

Rochelle, T.L. (2005). Health-seeking behaviours and use of traditional Chinese medicine among the British Chinese. (Unpublished Doctoral thesis, City University London)



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**HEALTH-SEEKING BEHAVIOURS AND
USE OF TRADITIONAL CHINESE
MEDICINE AMONG THE BRITISH
CHINESE**

TINA LOUISA ROCHELLE

**In partial fulfilment of the requirements of the degree of
Doctor of Psychology at the Department of Psychology, City
University, London**

JULY 2005

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SECTION A: INTEGRATIVE SUMMARY

This dissertation for the Degree of Doctor of Psychology (Health) presents three pieces of work: 1) Systematic Review of Acupuncture as an Intervention for the Alleviation of Chronic Back Pain. 2) Health-Seeking Behaviours and Use of Traditional Chinese Medicine among the British Chinese 3) Design of an evaluation to measure outcomes of a Traditional Chinese Medicine Clinic for a Chinese Health Centre in London's Chinatown. The underlying theme linking these three pieces of work is Traditional Chinese Medicine (TCM) and health-seeking behaviours. This thesis applies different methodologies to examine the use of TCM amongst British Chinese communities and also to explore the influence of culture and values on the health-seeking behaviours of British Chinese communities. The main aim of this thesis is to attempt to better understand the health-related issues of TCM and Chinese people living in Britain.

At the 30th World Health Assembly in 1977, the World Health Organisation officially recognised the importance of integrating traditional medicine into health care systems. This policy change was based on the understanding that traditional medical knowledge can work as an additional resource for health care delivery (WHO, 1979).

The empirical research entitled 'Health-Seeking Behaviours and Use of Traditional Chinese Medicine among the British Chinese' encompasses two studies; in the first study 'The influence of cultural beliefs and cultural values on the health-seeking behaviours of British Chinese' a Chinese Health Behaviour and Value Survey is conducted in an attempt to explore British Chinese attitudes, beliefs and behaviour towards TCM and Western medicine.

The second study is entitled: 'An examination of British Chinese health-seeking practices and beliefs: Perspectives of Chinese health and community workers and lay members of the London Chinese community'. This study uses qualitative research methods in the form of focus groups to explore the relationship between cultural beliefs and cultural

values and the effect these values and beliefs have on the health-seeking behaviours of British Chinese individuals.

Results revealed that cultural beliefs play an important role in contributing to and influencing health-seeking behaviours, odds of using TCM were revealed to increase if the individual is a Cantonese speaker, concurrent use of both Western medicine and TCM is shown to be both widespread and common many respondents use TCM when Western medicine (WM) fails to clear symptoms of ill health TCM is also regularly used to boost health and restore balance to the body after taking WM to recover from an illness. Respondents were shown to have a higher expectation of Western medicine and a lower expectation of TCM in relation to the power of the medicine and the speed of the recovery process.

Bad practice of TCM is shown to influence perception of UK TCM practice this is shown through the lack of confidence in the UK TCM system expressed by respondents due to lack of official regulations for TCM and practitioners and previous bad UK TCM experiences. However, despite a demonstrated lack of confidence in the practices of TCM in the UK, use of TCM was shown to be prevalent amongst British Chinese communities. Culture and religion were both shown to be highly significant factors in the prevalence of TCM use, though interestingly respondents failed to identify the importance of religion and culture in health-seeking behaviours.

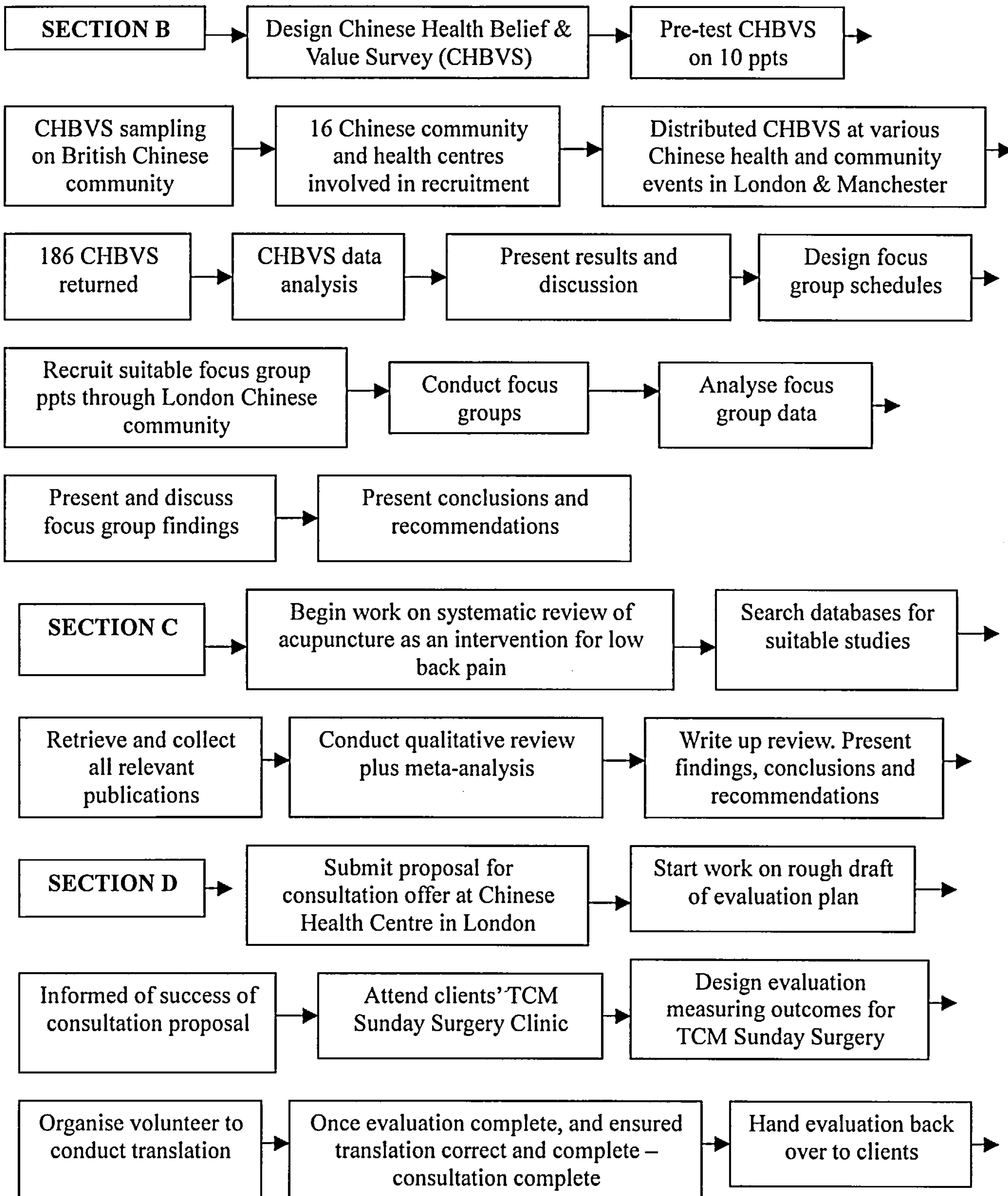
Answers from open-ended questions reveal that British Chinese individuals believe Western medicine to be faster acting than TCM and more scientifically-based than TCM though Western medicine was strongly believed to have more side effects from the chemicals of the drugs prescribed than Traditional Chinese Medicine. TCM was more commonly used for chronic illnesses and for maintaining and regulating health status TCM was viewed as more effective than Western medicine for treating some chronic illnesses.

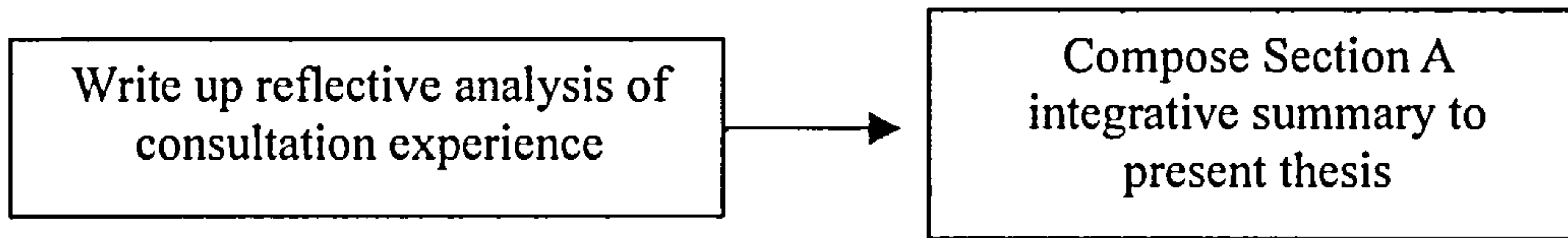
The systematic review of acupuncture as an intervention for back pain relief gives insight into the poor quality of research in the field of acupuncture in the last two decades. Different researchers contradict each other in regard to the value of acupuncture as an intervention for back pain relief, only recently in the last few years have we started to see evidence of an improvement in the standard of research conducted in the field of acupuncture. It is difficult to see how research can inform practice when there appear to be so many inconsistencies in the current literature relating to the effects of acupuncture as an intervention for the alleviation of back pain.

In the case study of professional practice the author was involved in the design of an evaluation to measure outcomes of a Traditional Chinese Medicine Clinic. The purpose of the evaluation was to inform a report necessary for a Chinese Health Centre's main funders the reflective analysis emphasises the importance of networking with other professionals in one's line of work. For the evaluation, two short surveys were designed to assess the expectations and satisfaction of clients using the TCM service at the Chinese health centre. Working on this piece of professional practice highlighted the importance of clear communication between clients and also the importance of working within deadlines and ensuring that these deadlines are upheld.

In multicultural societies where different ethnic minorities live together with the cultural system of the indigenous society, traditional cultures emerge as a key factor in the planning of health care delivery. Awareness and sensitivity to cultural diversity produces gains at the level of both costs and quality of health care this thesis seeks to add to the understanding of the health-related issues of British Chinese communities and their utilisation of TCM.

THESIS OUTLINE





CHAPTER ONE - INTRODUCTION

There has been a steadily increasing interest in recent decades regarding how notions of health and illness are constructed by different cultures. Despite the dominance of the biomedical model in the Western world and Western cultures, it would be naïve not to believe that a variety of modes of health knowledge and practices coexist in any society.

In multicultural societies where many ethnic communities live side by side with the cultural system of the host country, cultural backgrounds and the corresponding representations attached regarding health and illness are emerging as important factors in planning the delivery of health care (Chi, 1994). The UK is characterised by its cultural diversity. Migrants from diverse socio-cultural and linguistic backgrounds have been found to possess varying perceptions of health and illness. Given the multicultural nature of contemporary British society, and that health and illness are culturally constructed experiences, it is important to include the perspectives of people from different ethnic cultures in health-related research, in order to provide culturally sensitive health care during an illness. Moreover, as one's experience of health and illness is likely to be influenced by one's culture, culture may affect and have implications on a patient's recovery process.

Contemporary societies live in a period of increasing and rapid change. Few societies have been immune to the pace and speed of this transformation. One of the more prominent features of this process is the coexistence of different cultural backgrounds, different traditions and different ways of life within a single context. However, there still remains a tendency to ignore or brush aside factors such as cultural beliefs and cultural values in influencing everyday healthcare and healthcare beliefs. In many instances lay knowledge deriving from cultural traditions is not taken seriously, it is considered an obstacle to compliance with treatment. To assume socio-cultural factors only as mere obstacles and barriers to 'proper' treatment can delay treatment by Western healthcare systems, interfere with the patients' compliance in taking Western medication, or could even exacerbate existing health problems (Koo, 1984).

