Clinical Encounters with Chinese Medicine

Experiences of Chinese Practitioners and Dutch Patients
in a Chinese Clinic in Amsterdam

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Summary

摘要

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Chapter 1.
Introduction

Last year when I first came to Amsterdam, my preconception was that since, as an occidental city, it is too far away from my homeland of China, it would be impossible for me to find something related to China. To my great surprise and rejoice, there is a so-called “China Town” in the center of the city with all kinds of oriental shops, Chinese restaurants and, among other things, several Chinese clinics. Later I learned that not only in Amsterdam, but also in other cities in the Netherlands, such as Rotterdam, The Hague, and Utrecht, Chinese clinics are widely spread. Their existence countrywide aroused my great curiosity. I had always thought that within the dominant biomedical health care system in this society, absolutely no other forms of healing could survive. In these Chinese clinics, where are the doctors from? Who are their patients? What are the differences and similarities of doctor-patient relationships compared with those in China? At that time I was already thinking this would be a very interesting topic worth further exploration.

In this small research, I thus tried to understand cross-cultural Chinese doctor-Dutch patient relationships in Dutch society. This thesis is organized into seven chapters, the first of which gives some background information about my research site, my objectives and research questions. The second chapter is devoted to methodology, which includes my study type, sampling, data collection techniques, data processing and analysis, ethical considerations, and experiences in fieldwork. In chapter three I will review literatures related to my study. It is divided into three sections: background knowledge about complementary and alternative medicine (CAM) and Chinese medicine, Chinese medicine in China, and CAM in the Western world. I will present my findings in chapter four and five. Chapter four is about Chinese doctors. It includes Chinese doctors’ medical practices in the Netherlands, how they see their Dutch patients, what it means to Chinese doctors to practice in the Netherlands, and observations of clinical encounters. Chapter five is about Dutch patients. It explores the reasons why Dutch patients choose TCM (Traditional Chinese medicine) and shows the results of my questionnaire survey.
about Dutch patients' health situations and health seeking behavior. I decided to do this small quantitative study as I only had time to interview intensively six Dutch patients. My paramount focus was on Chinese doctors. I wanted to get a general idea about Dutch patients' health profiles by referring to this questionnaire. After presenting my questionnaire results, a comparison with the results from the literature is followed. The last chapters, chapter six and seven, are discussions of my findings and my final conclusions.

1.1. Background

Although plenty of literature has already repeatedly stated the popularity of alternative medicine in Western world, hardly any English literature exists, as far as I know, concerning the situation of the specific form of Chinese medicine in the Netherlands, although several Dutch studies exist about Chinese immigrants' health problems and their health seeking behaviors in the Netherlands (Blaak 1996; Haster 1997). I at last decided to do my fieldwork for the AMMA course (Amsterdam Master's in Medical Anthropology) on this topic owing to some informal conversations from which I learned that the majority of the doctors in those clinics had a Chinese origin, which was a sharp contrast to their patients, the majority of whom were non-Asian people. I had been more curious from then on about inter-cultural clinical relationships between these Chinese doctors and Dutch patients. All kinds of questions were in my mind already. For what kinds of diseases do Dutch patients seek treatments from Chinese medicine? What's the communication like without sharing the same mother tongue? From the Chinese doctors' view, what are the differences when treating Dutch compared with treating Chinese patients? What are the advantages and disadvantages of practicing Chinese medicine in the Netherlands? From the perspectives of Dutch patients, why did they choose Chinese medicine? What were their experiences of getting treatments from Chinese doctors and taking Chinese raw herbal medicines?
I had decided to choose a Chinese clinic—TongRenTang\(^1\)—in Amsterdam as my study site after gaining consent from the manager, the gatekeeper, in early March this year by means of a formal conversation with him together with my supervisor. Before that first contact, a telephone call was made and a formal letter from the department stating my identification and research aims was sent to him. He warmly welcomed me to do my research in his clinic. After that conversation and also a conversation with an experienced translator there before formal fieldwork started, I came to know the overall situation of my research site, which was very helpful to determine to which direction the research should go and what kinds of research themes should be chosen.

TongRenTang is located in "China Town" in the center of Amsterdam. Not only because of its geographical location, but also because, it has been referred to as the largest TCM (Traditional Chinese Medicine) center in Europe, encompassing TCM medical treatment, education, and trading, that I decided to do my research there. It is comprised of a clinic for out-patient treatment, international sales department, and a TCM educational institution.\(^2\) I hoped I could learn more from it about trans-cultural practitioner-patient relationships than from other relatively small-scaled clinics. Because of time limitations of my study, I only wanted to choose one site to gain deeper insight instead of choosing several with rather shallower understandings.

Most of the doctors in TongRenTang were of a Chinese origin while most of the patients were living in the Netherlands and were non-Asian. It's not uncommon that there were also patients from neighboring countries such as Great Britain, Belgium, Germany, etc. As had been devised before the study, however, these people were not selected for my interviews. Although I could not give a full description about Chinese doctor-Dutch patient relationships in the Netherlands, I did hope to gain as much insight as possible in this specific clinic, whose case was at least a partial representation of the situations in the whole country. I hope this study can have some implications for both Chinese and Western practitioners to better serve their shared patients, for Chinese medicine’s development in

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\(^1\) This name is pseudo in order to protect doctors and patients interviewed. In China, many TCM pharmacies are named as TongRenTang.

\(^2\)
the Netherlands, and if relevant, for Chinese medicine’s possible integration into Dutch health care system in the future.

In this study, I use the concept of “Chinese medicine” to refer to the medical system based on the orthodox medical theory developed in China. This restrictive definition includes acupuncture, herbal remedies, moxibustion, cupping, and Tuina/massage while excludes other types of healing systems in Chinese culture such as religious or demonic medicines (Chi 1994:308-309; Rosenthal 1981:600). It also includes Traditional Chinese Medicine (TCM), which refers to the post-1949, official- and state-sanctioned practice of Chinese medicine in China (White 1999: 1333-1347). Since all Chinese doctors I interviewed in TongRenTang had formal Chinese medical training in China, they can also be called as TCM doctors. Here attention should be paid that in China, Chinese medicine is orthodox in the sense that it is state-sanctioned; only in the West does it fall into the category of complementary and alternative medicine.

“Chinese doctor” refers to physicians who practice Chinese medicine with Chinese cultural background, not necessarily from China itself. Sometimes I also use the term “TCM doctor” since the Chinese doctors I interviewed in TongRenTang all got government sanctioned TCM education in China. “Dutch patient” broadly refers to people who currently reside in the Netherlands with non-Asian origin.

1.2. Objectives

The main objective of this study is to understand the experiences of Chinese doctors and Dutch patients in their clinical encounters. Why and how do certain factors, mainly culture-related factors, influence their respective experiences? My primary interest is portraying Chinese doctors’ medical practices in the Netherlands that I presume to be different from those they experienced in China before, their perceived differences in treating Dutch and Chinese patients in medical and broader cultural aspects, and their attitudes towards practicing in the Netherlands. Besides, I am also interested in the

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2 This information is from the clinic’s introductory materials.
patients' ideas about the reasons why they go to a Chinese clinic, their opinions of Chinese doctors' medicine and disease explanation, unique communication situations because of not having a shared mother language, and their overall experiences of being treated by Chinese medicine.

1.3. Research questions

I concentrate on the following research questions for the Chinese doctors:

Clinical encounters between Chinese doctors and Dutch patients:
1. What kind of diagnosis do Chinese doctors give? Do they only give Chinese-style diagnosis or they give Western-style diagnosis as well?
2. Do the doctors give disease explanations to their Dutch patients? If yes, how? If no, why?
3. Do Chinese doctors differentiate between patients that have physical or psychological problems in terms of explanation and treatment?
4. To what extent are biomedical laboratory results used in this Chinese clinic? Why is it used?
5. Under what circumstances and for what types of complaints do the doctors prescribe raw and processed herbal medicines, respectively?
6. How do they experience/value their communication with Dutch patients?

Chinese doctors' experiences:
7. What are the differences when treating Dutch compared with treating Chinese patients in their home country?
8. What are the advantages and disadvantages of practicing Chinese medicine in the Netherlands?

For Dutch patients, I have the following research questions:

Disease profiles of Dutch patients:
1. For what kind of diseases do Dutch patients visit Chinese doctors?
2. Why do Dutch patients choose Chinese medicine?
3. Have they been to Western doctors for the same problem before?
4. Do they inform their GP about their visit to a Chinese doctor?
5. Do they have health insurance to cover their Chinese medicine expenses?

Clinical encounters between Chinese doctors and Dutch patients:
6. What do Dutch patients think about the explanations given by Chinese doctors?
7. How do they experience the communication with Chinese doctors?

Dutch patients' experiences:
8. How do the Dutch patients experience Chinese medical treatments?
9. How do the Dutch patients experience taking Chinese herbs?
Chapter 2. Methodology

2.1. Study type

The study type is exploratory, trying to find out what themes are important in intercultural Chinese doctor-Dutch patient relationships. Little is known from literature about Chinese medicine in the Netherlands; whether it is heterodoxy or orthodoxy; how Chinese doctors think of their practices in the Netherlands. Therefore, Chinese doctors are chosen as my main research subjects. Obviously, doctors cannot exist without patients. Their relationships are diadic. So in order to understand Chinese doctors better, I also want to explore what Dutch patients think about their clinical contacts.

2.2. Sampling

In TongRenTang, there are branches of internal medicine, gynaecology, dermatology, Chinese Tuina/massage, acupuncture, as well as an herbal dispensary. Since at the time of my research, there were only six residential Chinese doctors in the whole clinic, except one Indonesian acupuncturist, three part-time Chinese doctors and several non-Asian students from the clinic's own educational part, it was possible for me to have in-depth interviews with all of them. At last I indeed did my in-depth interviews with each of all six doctors many times. Among the six doctors, there was one acupuncturist who was from Indonesia with Chinese origin and who, also quite different from the other Chinese doctors, was a Dutch family doctor (GP) speaking fluent Dutch. I therefore thought that it's a good idea to observe his treatments instead of talking with him much to see differences, if any, between his medical behaviors and those of other Chinese doctors from China. I decided to do so not only because he's not so fluent in Chinese as in Dutch, which hindered our conversations to some extent, but also because he's the busiest doctor in the whole clinic.

Since it's quite easy for me to observe the whole duration of doctor-patient
Chapter 2. Methodology

encounters and read the patients' medical records provided I gained consent beforehand, I had a lot of freedom to decide which patients I wanted to interview. My idea was to have some heterogeneous patient respondents in order to get more information in a short period of time. As a result, Dutch patients with different age groups, genders, and ethnicities were chosen for interviews. Consideration was also made to assure that patients who visited different branches, who were with somatic- or physical-dominated problems, and who were satisfied or not-yet-satisfied with Chinese medicine were also included in the interviews. However, I did not search for representative patient samples. Because of the stringency of only six weeks' time for this study and little research has been done about Chinese doctors' practices in the Netherlands, my leading consideration was Chinese doctors. I only want to explore what patients think about their clinical interactions with Chinese doctors in order to better understand TCM doctors' practices and ideas.

At last, six patients were chosen to have in-depth and semi-structured interviews immediately after their treatments. I chose all of them in the consultation rooms in different branches of the clinic. Before this study started, I had already read some related literature to know some general themes about Western patients' alternative medicine seeking behaviors. During my research, I thus tried to understand from these six Dutch patients important themes I found in the literature. In order to avoid the medical atmosphere as much as possible, I did most of my interviews in a nearby bar where the environment was quite nice and relaxed, or in the clinic's waiting room or guest room somewhere outside the consultation and treatment sites when the patient interviewees preferred to do so.

2.3. Data collection techniques

This study was conducted from May 14th to June 24th, 2001. During the first five weeks, a combination of in-depth interviews with doctors and patients respectively as

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3 I considered it's better to have the interview in this way so people didn't need to make another appointment especially for me. I wanted to choose a time that is most convenient for them.
well as observation of clinical encounters were conducted. My chief focus was on TCM doctors as I talked to all six of them. The last week of the study was reserved for quantitative study. Data collection techniques are as follows:

**Literature that is relevant to the study:**

I reviewed some literature about alternative medicine and Chinese medicine in China, in Europe and in the United States, with special attention paid to the situation of alternative healing in the Netherlands. From those literatures, after obtaining some concrete figures about widespread use of complementary and alternative medicine in the West, I also get information about Western doctor’s attitudes to alternative healing, patients’ relationships with alternative practitioners, and reasons why patients use alternative medicine. So I can have a comparison of my findings with the available literatures later. I also collected materials in the waiting room of TongRenTang, where some brochures introducing Chinese medicine in general were there ready for free reading.

**In-depth semi-structured interviews with Chinese doctors and Dutch patients:**

I interviewed all six Chinese doctors during their office hours. When they were treating patients, I just sat aside to observe the consultation and treatment sessions. I interviewed them only at the intervals when they did not have patients. The conversations were informal, just letting them talk broadly about their experiences with Dutch patients. By doing so, I got plenty of information when conversations flew out naturally. Meanwhile, I also prepared an interview guide to refer to when the information I wanted to obtain was not discussed. I interviewed the six patients after they finished their consultation. The interview place was near or just inside the clinic.

**Informal interviews with translators and a Western specialist studying Chinese medicine:**

As Loustaunau et al (1997: 158-159) put it, a researcher gathers data from key informants and other informants or, rather, participants--people willing to help with and participate in the research but not so intensively—through ethnographic interviews. This was nowhere more true than during my interviews with two translators and one medical
student of the clinic who was also a Western anesthetist. These casual, unplanned conversations came out naturally when the translators explained to me about the patients' health seeking or medicine taking behaviors when the patients consulted a doctor. As a coincidence, I met an anesthetist one day who was currently studying Chinese medicine in TongRenTang. It was interesting to talk with him to know some general ideas of Western doctors' attitudes to alternative medicine and Chinese medicine in particular in the Netherlands. These small talks were unexpected, which were in sharp contrast with formal interviews where a researcher purposefully sits down with an informant to talk about a given topic.

**Participatory observation:**

I tried to have as full access as possible to the clinical interactions between Chinese doctors and Dutch patients. That is, I took part in the consultation and treatment sessions to understand this clinical situation as best as I can. I also listened to informal talks among doctors about different patients' stories. Owing to my own identity as a Chinese, it gave the doctors, as well as the patients, a feeling that I was not totally an outsider as a researcher but partly an insider as a Chinese. It did happen that some doctors talk with patients in Dutch. In that case, I asked the doctors afterwards for explanations as soon as possible. It was proved later that the combination of interviews and participatory observation was very useful since when a question was raised to a doctor about his experiences, he may talk about the situation not what he actually did, but what he thought he should do. In that case, observation was served as crosschecks on interview data.

**Quantitative method:**

In the last stage of my study, I did a quantitative research in the form of a questionnaire, asking patients about their diseases and health seeking strategies to crosscheck the information I got by interviewing six patients. I devised the questionnaire myself by referring to various literatures. My research period of six weeks was too short to conduct more than six in-depth interviews with Dutch patients, so I collected additional quantitative information by using this questionnaire. The questionnaire was self-administered, aiming to be finished by patients in a few minutes. Also in order to
give convenience to patients, two versions of questionnaire, Dutch and English, were distributed for the respondents to make their free choice.

I did this survey in the clinic's waiting room. At first I approached people by briefly introducing myself and my study aims to them, since these information was provided in detail in the questionnaire. After that I asked them whether they would like to help me to fill in the questionnaire. People were willing to do so, and I encountered no refusals for all 30 people I asked. I sat beside them when they worked on the questionnaire. After they finished, I asked them questions when something unclear occurred. I did not decide beforehand how many questionnaires should be distributed. Although I devoted most of my last week's research time in TongRenTang for this questionnaire, I didn’t wait in the waiting room all day long for patients to come. I sometimes went to the doctors for conversations and observations. After that one week, I counted my collected questionnaire answers and found they were 30.

2.4. Data processing and analysis

All the in-depth interviews with patients were tape-recorded after having the interviewees' consents and fully transcribed for analysis. At the early stage of interviewing doctors, efforts were also made to record the conversations. But later I found it's not realistic any more. After I had become more familiar with the doctors, other topics—usually raised by doctors—appeared, which were not always relevant to my research. So I changed the recording method to taking notes, and later, when I went back home, I reorganized the notes and compiled them as soon as possible.

When all the interviews had been done and all the original data had been compiled ready for use, I selected the topics that appeared often in conversations with different informants, trying to find out similarities and differences of people's opinions to the same topic. Thus, useful data and findings were obtained.

2.5. Ethical considerations
Chapter 2. Methodology

The information collected is kept confidential and no attempt has been made to identify individual informants in the study report especially when patient informants are concerned. All informants were told of the purpose of the study and their oral permission sought before collecting any information from them. This was especially the case when observations were made in the treatment rooms of acupuncture and Tuina/massage where patients were required to undress themselves. I always kept it in mind that patients' privacy should be highly respected in any case.

