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A qualitative study of classical Chinese medicine in community health focusing on self-care: practitioner and staff perspectives

Alaia Harvie ^{a,*}, Amie Steel ^b, Jon Wardle ^b^a Faculty of Health, University of Technology Sydney, Ultimo, Australia^b Australian Research Centre in Complementary and Integrative Medicine, Faculty of Health, University of Technology Sydney, Ultimo, Australia

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ABSTRACT

Background: Classical Chinese medicine (CCM) encompasses many simple lifestyle recommendations which can be adopted into daily routines in support of short and long-term health outcomes. The rise in non-communicable diseases (NCDs) globally in recent decades has led to a need for cost-effective and scalable health care interventions to address lifestyle risk for NCDs in the community. This analysis explores the experience of staff and practitioners delivering a CCM community health care program designed to improve health behaviors in the community in rural Scotland.

Methods: A qualitative study employed semi-structured interviews with a sample of program practitioners and staff (n = 7). Informants were asked to share their experience in delivering the CCM program. Emergent themes were identified via analysis using the Framework Approach.

Results: Themes emerged from the data in three key areas: Cultural challenges within the local region; Integration with the existing local health care network; and Team dynamics, co-creation and communication integrity.

Conclusion: This study highlights the importance of accessibility, integration, networking, secure funding and team unity in the context of community health program delivery, as well as noting a diversity of practice among Chinese medicine practitioners. CCM concepts may hold potential for integration into community health, however, further research is warranted.

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1. Introduction

In response to the global rise in non-communicable disease (NCD), there has been a call from the World Health Organization (WHO), for, cost-effective and scalable health intervention strategies which promote behavior change.¹ Such change is most effectively adopted and sustained when supported by integrated community-based approaches which incorporate a range of intervention strategies.² Easily adopted health care practices that can be incorporated into daily routines and largely align with current WHO recommendations¹ are found in many traditional cultures and their traditional medicine systems, including that of Chinese medicine.^{3,4}

A number of foundational texts, largely recorded in the Han dynasty (206BCE–220CE), have had considerable influence on the transmission of Chinese medicine throughout the past two thou-

sand years and convey principles by which to not only practice medicine but also by which to live.^{4–6} These principles, recorded in texts such as the *Dao De Jing* (Path of Virtue) and *Huang Di Nei Jing* (Yellow Emperor's Inner Classic), express an interweaving of Daoist, Buddhist and Confucian schools of thought, reflective of the cultural matrix of the time.⁷ Passages from the *Huang Di Nei Jing* also provide background to specific lifestyle practices, historically common to Asian culture, such as: following patterns of rising with the sun and taking to rest with the sun; undertaking strenuous activity in the earlier part of the day; taking a midday rest; adapting one's diet and patterns of dress according to the seasons and one's constitution; acknowledging one's place within the greater environmental and social context; and maintaining a balanced emotional perspective on life.^{4,7–9} Similar lifestyle principles have been reflected in numerous traditional cultures around the world and are suggested by those who follow them, to be associated with health, longevity and sustained vitality.³

Within the Chinese context, certain sources are described as 'classical texts' due to their historical dating and the translation of the term *Jing*, in their title, which denote them as being considered foundational content for the field.¹⁰ The principles espoused

* Corresponding author at: University of Technology Sydney, Faculty of Health, Level 7, Building 10, 235 Jones St, Ultimo, NSW, 2007, Australia.
 E-mail address: aharvie@protonmail.com (A. Harvie).

in these records continue to hold influence on the modernized practice of Traditional Chinese Medicine (TCM),¹¹ however, the detailed and nuanced approach, described in the classics is suggested by some within the field to be incomplete in the TCM construct.^{12,13} It is against this backdrop that the term Classical Chinese Medicine (CCM) has thus been emerging to define a field of Chinese medicine practice which aims to draw more consistently on the principles and specifics detailed in the classical texts.^{13–17}

