

Chapter 2

TCM and WM Collaboration in Chinese Healthcare Organisations

This chapter describes and discusses the context of this research project. To be more specific, this chapter aims to (1) provide a perspective on the context; and (2) enhance the contextual sensitivity, which is essential to the researchers in order to understand, contextualise, and interpret informants' responses. To achieve these two aims, this chapter discusses five contextual issues: the development and current situation of TCM, the development and current situation of WM, differences between TCM and WM, the structure of the Chinese healthcare system, and the patient-centred approach in Chinese healthcare organisations.

2.1 Development and Current Situation of TCM

According to Hyatt (1978), the origin of Traditional Chinese Medicine (TCM) is usually related to three ancient emperors in Chinese history: Fu Hsi, Shen Nung, and Huang Ti. Fu Hsi, the first Chinese emperor, who began his reign in 2852 BC, is recorded as the formulator of TCM. Fu Hsi was the author of the book *I-Ching* (Book of Changes), the first book in Chinese history, which contains some fundamental theories such as Yin-Yang and Ba-Gua, which are the cornerstones of Chinese philosophy and Chinese medicine (Ma 2009). Shen Nung, the second emperor, is known as the father of agriculture and herbal medicine. His contribution, the book *Shen Nung Pen Ts'ao* (Shen Nung's Herbal), based on his own experimentation and research on native plants, is the very first reference to herbalism in China (Hyatt 1978). The third emperor, Huang Ti, is credited with the invention of wheeled vehicles (chariots), ships, the planetarium, cloth clothing, currency, musical notation, and so on. He wrote the book *Huang Ti Nei Ching* (The Yellow Emperor's Classic of Internal Medicine), which was the most important and the earliest extensive work on TCM (Xu 2009). However, TCM was most probably developed by the collective knowledge and efforts of Chinese people, rather than these three legendary emperors alone.

The Han Dynasty, which flourished at the same time as the Roman Empire, represents the emergence of China as a world power. All kinds of scientific developments were cultivated and stimulated, including medical studies. In fact, the basic principles of TCM were fostered under the Han Dynasty (Hyatt 1978).

India was the first country historically to influence Chinese medicine, in the golden age of Buddhism, which was brought into China by Buddhist missionaries in the first and second centuries (Hyatt 1978). However, the influence of the Indian medical system was not well accepted by Chinese people, though it was not completely unsuccessful (Chi 1994). In fact, there seem to have been a number of foreign influences in Chinese medicine. For instance, the critically important theory of Wu Hsing (five elements), both in Chinese culture and medicine, originated in Greece and was transmitted to China by Indian influence (Hyatt 1978). As Buddhism became gradually accepted, these concepts also became widespread (Chi 1994). Beside Buddhism, Taoism was the other religion that had profound effects on Chinese medicine, from the formative years directly to the golden age of the Tang Dynasty (Hyatt 1978). Chinese medicine steadily developed and took a dominant position in the health care system until the end of the Qing Dynasty, the last dynasty in Chinese history, when Western Medicine entered China (Li and Liu 1992).

TCM dominated the Chinese healthcare system until the early twentieth century. Due to a loss of confidence in Chinese civilisation and its values after a series of defeats and humiliations by Western powers, the entire official health care system turned into modern WM, long before the establishment of the People's Republic of China (Chi 1994).

TCM was reintroduced into the health system after 1949 by the communist party, mostly for political purposes. As discussed in Chap. 1, the Chinese government used TCM as a strategic tool to distinguish the new communist China from its superstitious and feudal past as well as to illustrate the Chinese cultural heritage. Since then, TCM specialist hospitals, universities and institutions have been set up in various cities in mainland China (Hyatt 1978). The development of and researches on TCM were greatly improved by the new Chinese government. In 1954, both Traditional Chinese and Western medical communities were asked to collaborate in a study of integration of the two distinct types of medicine, which was unexpectedly successful (Hyatt 1978). The first mutual understanding between TCM and WM practitioners led to suggestions for the modernising (or developing) of TCM and the emergence of the Integration of Chinese and Western Medicine in the same healthcare system.

