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中醫認證制度於世界各國之現況調查(2-1)

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摘　要

研究目的：

本研究計畫旨在調查分析國際接受傳統醫學之現況。第一階段研究計畫內容主要是針對現今國際上執行傳統醫學較為完備之北美國家，分別在傳統醫學之政策、實務、教育以及認證制度等方面，進行比較與分析。

研究方法：

本研究計畫之研究方法以問卷調查法、訪談法、資料搜尋法來獲得所需之資料與訊息。繼而，採用量性統計分析法與質性內容及主題分析法比較與分析資料。本研究計畫預期結果將闡明中醫因應各國之文化與人口改變之影響，與既有醫療實務、法規、認證等之現況。

結果與討論：

本研究計畫已發展完成中醫相關議題之調查問卷初稿，以及訪談實際參與加拿大中醫發展的五位專家。藉由加拿大之前趨研究分析結果，進一步了解中醫學療的臨床實務、教育、管理、政策法規、認證制度等，期望相關資料與訊息將可提供台灣中醫專業之未來與永續發展。

關鍵詞：傳統醫學、實務、教育、政策、認證制度

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Survey on the Legitimization of Chinese Medicine in the World (2-1)

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ABSTRACT

Aim:

The purpose of this research project is to investigate and compare the trend and development of traditional medicine. The scope will be focused on policy, practice, education, research, and certificate of traditional medicine in the countries of the North American.

Method:

Survey, data collection will be conducted by interviewing and information searching. And then the quantitative methods of descriptive analysis and qualitative method of content analysis as well as thematic analysis will be used to analyze data.

Results & Discussion:

This research project developed and accomplished a survey questionnaire for the investigation of Chinese medicine development and the current situation. In addition to the development of questionnaire, five informants who participated in proceeding legitimization for Canadian Chinese medicine were interviewed in terms of the ethnographic method. The results of this research project could contribute to provide the government and decision-makers the analyzed information.

Keywords: Traditional medicine, practice, education, policy, legitimization

壹、前言

WHO發表「2002-2005年傳統醫學全球策略」籲請各國政府正視傳統／互補另類醫藥，又將傳統醫學列為世界衛生大會重要議題，籲請各國政府採行傳統醫藥策略，並建立完善制度。世界各地都自有其民族醫藥學的存在，中醫藥之理論基礎有別於其他民族醫學且淵遠流長，隨著主流醫學在救治有一定限度的影響下，傳統中醫醫學逐漸被北美、歐洲以及亞洲等國家所重視。惟風俗民情及地域文化之不同，各國對傳統醫學的實務、教育、政策及認證之制度皆有所差異，其中，又以北美地區加拿大發展之傳統醫學較為積極與完備，由於該地區華人人口數多，當局也相對地重視民眾對傳統醫學之就醫需求，現已設有中醫藥管理局以及專業人員訓練課程與認證之法規制定。因此，本研究計畫旨在調查北美洲國家接受傳統中醫學(Traditional Chinese Medicine practice; TCM)之現況，並以北美地區加拿大為例來呈現，分析該國中醫藥專業人員之相關認證及管理情形，以供我國參考及因應。藉由分析結果，進一步了解中醫學的臨床實務、教育、政策、法規、認證等，以提供台灣中醫專業之永續發展。

本研究計畫目標：

一、調查與分析中醫醫療；

二、研發中醫醫療相關主題之結構性調查問卷；

三、以加拿大中醫發展經驗建立分析模式；

四、以及分析加拿大在中醫相關實務、教育、政策、法規與認證制度。

貳、材料與方法

本研究計畫方法採用問卷調查法、內容分析法、主題分析法及訪談法等。研究資料將遵循歷史軌跡以檢視北美洲在實務、教育、研究、政策等之發展與管理情形。本研究計畫將闡明中醫因應國家之文化與人口改變之影響，與既有醫療實務、教育、法規、證照制度等之關係。藉由分析結果，進一步了解中醫學療的臨床實務、教育、政策、法規、認證等，以提供台灣中醫專業之永續發展。

本年度（第一階段）主要是針對中醫醫療之臨床實務、教育、政策、法規、認證制度等發展調查問卷，又以加拿大發展經驗建構調查分析模式；實施步驟如下： 計畫目標一：調查與分析中醫醫療，分成三階段步驟進行。

一、資料庫確認：以經常用之資料庫(database)進行資料檢索與搜尋，透過網際網路、期刊資料庫、參考書或是出版品等方式收集中醫藥相關文獻資料。

二、年代確認：依本研究計畫之目的，確定搜尋之年代範圍。

三、關鍵字確認：依本研究計畫之目的，擬訂適用之關鍵字。

計畫目標二：研發中醫醫療相關主題之結構性調查問卷，分成四階段步驟進行。

一、問卷架構化發展：根據本研究計畫目的、資料分析結果、訪談結果等，擬定問卷之調查目標、主要概念架構、主要內容架構及題項數。

二、問卷內容化發展：根據本研究計畫調查問卷架構化結果，進而發展調查中醫發展與現況調查問卷之內容。

三、問卷結構化發展：根據本研究計畫問卷內容化結果，進而發展調查問卷之結構。

四、問卷效度：敦請三位相關領域專家，針對研發之問卷進行題項與測量目標之效度檢定、審查，再依照專家建議進行問卷修改，以備未來第二年執行資料收集之填寫與使用。

計畫目標三：以加拿大TCM發展經驗建立分析模式，分成兩階段步驟進行。

一、口述訪談：將訪談實際參與加拿大TCM 發展的五位專家進行質性研究，在訪談收集資料過程開始之前，訪談者先解釋本研究計畫之研究目的和研究主旨，並獲得受訪者同

意，再開始收集相關資料。五位專家將各自先完成文化自我描述，再採用開放式對答。訪談時，調查員錄音與記錄訪談內容、訪談情境、受訪者基本資料與特性、肢體行為以及其他影響訪談結果的任何問題；訪談後，錄音與記錄訪談內容轉譯文字表達。最後，進行內容分析。

二、專家諮詢：諮詢目前位在加拿大之四位中醫專家，提供他們在加拿大的臨床實務經驗。

計畫目標四：分析加拿大在TCM相關實務、教育、政策、規章與認證，說明如下。

資料統整：此部分藉由計畫目標(一)與(四)結果而彙整，依照實務、教育、政策、規章與認證逐項分析與整理。

參、結果

一、調查與分析中醫醫療：

在全球發展的前瞻性願景與世界潮流的衝擊下，以及各國傳統醫療使用情形之大增，WHO在2004年發表一份傳統醫學新使用指導方針中指出，開發中國家由於文化傳統或者缺乏醫療，有80%人口使用傳統醫學為主之醫療系統。資料統計顯示出各國傳統醫療使用情形：澳大利亞為48%，法國為49%，加拿大為70%，比利時為31%，智利為71%，哥倫比亞為40%，美國為62% (NCCAM, 2003; WHO, 2002; Zollman & Vickers, 1999)。故本研究計畫首先以全球最大宗、經常性使用之MEDLINE、EBSCO、SODS三大英文資料庫，以及CEPS、全國博碩士論文二大中文資料庫進行文獻資料蒐集。年代設定為2000~2007年，主要關鍵字首先設定為traditional Chinese medicine, complementary and alternative medicine再以education, policy, practice, regulation, legitimization, license等關鍵字進一步蒐集。

自搜尋獲取資料分析結果，在Medline蒐尋到與關鍵字相符之文獻有42篇；EBSCO有80篇；SODS有16篇；CEPS有31篇，以及全國博碩士論文資料庫有166篇。在文章類別與篇數部分，與實務相關之文章最多，篇數共242篇，其次是與教育相關之文章，篇數共49篇；再則是與政策相關之文章，篇數共43篇；最少的是證照類之文章，僅有1篇。茲將資料篇數結果整理匯製成表格，請參見表一。由於所蒐集之資料龐大，以EBSCO資料庫之實務類文章為範例，摘錄部分資料於表二呈現。

二、研發中醫醫療相關主題之結構性調查問卷：

根據本研究計畫目的、資料分析結果、訪談結果等，擬出問卷之三大調查目標與主要概念架構，進而發展調查中醫發展與現況調查問卷之內容。主要內容架構文章來源與國家、研究主題與方向、研究方法、研究結果等。問卷結構含量性與質性的題項。完成之調查問卷初稿敦請三位具中醫或測量研究法之相關專家，進行內容效度檢定、諮詢、審查等。此問卷根據專家建議已修改之第一版可使用之問卷，請參見表三。此卷將用於本研究計畫未來第二階段相關資料之填寫與收集。

三、以加拿大TCM發展經驗建立分析模式：

中醫藥在加拿大的訪談與諮詢結果：本研究計畫實際訪談參與加拿

大中醫發展歷程的五位專家，他們主要背景分別有加拿大卑詩省中醫針灸管理局主席、加拿大卑詩省針灸師和TCM學會理事長、溫哥華TCM國際學院院長、加拿大卑詩省針灸師和TCM學會副理事長暨以及PCU醫學院教務長暨臨床指導主任，請參見表四。除了在資料收集部份之整理內容，亦將訪談之部分內容摘錄整理加拿大與中醫或針灸相關學校機構，請參見表五。加拿大與中醫或針灸相關之學術團體，請參見表六。本研究計畫諮詢參與加拿大中醫臨床實務的四位專家，他們主要背景為中醫師。此諮詢內容與專家訪談內容合併分析，內容摘錄呈現於表七。

四、加拿大在TCM相關實務、教育、政策、規章與認證制度之分析：

本研究計畫自目標(一)所獲取之資料中，整理出中醫與針灸在加拿大的發展、臨床實務、教育訓練、政策、認證以及研究發展等，說明如下。

(一) 中醫藥在加拿大的發展階段：

1. 1970s：針灸醫學的發展在70年代的早期，曾遭到西醫的排斥。當時的加拿大政府規定沒有西醫、牙醫、獸醫等執照者，不能進行中醫、針灸的醫療行為，故只能被西醫院雇為針灸技師，而不能單獨行醫，也不允許使用“醫師　職稱。
2. 1980s：在80年代加拿大中醫藥針灸界的針灸師，籌劃成立中醫藥針灸學會，以保護針灸師權益和發揚針灸國粹。終於1983年，在加聯邦商業註冊部長的支持下，成立“加拿大中醫藥針灸學會(Chinese Medicine and Acupuncture Association of Canada, CMAAC)　，並召開兩次國際性中醫藥針灸學術會議。1987年，加拿大中醫藥針灸學會進一步成為世界針灸聯合會的會員之一。1989年，CMAAC領導之下成立中醫藥針灸研相關教育訓練分會，在7個省分別成立7個分會。日後又增至8個省分別成立8個分會。
3. 1990s：加拿大中醫藥針灸事業的發展進入了第三個階段。這一時期更明顯的行為就是相關合法化、規範等議題的討論。此時全加拿大約有68名針灸註冊。
4. 2000s：此時全加拿大約有2000餘名中醫針灸執業者，中醫之針灸診所可見於加拿大全國各省。而這些診所大多為華人所開設，且多附有中藥店。目前，加拿大的四個省，卑詩省、魁北克省、阿爾比省及安大略省，已有相關的針灸法則，承認針灸的合法性。針灸師可以依據該省法律自行開業。開業者可以使用“醫

師　的職業頭銜，但不能使民眾認為開業者就是西醫醫生。另有卑詩省與安大略省有中醫的相關法規，並承認其合法性。

(二) 中醫藥在加拿大的臨床實務

近年來，在加拿大中醫針灸之療法已被用於治療多種疾病，包括：偏頭痛、頭痛、風濕病、類風濕關節炎、三叉神經痛、面癱、腰背痛、坐骨神經痛、高血壓病、中風後遺症、小兒中耳炎、多發性硬化症、哮喘、失眠、各種過敏症、肩凝症、膽石症、慢性鼻炎、鼻衄、落枕、糖尿病、足跟痛等。此外，還有應用針灸治療於戒煙、減肥、某些免疫缺陷疾病，亦有一定的療效。目前，在加拿大接受中醫藥療法與針灸療法還不包含於醫療健康保險範圍內，病人需要自付醫療費用。民眾自費接受針灸治療每次費用約需 40元至80元加幣。加拿大卑詩省政府2007年10月正式宣佈，自2008年4月1日起，將針灸納入醫療服務計畫(Medical Services Plan, MSP)之內，包括物理治療、按摩治療、脊柱治療等，但是針灸治療師必須是在加拿大卑詩省中醫針灸管理局中登記，才能參與該計畫。

