Taking Charge – Examining the Need to Take Ownership of Our Profession

Stephen Birch

INTRODUCTION

Recently I was listening to various presentations in Rothenburg at the 2016 TCM congress which gave me opportunity to reflect on the status of our profession. Traditional East Asian Medicine (TEAM), especially acupuncture and all its related approaches[i] seem to be constantly under pressure and threat from various sources and it often feels like sailing a small boat on stormy waters, where we seem to have little influence on the frequency and intensity of the storms. In this article I will muse on some topics already raised by others like Volker Scheid, but I will contextualise them more in relation to how they pose threats to our profession and what kinds of actions will probably be needed to try to counter them. This piece is by no means extensive and detailed, rather I am raising issues that many fellow acupuncturists seem to pay little attention to but which seem rather urgent to me.

The kinds of threats to our profession that appear are both external and internal. External threats come from groups that want to rid or sideline the profession, groups that want to dictate to us what we do and how to do it, and groups that want to usurp its methods or take ownership of it. Internal threats come from inconsistencies within the field, not being well informed about academic debate and knowledge of the profession, and thus a paucity of efforts to identify and solve the academic and scientific problems faced by our field.[ii]

External Threats

Medical and scientific

The increasing success of acupuncture on the world stage[iii] has triggered a highly successful opposition. Many of us have followed the successful campaigns of the sceptics in the name of 'science' to drive alternative and CAM therapies like acupuncture out of UK universities. A similar attempt was made in Australia, where it was successfully rebuffed by Australian academics.[17] The TV programme 'Folkeopplysningen' in Norway did a series of six documentaries of CAM, one on acupuncture in the fall of 2012. This programme was influenced by a Norwegian sceptic group. The documentary left the impression that acupuncture is only a placebo effect, which had major negative repercussions for acupuncture practice, referral, student enrolment and even research in Norway.

Some in established medicine seem to use their position to find ways of limiting or getting rid of acupuncture, despite all the evidence that it should be being accepted more. The National Institute for Health and Care Excellence (NICE) allowed one clinical practice guideline group to rule against acupuncture for osteoarthritis employing clearly biased procedures.[4, 6, 7] The leaders of the NICE group on low back pain have attempted the same procedures to remove acupuncture as a treatment option for low back pain.

Intra-field and political

I will not talk here about external threats to the acupuncture field that arise due to the desire of other medical professionals to use acupuncture as a technique within their medical practice under the name of for example 'dry needling'. Recent publications can be found discussing this.[12]

In the early 2000s the Chinese government announced its strategy to take over TCM worldwide, an important mechanism for doing this being to establish standards for the TCM field. Once such standards are established the Chinese government can, in government-to-government level trade talks, place the enforcement of those standards on the table as part of the deal they cut with each government. Of course establishing standards for any field is an important factor for the development of that field. But the establishment of standards is important both inside China[29] as well as outside China in their bid to expand the market share for TCM and its derivative products globally: 'The reason why TCM cannot grab a favourable international market share is partly due to the lack of strict management and supervision. Development of TCM industry calls for the standardisation in every aspect, including production, storage, diagnosis and treatment and etc.'[18] Efforts have been made on several fronts to establish standards that can be used to pressure governments to allow the Chinese to dictate and redefine standards within our field.

In 2009 the Chinese approached the International Standards Organisation (ISO) proposing to help them establish standards for the TCM/TEAM field. If ISO establishes a standard, particularly in the area of product specifications, it is common that many governments around the world agree to follow these standards. The threat arose when Chinese participants at the ISO TCM meeting attempted to transform the process for establishing better international production standards for needles and herbs under the auspices of ISO, into efforts to dictate standards of practice to all TEAM practitioners in countries that agree to ISO standards. This was successfully blocked by Korean, Japanese and other ISO participants. We heard in Rothenburg this year from Dr Schroeder, who chairs one of the ISO TCM committees, that the plan for this has not been removed,[30] it is currently given a low priority, but can easily be prioritised again at a time judged more suitable.