The Integration of Chinese and Western Medicine represents a new scientific medical system—distinctively Chinese—incorporating contemporary scientific methods and knowledge into the study, collation and exploration TCM in order to enrich current medical and scientific research (Yan 2006). Yan (2006) proposes that the basic purpose of research into the integration of TCM and WM is to combine advantages from both medicines and at the same time minimise apparent disadvantages. Even though many TCM professionals and researchers protest that it is virtually impossible to integrate the two very distinctive types of medical philosophy and methodology (Liu 2003), the movement towards TCM and WM integration has reinforced the coexistence of TCM and WM in the Chinese healthcare system.

It is important to note that some authors regard the modernisation of Chinese medicine and the Integration of Chinese and Western medicine as rather different. Lv (2005) states that the modernising of TCM is the development of traditional theories and methods and would occur even independently from integration with WM; however, the integrating process has accelerated the speed of modernisation. To support this statement, a number of research studies (e.g. Taylor 2004; Tian 2003; Fruehauf 1999) point out that the Integration of Chinese and Western medicine is one of the products, or one of the divisions, of the modernisation of Chinese medicine.

The definition of Traditional Chinese Medicine (TCM) widely used by current healthcare professionals and academics is: a modernised Chinese medicine, which includes not only the traditional views of TCM based on the accumulation of subjective understandings of healing throughout Chinese history, but also theories, concepts and practices that are newly developed nowadays on the basis of scientific investigation and exploration of ancient understandings (Li 2009). On the other hand, TCM is no longer just a medicine from the past but is also a medicine of the present as well as a functional medicine that plays an indispensable role in current Chinese medical care together with WM.

2.2 Development and Current Situation of WM

In contrast to TCM's basis in culture, religion and long experience, WM employs a scientific attitude in diagnosis and treatments (Dally 2003). Unschuld (1985) claims that achievements from intensive and evidence-based scientific research have brought WM to an unchallengeable dominant position in world health care.

In China, WM was first presented in the seventeenth century, to Emperor Kang Hsi (1661–1722) of the Qing Dynasty. However, the emperor considered it to be too revolutionary and a potential threat to the harmony of Chinese civilisation and, therefore, ordered its suppression (Hyatt 1978).

Modern WM was only successfully introduced and widely used at the end of the Qing Dynasty when it finally won its dominance in the Chinese public health care system (Chi 1994). The expansion of Western medical knowledge during the period from the 1840s to the 1940s had an immediate impact on Chinese healthcare theories and practices. Chinese considered modern WM as one of the new Western scientific wonders and viewed it as a sign of modernity and a vehicle to lift China from its feudal and antiquated practices (Unschuld 1985).

Despite its very high popularity and demand, WM remained a privilege of the upper classes, and access was very difficult for the common Chinese people (Chen 1989). Moreover, there was very little research and development in WM before the institution of the People's Republic of China. WM was fed mostly from advances made abroad and transferred from health practices developed in the West. In the period immediately after the foundation of the current Chinese regime, major developments in WM were mainly due to the reorganisation during the 1960s of the Higher Education (HE) systems and an institutional structure for teaching and

research in WM (Chen 1989). At the same time, the Chinese healthcare system was being built on the basis of an extensive network of hospitals and clinics, many of which actually provided both WM and TCM practices (Hillier and Jewell 1983).

In the late 1970s, China entered a new era in its history with a national policy reformation in order to propel economic development (Chen 1989). In this era, the Chinese healthcare system developed into a systematic structured healthcare organisation covering both urban and rural areas. Remarkably, WM and TCM became inseparably integrated into this structure with the basic intention of uniting the “old-style doctor” and those trained in modern methods, as suggested in the First National Healthcare Conference in 1950 (Hillier and Jewell 1983). At this point, it is worthwhile to recall that, as explained in Chap. 1, the coexistence of WM and TCM was politically decided and enforced.