(三) 中醫藥在加拿大的教育訓練

加拿大的中醫相關教育機構中，有一所中醫藥針灸學院，成立於1989年，位於安大略省倫敦市，為四年學制，所招的學生必須具備理科的大學學位，所開設的課程除中醫、中藥、針灸、耳針外，也兼具有西醫的基礎課程。多倫多米奇倫學院(Michener)針灸中心，則是加拿大首家針灸中心，有針灸系的設立，由具有中國中醫大學學位、中醫行醫經驗、取得北美洲醫學學位的華人，為教師擔任教學工作。針灸中心為全日制課程，是加拿大第一個集教學、研究和臨床一體的針灸中心。為使中醫之針灸教育訓練在加拿大取得承認，在加拿大針灸界多次促請政府大學部門設立中醫針灸科的努力下，目前阿爾比大學有一所提供中醫課程的大學，該大學程度課程已獲得官方認可。在多倫多市的社會自然科學大學中的醫學院也設有中醫專業相關課程，用以培育中醫針灸專業人才。

長期以來，加拿大各省的中醫藥針灸學術組織，在維護行業利益、推動加拿大中醫藥針灸事業發展方面，引領專業組織與發展。簡介其中較著名的組織，其於請參見表六。

1. 魁北克針灸協會(Acupuncture Association of Quebec, AAQ)：成立於1972年，是加拿大最早的中醫針灸學術組織。該協會的創始人Oscar Wexu醫師曾是法國國際針灸學會的副會長，在他的領導下，魁北克針灸協會為加拿大中醫和針灸的發展有突出的貢獻。

2. 國際中醫協會(International Association of Traditional Chinese Medicine, IATCM)：成立於1980年，會址設在蒙特利爾。主要負責人亦為加拿大Oscar Wexu，該會主要從事中醫、針灸的學術研究和經驗交流工作，並發行《中醫與針刺(Traditional Chinese Medicine and Acupuncture)》專業雜誌。
3. 加拿大中醫藥針灸協會(Chinese Medicine and Acupuncture Association of Canada, CMAAC)：成立於1983年，是加拿大全國性的中醫針灸學術組織。該會創始人Cedric Cheung現為世界針聯副主席，在他的領導下，現該會已擁有1800名會員，是加拿大最大、最健全的組織，在全加拿大10個省中，有8個省已有分會，會員遍布全國，但80%集中在安大略省。
4. 安大略職業針灸師協會(Professional Acupuncture Association of Ontario)：成立於1987年12月，該協會為CMAAC的分支機構。

(四) 中醫藥在加拿大的政策制度

加拿大聯邦政府衛生部計畫以正在實施的優質生產管理(GMP)規定來管制中成藥，使在加出售的中成藥更符合安全衛生標準。加衛生部計畫將中成藥納入優質生產管理範圍，除要求製藥廠符合安全衛生外還要詳細列明藥物的成份，也對進口批發商儲存藥物的場所，同樣有嚴格的規定。加拿大卑詩省已經成立中醫針灸管理局。目前，針灸療法已在魁北克省和亞伯達省立法管理。

加拿大卑詩省政府成為全加拿大首個省分提供針灸補貼，其於2007年10月正式宣佈，自2008年4月1日起，將針灸納入醫療服務計畫(Medical Services Plan, MSP)之內，使該省共計93萬名年收入2.8萬元加幣或以下的家庭，在尋求補助性治療時多一項選擇。可使用高達10次的輔助醫療專案，包括物理治療、按摩治療、脊柱治療等，每次加拿大省府補助23元加幣。日後針灸納入在卑詩省政府MSP後，受惠者一年可省下最多800元。其實，卑詩省府早在1996年依據醫療專業法案(Health Professions Act)已把中醫列為卑詩醫療專業專案之一，但遲遲未納入醫療健康保險中，或許因加拿大雖接受中醫針灸，但相關政府體系並沒有接納。故在政策制度面，加拿大的中醫專業者尚存有努力的空間。

(五) 中醫藥在加拿大的認證制度

政府主導之專業發證單位加拿大中醫針灸管理局(The College of Traditional Chinese Medicine and Acupuncturists, CTCMA)，於2000年著手建立證照制度。加拿大中醫針灸管理局是擴編自原成立於

1996年之英屬哥倫比亞針灸學院。該學院在1999年開始設置針灸專業為“針灸註冊　。要在加拿大執行中醫藥針灸開業醫生須具備該執照，學院規範訓練證明書，以及考試的類型。至2006年6月，已有1,212位TCM 開業醫生得到這些證書。歷經30餘年的監管制度，加拿大卑詩省是首次在北美正式劃定管轄中醫。

肆、討論

從本次研究結果得知，加拿大TCM正處在發展專業地位的過渡時期。發展專業須包括建立完整之法規制度、實行標準、實證研究以及有制度的學習教育和培訓訓練中心、認證標準程序、繼續教育、專業學習指導和能力的評估等等，如此，才能使在發展過程中有所增長專業人員的知識和能力。或許，正因處於發展的過渡時期，尚未見有中醫護理人員之相關教育課程與培育計畫，而一個專業要能有所發展，醫與護之培育與成長應當共同重視，如此，才能大力提升健康照護之品質。然而，目前全球護理在傳統醫療領域中尚處於急待努力與發展的階段。隨著世界使用傳統醫療潮流與趨勢逐年提升，以西醫基礎養成教育為主的護理，可積極將此理論與實務融入於護理正規教育與在職訓練中，繼而戮力於實務照護模式的研發與落實。此可提供作為借鏡，思考未來如何在已發展的中醫政策及相關制度中，做適度增強，使專業更有成長空間。在完善之制度下，未來應可期待與推動更多的相關研究與實務應用。

伍、結論與建議

本年度研究計畫已陸續完成預定之工作目標，建立之中醫醫療調查與分析模式可提供第二年之計畫使用，期使各國資料能收集更完備；研發完成之中醫醫療相關主題之結構性調查問卷，能提供在第二年執行文獻資料有所評讀依據與標準；以加拿大TCM發展經驗建立分析模式，可提供第二年執行各國發展經驗分析之參考；以及分析加拿大在TCM相關實務、教育、政策、規章與認證制度，能提供相關人員參考之。而研究計畫要能美滿完成，建議除有經費大力資助，人力、物力皆不可缺，尚須在研究期程上能有所延續性，如此，才能讓計畫內容更添豐富與內涵，達到相當水準與品質。

一門學科要永續發展，除了須有專業學門與教育制度外，更須有相當政策面、制度面相輔，才能加速該領域之茁壯。從本年度研究成果顯示，無論是在資料收集部分或是專家訪談部分，相較於實務而言，在政策面與教育面更顯出諸多不足，此有待我們大家未來之努力，以提升專業領域之素質。

在新世紀中的傳統中醫醫學，一定要能與學術、理論和政策結構體系相互緊密結合、積極發展，如此，才能將此醫學推向國際舞台，得以有所發揮空間。亦應當本著取長補短、互相促進的原則，發揮暨有的特點，積極地學習實證科學的長處和成就，完善學術體系之建構，以實現能與現代醫學並肩地為民眾健康服務的目標，以及推動中醫學加速走向國際的步伐。

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柒、圖表

表一、TM/CAM相關文獻搜載篇數表

資料庫名稱	教育	政策	證照	實務	總計
MEDLINE資料庫	16	10	0	16	42
EBSCO資料庫	12	1	0	67	80
SDOS資料庫	2	4	0	10	16
CEPS資料庫	15	4	1	11	31
台灣地區博碩士論文資料庫	4	24	0	138	166
小計	49	43	1	242	335

表二、摘錄資料蒐集之部分資料（以EBSCO資料庫之實務類為例）

資料庫	作者	篇名	年代	出處	關鍵字	摘要
EBSCO	Abubakar MS; Musa AM; Ahmed A; Hussaini IM	The perception and practice of traditional medicine in the treatment of cancers and inflammations by the Hausa and Fulani tribes of Northern Nigeria.	2007 May 22	Journal of Ethnopharmacology (J ETHNOPHARMACOL); 111(3): 625-9 (29 ref)	traditional medicine & practice (both in title)	A survey was conducted among Hausa and Fulani, two major tribes of Northern Nigeria to identify plants and methods used traditionally in the treatment of cancers and inflammatory diseases. The ecological zones that were considered include Zaria, Kaduna and Kano in the Northern part of Nigeria. The survey involves *traditional* healers, hunters, farmers and Fulani nomads. This survey has identified plants useful in the treatment of cancers. The plants were identified via taxonomic means and classified according to their habitats, families, genera. Evidently the plants span families and genera, the knowledge and values of the plants was evaluated with the aim of understanding the scientific basis for the use of the plants. The inventory provides the unique opportunity of capturing plants of common uses across the communities.
EBSCO	Nigenda G; Cifuentes E; Hill W	Knowledge and practice of traditional medicine in Mexico: a survey of healthcare practitioners.	2004 Oct-Dec	International Journal of Occupational & Environmental Health (INT J OCCUP ENVIRON HEALTH); 10(4): 416-20 (15 ref)	traditional medicine & practice	A cross-sectional study combined anthropologic (ethnographic) techniques to obtain qualitative information from decision makers and a questionnaire designed to investigate the population that used health services provided by the medical centers in Mexico. The results demonstrate that non-biomedical therapists fell into three main groups: 1) practitioners of *traditional medicine*; 2) practitioners of alternative *medicine*; and 3) faith healers. The cultural affiliations, academic backgrounds, training, and preparation of these practitioners differed markedly. They employed many strategies to finance their services, create and utilize therapist networks, and provide care to different segments of the population. The authors recommend further research on non-biomedical health care models, which are becoming more important with expanding globalization.
EBSCO	Homsy J; King R; Tenywa J; Kyeyune P; Opio A; Balaba D	Defining minimum standards of practice for incorporating African traditional medicine into HIV/AIDS prevention, care, and support: a regional initiative in eastern and southern Africa.	2004 Oct	Journal of Alternative & Complementary Medicine (J ALTERN COMPLEMENT MED); 10(5): 905-10 (18 ref)	traditional medicine & practice	In many resource-poor settings of Africa, a majority of people living with HIV/AIDS depend on and choose *traditional* healers for psychosocial counseling and health care. If the current pan-African prevention and care efforts spurred by the HIV pandemic do not actively engage African *Traditional Medicine*, they will effectively miss 80%, the vast majority of the African people who, according to the World Health Organization, rely on *traditional medicine* for their primary health care needs. In 2001, the Ugandan nongovernmental organization, *Traditional* and Modern Health Practitioners Together Against AIDS and Other Diseases, in Kampala, identified the need for a concerted, systematic, and sustained effort at both local and regional levels to support and validate African *Traditional Medicine* on several fronts. The Eastern & Southern Africa Regional Initiative on *Traditional Medicine* and AIDS was borne out of this assessment. It convened a regional consultation in May 2003, which produced a series of proposed standards around six main themes related to *traditional medicine* and HIV/AIDS: the systematic evaluation of *traditional* remedies; spiritual aspects of healing; HIV prevention and care; processing and packaging of *traditional* remedies; protection of

資料庫	作者	篇名	年代	出處	關鍵字	摘要
						indigenous knowledge; and intellectual property rights related to *traditional* health systems. These standards, summarized in this paper, will be incorporated into programs on *traditional medicine* and HIV/AIDS by various implementers in the region. A number of strategies to test and implement these recommendations are also defined.
EBSCO	Omonzejele P	Current ethical and other problems in the practice of African traditional medicine.	2003	Medicine & Law (MED LAW); 22(1): 29-38 (13 bib)	traditional medicine & practice	*Medicine* in Africa is regarded as possessing its own "life force", not just using a system of prescribing. This is because health problems are not only attributed to pathological explanations alone, but also to other "forces". Hence, *traditional* healers utter incantations to take care of negative forces which militate against achieving cure. Treatment in African *traditional medicine* (ATM) is holistic. It seeks to strike a balance between the patients' body, soul and spirit. The problems arise from the infiltration of charlatans into the field, the *practice* of using mystical explanations for ill-health, and inadequate knowledge of the properties and clinical use of herbal remedies. Despite its problems, ATM can work in parallel with orthodox *medicine* using its strengths rather than its weaknesses. ATM has to be applied within a uniform ethical system. Practitioners of ATM must follow the principles of autonomy and confidentiality.
EBSCO	Scheid V	Not very traditional, nor exactly Chinese, so what kind of medicine is it? TCM's discourse on menopause and its implications for practice, teaching, and research... Traditional Chinese Medicine.	2006 Oct	Journal of Chinese Medicine (J CHINESE MED)(82): 5-20 (53 ref)	Medicine, Chinese Traditional -- History ;Menopause	Textbooks of contemporary *Chinese medicine* regularly claim that the *Chinese* medical tradition makes available treatment strategies for biomedically defined disorders and that these treatment strategies are rooted in *traditional* doctrine and thousands of years of experience. The present article shows that at least for the case of menopausal syndrome this claim is plainly untrue. *Chinese* treatment strategies for menopausal syndrome emerged in the early 1960s as part of ongoing efforts to modernise *Chinese medicine*. This process involved translation of the biomedical understanding of menopause as a problem of hormone deficiency into the *Chinese* medical idiom of Kidney deficiency. In the course of this translation contrary views were systematically edited out of official discourse. Given the debatable content of biomedicine's understanding of menopause -- characterised by an emphasis on biology that ignores important social and cultural differences in the subjective experience of menopause, as well as a process of medicalisation that turns a natural process into a disease -- this translation is extremely problematic. Through a comparison with Japanese Kampo approaches to menopause the author shows that these problems are not merely conceptual but may impact directly on efficacy in clinical *practice*. Comparing the creation of TCM to that of colonisation -- a process in which natives are often active participants -- allows us to question *Chinese* medical textbook knowledge in an effort to create treatment strategies that best serve the needs of patients in the West.

