

# A Consumer's Reflections on Traditional Chinese Medicine and Traditional Western Medicine

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## ABSTRACT

This article presents a consumer's reflections on traditional Chinese medicine and traditional Western medicine, with a particular focus on the processes in the relationship between the practitioner and the consumer. It does not engage with the broader debates about efficacy and 'scientific validity'. The article aims to show why it is important to listen to patients-as-consumers about their experiences of health services. It is informed by contemporary scholarship that sees consumer participation as an ethical practice, and as essential to compliance with treatment and service effectiveness. The article uses an auto/biographical methodology that is consistent with encouraging consumers' participation in health and welfare services, and in evaluating interventions beyond narrowly-defined outcomes, experimental designs, and randomised controlled trials. This personal narrative is a reflection on experiences over at least 10 years of receiving health services from practitioners of traditional Chinese medicine (TCM) and traditional Western medicine (TWM) in a large regional town in eastern Australia. Differing models of health, intervention, and the relationship between practitioners and consumers, influence individual practitioners' approaches to consumers. Recommendations are offered on how listening to a consumer's experiences may improve professional practice in health services.

**KEYWORDS** consumer participation, traditional Chinese medicine, traditional Western medicine, professional practice, auto/biography, narratives.

## Introduction

This article presents a consumer's reflections on traditional Chinese medicine (TCM) and traditional Western medicine (TWM), with a particular focus on the processes in the relationship between the practitioner and the consumer. It aims to show why it is important to listen to patients-as-consumers about their experiences of health services that may offer insights to health professionals in regard to the processes, if not the outcomes, of health care. This personal narrative is a reflection on experiences over at least 10 years

of receiving health services from practitioners of TCM and TWM in a large regional town in eastern Australia. The article does not engage with the broader debates about efficacy and 'scientific validity'.<sup>1-3</sup>

There is substantial literature from a range of disciplines and professions on the importance of consumer participation in health and welfare services.<sup>4-12</sup>

Consumer participation may be condensed into two main aims: (1) As an end in itself: Professional ethics may espouse consumer participation, promoting values such as 'greater inclusion' and

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empowerment';<sup>13</sup> aiming to equalise power and minimise hierarchy between service users and professionals, and to increase professionals' empathy for service users' experiences.<sup>14</sup> Ethical practice aims to be collaborative, to show respect for consumers' knowledge, values, beliefs, and strengths;<sup>15-17</sup> and perhaps more controversially, 'to explore (and critique) implicit assumptions that may be inherent within traditional professional value bases'.<sup>18</sup>

(2) As a means to an end: Consumer participation is promoted to foster patients' independence and self-management;<sup>19</sup> and where professionals through 'interactive knowledge',<sup>20</sup> gain a better understanding of the patients' experiences allowing specific goals to be set, appropriate therapeutic interventions, and in some professions, like physiotherapy or occupational therapy, to be able to measure outcomes.<sup>21-2</sup> The ultimate aim is to maximise compliance with the interventions.

Consumerism as an approach to participation may be critiqued as 'merely concerned with rights', appearing to give equal or greater weight to patients-as-consumers than to professionals and their expertise.<sup>23</sup> There is also a tendency to perceive professional services as a commodity similar to material goods with related attitudes to quality and satisfaction. There are also legal liabilities for duty of care confronting professionals associated with their perceived greater expertise that may temper how consumers may participate in various health services.<sup>24-5</sup> So, while this article aims to show why it is important to listen to consumers of health services, it is also mindful of the complexities associated with differences in expertise derived through formal education and personal experience. The article examines personal experiences of the practitioner-patient relationship (process), and suggests ways to improve professional practice in health services that would not disrespect professional expertise.

## Methodology

Auto/biographical approaches such as narratives or storytelling are useful to find out people's perspectives in a range of areas, for example, their experiences of problems,<sup>26</sup> participation in health interventions as processes, and evaluating outcomes.<sup>27</sup> Stanley<sup>28</sup> has argued that writing about the self cannot be separated easily from writing about other's lives, for which the personal story has resonance. Sometimes narrative approaches involve a researcher retelling the stories of participants, for example, 'delinquent girls' life stories' connecting 'their public actions ... and their private lives, [including] sexual abuse by family members',<sup>29</sup> or 'life story work' with ex-prisoners with an intellectual disability.<sup>30</sup> However, a narrator can also tell stories about her

own experiences, for example, as a practitioner reflecting on her practice, implementing disability policies.<sup>31</sup>

Narrative approaches do not mean that an individual's story is an exact fit to others' stories. However, there is potential in generating more stories told from a range of perspectives, that may both resonate and differ so that wider human experience can be understood. Whether the story being told is about the self or about others, a single case-study allows for in-depth examination of individual cases; generalisation is inferential and impressionistic,<sup>32</sup> with the findings relatable to broader social patterns.<sup>33-4</sup>