The Chinese are one of the least understood of Britain's immigrant minorities despite constituting Britain's third largest ethnic minority. Remarkably little research has been carried out into the Chinese community in Britain. The relative lack of understanding surrounding the Chinese lies in the pattern of settlement that sets the Chinese apart from many other British immigrant groups; despite the existence of Chinatowns in various cities, the main feature of Chinese settlement is that it is scattered. China has been a literate civilisation for centuries and although Hong Kong in particular is very much a modern city, there are profound cultural and linguistic differences between Chinese and Westerners.

In a report made by the House of Commons it was reported that the Chinese had figured little in any discussions concerning race relations and ethnic minorities in Britain. (House of Commons, 1985). They claimed that there were few reports of racial incidents involving the Chinese. The report stated that the Chinese have "little contact with wider society and have appeared to want to keep a low profile". The House of Commons went on to report that the Chinese are regarded as law-abiding and hard working and that they rarely make complaints about any aspects of their lives. However, they admitted that the lack of official perception of any problems does not mean that no problems exist.

The Chinese belong to a unique and well-developed medical and health tradition. As a result, Chinese immigrants may often have an alternative perspective of health and well-being. The main difference between the Chinese health system and the Western biomedical model is the Chinese emphasis on maintaining balance among the elements of the mind, body, spirit, and the natural environment. The Chinese health system approaches health care from a holistic perspective, utilising both practical and spiritual means to maintain balance.

Health is an ever-evolving concept. A meaningful understanding of the concept of health in a cultural context requires the consideration of many factors including beliefs with respect to anatomy and physiology, components of health, health cognitions and

classification of disease, and health interventions. A lack of knowledge amongst health professionals regarding cultural health concepts and practices, in addition to intercultural communication difficulties, is a major issue in health care provision in multicultural countries (Kazarian & Evans, 2001).

Population Demography

Compared with other ethnic minority populations in the UK, the Chinese are one of the more recent arrivals together with Bangladeshis and Pakistanis (House of Commons, 1985). There are currently nearly 250,000 Chinese people residing in Britain, 0.4% of the overall UK population (National Statistics Bureau, 2004). Compared to figures from the 1991 Census when there were nearly 165,000 Chinese in Britain, this shows an increase of over 50% in the past decade. The Chinese were recently shown to be one of the top five nationalities applying for asylum in the UK, which could go further to explain the sharp rise in the Chinese population in Britain (National Statistics Bureau, 2004).

In a recent survey it was revealed that almost one-third of Chinese people in Britain are aged between 16 and 29 years, whilst half are aged between 30 and 49 years. Six in ten British Chinese are married. Only one in five Chinese people living in England stated that they had been born in the UK. Hong Kong was the most commonly reported place of birth for people aged 30 years or over. Overall, the Chinese population in England is in general long established. Over 60% of Chinese in the UK have either been born in the UK or living in the UK for over twenty years (Sproston et al., 1999). London is an area that is, not surprisingly, heavily populated by Chinese. According to the Department of Statistics, the London Chinese population was 57,000 in 1991. This number increased sharply by nearly 25% by 2000, while in 2001 the London Chinese population had increased to nearly 71,000. In fact, Chinese people form more than two percent of the population in Westminster, City of London and Barnet (National Statistics Bureau, 2004).

A significant change taking place within the Chinese community is linked to the increasing proportion of British-born Chinese. As more and more British-born Chinese are emerging from the British education system, the character of the Chinese community is beginning to change. More Chinese are now British-born and English speaking, less are now involved in the catering trade and more now see themselves as British Chinese than ever before. However, as a result of changes in the community come the problems associated with intergenerational relations, communication problems and the generation gap between Chinese-born parents and British-born children.

Language incompetence is often a parent-child issue amongst Chinese families in England, with parental strictness regarding the preservation of Chinese traditional values, behaviours and choice of friends. This is often associated with inter-generational conflict, with young people being caught between the differing values, behaviours and social patterns in the family home and at school.

Chinese pupils in British schools are vulnerable to a variety of cultural conflict and crisis. Despite Chinese communities in Britain having been well established for a number of years, little attention has been paid to Chinese communities by successive British governments. The first official inquiry into the needs of the Chinese community was not until 1985, despite the fact that the Chinese first started to migrate to Britain as early as the 1860's. However, despite the lack of attention paid to the Chinese community in Britain, there is a sense of resilience amongst the Chinese community. One study has revealed that British Chinese children are seen to have more positive feelings and academic confidence in being themselves and as members of society. Though the majority of British Chinese children come from working class backgrounds, their self-esteem derived from school or family is seen to be strong compared to other cultural groups (Chan, 2000). In fact, it has been suggested that Chinese students are more likely to achieve academic degrees than the White population (Cheng, 1996).

The Chinese rarely enter into the politics of the public arena of race relations they seem to prefer not to draw too much attention to themselves (Chau & Yu, 2001). According to

the 1991 Census, the Chinese had two and a half times more than all other ethnic minority groups in the socio-economic status category I: professional and managed occupations, and also fewest in category V: unskilled and unemployed. Over 60% of the British Chinese population could now be classified as white-collar workers (National Statistics Bureau, 2004).

Migration to Britain

There have been several distinct phases in the migration of the Chinese to Britain. Chinese people from different parts of the world have migrated to Britain at specific periods for different reasons. The Chinese first started to migrate to Britain as seamen on British merchant ships in the 1860's. As a result of this Chinese seamen and their families started to settle close to ports such as London and Liverpool from the mid 1880's, however the number of Chinese settlers was minimal, with just over 1000 Chinese in Britain in 1911 (Lynn, 1982).

Britain experienced a more wide scale influx of Chinese migrants when the British Nationality Act in 1948 prompted the second wave of immigration. This gave New Commonwealth citizens the right to live and work in Britain until more stringent immigration legislation in 1962 required work permits (Race Relations Unit, 1996). This period coincided with land reforms and the collapse of the agriculture industry in the New Territories part of Hong Kong, which resulted in the migration of 30-50,000 Chinese to Britain during the 1950's. These Chinese migrants were mainly Cantonese speaking most had received minimal formal education and could speak very little or no English (TMBC, 1995).

Since the 1950's, a steady stream of students nurses and other professionals have been arriving in Britain from other areas such as Singapore, Malaysia and Taiwan. The next phase of migration occurred as a result of the rapid growth of the Chinese catering business, resulting in the need for more Chinese workers. In Britain this happened in the late 1960's, it was believed to be cheaper to bring Chinese workers' families over to work

in the business and this combined with Britain's increasingly restrictive immigration legislation led to an influx of wives and children of Chinese workers from Hong Kong. This phase of emigration constituted 75-80% of the Chinese community living in Britain during the 1980's (House of Commons, 1985).

Towards the end of the 1970's the arrival of the 'Boat People' and the Cultural Revolution both contributed to the gradual opening up of China to the rest of the world. This in turn, led to an increase in the number of students and scholars arriving in Britain, many of whom have chosen to stay in Britain and gain permanent citizenship. During the 1980's and early 1990's the number of migrants arriving from Hong Kong increased, this was mostly as a result of the anxieties and uncertainties of Hong Kong people surrounding the return of the colony to Chinese rule in 1997 (Chau & Yu, 2001).

There is some evidence to suggest that migration can have a significantly negative effect on psychological well being (Furnham & Li, 1993). Furnham & Li found a correlation between language difficulties and unfulfilled expectations with psychological symptoms and depression in second-generation immigrants, but not in first generation immigrants. However, the likelihood of depression was greater among those first generation Chinese immigrants who were involved in the Chinese catering trade, were working part-time, or who were unemployed. Contrary to Furnham and Li's (1993) findings, Wong & Cochrane (1989) found greater assimilation with the host society among second generation Chinese compared with the first generation. However, no difference was found between the first and second generations in the reported level of psychological symptoms. It was found that the more the first generation was assimilated culturally or identificationally to British culture, the lower their level of psychological distress. However, a different case was presented for second generation Chinese. Language was seen as essential to assimilation and for the majority of the first generation, the language barrier was seen as the main obstacle to full participation of British life (Wong & Cochrane, 1989).

The large number of Hong Kong Chinese in the UK has led to a tendency to look at this

group as representative of all Chinese. It is, however, important to note that there are subtle differences among the Chinese in terms of diet, customs, religion and health beliefs and practices. Educational attainments, occupational groups and socio-economic status also differ between the various groups.

Southeast Asian Chinese, primarily from Malaysia and Singapore, came to Britain in search of a Western education and improved career opportunities. This was a direct result of the introduction of Western technology and ideology in the 1950s, which in turn increased the importance and value of an English education in obtaining successful employment. Later migrants from Mainland China were students and scholars who remained in the UK after completing their education (Cheng, 1996). These were the most highly qualified among the Chinese migrants. Their numbers are rapidly increasing and this is therefore highly likely to have an impact on the socio-economic composition of the British Chinese in future generations.

Cultural Adaptation and Assimilation

The number of Chinese migrating to other countries was estimated at 27-28 million people in the late 1980s (Poston & Yu, 1990). As a result of the wide distribution of Chinese people around the globe, the issue of Chinese adaptation to foreign countries and cultures is of great importance.

Acculturation refers to a process of “overall” adaptation on both individual and group levels, including cultural and psychological aspects (Lee et al., 2003). There are two major models in acculturation, a unidimensional and bidimensional model (Bourhis et al., 1997). Early models of acculturation were unidimensional (Graves, 1967), this model assumes that as individuals become more acculturated to their host culture, they become less acculturated with their native culture. However, this model has been severely criticised for alienating individuals who may become equally acculturated to both their host and native culture (Cuellar et al., 1995). Thus, more recent models are bicultural (Berry, 1980, 1992, 1995), suggesting that individuals may be highly acculturated to both

their native and their host culture.

Because many Chinese in England are foreign born, strong Chinese cultural values, beliefs and traditional health practices are still evident in their overall behaviours. Many Chinese are unfamiliar with Western concepts and terminology of illness and diseases, a lack of understanding of the British health care system could potentially prevent many Chinese from utilising available health services or following prescribed treatments. Many Chinese may also be apprehensive about seeking medical help from Western doctors and practitioners due to their perceived cultural differences, and as a result, may hold back or avoid disclosing information about their cultural practices. Therefore, the lack of culturally competent services can become a great obstacle for Chinese patients in defining, evaluating and presenting challenging problems to health care providers.

Acculturation refers to changes in cultural attitudes, values and behaviours that result from contact between two distinct cultures. For ethnic minorities such as the Chinese, in multicultural societies such as the UK, acculturation can be seen as a two way process where the relationship with both the host and native cultures must be taken into account. Adoption of Western values has also been shown to be associated with greater conflict (Wong & Cochrane, 1989). Common themes include Chinese and Western value opposition, the need for personal development and fear of social isolation. However, assimilation should not be regarded as essential to an individual's psychological well-being. Individuals who move into new societies and cultures may not wish to assimilate any more than they need to. This can be observed through the way many British Chinese have lived in the UK for a number of years and still have not mastered the English language, yet they get by fine in life and seem perfectly content and unbothered by this issue.

Many foreign-born British Chinese are at different levels of acculturation. This is due to the various influxes of Chinese communities in to the UK at different times over the last few decades. Many individuals may be vulnerable to the physical effects of stress related to moving to a different country, many may also hold on to their cultural health beliefs,

traditional Chinese theories of health and illness, and health practices. For Chinese refugees, in addition to the problems of acculturation, there are many other worries such as the loss of country, home, family and friends. All these stresses can add to health problems when an individual settles in the UK.

