care. *Journal of Manipulative and Physiologic Therapeutics*, 16 (1), 25-32.
- Scheff, T. (1966). Being mentally ill: A sociological theory. In S. Porter, *Social Theory and Nursing Practice* (1998), (pp. 91-92). London: MacMillan.
- Scheid, V. (2001). Shaping Chinese medicine: two case studies from contemporary China. In E, Hsu (Ed), *Innovation in Chinese Medicine* (Needham Research Institute Studies). (pp. 370-405). Cambridge: Cambridge University Press.
- Scheid, V. (2003). *Chinese Medicine in Contemporary China: Plurality and Synthesis*. USA: Duke University.
- Schreiber, K. (1991). Culture, health and illness: An introduction for health professionals. *The Journal of the American Medical Association*, 266(2), 283-4.
- Schwarz, V. (1997). Public uses of personal grief in Modern China. In A. Kleinman, V. Das & M, Lock (Eds.), *Social Suffering* (pp. 119-147). Berkley: University of California Press.
- Shank, G.D. (2002). *Qualitative Research. A Personal Skills Approach*. New Jersey: Merrill Prentice Hall.

- Siahpush, M. (1999). Post-modern attitudes about health: a population-based exploratory study. *Complementary Therapies in Medicine*, 7(3), 164-169.
- Sirios, M. F., & Gick, M.L. (2002). An investigation of the health beliefs and motivations of complementary medicine clients. *Social Science and Medicine*, 55(6), 1025-1037.
- Sharp, L.A. (2000). The commodification of the body and its parts. *Annual Review of Anthropology*, 29(2000), 287-328.
- Soothill, W.E. (1945). *The Analects of Confucius*. London: Milford, Oxford.
- Spradley, J.P. (1980). *Participant Observation*. Orlando: Holt, Rinehart & Winston.
- Stafford, C.C., & Furze, B.J. (Eds.). (1997). *Society and Health. A Sociological Introduction to Contemporary Australia*. (2nd ed.) South Melbourne: MacMillan Education Australia Pty Ltd.
- Stake, R. E. (1978). The case-study method of social enquiry. Educational researcher 7:5-8. In N.K. Denzin (1989) (p. 26) *Interpretative Interactionism: Applied Social Research Methods*. (Vol. 2). United States of America: Sage Publications.
- Stake, R.E. (1995). *The Art of Case Study Research*. Thousand Oaks, CA: Sage.
- Stepan, J. (1983). Patterns of legislation concerning traditional medicine. In R, Bannerman., J, Burton., & C, Wen-Chieh. (Eds.), *Traditional Medicine and Health Care Coverage* (pp. 290-313). Geneva: World Health Organisation.
- Stoeckle, J.D., & Barsky, A. J. (1981). Attributions: uses of social science knowledge. In L. Eisenberg, & A. Kleinman (Eds.), *The Relevance of Social Science for Medicine* (pp. 223-240). Dordrecht Holland: D. Reidel Publishing Company.

- Straus, S. (2000). *Expanding Horizons of Health Care*. National Center for Complementary and Alternative Medicine. Five Year Strategic Plan. September 25, 2000. Preface.
- Strauss, A., & Corbin, J. (1998). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park. California: Sage Publications.
- Susser, M., Watson, W., & Hopper, K. (1985). *Sociology in Medicine*. New York: Oxford University Press.
- The Cochrane Collaboration. (2007). *The Australasian Cochrane Centre. Role of the Centre*. Monash University. (Accessed 18 September 18, 2007).
<http://www.cochrane.org.au/about>
- The Research Council for Complementary Medicine (RCCM). (2000). *Dialogue between Conventional and Non-Conventional Practitioners*. (Accessed November 12, 2000).
<http://www.rcsm.org.uk/costdialogue.htm>
- The Research Council for Complementary Medicine RCCM. (2003). *The Historical Context*. (Accessed December 1, 2007).
http://www.rcm.org.uk/static/Report_COST_historic.aspx
- Thom, D. H., & Campbell, B. (1997). Patient physician trust: an exploratory study. *Journal of Family Practice*, 44(2), 169-76.
- Turner, B.S. (1992). *Regulating Bodies: Essays in Medical Sociology*. London: Routledge.
- Unschuld, P. (1992). Epistemological Issues and changing limitations of Traditional Chinese Medicine in the twentieth century. In C.M. Leslie & A, Young (Eds.), (pp. 41-61). *Paths to Asian medical Knowledge: Comparative Studies of Health Systems and Medical Care*. Berkley: University of California Press.

- Unschuld, P. (1985). *Medicine in China: A History of Ideas*. Berkeley, Los Angeles: University of California Press, Ltd.
- Unschuld, P. (1998). *Chinese Medicine*. Brookline Massachusetts: Paradigm Publications.
- Unschuld, P. (2003). *Huan Di Nei Jing Su Wen*. California: University of California Press.
- Veith, I. (1972). *Huang Ti Nei Ching Su Wen. The Yellow Emperor's Classic of Internal Medicine*. (First paperback ed.). Berkley: University of California Press.
- Verhoef, M., Epstein, M., Brundin-Mather, R., Boon, H., & Jones, A. (2004). Introducing medical students to CAM: response to Opper et al. *Can Fam Physician*, 51(2), 191-192.
- Veeramah, E.K., & Holmes, S. (2000). Complementary therapy: complement or threat to modern medicine? *Journal of the Royal Society of Health*, 120(1), 42-6.
- Victorian Ministerial Advisory Committee (1998). *Traditional Chinese Medicine Report on Options for Regulation of Practitioners*. Victoria: Victorian Government Department of Human Services.
- Vincent, C., Furnham, A., & Willismore, M. (1995). The perceived efficacy of complementary and orthodox medicine in complementary and general practice patients. *Health Education Research*, 10(4), 395-405.
- Vincent, C., & Furnham, A. (1999). Complementary medicine: state of the evidence. *Journal of the Royal Society of Medicine*, 92(4), 170-177.
- Waddell, C., & Peterson, A.R. (1994). *Just Health. Inequality in illness, care and Prevention*. Melbourne: Churchill Livingstone). 286-287.

- Walach, H. (2009). The campaign against CAM and the notion of “evidence based”.
J. Altern Complement Med, 15(10), 1139-42.
- Webb, E.C. (1977). *Report of the Committee of Inquiry into Chiropractic, Osteopathy, Homeopathy and Naturopathy*. Canberra: Australian Government Printing Service.
- Wetzel, M., Eisenberg, M., & Kaptchuk, T. J. (1998). Courses involving complementary and alternative medicine at US medical schools. *Journal of the American Medical Association*, 289(9), 784 –90.
- White House Commission (2002). *Complementary and Alternative Medicine Policy*. Transmittal Letters March 22. (Accessed January 28, 2007).
<http://www.whccamp.hhs.gov/tl.html>
- White, S. D. (1998). From barefoot doctor to village doctor in Tiger Springs Village: A case study of rural health care transformations in socialist China. *Human Organisations*, 57(4), 480-490.
- White, K. (1999). The social origins of illness and the development of the sociology of health. In C.Grbich (Ed.), *Health in Australia* (2nd ed., pp. 35-46). Forestville, Australia: Longman.
- Wikipedia (2010). Therapeutic Goods Administration. Wikipedia, the free encyclopaedia. (Accessed October 12, 2010).
<http://en.wikipedia.or>
- Willis, E. (1989). *Medical Dominance*. (Rev. ed.) Sydney: Allen & Unwin.
- Wilson, I.B. (1999). Clinical understanding and clinical implications of response shift. *Social Science and Medicine*, 48(ill), 1577.