The criteria of trustworthiness applied to scientific studies are not applicable to narrative approaches.<sup>35</sup> Instead, credibility is demonstrated by showing that 'reality' is represented in a meaningful way in re-presenting lived experiences. Transferability of knowledge is achieved through asking what can be learnt from the everyday experiences recounted. While the replicability of an individual story is not possible, nor is it the aim, it is possible to generate more stories on the same topic to expand knowledge beyond the single story. Objectivity is not possible, due to the positioning of the research participants within their own stories, and in this case, of the narrator telling her own story. Nor is objectivity desirable, if the aim is to generate knowledge from human experiences to improve professional practice, while recognising that there may be multiple perspectives of the same 'facts' influenced by different personal histories, biographies, and institutional location, such as being a 'health practitioner' or a 'patient'.

This article does not identify where the experiences being narrated have occurred and therefore protects the identities of third-parties. The experiences of users of health services will be recounted using topic headings that are relevant for professional practice. The author's awareness of the differences between TCM and TWM has emerged over the years, as help has been sought for chronic health problems. It has not been a planned, systematic comparison between the two models of health care. Instead, as a patient of health care provided by TWM and TCM practitioners, awareness of the differences has generated a personal interest and reflection on the experiences, including how the experiences have differed and why they have been experienced as different.

The author's perspectives are significantly influenced by her professional affiliations and experience over more than 30 years: as a professionally-qualified social worker with experience in direct service provision to children and families; in policy and programme development and research; and as an academic and qualitative researcher at several Australian universities where she has taught in social work programmes.

## 'Helping people': relationships between practitioners and patients

Professional 'helping' generally involves stages that are common to most professions, although they may be named differently. The stages include: (1) finding out what the problem is (why has the patient come to see you?); (2) naming the problem (or, making a diagnosis); (3) offering help in various forms (material, technical, therapeutic, pharmacological, 'talk'), depending on the profession; and (4) some method of ascertaining effectiveness, that may include telling the patient to return if the problem is not resolved and conducting various diagnostic tests. Within this framework, this article reflects on the key differences between TCM and TWM by focusing on: (1) finding out what the problem is; (2) categorising the patient as 'sick' or 'unwell'; and (3) perceptions of effectiveness.

### (1) FINDING OUT WHAT THE PROBLEM IS

The amount of time allocated to patients differs significantly between TCM and TWM. TCM practitioners typically spend up to an hour on a first consultation that may include treatment, with subsequent consultations for about 40 minutes, again including some treatment. However, treatment is only provided after a detailed consultation about the patient's description of the problem. The TCM practitioner asks a lot of questions to clarify the qualitative aspects to explore whether the patient has symptoms that he or she has failed to mention, and to ascertain life circumstances that may influence the problems being experienced. This in-depth questioning occurs even after the initial consultation as, it appears to me, there is an expectation that the problem may have changed since the previous visit. The patient's circumstances may also have changed. It is also a way of checking on the effectiveness of the previous intervention.

This experience with TCM differs considerably from consultations for TWM. In TWM, the GP tends to work to a tight schedule, with expectations that each patient will be finished within 15 minutes. This approach tends to hurry the patient along, with little time for the practitioner to ask in-depth questions. The time allowed for each patient with a large number of patients still waiting to be seen can communicate an impatience and a subtle 'hurry up'. I have had the experience of telling a GP about one set of symptoms which we discussed, after which she stood up, ready to show me out of her office. I was embarrassed to tell her that I still had more to discuss, and then felt like I was taking up her time or even wasting her time with 'trivial' ailments. There are also legal requirements on GPs that may disrupt their tight schedules, as on one occasion, when the news went round a waiting room that a patient had presented with yellow fever that necessitated a

substantial amount of work and that was the cause of lengthy delays for other patients. This is clearly not the GP's fault and the scheduling that expects a 'standard' consultation can be completely disrupted by one non-standard consultation.

I have been told by GPs that my symptoms do not make sense – because the recounting of various aches and pains and other signs of being unwell do not readily coalesce into a pattern that can be diagnosed. It may well be that I have omitted to tell about something that I believe is unimportant, or that I have told my symptoms using descriptions that are unfamiliar to the GP. Also, multiple problems may co-exist and may contribute to apparently-odd symptomatic patterns. However, expert questioning to further explore the problem does not occur. The reliance on technologies to aid diagnosis in TWM and the use of 'normal' and 'abnormal' scores in test results can also work against the patient's actual experience of ill health or feeling unwell. This was my experience for many years as I had just about every test available to find out why I felt so unwell all the time. All tests came back 'normal' and so there was no possible action to be taken.