Within the published literature, lifestyle recommendations, which draw heavily on CCM principles, have primarily been evaluated when delivered alongside a course of acupuncture and have been found to be associated with increased self-efficacy^{18,19} and increased patient empowerment.²⁰ Furthermore, improvements in self-efficacy and self-care were found to be associated with a longer-term reduction in pain at 12 months post-intervention.^{18,19} A number of studies have evaluated self-care techniques, such as acupuncture or moxibustion, for bio-medically defined conditions,²¹ however, there has been little investigation into how the TCM/CCM framework might be applied in the community context in settings outside of Asia or the Asian diaspora.²¹

The success and sustainability of new community-based programs has been found to be influenced by numerous factors including the level of local integration and community engagement achieved²² and may also be considered to be influenced, from a creative and inclusivity perspective, by the degree of intuitive leadership, unity and flexibility within the delivery team.^{23,24} Such aspects may hold particular value in respect to programs which adopt elements from outside cultures, such as that of a CCM program, delivered in a regional area of the United Kingdom (UK).^{25,26} Although the co-existence of multiple medical systems exists within the UK context, the dominant healthcare system in the UK, as delivered through the National Health Service (NHS), differs somewhat in its overarching framework to that of the CCM approach.²⁷ The aim of this study is to examine the experience of staff delivering a community-based program in the north of the UK, in regional Scotland, that focused on promoting health behavior change by sharing knowledge with participants based on self-care principles drawn from CCM. An applied research approach²⁸ was implemented to explore the staff experience, inclusive of both administrative and practitioner feedback, in order to: assess the impact, if any, of the program on the health and wellbeing of participants; examine the staff perception as to the practicality and feasibility of the program; and to examine any other themes which might emerge from the interview data.

2. Methods

2.1. The context of the analysis: the CCM program

A community health care program, based upon CCM concepts, was implemented in a small town in the Highlands region of Scotland. The program ran between November 2015 and September 2016 and was primarily supported by private donor seed-funding. The program focused on initiating and supporting pro-active self-care in participants' daily lives, through the teaching of daily lifestyle practices. Key to the program was a focus on educating participants about the potential influence of each CCM practice on individual health.

The program was delivered through a paid membership approach, allowing open access to any number of different classes being held at the program center throughout the week. Most classes were based on CCM concepts that focus on adjusting periods of rest and activity to align with the natural rhythm of a day and incorporated a routine of simple practices to be adopted at morning, midday, late afternoon and prior to bed. There were also classes on

topics of interest such as dietary therapy from the context applied in TCM, or the practice of drinking tea, such as green, oolong, or pu'erh tea, which is considered within Chinese culture, to support cleansing, nourishing or digestive health, respectively.^{29,30} Other classes focused on non-CCM exercise, including aerobic and stretching routines. Low-cost acupuncture and/or biofeedback treatments were available with membership, which also included a one-on-one monthly appointment with a practitioner trained in the CCM concepts. In this appointment practitioner and participant would review the participant's health status and co-create a health focus and lifestyle adjustment plan for the coming month.

The organization ran three pilots of the program between November 2015 and September 2016. The initial program had 50 participants enroll, with smaller numbers on the subsequent two programs. Digital monitoring was incorporated into the program as a self-reflective tool for participants and was achieved, in the initial pilot, via a wristband fitness tracker worn by participants for up to 3 months. This was also used as a method to monitor participants' adherence to the lifestyle routine suggested. On the two subsequent pilots digital monitoring was implemented via monthly readings from a biometric machine, based at the program center. The third pilot focused on providing support for those with a biomedical diagnosis of diabetes (type 1 or type 2). Over the ten months of the program, a number of key staff members were involved on a full-time basis, from initial program concept and design, through to delivery. Other staff members were employed after the program had commenced and were primarily involved on a part-time basis in administrative roles.

2.2. Methodology

Semi-structured individual interviews were conducted, by AH, with staff involved in administration or delivery of the program. [Supplement A]. Ethical clearance was granted by the University of Technology, Sydney, Human Research Ethics Committee (registration number ETH160459). Formal written informed consent was obtained from all participants.