Meanwhile Chinese TCM experts have been working with the World Health Organization (WHO) under the umbrella of the WHO traditional medicine programme to try to establish an addendum to the International Classification of Diseases (ICD) codes. They have helped update the ICD-10 to the ICD-11, incorporating Chinese dictated standards and definitions of TCM patterns. Once such a standard is approved by the WHO this will allow the Chinese to turn round and pressure governments to follow this standard, effectively trying to dictate practice

standards to our field. There are many problems with these ICD codes. First, the traditional diagnostic codes only reflect current Chinese versions of TCM, they exclude pretty much all other diagnostic and practice systems (Japanese, Korean, European and so on). Second, there are major concerns about the validity of the codes that have been submitted and are currently being studied. Unlike the ICD codes for modern medicine, the traditional codes that have been appended to the ICD-11 draft are **not at all** scientifically based. This is very peculiar since the WHO usually makes great efforts to apply scientific standards to its work. This lack of scientific support for the TCM patterns and their descriptions will not only be another potential embarrassment for the WHO, but will likely undermine the TCM field if it tries to promote the field based on these codes. Third, a brief examination of the ICD-11 TCM descriptions identified potential problems of internal consistency. I was asked to examine the ICD-11 codes by Dr John Hughes and complete a brief questionnaire about them. As part of my analysis I looked at two common patterns described in TCM texts: *qi* deficiency and *qi* stagnation. I had already found that Chinese texts were inconsistent in their description of the principle signs and symptoms of these patterns,[3] but I found the ICD-11 codes gave very different descriptions from other Chinese sources, suggesting further inconsistency. Scheid has already summarised this situation: 'Hence, institutions concerned with the global governance of Chinese medicine assert the dominance of specific interpretations of *zheng* through bio-political arrangements and not through consensus among its practitioners.'[26]

Besides these overt economic and political strategies, are there other signs that we may have problems with current Chinese approaches to the practice of TCM (and by extension the larger field of TEAM) in the West? In their article 'Necessary conditions for the globalization of Chinese Medicine', Yu and Gong analyse the situation for TCM in the US as they see it. In their discussion of education for TCM in the US they describe how the programmes teach 'irrational teaching programs that contain two to three years curriculum totalling approximately 2,500 hours', they describe the situation for TCM in the US as one where the field is dominated by 'unqualified TCM practitioners' (70% unqualified vs 30% properly qualified (ie Chinese trained)).[36] The attitude reflected in this article is very telling of Chinese attitudes towards non-Chinese practitioners. Acknowledging that my analysis is incomplete since comparison between training programmes in different countries is fraught with difficulties, I point out the following: In the US programmes the 2,500 hours are 2,500 'contact hours'. This is many more contact hours than almost all acupuncture schools in Europe where one contact hour is often counted as three hours including home study so that a 3,600-hour programme may be around 1,200 contact hours.[iv] If the Chinese feel that US TCM education is insufficient, how much more so do they think that European education is insufficient? This situation is probably worsened by the fact that in Europe most schools teach acupuncture only, without TCM herbal medicine, and thus have shorter programmes anyway. Once some kind of TCM standard is established by the ISO or WHO ICD codes, arguments about why governments should agree to allow Chinese 'experts' to apply those standards in our countries will be partially based on their opinion that our education is inadequate. The WHO published an international guideline on the length and nature of training programmes in acupuncture.[33] The US, Australian and many schools in Europe clearly meet these guidelines, so how can they be considered inadequate? Further, most Western TCM schools were established with participation or consultation of Chinese experts, attempting to reproduce a curriculum that was originally developed in China, and it is 'irrational'? The Chinese attitude reflected in the article by Yu and Gong is fundamentally unacceptable and indicates a potential problem for us.