資料庫	作者	篇名	年代	出處	關鍵字	摘要
EBSCO	Luban JA	Traditional Chinese medicine in the information age: using your computer to aid your practice.	2003 Winter	California Journal of Oriental Medicine (CJOM) (CALIF J ORIENT 14(1): 20-1	Computers and Computerization;Medicine, Chinese Traditional MED);	Most of us have a vision of how we wish to *practice* long before we finish our schooling. We may imagine a great number of patients, the look of our office, and the joy of making money doing something we love.
EBSCO	Chen L; Chang M; Tzeng Y; Lin J; Lai T; Shih H	The views of Traditional Chinese Medicine institutional workers toward TCM nursing practice in Taiwan [Chinese].	2002 Oct	Journal of Nursing (J NURS (CHINA)); 49(5): 28-36 (21 ref)	Medicine, Chinese Traditional;Nursing Staff, Hospital;Nurse Attitudes;Nursing Knowledge	The purpose of this study was to explore the scope of *Traditional Chinese Medicine* (TCM) nursing from the perspectives of staff working in a TCM-related hospital. Stratified random sampling was used in this study. One hundred and nineteen staffs with a mean age of 35 years were recruited from 22 TCM hospitals and hospitals with TCM departments. The results of this study indicated that (1) nurses were expected to apply the knowledge and skills of TCM to assess and provide care for the patients; (2) most participants felt that nurses were not qualified to assess patients' pulse by the TCM method and that nurses needed to be supervised by doctors in order to perform negative pressure, scraping, acupressure, moxibustion, and ear-acupressure because of their lack of related skill, experience, and knowledge, and because these procedures are not within the scope of nursing *practice*. Recommendations for enhancing the scope of TCM nursing were: (1) nurses needed to receive training related to TCM, especially skills of TCM nursing, before working in TCM hospitals; (2) nurses needed to get support and consensus from doctors of *Chinese medicine* in order to perform moxibustion, acupressure, scraping, and negative pressure. This abstract was translated into English by the publisher or author.
EBSCO	Garvey M	Theory and practice... Traditional Chinese Medicine (TCM).	1996	Pacific Journal of Oriental Medicine (PAC J ORIENT MED)(8): 14-22 (12 ref 6 bib)	Drugs, Chinese Herbal;Medicine, Traditional -- China	*Traditional Chinese Medicine* (TCM) offers the late-20th century a true complement or alternative to the medical practices of its Western counterpart. Reasons explaining the success of TCM in the modern Western setting are offered and discussed. Apart from its ongoing record of positive clinical outcomes, *Chinese medicine* also offers a unique perspective on life, health and the *practice* of *medicine*. Not only is this perspective in marked contrast to the methodologies arising from scientific materialism, but it is rapidly grasped and understood by Westerners. Part of the Western enchantment with *Chinese medicine* and part of its success is that some of its foundational philosophies actually resonate with recent scientific theoretical developments. The changing Western paradigm is explored and compared to *Chinese medicine*'s conceptual traditions.
EBSCO	Sherwin DC	Traditional Chinese medicine in rehabilitation nursing practice.	1992 Sep-Oct	Rehabilitation Nursing (REHABIL NURS); 17(5): 253-5 (4 ref)	Medicine, Traditional -- China;Rehabilitation Nursing;Acupuncture	*Traditional Chinese medicine* (TCM) employs methods of treatment such as acupuncture, acupressure, and Qi Gong (treatment based on meditation). The nurse using TCM can affect rehabilitation patient outcomes positively. With TCM training, nurses have an opportunity to learn the nuances of the Oriental environment and integrate them into their skills to nurse the spirit, mind, and body of patients in a holistic manner.

資料庫	作者	篇名	年代	出處	關鍵字	摘要
EBSCO	Wu KM; Farrelly JG; Upton R; Chen J	Complexities of the herbal nomenclature system in traditional Chinese medicine (TCM): lessons learned from the misuse of Aristolochia-related species and the importance of the pharmaceutical name during botanical drug product development.	2007 Apr	Phytomedicine (PHYTOMEDICINE); 14(4): 273-9 (9 ref)	Plants, Medicinal	Herbs used in *traditional Chinese medicine* (TCM) have diverse cultural/historical backgrounds and are described based on complex nomenclature systems. Using the family Aristolochiaceae as an example, at least three categories of nomenclature could be identified: (1) one-to-one (one plant part from one species): the herb guan mutong refers to the root of Aristolochia manshuriensis; (2) multiple-to-one (multiple plant parts from the same species serve as different herbs): three herbs, madouling, qingmuxiang and tianxianteng, derived respectively from the fruit, root and stem of Aristolochia debilis; and (3) one-to-multiple (one herb refers to multiple species): the herb fangji refers to the root of either Aristolochia fangchi, Stephania tetrandra or Cocculus trilobus; in this case, the first belongs to a different family (Aristolochiaceae) than the latter two (Menispermaceae), and only the first contains aristolochic acid (AA), as demonstrated by independent analytical data provided in this article. Further, mutong (Akebia quinata) is allowed in TCM herbal *medicine practice* to be substituted with either guan mutong (Aristolochia manshuriensis) or chuan mutong (Clematis armandii); and mu fangji (Cocculus trilobus) by guang fanchi (Aristolochia fangchi) or hanzhong fangji (Aristolochia heterophylla), thereby increasing the risk of exposing renotoxic AA-containing Aristolochia species to patients. To avoid these and other confusions, we wish to emphasize the importance of a pharmaceutical name, which defines the species name, the plant part, and sometimes the special process performed on the herb, including cultivating conditions. The pharmaceutical name as referred to in this article is defined, and is limited to those botanicals that are intended to be used as drug. It is hoped that by following the pharmaceutical name, toxic herbs can be effectively identified and substitution or adulteration avoided.
EBSCO	Scheid V	Traditional Chinese medicine -- what are we investigating? The case of menopause.	2007 Mar	Complementary Therapies in Medicine (COMPLEMENT THER MED); 15(1): 54-68 (59 ref)	Medicine, Chinese Traditional;Perimenopausal Symptoms -- Therapy	CAM researchers commonly treat *traditional* medicines as unchanging systems. This article questions the validity of this approach by examining the treatment of menopausal syndrome by *traditional Chinese medicine* (TCM). Such treatment strategies were invented in 1964 and betray a strong influence of biomedical thinking. While they determine TCM treatment of menopausal syndrome in the West, physicians in China and Japan use many other treatment strategies from within the wider *Chinese* medical tradition in clinical *practice*. Cultural variability in the manifestation of menopausal syndrome furthermore questions the usefulness of simply importing treatment strategies from China to the West. This leads me to conclude that *Chinese medicine* as such can never be evaluated by means of clinical research. What we can do is use *Chinese medicine* as a resource for thinking about illness, and for formulating clinical interventions that may then be assessed using methods of evidence based research. Copyright © 2007 by Elsevier Inc.

資料庫	作者	篇名	年代	出處	關鍵字	摘要
EBSCO	Chen S; Lv F; Gao JG; Lin J; Liu Z; Fu T; Liu Y; Lin B; Xie Y; Ren X; Xu Y; Fan X; Xu A	HLA class II polymorphisms associated with the physiologic characteristics defined by traditional Chinese medicine: linking modern genetics with an ancient medicine.	2007 Mar	Journal of Alternative & Complementary Medicine (J ALTERN COMPLEMENT MED); 13(2): 231-9 (21 ref)	Diagnosis;HLA Antigens;Medicine, Chinese Traditional -- Classification;Polymorphism, Genetic	Objectives: The aim of this study was to test whether human leukocyte antigen (HLA) polymorphism contributes to the physical constitutions classified in *Traditional Chinese Medicine* (TCM). Design: Seven hundred six (706) individuals of the Han ethnic group inhabiting South China were classified into 7 TCM constitution groups, according to the criteria described in Theories of Physical Constitutions of *Traditional Chinese Medicine*, and the distributions of HLA-DRB1, DPB1, and DQB1 were investigated using the polymerase chain reaction-sequencing-based typing method. Results: The allele frequencies of DPB1*0501 in the Yin-deficiency group, DRB1*09012 in the Phlegm-wetness group, and DQB1*03032 in the Qi-deficiency and Phlegm-wetness groups were significantly different from that of the corresponding alleles in the Normality constitution, suggesting those alleles might be group-specific alleles and thus related to a particular constitution. Based on our analysis of serological groups of HLA, the associations of DR*04 with the Blood-stasis group and DQ*09 with the Qi-deficiency and Phlegm-wetness groups were observed. Conclusions: This was the first study to systematically investigate the relationship between HLA and TCM constitution using a high-resolution typing technique. The results suggested a genetic basis for the classification of physical constitution in TCM. This study laid the foundation, for the first time ever, toward gaining insight into the theory of *traditional medicine* using modern biological approaches.
EBSCO	Coeytaux RR; Chen W; Lindemuth CE; Tan Y; Reilly AC	Variability in the diagnosis and point selection for persons with frequent headache by traditional Chinese medicine acupuncturists.	2006 Nov	Journal of Alternative & Complementary Medicine (J ALTERN COMPLEMENT MED); 12(9): 863-72 (45 ref)	Acupuncture;Acupuncture Points;Headache -- Diagnosis;Headache -- Therapy;Medicine, Chinese Traditional	Objectives: The aim of this study was to compare *Traditional Chinese Medicine* (TCM) pattern diagnosis and acupuncture point selection for persons with frequent headache, as ascribed by three highly trained, licensed acupuncturists. Methods: Thirty-seven (37) study participants with frequent headaches were independently evaluated by three licensed acupuncturists trained in TCM. The acupuncturists identified the meridians and type of dysfunction they believed were contributing to study participants' symptoms. Study acupuncturists also ascribed one or more TCM diagnoses to each participant and selected eight acupuncture points for needling. Results: Some variation in TCM pattern diagnosis and point selection was observed for all subjects. Liver Yang and Qi dysfunction were diagnosed in more than two thirds of subjects. Acupuncture points Liver 3, Large Intestine 4, and Governing Vessel (DU) 20 were the most commonly selected points for treatment. Conclusions: Headache is a heterogeneous condition represented by a wide variety of TCM diagnoses. There is variability among acupuncturists in the diagnosis of TCM patterns and the selection of acupuncture points for needling. These data suggest, however, that most persons with frequent headache appear to have liver Yangand Qi disharmonies for which needling of Liver 3, Large Intestine 4, and/or Governing Vessel 20 may be appropriate. Further research is needed to determine the extent to which variability in the diagnosis or acupuncture

資料庫	作者	篇名	年代	出處	關鍵字	摘要
						point selection among acupuncturists affects clinical outcomes.
EBSCO	Chen J; Hu L	Traditional Chinese medicine for the treatment of chronic prostatitis in China: a systematic review and meta-analysis.	2006 Oct	Journal of Alternative & Complementary Medicine (J ALTERN COMPLEMENT MED); 12(8): 763-9 (22 ref)	Medicine, Chinese Traditional;Medicine, Herbal -- China;Prostatitis -- Therapy -- China	OBJECTIVE: To systematically evaluate the effectiveness of *Chinese* herbal *medicine* for treating chronic prostatitis (CPT) in China. DESIGN: Electronic medical database from China National Knowledge Infrastructure (CNKI) was searched, language is *Chinese*; date is from January 1, 1994 to December 31, 2003. A total of 108 trials were found, and all studies with words like "randomization" or "quasi-randomization" in their abstracts were included, whether they used blinding or not. Nineteen theses that met the entry criteria were downloaded and fully printed. Four groups were divided: *Chinese* herbs orally treated group (based on syndrome differentiation), *Chinese* herbs externally treated group, *Chinese* herbs orally and externally treated group, and integrated Western with *Chinese* herbs treated group. RESULTS: All 19 articles that met the entry criteria were clinical trial studies with low quality (Jadad Score <3). The results showed that *Traditional Chinese Medicine* (TCM) may benefit the patients who had CPT. However, from the results of the funnel plots analysis of all four groups of clinical trials that met the inclusion criteria in this systematic review are distant asymmetrical and irregular plots, which indicate that a positive publication bias may exist. There was no obvious evidence indicating that the efficacy of the therapy in the treated groups using TCM was superior to that of the control group (Western *medicine* treatment group). CONCLUSIONS: All of the four groups in the clinical trials have not provided evidence of evidence-based *medicine* (EBM) A class (including 1a, 1b, 1c level), failed to prove that the TCM may have beneficial effects for patients with CPT, because of low quality in all the trials and a positive publication bias. Therefore, in light of some positive outcomes, a good design of multicentered, randomized, parallel-controlled and blinding trials is needed in order to make further studies, and deserve further examination for the treatment of CPT with TCM.