2.3. Participant selection

All program staff (n = 9) (inclusive of practitioners, management and administrative personnel) were contacted via email and invited to interview, by the researcher (AH) in September–October 2016, with the exception of three staff members who were not contacted as their contact information was not provided by the organization. Of those contacted, seven agreed to participate in the study and were interviewed at a time and place preferred by the participant (e.g. cafe, meeting room, participant home). Interviews had no set time limit and lasted for 25–70 min. All interviews were conducted between 31 October and 5 November 2016.

2.4. Researcher background and relationships

Most staff interviewed were introduced to the researcher three months prior to interview, with the exception of two online meetings and brief email communication between the researcher (AH) and program manager six to twelve months prior. Additionally, a pre-existing professional relationship as co-workers existed between the researcher and two participants two years before the study.

The primary researcher had a background of 20 years' experience in studying and practicing 'Chinese medicine', as it is currently defined by the national regulatory board in Australia, and is a registered Chinese medicine practitioner and educator in Australia. All staff interviewed were made aware of the researcher's role as an investigator; however, they were only made aware of the

Table 1
Staff interviewee characteristics.

Roles	Age Range	Personal engagement with CCM practices	Gender
Managerial - 1 Administrative - 2 Practitioner - 4	Youngest – 32 yrs Eldest – 50 yrs	Managerial/Admin – 2 engaged casually for up to 1 year, 1 didn't engage Practitioners – 2 engaged regularly, over years; 1 engaged regularly over months; 1 engaged casually, over months	F – 4 M – 3

researcher's background in classical and/or traditional Chinese medicine if a shared context of understanding became relevant to the discussion.

2.5. Interview structure and administration

Semi-structured interview questions were used to guide the researcher during interviews. Participants were invited to describe their experience of delivering the program and provided opportunity to introduce new items as they felt appropriate. Interviews were digitally recorded, de-identified and transcribed verbatim by a transcription service, and re-checked and edited by the interviewer to ensure accuracy. Field notes were made during interviews and used to note prompts for further questioning on comments of interest rather than used as additional data.

2.6. Data analysis

Transcribed interviews were imported into NVivo 11 software for analysis and coding by AH and AS. Themes were derived from the data, using the *Framework Approach*, which involves a process of *data familiarization, framework identification, indexing, charting and mapping*.²⁸ This applied research approach draws from the direct experience and observations of those studied whilst also allowing for the objectives to be set out in advance.²⁸ Quotes were selected based upon their representativeness of the theme. Participants were not provided an opportunity to give feedback on the findings.

3. Results

3.1. Interview participant characteristics

Of the seven staff interviewed, one was in a managerial role, two were administrators and four were practitioners. Of the practitioners interviewed, three delivered the CCM core program, as well as acupuncture treatments (n = 2) and/or Western style fitness (n = 1) sessions, while one practitioner delivered bio-resonance treatments only. The practitioners who delivered acupuncture had over 10 years' clinical experience and were registered with the British Acupuncture Council. Similarly, the Western fitness instructor held formal qualifications and background experience. The bio-resonance practitioner was newly qualified and had a background in working in community health programs. Of the three teaching practitioners interviewed, two reported personally engaging with CCM practices on a daily basis, for over a year or more, and one had only become aware of the practices over the previous few months. Personal engagement with CCM practices varied amongst administrative and managerial personnel. Interview participants were aged between 32 and 50 years. Four were female and three male (Table 1).

3.2. Key themes

Themes emerged from the data in three key areas: *Cultural challenges within the local region; Integration with the existing local health care network and Team dynamics, co-creation and communication integrity.*

3.2.1. Cultural challenges within the local region

Delivery of the CCM program was perceived by staff to be challenging within the local region it was based. However, program staff perceived a positive potential in the program, with this view more pronounced amongst those who engaged with CCM practices personally and had experienced positive health outcomes as a result. Some staff noted the routine of practices throughout the day was difficult for them to personally integrate, both logistically and culturally, resulting in their adoption of smaller components of the program or simply taking inspiration from the concepts.