Internal Threats

Correlations and consistencies

We do not have to look far to see evidence of physiological, somato-psychic and socio-cultural differences important for the practice of TEAM methods like acupuncture. These raise a number of internal threats that need to be addressed.

Physiological differences: On occasion some of us have gone out drinking with colleagues and teachers from China, Japan, Korea. We have noticed that many of our Asian colleagues become very flushed after very little alcohol,[35] this is due to the fact that something like 70% of our Asian colleagues have different liver enzymes than we do.[10, 23] They likely also have different responses and sensitivity to treatments in part due to this physiological difference.[9, 34] If we are physiologically different, does that not mean that we might also respond differently to treatment than our Asian colleagues? Also, can we assume that we will show the same signs, symptoms and their derivative patterns of diagnosis?

Somato-psychic differences: I remember in the early 1980s when friends started going to China to study. They almost all reported that the patients they treated there told them that the needling they were applying was too light and that they needed to do more manipulation of the needle. Many of the same friends also reported that upon returning to their practices, they found that their patients generally could not tolerate the heavy-handed needling that they had learned in China, and that they needed to use lighter needling methods to be effective for their patients. In the 1980s and 1990s this was a widely enough known phenomenon in the US that there was debate about it. On the other hand some colleagues going to Japan to study found that the approaches to needling there were even lighter than the Japanese acupuncture techniques they were using in their practice. This trend to using gentler and more comfortable techniques continues to develop in Japan.[11] This big difference in needling techniques between China and Japan has been explained by pointing out that patients who do hard manual labour (like most Chinese patients at least prior to the economic revitalisation of the last decades) generally prefer to feel the needle, while patients that do not do manual labour, instead working in a more industrialised setting especially doing office work (like most Japanese patients), generally prefer not to feel the needle.[5] Whether one believes this or not, it does seem to explain the obvious differences of approach that are typically found in China and Japan. This implies that we need to find what needling approach works best for us with our patients. It is not a matter of one being better than the other, current scientific evidence does not support such simplistic understanding or claims.[37, 38]

Socio-cultural differences: Arthur Kleinman, among others, has explored differences in how diseases manifest and are treated due to important socio-cultural factors.[16] The evidence from this work clearly shows that we experience and express problems differently in different socio-cultural contexts and that we are likely to respond differently to interventions in part due to this as well. This implies that the diagnoses made in China or Japan might not be readily transferable to different Western countries and contexts. Do we have any evidence of these differences? In Japan, many of my Meridian Therapy teachers talk about finding pressure pain in relation to either certain diagnostic judgments or certain point locations. But the kind of pressure they apply is so light it is more like touch and would not elicit a pressure pain response on me or any of my patients. If the finding of 'pressure pain' is to be a useful clinical tool for diagnosis or point location in the context of trying to practise this system of Meridian Therapy, it is necessary to adapt it to our patients. My colleagues and I have to discover if there are other palpable findings (tissue changes) that correlate with what in Japan might be called 'pressure pain' or whether the pressure pain our patients express correlates with the Japanese observations and judgements.

Are the various signs and symptoms that indicate the presence of a specific TCM pattern the same in China and the West? This is a difficult question, mostly because few studies have been done to explore it (at least to my knowledge). In an important paper reflecting on the evolution of *'zheng'* patterns, Volker Scheid gives us many insights into TCM patterns showing how they have varied in China over time following complex socio-cultural factors and how the current trend on pattern identification in China is not the only approach we should accept.[26] He advocates that we engage in a more open debate about the system we practise. Scheid has also looked into the diagnosis and treatment of menopause showing that the diagnoses and treatments described in textbooks coming out of China in the 1960s are not based on experience. Indeed menopause had not been recognised as a medical problem until they found the need to describe treatment for a condition well described in Western biomedical texts. They consequently made up the diagnoses and treatments.[24, 25] Scheid and colleagues have advocated for and performed landmark studies to examine what practitioners in the UK do for patients with menopause so that we can identify what works for our patients.[27, 28] Among their conclusions we find: 'Almost without exception clinical research seeking to evaluate the effectiveness of Chinese medicine relies on TCM textbook knowledge – accessed directly or via practitioners' clinical usage – in order to frame its hypotheses. Recent historical research shows that these textbooks, products of a politically directed process of modernisation, constitute complex hybrids of western and Chinese knowledge that are designed to facilitate the integration of Chinese medicine into biomedically dominated contexts of practice. As such they produce a number of unresolved and generally unacknowledged tensions, such as between the emphasis on local illness experience in the Chinese medical tradition and the universality aspired to by biomedical knowledge.'[28]