When I began to interview patients, I was eager to ask them questions that were already written down in my interview guide, trying to find out their opinions mainly concentrating on cultural aspects. Later I found that patients had different conversation interests. Normally they had already tried several curative methods to treat their diseases, and they went to TongRenTang when these methods seemed to be ineffective or unsatisfactory to them. So their main concern was whether Chinese medicine worked for them. They did not pay much attention to cultural things. I sensed pretty soon that it's not good if I continued to stress on cultural aspects without showing much sympathy to patients' health problems. That meant I occupied their time for my own research's sake while giving them nothing in return. By using reflexivity, I thus tried to listen to the patients' own stories and understand their feelings while asking them my questions at suitable times. This reflexivity turned out to be much better for both sides' mutual understandings.

Sometimes the seemingly common topic such as occupation can also be sensitive! I had such impression due to my interview with a patient. As usual, I asked about her occupation, and she said, "I don't work because I could not walk. When you cannot walk, you cannot work. So end of the story." At that moment, I tried to use my reflexivity to console her, instead of listening only.

2.6. Experiences in fieldwork
The two doctors—one in internal medicine, one in gynaecology—can only speak Chinese, and other doctors spoke quite a lot of Dutch with little or no knowledge in English, so sometimes when English-speaking patients came and there were not enough translators available, I would temporarily work as a translator—a role quite different from being a researcher. At that time, I felt I was really part of the clinic, a member of the doctors, and tried my best to translate what the doctor said to the patients. I was happy to help them in this way, since I was not only asking something from them, I can also help. But of course, I did not choose patients with whom I behaved as a translator to interview for fear that they may be confused of who I was, and of what they should talk with me.

When I was a small child, I had a terrible experience with Chinese medicine. The unpleasant impression influenced me deeply. Later I chose biomedical sciences as my major in university and I had never been to a TCM doctor when I fell ill. This bias to Chinese medicine was still the same when I began to do my fieldwork. I chose this topic, because, on a macro level, as a Chinese myself, I think it is a good thing to see Chinese medicine thrive in the Netherlands especially when most patients are non-Asian. It's sort of chauvinism instead of my personal feelings about Chinese medicine on a micro level. After my fieldwork, I have completely changed my bias to Chinese medicine. I believe in many cases it works especially for some diseases which biomedicine fails to treat. It was only because of my bad luck as a child that I had encountered a quack. This is my personal gaining after the fieldwork.
Chapter 3.
Literature review

In this chapter, I will review related literatures about complementary and alternative medicine (CAM) in general, in which Chinese medicine is included when it is practiced in Western countries. I will try to give a general picture of, first of all, basic knowledge about CAM and Chinese medicine, and secondly, Chinese medicine in China. Thirdly, I will try to describe the current situation of CAM in Western world and in the Netherlands in particular. I will focus on usage of CAM, Western doctors' attitudes towards CAM, clinical relationships of CAM practitioners with their patients, and the reasons why Western people turn to CAM.

3.1. Background knowledge about complementary and alternative medicine (CAM) and Chinese medicine

Complementary and alternative medicine (CAM) is widely used by people all over the world. The world Health Organization estimated that 80% of the world's people used it as a primary source of care (Micozzi 1997: 6). In the United States alone, reports published in early 1990s estimated that one of every three people had tried at least one form of CAM (Drivdahl et al 1998: 193-199; Klepser et al 2000: 83-87). An estimated 60 million Americans used alternative medical therapies in 1990 at an estimated cost of $13.7 billion. The estimated number of annual visits to providers of alternative medicine (425 million) exceeded the number of visits to all US primary care physicians (388 million). (Weiss 1998: 50-52)

Before we define what exactly CAM is, let's first see some broad definitions about health care systems. Arthur Kleinman (1980: 49-60) illustrates three sectors of health care, which are popular, folk and professional sector of healthcare, and the key variable is who provides care, in what context. Popular sector treatment is based on shared cultural understandings and is provided by non-specialist, like oneself, one's mother, one's friends, or other acquaintances. Folk sector healers are specialists whose
practice is based on traditional methods and philosophies. Legally sanctioned official systems (e.g., biomedical) make up what Kleinman called the professional sector. In China where traditional Chinese medicine is state sanctioned, it belongs to professional sector; while in the West and also in the Netherlands, it should be included in folk sector in Kleinman’s model.

By dividing different kinds of practitioners instead of health systems, Wardwell classifies practitioners other than physicians and nurses, who are termed orthodox, as limited, marginal, and quasi. Limited practitioners, or specialist, are independent of but accepted by the medical profession and treat particular areas of the human body. Podiatrists, optometrists, and clinical psychologists are examples of this type; marginal practitioners generally treat a full range of disorders, but use therapies unacceptable to medical professionals. This kind of practitioners includes chiropractors, homeopaths, naturopaths, reflexologists, acupuncturists, etc. That is, they are in the realm of CAM. Quasi practitioners are those whose therapies are pseudoscientific, non-medical, and often incidental to other, possibly religious, functions. The quasi practitioners include those like the faith healers, magical healers, and quacks.

Allan Young divides all medical systems according to whether they entail accumulated, formalized teachings or, rather, encourage the fragmentation and diffusion of medical knowledge (Loustaunau et al 1997: 77-78). Accumulating systems involve the collection of knowledge, generally in written form, conferences at which knowledge is shared, professional associations, and institutions for formal training. Chinese medicine belongs to this system. On the other hand, diffusing systems do not have forums for communication between practitioners. Knowledge often is regarded as secret and rarely shared.

There are several versions of definitions about CAM. The definition used by the Federal Office of Alternative Medicine (OAM) in the United States is as follows (Weiss 1998: 50-52):
"CAM is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and wellbeing. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp or fixed".

Or, put it in an operational way, it is defined as those healing therapies that typically fall outside the Western biomedical model of disease, diagnosis, and treatment. They are not taught widely in medical schools, not generally used in hospitals, and not usually reimbursed by medical insurance companies (Drivdahl et al 1998: 193-199; Meinhardt et al 1998: 24-28; Oldendick et al 2000: 375-381). It's also known as complementary, holistic, unconventional, non-Western, natural, non-orthodox, mind-body, and new medicine. This way of classification as "complementary and alternative" is defined in relation to a "mainstream".

Chinese medicine, which is one form of CAM when practiced in the west but which is orthodox when practiced in China, centers on two contrasting forces of yin and yang (Loustaunau et al 1997: 83). Yin subsumes all that is dark, moist, watery, and female; yang is comprised of all that is light, dry, hot, and male. Yin and yang reside in both the body and the cosmos. In theory, human and natural forces must be brought into balance for good health. Basic to the Chinese system of medicine is a hypothesized body energy qi believed to flow through the body's meridian channels (Ulett et al 1998: 1115-1120). Each individual body is pervaded by this energy, which allows physical function and maintains health and vitality.

Although CAM is defined in such a way by OAM as if the concepts of "complementary" and "alternative" are synonymous, this is not always the case in reality. By using the word "alternative", there has been an implication of substitution, an either/or relationship, suggesting medicines used instead of conventional ones, while the word "complementary" means forms used together with or to complement conventional medicine (Weiss 1998: 50-52). When therapies are promoted as cure-oriented alternatives
to conventional treatment, they become alternative. It is not the therapy itself, but its goal or the intention behind its use that defines a regimen as alternative or complementary (Cassileth 1998: 3). According to this assertion, Chinese medicine is clearly viewed by my study group, some Chinese doctors, as alternative, although in principle, it's limited to the scope of food category by Dutch authority.

3.2. Chinese medicine in China

In China, besides Western medicine, Chinese medicine is also legally sanctioned as state medicine. The announced policy of Chinese government is to give Chinese and Western medicine an equal standing in the health care system, so Chinese-style doctors, together with Western-style doctors, usually practice in state-sanctioned comprehensive hospitals equipped with both out-patient and in-patient departments. It's no doubt that they are recognized by the government and the public as physicians having rights to prescribe both Western and Chinese medicine and request for lab examinations if necessary.

However, despite the support of training for dual system doctors, in medical education the schools for training new Chinese-style doctors are only a fraction of those giving Western medical training. In medical practice, although Chinese medicine evidently remains very popular, Western-style doctors are much more powerful in health administration. As a result, Chinese doctors do not have as high social status, although the difference is not so much compared with the situation in the West, as Western doctors. In cities, Chinese medicine normally treats chronic and less serious diseases, and people tend to seek help from Western medicine when they have life-threatening diseases. This situation is similar to the case in the West. The condition is different in the countryside where Chinese-style doctors outnumber Western-style doctors. People there are more dependent upon and trust Chinese medicine more.

4 Information from my previous essay written for AMMA course “Ethnographies of health and health care in Asia”
Kleinman (1980: 261-2) has made detailed observations and descriptions of Chinese-style practitioner-patient relationships in the Chinese cultural context. The doctor was the authority in this clinical encounter. Most Chinese-style doctors rarely explained about cause, pathophysiology, or course of illness. They may not even name the illness. Virtually the only thing they explained was how the patients should take the medicine he was given and what foods he may or may not eat. But they gave patients detailed prescriptions. The prescriptions were mostly herbal medicines, which the doctors and patients viewed as the source of efficacy and meaning in Chinese medical practice.

In Chinese society, Chinese doctors didn’t differentiate somatic and psychological problems in terms of explanation and treatment. They explained little with the emphasis on the somatic and social, not the psychological aspect of the disease. Somatic therapies were used in all cases Kleinman observed and were believed by most Chinese-style doctors to treat psychosocial as well as physical problems. (Kleinman 1980: 278-285)

Kleinman (1980: 270) also noticed that in the confrontation of Chinese and Western medicine, the Chinese ways of diagnosis appeared less adequate for certain problems than the Western scientific orientation. This was a view shared by Chinese-style and Western-style doctors and patients. Therefore, it would be interesting to discover the situations of Chinese doctors' social status, explanation of different kinds of diseases, and use of Chinese- and Western-style diagnosis in the Netherlands in my study.

3.3. CAM in the Western world

3.3.1. Usage of CAM

Eisenberg et al (1998: 1569-1575) reported the result of nationally representative random household telephone surveys conducted in 1991 and 1997 measuring utilization of alternative medicine in 1990 and 1997, respectively, in the United States. They found that alternative medicine use and expenditures increased substantially between 1990 and 1997, attributable primarily to an increase in the proportion of the population seeking
alternative therapies, rather than increased visits per patient. Moreover, the use of alternative therapies was distributed widely across all socio-demographic groups.

A 1990 study of US adults (Drivdahl et al 1998: 193-199) found that 34 percent had used at least one unconventional therapy during the previous year. Use was most common among the 30- to 49-year age group with a fairly even contribution among the other age groups. A report published in 1993 (Klepser et al 2000: 83-87) stated that use of alternative therapies was relatively widespread and did not differ by gender or health insurance coverage. Rates of use were significantly high among individuals with incomes greater than $35,000, aged 25-49 years, and with some college education. In a 1997 study (Cauffield 2000: 1289-1294), similar results showed that subjects using CAM therapies were more likely to be college educated and aged 35-49. In contrast, in some other surveys (Drivdahl et al 1998: 193-199; Oldendick et al 2000: 375-381) about American patients' profiles of alternative medicine use, it was found that women were significantly more likely than men to use CAM therapies, middle-aged and older respondents were significantly more likely to use a CAM than those younger than 30.

Drivdahl et al (1998: 193-199) concluded that in Australia the majority of patients seeking alternative care were women aged 30 to 49 years, and that 45 percent had some sort of tertiary education. Similarly, in Great Britain, 63 percent of attendees were women and the majority were 45 to 64 years of age.

A nine-country European study found utilization rates of 18 to 75 percent for having ever used alternative methods (Drivdahl et al 1998: 193-199). In the Netherlands, although most Dutch people preferred the usual type of medical care, many alternative forms of medicine and paramedical treatment were available. According to Sharma (1992: 16), in the late 1980s, the proportion of the population in the Netherlands having ever used alternative medicine was 18% and having used it in twelve-month period was 6-7%. The most frequently used forms of alternative medicine in decreasing order of frequency were homoeopathy, herbal remedies, manual therapies (chiropractic + osteopathy + manipulation), paranormal healing, acupuncture, diet therapy, naturopathy,
and anthroposophical medicine. Although no concrete figure about the usage of Chinese medicine in the Netherlands is available, we can infer from the above literatures that it is also actively consumed by Dutch people.

### 3.3.2. CAM and biomedical doctors

According to White et al (1997: 302-306) and Pirotta et al (2000: 105-109), international rates for the practice of alternative medicine by primary care physicians varied from 8% or 13% in Israel, 16% in Canada and the UK, 30% in New Zealand, 47% in Holland (mainly homeopathy) and up to 85%-95% in Germany (mainly herbal medicine). So in all, in the Netherlands, physicians had more open an attitude towards CAM.

Berman et al (1998: 272-281) found that in the United States, the four areas of complementary and alternative medicine in which a majority of the physicians had training, that they used in practice, and that they clearly considered to be a part of mainstream medical practice were diet and exercise, counseling and psychotherapy, behavioral medicine, and biofeedback and relaxation.

Pirotta et al (2000: 105-109) discovered that in Victoria in Australia, acupuncture, meditation and hypnosis were well accepted by the postal surveyed GPs, as over 80% had referred patients to practitioners of these therapies and nearly half had considered using them.

In Devon and Cornwall in England, a questionnaire survey was performed of all primary care physicians working in the health service about their attitudes to complementary and alternative medicine (White et al: 1997: 302-306). 68% of this sample of GPs had been involved in complementary medicine in the previous week and 16% had practiced it in one form or another. In addition, 25% of the respondents had referred at least one patient to a complementary therapist in the previous week, and 55% had endorsed or recommended treatment with complementary medicine.
In a survey conducted by Visser et al (1990: 227-232) in the Netherlands, it was found that most of the 360 (60%) GPs who replied the questionnaire expressed an interest in alternative practice; and 47% revealed that they used one or more alternative methods themselves, most often homeopathy. However, the number of patients given alternative treatment by each doctor was small. Almost all (90%) of the GPs referred patients to alternative practitioners.

Similar results were obtained from the register of GPs by Knipschild et al (1990: 625-626). A random sample of 400 doctors in the Netherlands received a postal questionnaire in the summer of 1989 to state their belief in the efficacy of many alternative procedures. With the response rate of 74%, it's found that many Dutch GPs believed in the efficacy of common alternative procedures.

In all, surveys of Western doctors' attitudes to complementary medicine showed that, physicians believed it was moderately effective; but low response rates made some studies unreliable. It's likely that those GPs who were interested in CAM were more enthusiastic in answering the questionnaires, resulting in a possible wrong impression of high CAM use. Some GPs may also realize the fact that certain diseases, such as chronic pain and arthritis, were not easy to be treated by conventional medicine, thus they would refer patients to CAM. GP's referral to CAM may also be caused by some patients' pressure asking for CAM themselves.

Despite the seemingly open attitudes to CAM by surveyed Western doctors, still quite a lot of patients didn't divulge their CAM use for fear of their doctor's disagreement. A general worry was that the doctor would regard resort to a non-orthodox practitioner as a flouting of his/her medical authority, thus ruining the otherwise harmonious practitioner-patient relationships. An example was that in the United States it had been estimated that 55%-73% of people who attended non-medically trained complementary therapists did not inform their family doctor (Crock et al 1999: 61-66; Drivdahl et al 1998: 193-199; Oldendick et al 2000: 375-381; Pirotta et al: 2000: 105-
109; Weiss 1998: 50-52). Cauffield et al (2000: 1289-1294) concluded that only 35.8% reported CAM use to their physicians, even though 96% had seen their doctor within the past year. Most users learned about alternative medicine form a family member or friend. Only 18 percent had obtained the information from a physician or nurse (Drivdahl et al 1998: 193-199).

In the Netherlands, although Dutch GPs had a higher tendency to accept CAM, it’s mainly restricted to homeopathy, and their actual contacts with alternative practitioners were mostly limited to those practicing acupuncture, homeopathy and manipulative medicine with a regular medical or paramedical education (Visser et al 1990: 227-232). It would be reasonable to speculate that in my study in TongRenTang, where most Chinese doctors got their degree in China, which is not considered as formal medical education in Dutch society, GPs’ referral and awareness of their patients’ Chinese medicine use remain low. Needless to say, in the west including the Netherlands where only biomedicine is legally sanctioned and financially supported as the only form of orthodox medicine in primary health care, biomedical practitioners have far higher a social status and prestige than CAM therapists.

3.3.3. Relationships of CAM practitioners with their patients

Sharma (1992: 166) concludes from her research in England that CAM practitioners try as much as possible to appease their clients, which makes such relationships patient centered. It’s safe to extrapolate her conclusion that situations are more or less the same regarding Chinese medicine in the Netherlands where Chinese medicine practitioners also cater their service for patients. Then what factors give rise to such clientele control?