An important issue in cultural adaptation of Chinese immigrants in the UK concerns the relationship between self-confidence with, and fluency in, English as a second language and modes of adapting to English cultural and linguistic contexts (Dion & Dion, 1996). There is some indication that Chinese patients are relatively hesitant in seeking appropriate and definitive help from medical experts (Lau, 1982; Sproston et al, 1999).

The 2001 Census revealed that 71% of British Chinese were born overseas, this demonstrates a decrease of 3% since the 1991 Census, which revealed that 74.4% of Chinese in Britain had been born outside the UK (National Statistics Bureau, 2004). These statistics could be seen to have an influence over the adaptation and assimilation of Chinese people into British society.

There are important cultural factors at work in the Chinese community. The Chinese are proud of their cultural heritage, a heritage that includes a distinct system of medical thought and medical practice. The presence of a parallel medical system in their home country may explain a little of the low rates of GP consultation. Some groups of Chinese people also adhere to traditional beliefs that link illness to evil, though these currently seem to be in more of a minority. Yet the Chinese are above all pragmatic, they will utilise what they consider to be useful and ignore or discard what they consider to be useless. This rings just as true in matters of health as it does in other aspects of Chinese life. The fact that there may be low rates of health service utilisation cannot therefore be blamed solely on the Chinese community. The primary and most important source of health information and advice in the Chinese community is the family. Family play a significant role in the everyday life of the Chinese community.

Employment & Education

Only 25% of first generation Chinese residents in the UK have been reported to be educated beyond primary school level (Li et al., 1999). Lack of education can be seen to have a negative influence on adaptation and assimilation of first generation Chinese, lack of education can also be seen to have an effect on one's ability to understand and utilise health services effectively.

Recent research reveals that British Chinese pupils are the highest achieving ethnic group in the British educational system (Francis & Archer, 2005), outperforming other ethnic groups at GCSE level (DfES, 2004). The proportion of Chinese with first or higher degrees is 10%, whilst just 5% for the white population (Cheng, 1996). Research also reveals a higher proportion of people with less than A Level qualifications among the white population than among the Chinese, 90% compared to 83% (Cheng, 1996).

Furthermore, over 90% of British Chinese students continue into full-time education (Owen, 1994), and are proportionally more likely than any other ethnic group to enter higher education (Gillborn & Gipps, 1996). The educational success of British Chinese pupils has been attributed to Chinese family and home culture, namely a high valuing of education in Chinese culture, high parental expectations, and much encouragement from parents (Archer & Francis, 2005).

Chinese employment is considered to be mainly in the catering trade. The concentration on catering has had immense consequences for the Chinese community's development in Britain, especially in shielding the Chinese community from wider society as a direct result of the long and unsocial hours the catering trade involves, and its ability to absorb nearly all available Chinese labour. The majority of Chinese immigrants have associations with the catering trade and are thus spread widely throughout the country nationwide. The Chinese catering trade served as the foundation for Britain's Chinese restaurant boom. Employment in the catering trade was initially particularly biased with

owners giving preferential treatment to their fellow countrymen, thus resulting in the increasing immigration rate from Hong Kong in the mid 1950s and 1960s.

According to the 2001 Census, Chinese people in the UK are more likely to be self-employed than other ethnic minority groups. Approximately 19% of Chinese people in employment were self-employed. 71% of the Chinese people in employment worked in the catering trade (National Statistics Bureau, 2004). This figure demonstrates that although there are more Chinese people in other professional trades, the majority of Chinese people are still involved in the catering trade.

The economic trade that the Chinese dominate allows them to live, work and prosper without drastically changing their way of life to accommodate British social expectations. Thus, research in this area has suggested that the Chinese are one of the least assimilated of Britain's ethnic minority groups (Furnham & Li, 1993).

Racial Abuse

Research has shown that the Chinese as an ethnic group face both discrimination and problems accessing public and social services (Chau & Yu, 2001). In an early report by the House of Commons in 1985 there were few reports of racial harassment. However, in a survey conducted in Liverpool just over a decade later, it was found that 33% of Chinese participants had experienced racial abuse within the past year, and 26% had experienced depression as a result of the stress caused by racial harassment (EOLAS, 1996).

There has been reported to be widespread neglect of the impact of racial discrimination and racism on health disparities across ethnic groups (Aspinall & Jacobson, 2004). The British Chinese community continue to remain a relatively invisible community they are not seen to be problematic to the same extent as other ethnic groups. This may explain the relative lack of concern concerning a number of issues, including racism, for the British Chinese community. From one perspective, such a lack of concern could be read

as positive. However, even seemingly 'positive' stereotypes of ethnic groups can serve to homogenise the diverse experiences of those drawn within its boundaries, concealing issues of inequality (Tam, 1998).

There has been widespread neglect of the impact of racial discrimination and racism in health and healthcare disparities across ethnic groups. While ethnic differences in health continue to be attributed to genetic and non-specific 'cultural' explanations in some research, the emerging evidence base suggests that socioeconomic factors and the experience of racism may be amongst the most important causes of these differences (Aspinall & Jacobson, 2004).

The significance and pervasiveness of racism in the lives of young Chinese people has been well documented (Parker, 1995). Parker (1995) identified the place of education as providing a route parallel with parental expectations leading away from the catering business and its associated relation to long anti-social hours and racial abuse, resulting in higher proportions of young Chinese people entering higher education. Parker (2000) has been critical of the way in which the British Chinese community has tended to be simplistically represented as a success story. He observes that in constructing the British-Chinese community as an 'economic success story', researchers are ignoring discrimination, difficulties and inequalities besetting many Chinese in Britain. This crude presentation of the Chinese as a success is thought to be based on popular Western stereotypes of the Chinese as conformist, collectivist, deferent, entrepreneurial and conforming to Confucian values, which ignore the specific British Chinese construction of ethnic identity (Parker, 2000).

In a study by Song (1999), racial abuse and discrimination were found to be a pervasive but not a universal experience. Verma et al. (1999) found that the majority of their sample had experienced racism and that fear of racism was universal. Nevertheless, self-esteem was higher for a Chinese group than for a White European comparison group. In other research, Chinese victims of racial harassment have been revealed to be reluctant to report to police (Victim Support, 1997).

Racism is a commonplace experience, possibly more obviously apparent to the younger generation than the older generation. Assimilation appears to yield benefits for the older generation in terms of psychological symptoms (Wong & Cochrane, 1989), but not for the younger generation. This could be a result of the younger generation's more advanced identification with the values of mainstream British society not resulting in unfulfilled expectations of British life and their experience of racism.

Language

Cantonese is the common Chinese dialect of Hong Kong while Mandarin is the common dialect of much of China. Lack of knowledge and understanding of the English language is a massive problem and the cause of a number of social problems, such as ignorance and lack of awareness of the British health system. Lack of English language renders many essential services inaccessible. Many foreign-born Chinese lack an adequate grasp of the English language, in particular the older generation they cannot use their knowledge of English as an adequate vehicle of communication with health providers (Dhooper, 2003). As a result of their lack of knowledge of the English language, many Chinese are ignorant as to what rights they could claim in relation to, for example, social security, employment and housing.

In a study recently conducted by the Health Education Authority it was reported that as much as 94% of Chinese in Britain claimed to speak English (Sproston et al, 1999). However, much depends on what is meant by the ability to speak English. A recent survey of residents in the East End of London discovered that spoken English was poor in 35% of the Chinese interviewed. The use of interpreters, primarily friends and family, was found to be common. However, despite this, 21% considered English as their first or main language and 63% reported that they could speak English very or fairly well (MORI, 1995).

The Traditional Chinese Medical Model

The dominant medical model that has been active for centuries in China and Hong Kong is the traditional Chinese medical model. It is a holistic model and is based on a theory of both internal and external balances. According to the theory, an individual's physical well-being is influenced by the movement of specific elements. When an individual is in a state of good health, the relationship between the elements is one of harmony and balance. However, when imbalance occurs ill health is believed to inevitably follow. Accordingly, from the perspective of the traditional Chinese model, disease disrupts the balance of internal elements caused by some physical, social, emotional or spiritual dynamic. Interventions are intended to restore the natural harmony and balance of the individual. The traditional Chinese model incorporates the social, psychological and spiritual aspects of disease and the notion of balance dominates concepts of health and illness in a similar fashion. These health and illness beliefs reflect the collectivist philosophy of the importance of the other in Chinese culture and also the importance of the self in harmonious relation to others.

The Western Biomedical Model

The dominant theory of Western medicine is the biomedical model. The biomedical model is based on two fundamental assumptions: reductionism and materialism. Reductionism is the view that an individual can be understood by studying an individual's smallest constituent parts. From this perspective, illness is understood by examining biochemical processes. Materialism is the view that individuals are physical beings whose existence and functions can be explained exclusively by principles of physiology, anatomy and biochemistry. Fundamental to the biomedical model is the view that psychological processes are indifferent and unimportant in determining health. Therefore, from a biomedical perspective, disease is a disruption in physiological processes caused by some physical or chemical factor. Interventions involve using a corrective physical or chemical remedy. Accordingly, interventions not involving the use of biological or chemical manipulation are not considered to be 'medicine' (Kazarian &

Evans, 2001). The biomedical model allows no room for the social, cultural, psychological or behavioural dimensions of health and illness.

However, it is important to note that although the biomedical model has been the dominant model in the Western world, it has not been the sole influence on Western medical thought. The biopsychosocial model, where health and illness are seen to be determined and influenced by an interaction of biological, psychological and social factors was introduced in the late 1970's (Engel, 1977). However, despite a reign of popularity the biomedical model has proved to remain the sustainable general guide to daily practice. The biopsychosocial model was slow to gain acceptance in Western medical practice and thus, the materialistic biomedical model continues to dominate.

Traditional Chinese Medicine

China is the only country in the world where Western and traditional medicine are practised alongside each other in all levels of the healthcare system (Hesketh & Zhu, 1997). Traditional Chinese medicine (TCM) has been practised in China for over 2000 years; it has a history of several thousand years and is one of a few forms of 'alternative' medicine that has support from the World Health Organisation.

Although not as expansive or popular as Western biomedicine Chinese health care traditions have a similar pattern of systemisation and organisation. TCM has its own department at the Ministry of Public Health in China. TCM also has independent medical schools, hospitals and research institutes. It is hard to believe that in 1929 Chinese medicine was almost legally abolished by the Chinese Republican government (Hesketh & Zhu, 1997), TCM is now a fully institutionalised and government-supported part of the Chinese health-care system in China and Hong Kong, with the same legal status as Western medicine. TCM developed alongside Taoism, Confucianism and Buddhism, and follows the belief of eastern philosophy that both physical and mental exercise can be used to achieve health as a result of an interdependence of the body and the mind.

TCM has a unique theoretical and practical approach to the treatment of illnesses. Traditional treatments include tai chi, herbal remedies, acupuncture, acupressure and massage and moxibustion. Over thousands of years TCM has developed a theoretical and practical approach to the treatment and prevention of disease. The first documented Chinese medical theory is the 'Inner Classic of the Yellow Emperor', which was written between 300BC and 100BC. It went into detail to describe the diagnosis and treatment of a great variety of disorders in addition to giving advice about healthy lifestyles, exercise and diet, which relates well with contemporary recommendations for the prevention of chronic disease (Hesketh & Zhu, 1997).

In TCM, health is thought to be achieved by maintaining the body in harmony with one's internal psychological functions, as well as external, social and ecological conditions. According to Lin (1981) the importance of nature and harmony being reflected in the body are the most fundamental Chinese health constructs. The Chinese holistic model of health addresses the balance and movement of internal factors (such as psychological and physical factors), in addition to harmony between forces within the individual and contextual conditions.