資料庫	作者	篇名	年代	出處	關鍵字	摘要
EBSCO	Xu W; Towers AD; Li P; Collet J	Traditional Chinese medicine in cancer care: perspectives and experiences of patients and professionals in China.	2006 Sep	European Journal of Cancer Care (EUR J CANCER CARE); 15(4): 397-403 (14 ref)	Cancer Patients -- China;Medicine, Chinese Traditional -- China;Oncologic Care -- China;Traditional Healers -- China	Although *traditional Chinese medicine* (TCM) is widely used in *Chinese* cancer centres, it is a brand new area for formal scientific evaluation. As the first step of developing a research programme on clinical evaluation of TCM for cancer patients, we conducted a qualitative study to explore the perspectives and experiences of *Chinese* cancer patients and TCM professionals. Twenty-eight persons participated in two cancer patient focus groups and one professional focus group. Semi-structured interviews were audiotaped, transcribed and translated. Textual transcripts and field notes underwent inductive thematic analysis. We found that patients' decision to use TCM for cancer is a self-help process with a deep cultural grounding, which is related to the *traditional Chinese* philosophy of life. Participants perceived TCM to be an effective and harmless therapy. They highly valued the fact that TCM is tailored to patients, and believed it was the basis of an optimal and safe treatment. Participants also highlighted the long-term positive effects, the benefit of group interventions and the low cost as important features of TCM. Subjects believed that conducting clinical research would be crucial for the recognition and dissemination of TCM in Western countries. The findings of this study are expected to contribute to the knowledge base on the current TCM use for cancer in China, and to provide useful information for developing future clinical research in this area in Western countries.
EBSCO	Meier PC; Rogers C	Reporting traditional Chinese medicine morbidity -- a University of Technology, Sydney, project with an emphasis on developing standards for testing and reporting data.	2006 Jul/Aug	Journal of Alternative & Complementary Medicine (J ALTERN COMPLEMENT MED); 12(6): 529-34 (9 ref)	Case Mix;Medicine, Chinese Traditional;Morbidity	OBJECTIVES: Morbidity in *Traditional Chinese Medicine* (TCM) research is an emerging field. Few studies have been published, and there is a lack of international standards for data collection and reporting. Based on the experience of developing a computerized system for patient data collection at the University of Technology, Sydney, (UTS) Acupuncture Clinic (Sydney, Australia), and reporting results from that database, a start can be made toward developing guidelines for reporting similar results from TCM clinical audits. METHODS: This study reports on data relating to 5735 patients who had undergone 29,697 treatments. Patient information is collected by a computerized database recording International Classification of Primary Care (ICPC) reason for encounter (RFE) and symptom for encounter (SFE) data and TCM tongue, pulse, diagnostic, and treatment data. Data coding is automated, and systems for reliability testing and error reporting were developed. RESULTS: UTS data has a 2.7% error rate and is within international standards of 5% error. Sixty-one-point three percent (61.3%) of patients were female and of these, 59.45 were 25-44 years of age. Musculoskeletal disorders are the most common presentation (41.4%) of all RFE, followed by general disorders (13.1%) and digestive disorders (8.1%). CONCLUSIONS: International standards must be set for TCM morbidity data collection methods and reporting. It is hoped that the methods described and reported in this paper are an initial step in the setting of such standards and that they will be adopted by other

資料庫	作者	篇名	年代	出處	關鍵字	摘要
						researchers. In particular, methods for testing and reporting data reliability must be adopted if TCM morbidity studies are to maintain any credibility.
EBSCO	Robinson N	Integrated traditional Chinese medicine.	2006 May	Complimentary Therapies in Clinical Practice (COMPLEMENT THER CLIN PRACT); 12(2): 132-40 (22 ref)	Integrative Medicine -- China;Medicine, Chinese Traditional	To experience the integration of *traditional Chinese medicine* (TCM) in China was 'the chance of a lifetime; thanks to the support of the Winston Churchill Memorial Trust. The scale and range of TCM available in terms of health care provision, education and research is unique in the world. This holistic integrative *medicine* is part of *Chinese* culture. Regulation and training of practitioners has similarities with current structures emerging in the UK in preparation for the statutory regulation for acupuncture and herbal *medicine*. China's research activity is a critical component of informing the debate on evidence-based *practice* and now real opportunities for collaboration and dissemination are beginning to emerge.
EBSCO	Hon KE; Twinn SF; Leung TF; Thompson DR; Wong Y; Fok TF	Chinese nursing students' attitudes toward traditional Chinese medicine.	2006 May	Journal of Nursing Education (J NURS EDUC); 45(5): 182-5 (20 ref)	Chinese -- Psychosocial Factors -- Hong Kong;Medicine, Chinese Traditional -- Utilization -- Hong Kong;Student Attitudes -- Evaluation -- Hong Kong;Students, Nursing, Baccalaureate -- Hong Kong	In this study, we examined *Chinese* nursing students' attitudes toward and use of *traditional Chinese medicine* (TCM). Survey questionnaires were distributed to 439 nursing students, 263 of whom (60%) returned them. Of the respondents, 92% had used TCM, while 48% had used TCM at least once during the previous year. Forty-five percent of respondents reported positive attitudes toward TCM use, 52% had neutral attitudes, and only 3% reported negative attitudes. The majority of respondents (76%) reported no change in their attitude toward TCM after studying nursing. Mean scores related to the adequacy of the current curriculum in TCM training and the state of respondents' TCM knowledge were generally low. Of the respondents who had used TCM during the past year, the most common use was for upper respiratory tract infection. The most common type of TCM used by respondents was herbal tea or soup. Final-year nursing students were more likely to have used TCM during the previous year, report they would like more courses on TCM, and consult Western *medicine* physicians before using TCM; they were also less likely to develop more negative attitudes toward TCM after studying nursing.
EBSCO	Wang X; Jia W; Zhao A; Wang X	Anti-influenza agents from plants and traditional Chinese medicine.	2006 May	Phytotherapy Research (PHYTOTHER RES); 20(5): 335-41 (42 ref)	Antiviral Agents -- Therapeutic Use;Drugs, Chinese Herbal -- Therapeutic Use;Influenza -- Drug Therapy;Medicine, Herbal -- Drug Therapy;Plants, Medicinal	Influenza is a serious threat to health in all parts of the world. The control and treatment of influenza depends mainly on chemical or biochemical agents and, to date, some anti-influenza agents have been isolated from plants as a result of chemical and pharmacological studies. These agents include a variety of polyphenols, flavonoids, saponins, glucosides and alkaloids. *Traditional medicine* focuses on the use of herbs and *traditional Chinese medicine* has performed well in clinical *practice* and shows a potential in the therapy of influenza and its symptoms. The present paper reviews some constituents and extracts from plants and *traditional Chinese medicine* with anti-influenza activity.
EBSCO	Shea JL	Applying evidence-based medicine to traditional Chinese medicine: debate and strategy.	2006 Apr	Journal of Alternative & Complementary Medicine (J ALTERN COMPLEMENT	Medicine, Chinese Traditional -- Evaluation;Treatment Outcomes -- Evaluation;Clinical Trials;Professional	Drawing on recent paper published literature in both English and *Chinese*, this explores reactions to the evaluation of *Chinese medicine* using randomized controlled trials (RCTs) and the standards of evidence-based *medicine* (EBM). The literature review revealed a few sources

資料庫	作者	篇名	年代	出處	關鍵字	摘要
				MED); 12(3): 255-63 (52 ref)	Practice, Evidence-Based	which contend that *Chinese medicine* should not be evaluated on the basis of RCTs, but a far greater number which advocate for applying RCT and EBM standards to *Chinese medicine*. This paper describes the position of the detractors and points out ways in which their arguments contain oversimplified representations of *Chinese medicine*, biomedicine, EBM, and RCTs. In describing the position of the proponents, the analysis outlines some of the numerous innovative techniques they are developing for dealing with issues of control and standardization in efficacy research. Overall, the analysis indicates that important refinements are being generated in *Chinese medicine* research and clinical trial design in response to the challenges posed by the forced encounter of these two paradigms.
EBSCO	Wong WCW; Lee A; Wong SYS; Wu SC; Robinson N	Strengths, weaknesses, and development of traditional Chinese medicine in the health system of Hong Kong: through the eyes of future Western doctors.	2006 Mar	Journal of Alternative & Complementary Medicine (J ALTERN COMPLEMENT MED); 12(2): 185-9 (19 ref)	Medicine, Chinese Traditional -- Hong Kong;Students, Medical -- Hong Kong;Student Attitudes -- Hong Kong	Five focus group discussions were conducted with 28 (fourth-year) medical students from the *Chinese* University of Hong Kong (CUHK) to explore attitudes to *Traditional Chinese Medicine* (TCM) and its impact on the future of medical training. Most students perceived that TCM was a good alternative for certain health problems but lack of scientific evidence and the absence of regulation were major barriers. Students were concerned about the limitations of TCM, but identified their need to understand TCM to effectively communicate with their patients. Paralleled with the experience in the United Kingdom and other countries, if *traditional* and conventional doctors are to work effectively side by side, current medical education and health service arrangements need to change.

表三、調查問卷量表

編號：_____

一、國家：

1 亞洲：_____(國家)_____(區域)

2 北美洲：_____(國家)_____(區域)

3 歐洲：_____(國家)_____(區域)

4 澳洲：_____(國家)_____(區域)

5 其他：_____(國家)_____(區域)

二、出版年度：_____

三、題目：_____

四、作者：_____

五、來源：

1 期刊：_____

2 研究報告：_____

3 政府出品：_____

4 網站：_____

5 其他：_____

六、研究主題類目：

1 教育：_____

2 證照：_____

3 業務：_____

七、研究方法：___

1 質性 2 量性 3 質與量性混合

4 其他_____

補充說明：_____

八、研究設計方法：___

1 歷史研究 2 行動研究 3 觀察調查 4 訪問調查

5 問卷調查 6 個案研究 7 內容分析 8 相關研究

9 實驗研究 10 類實驗研究 11 其他_____

補充說明：_____

九、是否描述研究測量工具之信度：___

0 否 1 是

補充說明：_____

十、是否描述研究測量工具之效度：___

0 否 1 是

補充說明：_____

十一、統計分析方法類目：___

1 次數及百分比　2 平均數及標準差　3 卡方

4 相關分析　5 回歸　6 平均數檢定

7 變異數檢定　8 未使用統計方法

補充說明：_____

十二、電腦統計軟體使用情形：___

1 量性：_____

2 質性：_____

3 其他：_____

4 沒有使用電腦統計軟體或無法辨識

補充說明：_____

十三、是否有正統中醫醫事教育：____

0 否（直接跳至第十六題）　1 是

補充說明：_____

十四、正統中醫醫事教育為何種類：____

1 中醫醫學　2 中醫護理　3 中醫藥學　4 其他____

補充說明：_____

十五、其最高正統醫事教育階層為：____

1 高中　2 大專　3 碩士　4 博士　5 其他_____

補充說明：_____

十六、是否有國家核准中醫醫事證照：____

0 否　1 是

補充說明：_____

表四、專家背景介紹（專家以匿名方式呈現）

專家 1	Vice Chair, College of TCM Practitioners and Acupuncturists of BC Member, Expert Advisory Board, Natural Health Product Directorate
專家 2	President, BC Qualified Acupuncturists and TCM Practitioners Association
專家 3	President, International College of TCM of Vancouver
專家 4	Vice President, BC Qualified Acupuncturists and TCM Practitioners Association Registrar, College of TCM Practitioners and Acupuncturists of BC
專家 5	Dean of Faculty & Clinic Director, PCU College of Holistic Medicine

表五、加拿大與中醫或針灸相關之學校機構表

Name of Schools	Contact	Address		Email/ Website	Accredited
Alberta College of Acupuncture & Traditional Chinese Medicine	Tel: 403-286-8788 Fax: 403-247-4648	#125, 4935 40th Ave. NW Calgary, AB T3A 2N1	AB	www.acatcm.com	
Calgary College of Traditional Chinese Medicine & Acupuncture	Tel: 403-287-8688 Fax: 403-287-8660	#107, 4014 Macleod Trail. S Calgary, AB T2G 2R7	AB	www.cctcma.com	
Grant Macewan college	Tel: 780-497-5040 Fax: 780-497-5001	P.O. Box 1797 Edmonton, AB T5J 2P2	AB	www.macewan.ca	
Academy of Classical Oriental Sciences	Tel: 250-352-5887 Fax: 250-352-3458	303 Vernon St. Nelson, BC V1L 4E3	BC	www.acos.org	Y
Canadian College of Acupuncture and Oriental Medicine	Tel: 250-384-2942 Fax: 250-360-2871	551 Chatham St. Victoria, BC V8T 1E1	BC	www.ccaom.com	Y
Canadian College of Oriental Medicine	Tel: 604-581-8659 Fax: 604-581-8756	#520, 4400 Hazelbridge Way Richmond, BC V6X 3R8	BC	www.cacom.ca	N
Central College	Tel: 604-523-2388 Fax: 604-523-2389	314 Agnes St. New Westminster BC V3L 1E8	BC	www.centralcollege.ca	Y
Columbia Science College	Tel: 604-931-0544 Fax: 604-931-0678	#301, 566 Loungheed Hwy Coquitlam, BC V3K 3S3	BC	www.coscollege.com	N
Concordia International College	Tel: 604-682-0079 Fax: 604-682-0794	#126, 970 Burrard St. Vancouver, BC V6Z 2R4	BC	www.concordiacanada.com	N
International College of Traditional Chinese Medicine of Vancouver	Tel: 604-731-2926 Fax: 604-731-2964	#201, 1508 West Broadway Vancouver, BC V6J 1W8	BC	www.tcmcollege.com	Y