One reason is that people usually consult a CAM practitioner for the first time as a consequence of a personal recommendation from a friend or acquaintance, namely, through lay referral (Sharma 1992: 30-31). Impersonal sources of information are unimportant. Only when patients are satisfied in every aspect with CAM are they willing
to recommend other people to come. People try the most familiar or simplest and cheapest treatment first, normally this is biomedicine; and then seek more expensive, complex, or unfamiliar treatments, for example, Chinese medicine, if necessary.

It is quite natural that Western patients are unfamiliar with the techniques used by the non-orthodox practitioner, which is not the case when they go to a Western doctor. They already have some knowledge about what is going to happen before they undergo a surgery, for example. So they really need to make up their mind to visit a CAM practitioner, one determinant of which is that the CAM therapists can please them and satisfy their needs during clinical contacts.

Patients' not always having health insurance for alternative therapies is the third reason for CAM's aiming at patient satisfaction. In the specific situation of the Netherlands, it is well known that virtually everyone is covered by health insurance, which is aimed at being affordable and accessible with high quality. Recent estimates show that less than one percent of the population has no health insurance (Scheerder R.L.J.M. 1999: 169; Borst-Eilers E. 1999: 16). On the other hand, alternatives are rarely supported by government insurance plans and are only partly supported by private insurances (Kelner et al 1997: 203-212), which is manifested by the fact that the National Health Insurance (ziekenfonds) and private insurance companies only pay for a limited number of alternative therapies, and only if the claim is accompanied by a referral letter from a general practitioner—the gatekeeper (huisarts) (Boonstra et al 1999: 37).

As far as different forms of Chinese medicine are concerned, although no English literature has been found about its reimbursement policy in the Netherlands, it is likely that all kinds of Chinese medicine can get partial or full reimbursement depending on what kind of health insurance patients have and how much premium patients pay. In general, since acupuncture has been empirically researched with curative results, it is much easier than other forms of Chinese medicine to be supported by health insurances.

Nevertheless, under many circumstances it still means that patients need to invest
their own money to maintain good health from alternative medicines, compared to the situation in biomedicine, where their investment can be reimbursed. For most Western people and Dutch patients in particular, healthcare for them is something that should always be free and for which the individual or household should not have to embark funds. Now since they have already invested money for CAM, to them it's evident that they should get satisfactory health care from CAM practitioners. They have every preparation to look for another form of CAM or turn back to biomedicine if their requirements are not met, a fact clear both to patients and CAM doctors. CAM can definitely not survive without the supports of patients.

3.3.4. Why do patients choose CAM?

When considering people's decisions of what kind of treatment to get, we should be looking at both the ideological and the practical considerations (Sharma 1992: 30). Patients, or those who make decisions on their behalf, are best seen as essentially pragmatic and rational actors, making choices in the light of the costs and benefits which are held to accrue from the use of particular medical options. Preferences may be ordered according to various criteria in a hierarchy of resort, so that the patient will turn to second and third choices—in an order that is far from random—if the cure of the first resort fails. A patient is prepared to use new forms of medicine, for example, CAM, when they present perceived advantages. That is, while people may be conservative in terms of their perceptions of how disease is caused or how it should be classified, they are not necessarily conservative in the sense of being unprepared to use new forms of healing when these are made accessible to them and are seen to be effective. Here explanatory model is not so important.

Come to the specific topic of complementary and alternative medicine, how are patients' decisions made and why do they choose these non-orthodox healing methods? In the Western world where orthodox medicine very much prevails, how do patients rationalize their health seeking behaviors of whether to visit a Western physician or an alternative therapist?
According to Sharma (1992: 48-52), there are three patient types, namely, earnest seekers, stable users, and eclectic users. Earnest seekers are sufferers who are desperately casting about for a remedy for a specific illness but who seem neither to have settled down with any one system of therapy nor to have abandoned the search and accepted their condition as incurable. Sometimes the positive results of non-orthodox treatment are such that the patients intend to continue to use the practitioner, feeling optimistic about the eventual outcome. This type of patients either hasn’t found curable methods available yet or they usually have limited satisfaction with the treatments they receive, so they will keep trying.

The next category of patients is defined as stable users. These people have had a favorable initial experience of non-orthodox medicine and in the course of time have achieved a fairly regular relationship with a particular practitioner in whom they have great confidence, or make regular use of particular system of treatment in which they have faith. Their characteristic of health seeking behavior is that they regularly consult a certain non-orthodox practitioner, or use a single form of complementary medicine for most problems.

The third group is best described as eclectic. While the earnest seekers are looking for a cure for a single specific problem, and do not express any particular intention to continue to use non-orthodox medicine once this is achieved, the eclectic users are those who, after an initial experience of non-orthodox medicine, have decided that it is a good thing and tend to shop around for what they feel is the best form of treatment (orthodox or non-orthodox) for any particular problem. They use different forms of complementary medicine, together with biomedicine, for various problems.

Patients with medical conditions that were difficult to treat or did not have easy or positive answers by conventional medicine standards seemed predisposed to CAM (Cauffield et al 2000: 1289-1294). According to Sharma (1992: 36), all her interviewees, except one person, said that they had used non-orthodox medicines for the first time in
order to cure some condition for which orthodox medicine had been either unable to offer any relief at all, or unable to offer a cure which was deemed satisfactory by the patient. Cassileth’s study (Cassileth 1998: 3) also found that widespread frustration existed among patients concerning establishment medicine’s inability to effectively treat chronic illnesses. Inadequate pain control often moved patients to seek more effective and less toxic alternatives. Patients wanted more gentle, effective, and natural approaches to chronic illnesses. Similarly, in a survey of rheumatology clinic patients conducted by Cauffield S. et al (2000: 1289-1294), the most common reasons for CAM use were to alleviate pain and ease their rheumatic condition.

Furnham et al (1988: 686-8) described that patients may turn to alternative healing because of dissatisfaction with Western medicine or the attitudes and behavior of biomedical practitioners. Patients complained about the impersonality of modern medical care and hurried interactions with physicians, while complementary therapies can be cost efficient as well as responsive to patients’ needs (Cassileth 1998: 3).

In clinical realities, the need for information rather than treatment may actually be what brought many clients to clinicians. However much they may desire information, findings about patients’ clinical contact with their physicians suggested that one in five patients asked no question at all and that 13 percent of patient questions went unanswered. Patients in one study of biomedical consultations spent an average of only 8 seconds asking questions, physicians in the study believed that they spent an average of 9 full minutes providing information, when in actuality they spent an average of 1.3 minutes doing so (Loustaunau 1997: 147-149). This is clearly the difference between what people think they should do and what they really do. The use in clinics of the biomedical slang referred to as “medspeak” or “doc talk” and the rationalization by clinicians that communication was not important because patients could not possibly understand medical terminology was another major problem. This bias, as well as a disregard for cultural and personal attitudes, values, beliefs, and concerns, and the insistence by clinicians on total medical control, had worked against the establishment of trust and, therefore, communication between biomedical physicians and their patients.
Hare (1993: 33-5) conducted a research about patients using Chinese medicine in New York City during 1989 and 1990. The choice for Chinese medicine was also a reaction to the dissatisfaction with biomedicine. Here, efficacy was not necessarily defined as cure. Chinese medicine was also served as a good social treatment. Some respondents spoke highly of the time and attention they had received from the practitioners, while other patients were very pleased with the physical results of, in this case, acupuncture. The same as Murray et al (1993: 983-988) put it, the therapist's time and attention were one of the most highly valued aspects of alternative practice. Other opinions included complaints that orthodox medicine was too concerned with treating symptoms rather than finding the causes of the disorder in that individual, while unorthodox practitioners were most appreciated for their 'holistic' view of the patient's constellation of symptoms, personality and lifestyle.

One popular hypothesis was that patients who seek CAM desired more control or autonomy over decisions involving their health, or saw CAM as more compatible with their worldviews and beliefs (Cauffield et al 2000: 1289-1294). This opinion was the same with that by Loustaunau (1997: 89) who stated that the most significant factor for people visiting complementary medical practitioners was health beliefs: they believed more strongly that mental, emotional, and environmental factors played a significant part in both health and illness. These people also tended to emphasize the importance of positive attitudes and happiness and took more control of their own health behavior. But it remains unclear whether health beliefs leads to choice of practitioner, or practitioners educate or lead clients to particular health beliefs.

A similar result was obtained by Astin (1998: 1548-1553) in the United States. He found that users of alternative medicine tended to hold a philosophical orientation toward health that can be described as holistic (i.e. they believed in the importance of body, mind, and spirit in health). They were more likely to have had some type of transformational experience that had changed their world view in some significant way, and they tended to be classified in a sub-culture group as “cultural creatives”; for
example, they liked foreign and exotic things. A central finding by this study was that users of alternative health care were not more dissatisfied with or distrustful of conventional care than non-users were, but largely used alternative care because they found these health care alternatives to be more congruent with their own values, beliefs, and philosophical orientations toward health and life.

In all, there are good grounds for suggesting that most people who use non-orthodox medicine have tried orthodox medicine for their particular problems and find it wanting. Yet the criticisms are fairly familiar ones—orthodox medicine has too little time for the patient, is invasive, relies overmuch on drugs and technology, addresses symptoms rather than causes. Patients are dissatisfied about poor communication with orthodox medical practitioners, concerned about the adverse side effects of medical care, and they believe in the positive value of alternative care.

To test the above hypothesis is one of my study aims. Do Dutch patients also have the same reasons, namely, chronic medical conditions difficult to be treated by biomedicine, dissatisfaction with cosmopolitan medicine and medical practitioners, or unordinary worldviews and health beliefs, to turn to Chinese medicine or they have other different considerations?
Chapter 4.

Practicing Chinese medicine in the Netherlands—Chinese doctors’ perceptions

I will present my findings in chapter four and five, concentrating on perceptions of Chinese medicine by Chinese doctors and Dutch patients respectively. Every finding is closely related to the fact that Chinese medicine is practiced by Chinese practitioners in the Netherlands, the main patient groups being non-Asian. Intercultural communication and (mis)understandings are pervasive in these findings.  

4.1. Chinese doctors’ medical practices in the Netherlands

Obviously, Chinese doctors' medical practices have many differences in the Netherlands compared with those in China. I will discuss these differences one by one, namely: diagnosis of a disease, use of lab reports, explanation of Chinese medical theory to patients, treatment of somatic and psychological problems, prescribing raw and processed herbal medicine, duration of medicine taking and, the unique phenomenon of using a translator in clinical encounters.

Doctors in TongRenTang wore white uniforms during their office hours, as they did in China. When patients came, after some minutes' talk with them, feeling their pulses, and inspecting their tongues, doctors began to have a diagnosis and make their prescription. TCM doctors were very friendly to their patients, and the clinical transactions were quite relaxed. Translators were used but not all doctors needed translators’ help if they already knew some Dutch.

There are two kinds of Chinese herbs, raw herbs and processed ones. Raw herbs are mixtures of different kinds and quantities of ingredients from plants, changeable according to different patients and disease situations. After getting the dry materials in separate packages for each ingredient, patients have to mix them by themselves at home and boil them with water for at least twenty minutes each time, two or three times a day.

5 For informants' profiles, please see appendix 1.
What the patient should drink is the resultant herbal soup. On the contrary, processed herbs have already been packed in pharmaceutical factories in China with fixed herbal ingredients inside. They can be in the form of capsules, granules, and pills. They are convenient to take.

4.1.1. Diagnosis and use of lab reports

All six doctors I interviewed stressed that they gave both Chinese-style and Western-style diagnosis. They deemed both kinds of diagnosis were useful and by doing so, they can treat patients best. For biomedical diagnosis, doctors should refer to lab results. Otherwise it was only clinical impression, not real diagnosis. Chinese-style diagnosis didn’t need lab results. As the Chinese doctor D4, who had practiced in TongRenTang for two years and who prescribed both raw and processed herbal medicine put it,

"I make both Chinese-style and Western-style diagnosis. Chinese-style diagnosis emphasizes the whole body, but it can’t judge precisely which part of the body is not functioning well; Western-style diagnosis is the opposite. It emphasizes particular organs or systems of the body, while not paying attention to the whole body. It has a clear disease name, and it points out accurately what part of the body is wrong with the patient. They are complimentary. I can treat patients better in defining a disease using both types of diagnosis."

But doctors’ usage of both diagnosis methods was only reflected on patients’ medical records. Rarely, if not at all, did they tell patients the disease’s Western and Chinese medical names. The routine was that a Chinese doctor listened to a patient’s complaints while writing down information including diagnosis on the medical record, felt the patient’s pulse, observed his/her tongue, then prescribed medicine or carried out corresponding treatment.

One difficulty here was that it was not always easy to get lab reports whenever they were needed to make biomedical diagnosis. In China, Chinese-style doctors had the right to request patients to take laboratory examinations. Here they cannot. If they wanted
to get the lab results from the patients, they can only do so through family doctors. Some GPs cooperated, but some did not. They were not obliged to provide such information to Chinese doctors. This situation was confirmed by an biomedical anesthetist, who was studying Chinese medicine in TongRenTang:

"Whether GPs are willing to release lab results to alternative healers depends very much on what kind of person the GP is. Some GPs are more open-minded, and they are willing to reveal lab results to alternative healers. Some even refer their patients to alternative doctors. Other GPs don’t believe alternative medicine at all, and they don’t cooperate. It is only stated that GPs should show lab results to other medical doctors, for instance. Alternative healers are not considered as doctors."

However, it was very helpful sometimes to know exactly what diseases patients had by referring to lab results. For example, in the case of hepatitis and nephritis, lab results of blood and urine were determinant to know whether the patient had such diseases. Here doctor D2 frankly admitted,

"Here it’s difficult to make full use of all possible methods to treat patients largely because of lab report problems. Without lab reports, Chinese doctors cannot get all possible information. Although it’s really important to obtain them, Chinese doctors don’t always ask patients for lab reports because they’re troublesome to get. Chinese medicine could develop rapidly here if doctors had free access to Western lab reports as they do in China."

If lab results were not available, Chinese doctors can only judge the diseases by Chinese medical diagnostic method using their own experiences without a definite biomedical disease name. (Here one precondition is that in China, if a Chinese doctor gets his higher education in a university, it means that he has studied both Chinese and Western medical theories, so he has the ability to understand biomedical lab reports. Alternatively, they may also ask patients what the lab results were according to their memory. Since most patients were not familiar with Western medical terms in a technical sense, how can they tell Chinese therapists precisely what was wrong with them?

4.1.2. Chinese doctors’ disease explanation
All the doctors I interviewed said that they explained very briefly to patients about their diseases. One reason was that they didn’t have time. This was especially true for acupuncturists. This branch was the busiest in the whole clinic, and every patient had only fifteen to twenty minutes to get consultation and treatment. As acupuncturist D2, who had practiced Chinese medicine in the Netherlands for 12 years, said:

"I explain very little. I tell them how to take medicines. I also tell them what the medicine is for. I don’t have time.... Usually I briefly tell them what they should and should not eat when taking medicines."

Another reason for this brief explanation was language problems. Chinese medicine is a complicated system full of unique Chinese medical terms and philosophical thoughts, most of which do not have equivalents in Dutch language. Most Chinese doctors can understand and speak simple Dutch, but it's still more or less beyond their ability to explain this sophisticated theory in understandable Dutch. As Tuina/massage doctor D5 said,

"Normally I explain when patients ask, otherwise I don’t, because I don’t have time, and also I can’t explain clearly to them with only one or two words. Chinese medicine is very complicated, it’s a whole system of theories."

Doctors also wanted to avoid misunderstandings caused by different cultural comprehensions of the same concept, according to translator T1, who had worked in the clinic ever since it was founded:

"For example, in Chinese medical theory, there’s a concept of shenxu (kidney weakness). If the doctors directly say that to Dutch patients, they may be in panic for fear that they have got nephritis. So normally doctors don’t explain if the patients don’t ask; otherwise they explain in a very simple way."
This brief explanation may save doctors’ time and avoid patients’ further queries, but patients were eager to know more, and they were really curious of how Chinese medicine treated their problems. Doctor D4 noticed that:

“Dutch patients want to know everything about their disease and Chinese medicine. Some patients want to know the functions of every ingredient in a herbal medicine: what this medicine is for, and how long it takes for the medicine to work.”

The above words were in accordance with some patients’ ideas, especially those having higher education, that the clinic should have an Dutch and/or English list of all ingredients for herbs, so that patients can at least know what they were taking, what the medicines were for, if they cannot get satisfactory explanations from doctors. Just as P1, a 22-year-old college student having skin problems, said:

“What I want to know from the doctors is what I have, and what I can do about it, not just giving me the medicines and it’s over. I want to know how it comes there. They don’t say the reasons, they just give me medicines and, it works, but they don’t give the reasons why they give it. I asked once but they didn’t answer. They just look at it, and then they start to write weird characters. … What I also want is a list, you know, what kind of things I get, so I can know what it is, what’s it that I take as tea. … I think for the patients it’s very good to see what they are taking, and they can understand. Because I think when patients come here, they have had a lot of doctors before, so they really want to know everything.”