Health and health-related values of the Chinese are heavily influenced by their cultural values. Many prominent Chinese philosophies and religions strongly influence the Chinese way of thinking and living. The Chinese believe in and seek a satisfying social life, happiness and peace to promote health and prevent illness. The Chinese view health to be the result of a sufficient accumulation and flow of energy in the body. Vital energy (qi) is considered to be the source of life for the Chinese, with the body as the physical manifestation of this energy. Qi is a key concept in Chinese medicine, the maintenance of good health requires a sufficient accumulation of qi in addition to its smooth flow throughout the body blockages or insufficiency of qi are believed to result in ill health. The fundamental importance of harmony and balance is shown through the concepts of yin and yang and the importance placed on maintaining good health through their balance (Beinfield, 1992; Hesketh & Zhu, 1997; Kaptchuk, 2000).

In TCM, a strong emphasis is placed on the body and the mind. Illnesses are discussed in terms of yin and yang and the five fundamental elements. Health is perceived as a harmonious balance that exists through the interaction of yin and yang and the five fundamental elements of 'metal', 'wood', 'water', 'fire', and 'earth', which interact in harmony with related forces and elements in nature. Illnesses are attributed to three groups: the six environmental conditions 'wet', 'dry', 'hot', 'cold', 'wind' and 'flame'; the seven emotions 'joy', 'grief', 'fear', 'anger', 'love', 'hatred' and 'desire'; and situational conditions such as stress, tiredness and irregular diet. These factors refer to traditional distinctions concerning imbalance and not physical temperature (Beinfield, 1992; Kaptchuk, 2000).

Diseases are classified as 'wet', 'dry', 'hot' and 'cold' on the basis of imbalances in the specified energy states. Food is a popular form of remedy within the Chinese culture. Foods and medicines are also classified according to the internal elements. A fundamental principle of Chinese medicine is that diseases are best treated through the use of foods and medicines traditionally believed by Chinese to remedy the imbalance. In one study it was identified that proper selection, timing and preparation of food were the most effective lay methods of dealing with the prevention and treatment of many common symptoms and illnesses by local Chinese people in Hong Kong (Koo, 1984). These food requirements are based on the traditional concept of maintaining the body's balance.

There are three ways in which TCM is integrated into the modern Chinese health care system: firstly the use of TCM drugs or therapy techniques by biomedical physicians to increase the effectiveness of biomedical treatment or to treat its side effects; secondly the utilisation of TCM as a medical system in its own right, and lastly, the integration of TCM and Western medicine. Over 300,000 practitioners in over 140 countries now practice TCM in its various forms. British GPs are increasingly finding a greater demand from the public for acupuncture services, and degree programmes in Chinese medicine are now offered at many British universities (Scheid, 1999).

In comparison with the TCM system, Western medicine has a higher prestige in the medical profession, evidently in Britain, but also in Hong Kong and China. Western medicine has a greater power over health service organisations. Western medicine is more popular amongst the community and receives more revenue from the government and the public than does TCM. However, despite all this, TCM remains extensively utilised by the Chinese both at home and abroad and is now more popular than ever.

The recent legislation in 1999 of TCM in Hong Kong (Hong Kong Government, 1999) demonstrates that the Chinese community has high expectations for the integration of Western and Chinese medicine. It is apparent that Chinese health concepts differ substantially from Western health concepts. Western medicine is based largely on the biomedical model, fundamental to the Western approach to medicine is mind-body dualism where the mind and body are seen as separate entities. This is in complete contrast to the Chinese worldview of health, which emphasises the importance of interconnectedness. The Chinese believe that the heavens, nature and humans are closely interrelated. This is reflected in the belief that good health is the result of a harmonious balance among and within the various systems both internal and external to the body.

Disease is perceived by the Chinese to be the result of disharmony or an overall imbalance (Koo, 1984). Western medicine views disease as resulting from biochemical abnormalities or the result of disease causing organisms or substances (Bishop, 1994). While Chinese medicine views disease as resulting from internal disharmony and imbalance of body energies, Western medicine explains the same phenomena in biochemical terms and often as resulting from external disharmony. The availability of two such different medical traditions can be expected to have a significant impact on the illness cognition of Chinese people, both in China and Hong Kong, and in Chinese immigrants abroad.

The theoretical and diagnostic basis of TCM cannot be explained in terms of Western physiology and anatomy. It is rooted in the philosophy, logic and beliefs of traditional Chinese civilisation and leads to a different perception of health and disease that is

unfamiliar with Western scientific thinking. Nonetheless, TCM has been proven, despite the differences in remedy and approach with Western medicine, to be an entirely coherent system with internal logic and consistency of thought and practice.

Traditional Chinese beliefs may have an inherent value to Westerners in that they offer an alternative explanation and an alternative remedy for health problems that do not have a clear causality in Western medicine. Acupuncture is an excellent example of the triumph of traditional medicine over Western medicine. Acupuncture, once viewed with much scepticism, is now more popular than ever before and has been recognised by the World Health Organisation as being a valuable clinical treatment for many illnesses (Kaptchuk, 2002). Yet the underlying theory of acupuncture is based on an energy concept, which cannot quite be translated into Western scientific terms.

Despite the importance of Western medicine in the early twentieth century and its present dominance in the formal medical practices of all Chinese societies, TCM has continued to remain a persistently popular form of treatment. The Chinese medical tradition is often considered by Chinese patients to be as good as or better than Western scientific medicine, primarily because of its emphasis on tonic care, cure of causes of disease rather than symptomatic treatment, and fewer side effects from its treatment (Cheung, 1991).

The Western biomedical and Traditional Chinese model differ in several fundamental ways. First, the notion of balance that pervades Chinese views of health and illness does not exist in the Western biomedical model. Secondly, the Traditional Chinese model is holistic while the biomedical model is reductionistic. The different operations of the two medical systems may provide an explanation for the discrepancy in the interpretation of Chinese patients' illness experience by Western trained practitioners. Studies involving the patterns of symptom manifestation have observed that Chinese patients tend to somatise health problems and delay consultation with a practitioner (Gervais & Jovchelovitch, 1998; Aspinall & Jacobson, 2004). In addition to this, patients may selectively report their illness experience according to their perception of the nature of the consultation.

Chinese Culture

Culture and traditional knowledge shape how people think, feel, perceive and socially represent questions of health and illness. This is an important issue considering that it is in the lay, popular, non-professional sector of society that the vast majority of health-related decisions are made. It has been estimated that between 70 and 90% of all health-related decisions are made in the popular domain in both Western and non-Western societies alike (Kleinman, 1986). All such health-related decisions are based on socially transmitted lay beliefs, based on social representations of health and illness.

The large legacy of Chinese culture gives much promise for an alternative perspective to view human values. China's history dates back over 4000 years and its philosophical reflections are firmly rooted in daily human concerns, additionally, its influence on surrounding cultures, rarely studied and researched, has been pervasive and long standing. Chinese culture is highly complex there is a lack of knowledge and understanding of Chinese culture in British society. If health beliefs and practices are related to cultural customs, values and identities, then cultural customs, values and identities need to be taken into account in addressing specific issues relating to health and illness.

In addressing the role of cultural orientation in illness cognition and behaviour, we are defining cultural orientation in the extent to which both Chinese and Chinese migrants orient towards Chinese culture and values. There has been very little research examining the role of cultural orientation on health-seeking behaviour. The effects of cultural factors on the perception and interpretation of health and illness suggest the underlying importance of cultural orientation. Individuals inherit from their cultures structured vocabularies of health and illness that restricts the possibilities for the interpretation of physical and psychological states (Angel & Thoits, 1987).

One fundamental aspect of cultural orientation concerns the individuals' values. A group of researchers, known collectively as the Chinese Culture Connection, developed a

Chinese Value Survey that addresses ones' orientation towards Chinese culture. The survey assesses a number of different Chinese cultural values such as filial piety, respect for tradition, loyalty to superiors, protecting 'face', sense of righteousness and chastity. Individuals gaining high scores on the scale can be assumed to have much Chinese cultural orientation, whereas individuals scoring low on the scale can be assumed to have little orientation towards Chinese culture (Chinese Culture Connection, 1987).

Language and religion are other indicators of cultural orientation. Culture and language are intimately bound as culture structures the vocabularies used in a language (Ahern, 1975). Individuals adopting a Chinese religion can be considered to have a greater orientation towards Chinese culture than those individuals who adopt a different religion or no religion at all (Lee & Cheung, 1989). The same can be said of language and culture; those individuals who practise the Chinese language regularly can be considered to have a greater orientation towards Chinese culture than those who do not practice the language, the language a person speaks is believed to control the ideas the person can have (Whorf, 1956).

Within the Chinese culture there is an emphasis on the importance of the family, the hierarchical structure of social life, the cultivation of morality and self-restraint and the emphasis on hard work and achievement, pride is also held in high regard within the Chinese culture (Bond, 1986; Chau & Yu, 2001). Chinese culture assumes and values reciprocal interdependence among individuals good human relations have long been a prominent aim of Chinese education. Social influences on Chinese moral development include the influences of the family, school and society at large they primarily involve parents, teachers, peers and individual life experiences. A number of factors determine the rate and direction of moral development discipline by parents and teachers, the moral atmosphere of the family, school and society, and the role-taking opportunities as provided by socialisation in the family, school and other social settings (Lew, 1998; Francis & Archer, 2005).

Despite the diversity of Chinese communities there does seem to be some persistent shared characteristics. These originate in the continuing influence of Confucian philosophy on Chinese culture and these are at the core of the Chinese identity. In particular since Confucian thought has dominated the Chinese way of life for over 2000 years it is unlikely to cease its influence on Chinese migrants, even after many generations in British society. This can be seen in the way that even British born Chinese, although very British in a number of characteristics, still retain many of their Chinese cultural values despite being born and raised in the UK.

Research has shown that Confucian values continue to be a pervasive influence in the Chinese character and that these values provide a strong philosophical foundation for Chinese communities to achieve both economic and educational success (Francis & Archer, 2005). However, the emphasis on the importance of the traditional culture in shaping Chinese people's life to a certain extent lends support to the view that their cultural characteristics are a stumbling block to their integration into mainstream society (Chau & Yu, 2001).

Chinese culture and personality are both changing. Wealth is increasingly becoming of great importance for Chinese people, this is particularly ironic when one considers that in Confucian tradition individuals are advised to disregard wealth. However, despite some changes in values, many elements of Chinese culture remain unchanged.

Social Contact and Support

The establishment of Chinese community centres, organisations and associations across the country in recent years has done much to break down the isolation of the Chinese community. In particular community centres are doing good and much needed work in increasing Chinese people's awareness of their rights in British society. Community centres are heavily depended on for matters such as filling in a passport application form and general advice.

There is a preference for self-help and mutual aid among the Chinese that is much less prevalent in British societies. The family and extended family are seen as the fundamental unit of Chinese communities and the focus of loyalty to a much greater extent than in British society. Problems are kept within the family as much as possible, and only when absolutely necessary is help sought from elsewhere in the community. Seeking assistance from beyond the Chinese community has traditionally been regarded as shameful. Although self-help is one of the strengths of the Chinese community, it can also be viewed as a weakness if the community cannot cope with the need. However, with the emergence of more and more Chinese community centres this is beginning to become less of a problem.

Recognition of the family unit as an important social resource reflects strong Chinese collectivist values; beliefs and values related to the family are as strong as religious beliefs for the Chinese. The traditional Chinese emphasis on the group is designed to ensure the strength of the family; a family member would be expected to sacrifice their personal interest if it did not benefit the family as a whole. For many years now it has been a Chinese custom for extended families to live together under one roof. However, this is becoming less of a tradition in modern Chinese society as more and more young couples choose to break free from the traditional culture and live independent of their family. Young people growing up in a traditional Chinese community are often not expected to leave home until they get married, and this can be the cause of much inter-generational conflict in British Chinese.