Within the traditional acupuncture system Keiraku Chiryo, Meridian Therapy in Japan we also see evidence of changes in the theory and diagnosis for diverse cultural reasons. Meridian Therapy was established by the late 1930s as an organised practical way of re-establishing traditional acupuncture in Japan after a period of several decades of active government suppression.[2, 5, 31] The system was established with the identification and treatment of four core patterns. In the late 1980s some practitioners in Japan became worried that with such a simple diagnostic approach they were unable to explain to patients why they got sick, which made them feel insecure.[20, 21] This led to efforts among some Meridian Therapy practitioners to extend the theory by incorporating TCM-like herbal diagnostic categories and thereby extend the number of diagnostic patterns,[15, 20, 21] in part at least so that it might be easier to explain treatments to their patients.[v] While practised by some Meridian Therapists in Japan this variation has not been adopted by more mainstream Meridian Therapy practitioner groups.[13, 22, 31] Today there are a number of variations of Meridian Therapy that have developed through clinical experience and adaptation.[2, 5]

I have already mentioned that there are indications that the patterns themselves within China might not be consistent in TCM texts, there are also indications that there are inconsistencies between practitioner TCM books in China and the West.[3] It remains to be seen in European and other Western countries whether we actually identify different patterns or use different clusters of signs and symptoms to identify the patterns in our patients. This holds for non-TCM systems such as Japanese Meridian Therapy, Korean Sasang, not just TCM. But given the socio-cultural influences in medical practice, differences in the way that patients describe and experience their problems, differences in physiology and so on, we should expect that there are important differences.

These and other differences reveal another fundamental problem for the acceptance of TCM diagnosis and treatment standards from China.[vi] In mainstream medicine, if we develop a diagnostic instrument in English such as a depression scale and want to employ that instrument in another country like France, Italy and so on, in addition to translating the instrument, it must undergo relevant tests to establish its reliability and validity in those different countries. This issue is probably even more important when we move from very different countries like the UK to China and vice versa. To my knowledge no such testing has been done for TCM diagnoses. This leaves wide open the question of whether the patterns that are described in China can reliably match patterns identified among our Western patients.

Presenting ourselves

In 2012 around the time of the negative TV documentary about acupuncture in Norway, a professor in the same college of health sciences as the acupuncture institute went for treatment to check out acupuncture for himself. He was impressed with the results and asked the teacher who supervised the treatments to explain about his treatments. He was really appalled when she explained everything to him in TCM-only lingo. As a mainstream scientist it was the last thing he expected to hear about his problems. This caused him to form a negative opinion about acupuncture which led to a lot of internal discussion and problems at the college of health sciences. This is an example of internal threats. When we explain what we are doing to others

outside our field, we have to know how to do that, we have to know the appropriate language for doing this.

Diversity of clinical practice

Regardless of what acupuncture practitioners studied in their initial schooling, a large number do not practise that, or practise that alongside other methods. Surveys in the UK have revealed a diversity of practice styles being common with many practitioners mixing approaches.[8, 14] A recent survey of European practitioners similarly revealed a broad diversity of practice methods and mixture of practice systems.[1] The diversity of practice styles that acupuncturists employ in their practice seems to be huge and is easily seen by looking at all the available continuing education courses listed in practitioner journals and national association publications each year. Although further surveys are needed to confirm the number of practitioners that stick to one practice style only or mix practice styles in their clinics, it is clear that many practitioners are using mixed approaches. The current situation has developed over several decades. While TCM-type acupuncture approaches have become dominant in the initial schooling of practitioners, it seems it does not remain so dominant in practice over time. The imposition of a Chinese-dictated standard would likely be detrimental to the field as it would suppress these organically evolving cultural adaptations of practice.