World Health Organisation. (2000). *General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine*. Geneva: World Health Organisation.

World Health Organisation. (2000). *Traditional and modern medicine. Harmonizing the two approaches*. World Health Organisation, Western Pacific Region. Geneva: World Health Organisation.

World Wealth Organisation. (2002). *WHO launches the first global strategy on traditional and alternative medicine*. Geneva, Switzerland. [cited 2005 January 12]. (Accessed November 14, 2009).

<http://www.who.int/mediacentre/news/releases/release38/en/>

World Health Organization. (2007). *Traditional Medicine: Definitions*. Extract from General Guidelines for Methodologies on Research and Evaluation of traditional Medicine. (Accessed February 28, 2007)

<http://www.who.int/medicines/areas/traditional/definitions/ent/>

Worsley, P. (1970) *Introducing Sociology*. Hammondsworth: Penguin.

Xinnong, C. (Ed.), (1987). *Chinese Acupuncture and Moxibustion*. Beijing: Foreign Languages Press.

Xiu, R.J. (1998). Microcirculation and traditional Chinese medicine. *JAMA*, 260(4), 1755- 1763.

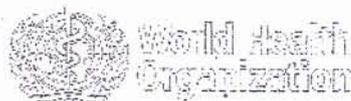
Xu, W., Towers, A., & Collet, J. (2006). Traditional Chinese medicine in cancer care: perspectives and experiences of patients and professionals in China. *Eur J Cancer*, 15(4), 397-403. (Accessed November 17, 2007).

<http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=Sho>

- Xue, C. L., Lee, C., Karagiannis, J., Chunguang, L., Yang, A., Zhang, L., & Story, D. (2005) Public attitudes towards Chinese medicine in Melbourne Australia. *Journal of Complementary and Integrative Medicine*, 2(1), 8. (Accessed May 22, 2006).
<http://www.bepress.com/jcim/vol12/iss1/8/>
- Yap, Y., & Cotterell. A. (1997). *Chinese Civilisation. From the Ming Revival to Chairman Mao*. London: Book Club Associates.
- Yu, N. (2003). Metaphor, body and culture: the Chinese understanding of gallbladder and courage. *Metaphor Symbol*, 18(1), 13-31.
- Yu-lan, F. (1989). *A Taoist Classic – Chuang Tzu*. Beijing: Foreign Languages Press.
- Zaman, H. (1983). The south east region. The role of the WHO regional office. In R, Bannerman. J. Burton., & C, Wen-Chieh. (Eds.), *Traditional Medicine and Health Care Coverage* (pp. 231-239). Geneva: World Health Organisation.
- Zhan, M. (2001). Does it take a miracle? Negotiating knowledge's, identities and communities of traditional Chinese medicine. *Cultural Anthropology*, 16(4), 453-480.
- Zhang, Y. (2007). *Transforming Emotions with Chinese Medicine. An Ethnographic Account from Contemporary China*. Albany New York: SUNY Press.
- Zhang, X. (2000). *Traditional Medicine: Definitions. Essential Drugs and medicines Policy (EDM)*. World Health Organisation: Geneva. (Accessed February 28, 2007).
<http://www.who.int/medicines/areas/traditional/definitions/en/>
- Zollman, C., & Vickers, A. (1999). Complementary medicine and the patient. *British Medical Journal*, December (319), 1486-1522.

APPENDIX 1:

Traditional Medicine Definitions
World Health Organisation

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Traditional Medicine: Definitions

The following terms are extracted from the General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine.

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Traditional medicine

Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.

Complementary/alternative medicine (CAM)

The terms "complementary medicine" or "alternative medicine" are used inter-changeably with traditional medicine in some countries. They refer to a broad set of health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system.

Herbal medicines

Herbal medicines include herbs, herbal materials, herbal preparations and finished herbal products, that contain as active ingredients parts of plants, or other plant materials, or combinations.

- **Herbs:** crude plant material such as leaves, flowers, fruit, seed, stems, wood, bark, roots, rhizomes or other plant parts, which may be entire, fragmented or powdered.
- **Herbal materials:** in addition to herbs, fresh juices, gums, fixed oils, essential oils, resins and dry powders of herbs. In some countries, these materials may be processed by various local procedures, such as steaming, roasting, or stir-baking with honey, alcoholic beverages or other materials.
- **Herbal preparations:** the basis for finished herbal products and may include comminuted or powdered herbal materials, or extracts, tinctures and fatty oils of herbal materials. They are produced by extraction, fractionation, purification, concentration, or other physical or biological processes. They also include preparations made by steeping or heating herbal materials in alcoholic beverages and/or honey, or in other materials.
- **Finished herbal products:** herbal preparations made from one or more herbs. If more than one herb is used, the term mixture herbal product can also be used. Finished herbal products and mixture herbal products may contain excipients in addition to the active ingredients. However, finished products or mixture products to which chemically defined active substances have been added, including synthetic compounds and/or isolated constituents from herbal materials, are not considered to be herbal.

Traditional use of herbal medicines

Traditional use of herbal medicines refers to the long historical use of these medicines. Their use is well established and widely acknowledged to be safe and effective, and may be accepted by national authorities.

Therapeutic activity

Therapeutic activity refers to the successful prevention, diagnosis and treatment of physical and mental illnesses; improvement of symptoms of illnesses; as well as beneficial alteration or regulation of the physical and mental status of the body.

Active ingredient

Active ingredients refer to ingredients of herbal medicines with therapeutic activity. In herbal medicines where the active ingredients have been identified, the preparation of these medicines should be standardized to contain a defined amount of the active ingredients, if adequate analytical methods are available. In cases where it is not possible to identify the active ingredients, the whole herbal medicine may be considered as one active ingredient.

For more information contact:

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APPENDIX 2:

Traditional Chinese Medicine (TCM) Theory

Traditional Chinese medicine theory

From the early beginnings of TCM, people realised that by using heat, medicated compresses and moxibustion (the use of certain herbs), alleviation from the discomfort of pain caused from damp and cold was achieved. From this background a system of medicine evolved and ancient Chinese philosophers and physicians developed a knowledge of the pulse, blood, body fluid, Qi, Shen essence, five colours, five flavours, six Qi, eight winds, as well as an understanding of the adaptation of the human body to the natural environment (Veith, 1972; Xinnong, 1987). The essence of TCM is to facilitate the restoration of health and wellbeing through locating disease and illness within a broader notion of health (Kaptchuck, 1983; Lu, 1994; Kleinman; 1981; Kleinman & Kleinman, 1994). Lu and Needham (1980) write that Chhien Fu Lun of Wang Fu, an ancient scholar of Chinese medicine said; “Superior physicians treat the body as a whole; inferior physicians simply treat the disease” (p. 116).

Table (Appendix 1) The Five Elements – Yin-Yang Qi (adapted from Enquin, 1988, p. 46).

Wood	Water	Earth	Metal	Fire
Liver Yin Qi	Kidney Yin Qi	Spleen Yin Qi	Lung Yin Qi	Heart Yin Qi
Gall Bladder Yang Qi	Bladder Yang Qi	Stomach Yang Qi	Large Intestine Yang Qi	Small Intestine Yang Qi

This representation of the organs of the body is derived from the body formed in totality as a system of correlations of the five elements and viscera (Enquin, 1988) Eisenberg refers to this as an expression of “... both physical and spiritual” (1993, p. 299). Examination of the systems of the body from a holistic perspective is governed by the elements of a tripartite notion of mind-body-spirit (Connelly, 1979).