Nowadays, TCM and WM healthcare professionals collaborate with each other and provide healthcare services on the basis of a complementary relationship, in which WM takes the primary position, being complemented by TCM as an alternative healthcare therapy. Although the TCM and WM collaboration has been proven beneficial to patients (Taylor 2004), the collaborative health service provision could be very complicated, because the two types of healthcare professionals adopt very different philosophical perspectives, theoretical foundations, and diagnosis and treatment methods.

2.3 Differences Between TCM and WM

The main difference of Chinese traditional medicine in relation to its Western counterpart is its adoption of a holistic concept of healing, which emphasises the integrity of the human body as a whole and its close relationship with the environment (Cheng 2000). In contrast, WM doctors are more interested in localised diseases or illnesses and the corresponding part of the human body. WM practitioners aim at healing that specific part of the human body rather than the more general problems of the patients (Dally 2003).

Moreover, TCM and WM have entirely different conceptual systems. For TCM doctors, the Yin-Yang theory¹ is an ancient Chinese belief and way of understanding the universe and is the most essential theoretical foundation to the practice of TCM (Cheng 2000). In contrast to TCM, which is based on Chinese ancient beliefs, WM is based on scientific paradigms and evidence-based research and is a combination of modern science and the art of healing (Warrell et al. 2005).

¹ Yin and Yang are “opposite but complementary qualities” (Maciocia 1989, p. 1). Yin represents inner and negative principles, such as cold, darkness, or passiveness. On the other hand, Yang stands for outer and positive principles, such as heat, light, stimulation, dominance, and dynamic potential (Eisenberg and Kaptchuk 2002). Cheng (2000) further points out that Yin and Yang are believed to be two interchangeable qualities of the human body. Therefore, the balance of Yin and Yang is the key factor of human health, and diseases result from imbalance.

Furthermore, the two types of healthcare methodology have completely different diagnosis methods. TCM doctors follow the ancient theory of Bian-zheng (distinguishing patterns) (Cheng 2000), which can be generally defined as “the process of identifying the basic disharmony that underlies all clinical manifestation” (Maciocia 1989, p. 175). To support the processes of Bian-zheng, TCM doctors apply four diagnosis methods to patients, namely: inspection, listening and smelling, inquiry, and palpation (Wang et al. 2004). Liu (2003) further points out that the TCM diagnosis mainly relies on the doctors’ professional experiences and personal understandings of Bian-zheng. In this case, it is very common for different TCM doctors to produce totally different diagnoses of the same patient (Liu 2003). In contrast, WM professionals investigate the problems of patients and make decisions based on the identification of accurate medical evidence and the employment of modern diagnostic technologies, such as x-rays, laboratory tests, and computed tomography (CT) (Fitzgerald 1990).

Additionally, TCM and WM professionals have very different treatment approaches to dealing with patient problems. In the TCM methodology, there are four main categories of treatments: herbal medicine (oral intake and external use); heat therapy (moxibustion and cupping); massage (oriental massage, Gua Sha and magnets); and acupuncture (Sherman et al. 2005). These methods used by TCM doctors are often considered as too unusual by those WM healthcare professionals who are following the doctrine of modern medical science. To them, patient treatments can be simply divided into two categories, namely: medication and surgery (Goldman and Ausiello 2008).

Finally, both TCM and WM approaches have different advantages and can be used for different purposes and different patient conditions. It is widely accepted in China that WM is more effective in the acute stage of many diseases and works much faster than TCM in treating these acute diseases (Ma 1999). However, it is also acknowledged that WM creates more adverse side effects (Kaptchuk 2000). Nevertheless, healing herbs, acupuncture, massage and other health methods from TCM may sometimes be perceived to be more appropriate in long-term health promotion, prevention, treatment, and rehabilitation. Moreover, TCM may be used as a last resort, when Western medicine is either too toxic or unable to provide any further expected benefit (Chen 1989).