Another patient, P2, a 44-year-old lady with chronic pains, applied the strategy of buying Chinese medicine books to try to understand more:

“I have a lot of books (about Chinese medicine). Of course you have to when the doctor tells you there are cold and wind in you body. I think what is he talking about? I don’t understand him well, so I buy books. I want to know. For what, how, then I can make a choice.”

It is clear that doctors explain little not because they don’t want to, but because of lack of time in their contacts with patients, language problems, and avoiding possible misunderstandings due to oriental and occidental, cultural differences. Most Chinese
doctors are from China where they didn’t explain much to Chinese patients, so they are not used to detailed explanations yet. Patients are not satisfied with the short explanations, however, and they try to find other ways to understand more.

In addition, Dutch patients tend to narrate their disease history in a lengthy way with a lot of emotional details, and they expect Chinese doctors to react accordingly. Patients see Chinese medicine as physiotherapeutic as well as psychotherapeutic (Barnes 1998: 413-443). But Chinese doctors are used to treat diseases by prescribing therapeutic herbs that they view to be most important to relieve patients’ symptoms. They don’t live up to patients’ psychological expectations.

An exception was doctor D1, who was an acupuncturist and Dutch family doctor, a Chinese from Indonesia. He spoke fluent Dutch and talked a lot with patients. Although I was unable to understand their clinical conversations, I noticed from the non-verbal gestures that he was more friendly and chatty. By providing hope for overcoming the complaints and giving much personal attention and support, he can indirectly serve some of the patient’s emotional needs that were related with their complaints. He had most patients among all doctors, which may be a reflection of his amicable attitudes and use of Chinese medicine as psychotherapeutic drugs as well.

4.1.3. Doctors’ treatments of somatic and psychological diseases

Patients visiting Chinese doctors had all kinds of chronic problems. These included psychologically dominant diseases such as depression and stopping smoking, and somatically dominant diseases such as pains and skin diseases. Doctors considered that almost every disease had both somatic and psychological aspects, so they didn’t differentiate disease so clearly according to either somatic or psychological types. They were intertwined. Doctor D2 had the following to say:

“For example, depression patients also have intestine and cardiovascular problems. So you need to cure these somatic problems accompanying depression. If you only use psychological method to console patients
without curing their physical discomfort, it’s useless. Every doctor knows how to console patients, ordinary people also know how to do that, but not everyone knows how to cure the physical disease accompanying psychological complaints. Only when your treatment is effective does the patient believe in you, and your psychological conciliation can be accepted by them.”

My impression was that doctors seldom paid attention to the patients’ psychological problems. Every disease was described in somatic terms. This phenomenon, together with the doctors’ simple explanations about Chinese medical theory, confirms once again that in Chinese medical practice, therapeutic drugs and physical treatment such as acupuncture are seen as the most important and only way to cure disease.

4.1.4. Raw and processed herbal medicines

Doctors were in agreement that generally speaking, raw herbal medicines were better than processed ones. They were prescribed and prepared according to different patients. Patients with the same disease usually got different prescriptions for raw herbs according to their gender, age, general health situations, etc. Raw herbal medicines were thus seen as faster and more effective. So doctors prescribed this kind of medicine more. On the other hand, the disadvantages of raw medicines were that they were bitter and troublesome to prepare and take, while processed ones were convenient and had a more pleasant flavor. Doctors would prescribe processed herbal medicines when the disease situation became stable or when the disease was not so serious. As doctor D3, who had practiced in the branch of gynaecology for more than three years in the Netherlands put it,

“I prescribe more raw herbs than processed ones because raw herbs can be prescribed differently according to different patients and different diseases. Processed herbs have fixed ingredients that you can’t change. Raw herbs are also quicker to take effect.”
Herbal medicine, especially raw herbal medicine, was quite alien to Dutch patients, and they must adapt themselves to it, especially its bitterness and time-consuming preparation processes. Chinese people accepted herbal medicine's bitterness as one of its characteristics, while Dutch were not used to it.

P1 had the following experiences when taking raw herbs:

"Oh, it tastes bad. But it's also difficult because you can't leave home. I have to take it three times a day, so I have to take it in the morning, in the afternoon and in the evening. You can't leave because it's very difficult to take tea with you. ... I put a lot of sugar in it. It's terrible."

P4, a 30-year-old man with a depression history of one year and a half, had the following to say about raw herbs:

"It takes a lot of time to prepare, as you have to get up one and a half hours earlier, and it's not so nice to drink.... It tastes bad. I have to close my nose and take it."

How doctors coped with patients' complaints concerning raw herbs' unpleasant flavor? On the one hand, they knew raw herbs were like that, bitterness and time-consuming preparation were one of its characteristics; on the other hand, they had to think out some methods to alleviate it, otherwise they ran the risk of losing their clients. Doctor DI 4 had the following coping methods:

"I let them take less medicine soup each time, while taking more times every day or take the medicine after meal. I also let the patients add sugar to the medicine soup if it tastes bitter."

Doctor D3 had other strategies besides the above mentioned ones. He may ask the patients to get rid of the certain ingredient which gave rise to the bitterness provided discarding that ingredient only decreased a little of or didn't affect the efficacy of the whole herbal medicine. However, when some patients really can't endure the raw herbs' taste or felt uncomfortable in their stomach, doctors changed to prescribe processed
herbs. It's true that processed ones worked slowly, but it's better to take them than nothing if the patients can't take raw herb in the form of tea at all.

Patients' complaints and doctors' coping strategies towards the troublesome preparation and bitterness of raw herbs clearly denote the most salient characteristics of Chinese medicine practices in the Netherlands: it is patient-centered.

4.1.5. Duration of medicines per prescription

The time needed for a patient to take Chinese herbs varies according to disease types and different patients, but in general, for chronic diseases, three months' time is an average. When patients first came, doctors prescribed raw herbal medicines for one week; after that medicines for two weeks were prescribed. Sometimes patients asked for as long as one month's herbs, when they wanted to, say, go for a vocation. Doctors always tried to satisfy patients' needs as far as they can. While in China the situation was quite different. In any case, either during the first or the follow-up visits, herbs were prescribed for only three or five days, at most seven days, which was better, according to Chinese doctors, because then they can adjust their prescriptions according to patients' changing disease situations. When asked why such differences existed, doctor D4 had the following to say,

"Here patients come from all over the country. It's a longer distance compared to China where normally only patients in the same city are involved. Most diseases here are chronic, they don't change very quickly within one or two weeks, so it doesn't matter much to prescribe herbs for a longer period than in China."

Despite this seemingly reasonable explanation given by doctors, a hidden reason is that doctors are trying their best to appease the clients. Patients' requirements need to be met in any case. Chinese doctors have to make their care patient-centered in order to make Chinese medicine survive and thrive.

4.1.6. Translator as medium of communication between doctors and patients
One unique phenomenon in TongRenTang was the use of a translator, especially for doctors who can only speak Chinese. So during clinical encounters, at least three persons were present. This is quite different from ordinary doctor-patient relationships where both parties can communicate directly without a third party. Communication problems did exist, as many Chinese medical terms didn’t have corresponding parts in Dutch, which made it difficult for the translators to explain clearly to patients.

Another problem was that some translators didn’t have a sound Chinese medical background, so they didn’t know much about Chinese medicine, which may also cause misunderstandings even between doctors and translators, let alone to explain correctly to patients. Once doctor D3 gave a patient the diagnosis of “zaoxie” (prospermia), a Chinese medical term as well as a metaphor in Chinese culture in order to avoid direct mentioning of sexual relations. The Dutch translator mistook it as “fuxie” (coprorrhoea). The doctor had to explain to her first to avoid further misunderstandings.

In addition, some translators talked with patients too much while only translating a little to the doctor. In this situation, they behaved like a doctor themselves. It also happened that doctors may talk about basic Chinese medicine theory concerning a particular disease, but it depended on the translators whether to translate these words to patients or not. Sometimes translators just worked without knowing a patient’s disease profiles beforehand, since this time the patient had, for example, translator A, while the next time, he may have translator B. It is better to have a patient-translator-doctor team that persists for the duration of the treatment.

To complicate things further, in TongRenTang, the only medical dictionaries were Chinese-English and English-Chinese, not Chinese-Dutch and Dutch-Chinese. In a country where most of the written materials are in Dutch, it is difficult to get effective help from these English-Chinese dictionaries.
Concerning translators’ sometimes talking more than doctors, the translator T1 had yet a different opinion:

“Some doctors don’t want to talk much. Patients may ask them many questions, but they just say, ‘Take the medicine and we will see.’ Since patients are really expecting answers, I have to make up answers by myself and explain to patients.”

Some patients I interviewed also expressed the idea that it’s a pity that some doctors can’t speak Dutch, which made direct communication impossible. P1 expressed her idea as follows:

“I don’t really have a conversation with a doctor, but with a translator. You know, the doctor can’t say to me what I have and I can’t explain to him what I’ve got directly. But I’m a patient, he’s a doctor and that’s what the natural interaction should be like, I think.”

It’s not realistic that all doctors in TongRenTang should manage to speak with their patients directly, especially when one knew the fact that most doctors were invited by the manager from China, and in principle, they would practice in the clinic for about two years before they went back. Translators will continue to exist during clinical interchanges. It’s worth taking time to think seriously about how to solve problems during doctor-translator-patient clinical transactions.

4.2. How do Chinese doctors look upon their Dutch patients?

4.2.1. In medical aspects

Dutch patients were much more sensitive to pains than Chinese when they got treatment in the branch of acupuncture and Tuina/massage. Sometimes it happened that patients ran away when they thought the treatment was too painful to endure. This was especially true for those who first visited TongRenTang. Sometimes doctors complied with patients although acupuncture doesn’t work well if patients don’t have much feeling when the needles are inserted into the body. Dutch patients also thought it hurt a lot
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...treated by Chinese Tuina/massage compared with physiotherapy. In this case, Chinese doctors had to adjust their strength applied on their hands to satisfy the patients. Doctors however didn’t think these treatments were too painful to be endured: acupuncture and Tuina/massage were like that; they should be painful to take effect. But on the other hand, if they insisted in their own ways, they would lose patients. Here the same situation existed as that for raw herbs when doctors were trying hard to find equilibrium between the treatments' effectiveness and patients' feelings about bitterness of herbs and pains.

In the realm of biomedicine, usually patients already have some general knowledge about how a consultation will proceed. It is unlikely that, for example, s/he will arrive at the surgery without some fairly well formed notions as to what is likely to happen. This is not the case with Chinese medicine. It is normal that patients do not have any knowledge about what is going to happen during treatment. The patient P6, 46 years of age with chronic pains, had the following vivid description about his perceptions of acupuncture treatment before getting it:

“I thought I would have pain, I can’t sleep, I can’t walk. If I go home I will cry because of the pain. You see, they put needles in your skin. I thought that’s painful. I told my friends ‘Today I have to go to the acupuncture, but I’m scared.’ My friends told me, ‘No, maybe, maybe not, you don’t feel anything. But because you are unhealthy, you have to do it.’ I said, ‘OK, OK.’ The first time I was here, I was shaking. I asked the doctor ‘Is it painful?’ He said ‘No, no, you don’t have to be afraid, it’s OK.’ I lay down, he said, ‘This is the first needle, now the second.’ I said, ‘Oh, it’s OK!’ At that time I was relaxed.”

For Tuina/massage, its functions were mainly preventive, compared to its chief curative function in China\(^6\), where many diseases were acute or even life-threatening. If

\(^6\) At first, the branch of Tuina/massage was called massage for patients' understanding. Doctor D5 strongly objected it as he thought Tuina was not the same as massage. Only Chinese doctors know how to do Tuina; they pay much attention to the techniques according to different diseases, while everyone can do massage, and no special technique is needed. It only aims at making people feel comfortable, not necessarily for disease treatment. Here we can see doctors are struggling in every possible way to ensure themselves, as well as others, that they are of equal status as Western orthodox doctors. They also have expertise not shared by ordinary people.
Dutch people have serious diseases, their first choice will be biomedical treatment. When they are treated by Tuina/massage, they want to feel comfortable besides expected effectiveness, as doctor D5, who had practiced Tuina/massage in the Netherlands for more than eight years, said:

"Zai Zhong Guo, Bing Ren Shi Tai Zhe Jin Lai, Zou Zhe Chu Qu. (In China, patients can’t move before treatment and walk out by themselves after treatment.)"

Doctor D2 had perceived a lot of differences in treating Dutch and Chinese patients in acupuncture. In principle, it didn’t matter whether the needles remained in the patients’ body for some time as long as patients felt sensations like sour, tingle, bulge, and ache when the needles were piercing, which was called deqi (getting energy) in Chinese medical terms (Ulett et al 1998: 1115-1120). But here Dutch patients had different ideas and according to them the needles must remain in the body for some time; otherwise the patients would not be satisfied. They tended to think the longer the needles remained in the body, the better the treatment. This idea was expressed clearly when I interviewed P3, a Dutch man of 38, having problems of headaches, pains in the legs, asthma bronchitis, and too much sweating:

"Yesterday I read an article about a Chinese doctor in Haarlem. When he uses the needles for the patients, they are stuck there for one and a half hours. I don’t know what’s the difference between here 10-20 minutes and one and a half hours there."

He repeatedly expressed his worries that the reason why acupuncture hadn’t worked for his problems until then was that the needles remained in his body for too short a time of about 20 minutes. The doctor’s explanation that efficacy didn’t depend on how long the needles were remained in the body didn’t convince him.

Sometimes it occurred both in China and Netherlands, although the frequency differed, that patients fainted during acupuncture treatment. The mechanism of acupuncture, according to doctor D2, was to use the body’s own energy to react the
disease. When treated by acupuncture while the patient was already tired, s/he was forced to use up all the remaining energy. The consequence was faint. So it was prohibited to use acupuncture in case of hunger, alcoholic intoxication and fatigue. Dutch people were in panic when they fainted. In China, people have common knowledge of acupuncture, and know what to do in this case. Here doctors came across much more patients of acupuncture faint than those in China, because people here were more nervous of getting acupuncture treatment owing to the unfamiliarity with it.

In China, it's not a big affair if patients bled a little when the needles were taken out. There are plenty of blood vessels around acupuncture points. But here people are not familiar with acupuncture, and they may be in panic seeing bleeding. So the doctors were careful as much as possible not to let patients bleed.

Cupping, one kind of acupuncture techniques, is very effective in curing pains, also according to doctor D2. In TongRenTang it was rarely used, only applied to unexposed parts of the body. Dutch may be afraid of it because when the treatment finishes, a colored mark, which is the manifestation of a little internal bleeding, was left. The treatment itself was not so painful, but the mark was too ungainly to appear on the skin. Sometimes people agreed to get this treatment when doctors explained to them, but very rarely. In order to leave as shallow marks on the skin as possible, this treatment only lasts 2-3 minutes, while in China it can be 10-30 minutes.

It seemed that Dutch patients' common knowledge of acupuncture was that by allowing needles to be inserted in their body, every disease was equally treated. Similarly, if they happened to have other illnesses during their acupuncture treatment, they tended to think that these problems were also caused by acupuncture. In this case, Chinese doctors needed to explain to them that acupuncture only treated this particular disease, and it had no connection with their other problems. Doctor D2 had the following experiences:
“They don’t understand the way acupuncture functions, and they think by using needles, you treat the whole body. So even if you only treat their backaches, when they catch a cold, they may think it’s because of (the side-effects of) acupuncture. You must tell them clearly that they are totally unrelated diseases.”

All these medical-related differences in the Netherlands, including pain sensitivity, consultation situations to Tuina/massage, concepts of maintenance of acupuncture needles in the body, views on fainting and bleeding in acupuncture, attitudes towards cupping, and the misunderstanding that acupuncture treats the whole body instead of a specific problem, illustrate that Dutch patients in general have little acquaintance with Chinese medicine and treatment procedures.

4.2.2. Cultural related aspects

Many patients went to Chinese doctors for several problems instead of only one. It may take up to thirty minutes for them to talk about their problems. During my clinical observations, sometimes I was confused to hear several different problems and I was wondering for which one they were now seeking help from Chinese doctors. These cases are much fewer in China. Patients see a doctor for only one problem although they may have several. They talk about their problems in a very concise and neat way, with little psychological and existential detail involved.

Types and numbers of questions patients asked were also different, according to Chinese doctors. Dutch patients asked more. They may ask when they could recover from the disease; how many times they needed acupuncture treatment to cure the disease; whether the disease would relapse. In China, people don’t ask why because they already know. It is part of their background; even if it is the first time they are going to see a practitioner. They are not tending to ask questions.

Sometimes Dutch patients wanted to differentiate the yin and yang aspects of weather and food. It’s true that everything has yin and yang aspects according to Chinese medicine theory, but Chinese doctors were treatment oriented, and they didn’t put the
concept of *yin* and *yang* to a very broad sense.\(^7\) As for Chinese people, *yin* and *yang* are widely used in daily life. A simple example is that in Chinese language, *yin* is a metaphor for everything related with female, and *yang* with male. They are in their subconsciousness, and they don’t ask those questions Dutch people may ask.