To understand the underlying background of philosophical basis of traditional Chinese medicine is necessary to draw on how holistic elements within the practice have been important in the formation and practice of this form of medicine explained in Chapter Three. Skills evolved from human adaptation to harsh climactic changes developing first as an art form then as healing techniques as the healer became accustomed to the energy of the environment explained through the Five Element theory (Xinnong, 1987). Understanding the natural laws of the universe and the five elements of nature were an essential foundation of the early art of ancient healing techniques. The 'Tao' was considered to be the life source of all energy governing the flow of Qi, Yin Yang and five elements which reflect the laws of nature (Connolly, 1979; Enquin, 1988a; Kaptchuk, 2000; Lu, 1994; Maciocia, 2005; Veith, 1972). These elements of nature explain the physiological process of TCM theory, guiding the principles of clinical practice and assist to identify pathological change as they occur within the body. Understanding the physiology of the body is guided through the diagnostic assessment that examines:

- Yin Yang and the five elements
- Functions of the Qi and flow of blood
- Meridian pathways that act as conduits for the flow of Qi
- Six exogenous factors
- Seven emotional factors
- Stress, strain, lack of exercise and trauma
- Phlegm fluid and stagnant blood

The Qi

The practitioner assesses the treatment according to the pathogenesis of disharmony of the balances of Yin Yang. Any evidence of disharmony found in relation to the normal functioning of Qi forms the basis upon which an appropriate therapy is selected to restore and regulate the flow of Qi. Energy or Qi undergoes cyclic transformations throughout its journey as it connects with the Zang Fu organs of the body along the varying meridian pathways (Connolly, 1979; Enquin, 1988a; Veith, 1972; Xinnong, 1987). Meridian pathway act to provide a continuous flow of interconnected energy throughout the body.

Meridians connect to the organs of the body in a complex circuitry unlike that found in Western medicine. The meridians do not correspond with the anatomical nervous system of Western science. Eisenberg (1993 cited in Moyes) suggests that the Chinese would “... tell you its about a force called Qi” (p. 253).

The Chinese practitioner looks for an imbalance of Qi throughout the different organs of the body (Kaptchuk, 1983; Ross, 1985; Maciocia, 1989). Xinnong describes that usually the Qi flows without any disruption hence a balance exists between the Yin and Yang. Along the pathways of the meridians are varying acupoints that have a fixed location at different intervals of the anatomy of the body linked to the Zang Fu organs. The TCM practitioner seeks to rebalance these subtle energies by focusing on the underlying nature of the problem rather than on the symptom to correct imbalance in the flow of Qi. The focus of healing is applied from a holistic perspective rather than from a science based perspective.

The Zang organs

The Zang organs are classified as the major organs of the body. These are considered to be solid and constitute: the heart, liver, spleen, kidney, and lung. The major function of the Zang organs are, “to manufacture and store essential substances, including vital essences” (Xinnong, 1987). The Zang and Fu organs are interconnected by the flow of energy of the meridian pathways of the individual organs.

The Fu organs

These organs are classified as the minor or extraordinary fu, being hollow. They consist of the small intestine, gall bladder, stomach, urinary bladder and large intestine. Their function “is to receive and digest food, and transmit and excrete wastes” (Xinnong, 1987, p. 25).

The theory of the Zang Fu organs forms a very complex therapeutic and diagnostic analysis upon which treatment is based. In treatment the meridian connections of the body and specific acupoints for acupuncture or herbs are selected. Each organ is dependent on the other for support and is explained as being interacting and over acting, counteracting and interpromoting. Each

element of the natural world represents a specific organ and function, for example; earth represents the organs of the stomach and spleen and earth may be reinforced to generate metal [to strengthen spleen function to benefit the lungs. Water nourishes wood [to benefit the liver] and hence supports heart [supplementing the function of the spleen to treat hyperactivity of the liver]. The kidney is strengthened and water controls fire [the essence of the kidney treats hyperactivity of the heart] (Enquin, 1988).

Yin and Yang interrelationships

The supporting framework of TCM and the Five Element theory is the philosophy of the ‘Nei Ching’. Yin Yang constitutes the spirit of Tao of heaven and the earth of balance and harmony in the five elements of nature and represented by each Zang Fu organ. Maciocia suggests the “whole of Chinese medicine, its physiology, pathology, diagnosis and treatment, can all be reduced to the basic and fundamental theory of Yin and Yang” (2005, p. 6). These components of duality form complex interrelationship throughout the body, hence harmony is necessary between the organs closely connected with each other.

Table (Appendix 2) The Yin and Yang Qi of the Organs

The Qi	Zang Fu	The Five Elements
The absolute Yin The lesser Yang	Liver Gall Bladder	Element wood
The lesser Yin The great Yang	Heart Small intestine	Element fire
The great Yin The sunlight	Spleen Stomach	Element earth
The great Yin The sunlight	Lungs Large intestine	Element metal
The lesser Yin The sunlight	Kidneys Bladder	Element water

(Adapted from Veith, 1972, p. 16).

The assessment of the client is based on the condition of the Qi energy, to reveal the nature of an illness the assessment examines all aspects about a person. Pathological changes of a person's wellbeing are described as abnormalities noted from the observations made by the practitioner. This includes the appearance, skin tone, colour, tone of voice, predominant emotion, the posture, favourite taste (bitter, sweet, sour, salty), appetite, sleep, the function of the bladder and bowels, sexual energy and stresses within the family and at work (Connelly, 1979).

From observations made that include the pulse and tongue diagnosis, disturbances of the harmony of the internal organs can be detected. This detection of internal disturbance by observing external signs is based on a system developed by a Dr Hinging at Shandong University. In 1973 he identified a system of acupuncture points that corresponded to organ and limb (Enquin, 1988c). When the body is examined and a tender point 'ah si' is found, attention is paid to the corresponding internal organ involved in producing that pathological change. The interconnections of external acupoints corresponding to an internal organ dysfunction reflect the body reacting to the changing flow of Qi (Ferigno & Wang, 2000).

Interconnectedness is explained through the following transactions that occur between the Zang and Fu organs of the body. Living in accordance with the Tao and harmony enures longevity, the acquisition of wisdom found in the Nei Ching (Veith, 1972). Harmony is understood from a perspective of understanding the doctrine of 'Wu Yun Liu Qi', the six natural forces of wind, cold, heat, dryness, dampness or extreme heat can become pathogenic factors (Enquin, 1988b; Rose, 1999). The image of the interplay between the organs as a complex body-mind-spirit synergy is governed by the life force 'Qi' flowing throughout the organs producing a composite whole. When Yin Yang are out of balance they necessarily have an effect on each other and the balance of the Qi flow (Maciocia, 2005). It is expressed this way by Veith;

When Yin is stabilised and Yang well conserved, the spirit will be in harmony; separation of Yin and Yang will cause exhaustion of essential Qi. Man has a physical shape which is inseparable from Yin and Yang (1972, p. 15).

APPENDIX 3:

**Review of the Practice of
Traditional Chinese medicine (TCM)**

Review of the Practice of Traditional Chinese Medicine (TCM)

In August 1995, the Victorian Department of Health and Community Services (H&CS) commenced a review of the practice of Traditional Chinese Medicine (TCM). The purpose of the review is to assess the need, if any, for registration of TCM practitioners and regulation of Chinese herbal preparations. The first stage of the review is a major research project which has been tendered to a consortium of Universities led by University of Western Sydney (Macarthur). The research has been jointly funded by H&CS and the Department of Health in NSW.