As it turned out, my increasing debilitation was due to three seriously-blocked arteries that was not diagnosable using cholesterol tests and blood pressure checks and I did not meet any of the other indicators of risk of heart disease, such as being overweight, being a smoker, and so on. Because all these indicators were 'normal' there was nothing to diagnose – until I had a heart attack and a subsequent angiogram identified the seriousness of the problem (attributed to 'family history'). After which, the surgical and medical care I received were excellent.

It was also reassuring and instructive to listen to the stories of about a dozen people who were present at the cardiac rehabilitation sessions I attended, particularly about their experiences of misdiagnoses by their GPs. Rather than this being an indictment of medical expertise, it emphasised the difficulties of making clear diagnoses until the event had occurred, after which treatment is easily decided.

### (2) CATEGORISING THE PATIENT AS 'SICK' OR 'UNWELL'

In TCM, the model is of prevention and intervention. Cause and effect are conceptualised differently because there is recognition that a person may be or feel unwell without having a serious illness that is diagnosable by medical technologies. This view is encapsulated in a response from a TCM practitioner to my lamentation of the continuing lack of diagnosis using various tests under TWM. She said, 'It is good that the tests are normal. They show that you are not sick, but you are also not well'. There appears to be a continuum rather than a dichotomy between 'sick' and 'well'. Hence, treatment

of energy imbalances is offered and the patient's experience of feeling unwell is accepted as valid and 'normal'. There is also a clear recognition of the limits of TCM and patients are advised to see their GP for particular problems, such as chest pains and shortness of breath.

On the other hand, my experience of TWM is that the diagnosis tends to pathologise the patient, even when no diagnosis is made, as outlined above. The patient is reduced to a set of symptoms as a diagnostic category, even when there do not seem to be clear grounds for this. This approach does not seek explanations in the patient's circumstances as causes of the problem (as prevention), but solely as an opportunity for treatment. Furthermore, when patients' diagnostic tests return consistently with 'normal' results, the hope that 'something' may be found to validate the experience of feeling unwell is continually dashed. This reliance on medical technologies to generate 'answers' and their continual failure to do so, also tends to invalidate lived experiences of debilitation, fatigue, or whatever else. This has a tendency to implicitly generate other categories of pathology, such as 'malingerer' or 'hypochondriac'.

The need for a diagnosis has been so strong that frustrated GPs have offered me SSRIs (Selective Serotonin Reuptake Inhibitors – anti-depressants) for depression and anxiety, after I said that the failure to find a medical diagnosis was causing me depression and anxiety. I meant this as a way of explaining the consequences of having a lived experience continually invalidated, and at the same time, being expected to function in a stressful work environment while feeling so unwell. So it turned out that depression and anxiety became seen as the cause, not the consequence, of my experiences of ill health.

While there was some recognition of the extreme stress of work (workload and toxic workplace dynamics), there was no possibility of being given respite through sick leave unless a medically-diagnosed condition was possible. Instead, I was advised to get another job or to refuse extra work, as if this was an actual option available to me in the workplace. All this approach did was to blame me as the patient rather than appreciating the consequences of workplace demands on health. One GP told me that my health problems were work related, but she was not going to give me a medical certificate as I would use it for a Work Cover claim. Failing a physiological explanation, a diagnosis of a mental or emotional illness apparently was possible — hence, the possibilities offered by depression and anxiety — but even these diagnoses involved receiving medication and nothing else.

### (3) PERCEPTIONS OF EFFECTIVENESS

I have received herbal remedies and acupuncture from TCM practitioners. The herbal remedies were prescribed for otherwise-undiagnosable stomach problems for which I was using over-the-counter medication as advised by my GP. The herbal treatments took a few days to work, but they did resolve the problem.

Whenever I have received acupuncture interventions from a TCM practitioner I have 'felt better'. Usually this occurs while I am in the clinic receiving acupuncture, as I can feel the changing quality and intensity of pain, for example, of sinus headaches or painful shoulders. There is a sensation of the pain 'draining away' from the insertion site of the needle. Quite often, while the needles are being inserted or manipulated, I have experienced sensations in other parts of my body, sometimes quite distant from the site of the inserted needle. I have tentatively mentioned these experiences to the TCM practitioner who affirms that is the meridian path. However they never tell me in advance what is to be experienced and have even expressed surprise when I have described the experiences as they occur.

When I have asked TCM practitioners why they are surprised at my experiences, they have told me that it is unusual for patients to show such sensitivity to the acupuncture treatment. I enjoy continuing this treatment away from the clinic with auricular acupuncture, which I find soothing. All I can say is that the acupuncture treatments for various experiences of pain for different reasons seem to work. This does not mean that I am symptom-free forever, any more than I expect to be after receiving TWM treatments.