Another discrepancy perceived by Chinese doctors was Dutch patients’ strictness in taking medicines. D6, a female doctor in dermatology, had the following comments:

> "Dutch patients are rather rigid in taking Chinese herbs, while Chinese are very flexible. Each time I must tell Dutch patients every detail about how to prepare and take herbs. I tell them the exact volume of water needed to prepare raw herbs. Chinese know that automatically in Chinese culture even though it’s their first time to prepare herbal medicine. Once I told a Dutch patient to take his herbal soup half an hour after his meal. In order to make it sure, he brought a thermal flask with him in the train, and took the medicine according to his watch. Chinese will take it for granted that the doctors mean an approximate time, not so accurate."

In several aspects, Chinese medicine also adapted itself to Dutch culture, which was shown in the form of consultation time, appointment, privacy, and equality. Here every patient got twenty minutes, or forty if it’s his/her first consultation, except in Tuina/massage, where every patient got one hour. In China there’s no limit to the consultation time, and doctors can decide by themselves.

In China, no appointment was needed. Patients can come whenever they wanted. The earlier a patient came to register in the hospital, the earlier s/he got treatment. Here patients must make an appointment to visit a doctor, and then they can come according to the time schedule. If a patient comes one hour earlier than scheduled, it’s her/his problem, and s/he has to wait.

\(^7\) Noticeably, Chinese doctors did not stress much to me about the concept of *yin*, *yang*, and *qi*, for example. They simply thought these concepts were in every Chinese’s mind so they didn’t need to mention any more. When I probed, they can’t explain in a systematic and lengthy way as some Western literatures did.
Equality and privacy were highly appreciated compared to the situations in China. Patients and doctors shook hands when patients entered and left the consultation rooms. In China it didn’t happen unless the doctor and the patient knew each other from their social network.

As for privacy, doctor D2 had vivid comparisons about the situations in China and in the Netherlands to illustrate:

“When I talk to patients here, other people are not allowed to be present. In China, there were two big rooms, one for men, one for women. All patients with same gender lay in the same room to get treatment.”

These cultural aspects were quite new at first to Chinese doctors compared with their previous experiences in China, so they needed to find their way and to adapt themselves not only in their medical practices but also to Dutch culture in a broad sense.

4.3. What do Chinese doctors think about practicing TCM in the Netherlands?

One regret Chinese doctors expressed was that in China, they can prescribe both Chinese and Western medicines, and they can use a lot of medical facilities. Here only Chinese medicines can be prescribed, and the number of medical facilities that can be used are few. This situation is, of course, closely related to the fact that in China, both Western and Chinese medicine are accepted and supported by the government as state medicines. Chinese doctors are also recognized physicians, and they have every right and privilege to prescribe all kinds of medicines, and ask patients to do all kinds of Western lab examinations if necessary. But here in the Netherlands, being one form of complementary and alternative medicine, Chinese therapeutic substances fall into the food category and are not considered as “medicines” by Dutch legislation.

When asked what they felt about practicing in the Netherlands, doctors generally thought that here they cannot fully develop their professional potentials. In China, Chinese medicine is supported by the state financially for research and clinical trials. As
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part of Chinese culture, it was in everyone's subconsciousness. The root of Chinese medicine is in China. If a Chinese medicine doctor wants to do academic research and clinical breakthroughs in Chinese medicine, he should be in China. Just like doctor DS put it,

"Chinese doctors have a more promising future in China than here, because all kinds of experts are needed in China as it's so big a country. The Netherlands is a small country already full of experts. As a Chinese here, sometimes you are not paid attention to and even discriminated. Chinese medicine belongs to preventive medicine, and Chinese doctors are not considered as 'real' doctors as Western doctors are."

The attractive thing for Chinese doctors to practice here, however, was that the Netherlands had a better environment, and people were better educated. Obviously they felt more or less a loss in their personal reputation and social status as being a doctor, but their life quality remains the same or better in a broader sense in most cases.  

4.4. Observations of clinical encounters with Chinese medicine

During my study, I also paid much attention to direct observations since I understood that clinical encounters were most important between doctor-patient relationships. By observing I could find something that was missing by simply talking with people. Also, I could crosscheck whether the information I gathered was true by observations besides talking with different people on the same topics. I made observations mainly with the two doctors who needed translators to help them. I myself wanted to see the doctor-patient relationships with my own eyes. Although I could observe other clinical encounters with doctors who spoke some Dutch, and they could explain to me later, obviously, it was not the same as listening directly myself. So below all these four conversations were conducted in the presence of a translator. I selected these four cases in order to illustrate four important themes that structure the encounters.

8 I highly doubt that financial advantage in the Netherlands is one of the most important attractions for Chinese doctors to practice here. When I raised this issue, however, doctors denied it as a reason, saying they almost earned the same as that in China. I sensed this was a sensitive topic unsuitable to probe further in my short study period.
between Chinese doctors and their Dutch patients. These four themes are about Chinese and biomedical therapeutic drugs, biomedical laboratory reports, a patient with many complaints conducting self-diagnosis and medication, and a situation when Chinese herbs don’t work.

The routine of every consultation with a translator was like this: the translator showed the patient in with the medical record. The patient shook hands with the doctor, and then sat opposite to the doctor with a table in between. The translator sat at the same side with the doctor. When I was there, I sat at the third side of the table, wearing a white coat. I explained myself to the patient as a medical anthropology student doing research in TongRenTang when I shook hands with her/him. Normally they didn’t show any surprise to my presence. During the consultation, the doctor wrote down the medical records carefully when listening to the translations. After the consultation, the translator showed the patient out to the dispensary to take herbs. The patient shook hands again with the doctor (and me), saying ‘Dag’.

4.4.1. Therapeutic drugs in the confrontation between Chinese medicine and biomedicine

Case introduction:
It was the afternoon of June 15, 2001. I was chatting casually with doctor D3 in the branch of herbal medicine, when the Indonesian translator T2 showed a female patient in. She’s a black woman, 61 years old. That day it was her first visit to TongRenTang. This case shows how the Chinese doctors reacted to patients’ combined use of both biomedicine and Chinese herbs.

Case description:
As usual, T2 started to ask questions. She began to translate after talking with the patient for a while. The patient said that her hair began to shed six years ago. From October last year, she had been nervous. Since then her hair disease aggravated. She had had high blood pressure for twenty years, but it was well controlled by Western
medicines. Then her GP thought maybe her hair problem had something to do with her medicines for high blood pressure, so he prescribed a hormone medicine for her hair problem, and also reduced the amount of medicines she needed to take for high blood pressure. She’d also got examinations for her thyroid glands and kidney. The result was fine. D3 asked, “Is your scalp itching?” “No.” “Do you have a lot of grease on the scalp?” “No.” Then the patient asked whether the doctor needed to see her Western medicines. He said OK without much interest. She took out four medicines, including two for heart disease, one for widening the blood vessels, and one for hair problem, which was a kind of female hormone. T2 wanted to find out whether these medicines had side effects. Since she’s not familiar with Western medicine, and the dictionaries the clinic had were only English-Chinese ones, she didn’t find any useful information. D3 didn’t look at the medicines at all. [A contradiction here is that doctor D3 told me that he referred to patients’ Western medicines, but from my observations he didn’t. A possible reason was that the instructions for Western medicine were in Dutch that he could not read. He told me what he thought he should do, not what he really did.] When T2 was busy with looking up a dictionary, the doctor took the patient’s pulse and asked about her sleep. She said it was not so good. After that, he prescribed herbal medicines for three weeks. The patient asked, “Can I take Western and Chinese medicines at the same time?” “Yes.” [He cannot say no because he is in a biomedicine dominated society. Maybe he also thinks whether to take Chinese and Western medicine simultaneously is not his business.] She also said her GP recommended her here. After that the patient asked about the time schedules for taking Western and Chinese medicines. [Here the translator explained without asking the doctor. Maybe she’s already familiar with these routines. So I didn't know what she's talking about because of the Dutch language she used.] She also said she had been to a homeopathy, but the medicines made her problem worse. She wanted to know whether she should continue those medicines. [Again the translator answered, she said it’s the patient’s own business without asking the doctor.] The whole process lasted 27 minutes.

Case analysis:
This consultation has at least one thing worth noticing, besides translating problems. There is a problem that Chinese doctors can’t get enough information about Western therapeutic drugs especially when the instructions are in Dutch while translators don’t have enough medical knowledge to give sufficient language help. Thus doctors are unable to give patients recommendations of whether and how to take Western and Chinese medical substances together. Or maybe, doctors don’t care because they think it’s not their business. Klepser et al (2000: 83-87) found that although many drugs and herbals may be safe when taken alone, the risk of significant interactions increases when several agents are ingested in combination. In this case the patient is recommended by her GP, but in many other cases, GPs don’t know about their patients’ visits to Chinese doctors, so possibly, side effects of combinations of different kinds of drugs can arise, sometimes they may be very serious, I suppose. An alerting fact is that Drivdahl et al (1998: 193-199) found that two-thirds of patients who used alternative care did so in conjunction with traditional medicine, whereas only 16 percent used it in place of traditional medicine, and 18 percent used it where traditional medicine failed. There is hardly any evidence that those who consult heterodox practitioners have lost faith in orthodox medicine. Therefore the interactions between different kinds of drugs need more attention.

I was told on another occasion by T2 that some patients thought it’s enough to take only one kind of medicine, so they tended to stop their Western medicines when starting to take Chinese medicine. They did this without informing their GPs. This is dangerous as well, since their health might suffer if medication is stopped without consulting a Western doctor.

4.4.2. Biomedical laboratory reports in the practice of Chinese medicine

Case introduction:

This case happened on the same day with the same doctor and translator. The patient was also a black woman, 37 years old. She came here with her daughter. Both had problems to consult Chinese doctors. It was her turn now after doctor D3 prescribed
medicines for her daughter first. Her case is an example of how Chinese doctors asking patients for lab results. Indirectly, it also reflects subtle relationships between Chinese practitioners and biomedical doctors.

**Case description:**

The patient had a skin disease and gallstone problems. Her GP asked her not to eat peanuts and beans and to take less oil than usual. She had swollen thyroid glands ever since she gave birth to her daughter eight years ago. She didn’t take clinical examinations for the swollen glands. D3 asked her to get physical examination next time. But he didn’t stress it, nor did he ask the patient to take the result with her next time. [Doctor D3 told me he always asked patients for lab reports, a contradiction with his actual behavior.] The patient said she didn’t have a good appetite. D3 prescribed herbs for two weeks including ingredients to treat her skin disease and improve her appetite. The consultation lasted 20 minutes.

**Case analysis:**

After the patient left, D3 told me he had a different opinion about her GP’s instruction to take less oil. He said that if the stone in the gallbladder was small, more oil should be taken to excrete it. But since he didn’t know whether the patient’s gallbladder had been examined or not, and because the patient came for her thyroid glands problems, he didn’t say anything about that. This was also an indirect confrontation with the family doctor, which clearly shows unequal social status of Chinese doctors and Dutch GPs.

Another problem arising was about lab reports. In this case the patient hadn’t taken a lab examination yet but the doctor knew it’s important to get it to facilitate his diagnosis and prescription. But he didn’t stress it. Here it’s safe to conclude that he was afraid of the GP’s possible non-collaborating. He didn’t want to confront such kind of situations because otherwise he would have to admit that he has not the same status in Dutch health care system as biomedical doctors have, while in China he had been for many years a respectful doctor in a big comprehensive hospital. This case illustrates clearly Western doctors’ higher social prestige and Chinese doctors’ insecurity in
practicing in the Netherlands. Chinese medicine is heterodoxy, so TCM doctors are very careful to find a position between Dutch patients and biomedical doctors.

4.4.3. A patient with a lot of complaints conducting self-diagnosis and medication

Case introduction:
A 51-year-old white female patient came to doctor D3’s consultation room. She was an example of a Dutch patient having a lengthy statement of their complaints. Information can also be got from my descriptions below about how self diagnosis plays a part in clinical encounters with Chinese medicine.

Case description:
The patient said her dental laminae had been swollen for some time, so she took antibiotics, but with little effect. Normally she didn’t take antibiotics. She caught a cold the Sunday before and had a high fever of 39°C the following Monday and Tuesday, accompanying joints aches, sneezing and coughing. Before she had problems in her right arm’s joint, but it recovered after physiotherapy and acupuncture. But now it came back again and the pain spread. She had a sore throat at the beginning of her cold, but now it was OK. Her mood was not stable and she wept a lot. Also her left ear ached. The aches caused her headaches. She also sweated so much that her back always got wet. After her statement, the doctor measured her pulses. The patient wanted to have herbs in order to enhance her immune system. [Here the patient diagnosed herself] She asked, “I’ve had the problem with my dental laminae for one and half months, can you also prescribe herbal medicines treating that?” She also thought her dental laminae problem gave rise to her cold. D3 didn’t answer any of her questions. He prescribed herbal medicines for one week. T2 gave her the instruction of how to prepare herbs. The consultation lasted 19 minutes.

Case analysis:
This patient was typical in that she had a lot of complaints. She seemed to have some knowledge of Chinese medicine as she asked for herbs to enhance her immune
system. I could not judge whether her diagnosis and "prescription" were the same as the doctor's, since the doctor didn't say anything.

After she left, I asked doctor D3 why he didn't answer any of her questions. He's a doctor who usually doesn't talk much. He said sometimes it's hard to give a judgment, such as to her question of whether her dental laminae problem gave rise to her cold. So he just prescribed raw herbs for one week to see whether it worked. TCM doctors always say about Chinese medicine that 'we know it works but not how it works'. Just try at first before any judgment is made.

It was not clear of what was her main problem. I thought it was pain, but the doctor said it was cold. The medicine was mainly for her cold. He thought she would be fine when her cold was cured.

4.4.4. What does a Chinese doctor do with patients for whom Chinese medicine does not work?

Case introduction:
This was a sunny Saturday morning of June 16. I was chatting with another doctor, doctor D4, also in the branch of herbal medicine. A 36-year-old male patient with the problem of psoriasis came. With this case I want to illustrate how a Chinese doctor reacts when Chinese herbs do not seem to work. Meanwhile, the way doctors deal with lack of herbs is also described.

Case description:
First the doctor asked, "How do you feel now?" The patient answered, "No improvement." The doctor then inspected the patient's hands and asked, "How about itching?" "The same, especially in the knees." "How about your stool?" "Good." Then the doctor said, "You need a relatively long time to see the improvement of your problem. Be patient. Also, since you are now taking processed medicines, they work more slowly than fresh herbs. But they work at last." Then the doctor measured the patient's pulse and
tongue. He continued to prescribe processed herbs this time, and gave one more medicine than last time. They were for two weeks’ use. When the patient went to take his medicines, people in the dispensary called to say they didn’t have a certain medicine in the prescription. The doctor then changed the prescription. The consultation lasted only 5 minutes.

Case analysis:

This time the doctor was a different one, and he talked more. But in general, doctor D4’s clinical interchanges with patients were not as long as those of doctor D3. One possible reason was that his clinical encounters with patients I observed were not the patients’ first visit, so they took less time. Also different doctors had different personal characteristics and ways of treating patients. For this patient to whom the medicine hadn’t worked until then, he reassured the patient about the treatment, no matter whether he’s sure he can cure the disease or not. According to him, doctors should be confident of their treatments in any case, and then it’s helpful to establish patients’ own confidence to cure the disease.

Sometimes it happens that a certain herb, processed or raw, is out of stock, so doctors have to change their prescriptions. This did, more or less, influence the medicine’s efficacy. All the medicines in the clinic—raw herbs and patented ones—were imported from China.

These clinical observations, together with my in-depth interviews with all six doctors in TongRenTang, show Chinese medicine’s heterodoxy in the Netherlands, and its care is mainly patient-driven.
Chapter 5.

Confrontations with Chinese medicine—Dutch patients’ perceptions

The first part of this chapter is an exploratory study of the reasons why Dutch patients visit Chinese medicine therapists. I had in-depth interviews with six patients since my primary interest was to have intensive conversations with all Chinese doctors in TongRenTang. I interviewed patients in order to better understand TCM doctors’ medical practices in the Netherlands. Doctors and their patients can never be separated in their clinical diadic relationships. In order to get more information about patients’ health profiles, I conducted a quantitative study in the form of a questionnaire, the results of which are shown in the second part of this chapter.

5.1. Why do Dutch patients turn to Chinese medicine?

In order to find some important and sensitive themes that played a part in the decision of Dutch patients’ visiting TCM practitioners, I conducted in-depth interviews with six patients. My main focus was on Chinese doctors’ perceptions and experiences, since few researches were done about TCM doctors’ medical practices in the Netherlands. I interviewed all six TCM doctors in my study site, having long conversations with each of them many times besides observing their actual clinical practices. Doctors and patients are a union in the medical reality, so in order to understand Chinese doctors better, I also hope to gain some insight about factors that influence Dutch people’s health seeking behavior, especially their choice for Chinese medicine.