'We need to explain to our respective governments or regulatory bodies why we need to develop our own standards and why standards developed by the Chinese or Japanese for practice in China or Japan will not work for us.'

WHAT TO DO?

In his preface to the first edition of *The Foundations of Chinese Medicine*, Maciocia briefly mentioned about the need to adapt Chinese TCM to what we do for practice in the Western context.[19] While insightful, we are left with the solution of having a single person across the very large field of TCM do this for us. This would not be a problem but for the fact that this and other books by Maciocia have become standard TCM textbooks for studying acupuncture in many schools and many countries. We need a broader-based approach to this that reflects the practice of acupuncture in our own cultures/countries.

In the Japanese tea ceremony tradition there is a saying *'shu hari'*, which refers to the notion that one should first try to emulate our teachers, to try to reproduce and protect what they do, but that eventually this becomes a chain that binds us, which we have to break and strike out on our own if we are to make our own contributions and make it work optimally for us. This makes sense for learning any practical skill. It is natural that when we are beginning to practise we would focus on trying to reproduce what our teachers taught us. It is natural that it takes time to develop enough experience and insight as a practitioner to find limitations and problems. It is also natural that we should eventually be able to identify our own specific ways of doing things, perhaps develop new methods, approaches. In a sense this has happened already in the acupuncture field in the West. There are quite a number of practitioners in Europe, North America, Australasia that have been practising for three or more decades. This is more than enough time to iron out the kinks in our early education and to have become mature practitioners. These practitioners have extensive knowledge about how TEAM and acupuncture can be applied and made to work on **our** patients. Practitioners in China, Japan, Korea, do **not** have these experiences, they have a **different** developed expertise. Thus it makes sense to work on establishing our own standards drawing from the extensive experiences of how our practitioners use acupuncture and TEAM. This is the way to deal with the threat of having Chinese-dictated standards through ISO or WHO ICD codes forced on us. We argue that they are not relevant and that if our governments want us to have such standards they should fund us to do that work for ourselves. This work will naturally involve consulting the written ISO or WHO standards as one among many reference guides, but the principle sources of information for these standards must come from our shared clinical experiences and observations. To obtain these data, it is likely that a number of field-wide surveys be undertaken to collect the data, identify the variants, etc.

Basically what needs to be done is for the field to take ownership of what we practise. The field needs to define its own standards. Those standards will need to be based on what is actually being done and seek to improve on that, rather than replace it with untested and probably unworkable methods such as the WHO ICD-11 codes or potential 'standards' that might emerge from renewed ISO pressure. The evidence for why the field needs its own standards needs to be laid out. We need to explain to our respective governments or regulatory bodies why we need to develop our own standards and why standards developed by the Chinese or Japanese for practice in China or Japan will not work for us.

The general lack of academic and scientific education and knowledge in our field has created a general void where the academic and scientific work needed by our field is not being done. Only a few of our education centres (in Europe, the UK and Norway) are university based or affiliated and are thus attempting to educate practitioners in the needs and potential solutions. These institutions naturally become a focal point for these efforts at developing our standards and descriptions. It is also likely that

within Europe for example, there might need to be different standards and guidelines for practice, based upon different experiences and adaptations of practice in each country. Finding the common ground and identifying important differences will be important for these efforts. Our academic centres will need to collaborate more internationally to help with this.