表六、加拿大與中醫或針灸相關之學術團體

Name of Schools	Contact	Address		Email/ Website	Accredited
International College of Traditional Chinese Medicine of Victoria	Tel: 250-388-4266 Fax: 250-380-6738	769 Pandora Ave Victoria, BC V8W 1N9	BC	www.tcminternational.com	Y
Langara College Continuing Studies	Tel: 604-323-5263 Fax: 604-323-5899	100 W. 49th Ave. Vancouver, BC V5Y 2Z6	BC	www.langara.bc.ca	Y
Merinol College	Tel: 604-437-7757 Fax: 604-437-7759	#402, 4603 Kingsway Burnaby, BC V5H 4M4	BC		
Oshio College of Acupuncture and Herbology	Tel: 250-472-6601 Fax: 250-472-6611	#110/114, 1595 McKenzie Ave Victoria, BC V8N 1A4	BC	www.oshio.ca	Y
PCU College of Holistic Medicine	Tel: 604-433-1299 Fax: 604-433-1298	#509, 5021 Kingsway Burnaby, BC V5H 4A5	BC	www.pcu-chm.com	Y
Shang Hai TCM College of BC Canada	Tel: 604-430-5838 Fax: 604-430-5878	#212, 4885 Kingsway Burnaby, BC V5H 4T7	BC	www.acupuncture-college.com	Y
South Bay College	Tel: 604-685-5316 Fax: 604-685-5376	#202, 440 Cambie St. Vancouver, BC V6B 2N5	BC	www.southbaycollege.ca	N
Supreme Harmony College of Chinese Cultural Studies	Tel: 604-939-6628 Fax: 604-939-6227	#610, 4538 Kingsway Burnaby, BC V4H 5T9	BC	www.supremeharmony.com	N
Vancouver Beijing College of Chinese Medicine	Tel: 604-207-9389 Fax: 604-207-9389	#3135, 8888 Odlin Crest Richmond, BC V6X 3Z8	BC	www.tcmvbc.com	N
Ontario College of Traditional Chinese Medicine	Tel: 416-222-3667 Fax: 416-646-3667	#100, 102, 201, 145 Sheppard Ave. East, North York ON M2N 3A7	ON	www.octcm.com	
The Toronto	Tel: 416-782-9682	#302, 2010 Eglinton	ON	www.tstcm	

Name of Schools	Contact	Address		Email/ Website	Accredited
School of Traditional Chinese Medicine	Fax: 416-782-9681	Ave. W. Toronto, ON M6E 2K3		.com	
College de Rosement D'epartment D'acupuncture Traditionelle	Tel: 514-376-1630 Fax: 51-376-3211	6400 16e Ave. Montreal, QC H1X 2S9	QC	www.agora .crosemont .qc.ca	
Acupuncture Foundation of Canada Institute	Tel: 416-752-3988 Fax: 416-752-4398	#204, 2131 Lawrence Ave. East Scarborough, ON M1R 5G4	ON	www.afcin stitute.com	
University of Alberta, Faculty of Extension, Medical Acupuncture	Tel: 780-492-4057	#8303, 112 Street NW Edmonton, AB	AB	www.exten sion.ualber ta.ca/acupu ncture/pro gram.aspx	
McMaster Medical Acupuncture Program	Tel: 905-546-5500 Fax: 905-648-4426	PO Box 89088, 991 Kings St. W Hamilton, ON L8S 4R5	ON	www.acup uncture- pr ogram.c om	

表七、摘錄之專家訪談內容

Canadian Experiences of Chinese Medicine

1. Introduction:

Throughout most of their history in Canada, Chinese comprised less than one percent of the country's population (Li, 1998). Since the 1970s the numbers of Chinese immigrants to Canada have increased. Chinese immigrants account for 73 per cent of the Chinese Canadian population in 1991, and 63 per cent of them immigrated only after 1970 (Statistic Canada, 2007). Chinese is presently the largest visible minority group in Canada (Statistics Canada, 2007).

TCM is widely practiced within Chinese immigrant community and became part of Chinese life style (Chiu, 2006; Chiu et al., 2006). It is known that immigrants tend to seek care outside of the conventional medical system according to their own values and beliefs (Blanch & Levin, 1998; Lin, Tardiff, Donetz, & Goresky, 1978; Zuess, 2003; Lin & Cheung, 1999). Chiu found that most Chinese immigrant mothers practiced traditional healing on a daily basis, though the individuals who were acculturated to the dominant Canadian society tended to adopt conventional health practices (Chiu, 2005).

Chiu (2006) examined TCM practice in a Canadian study which found that TCM in BC is currently in a transition period leading to professional status. Many TCM practitioners receive little in the way of formal training – in some cases only a few courses given by the College of TCM Practitioners and Acupuncturists. In contrast, others, particularly those trained in China, undergo as many as five years of TCM training, in addition to post-secondary education. Moreover, the training in China can vary, depending on the nature of the program and the extent to which Western medical science and practice have been integrated into the respective curricula.

As an example of the issues we note that as TCM became established in North America, changes in its practices have been noted (Barnes, 1998). For example, under current immigration policy, a degree or certificate or background related to TCM does not help a prospective immigrant gain entry to Canada. The majority of TCM practitioners were either business or independent immigrants (Chiu, 2006). Immigration regulations require that immigrants in the self-employed or entrepreneur categories must plan to establish a business in Canada (Li, 2003). Some in the skilled worker category who could not compete in the labor market established TCM practices. In any case, to practice TCM in Canada, entrepreneurial skills are essential.

Moreover, TCM's accommodation to Canada has varied from practice to practice, depending on location, the imperatives of practitioners, and the type of patients and their demands (Chiu, 2006). The ways in which TCM practitioners respond to these demands can significantly shape their practice. Clearly, the body of knowledge currently identified as "Chinese medicine" is the product of accommodation to the dominant ideology and social structure prevailing in Canada.

Although TCM in BC enjoys a legal body, it struggles for legitimization in most provinces in Canada. More studies are required to advance our knowledge of the role played by culture in determining attitudes toward health and health care practice and of the factors that facilitate or inhibit the development of TCM in Canada. Such studies would be particularly useful in elucidating the influence on TCM practice of Canadian culture and population change, education, relations with conventional medicine, research, and legislation.

2. Methods:

In this study, data was collected from two sources: written records and interviews. We examined the data in terms of practice, education, regulation, and policy. In discussing the transformation and the development of TCM practice, we considered the completion of the legitimization process in BC as the cutting point between the past and the present. The primary data sources included interviews, original legal documents, collected-works, dialogues, minutes of meeting, and so forth. The secondary sources were reference books, newspaper articles, published articles, and internet publications. We evaluated the data sources by examining the consistency and contradictions of the texts and comparing between documents, interviews, and field notes. After evaluating the authenticity and accuracy of the data, we coalesced the materials and perform a historical comparative analysis.

Interviews were conducted with people who participated in the TCM development. Six key informants from British Columbia were interviewed . The open-ended ethnographic interviewing was conducted with each informant in the language of their choice and in a place mutually agreeable to participants for sessions of 90 ~ 120 minutes. The investigator explained the purpose and nature of the research and collected relevant demographic information at the interview. After the interview, the investigator recorded fieldnotes to document environmental circumstances, informant characteristics, nonverbal behaviors, affect, the discussion process, overall impressions, and any problems. These data were useful for comparing and contrasting during the data analysis and for additional references. A thematic analysis was conducted.

3. Changing Population in Canada: Chinese Immigrants:

In the history of Chinese immigration to Canada, the first major wave occurred during the late 1800s when Chinese laborers arrived in western Canada to build the Canadian Pacific Railway. For decades following its completion, Chinese immigration was discouraged until the 1960s when the restrictions on Chinese immigration were lifted. With the changes in immigration policy in 1967, the second wave of Chinese immigration began. Since the 1970s, the numbers of Chinese immigrants to Canada have increased, and their arrival has substantially increased the population of individuals of Chinese origin – from 124,600 in 1971 to 185,800 in 1981 to 600,000 in 1991. Between 1971 and 1991, the number of Chinese increased five times. It is estimate that, by 1994, 92 per cent of Chinese Canadians have immigrated to Canada after 1967 (Li, 1998).

Chinese now is the largest visible minority group in Canada, surpassing one million

individuals in 2001 (Statistics Canada, 2007). A total of 1,029,395 individuals claimed "Chinese" as ethnic origin, up from 860,100 in 1996. They accounted for 3.5 per cent of Canadian population (29.6 million) and 26% of the visible minority population (Statistics Canada, 2007). Between 1996 and 2001, the number of Chinese increased 20%. It is expected that Chinese individuals will reach 1.8 million by 2017, an increase of 80% from the 2001 national census (Statistis Canada, 2005).

Chinese comprised the largest proportion of the visible minority population in British Columbia (44%), Alberta (30%), and Saskatchewan (29%) (Statistics Canada, 2007). Ontario had the highest number of Chinese (481,500). But they comprised the second highest proportion (22%) of the visible minorities in that province, after South Asians (26%).

The official languages used in Canada are English and French. Sixty one per cent of new immigrants who came in the 1990s used a non-official language at home. Those born in the People's Republic of China were the most likely to speak a non-official language at home (88%) as well as being unable to direct a conversation in an official language (29%). Among immigrants, Taiwan (13%) had the next highest proportions of those unable to speak either official language. Both numbers indicated that a large number of Chinese immigrants may not assimilate or access to the Canadian health care system. Chiu found that languages and communications were an important factor in the use of Chinese medicine (Chiu, in progress).

The changing population and the increasing number of Chinese immigrants have made Canadian physicians become more aware than ever in TCM. The health care system accordingly must adapt to this cultural diversity to deliver the high quality health care services.

Ethnic Practices and Changes

An official policy of multiculturalism was instituted in 1971 and incorporated in the Multiculturalism Act of 1988. The policy demands health professionals to provide culturally sensitive care to their patients. Despite the efforts of the Canadian Council on Multicultural Health which was founded in 1986, it is difficult to attain an agreement on integrating multicultural health into conventional health care (Crellin, Anderson, & Connor, 2007). A report in 1991, "Cultural and Racial Sensitivity: Implications for Health Curricula," underlined ongoing problems such as discrimination, racism, inequality, and stereotyping (Crellin et al.). Nonetheless the growing number of multicultural groups is gradually raising public awareness of multicultural health.

The medical profession as a whole was slow to respond to the change. Although the Canadian Medical Association published an article in 1993 entitled, "TCM becomes another health care option for Canadians," this article has less to do with ethnic practice than with the general public's interest in alternative medicine and the readiness it embraces ethnic practice (Crellin et al.). Some physicians even have begun training and incorporated acupuncture into their conventional medical practices (Goldszmidt et al., 1995; Ko & Berbrayer, 2000; Verhoef & Sutherland, 1995). In July 1984, the College of Physicians and Surgeons reported

about 0.02% of physicians in British Columbia who used acupuncture in conjunction with their practice. Physician interest nowadays in TCM emerged more from Canadian consumers which include increasing number of Chinese immigrants, from public concerns about alternatives, and from media promotion (Crellin et al).

The TCM profession, however, made much effort to implant the new medical regime in the host country. Nowadays about 1300 registrars practice TCM in British Columbia. Before and during the transition period of legitimization in British Columbia and other Provinces, we noticed a few characteristics in their TCM practice in 1999 - 2002 (Chiu, 2006, p. 112; Crellin et al., 1995):

(1) Establishing a TCM practice is an arduous task, requiring creativity and new skills. Being limited to private practice, rather than institutional care in a hospital environment, TCM involves considerable entrepreneurship, including financing, advertising, packaging, and re-packaging. The findings also reveal more negative views towards competition among healers, which makes it harder for new immigrants to practice in the host country.

(2) The scope of practice is limited to traditional and basic methods. Diagnostic processes, for example, are restricted by regulation. Thus, TCM practitioners who are not licensed physicians in Canada are not permitted to order X-rays.