5.1.1. Beliefs in Chinese medicine’s efficacy and previous experiences of orthodox medicine as ineffective

Patients may turn to Chinese medicine for several reasons, the most important of which was its effectiveness. Effectiveness was equally stressed by both doctors and patients, as doctor D2 said:
"Some people try Chinese medicine for only once to see whether it works. So you must be really good in your treatments, skills and techniques to solve at least some of their problems in the first time. He will continue his treatment only if he can feel the improvement of his health situation."

P1 said she’s not happy with the flavor of raw herbs, but she turned to it willingly when processed herbs failed to treat her skin problem and it relapsed after she stopped taking raw herbs. She said:

"But it (herbs) works. You can see the result, and then you do that (drink herbal tea). ... I’ve been to all different doctors, Western, homeopathy, everything. I’ve taken all kinds of pills. But nothing really works."

P2 was very satisfied with Chinese herbs, as she thought only with herbs can she walk again. At the same time, she was disappointed by biomedicine, which she expressed in the following words:

"The Western doctor, he knows, there’s nothing he can do for me. He told me already, ‘We know you have that problem, but there’s nothing that we can do about it.’ Then I looked for something else. ... All the time when I go to a Western doctor, I’m terribly sorry, but they never can help me. Whatever I’ve got, they can’t help me.... I’m very grateful about that, only with the herbs I can walk again. It took me two years before I could walk again, but I can walk now, and I walk well. I cannot run, I cannot climb mountains or whatever, but I can walk...."

At the time of my interview, P4 had tried Chinese medicine for three times after biomedicine had failed to cure his depression. Chinese medicine hadn’t worked for him yet, but he hoped that it would work:

"I had used one and half years of Western medicine, but I’m still depressive, now I don’t trust them anymore. So I take an alternative medicine. ... If they (Western doctors) don’t know what is going on, they say you have to live with it. I don’t accept that. I’m thirty years old now, and I lived twenty-eight years without depression. I want to reach that situation again. Chinese medicine has a history of thousands of years, while Western medicine doesn’t have so long a history. So I think they have more experiences in treating diseases."
Patients were willing to endure the bitterness of raw herbal medicine, tolerate the uncomfortable feeling of acupuncture treatment, and pay by themselves if they can see the improvement of their complaints. Sometimes they confided in Chinese medicine with the hope that Chinese medicine would work for their problems although it took time to see the positive consequences immediately. It’s common that before patients visited Chinese doctors, they had already tried Western medicine for the same problem, and sometimes also other forms of alternative medicines. They turned to Chinese medicine after they were disappointed by all methods they had tried. Chinese medicine was one of their last resorts.

5.1.2. Belief in the safety of Chinese medicine and concern about the adverse side effects of biomedicine

Patients had a common opinion that Chinese medicines are from nature, so they had no side effects as chemical Western medicines had. Like P2 put it:

“It’s herb, it’s the same as food. You need that food, like you need ginger. You need the herb. We eat it normally, like an animal does. It’s normal. I’ve always been against pills from the Western doctors, like aspirins, like whatever. Western medicines have a very strong taste, and I have been so sick from the medicines. So sick that I could not walk. I had a diarrhea, and I could not go to the toilet. That is hell! That is hell!! I think Western medicines are very strong. Like penicillin, it kills so much in your body.... All pills are processed and I don’t like it. I try not to use them.”

P4 had the same opinion with P2:

“I prefer herbs to chemical medicines. Herbs are natural, so I trust them more. If you take chemical medicines, you may not drive, you may not drink, ...and you get so many other problems. I hope those herbs don’t have side effects. I hope they can work, then I can drive cars and do all other things I want to do, like I used to do in early times. Officially when I take Western medicine, I can’t drive a car, because it takes your concentration away.”

Although it’s too early to generalize my findings about patients’ different images about Chinese and Western medicine, and it’s questionable to agree with patients that
Chinese medicine is completely free of side effects, it seems that the perceived non-toxicity of Chinese therapeutic drugs attracts Dutch patients.

5.1.3. More attention from Chinese doctors

Another important factor why patients favor Chinese medicine was that they felt they got more attention from Chinese doctors. As P1 put it:

“The Western doctors say, ‘Here you get the pills. Bye!’ It’s more like that, and here I can talk. I’m not sent away easily.....I think they (Chinese doctors) are really trying to make people better and not come back. They are really enthusiastic when they see you and it’s better. You don’t have that in Western doctors.”

P4 expressed his feelings from another way:

“The Western doctors only give you medicines, but they don’t ask what is really going on. I have the feeling that they don’t take me seriously. Chinese doctors ask the right questions concerning my feelings. What is important is that the doctor takes me seriously, and he listens to my story.”

P5, a fifty-seven-year-old woman wanting to reduce weight, was very satisfied with the Chinese doctor D1, who is a Chinese from Indonesia:

“He tells you everything that you want to know. If you ask something, he will tell you. He doesn’t close his mouth. That’s good, that’s what I like. But when I went to a Western doctor to say I wanted to lose my weight, he said, ‘Do it at home.’”

In the West, more attention from alternative healers has already become a marker and advocating slogan for alternative medicine. In TongRenTang, the fact that doctor D1 had more patients than other doctors also proved that patients were expecting care and concern. Attention seems to be an important factor and provides a reason why they visited Chinese doctors.
5.1.4. Cultural affiliation

Cultural affiliation was also an important reason for patients' turning to Chinese doctors. Two of the interviewed patients had had experiences with Chinese medicine before and even had had some connections with Chinese culture in one way or another. Both of them, P4 and P6, were from Surinam originally. As P4 said,

"My elder sister married a Chinese guy. I eat and make Chinese food myself... If you want to go to a specialist, you have to take a paper first from the family doctor. My preference is a Chinese or a Surinam doctor, or a doctor from another (Asian or African) country."

P6 was quite familiar with Chinese medicine, since when he was in Surinam, he had already got treatment from Chinese doctors:

"There are many, many Chinese doctors in Surinam. They brought medicines there. We also use herbal medicine.... In Surinam only Chinese doctors treated me. My doctor in Surinam was a Chinese."

Cultural affiliation made Chinese medicine easier to accept, and they complained less about raw herbs' bitterness, while trusting Chinese medicine more. In all, because of cultural background that familiarized some patients with alternative medicines, they had some knowledge about them already, thus they had fewer puzzles and baffles than original Dutch patients.

5.2. Results of questionnaire for Dutch patients

Since my main interest was concentrated on Chinese doctors' TCM practices and experiences in the Netherlands, I only interviewed six patients in an in-depth way. In order to gain some more general information about Dutch patients' health profiles and health seeking strategies to complement my interviews, I conducted this preliminary quantitative study at the end of my study. Six patients I interviewed were not included in this survey. I distributed 30 copies of a questionnaire in the clinic's waiting room in a random way. After the patients finished the questionnaires, I sometimes asked them a few questions for clarification of their answers and some related topics that did not appear in
the questionnaire. It usually depended on whether the patient was willing and able to talk in English.

With the purpose of making it easy for both myself and the patients, I made two versions of it, Dutch and English. Twenty-four were filled in Dutch, and six were in English upon my request that if they can also read and write in English, please do so for my convenience. No refusal was met. The results are shown in appendix 4.

After I carefully analyzed my quantitative research results, six general themes came out about Dutch patients who visit TongRenTang, which are patients’ gender, age, and education; lay referral; health problems; previous visit to Western doctors for the same problem; GP’s awareness; and health insurance status. Below I will present the results successively by comparing them with literature.

5.2.1. Patients’ gender, age, and education

Female patients are slightly more than male patients, which are 17 (57%) and 13 (43%) respectively. People between ages 35 and 49 consist the largest group visiting Chinese doctors, which are 33% in percentage (10 respondents). The next largest groups are people between 50 and 64, and above 64, which are 27% (8 respondents) and 23% (7 respondents) respectively. So in my survey, the majority of people using Chinese medicine are above 35. The percentage of patients getting education at or above college levels is 44% (13 respondents), and the percentage of patients receiving middle school education is 40% (12 respondents). These two groups are the largest ones among all the patients in this survey. Sharma (1992: 20) stated that in the Netherlands, more females used alternative medicine, and age groups were concentrated between 30 and 60 years of age, especially those who were between 35 and 50 years, fewer users were under 30 years and over 60 years. Users were normally with higher educational level than non-users. My result about Chinese medicine use shows the same tendency as that for people using alternative medicine in a broader sense in the Netherlands.
5.2.2. Lay referral

Sharma (1992: 42) concluded from her interviews that people usually consulted a complementary practitioner for the first time as a consequence of a personal recommendation from a friend or acquaintance. Impersonal sources of information were unimportant compared to local lay referral systems. The Dutch NIPG survey also found that 71 percent of respondents claimed that they had arrived at the idea of trying complementary medicine through suggestions made by friends, acquaintances or family members. In accordance with this literature, my survey found that 77% of the patients (23 people) are recommended to Chinese doctors by acquaintances, including friends, family members, and neighbors. It's interesting that so many patients are recommended by people they know. When I asked a respondent why he didn't come by himself, he said, "Of course you need a friend's idea about whether to go to this Chinese clinic. I'm not familiar with Chinese medicine at all, and I don't know what to do if I just come by myself."

5.2.3. Health problems

Health problems are all chronic, not acute. They can best be described as disruptive of normal life rather than life-threatening. Also these disorders are not easily treated with conventional medical therapies. Drivdahl et al (1998: 193-199) found that the most common problem for seeking alternative care was back pain, with 56 percent of users he asked listing this as their presenting complaint. In my survey, the two leading complaints are chronic pain (10 respondents, 28%) and skin diseases (7 respondents, 19%) respectively. I don't find in the literature about high percentage of alternative medicine use for skin problems. This is due to, according to Chinese doctors, the unique Dutch weather of humidity and having a lot of rain most time of a year. Skin disease is also difficult to treat with Western medicine. Quite a few patients visit Chinese doctors for more than one complaint, which is the same as the kinds of treatments they get. Some

9 The questionnaires in English and Dutch are shown in Appendix 2 and 3, respectively.
patients get treatments from different doctors. But it also happens that the same doctor can carry out different treatments.

**5.2.4. Previous visits to Western doctors**

The majority of the patients, which are 77% in percentage (23 in number), have visited Western doctors for the same problem(s) before they visit Chinese doctors. Chinese medicine is one of their last resorts. This is in accordance with the patients' expectations from Chinese medicines, where 60% (18 respondents) expect improvement and only 40% (12 respondents) expect complete recovery. Drivdahl et al (1998: 193-199) also found that most of the users of alternative health care (57 percent) had already seen their family physician for their medical condition.

**5.2.5. GP's awareness**

To the question of whether they inform their family doctors about their visits to Chinese doctors, 47% of the respondents (14 people) say “yes”, compared to 53% (16 people) saying “no”. Probably those who have discussed their use of non-orthodox medicine with their GPs are mainly articulate and highly educated people with a good deal of confidence in their ability to convince the doctors that their resort to non-orthodox medicine is justifiable, or at any rate in their own capacity to withstand his or her disapproval. This phenomenon may also due to physicians’ more open attitudes to alternative medicine in the Netherlands than internationally in general, as was stated by Knipschild et al (1990: 625-626), who said that especially for patients with chronic pain, acupuncture was considered efficacious by half of the Dutch doctors.

It is true that more GPs in the Netherlands than in other countries accept complementary and alternative healing, but the results from literatures are not always reliable due to low response rate (Visser et al 1990: 227-232). Irrefutably, still many Dutch GPs don’t accept Chinese medicine and have a very skeptical attitude toward it. Limitations and narrow-mindedness on the part of their physicians were cited by patients
on answering the question of why patients didn’t tell their GP for alternative medicine use. In a survey of women with breast cancer, 55-85% partook in CAM therapies but did not divulge use to their physicians due to assumed disinterest (Cauffield et al 2000: 1289-1294). Other reasons included that the sufferer had consulted the complementary practitioner about a very specific problem (e.g. back pain) which the GP had already been unable to treat and which the patient regarded as having no bearing on any other problem subsequently presented to the GP. The patient simply found no occasion to mention the non-orthodox treatment. More frequently, patients expressed a positive concern that their GP should not find out about it, fearing ridicule or disapproval. A general fear was that the doctor would regard resort to a non-orthodox practitioner as a flouting of his/her medical authority, a breach of the rules governing proper patient behavior that would disturb an otherwise harmonious relationship (Sharma 1992: 55-56).

5.2.6. Health insurance

16 respondents (53%) can get their money back for their visits to Chinese doctors totally or partly, while 9 of them (30%) have to pay out of their own pockets, and 5 respondents (17%) don’t know yet. So it can be concluded that use of Chinese medicine doesn’t differ in terms of health insurance status. The costs of treatment are not a disincentive to use. Chinese doctors also said that they didn’t consider patients’ insurance situations when they prescribed medicines to them.
I will now integrate my findings with the literature. The discussion will be divided into three parts. Two of them, Chinese doctors' medical practices in the Netherlands and perceived differences of Dutch patients are from the perspective of Chinese doctors and the third, reasons why Dutch patients visit TCM doctors, is from the perspective of Dutch patients.

6.1. Chinese doctors' medical practices in the Netherlands

Most doctors I interviewed pinpointed that they needed both Chinese- and Western-style diagnosis in order to treat patients better. Doctors viewed these two diagnostic methods as complementary. They thought biomedicine system of diagnosis was a valuable resource, and they referred to it whenever it was possible. Although doctors told me that Chinese-style and Western-style diagnosis were equally important in judging what diseases patients had, I had a strong impression that Western-style diagnosis was considered by Chinese doctors to be superior in many cases because it has a clear and definite disease name, while Chinese-style diagnosis was more or less vague. Doctors didn't express it clearly to me probably because they thought I was doing research to advocate Chinese medicine in the Netherlands, so they should highlight Chinese medicine's merits and Western medicine's limitations as much as possible.

This conclusion is in agreement with Kleinman (1980: 270) who says that in the confrontation of Chinese and Western medicine, the Chinese-style cognitive framework appears less adequate for certain problems than the Western biomedical orientation; and it is changing by attempting to absorb elements from Western medical science, especially its diagnostic procedures and disease names. This is a view shared by Chinese-style and Western-style doctors and patients in China.
Three basic principles of the Dutch primary health care system are listing, gatekeeping, and family orientation.Listing means that each Dutch inhabitant appears on the list of his or her own family doctor (huisarts). Patient records are maintained by the family doctor for each such patient, including medical history, risk factors, chronic diseases, medications, and all professional contacts/visits. The gatekeeping principle denotes that patients do not have free access to specialists or hospital care. Patients covered by the sickness fund require a referral card, and the privately insured must have a referral letter from their GP. (Melker 1997: 62-63). From this national health care context, we can infer that Chinese doctors' requests for lab results will be more easily met when a patient is referred by his/her family doctor.

Although a questionnaire survey conducted by Visser et al (1990: 227-232) in the Netherlands showed that almost all (90%) of the GPs sometimes referred patients to alternative practitioners, we should be cautious about the results. On the one hand, since the response rate of the questionnaire was only 60%, it's highly likely that only those GPs who were interested in alternative healing returned the questionnaire, which made the conclusion less reliable; on the other hand, actual contacts of GPs with alternative practitioners were mostly limited to those with Dutch government sanctioned medical or paramedical education. In my study group, most Chinese doctors get their degree in China, which is not approved by Dutch authority as formal medical education. So it would be safe to conclude that lab reports problems will continue to exist in TongRenTang in the foreseeable future. My small survey showed that only 3 out of 30 patients (10%) had been referred by a biomedical doctor.

Most patients (16 persons, 53%) in TongRenTang prefer not to inform their GP of their visits to Chinese medicine, which infers that they also have high tendency not to ask them for lab reports. During my research, I felt that in some situations where lab reports were needed, Chinese doctors didn't even ask for them because they thought there was a great chance that they would not get them, either because of the GP's reluctance to release them, or because patients would not ask at all. They were afraid of direct confrontation with the fact that their social status is much lower than that of Western
doctors. In Dutch society, only Western doctors are the authorities in the realm of health care.

Kleinman (1980: 262-277) observed in Chinese society that Chinese-style doctors do not name the problem for the patient. Their explanation is concentrated on how the patient should take the medicine and what foods he may or may not eat. Therapeutic substances are the most important component of Chinese medical care and are the focus of concern of patient and practitioner in Chinese culture. Diet is viewed both as a treatment and as a potentially major influence on the medicine. Dutch patients may have different views concerning Chinese herb's central status in Chinese medical care, but Chinese practitioners' perceptions about the importance of herbs and diet are the same as those in China. For them herbs are the heart of TCM.