An important element of Chinese family life is the emphasis on education and the notion that academic excellence leads to a better future. This is an important source of strength for many Chinese families. Parental attitudes towards the importance of education are embedded deep in the psyche of the Chinese relating historically with Confucianism. Much pressure can be put on Chinese children to do well academically and bring pride and success to the family.

Chinese Values and Beliefs

For an ancient culture such as the Chinese a great variety of traditional beliefs are identifiable and recognisable, for example, Confucianism and Taoism. Confucianism has had a powerful influence on Chinese behaviour and social structure for over the past 2000 years. Eastern philosophies, such as Buddhism, Taoism and TCM adopt a holistic conceptualisation of an individual and their environment.

Confucianism has had a profound influence on the development of Chinese cultural history. Confucian thinking emphasises the discussion of human nature, education, human development and interpersonal relationships. A prominent assumption of Confucianism is that people are essentially benevolent this assumption has had a significant impact on the social practices and structures of Chinese societies. For example, the Confucian emphasis on education regardless of social class reflects the belief that all individuals have the potential to be developed. The emphasis on effort by Chinese educational settings can also be viewed as being related to the Confucian belief of perfectibility. In Confucian thought, all individuals are believed to have the ability to develop their moral standards and to conform and abide by them. The teachings of Confucius are principles for social interaction and the influences on Chinese behaviour cannot be overestimated. Five important characteristics and concepts of Confucianism include benevolence, righteousness, loyalty, filial piety and virtue. Harmony with all others, lack of selfishness, parental respect and family loyalty are the main teachings of Confucianism. Confucian values also emphasise the importance of family in the management of life problems.

For Chinese communities, traditional Chinese philosophies such as Confucianism, Taoism and Buddhism provide perspectives on health and share an approach to the management of life stresses. The Chinese view is that these life stresses are determined by fate and any associated suffering is valued because it helps to develop character.

What research has been conducted regarding Chinese populations and illness reports of the passivity of the Chinese patient this may be a result of Confucian philosophies 'do nothing' approach and allowing fate to take its natural course.

In Taoism, a primary belief is that individuals should follow the way of nature and the concept of morality should be abandoned (Sun, 1991). This belief that the natural way is the most effective way seems to influence the behaviour of Chinese people in a wide variety of contexts. Taoism emphasises the importance of passive attitudes, such as 'no action' and internal peacefulness for physical and psychological harmony and well being. Taoists believe that pursuing many material possessions can lead to desires and confusions, which, in turn may cause behavioural and psychological disturbances. According to Taoism, softness, tenderness and weakness are considered desirable attributes to life whereas firmness, strength and stiffness are considered to be associated with death. It is therefore seen as beneficial for health to remain flexible and to take 'no action' in daily life (Sun, 1991).

Values reflect culture and personality they interact with natural development. Values and personality are closely linked and thus much can be learnt about a person through their values. Therefore, a study of people's values should contribute to an understanding of their personality and a study of personality traits should aid a greater insight into underlying values.

Morality and human relations are two characteristics of great importance in Chinese culture. The main theme of Chinese philosophy focuses around ethics; ethics for Confucians is not only the study of standards of conduct and moral judgement, but also a way of life. The most influential factor on moral development comes from the family; family harmony is a prominent value in Chinese culture it is seen to reflect good family relations, while a family lacking harmony is characterised by conflict and tension and is seen to reflect bad family relations.

Schwartz (1992) has demonstrated that values represent an attempt to meet three universal requirements of human existence; the needs of the individual, the needs for coordinated social interaction, and the needs for the survival and well-being of the group. Leung & Bond (1992) proposed this functional framework applicable to beliefs. Beliefs can therefore be identified as three main types; firstly, psychological beliefs are concerned with individual characteristics related to a person's functioning and well-being in society. Secondly, social beliefs are concerned with principles, guiding individuals in effective interactions with others, finally, environmental beliefs are concerned with guides that assist individuals in functioning effectively in their physical environment.

The Chinese are particularly concerned with interpersonal relationships. In Confucian tradition, selected relationships are designated positions of great importance. These are known as the 'Five Cardinal Relationships' those between ruler and minister, father and son, husband and wife, elder brother and younger brother, and friend and friend. In Confucian teachings, the five relationships are established on the basis of mutual moral obligation. Critical aspects of Confucianism include; that man exists through and is defined by his relationships with others. Relationships are structured hierarchically and social order is ensured through each individual honouring relationship role requirements. Of the five cardinal relationships three exist between family members (between father and son, husband and wife, and elder and younger brother). It is evident that the Chinese have long been socialised and accustomed to value relations between individuals close to each other, particularly between family members, rather than public relations between individuals unfamiliar with one another. Loyalty and filial piety have thus become the two central values embodied in the five principal relations (Bond, 1995).

Chinese Health and Health Beliefs

The World Health Organisation redefined health as being a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1946). This redefinition is more appropriate to the eastern view of health, which is

related more to personal harmony and balance and not solely to medical and internal symptoms of illness.

Illness is a human universal, how members of a particular culture cope with explaining, treating and preventing ill health is parallel to their worldview and the values placed on various activities of life. Cultural variables play a contributing role in lay illness cognition and behaviour. Anthropological and sociological studies of illness beliefs and behaviour indicate great diversity in beliefs and causes of illness as well as illness behaviour (Landrine & Klonoff, 1992).

Health beliefs and practices are constructed against a background of constant social interaction and negotiation, where allegiances to social identity, group norms and cultural traditions play a key influential role. In this context, beliefs regarding health and illness express larger psychological factors which shape the choices people make about health-related behaviours and practices. Understanding health and health-related practices demands sensitivity to culture, context and ethnic groups. Health beliefs and health behaviours are largely dependent on cultural backgrounds and people carry with them the assumptions, values and knowledge that belong to their communities and serve to make up the social identity.

In Chinese populations, the predominant TCM therapy is Chinese herbal remedies (Wai et al., 1995; Ng et al., 2004). The popularity of TCM among the Chinese seems to remain unabated despite the dominant use of modern Western medicine. Chinese herbalists have been seen to play an important supplementary role when Western medicine fails to provide relief (Ng et al., 2004).

In contrast to Western populations who focus on individual need, the Chinese have a strong emphasis on collectivism (Bond, 1995; Chinatown Online, 2004). Hence Chinese people are traditionally less inclined to express individual need unless they are encouraged to do so. Research has found that many Chinese people tend to take a passive role in expressing their needs, which is particularly related to their educational, social and

cultural background. Chinese people in general tend to receive a lot of the support they need in illness from their families and extended families, rather than from the medical profession and health care services.

Previous research suggests that Chinese people in Britain are more similar to white people than to people from other ethnic minority groups in terms of their health status. The differences found between other ethnic minority populations and white people have been much wider than the differences found between white people and people of Chinese origin (Nazroo, 1997). However, it has also been shown that there are differences in terms of how subgroups of the Chinese population report their health.

Complementary medicine is rapidly gaining popularity in the Western world. In addition to this, the trend of international migration in recent decades means that medical practitioners in Western countries are more and more likely to be consulting with patients of different ethnic origins, many of whom may also likely to be using traditional therapies from their own country of origin.

According to the Chinese holistic model, physical health is determined by a person's emotional functioning and is also subject to socio-ecological influences. Each of the seven emotions (joy, grief, fear, anger, love, hatred, desire) can affect the flow of qi around the body and yin-yang balance in the organs. The heart and liver are reported to be the most affected by emotional upset because their normal functions are seen to be more dependable on emotional harmonies (Hammer, 1990).

The Chinese believe that the influences of external, social and ecological conditions are mediated by the lifestyle a person chooses to lead. Health is believed to be conserved when a person lives in harmony with social and ecological conditions and attains an inner balance. A healthy lifestyle is viewed as essential in achieving these goals. In day-to-day living, diet and physical activity are seen to be of particular significance.

There is considerable documentation of the inseparability of food and medicine in

Chinese culture. Food not only plays a major role in the treatment of illness but it is often also seen as a cause (Joffe & Lee, 2004). Diet is instrumental to the preservation of health because food is believed to affect the function of the stomach and the spleen, which are responsible for converting food into qi. The importance of diet is widely recognised by the Chinese population in relation to diet, physical activity is also believed to aid in the flow of qi and also in the development of strength in the body. In spite of this, too much physical activity is thought to be harmful to health and can cause weakness.

Different types of exercise are used and encouraged by different age groups in Chinese communities. For example, adolescents and youngsters are encouraged to participate in more active sports, while older adults are encouraged to use exercise such as Tai Chi to improve and maintain health (Li et al., 2001; Woo et al., 2002). Tai Chi is popular for its effects and benefits for overall health it is unique in that it combines the body and mind and is a low impact exercise (Wang et al., 2004).

In a study by Facione et al. (2000), it was revealed that Chinese women view health in general as a precarious state that could be lost easily if one does not maintain a balance by practising preventative behaviours, such as eating more responsibly, exercising, avoiding stress and performing virtuous deeds. They found that adhering to regulatory behaviours regarding diet and demeanour, as central to the maintenance of health, was important for Chinese women.

The holistic perspective of health in Chinese culture indicates that strong emotional experiences can be harmful to a person's health. Excessive experiences of emotions such as anger and sadness, or even joy can affect the flow of qi and in turn can cause organ dysfunction (Kaptchuk, 2000). Additionally, Confucianism teaches that self-control of behavioural and emotional reactions in social interactions is necessary to establish and maintain harmonious social relations and as a result of this people are encouraged to control and restrain emotions.

Mental Health

Research concerning the mental health of the Chinese population in Britain is much more limited than for other British ethnic minority groups. Only one recent publication specifically on the subject of mental health in multiethnic Britain made any reference to Chinese people (Mental Health Foundation, 1995). Mental illness is highly stigmatised among the Chinese, and in general Chinese attitudes towards mental illness and the mentally ill are negative. This may cause many families to conceal any problems that may arise concerning the mental health of family members.

A national survey of the mental health of Chinese people in Britain was recently conducted (Li et al., 1999). This study was unique in identifying and interviewing a sample of mentally disordered Chinese people. In relation to emotional control and suppression, Chinese people are seen to somatise their psychological problems (Li et al., 1999). Different explanations have been presented for somatisation in Chinese, it has been argued that in Asian particularly Chinese cultures, mental illness carries with it serious social stigmas indicating weak will and spirit (Li et al., 1999). In addition to this social stigma associated with mental health problems is believed to damage the reputation of the family, whereas physical illness does not bring with it the shame and humiliation to the individual or family. It is therefore not surprising that Chinese people tend to deny any psychological problems and seek treatment from physicians rather than mental health professionals themselves, it is also possible that Asian cultures could perhaps facilitate the development of somatic problems.

Due to the cultural emphasis on emotional control Chinese people are often quite reluctant to express their emotional distress. The suppression of cumulative psychological problems may, in turn, lead to somatic dysfunction of the bodily organs as a result of the disrupted flow of qi, highlighted in the Chinese holistic health perspective.

It has been suggested that conflict between the explanatory models of TCM and modern Western medicine may lead to alienation from professionals, particularly over the use of

Chinese herbal medicines (Sham, 1996). Thus Chinese families may find conventional service provision in opposition to their natural cultural values. Significant themes emerging from mental health research on Chinese communities in the UK include the impact of a mother's poor command of English, the inadequacies of using family members for interpreting, the lack of access to written material relating to benefit claims and the difficulties of close friends to share experiences when caring for a family member with mental health problems (Sham, 1996).