I still do that in my life, [the midday rest], and sort of, being more in touch with biorhythms, so I didn't join in the formal sense, but I did totally take inspiration from what was happening. (WG-Practitioner)

A sense of self-awareness, reflected by some staff in relation to the potential impact of the program's cultural differences, seemed to contribute to varying recruitment approaches to attract participants to the program. One member of administration personnel commented that the online information was sparse on details in an attempt to capture a broader cross-section of the community.

The approach that we had on the website, and our materials, was that we were skirting around the fact that what was being offered was classical Chinese medicine. There was no mention on the website of acupuncture treatments or anything. So, through that, people perhaps saw a vagueness to it. (RK-Management/Admin)

Having a pre-existing philosophical understanding or experience of the CCM concepts appeared to predetermine staff having a positive and enthusiastic vision of the program's objectives. Similarly, community participants who remained on the program were noted by staff to be those who already had some positive experience with alternative health practices, or to be those who had prior knowledge of the program teachers.

Practitioners also reported that other participants, for whom the CCM content was more unknown and who had enrolled with initial enthusiasm in response to sponsored places or direct recruitment techniques, did not often remain on the program for long. One practitioner suggested that clear communication at sign-up, in terms of clarity as to the associated time, effort and commitment required from participants, as well as a stronger focus on relationship building between practitioners and participants, after sign-up, may have resulted in more long-term engagement.

They hadn't necessarily thought through in a practical way what it would mean in terms of dedication of time and commitment. I think there was then a gap between an initial excitement and a realization that they would need to take some responsibility themselves, which is the whole idea of the program, over these months, for transforming their lives. (AQ-Practitioner)

Variability in treatment delivery – perhaps attributable to cultural influences – was also seen in delivery of acupuncture treatments between treating practitioners. The treatment styles of the two most regularly scheduled acupuncturists were reported by patients, via administrative staff, to differ considerably. This variability in treatment approach was seen to impact administrative

and record-keeping processes as well as alignment of the practitioner team in working together.

[In the design of the intake forms] I was trying to capture enough information to work with, in their consultation, based on three very different styles of treatments, for the three different [acupuncture] practitioners. (YU-Practitioner)

It's very clear to me that when Chinese [medicine] practitioners talk about what they're doing, and that when a fellow Chinese medicine practitioner may be using the same language, our understandings may be completely different. . . So, on a basic level, to create a team that can really work together, that takes time. (AQ-Practitioner)

This heterogeneity also extended to the teaching of the CCM lifestyle content. Administrative staff noted that feedback from class participants suggested that practitioners new to the program's interpretation of CCM concepts were less effective in delivering the content.

Ideally [the teaching practitioners] sign up to practice [the exercises] themselves personally every day. . . That's kind of a two month, three month, kind of process . . . [It's important] because . . . If they haven't done the [practical work], they won't know how to explain it, or to support someone when they're going through those transitions. (YU-Practitioner)

Practitioners who had worked with the CCM practices for years, however, expressed that although experiential engagement with the practices was important, any health care practitioner could become competent in the CCM teachings within a few months of training. Elements which were perceived to lead to effective teaching strategies for those from other health care fields included: preferencing English terms, over CCM terms, for key concepts, for example, using the term *duality* rather than *Yin-Yang*; recognizing and discussing that the practices have a relationship with cycles observed in nature; having a personal resonance with the concepts; and adopting flexibility in delivery.