The purpose of the research is to investigate:

- The risks associated with the practice of TCM.
- The nature of the TCM workforce in Victoria and NSW.
- The need for legislative regulation of TCM practice.

The study has the full support of both the Victorian and NSW Health Ministers. It has been prompted by the increase in demand for TCM with a concurrent rise in complaints from consumers about the use of herbal preparations and the difficulties in ensuring appropriate standards.

H&CS is keen to ensure that those who have an interest in TCM are kept informed of progress with the research project and the review process. This is the first in a series of information sheets designed to provide information to practitioners, consumers and TCM organisations. If you require any further information on the review, you can contact:

Ms Anne-Louise Carlton
Public Health Division
H&CS
G.P.O. Box 4057
Melbourne 3001
Tel: (03) 9616 8524
Fax: (03) 9616 8383
Email: pub.health@hna.ffa.vic.gov.au.

The Research Team

The Project Directorate for the research project consists of:

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Studies
University of New England
Tel: (03) 9429 1682

Melbourne based project manager is:

Mr Rey Tiquia
TCM Practitioner
Tel: (03) 9499 1362

Scope of the Research

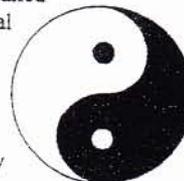
The research project will investigate and report on seven main areas:

1. The regulatory frameworks in China, other countries, and all states of Australia.
2. The profile of the TCM workforce in Victoria and NSW including the organisations that represent practitioners.
3. The profile of patients using TCM and patient satisfaction.
4. The risks and benefits of TCM.
5. The nature of the links and referral networks between practitioners of TCM and other health care practitioners.
6. The nature of TCM education in Australia and China.
7. The adequacy or otherwise of the current state regulatory frameworks.

All components of the study will be undertaken in both NSW and Victoria.

The research team is due to provide an interim report in April 1996, with the final report scheduled for August 1996. Mr Bensoussan has stated:

'This is a landmark project in its detailed analysis of the practice of Traditional Chinese Medicine. It deserves the ongoing support and contribution of the TCM profession and all relevant interest groups in order to ensure comprehensiveness, accuracy and validity of the final document.'



Below is a report prepared by University of Western Sydney (Macarthur) on progress with the research project.

Risks and Benefits

The risks analysis will focus on two key areas - Chinese herbal medicine and acupuncture. We have commenced with extensive computer database searches, manual searches through Chinese journals (which do not appear on the computer databases), and contacts with managers of specialist databases in the United Kingdom, USA and Hong Kong.

Evaluation of the potential benefits of acupuncture and Chinese herbal medicine has commenced and, as would be expected, is hard labour. Information is also being compiled on education of TCM practitioners in China for inclusion in the Interim Report.

Meetings with TCM Associations

A number of meetings of TCM and other associations have already been held in both Melbourne and Sydney. An executive representative from each association, with practising members in Victoria or NSW, was invited to attend. The first meeting in each city brought together representatives from associations who were solely involved in TCM. The second meeting brought together representatives of associations who were concerned with more than TCM or whose members generally practised at least one other health care modality, for example medical practitioners, chiropractors, osteopaths, nurses, massage therapists and so on. At the meetings, the overall project brief was outlined.

The study, whilst applauded, triggered some concern by the attending members as being a very extensive review given the time frame. Overall, the meetings served as an excellent opportunity to receive input and views from the profession and, in general, to discuss a range of components of the research.

Practitioner Survey

The practitioner survey instrument was pilot-trialed in both Sydney and Melbourne, and the Project Directorate is grateful for feedback received during and after those meetings. Keep it coming on all matters! The patient profile was also submitted to scrutiny at the TCM practitioner meetings and was well received.

The practitioner survey instrument and the related process, as well as the patient profile, were submitted for approval to the Ethics Committee of H&CS. The survey has been accepted subject to some further clarifications and amendments. The practitioner survey instrument and patient profile are currently being typeset into their final formats.

Developing the Mailing List

Professional TCM associations have been requested to provide their mailing list of practitioner members for participation in the survey and to commence preparing information about their organisation. Some associations have already responded and, as there were no objections in principle at the association meetings, we anticipate having a comprehensive mailing list compiled fairly soon.

The practitioner survey instrument will be sent out in late March. Practitioners are asked to respond within two weeks of receipt and associations are requested to encourage their membership to respond. Whilst all practitioners will receive a bilingual (English/Chinese) explanatory letter, the survey will also be translated into Chinese and available on request. English, Mandarin and Cantonese assistance will be available.

Interviews

Approximately one in twenty practitioners (who practise TCM as their primary modality) will then be invited to participate in further in-depth interviews. The interviews will be performed in English, Mandarin and Cantonese as required. Furthermore, approximately one in twenty practitioners will also be invited to participate in gathering non-identifying data about their patients (the patient profile). This will require practitioners to complete a form for each patient contact during specified time. There will be no great burden of time on participating practitioners.

Legal Consultant

Ms Caroline Marsh from Blake, Dawson and Waldron solicitors has agreed to act as a consultant in the compilation of the information on direct and indirect regulatory controls in TCM both locally and overseas. Dr Arthur O'Neill has also commenced work in this area, gathering data from departmental documents in Melbourne and interviewing departmental staff.

Media Watch

Announcement of this TCM review project has attracted significant media interest resulting in a number of newspaper articles, including the Sunday Age and Herald Sun, and on ABC radio (Melbourne).

For any further information on the research project, contact Mr Bensoussan or Mr Tiquia on the above numbers. If you require this newsletter in Chinese, please contact Anne-Louise Carlton.

APPENDIX 4:

TCM Course Details for Health Graduates

acupuncture

ACUPUNCTURE COURSE FOR HEALTH GRADUATES

INTRODUCTION

The science of acupuncture and moxibustion (A and M) is an important part of Traditional Chinese Medicine (TCM). For thousands of years Chinese people have appreciated it for non-pharmaceutical treatment, simple application, wide range of uses, good curative effects and low cost. Since the 1950s it has been greatly popularised and developed and is becoming an increasingly important component of world health treatment.

Today in Western Australia, more and more people prefer the treatment of A and M to drugs in appropriate circumstances. In addition, people are seeking to be trained in formal and advanced acupuncture courses. This new graduate acupuncture course is designed to address the needs of those people who already possess an appropriate qualification in the health field and who wish to become competent and professional acupuncturists.

The Centre for the Development of Human Resources is a division of the School of Community and Language Studies of The Western Australian College of Advanced Education. The Centre provides a wide range of training and consultancy in the field of human services and is the administrator of this course. The Centre is formalising links with sister institutions working in A and M or TCM in Australia and China.

Given adequate support and interest, the graduate course will commence in early February 1990 and be provided over two years for part-time study only. Arrangements are being made for a final semester practicum in GUANGZHOU College of TCM in China where two renowned professors in A and M and TCM are consultants for the acupuncture course.

Should prospective students wish to make further enquiries about the course, they can contact the Course Lecturer, Dr Zhou Zhen Wu or the Centre's Executive Officer, Mr Errol Cocks on 3830333.

BRIEF DESCRIPTION OF UNITS

THEORY OF MERIDIANS

This unit is a general introduction to the important theory of Acupuncture and Moxibustion and its modern research base. It includes:

1. The basic concepts of the meridians and collaterals.
2. The twelve regular meridians.
3. The eight extra meridians, twelve divergent meridians, fifteen collaterals and others.
4. The phenomenon of the meridians and its modern research.