There is very little research on the mental health of the Chinese in Britain. However, there has been found to be an under-representation of Chinese psychiatric patients in the NHS (Wong & Cochrane, 1989; Aspinall & Jacobson, 2004). Surprisingly, no national register exists for people with mental illness for the Chinese community therefore it is very difficult to estimate the extent of the problem. Given the linguistic difficulties experienced by first generation Chinese and the social constraints and disadvantages experienced by all ethnic minorities, it is easy to see how these factors could have an impact on mental health. However, it could also be argued that the close-knit structures of the family in Chinese communities are able to provide stronger support for its members.

Though there may be variations in the literature, it is clear that Chinese people have poor access to mental health services. There is agreement from a variety of sources that the most significant problem is the lack of a common language between Chinese patients accessing mental health care and professionals, and the limitations of inappropriate reliance on younger family members for interpreting skills. This can commonly result in mental health problems being unrecognised in primary care and poorly managed in secondary care (Cowan, 2001).

Utilisation of Health Services

Equity of access to healthcare is widely interpreted as equal access for equal need and ethnicity is one of several characteristics that may unfairly affect access. There is much

evidence to suggest that Chinese communities consistently under-utilise healthcare facilities. This was first reported in a House of Commons Report twenty years ago (1985). Since then what little research there has been on the Chinese community in England, reveals that uptake of health services by Chinese people is still considerably lower than that for white and other ethnic minority populations, both in terms of GP and outpatients services (Sproston et al, 1999; Gervais & Jovchelovitch, 1998; Erens et al., 2001; Aspinall & Jacobson, 2004; Gill et al., 2004).

In a small-scale study, Watt and Chui (1994) interviewed GPs in a Yorkshire town with a substantial number of Chinese patients. Three main findings emerged; Chinese people were perceived as having both higher and different expectations of primary healthcare services than white and other ethnic minority populations. Doctors reported that Chinese patients attempted to avoid or postpone consultations until medical attention was absolutely necessary, this was demonstrated in the way Chinese patients attempted to keep consultations to a minimum by requesting repeat prescriptions, both for themselves and for their friends and relatives. The GPs interviewed were all in agreement that their Chinese patients made very limited use of preventive care (Watt & Chui, 1994).

Possible explanations for the Chinese under-utilisation of health services include a lack of knowledge of the health facilities available. Language problems may also prevent new immigrants in particular from communicating effectively with health providers. There is also a reluctance to admit health problems, though this applies mainly to individuals with mental health problems and the stigma attached. In addition to this it is also possible that individuals may choose to rely on friends, relatives and other social networks for emotional support and advice.

The Chinese culture of under-utilisation of health services needs to be understood in a larger cultural context. Firstly, as a result of the pure interpretation of psychological functions and dysfunctions in the Chinese holistic perspective, it is justified for Chinese individuals to seek help from medical doctors for the assessment and treatment of somatic problems that are believed to be the causes of the psychological problems. It is difficult

for Chinese who believe in somatic origins of mental problems to develop confidence and trust in mental health professionals who focus primarily on the psychological and psychiatric symptoms of an individual.

Health-Seeking Behaviours

Failure to seek treatment for illness can threaten the health of individuals, groups and society as a whole. Treatment delay and avoidance can determine the outcome of illness (Glasgow et al., 2000). Health and health-related attitudes of Chinese people are likely to be influenced by their cultural values. Many Chinese philosophies and religions strongly influence the Chinese way of living and thinking, such as Confucianism, Taoism and Buddhism. Chinese health-seeking behaviours cover a broad spectrum of diverse health resources. This diversity ranges from the use of Western health care services, the traditional Chinese health system, self-care and home remedies. Although around 50-60% of Hong Kong citizens are estimated to have consulted TCM practitioners at least once (Tang & Wong, 1998), Western medicine has been the only officially recognised system of healthcare in Hong Kong for many years, until just recently.

A common health practice among Chinese treatment processes is self-medication using Chinese and/or western home remedies, consultation with a western doctor, consultation with a TCM practitioner or herbalist, and then perhaps attendance at a western medical hospital. The implication of the simultaneous existence of TCM and Western medicine can be reflected in the manifestation of illnesses and the process of help-seeking among the Chinese. The utilisation of native healing practices has been recorded (Watt et al., 1993; Sproston et al., 1999; Lau & Yu, 2000).

Patterns of help-seeking behaviour have been found by Wen (1990) in his study of psychiatric patients treated in a Buddhist temple. Wen classified four groups of modes of healing: the popular sector includes herbs, secret recipes, massage, Chinese or Western style tonics and non-prescriptive drugs; the folk healing sector includes shamanism, physiognomy, temple worship, and spirit calling. The traditional-professional sector

includes TCM, bonesetting and acupuncture; and the western professional sector includes general medical clinic, general hospital and psychiatric clinic or hospital. The intertwined utilisation of these modes of practice suggests that patients seem to take a global, multidimensional view of their illness experience as opposed to the biomedical model of Western medicine (Wen, 1990).

One of the important factors determining health care choices for Chinese is their belief and perception of illness causation and health management. Simultaneous use of Western medicine and TCM practices is very common, especially among Chinese immigrants. While favouring a combination of TCM and Western medicine, most Chinese people believe Western medicine to be more effective for treating chronic and acute diseases. Generally, however, Chinese people believe that despite Western medicine taking a faster effect on an illness than TCM, for acute diseases, it can create adverse side effects (Ma, 1999).

Because there is a culture in Chinese societies for self-help, it is popular amongst Chinese people to consult with their families about their illnesses or complaints before approaching a medical practitioner or even a Chinese herbalist. One of the key barriers for meeting the health needs of British Chinese is an improvement in the knowledge of the English language. In addition to this as a result of the conflicting models of health, the Chinese holistic model and the Western biomedical model, there is often confusion between the patient and practitioner as to the cause of the illness. There is a lot of mistrust of Western practitioners within Chinese communities mainly due to language complications and health model problems. There is a widespread lack of confidence within the Chinese community concerning the effectiveness of Western treatment. Many Chinese believe that Western practitioners will not be able to give a full diagnosis of their illness because they do not understand the culture of Chinese medicine, health and illness. As a result of this, many Chinese may prolong appointments to see their Western GP until treatment is absolutely necessary, or until they have tried all alternative routes such as a herbalist or Chinese medicine practitioner. Many may even avoid consulting a Western practitioner altogether.

It has been suggested that patients' expectations and values are not necessarily consistent with the type of care typically delivered by the Western health care system, and that these patients may choose to conduct their health care in accordance with their particular cultural expectations and beliefs (Anderson, 1986; Watt & Chui, 1994). This could be seen as one possible explanation for the under-utilisation of health services by Chinese people, and the reason why Chinese people may choose to consult with a Chinese herbalist or a Chinese practitioner before consulting with a Western practitioner.

Research Objectives

Despite being the third largest ethnic minority group in Britain, the Chinese are one of the least researched ethnic minority groups in Britain. The Chinese community is not a homogenous group and there are considerable contrasts within it. The Chinese are from different countries, they have no common religion, several different dialects are spoken, there are social differences between workers and some were born overseas whereas others are British-born.

Much research already conducted in health psychology regarding the Chinese population is conducted in America, and much less is known about how Chinese culture can influence British Chinese health-seeking behaviours. There is evidence to suggest that cultural variables play a contributory role in illness cognition and behaviour (Angel & Thoits, 1987; Hwu et al., 2001).

The Chinese are seen to have an impressive capacity for self-help, which is perhaps one reason why their needs often go unrecognised. There is some evidence to suggest that the Chinese community does not make full use of primary care or hospital psychiatric care (Wong & Cochrane, 1989; Aspinall & Jacobson, 2004). The absence of health information on the Chinese community in Britain is one of the main obstacles encountered in the planning of research and health care to meet the needs of the Chinese community both at a national and a district level.

In the context of healthcare, very few studies have been published examining the British Chinese community and the influence of Chinese traditions on the use of Western health services in the UK, despite controversies surrounding the topic. Do the Chinese maintain their traditional beliefs? Do they reject Western biomedical systems? Or do they combine the two? This study examines the use of Traditional Chinese Medicine and Western health services by Chinese people in Britain and the influence of cultural factors in Chinese health-seeking behaviours. In addition to this I will be examining how a person's Chinese values can influence their health-seeking behaviours.

The objectives of the study are as follows:

- To investigate the health-seeking behaviours of the British Chinese community
- To explore the relationship between cultural beliefs and values and the influences these may have upon a person's health-seeking behaviours
- To explore the relationship between cultural orientation, cultural values and utilisation of TCM and/or Western medicine
- To explore the relationship between age, choice of medicine, nature of illness and country of origin.

CHAPTER TWO - METHODOLOGY & RESULTS

STUDY ONE

Research Design

The British Chinese community are well known for being considered a 'hard to reach' group. One of the main reasons for this is the lack of existing and easily accessible sampling frames (Prior et al., 1997), another contributing factor is the wide distribution of the British Chinese community throughout the UK. In the current study given the dearth of research on Chinese health-seeking behaviours in the UK and considering the complexity of the issues involved regarding language, a number of different data collection methods were utilised by the researcher.

In the initial stages of the empirical research I aimed to broaden my knowledge and understanding of the British Chinese community and their culture by working with the London Chinese community on a regular basis. I worked as a volunteer in Chinese Health Centres in the Chinatowns of Manchester and London, I became a member of the London Chinese Community Network's mental health sub-group and also attended functions and events with and for the Chinese community, I have also been invited to become a trustee of the Chinese in Britain Forum as a result of my continued involvement with the British Chinese community. This kind of working relationship proved to be crucial in my strive to gain a deeper understanding of the critical knowledge of Chinese culture, Chinese people and their community, and how this in turn influences both their health behaviours and their health-seeking behaviours.

Open-ended and flexible research methods were used in the design, it was felt these methods would be a more appropriate way of attempting to gain valuable insight into the health-seeking behaviours of British Chinese communities. It was hoped that this would be the most effective way of trying to break down the barriers into understanding how Chinese people think about their health-seeking behaviours and what contributes to this

in their terms. In particular, since the researcher could not communicate fully with non-English speaking participants, the use of a bilingual questionnaire, in both Chinese and English, was felt would be of great benefit.

The research design incorporates two different styles of data collection focus group discussions and a self-completion questionnaire, the Cultural Health Belief and Value Survey (CHBVS). Two focus groups were conducted the first with Chinese health professionals working in the Chinese community, while the second focus group was with lay members of the Chinese community. The Cultural Health Belief and Value Survey combined questions designed by the researcher, with a Chinese Value Survey (CVS) originally designed by the Chinese Culture Connection (1987). Both of the focus group discussions were tape-recorded and then duly transcribed verbatim for analysis. The quantitative data gathered in the Cultural Health Belief and Value Survey was analysed using univariate and multivariate analysis. All data for the study was collected between October 2003 and June 2004.

The participants in the study were randomly selected. The 2001 Census data in part guided the selection (tables summarising descriptive UK Chinese population information can be found in the Appendix 3). The researcher chose to concentrate primarily on two main areas in the UK where the Chinese population is most concentrated – Greater London and the North West of England.

The one inclusion criterion for the study was to be of Chinese origin regardless of birthplace. The researcher was not particular as to a specific national origin in the recruitment of participants for the study. However, it transpired that the majority of respondents originated from Hong Kong and China, in line with findings from the 2001 Census. UK-born subjects are somewhat under-represented this is due in some part to the age structure of the Chinese population itself (Gervais & Jovchelovitch, 1998). The age pyramid for the second generation demonstrates that only a small proportion of this group are above age 20 and that virtually no one age 35 and over was born in the UK (Cheng, 1996).