(3) Institutional factors play a role in circumscribing treatment. Thus a TCM practitioner may limit the course of treatment because of economic considerations, e.g., treatment is not covered by medical insurance; avoid “unusual methods”, e.g., ear needle stimulation; and compromise the effectiveness of treatments using inappropriate analytic methods.

(4) A lack of resources and social networking, language barriers, and discrimination, singly or in combination, impede TCM practice in the host country.

(5) The great majority of patients learn of the existence of TCM services via word-of-mouth.

(6) Personal experience constitutes empirical evidence. The assertion that “no scientific evidence exists” regarding the efficacy of a particular treatment seldom deters patients from availing themselves of it (O’Connor, 1995), in part, because many are aware that few TCM treatments have been investigated scientifically, in part, because TCM meets cultural expectations (Micozzi, 2002). Moreover, TCM patients tend to rely on other types of evidence, in addition to the findings of scientific studies. For example, anyone who obtains the desired effect from a treatment is likely to be convinced of its efficacy. Thus, personal experience which constitutes empirical evidence is typically considered both trustworthy and sufficient (O’Connor). Science is not necessarily eschewed, merely regarded as one of a number of sources of valid information.

(7) Financial barriers to accessing TCM services are still substantial as Medical Service Plan[1] does not cover the services.

(8) TCM has been officially recognized since 2001 and is currently in a transition period leading to professional status. The components of professionalism -- a code

of conduct, standards of practice, evidence-based practice, accredited education and training centers, certification procedures, continuing education, professional practice guidelines, and evaluation procedures for competence -- are in the process of development.

(9) The knowledge and competence of TCM practitioners varies. Many practitioners receive little in the way of formal training – in some cases only a few courses given by the College of TCM Practitioners and Acupuncturists. In contrast, others, particularly those trained in China, undergo as many as five years of TCM training, in addition to post- secondary education. Moreover, the training in China can vary, depending on the nature of the program and the extent to which Western medical science and practice have been integrated into the respective curricula.

(10) A tension exists between TCM and Western medicine that impedes their integration and creates inter-professional isolation and mistrust, along with asymmetric power relations.

4. History of Legalization of Chinese Medicine in British Columbia

The history of the legalization of Chinese Medicine in Canada focused on British Columbia, which were chronologically discussed according to four historical periods.

1970s – Opening the "Bamboo Curtain"

The interest in TCM in North America was dated in 1972 when President Nixon encountered acupuncture for its analgesic effect first time in China who later published an article on his experience with acupuncture in Time Magazine which brought about a vast interest in acupuncture in the United States. Dr. Henry Lu, previous Assistant Professor of the University of Calgary, translated Chinese books (1973, 1974, 1975a, 1975b) of acupuncture into English, which greatly facilitated the development of acupuncture in North America. Dr. Lu's books are currently listed as reference books for licensing exams by the Board of Acupuncture Examiners in the United States.

The BC Government could not determine the legal status of acupuncture in early 1970s. In 1972, Acupuncture Advisory Committee was appointed from the BC College of Physicians and Surgeons to establish and evaluate acupuncture pain clinics and to make recommendations to the Minister on the future practice of acupuncture in British Columbia. Twelve years later, the Committee has failed to produce a final report (AABC, 1984).

In 1974, Ministry of Health of BC Dennis Cocke announced the opening of two acupuncture clinics as pilot projects to evaluate the effect of acupuncture for pain management, one at Vancouver General hospital and the other at Victoria General Hospital (AABC, 1984). The acupuncturists had to meet certain criteria and work on a day care basis under medical supervision (Vancouver Sun, July 19, August 21, 1974). The Ministry of Health Dennis Cocke claimed that he was mainly interested in the anesthetic or analgesic effects of Prepared by Drs. Lyren Chiu and John Crellin on October 31, 2007 Canadian Experience of Chinese Medicine 9 acupuncture and that he did not approve healing aspect of TCM use (Vancouver Sun, July 16, 1974).

In the same year, the BC College of Physicians and Surgeons alleged the North

American College of Acupuncture Ltd. and Kok Yuen Leung for operating an illegal medical school (Vancouver Sun, July 16, 1974). In 1974-1983, seven non-physician acupuncturists were prosecuted by the College of Physicians and Surgeons (Ministry of Health, 1986). Unfortunately the College of Physicians and Surgeons had exclusive right to practice medicine since 1886 under *Medical Act* (AABC, 1984).

In August 30, 1974, the first TCM association – Western Acupuncture Association (WAA) was incorporated under the BC Societies Act. Later in 1982, WAA changed its name to the Acupuncture Association of BC (AABC). Since then AABC instigated intensive lobbying to the BC government. The association has made six formal submissions to the BC government and met 20 times with the four health ministers appointed since 1974 and once with the provincial cabinet (Acupuncture Association of BC [AABC], 1984).

1980s – Lobbying the government and struggling for legal status

In Alberta, acupuncture was legislated in 1984 under *Health Occupations Act* and regulated in 1996. Quebec also regulated. Ontario drafted legislation in 1984 but only enacted in December 2006. British Columbia drafted legislation in 1986. Practitioners in British Columbia continued to be prosecuted by the College of Physicians and Surgeons. In 1981, the Minster of BC appointed a Medical Advisory Committee under the Ministry of Health to examine role, qualifications, and standards of the practice of acupuncture by the medical profession in British Columbia (AABC, 1984). The Committee comprised members of the College of Physicians and Surgeons and one registered nurse. Twelve years later, the College of Physicians and Surgeons still could not generate a final report to the Ministry of Health. Nevertheless, the College already dictated the regulation of the practice of acupuncture in BC and prosecuted seven acupuncturists since 1974 (AABC).

The Acupuncture Foundation of Canada (AFC) whose membership was restricted to physicians, dentists, and veterinarian attempted to establish itself as representative of Acupuncture in Canada (AABC, 1986). This attempt was disapproved by the International Congress of Acupuncture which consisted of representatives from 96 countries owing to inadequate hours of training and being ignorant of TCM theory and philosophy (1981).

The Acupuncture Association of BC has intensively lobbied the government for legislation since it was incorporated. In 1984, Mary Watterson, previous president of AABC, spoke to the Vancouver Sun, “the association has already delivered over 13,000 petitions to the Minister of Health and letters of support from community organizations representing more than 50,000 British Columbians” (AABC, 1986, p. 56; Watterson, 1984). In addition, “over 12,000 petitions have been signed in support of MLA John Reynold’s motion for the legalization of acupuncture and other health care approaches being prohibited under the *Medical Practitioners Act*” and “over 6,000 more petitions have been signed by British.

Columbians requesting acupuncture legislation" (AABC, p. 56). Fifty four acupuncturists practiced in BC in 1983 (Vancouver Sun) and over 30,000 patients paid from their own pockets for acupuncture treatments in 1986 (AABC).

Health Minister Nielsen explained why the government would not change the law because of economical considerations. He said, If the government legislatively recognized acupuncture, it would be "very difficult to argue" why it should not also be prepared to offer medical insurance coverage for the treatment (Watterson, 1984).

In 1985, MLA Dennis Cocke introduced a private member's bill to amend the *Medical Practitioners Act* to legally recognize acupuncturists (Vancouver Sun). However, the bill did not go far. In 1986, the Acupuncture Association of BC submitted a position paper to the BC government to delineate regulation, qualification requirements, examination, standard of training, competencies, rule of practice, and code of ethics, which also included a drafted proposal of Acupuncturists Act.

1990s – Becoming a designated health profession

TCM became a designated health profession in 1990s. In 1991, five associations of acupuncturists in British Columbia, representing a total of 236 practitioners, applied to the Health Professions Council for designation under the *Health Professions Act*. In 1993 the Council, after it held an extensive stakeholder consultations, recommended that acupuncture be designated as a health profession. In 1996, the Acupuncture regulation was created under the *Health Professions Act* and the College of Acupuncturist of BC was formed to administer the regulation.

In 1992, the Traditional Chinese Medicine Association of BC submitted an application for designation of TCM as a self-regulating health profession. The Canadian SinoBiology Practitioners Association and the Pacific Region TCM Practitioner and Acupuncturist Society submitted the second and the third application in 1996 to designate TCM as a health profession. In June 1999, the BC government announced the creation of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC (CTCMA).

After nearly 30 years of lobbying for and implementing a self-regulatory system for Chinese medicine, BC has become the first jurisdiction in North America to officially designate TCM profession.

In December 1999, the firsts group of 68 registered acupuncturists was bestowed.

2000s – Heading toward professionalism: education, examination, registration, core-competencies, MSP inclusion

In 2000s four of Canadian provinces regulated acupuncture, which includes British Columbia, Ontario, Alberta, and Quebec. TCM is regulated in both British Columbia and Ontario.

TCM in British Columbia is heading toward professionalism. On April 12, 2001, TCM and Acupuncturist Bylaws was passed. On April 12, 2003, a valid professional license issued by CTCMA is required in order to practice TCM and acupuncture in British Columbia. In 2007, four annual exams were already provided.

British Columbia allowed a two-year registration grace period for both acupuncture which ended in June 2001 and TCM which ended in April 2003. While many practitioners felt disadvantaged by the exception, others won't feel bothered. "They will eventually fade out if they could not meet the requirement of core-competencies," said by one of the informants.

In 2000-2007, various educational events were planned and implemented by 13 TCM and/acupuncture associations. Unfortunately some of the training programs were poorly planned due to divided and limited resources.

TCM Schools reallocated teaching hours to meet the requirements for each designation. Only diplomas were awarded by the programs. Unfortunately CTCMA could not allocate resources to accredit current schools. Private Career Training Institutes Agency (PCTIA), the only accreditation agency of BC, had minimum knowledge of TCM. No professional accreditation body was presently instituted in Canada.

Qualified Acupuncturists & TCM Practitioners Association (QATCMA) and other 12 TCM/acupuncture associations met on May 27, 2007 to sign up a petition for the inclusion of acupuncture in MSP. Both chairs of the CTCMA and the representatives of the associations met Health Ministry George Abbott and 10 more MLAs on May 29, 2007. Drs. Harvey Hu, Chris Valle, and John Lee organized a MSP committee to plan for this petition since 2006. On October 9, 2007, Minister Abbott announced that acupuncture treatments will be included as a supplementary benefit for Medical Services Plan premium assistance recipients by April 2009. This is the first time that TCM has ever been included in MSP in Canada (www.gov.bc.ca/health/). Contrasted with 1984 when Health Ministry Nielsen openly denied the inclusion of acupuncture in MSP, the decision to include MSP was a big milestone. After years of intensive lobbying, acupuncture is finally acknowledged and accessible to low income British Columbians.

On October 25, 2007, the Ministry of Economic Development awarded $50,000 to the College to develop a competency profile for acupuncture. Code of ethics, standard of practice, core competencies, education guideline, and examination fees can be found on the website: www.ctcma.ca.

5. Current Development of Chinese Medicine in Canada

1. Registration and Regulation of the Profession by Provincial Governments

Regulation of TCM

In Canada, four provinces regulated acupuncture, which includes British Columbia (BC), Ontario, Alberta, and Quebec. Traditional Chinese Medicine, which includes the practice of acupuncture, is regulated in both British Columbia and Ontario.

In British Columbia, there are four types of licenses: Doctor of Traditional Chinese Medicine (Dr. TCM), Registered Practitioner of TCM (R.TCM.P.), Registered Herbalist (R.TCM.H.), Registered Acupuncturist (R.Ac.). Typical time-frame for an applicant to be assessed and registered is 3 ½ ~ 4 ½ months. To be eligible for registration in British Columbia, applicants must have two years of university education or equivalent. A summary of each designation is described below.

Doctor of Traditional Chinese Medicine

To be eligible for registration as a Doctor of TCM, applicants must have completed 3,250 hours of training within five academic years, including 1,050 hours of practicum. Applicants must pass both written and clinical exams including Western Medical Science, Herbology, Acupuncture, and Legal aspects.

Registered TCM Practitioner

To be eligible for registration as Registered Practitioner of TCM, applicants mush have completed 2,600 hours of training within four academic years, including 650 hours of practicum. Applicants must pass written and clinical exams including western Medical Science, Herbology, and Acupunture.

Registered TCM Herbalist

To be eligible for registration as Registered TCM Herbalist, applicants must have completed 1,900 hours of training within three academic years, including 450 hours of practicum. Applicants must pass both written and clinical exams including Herbology ankd Western Medical Science.

Registered Acupuncturist

To be eligible for registration as Registered Acupuncturist, applicants must have completed 1,900 hours of training within three academic years, including 450 hours of practicum. Applicants must pass written and clinical exams in Acupuncture.

Applicants from outside Canada and the United States must submit a Basic Report with their application from the International Credential Evaluation Service (ICES). ICES requires a full set of original educational documents for each fully or partially completed educational program to be evaluated, which includes the academic record, the grades earned, and the hours of study or number of credits for each course and the document awarded upon completion of the credentials. Processing the required Basic Report takes a minimum of

seven weeks. In terms of educational equivalency, the College accepts the ICES report as complete. Graduates of TCM schools in China must obtain a credential evaluation report from that country (CTCMA, 2007).