The unit aims to lay a good foundation of acupuncture for students' further study. Students will be made familiar with the theory of meridians and collaterals and how these phenomena were discovered. They will be given a grounding in research methods in this field.

ACUPUNCTURE POINTS

This unit covers the basic theory of acupuncture therapeutics, including:

1. An introduction to acupoints, classification and nomenclature of acupoints, methods of location of acupoints, specific points and an outline of the therapeutic properties of the points of the fourteen meridians.
2. The acupoints of fourteen meridians and the extraordinary points.

The unit aims to teach the concepts of acupoints, 150 common points and their location, function and treatment rules. This unit assumes at least a basic knowledge of anatomy and physiology.

BASIC THEORIES OF TCM

This unit extends over two semesters and provides a general introduction to the basic theories of TCM including:

1. A brief history of TCM
2. Yin–yang and the five elements
3. The Zang–fu organs
4. Qi, blood and body fluid
5. Aetiology
6. Pathogenesis

The unit aims to coordinate the basic theories of TCM with the basic theory of A and M and to lay a foundation for students' further study.

DIAGNOSTICS OF TCM

This unit extends over two semesters and is a connecting course between pre–clinical and clinical courses. It covers:

1. Diagnostic methods including inspection, auscultation and olfaction, inquiring and palpation.

2. Differentiation of syndromes according to eight principles, and the theory of qi and blood, fang-fu organs and meridians.

This unit aims to provide the methods of diagnosis and differential diagnosis of TCM.

TECHNIQUES OF ACUPUNCTURE AND MOXIBUSTION APPENDIX 4:

This unit is an introduction to A and M techniques. It includes:

1. Acupuncture techniques of filiform needles, needling methods, precautions, contraindications and management of possible accidents in acupuncture treatment, the three-edged needle and others.
2. Moxibustion and cupping including materials, classification, function and application of moxibustion and cupping methods.

The unit aims to teach the therapeutic techniques and methods of A and M including cupping and the various manipulating methods of acupuncture in order to lay a foundation for further study of acupuncture therapeutics.

TCM Course details for Health Graduates THERAPEUTICS OF A AND M

This unit is a clinical course of A and M and extends over two semesters. It covers:

1. A general introduction to acupuncture treatment including general principles, therapeutic methods and basic principles for prescription and selection of acupoints.
2. Treatment for common diseases.
3. Ear acupuncture and acupuncture anaesthetics.

The unit aims to provide therapeutic principles and methods for common diseases and students should be able to analyse relevant cases, establish a correct diagnosis and therapeutic plan and master the general operational skills of A and M, as well as understand ear acupuncture therapy and acupuncture anaesthesia.

CHINESE LANGUAGE

This unit extends over four semesters and is intended as a beginning course for learning the Chinese language to enable students to understand terminology and to complete their practicum in China. It covers:

1. common words used in daily life and practical work.
2. situational dialogue covering a wide range of typical situations in both social life and acupuncture work.
3. phonetics including initials and finals, tones and stress and intonation.

The unit aims for students to master correct basic pronunciation, basic grammar and common words.

COURSE OUTLINE

YEAR	SEMESTER	UNIT	HOURS PER WEEK	TOTAL HOURS
APPENDIX 4:				
1990 Feb-Jun	One	Theory of Meridians	3	45
		Basic Theories of TCM I	2	30
		Chinese Language	1	15
1990 Jul-Nov	Two	Basic Theories of TCM II	3	30
		TCM Course details for Health Graduates Diagnostics of TCM I	3	15
		Acupuncture Points	2	30
		Chinese Language	1	15
1991 Feb-Jun	One	Diagnostics of TCM II	3	15
		Techniques of A and M	3	30
		Therapeutics of A and M I	2	30
		Chinese Language	1	15
1991 Jul-Oct	Two	Therapeutics of A and M	5	50
		Chinese Language	1	10
Oct-Dec	PRACTICUM		Two Months	

APPENDIX 5:

Guangzhou College of TCM China

廣州中醫學院

Guangzhou College of Traditional Chinese Medicine



About the College

Guangzhou College of Traditional Chinese Medicine, one of the four earliest colleges of its kind in China, was founded in 1956, with a total area of 300,000 square metres. Since its founding, the college turned out more than 10,000 senior TCM workers making up one-sixth of the sum totally trained during the same period in all TCM colleges of the country. Distributed all over the country, most of the graduates are playing an important role in clinical practice, teaching, scientific research and administration as well.

In the beginning of its founding, the number of the students enrolled was only 106, and now over 600 students are studying in the college, including undergraduates, postgraduates, foreign students and advanced students taking various kinds of courses. The college is now composed of three departments: Department of Traditional Medicine, Department of Acupuncture and Moxibustion and Department of Chinese Pharmacology. Besides, an affiliated nurse school has been set up.

In the early days the number of teachers of the college was about 40 but now has been raised to 456, which includes 50 professors and associate professors, 6 chief physicians and assistant chief physicians, 332 lecturers and attending doctors. Among them there are some professors and experts known all over the country, they are Professors Luo Yuankai (羅元愷), Deng Tietao (鄧鐵濤), Huang Yaoshen (黃耀榮), Situ Ling (司徒鈴) and Chief Physician Liang Naijin (梁乃津), etc. There are also 17 doctors given the title of 'Provincial Veteran Doctors of TCM', and one being a member of the Committee of Academic Degree of the State Council. Fourteen branches in this college has been designated as master's and doctoral degree-granting units.

Just after its founding, the college had only the Guangdong Provincial Hospital of TCM as its affiliated hospital, with a total number of 50 or more beds. Now the beds of this hospital have increased to more than 400 in number. In 1964, a new affiliated hospital was built beside the college, and in 1985, the traumatology hospital was established. At present these three affiliated hospitals have altogether over 1,000 beds and a total number of more than one million out-patients yearly.

Guangzhou, the major city of South China, applies an open-policy earlier than other cities. This creates a favourable situation for running the college in an open way, and for widely spreading the knowledge of Chinese medicine and pharmacology. Since 1974, the college has been receiving per year 10 foreign undergraduate students and 40-100 postgraduate students from more than 30 countries such as Korea, U.S.A., Japan, West Germany, France, Britain, Australia, etc. as well as from Africa and South-east Asia. Besides, academic exchanges between this college and the other medical colleges and research institutes in about 50 countries and regions has been carried on. Agreements on academic cooperation have been signed with American College of TCM, University of Illinois, Acupuncture Colleges of Australia, College of TCM of Japan and TCM Institutes of Thailand and Singapore.

In these recent years, there have been a number of teachers sent abroad as visiting scholars and 31 teachers have been invited to other countries to give lectures or hold group consultations with doctors there. More than 40 academic theses have been published in some popular magazines abroad. Now, the college is enjoying an increasing prestige in the world.

There are 9 research sections of TCM in the college, i.e., Malaria, Clinical Pharmacology, Spleen-Stomach Theory, Channel & Collateral, Qigong, Tumor, Immunology, Gerontology and Acute Coeliac Diseases. Since 1978, there have been 67 research projects respectively awarded prizes, instituted at national, provincial and municipal levels. In 1985, the college won the bid on undertaking 3 items of the national scientific research projects. A lot of achievements in scientific research have been transferred to productive units, for instance, Tablet for Senile Cataract, Pill for Nourishing Kidney and Fetus, Tablet for Osteohyperplasia, Tablet for Primary Carcinoma of Liver, Capsule for Gastritis and Peptic Ulcer and He-Chan Tablet. Production of these new drugs are bringing more and more benefit to the whole society.