Study One - Cultural Health Belief and Value Survey

The Cultural Health Belief and Value Survey (CHBVS) was initially developed in English by the researcher. It was then translated into Traditional Chinese, and checked for language suitability and accuracy by native Chinese speakers. The two main written languages in Chinese are Traditional Chinese and Simplified Chinese. The researcher decided to use Traditional Chinese in the CHBVS as this is the dominant written language used by Hong Kong Chinese, with most people from China also able to read Traditional Chinese it was felt that this would be the best language to use as it would potentially reach a wider audience than using Simplified Chinese, which only some people in China can read. Considering the origin of the majority of the British Chinese population according to the 2001 census, the decision to use Traditional Chinese was felt to be the most sensible option.

The CHBVS combines questions designed by the researcher together with a Chinese Value Survey created by the Chinese Culture Connection (1987). In 1980, Hofstede published results from a Western survey of work-related values; there was uncertainty as to whether some of the values in the instrument correlated with Chinese culture. The questions developed by the researcher in the CHBVS were designed to explore the importance of cultural traditions and beliefs and the orientation of these values in shaping health-seeking behaviours among the British Chinese community.

The questionnaire was six pages long and took approximately 10 minutes to complete. It was divided into four parts: the first part concerned demographic data and consisted of eleven questions concerning date of birth, sex, marital status, religion, language, place of birth etc. The second part contained seven questions designed to be answered qualitatively, such as; 'what do you feel are the strengths of TCM?', 'For what illnesses would you normally use TCM?', and vice versa for Western medicine. The third part of the CHBVS contained 23 items asking questions about Chinese and Western values and culture. Participants were required to indicate on a five-point scale the frequency of each of the questions asked; five being 'always' and one being 'never'. The final part of the

CHBVS contained the Chinese Value Survey (CVS). The aim of the CVS was to develop a measure of values that would reflect native, original themes and concerns of the Chinese culture. Forty items considered “fundamental and basic values for Chinese people” (Chinese Culture Connection, 1987), were included in the CVS. These items include values such as ‘obedience and respect of parents’, ‘loyalty to superiors’, and ‘having a sense of shame’. Participants were asked to rate the values on a scale of one to nine; nine being ‘of supreme importance’ and one being ‘of no importance at all’ (please refer to Appendix 2 to view the CHBVS).

The CHBVS covered areas that were felt to be of particular interest and importance by the researcher. The CHBVS was randomly distributed through Chinese community centres and Chinese health centres nationwide so as to gain a true representation of the Chinese population in England, the researcher wanted to try and represent as accurate a picture of the Chinese community as possible. The CHBVS was translated into Traditional Chinese in order to reach the widest possible audience within the Chinese community, not just members of the Chinese community that could read and write in English, but also those who could not. Having the questionnaire translated into Traditional Chinese also helped to ensure that participants could fully understand the questions in the survey and therefore misinterpretation of questions would be minimal. Once the translations were complete the CHBVS was distributed to staff members of a Chinese Health Centre in London to proof read, to ensure that the translations were an accurate translation from the English meanings. The questionnaire was initially piloted amongst ten staff members of a London Chinese Health Centre. This was to check the suitability of the questions and to see if there were any last minute amendments that needed to be made.

Participants were randomly selected through their memberships to various Chinese Health Centres and Chinese Community Centres throughout the country. Chinese Health Centres and Chinese Community Centres across the country were contacted by the researcher and invited to participate in the study. Those centres that agreed to help with the research did so by distributing the CHBVS questionnaire to their members through

their health and community centres. These centres were selected from 'The UK Chinese Community Service Directory' (CIAC & the Chinese in Britain Forum).

The researcher wrote a standard letter to all the Chinese health and community centres listed in the Chinese Community Directory. Those centres with an e-mail address were also sent the same standard letter by email. The letter briefly explained the purpose of the research and asked for help with the distribution of the CHBVS through their particular centre (please see Appendix 4 for an example of the letter). Those centres that agreed to help with the research were then sent a pack of questionnaires along with freepost envelopes attached to each questionnaire (please see Appendix 5 for a full list of centres that participated in the research). The first two pages of the CHBVS consisted of a participant information sheet for the participant to keep detailing what the study was about and why the research was being conducted. There was also a consent form for the participant to sign and return with the CHBVS in the freepost envelope attached, both the information sheet and consent form were written in English and Traditional Chinese. Towards the end of the recruitment period in a last-ditch attempt to increase recruitment numbers, the researcher stood in Chinatown Central London, distributing the Cultural Health Belief and Value Survey to Chinese passers-by and shoppers.

The CHBVS was distributed between October 2003 and April 2004. In this time a total of 185 respondents completed the Chinese Health Belief and Value Survey (please see Appendix 2 for a copy of the CHBVS). This is out of a total of 600 questionnaires being distributed through various Chinese health and community centres throughout the country; thus making the response rate 30%.

In order to obtain a profile of the respondent CHBVS sample (N=185), descriptive statistics were generated from the CHBVS data by using Statistical Package for Social Sciences (SPSS, version 12.0). Principal Components factor analysis was used to analyse the rest of the CHBVS data. The CVS was analysed separate to the rest of the CHBVS; Principal Components factor analysis was again used in the analysis of the CVS. Grounded theory analysis was used to analyse all descriptive items in the CHBVS.

Univariate and multivariate logistic regression analyses were used to estimate both crude and adjusted odds ratios (and corresponding 95% confidence intervals) of association of individual variables with TCM utilisation.

Demographic Characteristics

A summary of selected demographic characteristics of the CHBVS sample participating in the research is shown in table one below. 185 participants took part in the research, reliability analysis of both the CHBVS and the CVS indicate high levels of internal consistency, $\alpha = .86$, $\alpha = .97$ respectively.

Age and Sex: The survey found that the male to female ratio was 41:59. The mean age for men was found to be 38.1 years, whilst the mean age for women was 39.4 years. The overall mean age of respondents was 38.8 years (SD=16.1, range=18-79). Almost one third (32%) of Chinese respondents were aged between 16 and 29 years, whilst over one third (36%) were aged between 30-49 years. There were no real differences in the profiles of Chinese males and females.

Time spent in UK: Overall, the British Chinese population are generally long established residents of the UK. Despite the fact that only 8% of respondents were born in the UK, nearly one third of respondents (31%) reported residing in the UK for more than twenty years, this was the largest single proportion. A further 15% of respondents had lived in the UK for between 11-20 years; this is in keeping with findings from the 2001 Census where only 27.7% were born in the UK while 67.6% were born in the Far East (National Statistics, 2004). 22% of respondents reported residing in the UK for between 1 and 5 years, while 17% of respondents reported residing in the UK for between 6 and 10 years.

Table 1: Participant characteristics

Characteristic	%	Characteristic	%
<i>Gender:</i>		<i>Registered with a GP:</i>	
Male	41	Yes	86
Female	59	No	14
<i>Marital status:</i>		<i>UK resident:</i>	
Single	39.5	< 1 year	9
Cohabiting	4	1-5 years	23
Married	54	6-10 years	18
Divorced	2	11-20 years	15
Separated	0.5	> 20 years	35
<i>Children:</i>		<i>Religion:</i>	
Yes	50	Buddhism	24
No	50	Christianity	28
		Catholicism	11
		None	37
<i>Birthplace:</i>		<i>First language:</i>	
China	33	Cantonese	72
Hong Kong	46	Mandarin	16
Malaysia	5	Hakka	3
Singapore	0.5	Vietnamese	2
Vietnam	1.5	English	8
UK	8	Other	0.5
Other	7		
<i>Age Group:</i>		<i>Second language</i>	
16 - 29	32	Cantonese	11
30 - 49	36	Mandarin	5
50 - 74	22	Hakka	4
75 +	3	English	71
Missing	7	Other	2

Country of birth: The CHBVS survey found that only 8% of Chinese respondents were born in the UK. The largest proportion of respondents (46%) was born in Hong Kong, with a slightly smaller proportion born in China (33%). There were relatively few Chinese respondents born in other East Asian countries such as Malaysia, Vietnam, or Singapore.

Although only 8% of respondents were born in the UK, there was a wide variation with age. 10% of Chinese respondents aged between 16 and 29 years were UK-born. In

comparison, 13.5% of respondents in the 30 - 49 age group were born in the UK. Hong Kong was the most commonly reported place of birth for people aged 30 years or over (45% of people aged between 30 and 49 years and 56% of those aged between 50 and 74 years stated they were born there). Hong Kong was also the most commonly reported place of birth among the younger age group (46% of people aged between 16-29 reported being born there). The second most commonly reported birthplace for this age group was China (29% of those aged between 16 and 29 years).

Looking at other reported places of birth reveals some interesting patterns of countries of origin. For respondents aged between 50 and 74 years, China was the second most commonly reported place of birth after Hong Kong (56%), with nearly one third (29%) of people in this age group being born over there. This was also the case for people aged between 30 and 49 years, with 45% of people being born in Hong Kong and 32% being born in China. One reason for this could be the fact that respondents were recruited from Chinese health centres, where the majority of people using those facilities may indeed be more likely to be new immigrants rather than British-born Chinese, who are already familiar with the British health system and therefore need less assistance with their affairs.

Language: The main Chinese dialect spoken by respondents was Cantonese, 71% of respondents considered Cantonese to be their first language, 16% considered Mandarin to be their first language, while only 8% of respondents rated English as their first language. This reflects the large number of Chinese people in the UK who were born in Hong Kong (where Cantonese is the most widely spoken form of Chinese). 71% of respondents rated English as their second language, while 93% of respondents claimed to be able to speak a second language smaller proportions of respondents claimed to be able to speak other Chinese dialects such as Hakka or Vietnamese.

A large proportion of Chinese people in the 16-29 and 30-49 age groups (86% and 76% respectively) claimed to be able to speak English whilst people aged 50-74 were markedly less likely to say that English was their second language (58%). Older

respondents were also more likely than younger respondents to say they spoke each of the Chinese dialects (other than Cantonese). The proportion of respondents claiming to speak two languages was higher amongst younger people. Overall, 93% of Chinese people claimed to speak more than one language.

Marital Status and Religion: Five in ten (54%) Chinese people gave their marital status as married though this was a slim majority as over one third (39.5%) of respondents reported being single. This could reflect the large young Chinese student population in the UK. Very small proportions of respondents claimed to have some other marital status such as divorced, cohabiting and separated.

37% of respondents claimed to have no religion this was the largest proportion. These findings were in line with findings from the 2001 Census where just over half of all Chinese people stated they had no religion. 24% of respondents claimed to follow Buddhism while a greater proportion of respondents reported following Christianity. 11% of respondents followed Catholicism.

Self-Assessment of Health: Self-reported health has been shown to be a strong predictor of mortality (Moller et al., 1996) it has also been associated with uptake of primary care health services (Blaxter, 1987). In the CHBVS, respondents were asked to rate their perceptions of health status on a scale of 1 to 5 with “1” being very unhealthy and “5” being very healthy. Overall, nearly half of Chinese respondents rated their health as either ‘very healthy’ or ‘healthy’ (12% and 36% respectively). Most respondents rated their health as ‘average health’ (43%). Only a small number of respondents rated themselves as “unhealthy” or “very unhealthy” (6% and 3% respectively). There were no overall sex differences in response to this question. Interestingly, the proportion of people rating their health as ‘unhealthy’ or ‘very unhealthy’ was higher among the 30 – 49 age group than any other age group.

Health-related information: Respondents were asked where they obtained their health-related information. The most common responses were ‘Chinese health centres’ and

'Chinese community centres' other popular responses included 'internet', 'mass media', 'friends and family', 'GP surgery' and 'hospital leaflets'. Most respondents stated that they obtained their health-related information from Chinese Health Centres/Community Centres. This could have been, in part, influenced by the fact that the majority of respondents of the CHBVS were recruited through Chinese Health and Community Centres and therefore would be more likely to utilise their centre's services and also seek help or advice from these centres. It is interesting to note that friends and family were also a source of information on health issues. Another interesting point is the popularity of mass media for the respondents, in the forms of the Internet, newspapers and magazines, the news and radio. Mass media seemed to be a relatively popular way of learning information on health issues.