Regulation of Acupuncture

In Canada, practitioners are provincially regulated and regulation varies among health professional groups that may be certified to practice acupuncture. The designation "acupuncturist" is restricted in British Columbia, Alberta, Quebec, and Ontario.

The practice of acupuncture by non-physicians is regulated in British Columbia (designation Regulated Acupuncturists, R.Ac.), Alberta (designation Acupuncturist), and Quebec (designation Acupunctor). British Columbia, Alberta, and Quebec signed a Mutual Recognition Agreement (MRA) for Registered Acupuncturists. Registered Acupuncturists from Alberta and Quebec are not required to take additional training and exams except to complete the Jurisprudence section of the written exam when they decide to practice in British Columbia (CTCMA, 2007).

In non-regulated Provinces anyone with any level of training can practice TCM and acupuncture. Because of the absence of regulation in these jurisdictions, there is no difference among TCM practitioners. It is the responsibility of patients or consumers to inform themselves of their practitioner's level of training.

Physicians and other regulated health care practitioners are now regulated to practice acupuncture as part of their scope of practice in Canada with the sufficient training. Medical Doctors, Dentists, Physiotherapists, Registered Nurses, and Chiropractors can practice acupuncture in all provinces and territories (including those that do not have specific legislation for acupuncturists). In most cases, these health care practitioners require extra training beyond their basic professional training. For example, they could receive training via the Acupuncture Foundation of Canada Institute (CAFI). Some universities also offer continuing education in acupuncture. Naturopathic Doctors (regulated in British Columbia, Saskatchewan, Manitoba, and Ontario) are also certified to practice acupuncture in regulated Provinces only.

TCM Acupuncture

Alberta:

Acupuncture is regulated and licensed under the *Health Disciplines Act* (2006). The Acupuncture Committee of Alberta Health and Wellness is the body that certifies Registered Acupuncturists (R.Ac.).

British Columbia:

The regulation of TCM practitioners and acupuncturists was approved by the BC government on December 4th, 2000 under the *Regulated Health Professions Act* (RHPA). This regulation succeeds the previous Acupuncturist Regulation in 1996. The College of Traditional Chinese

Medicine Practitioners and Acupuncturists of British Columbia (CTCMA www.ctcma.bc.ca) is a self-regulatory body under the provincial RHPA and is the official licensing authority of the profession. This body was created in 1996 with the amendment of the Acupuncturist Regulation. The new regulation of TCM practitioners and acupuncturists grants the following titles after the applicant has completed the appropriate educational training and passes the appropriate licensing exame of the CTCMA: Doctor of Traditional Chinese Medicine (Dr.TCM), Registered TCM Practitioner (R.TCM.P), Registered TCM Herbalist (R.TCM.H), or Registered Acupuncturist (R.Ac).

Ontario:

On December 7, 2005 the Ontario Ministry of Health and Long-Term Care (2005) introduced Bill 50 into the Legislature to regulate Traditional Chinese Medicine under the *Traditional Chinese Medicine Act*. The proposed legislation includes creation of a new College of Traditional Chinese Medicine Practitioners of Ontario to set standards of practice and entry into the profession. The passing of Bill 50 in December of 2006 has brought TCM and acupuncture under government regulation in Ontario. New regulation is currently being implemented. A registrar was recently appointed. Training requirements and other details will be set in the near future.

Quebec:

Acupuncture is regulated in Quebec under the *Acupuncture, an act respecting* (2006). L'Ordre Professionels des Acupuncteurs du Quebec (2007) is the body that certifies Registered Acupuncturists (R.Ac.).Western Anatomical Acupuncture

The regulation and scope of practice of health care professionals varies between different health care providers and their jurisdictions. Physicians, dentists, physiotherapists, registered nurses, and chiropractors are regulated in all provinces and territories in Canada.

Naturopathic Doctors are regulated in British Columbia, Saskatchewan, Manitoba, and Ontario (regulation is pending in Alberta). Acupuncturists are regulated in British Columbia, Alberta, Quebec, and Ontario.

Most regulatory bodies or Colleges recognize the certification of the Acupuncture Foundation of Canada Institute (CAFI) and the Certification of Medical Acupuncture (CPMA) of the University of Alberta to licensed health care professionals.

2. Current TCM Practice

In Canada, only British Columbia (BC) institutes a system of mandatory registration of TCM practice. 933 practitioners registered right after the compulsory registration took effects on April 12, 2003. Current TCM manpower supply in BC is tabulated in Table 1. The majority of the TCM practitioners are still self-employed.

Table 1. Number of Registration Categories in 2004, 2005, 2006, and 2007

Registration Category	2004	2005	2006	2007 (Sept)
Doctor of TCM	250	281	301	298
Registered TCM Practitioner	196	206	245	270
Registered TCM Herbalist	58	57	56	58
Registered Acupuncturist	546	547	620	664
Total	1,050	1,091	1,222	1,290

Scope of Practice, Standards of Practice, Code of Ethics:

After legislation in British Columbia, the TCM profession is working its way toward professionalism. The establishment of scope of practice, standards of practice and code of ethics is essential to this profession in that it provides means for the exercise of professional self-regulation (Benjamin & Curtis, 1992). A code of ethics indicates "a profession's acceptance of the responsibility and trust with which it has been invested by society" (Benjamin & Curtis, p. 219). It implies the contract between society and the TCM profession that society grants the profession substantial amount of autonomy and authority to conduct its business.

The scope of practice, standards of practice (i.e., core competencies), and code of ethics are only relevant in regulated Provinces, such as British Columbia (http://www.ctcma.bc.ca/DataFile.asp?FileID=47). All other Provinces in Canada have no regulation of TCM and therefore, have no legal standards of practice and licensed scope of practice. In these provinces, it is the responsibility of patients or consumers to inform themselves of the practitioner's level of training.

The practice of acupuncture is regulated in Alberta, Quebec and Ontario. Scope of practice, standards of practice, and ethical guidelines vary among health care providers other than TCM practitioners (i.e., western medical doctors, dentists, chiropractors, naturopath, etc.) who practice acupuncture.

3. TCM Education and Training (schools and programs)

In the only Province (British Columbia) that regulated TCM, there are four levels of training in Traditional Chinese Medicine: Doctor of Traditional Chinese Medicine, Practitioner of TCM, TCM Acupuncturist, and TCM Herbalist. The length of study, training, and the number of completed academic and clinical hours determines the designation. Students applying to a program in TCM must have a minimum of two years post-secondary education. Graduates of the diploma program are required to write licensing exams and become registered by law in regulated provinces. No national examination is taking place right now.

The Doctor of Traditional Chinese Medicine Diploma (1)

This diploma requires a minimum of five full-time academic years. The program qualifies students to function as independent primary health care providers. Students are qualified in areas of biological and clinical sciences, TCM theory, herbology, acupuncture, massage, nutrition, and TCM diagnostics and treatment. Graduates of a program in Doctor of TCM applying for practice in British Columbia are required to write and pass a licensing exam by the College of Traditional Chinese Practitioners and Acupuncturists of British Columbia (CTCMBA) and are designated Registered Doctor of TCM (Dr.TCM). For more information about the requirements and eligibility to write the licensing exam, visit www.ctcma.bc.ca.

Graduates of the program in any other province are only required to write and pass an exiting exam of the school.

The Practitioner of Traditional Chinese Medicine Diploma

This diploma requires a minimum of four full-time academic years. Students are qualified in areas of basic biological and clinical sciences, TCM theory, herbology, acupuncture, massage, nutrition, and TCM diagnostics and treatment. Graduates of a program in Practitioner of TCM applying for practice in British-Columbia are required to write and pass a licensing exam by the College of Traditional Chinese Practitioners and Acupuncturists of British Columbia (CTCMBA) and are designated Registered TCM Practitioners (T.TCM.R). For more information about the requirements and eligibility to write the licensing exam, visit www.ctcma.bc.ca.

Graduates of the program in any other province are only required to write and pass an exiting exam of the school.

The Acupuncture Diploma

This diploma requires a minimum of three full-time academic years. Students are qualified in areas of basic biological and clinical sciences, TCM theory, and acupuncture. Graduates of a program in Acupuncture applying for practice in British Columbia are required to write and pass a licensing exam by the College of Traditional Chinese Practitioners and Acupuncturists of British-Columbia (CTCMBA) and are designated Registered Acupuncturists (R.Ac). For more information about the requirements and eligibility to write the licensing exam, visit www.ctcma.bc.ca.

Graduates applying to practice in Alberta and Quebec are required to write the licensing exam of the Alberta Health and Wellness and the Ordre Professionels des Acupuncteurs du Quebec respectively.

Graduates of the program in any other province are only required to write and pass an exiting exam of the school.

The Chinese Herbalist Diploma

This diploma requires a minimum of three full-time academic years. The program qualifies students in areas of basic biological and clinical sciences, TCM theory, and herbology. Graduates of a program in Chinese Herbalism applying for practice in British-Columbia are required to write and pass a licensing exam by the College of Traditional Chinese Practitioners and Acupuncturists of British-Columbia (CTCMBA) and are designated Registered TCM Herbalist (R.TCM.H).

For more information about the requirements and eligibility to write the licensing exam, visit www.ctcma.bc.ca. Graduates of the program in any other province are only required to write and pass an exiting exam of the school. Western Anatomical Acupuncture Training

Acupuncture Foundation of Canada Institute:

Acupuncture Foundation of Canada Institute (2007) is a body that certifies licensed Canadian health care professionals in acupuncture. There are two designated certifications: Anatomical Acupuncture (Level I) and Integrated Classical and Anatomical Acupuncture (Level II), open to licensed physicians, physiotherapists, dentists, chiropractors, naturopathic doctors, registered nurses (baccalaureate) and licensed acupuncturists. Upon certification, acupuncture is designated as a “modality” within the specific scope of practice of the practitioner. Licensed health care providers certified in acupuncture are trained by the ACFI by completing a series of courses (see below).

Level I certification in Anatomical Acupuncture (CAFI)

A health care practitioner with Level I certification in Anatomical Acupuncture (CAFI) will have the basic skill set to perform acupuncture and electro-acupuncture for the treatment of acute and chronic pain. The College of Family Physicians of Canada approves study credits for this course. For more information see http://www.afcinstitute.com/.

Level II certification in Integrated Classical and Anatomical Acupuncture (CAFI)

Level II certification in Integrated Classical and Anatomical Acupuncture (CAFI) builds on a Level I certification so that health care practitioners learn to treat central nervous system disorders, neurological problems, autonomic nervous system dysfunction, and pain syndromes. To obtain certification, 60 hours of class credits (4 days) are required. Further specialized courses in Classical Acupuncture are offered beyond the Level II certification. There are a total of five courses (A-E) that present the basics of Traditional Chinese Medicine (TCM) theory, diagnosis, disease concepts, concepts of meridians and channels, and treatments using the TCM paradigm. Each course is equivalent to 30 hours of class credits. The College of Family Physicians of Canada approves study credits for these courses. For more information see http://www.afcinstitute.com/.

University of Alberta, Faculty of Extension, Medical Acupuncture:

The Certificate in Medical Acupuncture (CPMA)

This certification is open to medical doctors, dentists, and physiotherapists. It is a part-time program that involves 200 hours of graduate-level academic and clinic instruction. It is divided into 4 modules or levels, of 50 hours each. The courses usually run over a weekend, Friday-Sunday, and the certification takes no longer than one year. This certification is recognized by many medical Professional Colleges in Canada. Please contact the local Professional College for more information.

McMaster Medical Acupuncture Program:

The Certificate of Recognition in Medical Acupuncture

This certificate program is open to medical doctors, dentists, and physiotherapists. Other health care professionals with acupuncture in their scope of practice may be considered on an individual basis. The program involves 220 hours of training in basic TCM theory and common acupuncture points for musculoskeletal pain and headache through evidence based acupuncture. The program meets the accreditation criteria of the College of Family Physicians of Canada. This certification is recognized by many medical Professional Colleges in Canada.

Currently there is no TCM specialized independent body which regulates TCM and/or acupuncture schools. TCM and/or acupuncture schools were accredited once by Private Career Training Institutes Agency (PCTIA) (http://www.pctia.bc.ca/), which is the only accreditation agency in the province of British Columbia. A list of TCM schools with or without being accredited is enclosed in the Table 1.

4. Roles and Functions of Government Legal Bodies

In Canada, all natural health products (NHPs) are regulated by the federal government, while health care practices are regulated provincially. Practice of Traditional Chinese Medicine is currently regulated in both British Columbia and Ontario. In British Columbia, the legal body is the College of TCM Practitioners and Acupuncturists of BC. Regulated TCM practitioners are allowed to prescribe herbs and other treatment modalities. Non-prescribed, public accessible TCM products are regulated by the Natural Health Product Directorate.