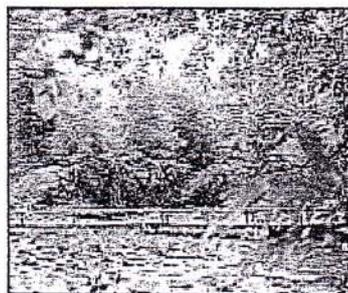
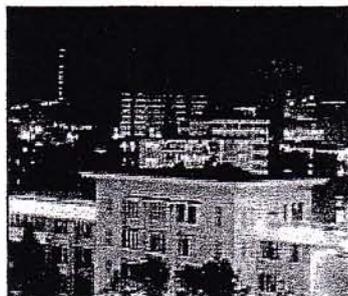
In addition to the Journal of Guangzhou College of TCM, the college also edits and publishes the monthly Journal of New TCM, which is distributed at home and abroad in a large number. Besides, the college is the chief editor in compiling the 5th edition of nation-wide used TCM text books of five different courses and by now it has systematized 16 kinds of ancient books of Chinese medicine.

The college has a library with an area of more than 5,000 square metres, and a collection of 240,000 books.

Continuing education has also been developing in quite a big way. Granted by the higher organization, a night school has been set up, and a nation-wide correspondence university has been started. The former has now a total of 113 students enrolled, and 600 were graduated in the past few years; the latter has received from other nine provinces 1,000 students. The periodical education of Chinese medicine and pharmacology has been held to assist the medical workers in their study, which now 6,585 students are taking part in. Various kinds of courses for advanced education are offered here, e.g., the course for western-type doctors to study TCM, the course for doctors to raise their level of TCM theory, and courses for specialists. With its brilliant achievements, the college has become one of the ten major bases for training medical teachers and also one of the four bases of clinical Chinese pharmacology in China. In addition, a DME (design, measurement, evaluation) training centre has also been set up, which is at present the only one in TCM colleges and institutes of the whole country.

Under the guidance of TCM policy formulated by the Party, all teachers, students and administrative staff, with arduous efforts, are exerting themselves in the spirit of reform and innovation to open up a new prospect in education of TCM, thereby making greater contributions to socialist modernizations of our country.

概 况 About the University



Guangzhou University of Traditional Chinese Medicine is one of the oldest colleges of its kind in China and is governed directly by the State Administration of TCM. The university is located at Sanyuanli, near the foot of Baiyun mountain in northern Guangzhou. The campus covers an area of about 400,00 square meters and has a building area of about 290,000 square meters (including the affiliated hospitals). The university was Guangzhou College of TCM until February 1995, when the State Educational committee approved the transition to university status.

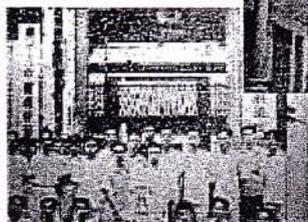
The university consists of two Departments of Medicine, the Departments of Acupuncture & Moxibustion, Department of Chinese Materia Medica, Basic Science and Social Science, and the Affiliated Middle School of TCM. Seven branches have been designated as the doctoral degree - granting units, and twenty-two branches as the master's degree - granting units. The university offers seven specialties for undergraduates, including Traditional Chinese Medicine, Acupuncture and Moxibustion, Chinese Materia Medica, Orthopedics and Traumatology, ENT and Ophthalmology of TCM, TCM Literature and Resources of Chinese Materia Medica (development and utilization).

A seven-term undergraduate and postgraduate TCM class and a two-term TCM class for the second bachelor degree for professionals of Western Medicine have been held since 1991 and 1992, respectively. At present, the total number of the faculties and staffs is more than 3,000, and about 400 of them hold senior titles of professional posts and over 700 of them hold intermediate ones. There are more than 2,000 full-time students studying at the university, including undergraduates, postgraduates, foreign students and students from Hong Kong, Macao and Taiwan. Continuing education includes evening, correspondence and self-paced classes have also been held.

[Brief History](#)
[Research](#)
[Guangzhou Main Page](#)

[Medical Facilities](#)
[Foreign Exchanges](#)

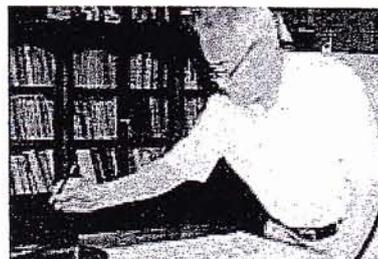
沿革 History of the University



1924

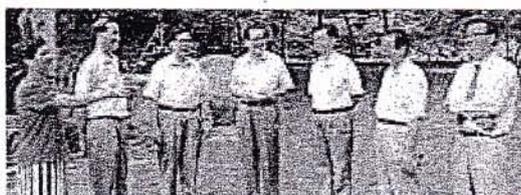


The gate and teaching building of Guangdong Professional Training School of TCM, the predecessor of the university.



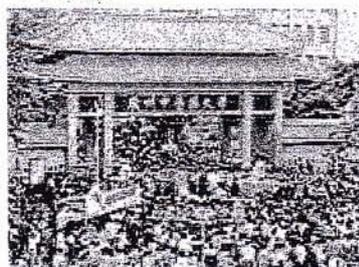
Professor Deng Tietao, former student, teacher and leader of the school.

Retired leaders of the university tour construction and discuss the development of the school. From left, Zhu Shanyou, Liu Rushen, Li Yingjie. From right, Ou Ming, Wang Yuhuai, Wang Yongxiang



Current leaders of the university engaged in a lively conversation. From right, Vice President Feng Xinsong, Vice Secretary of the Party Committee He Beicang, Vice President Qiu Heming, President Li Renxian, Vice President Li Guonqiao, Vice Secretary of the Party Committee Huang Xiaoling.

1995



An enthusiastic crowd at the renaming ceremony of "Guangzhou University of Traditional Chinese Medicine"

The University Today

Guangzhou University of Traditional Chinese Medicine combines high-technology with traditional medicine. Students use modern computer facilities and learn about the history

APPENDIX 6:

Ethics Approval Curtin University

MINUTE

Curtin

UNIVERSITY OF TECHNOLOGY

To	Patricia Anne Greene, Social Sciences
From	Max Page, Executive Officer, Human Research Ethics Committee
Subject	Protocol Approval HR 225/2001
Date	1 February 2002
Copy	Dr Robert Pokrant, Social Sciences Graduate Studies Officer, Division of Humanities

Office of Research and Development

Human Research Ethics Committee

TELEPHONE 9266 2784

FACSIMILE 9266 3793

EMAIL T.lerch@curtin.edu.au

Thank you providing additional information/amendments for the project "CULTURAL CONSTRUCTIONS OF HEALTH AND ILLNESS IN THE PUBLIC UTILISATION OF ALTERNATE FORMS OF MEDICINE IN PERTH, WESTERN AUSTRALIA". On behalf of the Human Research Ethics Committee I am authorised to inform you that the project is approved.

Approval of this project is for a period of twelve months **01/Feb/2002** to **31/Jan/2003**.

When the project has finished or if at any time during the twelve months changes/amendments occur, the attached FORM B is to be completed and returned to Ms Tania Lerch, (Secretary, HREC) C/- Office of Research & Development as soon as possible. The approval number for your project is **HR 225/2001**. *Please quote this number in any future correspondence.*

Please find attached your protocol details together with the application form/cover sheet.