Here we should not ascribe the apparent similarities of Chinese doctors' brief explanation both in China and in the Netherlands to the same reason. In Chinese society, as Kleinman(1980:262) stated, the Chinese-style doctor is the authority. He prefers not to explain much to maintain the secrecy of his knowledge as well as his high social status than his patients. In the Netherlands, however, Chinese doctors want to explain to satisfy their patients, since most patients visit them by lay referral, as is shown in my small survey and in the literature (Sharma 1992: 42), but they cannot owing to various reasons. First of all, they don’t have time. Normally they are busy during office hours and every patient has a certain time limit to get consultation and treatment.\(^\text{10}\) Another important reason is language problems. They can’t freely express themselves in Dutch. Doctors already noticed patients’ dissatisfaction with their explanations, and they tried had to have a better command of Dutch language. For example, doctor D5 had a Dutch-Chinese daily dictionary to which he always refers, and doctor D2 had several Dutch language learning materials and did self-taught study whenever he had time.

\(^{10}\)TongRenTang is privately owned and all the doctors are employed by the manager, so doctors are not free to decide how long they can spend for one patient. Therefore it would be dangerous to generalize my findings in the whole country of the Netherlands about Chinese medicine use. It’s very likely that a Chinese doctor who practices by his/her own treats patients differently in terms of length of time spent on each patient, extent of explanation of Chinese medicine, for example.
Chinese doctors in TongRenTang treat both somatic and psychological diseases in a medical and technical way. They rely on somatic and not psychosocial interventions to manage illness problems, with sole concern with the provision of a medical agent as a specific remedy. This is almost the same as Kleinman (1980: 278-285) who found that in Chinese society somatic therapies are used in all cases and are believed by most Chinese-style doctors to treat psychological as well as physical problems. Doctors discount the value of talk as a therapy, and see medicine as capable of curing the entire set of symptoms, which, though different in nature, are assumed to be manifestations of a single underlying problem. So instead of mentioning communication barriers as the reason for treating somatic and psychological problems alike, we should think of it as an intrinsic characteristic of Chinese medicine itself.

In clinical encounters in the Netherlands, Chinese doctors always tailor their care to the needs of the patients. When patients are afraid of raw herb’s bitterness, doctors apply strategies of allowing them to take raw medicine soup less in volume every time while taking more times every day, or to take it after meal contrary to the practice in China where Chinese herbs are normally taken before meal, or to add sugar to the medicine soup. When patients ask for processed herbs for fear of raw herb’s unpleasant taste and/or time-consuming processes, doctors always try to satisfy them as well. They also prescribe medicines for a longer time upon request, which may be as long as one month. While in China, normally the longest time for prescribing raw herbs is seven days.

The same applies to acupuncture and Tuina/massage. Doctors adjust themselves in treatment method in order to appease their patients, to let them feel less pain when they get treatments. In all, Chinese medicine, as a form of alternative health care, is a patient-centered care in a country where biomedicine is the only orthodox system. Alternative practitioners must "sell" their therapies to patients who have no strong motivation to continue treatment if they are not pleased with what they are getting and the best way of doing this is surely to provide customer-made treatment for the individual patient, a sure
case of client control. Most patients visit TongRenTang via lay referral, which also means that doctors should appease their clients in order to let them introduce other people in their social network to come when they fall ill.

Problems exist in the clinical encounters with the presence of a translator, the main problems being no Dutch corresponding words with Chinese unique medical terms, translators' lack of Chinese medicine background, unprofessional translating habits, and lack of proper dictionaries. According to Loustaunau et al (1997: 150), the translator must be perceived by the clients as non-threatening and encouraging. S/he must be trusted to translate the doctor’s communications exactly, without editing or altering what is said. It is advisable in the future to train translators about Chinese medicine knowledge and professional translating behaviors. A measure that can be immediately put into practice is to provide Chinese-Dutch and Dutch-Chinese dictionaries in consultation rooms.

6.2. Chinese doctors’ perceptions of Dutch patients

Some different perceptions by Dutch and Chinese patients about Chinese medicine, such as different situations to apply Tuina/massage, different perceptions of time needed for needle maintenance, different responses to faint, bleeding, and cupping in acupuncture, are mainly due to patients’ lack of experience with Chinese medicine. Patients can't receive enough Chinese medical knowledge by simply reading small brochures and introductory materials in the clinic’s waiting room. It's worthwhile for the doctors to invest their time by explaining more to patients about Chinese medicine, about how it works concerning the patient’s particular case. In a short run, it's good for the clinic to attract more patients; in a long run, it's helpful to facilitate Chinese medicine’s acceptance in the Netherlands.

A contributing factor about Dutch people’s misunderstanding concerning, for instance, acupuncture’s treating the whole body instead of a specific problem, is probably the result of misleading information about Chinese medicine from secondary literature in
European languages. Unschuld (1987: 1023-1029) has already found that in Western literatures, Chinese medical concepts are presented, and advocated, as alternatives to current Western interpretations of illness and disease. But in reality, Chinese medicine has many facets, and may be approached on various levels, and it is quite inappropriate to select one single facet, or approach one single level, and call this facet or level “Chinese medicine”, as is the case with the concept of holistic. These literatures tend to stress too much a dichotomy between a “Chinese medicine” that is holistically oriented, and a Western medicine that only pays attention to a specific organ or tissue.

Culture related differences about Dutch and Chinese patients perceived by Chinese doctors may due to different cultural backgrounds in these two Eastern and Western countries. For example, Dutch patients complain more than one problem in a lengthy way, they want to know more, and they strictly follow time schedules to take medicines. Chinese are more introvert, keeping their own ideas in their heart, which remains more or less the same in their health seeking behavior, while Dutch are more extrovert in expressing their ideas and feelings. In addition, Chinese people don’t ask a lot of questions because they already know the answers. Chinese medicine is part of their background, accompanying them ever since they were born. The fact that non-Chinese patients cannot provide descriptions that coincide precisely with Chinese diagnostic criteria, while Chinese patients can, illustrates the ways in which medical language is a learned phenomenon. (Bames 1998: 413-443) Besides adapting themselves to Dutch ways of thinking in their medical practices, Chinese doctors also need to be familiar with other cultural aspects such as consultation time, making appointment, privacy, and equality.

6.3. Why do patients turn to Chinese medicine?

My preliminary findings about why Dutch patients turn to Chinese medicine include four reasons. They are: trust in Chinese medicine’s efficacy and previous experiences of orthodox medicine as ineffective, belief in the safety of Chinese medicine and concern about the adverse side effects of biomedicine, more attention from Chinese
doctors, and cultural affiliation. However, I didn’t find patients who visit alternative healers because they consider Chinese medicine as more compatible with their worldviews and beliefs, as some literature states (Astin 1998: 1548-1553; Cauffman et al 2000: 1289-1294; Loustaunau 1997: 89). This may be because the number of patients I interviewed is not so much, and also, since my conversations with patients were in English, it may prevent them from talking freely about their deeper thoughts.

My findings show that perceived efficacy is the most important reason for patients seeking help from Chinese medicine. This opinion corresponds with Sharma’s conclusion (Sharma 1992: 205). Representatives of orthodox medicine have asserted time and again that before there can be any question of professional rapprochement between orthodox and heterodox medicine the latter must prove its efficacy scientifically. However I think that this is not so necessary to ensure clientele, since for many patients the question of scientific proof is not of primary importance. They have already tried orthodox remedies which are supposed to have been subjected to such rigorous testing but which have not worked for them. This has taught them that statistical rates of efficacy are less important than finding the treatment that works for the particular individual, who may or may not represent any kind of norm.

However, the requirement of providing scientific proof for Chinese medicine’s efficacy is relevant to Chinese doctors if they want to gain as much social prestige as that in China and be seen as physicians in the eyes of Western doctors. Some of them have already felt a loss because of different social status with Western doctors in the Netherlands. Whether to prove its effectiveness in biomedical way or more on the terms of TCM remains to be a dilemma in Chinese medicine’s future practices.

Sharma (1992: 48-52) stated that there are three patient types, namely, earnest seekers, stable users, and eclectic users, which also exhibit themselves in my study group of six patients. P4 is the one that behaved most obviously as an earnest seeker, willing to turn to other alternative methods if Chinese medicine also can’t help, while P2, P5, and
Chapter 7. Conclusions and policy suggestions

7.1. Conclusions

Most Chinese doctors in TongRenTang use both Chinese and Western methods to give diagnosis, the latter being related with the usage of lab results. On the one hand, Chinese doctors understand that their health care provided to patients could be facilitated greatly by referring to Western lab results; on the other hand, they sometimes, if not always, find it's difficult to obtain the copies of lab reports they want since it's not compulsory for Dutch general practitioners to give such information to them. Patients are not always willing to inform their GP about their alternative medicine use, so it's also not easy to get lab results through patients.

Chinese doctors only explain simply about Chinese medical theory concerning a patient's particular case, although patients are yearning for that. Possible reasons are doctors' lack of time during their busy clinical hours as well as language barriers. Most Chinese doctors can't speak Dutch freely. Patients also see Chinese medicine as physiotherapeutic as well as psychotherapeutic. But Chinese doctors are used to treat diseases by prescribing therapeutic herbs only and they don't live up to patients' psychological expectations. Although in China, situations are similar in that Chinese doctors also explain little to their patients, the reasons are different. In China, Chinese doctors appreciate their brief explanation in order to maintain their higher social status and to keep their somewhat mystery knowledge. In the Netherlands, however, Chinese doctors don't explain much not because they don't want to but because they are unable to. They want to please patients because their care is deemed to be patient-centered. In contrast, in China and in the Netherlands, doctors don't differentiate somatic and psychological diseases in terms of explanation and treatment. In both situations, doctors believe therapeutic drugs are the sole remedy. This phenomenon is probably something inherent in Chinese medicine itself, having little to do with cultural differences.
Doctors considered that raw herbs are much better than processed ones in that they are prescribed and prepared according to the needs of a separate patient. Different ingredients can be added or deleted on the basis of changing disease situations. The advantages of processed herbs, however, are that they are convenient and taste better. Doctors have developed several coping methods concerning patients' complaints about raw herbs' unpleasant taste. They may ask them to take less herbal tea in volume each time while taking more times every day, add sugar in the tea, or take it after the meal when the stomach is full of food, so they may not feel herbs' unpleasant taste. When patients can't tolerate its bad taste or are unwilling to undergo its time-consuming preparing routines, doctors have to change to prescribe processed herbs, although in most cases, raw herbs are more effective. This phenomenon, together with longer duration of herbs upon patients' requests, consideration of Dutch patients' high sensitivity to pains, among others, clearly reveals patient-centeredness of Chinese medicine in the biomedicine dominated Dutch health care system.

Because of different languages and cultural backgrounds, using a translator is common in TongRenTang. It will be a good idea to inculcate translators with Chinese medicine knowledge and train them how to translate accurately. Putting Dutch-Chinese dictionaries in the consultation rooms is also a solution to communication problems. Also it will be surely welcomed by patients to have stable doctor-patient-translator triangle relationships during clinical activities. Each patient should meet the same doctor and the translator in the whole duration of his/her visits.

Doctors feel that, compared with Chinese patients, Dutch patients have more complaints during a single consultation, and they elaborate all their disease histories, current as well as previous ones in a lengthy way. The also ask various types and numbers of questions. Another aspect of Dutch culture reflected in Dutch patients is their serious and rigid ways of taking raw herbal medicine. They take medicines punctually. At the same time, Chinese doctors also try to learn how to adapt themselves and their medical practices into local Dutch culture. For example, they acculturate themselves in terms of consultation time, appointment, privacy, and equality.
Doctors regret that in the Netherlands, they can only prescribe Chinese medicine instead of prescribing both Chinese and Western medicine as they did in China. They understand that Chinese medicine is not a form of officially accepted curative method. As a result, they express their opinion that Chinese doctors can have academic achievement and high social prestige only in China. The attractions of the Netherlands, however, are that it has better environment and fresher air, and people are better educated. Notably, doctors don’t specifically list economic factors as a chief reason for them to stay in the Netherlands, while I think money and medicine are closely related almost everywhere.

Dutch patients visit TongRenTang for chronic diseases. They are not acute and life threatening. According to the six patients I interviewed, the reasons—regardless of its possible bias due to small number of respondents—of Dutch patients’ turning to Chinese medicine are that, first of all, they believe in Chinese medicines’ effectiveness and their previous experiences of orthodox medicine are perceived as ineffective. Secondly, rightly or wrongly, patients perceive Chinese medicine as something from nature, thus it’s harmless to take, while Western medicines are processed and synthesized products, which are understood by patients as doing a lot of harm if taken for a long time in high quantity. Moreover, more attention getting from Chinese doctors is also an important reason. Patients criticize Western doctors for not emphasizing with them. Although communication problems because of language barriers exist during Chinese doctor-Dutch patient interactions, patients still feel their problems and their feelings are considered seriously by Chinese doctors, which satisfies them a lot. Last but not least, culture affinity also presents itself as a reason. Some interviewees have already had cultural affiliation with alternative and Chinese medicine in their home country, which makes it easier for them to accept Chinese medical treatment.

In all, my findings show that in the Netherlands, Chinese medical care is patient-oriented, and doctors try to meet patients’ requirements as much as possible. This is in sharp contrast with the situation in China where Chinese doctors are authorities in clinical encounters. The basic underlying fact is that in the Netherlands, only biomedicine is state
sanctioned and financially supported. It is the only orthodox form of primary health care. These two facts, patient centeredness and Chinese medicine's heterodoxy, are closely related and intertwined. They are the basis to understand my findings. Chinese medicine is heterodox in the Netherlands while in China it is orthodox.

7.2. Policy suggestions

Communication between biomedical doctors and complementary therapists, as well as between doctors and their patients, are indeed very important (Zollman et al 1999: 1558-1561). Greater cooperation and respect between orthodox and complementary practitioners would improve communication with patients. There are, however, often considerable barriers to such communication. These may result from philosophical and cultural differences, private versus public settings, and from underlying issues of power and control.

Bringing alternative services into the realm of managed health care is another issue worth considering by health policy makers (Weeks 1997: 14-28). By doing so, the providers of conventional and complementary services will be forced into a closer working relationship. Each will need to learn more about the strengths and weaknesses of the other. Perhaps only in the working triads of conventional providers, complementary providers, and their shared patients will complementary services be best understood and coverage decisions made. The integration of complementary and alternative medicine will be proved to be a good way to give doctors and the health profession an opportunity to bring together the strengths and to balance the weakness inherent in both systems of health care (Owen et al 2001: 154-158).
Appendix 1: Informants’ profiles

Chinese doctors:
D1: Male, 50*, Chinese from Indonesia, acupuncturist and Dutch GP, 24 years in the Netherlands.
D2: Male, 63, acupuncturist and herbalist, TCM doctor in China, 12 years in the Netherlands.
D3: Male, 61, herbalist, TCM doctor in China, 3 years in the Netherlands.
D4: Male, 55, herbalist, TCM doctor in China, 2 years in the Netherlands.
D5: Male, 47, Tuina/massage doctor, TCM doctor in China, 8 years in the Netherlands.
D6: Female, 45, herbalist, TCM doctor in China, less than 1 year in the Netherlands.

Dutch patients:
P1: Female, 22, Dutch, college student, not clear whether she can get money back from health insurance, herbal medicine treatment.
P2: Female, 44, Dutch with some origin from South America, high school degree, no health insurance for TCM, herbal medicine and Tuina/massage treatment.
P3: Male, 38, Dutch, HBO degree, not clear whether he can get money back from health insurance, acupuncture treatment.
P4: Male, 30, Dutch, high school degree, no health insurance for TCM, herbal medicine treatment.
P5: Female, 57, Surinamese, 33 years in the Netherlands, health insurance available, acupuncture treatment.
P6: Male, 46, Surinamese, 11 years in the Netherlands, HBO degree, health insurance available, acupuncture treatment.

Translators:
T1: Dutch translator
T2: Indonesian translator

* An approximate age
Appendix 2: English version of questionnaire for Dutch patients

Dear Sir/Madam,

My name is Xiaoqing Mao, a student of Medical Anthropology in the University of Amsterdam. I'm now doing a research about experiences of Chinese doctors and Dutch patients during clinical consultations and treatments. From this I want to know how different cultural factors influence doctor-patient relationships. I will be very grateful if you can fill in this questionnaire for me.

Since this questionnaire is for my Master thesis writing, it's not necessary for you to fill in your name. But if you are interested in my thesis, please write down your name and address, so I can send my thesis to you later. Thank you very much for your help!