3.2.2. Integration with the existing local health care network

Although the program obtained some local support, in the form of grants for a small number of sponsored patient places, and business support and training, in relation to integration of personal digital-monitoring devices during the initial pilot, it was felt the program failed to gain adequate traction with the existing local health care system. One practitioner commented that the team would have benefited from having a general practitioner or nurse within the practitioner team, and/or from having a connection via an NHS referral pathway to provide profession-based and recruitment support and to elevate the profile and credibility of the program. Interview participants noted similar local health and well-being programs being run at the same time and which had NHS funding, were able to invest comparatively more resources into planning and community consultation prior to onset, as well as establish more robust networks, due to having an NHS intermediary; aspects which were recognized as necessary but not as comprehensively integrated in the CCM program design. One practitioner, co-working on the community based NHS project, summarized the proactive consultation approach adopted in the NHS funded model:

I think what they're learning is, we can have ourselves a really good model and idea, and game plan, an idea that people come into, but life doesn't always work like that. We're going to meet in the middle and go out and really listen: What do you want?; What do you need?; What do you love?; How can we support you?; and these are our tools that we're offering, but, what else would you like? (WG-Practitioner)

3.2.3. Team dynamics, co-creation and communication integrity

A significant challenge faced by the majority of staff during program delivery was the perceived variation in integrity and consistency of internal and external communications. Miscommunications and delays in contact (between investor and management; between management and staff members; and between staff and participants), funding interruptions and changing timelines were reported by many staff to have increased stress levels and to have affected the majority of staff during various stages of program delivery. Additionally, the extent of collaboration and connection within the internal team was felt to vary, with one staff member noting that although an idea of a co-creative environment was espoused, structured hierarchal working relationships appeared to dominate during times of pressure.

I think the co-creative atmosphere is what we wanted, but I don't think there was anyone who had experience of it. There were a lot of different backgrounds there, that were working together, but all of the backgrounds were already based from a structured regimented environment. (PY-Practitioner)

In contrast to stated differences, a strong sense of collaboration and personal investment was noted during the project's initial phase, wherein personal resources (later reimbursed) were invested by three staff members.

I think, in some ways that was part of the strength, because when you're putting your cash in . . . people who are volunteering, or people who have given some personal risk, have a different relationship from people who are being paid and being employed. I noticed that that provided a strong collaborative culture in the initial phases. (AQ-Practitioner)

4. Discussion

To the authors' knowledge, this is the first study to examine a community health program, incorporating a whole-systems³¹ Chinese medicine approach, to be delivered in a Western setting. The emergent themes resulting from our analysis of this project highlight a number of key issues relating to the delivery of such a program outside of Asia or the Asian diaspora.

4.1. Chinese medicine: influences and variability in modern application

Chinese medicine research, outside of Asia, has to date been heavily focused upon studies of isolated treatment techniques such as acupuncture,³² moxibustion,^{33,34} herbal medicine preparations,^{35–40} or practices, such as Tai-Chi^{41–43} and Qigong,^{44–47} which are primarily applied, in isolation, as interventions to patients within bio-medically defined disease categories. This is the case when the intervention is applied to the patient, by the practitioner or research assistant, as well as in studies of Chinese medicine self-care approaches.²¹ The traditional practice of Chinese medicine, however, especially prior to the field being redefined as 'TCM' in the 1950s,¹⁵ has for many centuries drawn on classical concepts that incorporate a whole-systems approach to patient care and illness management.⁷

Of the three Chinese medicine registered and UK trained practitioners delivering aspects of the CCM program evaluated, data from our study indicated a difference in practitioners' interpretation of TCM/CCM concepts and in use of TCM/CCM terminology, as well as in acupuncture treatment styles. Although variance is to be expected within any professional field and has also been the case historically within Chinese medicine⁴⁸ these divergences in modern application may also be reflective of a disconnect between the modern practice of Chinese medicine and the whole-systems

approach which is both a construct in TCM,¹¹ as well as reflected in TCM's classical roots.^{4,7} In order to create coherence and consistency in health programs aiming to incorporate a whole-systems approach, such as that of a multi-faceted CCM program, adequate time should thus be allocated for practitioners to be trained and oriented to relevant concepts and terminology, as defined by the program, as well as time taken to orient researchers and readers to the paradigm of the intervention.