Tania Lerch

M Maxwell Page
Executive Officer
Human Research Ethics Committee

J:\OR\HREC\REG99\HR 225/2001

Please Note:

If information about the authorisation of this project is required, the following standard statement is suggested for inclusion in the information to subjects section of the protocol.

This study has been approved by the Curtin University Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.

APPENDIX 7:

Practitioner Rights

Informed Consent Form

Practitioner Participant in Complementary Health Care

My name is Patricia Greene and I am currently enrolled in PhD studies at Curtin University in the School of Social Sciences. The purpose of this study is to increase the understanding of the nature of practice of complementary health care accessed within Western Australia and in particular to examine the difference in the manner in which it is different from orthodox health care. The knowledge gained from this study will be of major significance to inform the health and humanities professions of the complexities involved in the social and cultural persuasion of health care.

The study will involve consumers accessing complementary health care practitioners and in particular Traditional Chinese medicine and herbal and nutritional health resources in the community. Information for this study will be collected during fieldwork through participant observation and by approximately 5 informal interviews lasting 30-45 minutes. Extracts of the interview may be used in the research report, however you will not be identified in any way. Participation is voluntary and you may withdraw at any time without any obligation. Every precaution will be taken to protect your anonymity.

In addition to the interview at the practitioners discretion access may be given to case histories of clients, the nature of which will be used to provide further information for the researcher but will remain completely unidentifiable and confidential. The case histories will not leave the premises of the practice and will not be photocopied or retrieved in any unlawful way.

If there are any questions or concerns you have regarding this study please contact me on 08 93550200 (home). You may also contact my supervisor Dr B. Pokrant on 08 92663326

Participants statement

I, _____, have read the above information relating to the study of complementary health care. I understand the nature and intent of the study and have the opportunity to ask questions. I know where to direct future questions that I may have. I have received a copy of the consent form. I understand that my participation is voluntary and that I may withdraw at any time.

Signed _____ Practitioner Date _____

Signed _____ Researcher Date _____

APPENDIX 8:

Client Rights

Annexure B.

Informed Consent Form

Client Participant in Complementary Health Care

My name is Patricia Greene and I am currently enrolled in PhD studies at Curtin University in the School of Social Sciences. The purpose of this study is to increase the understanding of the nature of practice of complementary health care accessed within Western Australia and in particular to examine the difference in the manner in which it is different from orthodox health care. The knowledge gained from this study will be of major significance to inform the health and humanities professions of the complexities involved in the social and cultural persuasion of health care.

The study will involve consumers accessing complementary health care practitioners and in particular Traditional Chinese medicine and herbal and nutritional health resources in the community. Information for this study will be collected during fieldwork through participant observation and by approximately 5 informal interviews lasting 30-45 minutes.

During the interview you may decline to answer any question and request that the tape recorder be turned off. No names will appear in the field notes or in the transcribed interview. Extracts of the interview may be used in the research report, however you will not be identified in any way. Participation is voluntary and you may withdraw at any time without obligation. Every precaution will be taken to protect your anonymity.

If there are any questions or concerns you have regarding this study please contact me on 08 93550200 (home). You may also contact my supervisor Dr B. Pokrant on 08 92663326

Participants statement

I, _____, have read the above information relating to the study of complementary health care. I understand the nature and intent of the study and have the opportunity to ask questions. I know where to direct future questions that I may have. I have received a copy of the consent form. I understand that my participation is voluntary and that I may withdraw at any time.

Signed _____ Participant Date _____

Signed _____ Researcher Date _____

APPENDIX 9:

Patient History Sheet

PATIENT'S HISTORY SHEET

Record No:.....

Name.....M/F Occupation..... Age.....

Chief Complaint(s) Date.....Time.....

History.....

Inspection

Vitality.....

Colour(face).....Temperature.....

Tongue proper.....

Tongue coating.....

Ears/Nose/Throat/Gums/Lips/Mouth/Eyes.....

Other.....

Auscultation & Olfaction

Speech.....Breathing.....

Cough.....Sputum: Yes/No Type:.....

Breath odour.....

Inquiring

Pain:Yes/No Locality.....Type.....

Relieved by:Heat/Cold/Change position/Cont./Intermittent/D/N

Body.....Limbs.....Palpitation.....

Headache:Yes/No Part of head.....Dizziness:Yes/No

Chills/Fever Insomnia.....Medic:Y/N Type.....

Appetite.....Thirst.....(Hot/Cold drinks)

Taste.....Perspiration.....(D/N)

Spontaneous or on exertion.....Energy.....

Bowels:.....Constipated:Yes/No How long.....

Diarrhoea.....Frequency.....Time.....

Offensive: Yes/No Pain: Yes/No Where pain.....

Blood/Mucus/Undigested food /Stool colour.....

Urination(frequency/colour/amount).....Pregnant:Y/N

Menses:Reg./cycle/amount/colour/clots.....

Discharge: Yes/No Colour.....Offensive: Yes/No

Allergies.....Medication type.....

Diabetic: Yes/No.....Hypertension: Yes/No.....

Palpation

Pulse type.....

(R) Cun.....Guan.....Chi.....

(L) Cun.....Guan.....Chi.....

Blood Pressure:.....Pulse rate.....

=====

Prognosis.....

Treatment.....

Remarks.....

.....Healer.....

APPENDIX 10:

**White House Commission on
Complementary and Alternative Medicine
Policy**



**White House Commission on
Complementary and Alternative Medicine
Policy**

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Transmittal Letters



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 22, 2002

The President
The White House
Washington, DC 20500

Dear Mr. President:

I submit to you the Final Report of the White House Commission on Complementary and Alternative Medicine Policy in accordance with Executive Order 13147. The Report contains administrative and legislative recommendations.

The Department appreciates the time and effort taken by the Commission to examine this area in detail. We are forwarding the Report to you and making it available to the public immediately. We will review carefully the recommendations addressed to the Department, and I am sending copies of the full Report to Congressional leaders.

Sincerely,

Tommy G. Thompson



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 22, 2002

The Honorable Richard Cheney
President of the Senate
Washington, DC 20310

Dear Mr. Cheney:

I submit to you the Final Report of the White House Commission on Complementary and Alternative Medicine Policy in accordance with Executive Order 13147. The Report contains administrative and legislative recommendations.



White House Commission on Complementary and Alternative Medicine Policy

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Chapter 8: CAM in Wellness and Health Promotion

In recent years, people have come to recognize that a healthy lifestyle can promote wellness and prevent illness and disease, allowing them to enjoy a long, high-quality life. To achieve this goal, many people have used various approaches, including complementary and alternative medicine (CAM).

Wellness is defined in many different ways, but all agree that it is more than the absence of disease. For some it is the achievement of one's fullest potential, for others it is an integration of body, mind, and spirit. Wellness can include a broad array of activities and interventions that focus on the physical, mental, spiritual, and emotional aspects of one's life.

Since the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* in 1979,¹ the U.S. Public Health Service has led an initiative to define goals and objectives for the health of the U.S. population and to direct resources for improving the Nation's health. The goals and objectives are updated periodically, along with a progress report on their attainment, and have been published as *Healthy People 2000*² and *2010*.³ Long-range goals and objectives for *Healthy People 2020* are currently being developed.