Xiaoqing Mao
Meer en Vaart 442, K8
1068 LH, Amsterdam
Tel: 020-6107446

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<td>0 18-24</td>
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<tr>
<td>0 25-34</td>
</tr>
<tr>
<td>0 35-49</td>
</tr>
<tr>
<td>0 50-64</td>
</tr>
<tr>
<td>0 &gt;64</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. What’s your profession?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4. What’s your highest education?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Primary school</td>
</tr>
<tr>
<td>0 Lower secondary school</td>
</tr>
<tr>
<td>0 Higher secondary school</td>
</tr>
<tr>
<td>0 College</td>
</tr>
<tr>
<td>0 University</td>
</tr>
<tr>
<td>0 Others, please specify:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Who recommended you here?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Friends</td>
</tr>
<tr>
<td>0 Newspaper</td>
</tr>
<tr>
<td>0 My GP</td>
</tr>
<tr>
<td>0 Others, please specify:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. For what problem(s) do you visit Chinese doctors?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>7. Did you go to Western doctors for this problem before coming here?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Yes</td>
</tr>
<tr>
<td>0 No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Does your GP know your visit to Chinese doctors?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Yes</td>
</tr>
<tr>
<td>0 No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. What kind(s) of treatment(s) do you receive?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Acupuncture</td>
</tr>
<tr>
<td>0 Herbs</td>
</tr>
<tr>
<td>0 Tuina/Massage</td>
</tr>
<tr>
<td>0 Others, please specify:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Can you get your money back from your health insurance for Chinese medicine treatments?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Yes</td>
</tr>
<tr>
<td>0 No</td>
</tr>
<tr>
<td>0 I don’t know</td>
</tr>
<tr>
<td>0 Others, please specify:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. What do you expect from Chinese medicine?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Improvement</td>
</tr>
<tr>
<td>0 Complete recovery</td>
</tr>
</tbody>
</table>
Appendix 3: Dutch version of questionnaire for Dutch patients

Geachte heer/mevrouw,

Mijn naam is Xiaoqing Mao. Ik studeer Medische Antropologie aan de Universiteit van Amsterdam. Op dit moment ben ik bezig met een onderzoek naar de ervaringen van Chinese dokters en hun Nederlandse patiënten tijdens spreekuren en behandelingen. Ik wil graag weten hoe verschillende culturele factoren de relaties tussen dokter en patiënt beïnvloeden. Zou u alstublieft deze vragenlijst voor mij in willen vullen?

De gegevens die u invult op deze vragenlijst zal ik vertrouwelijk behandelen en uitsluitend gebruiken voor het schrijven van mijn afstudeerscriptie. Het is daarom niet nodig om uw naam in te vullen. Als u daarentegen geïnteresseerd bent in de resultaten van mijn onderzoek, wil ik u vragen om wel uw naam en adres te noteren. Dan kan ik u na afronding van het onderzoek een exemplaar van mijn scriptie toesturen.

Hartelijk dank voor uw medewerking!

Xiaoqing Mao
Meer en Vaart 442, K8
1068 LH, Amsterdam
Tel: 020-6107446

1. Bent u een man of een vrouw?
   0 man
   0 vrouw

2. Wat is uw leeftijd?
   0 <18
   0 18-24
   0 25-34
   0 35-49
   0 50-64
   0 >64

3. Wat is uw beroep? ________________________________

4. Wat is uw hoogst genoten opleiding?
   0 basisschool
   0 middelbare school
   0 voortgezet middelbaar onderwijs
   0 voortgezet hoger onderwijs
   0 universiteit
   0 anders, namelijk: ________________________________
5. Wie heeft u aangeraden naar een Chinese dokter te gaan?
   0 vrienden
   0 advertentie in de krant of weekbladen
   0 mijn huisarts
   0 anderen, namelijk: _________________________

6. Voor welke klacht(en) bezoekt u een Chinese dokter?

7. Heeft u voordat u besloot een Chinese dokter te bezoeken, eerst een Westerse
dokter geraadpleegd?
   0 ja
   0 nee

8. Weet uw huisarts dat u een Chinese dokter bezoekt?
   0 ja
   0 nee

9. Welk(e) soort behandeling(en) krijgt u?
   0 acupunctuur
   0 kruiden
   0 Tuina/massage
   0 anders, namelijk: _________________________

10. Vergoed uw ziektekostenverzekering de kosten van behandeling door een
    Chinese dokter?
    0 ja
    0 nee
    0 ik weet het niet
    0 anders, namelijk: _________________________

11. Wat verwacht u van de Chinese geneeskundige behandeling?
    0 verbetering
    0 herstel
Appendix 4: Social-economic factors and health seeking behaviors of surveyed patients

<table>
<thead>
<tr>
<th>Sex</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>13</td>
<td>17</td>
<td>30</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age: y</th>
<th>&lt;18</th>
<th>18-24</th>
<th>25-34</th>
<th>35-49</th>
<th>50-64</th>
<th>&gt;64</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>10</td>
<td>8</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>3%</td>
<td>10%</td>
<td>33%</td>
<td>27%</td>
<td>23%</td>
<td>99%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education:</th>
<th>Too young to have education</th>
<th>Primary school</th>
<th>Lower secondary school</th>
<th>Higher secondary school</th>
<th>College</th>
<th>University</th>
<th>Special school for gardeners</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>8</td>
<td>4</td>
<td>8</td>
<td>5</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>10%</td>
<td>27%</td>
<td>13%</td>
<td>27%</td>
<td>17%</td>
<td>3%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referrals:</th>
<th>Acquaintances (including friends, family members, neighbors, etc.)</th>
<th>Western doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>77%</td>
<td>10%</td>
</tr>
</tbody>
</table>
Appendix 4: Social-economic factors and health seeking behaviors of surveyed patients

Mass media 1 3%
No recommendations 3 10%
Total: 30 100%

Health problems:
Chronic pain 10 28%
Skin diseases 7 19%
Intestine diseases 5 14%
Arthritis 3 8%
Stopping smoking 2 6%
Stress and exhaustion 2 6%
Losing weight 2 6%
Headaches 2 6%
Epilepsy 1 3%
Sinus 1 3%
No response 1 3%
Total: 1 36 102%

Previous visits to Western doctors for the problem(s): 1
Yes 23 77%
No 7 23%
Total: 30 100%

Informing family doctors for the visits to Chinese doctors:
Yes 14 47%
No 16 53%
Total: 30 100%

Kinds of treatments received: 2
Acupuncture 12 31%
Fresh herbs 20 51%
### Appendix 4: Social-economic factors and health seeking behaviors of surveyed patients

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Packed herbs</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>Tuina/massage</td>
<td>4</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>39</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

#### Reimbursement from health insurance:

<table>
<thead>
<tr>
<th>Reimbursement</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes or partly</td>
<td>16</td>
<td>53%</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>30</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

#### Expectation from Chinese medicines:

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement</td>
<td>18</td>
<td>60%</td>
</tr>
<tr>
<td>Complete recovery</td>
<td>12</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>30</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Note:

1. Patients may have more than one health problem, so the total number may exceed 30.
2. In the branch of acupuncture, patients came every 15-20 minutes, and in internal medicine and dermatology, patients came every 20 minutes, while in Tuina/massage, the doctors spent one hour for every patient. So from the result of my questionnaire, it’s hard to draw a conclusion about the percentage of patients receiving different types of treatments in this clinic.
3. Patients may get more than one kind of treatment, so the total number may exceed 30.
Summary

Much literature exists about the use of complementary and alternative medicine (CAM) in the Western world, some of which has discussed the situation in the Netherlands, mainly focusing on the biomedical doctors' attitudes towards alternative therapies. But little information can be got concerning the practice of Chinese medicine in the Netherlands. This thesis thus tries to deal with clinical, trans-cultural experiences of Chinese doctors and Dutch patients in the context of Dutch culture. In this study, I chose a Chinese clinic in Amsterdam to be my research site, and interviewed all Chinese doctors there and six visiting patients. This in-depth study is explorative, trying to answer the following questions:

Concerning Chinese doctors:
- What are the differences and similarities of their Chinese medicine practices in the Netherlands compared with those in China?
- What are the differences of treating Dutch compared to treating Chinese patients?

Concerning Dutch patients:
- Why do they choose Chinese medicine?

Chinese doctors use both Chinese-style and Western-style diagnostic methods, the same as they did in China, to give a diagnosis. Sometimes they need to refer to lab reports to facilitate their biomedical diagnosis. However, it is often not possible to get lab results from Western doctors.

Chinese doctors explain little to patients during their clinical contacts. They owe this phenomenon to lack of time and language problems. They also don't differentiate between somatic and psychological problems in terms of explanation and treatment. They view Chinese herbs as the sole remedy to solve both problems.

Raw herbs are perceived as more effective than processed ones, as Chinese doctors can add or delete certain ingredient(s) in raw herbs to make them fit different patients and disease situations. Processed herbs have already been packed so it is impossible to change their ingredients. However, it is not uncommon that Dutch patients complain especially about raw herbs' bitterness. Doctors have developed several strategies to cope with this kind of complaint, such as suggesting patients to put sugar into the herbal soup. Doctors also prescribe medicines for a longer period than they do in China.

Because of not sharing a same mother tongue, a translator is indispensable especially for doctors who can't speak Dutch. Problems arise, however, due to several reasons. The main reason is that in many cases, the unique Chinese medical terms do not have a correspondence in Dutch, which makes it difficult to explain to patients. In China simplified TCM terms are also widely used in daily life, such as yin and yang, while
Dutch patients do not have the same Chinese background, and they tend to comprehend the concept of yin and yang in very different ways.

Dutch and Chinese patients have different perceptions and experiences about Chinese medicine. Some of these differences are originated from Dutch people’s lack of familiarity with Chinese medicine, such as their perceptions of acupuncture treating the whole body instead of a specific disease. This is in contrast to the situation in China where Chinese medicine is an indispensable part in Chinese culture. It’s in every Chinese’s subconsciousness. Other differences, such as Dutch patients’ lengthy story about their complaints, while Chinese talk in a very concise way, are inherent in Dutch and Chinese culture in a broad sense.

Patients may turn to Chinese medicine owing to their belief in Chinese medicine’s effectiveness and safety, more attention from Chinese doctors, previous experiences of orthodox medicine as ineffective, concern about the adverse side effects of biomedicine, and cultural affiliation. These reasons are very similar with those stated in various literatures.

In all, my findings show that, here in the Netherlands, Chinese medical care is patient-oriented, and doctors try to meet patients’ requirements as much as possible. This is in sharp contrast with the situation in China where Chinese doctors are the authority in the clinical encounter. The basic underlying fact is that in the Netherlands, only biomedicine is state sanctioned and financially supported, it is the only orthodox form of primary health care. While in China both biomedicine and TCM are supported by the government. One could say that Chinese medicine is heterodox in the Netherlands while in China it is orthodox.
摘要

诸多文献报道了补充与替代疗法（CAM）在西方国家的应用，其中的一些讨论了它们在荷兰的情况，主要是关于荷兰西医对替代疗法的态度。但是针对中医药在荷兰的现状，这些文献却鲜有涉及。本文试图讨论在荷兰文化背景下中医和荷兰病人的医患关系。选择了阿姆斯特丹的一家中医诊所作为研究地点，对那里的所有中医和六个荷兰病人进行了深入访谈。本文试图寻求以下几个问题的答案：

对中医而言：
——在荷兰与在中国行医的异同；
——诊疗荷兰与中国病人的异同。

对荷兰病人而言：
——他们找中医看病的驱动因素。

和在中国一样，中医结合使用中西医诊断方法下诊断。有时他们需要参照西医化验单帮助进行西医诊断。但是由于种种原因，并不是每次都能得到西医化验报告的。中医向病人解释很少。这种情况被他们归因为门诊时间不足和一定的语言障碍。在解释和治疗方面，他们亦不对心理和生理疾病进行区分。在这两种情况下，具体有形的中药被等同地视为唯一有效的治疗手段。

中医普遍认为中草药的疗效强于中成药。中草药可以辨证施治，而中成药已是固定配方，无法针对不同的病人和疾病情况进行改变。常有荷兰病人抱怨中草药太苦。于是医生们想出了好几种办法试图减轻药的苦味，例如让病人在草药汤中加糖。另外在荷兰，开一次药可供病人服用的时间长于中国。

由于母语不同，门诊过程中常常需要翻译。现存的交流问题有好几种原因。主要原因为在很多情况下，中医特有的术语在荷兰语中没有对应词，于是很难向病人解释清楚。另外在中国，中医术语并不仅限于在中医药界使用，而是广泛地流行于日常用语中，比方阴阳。而荷兰人因为缺乏中国文化背景，只会孤立地看待与理解阴与阳的概念。

荷兰病人和中国病人对中医药有不同的感受和经历。这些不同之处有的是因为荷兰人对中医药不了解，例如他们认为针灸治疗全身所有疾病而不是只针对某个特定的疾病。在中国中医药是中华文化不可分割的一部分，它存在于每个中国人的潜意识中。其它不同之处则与广阔的中荷文化背景差异紧密相联，例如荷兰病人自述病史时间极长、极详细，而中国病人用语简洁。

荷兰病人找中医看病是认为：相信中医药安全有效；从中医处能得到更多的重视与关怀；同样的疾病以前看过西医无效；认为西药有副作用；以及文化亲合力。这些原因与现存的文献报道基本一致。
总之，我的研究结果发现在荷兰，中医药是以病人为核心的，中医尽最大可能满足病人的需要。这与中医在中国的现状形成鲜明对比。在中国的医患关系中，中医师是权威。造成这种不同的根本原因在于在荷兰，政府只认可西医，它是全民医疗保健中的唯一正统形式。而在中囯，政府对中西医同样承认与支持。中医药在荷兰是替代疗法，而在中囯，它是正统医药。
Samenvatting

Er bestaat veel literatuur over het gebruik van alternatieve geneeswijzen (Complementary and Alternative Medicine CAM) in Westerse landen, waaronder ook literatuur over de situatie in Nederland. Deze literatuur richt zich met name op de houding van biomedische artsen ten aanzien van alternatieve behandelingen. Slechts enkele studies hebben betrekking op de praktijk van Chinese geneeswijzen in Nederland.

Deze scriptie gaat over de klinische en trans-culturele ervaringen van Chinese artsen en hun Nederlandse patiënten in een centrum voor Chinese geneeswijzen in Amsterdam. De scriptie is het resultaat van een zes weken durend onderzoek in het kader van de Master-opleiding Medische Antropologie. Tijdens het onderzoek werden de in het centrum werkzame Chinese artsen en enkele van hun patiënten geïnterviewd. Daarnaast vulden dertig patiënten een vragenlijst in.

Het verkennende onderzoek had tot doel de volgende onderzoeksvragen te beantwoorden:

Wat zijn in vergelijking met de praktijk van Chinese geneeskunde in China de verschillen en overeenkomsten die Chinese artsen ervaren in hun Chinese geneeskundige praktijk in Nederland?

Wat zijn de verschillen die Chinese artsen ervaren in de behandeling van Nederlandse patiënten vergeleken met de behandeling van Chinese patiënten?

Waarom kiezen Nederlandse patiënten voor Chinese geneeswijzen?


De artsen geven de voorkeur aan losse kruiden in plaats van kruiden die verwerkt zijn tot pillen of al verpakt zijn. Zij kunnen bij losse kruiden namelijk zelf bepalen welke ingrediënten zij zullen kiezen en bepaalde ingrediënten weglaten of toevoegen als dit beter past bij de patiënt en zijn ziekte. Bij verwerkte kruiden is het niet mogelijk om ingrediënten te veranderen. Nederlandse patiënten klagen dikwijls over de bittere smaak van de losse kruiden. De artsen hanteren verschillende strategieën om op deze klachten in te spelen. Ze geven de patients bijvoorbeeld het advies om suiker toe te voegen aan hun kruidenbrouwsel. Iets wat in China niet gebruikelijk is. Daarnaast schrijven de Chinese artsen de medicatie voor een langere periode voor dan zij zouden doen in China.

Aangezien de Chinese artsen en hun Nederlandse patiënten niet dezelfde moedertaal spreken, is een tolk tijdens het klinische contact onmisbaar, vooral als de arts geen Nederlands kan


Nederlandse patiënten kiezen voor Chinese geneeswijzen vanwege een geloof in de effectiviteit en onschadelijkheid van Chinese geneeswijzen, het idee dat Chinese artsen meer aandacht aan hen besteden, negatieve ervaringen met orthodoxe geneeswijzen of bezorgdheid over de bijwerkingen van biomedische geneeskunde. De redenen die genoemd worden door de geïnterviewde patiënten in dit onderzoek komen overeen met de redenen die genoemd worden in de literatuur.

De Chinese medische zorg in Nederland richt zich op de patiënt. Uit de literatuur blijkt dat dit ook het geval is in andere Westerse landen. De artsen proberen zo veel mogelijk aan de vraag en behoeften van de patiënten tegemoet te komen. In China is dit anders. Chinese artsen in China zijn de autoriteit tijdens een klinisch consult. Dit verschil is te verklaren door de situatie waarin de Chinese geneeskunde in Nederland zich bevindt. In Nederland wordt alleen de biomedische geneeskunde erkend door de overheid en financieel ondersteund. Biomedische geneeskunde is de enige orthodoxe vorm van de primaire gezondheidszorg. In China daarentegen worden zowel de Chinese traditionele geneeskunde als de Westerse biomedische geneeskunde ondersteund door de overheid.
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