4.2. Program viability, integration & sustainability

Diversity in practitioner approach may have also influenced program viability which was additionally perceived to be impacted by: varying community interest and acceptance; un-sustained engagement from some participants following initial sign-up; a lack of ongoing financial support and/or financial sustainability by end-date; and limited integration with the existing health care network. The interactive and individualized approach to self-care incorporated in the program design is reflective of the nature of TCM self-care guidance delivered within TCM acupuncture consults, which has been shown to be associated with positive benefit to patients' long-term self-care and quality of life.¹⁸ Similarly, in a cross-sectional study of over 25,000 primary care patients in the United States, it was found that programs which focused on patient activation were most effective when: 1) focusing participants on skill development and reflective questioning and 2) when support staff tailored levels of encouraged change to align with the individual's own perceived ability to adopt change.⁴⁹ Future work in the area of CCM self-care may thus benefit from incorporating active enquiry and feedback systems in the early stages of a program, to ensure that individuals feel supported at a level appropriate to their individual circumstances and to counter participant withdrawal. Recommendations from interview participants for the allocation of further resources to the start-up phase and for incorporating a broader range of health care professionals within the core team, including, where possible, physician involvement, also aligns with data which has shown these to be key factors in the sustainability and success of community health programs.⁵⁰

4.3. Classical concepts, community health and connection

Our study found that staff and practitioners were perceived to be most effective in delivering program objectives when they engaged extensively with the practices and felt a personal resonance with the CCM concepts at the heart of the program: namely that the human body can be viewed as a microcosm of the macrocosmic natural world; and that by observing and following natural planetary rhythms we can draw methods of self-care and health maintenance, beneficial both to the individual and to the community.⁷ These concepts – as perceived by staff in our study – align with the stated philosophies of many systems of traditional and Indigenous medicine throughout the world,⁵¹ which acknowledge the importance of interrelationship with the natural world and promote activities, and an environment, in which the health of the community, and those who live within it, are harmoniously supported. Thus, these philosophies align with the objectives of community health.⁵² Furthermore, direction relative to teamwork and ethical and intuitive leadership can also be drawn from concepts inherent to CCM, and traditional cultures, to enhance project success: aiming for practitioner teams which embody ethics, compassion and empathy⁷ and team environments which create unity by considering the context, perspectives and values of all involved.²³

4.4. Limitations

Selection bias is a limitation, as only nine, of the twelve staff who had been engaged with the program, were contacted and invited to interview. As such the data gathered may have held bias towards staff members who had a stronger reason to maintain a working relationship with the program and its funding organization. There was also a previous working relationship between the researcher and two of the interview participants, potentially influencing the nature of data gathered from different participants. The relatively short duration of the program and its small number of participants are also limitations, as is the complex nature of the program, which included many aspects of intervention. While these are limitations for examining of the program itself, they are ideal for looking into the issues associated with establishing a new program and this study brings forth some important insights into working with CCM concepts in community health and the challenges of integrating non-conventional medical approaches in community programs.

4.5. Conclusion

This study highlights the challenges inherent in delivering a CCM program in a regional Western setting and has implications for future research in that the results obtained may be used to guide future programs in this area. CCM has a philosophical underpinning that is conducive to its integration into community health, but accessibility, integration, networking, ongoing funding and unity must be carefully considered and addressed when integrating CCM community health approaches in Western settings. The diversity of practice which may be found amongst CCM practitioners could also present challenges and highlights the need for adequate planning, appropriate timelines and stable resources, in order to achieve effective program delivery.

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Author contributions

AH conceived the study. AS, JW and AH designed the study protocol. AH conducted the research and drafted the manuscript. All authors contributed to revising the manuscript and have read and approved the final manuscript.

Conflict of interest

The authors declare no conflict of interest.

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Ethical statement

Ethical clearance was granted by the University of Technology, Sydney, Human Research Ethics Committee (registration number ETH160459). Formal written informed consent was obtained from all participants.

Data availability

Data are not available due to ethical considerations.

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