Liu (2003) asserts that WM is a *hard science*, whereas TCM is an *empirical [soft] science*. Even though the two approaches are entirely different, the integration of the two healing beliefs into the Chinese healthcare system constitutes a unique therapeutic plurality, which is believed to be beneficial to patients, and which is only presented in the structure of the Chinese healthcare system.

2.4 The Structure of the Chinese Health System

As discussed in Chap. 1, and even though the structure of the Chinese healthcare system was a political decision, the inclusive and fully integrated healthcare system may have its unique advantages. These advantages are maximised by current

healthcare practices at multiple levels and distributed through the Chinese healthcare systems. According to “A Health Situation Assessment of the People’s Republic of China”, reported by the UN (2005), the Chinese healthcare system has a dual urban-rural structure, encompassing both medical and preventive care. However, sub-structures for urban and rural sectors are rather different.

In the urban area, hospitals are the centre of patient care services and are organised into a three-layered structure. Third level hospitals are run directly by the central authorities, with more than 500 beds providing tertiary care. These hospitals are usually equipped with advanced medical staff and equipment. Second level hospitals have 100–500 beds and provide full healthcare services to a district or a clearly defined set of communities. First level hospitals provide the most basic healthcare services of prevention, sanitation and essential medical services for a particular community. Guo et al. (2007) state that in the large majority of these hospitals, from the highest third level to the lowest basic community clinics, a combination of TCM and WM services is offered.

The rural health service system includes three levels: county level, township level and village level. County level facilities are hospitals, TCM clinics, and maternity and children’s hospitals. Basic healthcare centres and village clinics provide the health services at both township and village levels. Hyatt (1978) asserts that TCM is more widely used in rural sectors than in the urban sectors. This may be due to the fact that the majority of the rural Chinese population can explain and understand their illness in Traditional Chinese medical concepts rather than in WM ones (Lam 2001). Another more pragmatic reason may be related to the fact that in general TCM services are cheaper than WM (Zhang et al. 2007). Moreover, poverty is a critical problem in Chinese rural environments (Beach 2001) and TCM becomes a primary instrument in fighting against many of the poverty-related diseases (Tao 2005). In support of this, a survey undertaken by Zhang et al. (2007) on township level health services in 2005 found that 73.1 % (84 out of 132) of registered health practitioners are certified to practice TCM, 90 % (317 out of 352) of clinics have specialised TCM services, and 34 % (14985 out of 44063) of patient treatments were exclusively through TCM.

At the national level, according to official statistics gathered by the National Bureau of Statistics of China in 2005, 3792 (4.64 %) out of a total number of 81,742 health service organisations or clinics are exclusively dedicated to TCM services. Out of 4,929,481 healthcare professionals, 465,703 (9.45 %) are TCM healthcare providers.

It is clear that the current framework for the Chinese healthcare system tries to integrate the TCM and WM communities and health service professionals. The provision of healthcare services in different levels and types of healthcare organisations should be based on the collaboration of TCM and WM healthcare professionals aiming at serving the centre of patient.

2.5 Patient-Centred Approach in Chinese Healthcare Organisations

The patient-centred healthcare approach is a fundamental requirement for Chinese healthcare organisations and a basic guideline for healthcare practices. This approach has been widely recognised as an essential principle in improving healthcare services, guiding the behaviour of healthcare professionals, and developing a harmonious doctor-patient relationship (Zhong 2009).

In fact, the concept of patient-centred healthcare is not new in China. As discussed by Yao (2009), in ancient China, medical practices were referred to as “仁术 (ren-shu)”. This term consists of two characters: “仁” means benevolence, which is the ultimate aim for healthcare practices; “术” refers to the actions of medical treatment and care. Additionally, Yao (2009) claims that thousands of years ago Confucius advised that benevolence and patient orientation are fundamental rules for a healthcare professional.