As the *Healthy People 2000* and *2010* reports illustrate, approaches to improving health and wellness, preventing illness and disease, and managing disabilities and chronic conditions require the involvement of a wide range of disciplines and social institutions. The effectiveness of the health care delivery system in the future will depend upon its ability to make use of all approaches and modalities that provide a sound basis for promoting optimal health. People with better health habits have been shown to survive longer and to postpone and shorten disability.⁴ CAM practices such as acupuncture, biofeedback, yoga, massage, and tai chi, as well as certain nutritional and stress reduction practices, may be useful in contributing to the achievement of the nation's health goals and objectives.

Helping people achieve a healthy, meaningful, and long life is the fundamental purpose of all health care systems. In the United States, great strides have been made in conquering disease and extending life, and the health care system reflects these remarkable scientific advances. Yet in the quest to conquer illness and disease, national wellness and prevention efforts have been focused primarily on immunizations, disease screening and monitoring (e.g., pap smears blood pressure checks), and services offered in response to an already identified illness or condition (e.g., physical therapy after stroke, nutritional counseling for diabetics). With some notable exceptions, wellness and health promotion have, for the most part, been left to the initiative and discretion of the individual. The Commission believes that it is time for wellness and health promotion to be a national priority and for the role of CAM in these efforts to be explored further.

The concomitant rise of interest in CAM and in wellness and prevention presents many new and exciting opportunities for the health care system. There is evidence that certain CAM practices, when administered by properly trained practitioners, may be beneficial. Evaluating safe and effective CAM practices and products to determine their applicability to wellness and health promotion activities presents new and exciting areas to explore in the quest to improve health outcomes and quality of life.

The Role of Safe and Effective CAM Practices and Products in Promoting Wellness and Helping to Achieve the Nation's Health



White House Commission on Complementary and Alternative Medicine Policy

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Chapter 4: Education and Training of Health Care Practitioners

Since the public utilizes both conventional health care and complementary and alternative medicine (CAM), the Commission believes that this reality should be reflected in the education and training of all health practitioners. Thus, the education and training of conventional health professions should include CAM, and the education and training of CAM practitioners should include conventional health care. The result will be conventional providers who can discuss CAM with their patients and clients, provide guidance on CAM use, collaborate with CAM practitioners, and make referrals to them, as well as CAM practitioners who can communicate and collaborate with conventional providers and make referrals to them.

Reaching this goal will require development of CAM faculty, curricula, and programs at both CAM and conventional institutions. Because of increased consumer demand for CAM services and products, national curricular elements should be established for CAM education and training. However, the Commission recognizes the barriers to and voluntary nature of such national curricular elements. An evaluation should be undertaken of whether postgraduate training should be established for appropriately educated and trained CAM practitioners. Continuing education programs should be developed for and required of all practitioners who provide CAM services and products. Finally, students of CAM want to participate in loan and scholarship programs, and it is important that this participation be evaluated.

Recommendation 10: The education and training of CAM and conventional practitioners should be designed to ensure public safety, improve health, and increase the availability of qualified and knowledgeable CAM and conventional practitioners and enhance the collaboration among them.

Education in CAM for Conventional Health Care Professionals

In 1995, a national conference on complementary and alternative therapy education recommended that CAM be included in nursing and medical education.¹ Although there has been notable progress in introducing CAM into medical, nursing, and other fields of conventional health care education in recent years, more needs to be done. For example, in 1997, 64 percent of allopathic medical schools reported offering elective courses in CAM or including such topics in required courses.² Data from all 125 allopathic medical schools in response to the 2000-2001 Liaison Committee on Medical Education Annual Medical School Questionnaire indicate that although no medical school requires a separate CAM course, 91 schools include CAM in required conventional medical courses, 64 offer CAM as stand-alone elective, and 32 include CAM as part of an elective.* Required and elective courses included acupuncture, herbal medicine, homeopathy, meditation, manual healing techniques, nutritional supplement therapy, and spirituality, according to the questionnaire. (Table 1).

* More than one response could be chosen, so the total number of responses does not equal the number of respondents.

In a study of an allopathic medical school with no formal or elective courses in CAM, third-year medical students were found to have insufficient knowledge about the safety of 10 common CAM modalities.³ These modalities included massage therapy, herbal medicine, meditation, chiropractic, hypnosis, spiritual healing, acupuncture, homeopathy, reflexology, and naturopathy. The authors of this study recommended including CAM topics in the medical school curriculum to better prepare the

practicing physician for soliciting information from patients about current CAM use, responding to patients' inquiries about CAM, and assessing the merit of introducing a CAM modality into, or removing it from patients' care plans.

Courses in CAM offered at conventional medical schools differ widely in content, format, and requirements.⁴ In light of this variation, consensus needs to be reached on the essentials of a core curriculum.¹ In November 2000, the Josiah Macy, Jr. Foundation convened a conference to develop guidelines for teaching CAM in medical and other health professional schools. The participants concluded that efforts to expand knowledge about CAM should extend beyond the education of medical students to all conventional health professionals.⁵ Addressing the myriad conventional health professions and programs will require a range of educational options.

CAM Conventional Health Care Professions Curricula in

While CAM can be taught in stand-alone courses, it may be more effectively and efficiently integrated into allopathic medical school curricula by combining it with current initiatives such as evidenced-based medicine, cultural competence, and interdisciplinary collaboration. CAM in medical education has evolved to the point where two fundamental questions need to be answered: What should be taught, and how should it be taught?

CAM taught in the context of conventional medical education should be evidence-based.⁶ New educational programs for physicians need to be developed that include the conceptual basis of CAM practices, along with a critical review of the safety and efficacy of CAM practices and products. This information should be incorporated into required courses of medical school curricula and graduate training programs, not relegated to electives, whose content may not be critically evaluated.⁷ While many CAM courses are taught from either an advocacy or neutral view, all CAM courses should be taught critically.⁸

Georgetown University School of Medicine plans to integrate CAM into the entire medical school curriculum as part of a recent grant from the National Institutes of Health's (NIH) National Center for Complementary and Alternative Medicine (NCCAM). Other innovative efforts to integrate CAM with existing medical school curricula are already underway; however, these efforts are geographically dispersed, not well known, and not systematically studied. They range from informal CAM seminars, such as brown bag lunches with CAM practitioners sponsored by student groups, to formal symposia or debates of controversial CAM issues by authorities with opposing views. While survey and other lecture courses are efficient ways of presenting a large volume of information, CAM is being integrated into a variety of courses. For example, information on acupuncture is being integrated into basic science courses, such as anatomy or physiology, as well as clinical courses, such as neurology, while herb-drug interactions are being included in pharmacology.

All of these methods of teaching about CAM offer opportunities to present the history, culture, and philosophy of CAM and training of CAM practitioners as well as a critical analysis of published research on its safety and effectiveness. They also provide opportunities to communicate effectively with CAM practitioners and discuss CAM comfortably and accurately with patients. However, these didactic opportunities can be coupled with opportunities to experience CAM personally, particularly mind-body approaches and stress management, as part of self-care. This is being done at the George Washington University Center for Integrative Medicine through a Department of Education Fund for Improvement of Post-Secondary Education grant. A cogent argument for including self-care in medical education is that the health and well-being of medical students has been so neglected that by the end of their training, they often feel drained of the compassion and spirit that drew them to medicine.⁹ In addition, students who learn the fundamentals of self-care will be better able to teach their patients to care for themselves. Medical education should include opportunities to experience CAM approaches, such as meditation and relaxation therapy, for students who personally may benefit from these approaches during their stressful journey through medical school.