Proposals for what needs to be done

I believe that the European Traditional Chinese Medicine Association (ETCMA) leadership and national membership associations need to take action on this. Likewise our academic centres, especially our university-affiliated programme centres, need to take the lead on this. We need to have collaboration between our academic centres and our practitioner organisations to facilitate and coordinate the work and identify leaders and teams for the work. Collaborative agreement to proceed with clearly articulated short- and long-term plans for how to proceed and what steps to take are needed. Funding will be important, there is only so much that volunteer committees can do. Maybe, for example, it is possible to go back to the UK government who threw out statutory self-regulation and present them with clear plans, and request that they support this financially as a less burdensome (for them) alternative? Perhaps in countries where acupuncture regulation has been adopted like Switzerland and Portugal, efforts should be made to press for financial aid to support this work since someone will eventually need to do it for them. Also, maybe the ETCMA and national membership associations can pool financial resources to help support some of the work? Whatever is to be done, we the acupuncture field, needs to be at the heart of it. It doesn't work that we sit by and let others do it for us.

What advantages are there in taking this approach?

We can effectively neutralise the external threats to our rights to practise that come from China in its desire to expand its market. If we lay out the evidence for why things have to be done differently in the West compared to for example China or Japan, then we effectively neuter arguments that we must follow the standards that they develop. By bringing our academic centres and practitioner organisations into closer collaboration, we can increase the availability and ease of access to knowledge informed by scholarly and scientific undertakings, thus helping deal with some of the internal threats I discussed above. But for this to work we need to take certain actions soon.

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ENDNOTES

i Acupuncture itself is an enormously diverse range of practice methods and styles. Not only do we have multiple styles found in China, Japan, Korea, Europe, the US, Australia and so on, but, within a single style there are multiple variants. Take for example TCM acupuncture. This method started in China in the 1950s, yet within China one can find many variants. Once it started spreading outside China we start to see Japanese, Korean, American, European and Australasian variants (also within Europe there are many TCM variants: German, British, French, etc.). But TCM also includes herbal medical therapies, which themselves are also varied, with Chinese, Korean, Japanese variants. Further, in Japan it is illegal to prescribe herbal medicine without a medical qualification, thus TCM acupuncture there is not backed up with herbal medicine and has needed to adapt to a separate practice, which is much less common in China.[5] There is no clearly accepted term to refer to this broad range of treatment approaches. Recognising that this is not perfect I tend to use the term 'Traditional East Asian Medicine' (TEAM),[5] which is even starting to be used by Chinese authors. The act of naming acupuncture itself is extremely complicated and sometimes fraught with conflict, so that even defining an 'acupuncture profession' is not always straightforward.

ii Few acupuncture schools train their students in the scientific method, how to read science papers, understanding the evidence from trials and reviews, etc. The colleges in the UK and Norway are accredited bachelor programs and thus teach about this, but outside those colleges, few if any other schools seem to train their students in this. Consequently many in our profession have little or poor understanding of these issues. A recent survey revealed not much knowledge in the field among practitioners in Europe.[1] With regard to more scholarly debates, issues of translation and understanding texts from Asia (especially historical texts), in my experience and observation almost all of the acupuncture schools teach little or nothing about this, leaving a significant knowledge gap.

iii There is currently much more positive evidence from clinical research and basic science research about acupuncture than most of us are aware of. This situation has led to a much larger number of positive recommendations for the use of acupuncture from expert groups, national, and state health departments, health services than the field is aware of.[4]

iv In the UK, the acupuncture schools adopted this standard as it is the standard within the university education system in the UK and elsewhere.

v This is controversial because in Japan herbal medicine can only be prescribed by medically qualified practitioners since the 1870s.[5] As a consequence few acupuncturists in Japan use herbal medical type theory (TCM theory), or some of the diagnostic methods of herbal medicine (tongue diagnosis) and the patterns of diagnosis of herbal medicine (TCM and its variants).[2, 5]

vi The same will be true for other systems like Japanese Meridian Therapy, Korean Sasang and so on.