Natural Health Product Directorate (NHPD)

The Natural Health Products Directorate (NHPD), established in 1999 under Health Canada, held an extensive stakeholder consultations, in the summer of 2003, announced regulations on licensing natural products and ingredients in Canada (NHPD, 2004), and began implementing the regulations on January 1, 2004. Health Canada seeks to “ensure all Canadians to have ready access to natural health products that are safe, effective and of high

quality, while respecting freedom of choice and philosophical and cultural diversity" (NHPD, 2007).

The new NHP regulations classify NHPs as a sub-category of drugs, and apply to products commonly known as herbal remedies, traditional medicines (e.g., Chinese medicine), homeopathic medicines, probiotics, vitamins and minerals, and others. Prior to January 2004, NHPs were regulated under the *Food and Drugs Act*, which indicated that either the food or drug regulations applied to NHPs, depending on whether medical claims were made. The new NHP regulations governing the licensing, manufacture, labeling, clinical trials, and adverse reaction reporting of NHPs (NHPD, 2007), are viewed as being more strict than the food regulations because applying companies must provide evidence of safety, efficacy, and quality to Health Canada, but less strict than the drug regulations (Laeeque et al., 2006). The regulations represent pre-market approval mechanisms by the government.

The standard of evidence used to regulate the NHPs allows for a range of evidence (e.g., anecdotal evidence, population studies) to support safety, efficacy and quality of the products. There are 3 levels of claim: risk reduction, structure and function, and cure. The last category requires the same level of evidence (i.e., double-blind, randomized clinical trial) as a prescription drug (NHPD, 2007).

Dr. Michael Chung, present Vice Chair of the CTCMA, is a member of the NHPD expert advisory committee who stated that the NHPD is already looking at developing a compendium of monographs to facilitate licensing of existing and new products. He believed that the regulation will increase public awareness of the quality of TCM products and facilitate the use of products of safety, efficacy, and quality. Health Canada has enforced the regulation and may eliminate a large quantity of items that do not meet the NHPD standard. The results may reduce international importation. College of TCM Practitioners and Acupuncturists (CTCMA) The College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia (CTCMA www.ctcma. bc.ca), established in 1996, is a self-regulatory body under the provincial *Health Professional Act* and is the official licensing authority of the profession. The CTCMA seeks "to protect the public by establishing a system of mandatory registration in which practitioners have to meet and maintain standards in TCM and acupuncture care" (CTCMA, 2007).

Therefore, the roles of CTCMA are to protect the public and regulate the profession. Its functions include providing public education and members' continuing education service, granting licenses to TCM practitioners and acupuncturist of the Province, defining core competencies, and enforcing standards of practice.

5. The Roles of TCM and/or Acupuncture Associations

The roles of TCM and/or acupuncture associations are to promote TCM profession, provide member services, and ensure member benefits. The functions of associations include promoting continuing competence activities and education, establishing scope of practice in collaboration with the CTCMA, adopting a Code of Ethics, ensuring quality

of TCM practice, and lobbying government agencies.

British Columbia exist a large group of associations which include 13 TCM and/or acupuncture associations serving diverse purposes. In 1996 when the regulatory body was formed, five acupuncture associations amalgamated into Canadian acupuncturists and TCM Alliance of BC. The Alliance included Acupuncture Association of BC, Canada Acupuncturists Headquarters Association - BC Branch, Canadian Chinese TCM and Acupuncturists Society, Korean-Canadian Acupuncturist Society of BC, and United Acupuncturists Association of BC. In March 2001, the Alliance formally merged with the Qualified Acupuncturists & TCM Practitioners Association (QATCMA). Unfortunately the TCM and/acupuncture associations in British Columbia are still divided and do not have the unified power to force membership enrollment and control the overall quality of TCM education and practice.

QATCMA presently is the largest and most culturally inclusive association in British Columbia. For further information: visit the website: www.qatcma.org.

6. Consumers, MSP, and TCM use

In a 2001 national survey, 75% of Canadians had used some form of traditional medicine and complementary and alternative medicine for a health condition (Bodeker & Kronenberg, 2002; de Bruyn, 2001). A recent survey indicated that the combined use of TCM and Western medicine is common among elderly Chinese immigrants (age over 55) in Canada (Lai & Chappell, 2007; Ferro et al., 2007). Culture related factors are important in determining use of TCM (Chiu et al., 2006; Lai & Chappell; Ferro et al.). The most common used treatment modality is Chinese herbs or herbal formulas. Twenty four per cent of elderly Chinese immigrants (N=2,167) consulted a Chinese herbalist (Lai & Chappell).

In our qualitative study with Chinese cancer patients who emigrated from Taiwan, China, or Hong Kong, one of the main reasons for using TCM was care for body, mind, and spirit (Chiu et al., 2006). Their perception of conventional cancer treatment was that surgery and adjuvant therapy was “taking away” energy. The study found that herbal remedies were the most popular among cancer patients and that individuals used plants and herbs with the purpose of restoring balance and increasing energy levels or *chi*. The need to maintain a holistic balance is important for Chinese, as health and well-being depends on the harmony among the physical, cognitive, and spiritual domains.

Another reason that underlies TCM use involved the failure of conventional medicine to manage the side effects of cancer and the conventional cancer treatments, such as fatigue, pain, and swelling, and to prevent a recurrence of cancer (Chiu et al.). Similar reasons were found by Cui et al. (2004), who conducted a survey of TCM use among more than 1,000 Chinese women with breast cancer in Shanghai.

Individuals of Chinese heritage value family and kinship. Although the majority of the Chinese patients indicated that they made their own decision, the support of family and friends was an important reason for using TCM, and Chinese used their social network to gain information about TCM (Chiu et al.). Similar findings were found in Simpson's qualitative study (2003), where family members had a great influence on health beliefs and TCM use in Chinese women with breast cancer in Hong Kong. For many individuals, the cost of TCM was expensive in Canada. In British Columbia, the College of TCM Practitioners and Acupuncturists does not require a common scale of professional fees. The informants of Chiu's study live between two worlds (Chiu, et al). They either ordered TCM herbs from or traveled to their places of origin for complete health care and the cost of TCM may pose a significant hardship for Chinese immigrant patients. Cancer patients, in particular, are vulnerable to unsubstantiated curative claims and may be taken advantage of by deceitful practitioners.

Cost was a crucial factor in determining Chinese cancer patients' TCM use. With most of the informants in my previous studies being unemployed as a consequence of their illness (Chiu, 2006; Chiu et al., 2006)), their financial resources were limited. TCM was not covered by the provincial medical services plan (MSP*) in BC until April 2008. Acupuncture fee ranges from $30 ~ $80 per visit. TCM diagnosis and prescription fees varied among TCM practitioners. A free consultation could be obtained if the patient purchased herbs in a TCM herb store. TCM herbs may cost about $20 ~ $75 CAD per visit (each prescription could last a week). While many informants of my previous studies returned to China, Hong Kong, or Taiwan for less expensive medicine, others reduced the amount of TCM they were using or discontinued TCM after a short period of use because of the exorbitant cost.

In many North American studies, TCM use is associated with higher education and higher income (Eisenberg et al., 1998; Astin, 1998). In ours and others studies, the affordability, availability, mobility, and language and cultural familiarity of traditional medicine, as well as family influence contribute to the continued use of TCM (Chiu et al., 2005; Chiu et al., 2006). Additionally, important primary care services may not be available (Bodeker & Kronenberg, 2002).

The newly announced supplementary health care benefit for Medical Services Plan premium assistance will support low-income British Columbian to receive acupuncture services. A total of 930,000 British Columbians, one fourth of the population, living in households earning $28,000 or less a year, including welfare recipients, students, the disabled, and seniors, are covered by the program (Vancouver Sun, 2007). Premium-assistance patients will permit $23 per visit for a combined annual limit of 10 visits for acupuncture treatments (www.healthservices.gov.bc.ca/msp/infoben/benefits.html). The users will be beneficiaries of a more regulated and safe acupuncture treatment. This policy may lead to a substantial increase in the use of TCM in British Columbia.

*The **Medical Services Plan of British Columbia** (MSP) is the government-administered monopoly health insurance system under the auspices of the Canada's national Medicare program. Under the Canadian constitution, provinces are responsible

for the delivery of health care, while the national Canada Health Act ensures access to universal health care for all citizens of the country.

The plan covers medically required services provided by a physician enrolled with MSP; maternity care provided by a physician or a midwife; medically required eye examinations provided by an ophthalmologist or optometrist; diagnostic services, including x-rays and laboratory services, provided at approved diagnostic facilities, when ordered by a registered physician, midwife, podiatrist, dental surgeon or oral surgeon; dental and oral surgery, when medically required to be performed in hospital; and orthodontic services related to severe congenital facial abnormalities. For further information: www. healthservices.gov.bc.ca/msp.

6. Future Implication and Opportunities for Chinese Medicine in Canada

The findings suggested that TCM is popular in British Columbia and Ontario because the increasing number of Chinese population resides there. Both British Columbia and Ontario already legislated to regulate TCM and acupuncture. Other Provinces may set up their own jurisdictions in the near time.

The findings suggest that TCM in Canada has been through four different stages: *Opening the bamboo curtain, lobbying and struggling for the legal status, becoming a designated health profession, and heading toward professionalism.* Recent historical breakthrough in TCM was that TCM will be soon accessible to low income earners in British Columbia. We believe that TCM will continue its process of professionalization in this and another decades.

Professionalization could create a common ground for interaction and integration between TCM and biomedical system. According to Abbott (1998), professionalization is a process of moving an occupation toward a higher status, something which might start with "a
school, an association, examinations, licensing, an ethics code …" (p. 431). TCM in BC is moving in this direction.

Professionalization is essential to attaining the kind of recognition, both official and public, that constitutes the foundation for integration. To achieve professionalism, TCM profession is advised to establish and enforce codes of conduct, standards of practice, as well as, evaluation procedures for competence. TCM profession is also advise to embrace evidence-based practice, accredit education and training centers, and standardize medical records.

As Abbott (1998) suggests, TCM practitioners in BC should consider their future in "the context of larger social and cultural forces, the context of other competing professions, and the context of other ways of providing expertise" (p. 433-434), in addition to the "likely evolution and the consequences of that evolution for (their) profession" (p. 432). There are various types of evidence could be used to support TCM, which include research evidence, clinical experiences, and patient preference (Craig & Smyth, 2002). Research in TCM differs from clinical evaluation of conventional drugs. Randomized controlled clinical trial (RCTs) have limitations in evaluating efficacy, risk, and benefits of TCM. Preliminary work is essential before one can design the appropriate RCT.

Ethnographic, epidemiological, observational, survey, and cohort methodologies can make a contribution to TCM research (Bodeker and Kroneberg, 2002). TCM profession should also develop methodologies that fit into its theory and complicated mechanism. Adequate funding is of central importance.

Although the CTCMA has set the entrance standards for each designated titles, the education program requires carefully reviewed. Currently, there is no accreditation body to examine the programs. The government should encourage the establishment of an independent agency that provides TCM accreditation services.

Previous studies have found that patients who avail themselves of both TCM and Western medicine believe that each possesses strengths that can complement the other's weaknesses (Chi et al., 1996; Chiu, 2006 ; Chiu et al., 2006). This, in turn, suggests the desirability of creating an integrative system of conventional and complementary and alternative health care that will allow the "bringing together of the strengths and (the) balanc(ing) of the weaknesses inherent in different systems of health care" (Owen et al., 2001, p. 156). It is essential for patient safety that TCM practitioners are cognizant of what their patients are being treated for by their Western counterparts and vice versa. A formal referral system would provide a communication channel between the two parties which would prevent over prescribing and adverse drug interactions (Chiu). As Chi and his associates suggest, the creation of a referral system could be a critical step in integrating the two systems.

For a referral system to function in this context, each party must possess at least a basic knowledge of the other's discipline or profession. Thus, the curricula of TCM schools should include courses relating to Western medicine and vice versa. As the findings of our previous studies suggested, many barriers exist in TCM research that impede the development of evidence based practice, thereby hampering professionalization. Given that the BC government supports the creation of a college for TCM and acupuncturists, it should consider allocating TCM research funding to advancing professionalization. The Canadian government supports alternative health care, believing it to be consistent with the country's broad "international and multi-cultural character" (Crellin et al., 1997).

Multiculturalism is a fact of Canadian life and, therefore, of Canadian health care; moreover, growing cultural diversity will exert ever greater pressure on the official health care system to broaden its perspectives and develop greater responsiveness to the needs of patients of all backgrounds and beliefs. This will require recognizing that Western medicine is itself a culturally determined institution reflecting the values and worldview of the dominant segment of Canadian society and that "traditional medicine may at times be the first-line treatment for the poor and those who do not speak the language of the dominant society" (Bodeker & Kronenberg, 2002, p. 1585). More studies are required to advance our knowledge of the roles played by immigration, legitimization, and integration in determining the development of TCM. Such studies would be particularly useful in elucidating the commonalities and differences among Asian Pacific, North America, as well as between provinces in Canada.

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