With TWM, clearly there is relief to be experienced from antibiotics that work directly on infections that can be diagnosed in a GP's surgery. There are also over-the-counter and prescribed medications which are effective for treating other acute and chronic problems like allergies, sinusitis, and heart conditions.

As a patient, I always want to know 'Why?' so that I can prevent the problems. Instead, this seems to be a futile question when treatment in TWM is to alleviate symptoms, and quite often why the symptoms are occurring is unknown or too complicated or expensive to investigate. While TWM can claim that there is 'evidence' in terms of 'cause and effect' related to pharmacological interventions, and more drastically, surgery, as discussed above, treatment cannot be offered when there is no clear diagnosis of 'ill health' or 'sickness'. There is also considerable scepticism towards complementary medicine such as TCM, and perhaps my description of 'outcomes' and 'effectiveness' of acupuncture may be dismissed as a placebo or imaginary.

## Insights for professional practice?

The reflections above that compare and contrast two aspects of health care received from TWM and TCM practitioners are not intended to negatively portray TWM practitioners. I may have been very fortunate in the TCM practitioners I have consulted and I have received excellent care from practitioners of TWM. The reflections and related insights for professional practice recognise the different demands on time amongst GPs and the expectations of an 'ideal medical consultation in non-urgent circumstances',<sup>36</sup> including lengthy and wide-ranging discussions between practitioner and patient, may be unrealistic and unrealisable. It is also implied in my descriptions of the processes of health care that TWM and TCM have treated different conditions, with clear boundaries between the two approaches, although at the time of receiving services, I did not know what the symptoms meant, and I was seeking relief wherever I could find it.

However, it is important that there is recognition of the potential insights for professional practice, while bearing in mind the different models of health and sickness informing practitioners of TWM and TCM. The following suggestions are made for practitioners – many of which are applicable to both TCM and TWM, and some which are specific to TWM. First, it is suggested that the limitations of medical technology and testing are understood in TWM, and that a patient with a 'normal' test result within a statistical distribution may still be unwell. Secondly, all health practitioners, whether of TWM and TCM, should realise that patients may not tell all their symptoms to allow for a pattern to be identified. Therefore, expert questioning may elicit additional information that aids in diagnosis. Thirdly, all health practitioners, whether of TWM and TCM, should realise that a patient may have multiple problems and that expert questioning may elicit patterns that allow for multiple diagnoses. Fourthly, all health practitioners, whether of TWM and TCM, should appreciate the vulnerabilities of patients and the emotional and practical consequences for them, of not being able to receive a diagnosis of troublesome symptoms. Fifthly, TWM practitioners should realise the consequences of pathologising patients including using mental health diagnoses as explanatory theories for experiences of ill health, rather than as consequences of chronic, yet undiagnosed problems. Finally, the differing systemic boundaries on practitioners of TWM and TCM should be appreciated, including time constraints on consultations and legal imperatives associated with public health that apply to TWM practitioners.

## Conclusions

This article has discussed one consumer's experiences of health services, received from TWM and TCM practitioners over at least 10 years for chronic health problems. It shows why it is important to listen to consumers' experiences as part of evaluations of health services. It questions the value of normal distributions and statistical probabilities when applied to individual experiences. It also shows why it is important to listen to consumers who present to health practitioners and whose accounts of problems with their health are stories that express how the person understands his or her experience. Consumer participation therefore does not mean dismissal of professionals' expert knowledge. It does mean that expert knowledge can inform in-depth engagement with consumers about their personal experiences, seeking to locate the individual's experience within broader, general expert knowledge of health, sickness, and 'being unwell'. In-depth, expert questioning to aid diagnosis could take the form of inductive, hypothesis-testing, seeking to identify how the pattern of presented symptoms may represent a range of diagnoses, that can be refined through pertinent questions.

Finally, patients' claims for effectiveness of complementary therapies including TCM are often dismissed as 'anecdotal' and placebo effects. However, in discussing complementary therapies in treating alcohol and other addictions, Miller<sup>37</sup> says that, 'In this context, complementary therapies — where the service user is able to get one-on-one attention and have something that feels therapeutic done to them — leaves them feeling happier than when they walked through the door.' Therefore, while debates may rage with regard to claims of 'scientific evidence', efficacy, and effectiveness in different models of health and sickness, it is also important to consider that improved processes of consumer participation and awareness of patients as individuals may improve outcomes.

## Clinical Commentary

This article has discussed one consumer's experiences of health services, received from TWM and TCM practitioners over at least 10 years for chronic health problems. It shows why it is important for health practitioners to listen to consumers' experiences when evaluating health services, and because consumers' accounts of health are stories that express how the person understands his or her experience. The article offers insights for professional practice that include ways of using professional knowledge to improve communication of symptoms and understanding of effectiveness as both processes of care and outcomes related to clinical interventions.

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