As explained in Chap. 1, in 2006 the Chinese government decided to install patient-centred healthcare into the healthcare system (Zhong 2009). Thus, the patient-centred approach is politically required to be employed as the ultimate principle which must be followed by all healthcare professionals and healthcare organisations (Hu 2009).

The patient-centred approach has been intensely discussed by many Chinese health and hospital management researchers. In more detail, the current discussions on this approach are mostly around the three main actors involved, namely, patients, healthcare professionals, and hospital managers.

2.5.1 *Patients at the Centre of Healthcare*

In the traditional healthcare approach, healthcare professionals have almost complete power over the patients (Li et al. 2009). Very differently, in the patient-centred approach, patients are at the centre of healthcare practices and are the empowered party. In this case, patients have the liberty to select whatever medical methods they consider appropriate (Yao 2009).

In more detail, Li et al. (2009) provide a definition of patient rights in Chinese healthcare organisations:

- Patients have the right to be fully informed.
- Patients have the right to choose medical methods.
- Patients have the right to be treated equally to other patients.
- Patients have the right to protect their personality, dignity, privacy, and emotions.

However, in reality, the interests of the patient are probably not very well protected. Cao and Sun (2009) conducted a study which included 20 medical departments and 260 in-patients from a public hospital in North China. Findings of this study show that 18.2% of the patients did not understand the purpose of specific treatments;

14.6% of the patients were not informed about laboratory test results; and 2.2% of the patients did not even know their medical conditions (Cao and Sun 2009). Additionally, these authors state that health professionals only provide information when patients ask them to do so. These results indicate that healthcare professionals still hold the decisive power over patients, who are probably not at the centre and whose rights might not be very well protected.

2.5.2 The Role of Hospital Management

Successful implementation of the patient-centred approach depends to a certain extent on the attention and support of hospital management (Zhong 2009). Liu (2009) and Hu (2009) assert that hospital management must motivate all healthcare professionals to follow this approach, and must integrate this approach into all regulations and protocols, definitions of professional behaviour, and aims and objectives for all hospital operations.

Furthermore, hospital management needs to reform the traditional information management strategies, which currently only aim at assisting the administration and running of the hospital. Information management in a patient-centred hospital environment should be patient-oriented, and should aim at managing patient information and knowledge, such as patient medical information, medical history, personal requirements, and expectations (Zhang and Cang 2009).

However, many studies (e.g. Zhong 2009; Yao 2009; Zhang and Cang 2009) claim that the patient-centred approach has not been truly implemented, due to hospital management prioritising the pursuit of financial income and profitability. In order to understand this problem, the Chinese context must be explained.

As discussed in Wang (2008), in 1978, the Chinese central government decided to implement a market economy policy, which resulted in a significant market reformation from the planned economy² (the communist economic system that was adopted by the PRC for the first 30 years) into the socialist market economy³. The market economy policy substantially boosted the Chinese economy and has been widely recognised as one of the most important decisions in the Chinese economic reformation since 1978.

However, this national policy is not flawless (Wang 2008). Hsiao (1995) and Shao (2007) claim that under the market economy policy, the central government

² Under a planned economy system as defined by the Chinese Government (2012), “industrial production, agricultural production, and the stocking and selling of goods in commercial departments were all controlled by state plan. The variety, quantity and prices in every sphere of the economy were fixed by state planners.”

³ According to Qian and Wu (2000), the goal for the Chinese “socialist market economy” is to achieve the transformation to a market economy. The word “socialist” is an adjective to show special Chinese characteristics and to distinguish the system from the “market socialism” advocated by some Eastern European reformers in the 1970s and 1980s. The Chinese Government (2012) states that the socialist market economic system has now taken shape and will become comparatively mature in 2020.

significantly reduced funds and financial support to healthcare organisations and health services. Therefore, hospitals are relying on themselves to support all hospital expenses, include paying tax, updating medical equipment, and providing salaries for healthcare professionals. In these conditions, hospital management is pressed to give more attention to controlling costs and maximising income, but has very little concern about the patient's interests and needs (Zhong 2009). This author also points out that, to many hospital managers, patients can be seen as service consumers, whilst healthcare professionals are tools for hospital management to use in pursuing higher financial profits, rather than saving lives and curing patients.

2.5.3 The Role of Healthcare Professionals

Healthcare professionals are the ones who apply patient-centred care to patients (Yao 2009). The centre of the discussion that emerges from the current literature focuses on the dialogue between healthcare professionals and patients, in which healthcare professionals are obliged to keep patients and their relatives fully informed (Ju 2009). Additionally, Huang and Huang (2009) state that healthcare professionals not only need to communicate with patients in a polite and respectful way, but also need to respect the requirements, needs, and social and cultural backgrounds of patients in communication, treatment and periods of interment in hospital.

However, Ju (2009) claims that healthcare professionals do not take communication with patients very seriously. She points out that 30% of nurses did not know how to talk to patients and relatives; 33.3% of nurses choose to ignore patient requirements when they are difficult to achieve; and, finally, 80% of medical accidents resulted from lack of communication. These figures show that healthcare professionals are probably not following the patient-centred approach.

Similarly, Yao (2009) demonstrates the results of a research project conducted by the Chinese Ministry of Health and aimed at evaluating the implementation of patient-centred care in six Chinese provinces. Astonishingly, only 54.11% of healthcare professionals admitted that they were following the patient-centred approach; 46.3% of professionals considered technical skills were the centre of healthcare; 31.34% of them admitted that they were practising medicine for their own benefit (e.g. salary, bonus, career progressions); and 22.56% of them claimed that care should be centred on the development of the hospital. Clearly, the implementation of the patient-centred approach was unsuccessful.

2.6 Summary and Discussion

Despite the significant differences between TCM and WM, the two approaches have been successfully integrated into the current Chinese healthcare structure and form a complementary relationship, in which WM takes the primary position,

complemented by TCM. As perceived, the collaboration of the two very different types of healthcare professionals could be very beneficial to patients and should be centred on patients.

All healthcare professionals and healthcare organisations in China are expected to follow the patient-centred healthcare approach. Certainly, TCM and WM healthcare professionals should protect the benefits, requirements, and rights of patients consistently and unconditionally throughout all collaboration stages and processes.

However, the review of literature shows that the patient-centred approach has probably not been successfully adopted and fully implemented in Chinese healthcare services. The rigours and requirements of the patient-centred approach are not fully satisfied by healthcare professionals. Moreover, it is reported that patients are unaware of the patient-centred approach and are almost unable to maintain their rights and requirements when receiving medical services. Additionally, and very disappointingly, the literature review has not found any materials reporting how the central role of the patient is maintained in the collaboration of TCM and WM healthcare professionals.

Furthermore, although, as explained in Chap. 1, the interaction of patient knowledge between healthcare professionals is one of the most essential requirements of patient-centred care, communication and KS between healthcare practitioners in Chinese hospitals are not well reported in existing literature. Thus, despite the recognition of communication problems in TCM and WM collaboration, there is a very limited body of literature discussing these problems and reporting the barriers to communication.

Therefore, at the beginning of this research project, and due to the lack of existing explanatory theory and studies, it is essential to review literature about the definition of knowledge and the definition and models of KS in the healthcare environment, the reality of KS implementation in Chinese healthcare organisations, and KS barriers identified by research studies conducted in the past. Reviewing these issues has allowed the researchers to acquire a relatively good understanding of the theory around KS, establish the necessary background for the exploration of KS barriers, and enhance theoretical sensitivity. These issues are discussed in the following chapter, Chap. 3.

Knowledge Sharing in Chinese Hospitals
Identifying Sharing Barriers in Traditional Chinese and
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