Strengths of TCM: Respondents were asked to comment on what they believed were the strengths of TCM. More common responses were related to the natural qualities of TCM such as the fact that TCM 'doesn't have too many side effects' and is 'not as strong as Western medicine'. Many respondents also highlighted the holistic properties; 'TCM looks after the whole body, treatment is more complete'.

Another popular response was related to the 'prophylactic' properties and TCM's 'non-invasive, more natural' treatment. The notion that TCM maintains well-being was a popular theory amongst respondents, many respondents claimed to use TCM not just when they were suffering from ill health but also 'for health, wellness, rehabilitation, for the whole body'. Other respondents commented on how 'TCM maintains health and wellness' with its 'treatment by cultivation and balance', once again emphasising the holistic properties of TCM. A number of respondents perceived TCM to have 'preventative' medicinal qualities, another prevalent TCM strength in the eyes of respondents was that it 'works to the root of the problem and can mostly cure diseases without side effects'; the belief that TCM 'can cure the root of the disease' was commonly held amongst respondents in the current study. Another popular belief was related to how TCM 'treats the body well' not harming the body seemed to be another issue of some importance for many respondents.

TCM was also considered to be ‘an alternative option with less side effects’ in comparison to Western medicine. One respondent commented on how ‘TCM and TCM theory explain our [*Chinese*] culture’ while another respondent claimed TCM was ‘better for Chinese people’s health, more suitable for our body’. Other respondents highlighted the advantages of the individual treatments and prescriptions that are commonplace with TCM where ‘the medication is tailored to the individual after the consultation’.

There were a number of comments relating to TCM’s ability to treat illnesses Western medicine sometimes fails to treat successfully ‘TCM can sometimes treat illnesses that Western medicine cannot’. The natural element of TCM was seen as one of its most important strengths according to many of the respondents, TCM is seen as a ‘non-invasive treatment that can be bought over the counter and contains organic constituents’ it ‘uses natural substances to work with the body’. Another strength of TCM according to one respondent was the fact that TCM treatment is ‘much more complete’ compared to Western medicine ‘and in depth with the emphasis not only on the symptoms’. ‘TCM can heal the origin of the illness rather than dealing with just the symptoms, it can improve health gradually with more natural ingredients’.

Strengths of Western medicine: Respondents were also asked to comment on what they believed to be the strengths of Western medicine. There was a varying response, one of the more popular answers was related to the convenience of carrying the medicine around and also the ease in consuming the medicine. Western medicine was described as ‘easy to carry around and to take, compared to TCM’ and ‘small, suitable, easy to carry around and convenient’. Another strength in the eyes of Chinese respondents was related to the speed of recovery once taking Western medication, many respondents viewed Western medicine as being ‘quick and effective to cure symptoms’. Many respondents believed Western medicine to be quicker in aiding the recovery process of ill health ‘it helps people to recover very quickly’, ‘quick fix for curable diseases and medication is easy to take’. Western medicine was viewed as ‘quick’ with ‘direct reaction’ and ‘good appearance’ with ‘fast recovery for the disease’.

Another strength of Western medicine according to respondents was related to the regulation of medicine in the UK. Respondents believed Western medicine to be 'scientific, more regulated and controlled', 'scientifically proven and tested', 'backed up by research', 'more scientifically based, more controlled and measurable'. A number of respondents also mentioned how Western medicine was 'easy to get lots of information on'. One respondent described the 'range of medical pills available and more detailed explanation for sickness'. Other respondents highlighted the use of 'more developed equipment', 'more advanced, new medicines and equipment, earlier detection'. While others referred to the display of ingredients on Western medicines and claimed to 'feel more confident using it as the formula can be traceable'.

An interesting strength in the eyes of some Chinese was the 'good taste for children to use'. Respondents also mentioned that Western medicine was 'better than TCM in an emergency', a 'quick fix for curable diseases', 'quick to see the result'. One respondent commented how it 'depends on what illness you have as to what is best to take TCM or Western medicine' intimating that respondents may use both TCM and Western medicine depending on the illness. Other respondents claimed that Western medicine's strength lay in its popularity 'mass marketing/manufacturing process', also the fact that Western medicine is 'more internationally ratified and recognised'.

One of the more important strengths of Western medicine lay in the fact that it is believed to be 'fast and effective' with 'fast action' and 'immediate effect' providing 'quick pain relief on some illnesses'. A number of respondents commented that 'surgery' was an additional strength of Western medicine and that Western medicine was 'more effective, especially for bacterial symptoms'.

Weaknesses of TCM: Many of the weaknesses of TCM reported by the respondents were related to the inconveniences involved in preparing the medicine in addition to the look and taste of the medicine. The inconvenience of 'having to cook the medicine' was one of the more common responses, TCM was viewed as 'troublesome to

prepare and administer', 'it takes time to make'. TCM was also popularly described as 'bitter tasting' or 'disgusting taste'. Respondents commented on the way that information on TCM treatments are often kept within the family 'ways of dealing with ailments stay in the family only'. One of the main weaknesses repeatedly mentioned was related to the relative slowness of the recovery process and how it is 'slow to see the result' with TCM, TCM was viewed as being 'too slow to cure the disease'.

One respondent described how there are 'no hard and fast rules' when taking TCM, while another described the trial and error involved with TCM 'you have to try it before you come to know if it is effective or not'. One respondent professed 'if you understand how TCM works it is good, but if you don't, it can work against you'. There also seemed to be a large amount of uncertainty with regard to dosage 'no hard and fast rules for taking, uncertain about contents of tablets'.

Many respondents expressed concern in relation to TCM practice in the UK, 'there is no control for doctor training/qualification, or herbs'. The fact that TCM is 'not regulated' in the UK was a matter of some worry for many respondents. Also, the 'difference in level of skills' with regards to the practitioners, all these factors seem to be a cause of some concern for many of the respondents. Respondents also expressed disappointment at TCM not being widely available in the UK and the fact that it is 'not available on the NHS'. Some respondents believed that TCM is 'still not widely recognised by Western countries' and that it is 'difficult and expensive to obtain'. Many felt that TCM was 'hard to get access to' and that the quality of both the TCM practitioner and medicine was 'not always the same', 'TCMP qualifications deviate a great deal'. Some respondents also emphasised the 'lack of information' available on TCM in the UK. While one respondent highlighted the difficulty in trying to convey the principals of TCM to other cultures, where the 'recovery process is sometimes difficult to explain and understand'.

A number of respondents commented on the lack of consistency in finding an efficient TCM practitioner in the UK, claiming to have difficulty 'to find a good, experienced TCM doctor'. The quality of TCM provision in the UK was seen to deviate a great deal,

respondents emphasised that the effectiveness of 'TCM relies on good practitioners'. One respondent described how the 'problem is not TCM itself, but seeking a good Chinese herbalist to make a good prescription', some mentioned that it 'depends on the quality of the practitioner, many of them conduct badly and are harmful to the community'. Others commented on the expense of the medication 'the medication fee is expensive especially in the UK and there is no NHS support for expenses'. A number of worries concerning respondents were related to the regulation of TCM 'ingredients are unknown which can make you worry and feel unsafe', 'so many ingredients, some of them are easily mixed up, not secure'.

Weaknesses of Western Medicine: Respondents were asked to comment on what they believed to be the weaknesses of Western medicine. The most common answer to this question was related to the side effects and the strength Western medicine was seen to have 'side effects harmful to health' with a 'high toxicity'. Western medicine was believed to 'weaken the immune system due to overuse over long periods of time'. Some claimed that taking Western medicine could have a harmful effect on your health and that there are 'side effects especially when a patient takes several different tablets it can affect the liver a lot'.

Another popular notion was the belief that Western medicine 'only treats the symptoms of the illness and not the cause of it'. 'It kills the symptoms but the illness is left not cured the patient can lose the actual indicator of their health which I think can be quite dangerous'. The claim that 'Western medicine cannot cure the root of the problem' was an imminent belief amongst respondents. Many Chinese people believe that TCM treats the whole body and not just the illness compared with Western medicine which respondents claim 'tends to look at the problem when it has already occurred', implying the lack of holistic and preventative qualities. A number of respondents also commented on the way that Western medicine does not 'cater for the individual' in the sense that TCM seems to.

Respondents repeatedly remarked on the chemical content of Western medicine 'too

much chemical substance', with a 'powerful chemical effect', 'most Western medicines have side effects which do great harm to the health'. In addition to this, concern was also expressed for the strength of the medicine with Western medicine being viewed as having 'too much stimulation' and being 'too strong'. Respondents remarked on the limiting factors of Western medicine claiming that Western medicine is 'too reliant on a few drugs if there isn't a drug then there isn't a cure' and that Western medicine 'only cures the symptoms' and cannot be used 'for rehabilitation or wellness'. One respondent commented on how Western medicine 'is drugs which is bad for you'. Others pointed to the addictive properties of Western medicines 'some medicines easy to get addicted', or that the 'continuous intake will cause addiction to medication'.

Use of TCM for illnesses: Respondents were asked for what illnesses they would normally use TCM. A great number of respondents reported that they would use TCM for illnesses 'when there is no effect from Western medicine', 'when Western medicine cannot cure', or when treatment is 'unsuccessful with Western medicine'. Some admitted using TCM when they 'don't get the right treatment' from their GPs, while some claimed to use TCM for 'any non-surgical cases'. Many respondents commented on the utilisation of TCM for general use, not solely for use with a 'specific illness' but also 'for maintaining health and wellness' and 'general well being'. While one respondent claimed 'I don't think I have the choice here in the UK' implying the only choice to be Western medicine in the UK.

Some respondents targeted specific illnesses they would use TCM for such as rheumatism, colds, nausea, upset stomach, flu, fever, bone dislocation, tendon injuries, allergies, and 'when I am feeling unhealthy like hair loss or weight loss'. Many respondents claimed to use TCM when they felt it was 'more suited' to the illness, 'especially skin problems'. Another respondent claimed it best to use TCM with 'any long term illness but not acute illnesses or any serious illness requiring operations', while others suggested using TCM for 'chronic diseases or prolonged symptoms'. Most respondents believed TCM to be useful for boosting health 'when I am feeling unhealthy I will use TCM', 'when I need to help my nutritional uptake', 'for rehabilitation'. A

number of respondents claimed to use TCM for 'general health preventative remedies' or for when individuals feel 'a lack of energy'.

Respondents also referred to the internal bodily feelings of 'hot' and 'cold' and told of how TCM is used when they feel they have bodily imbalances 'when I'm feeling hot – don't know how to explain in English'. Some respondents observed that when they take Western medicine for a long time it will make them feel 'heat' inside their body. Other respondents claimed to take TCM when 'fed-up of being prescribed antibiotics again and again' or 'when I feel a lack of something (e.g. heat)'. Some also mentioned 'when Western medicine doesn't seem to work at all times I will use TCM as an alternative to give myself another option'.

Use of Western Medicine for illnesses: Respondents were asked for what illnesses would they normally use Western medicine. Many respondents intimated that one of the reasons they utilise Western medicine is because of the free NHS service available over here in the UK. While one respondent stated 'I don't think I have the choice over here to choose other medicines' other respondents admitted always using Western medicine in the UK 'because mainly Western medicine is free in this country' or because 'Western medicine is mainstream'. Some respondents claimed to use Western medicine 'because it is cheaper' in the UK, others professed that it was 'more to do with free treatment than the type of illness'. While some respondents asserted that it 'depends on the illness' or 'when I need to see a Western GP' suggesting that respondents often choose their medicine on the basis of the type of illness they are suffering from.

A popular response was the use of Western medicine for acute illnesses or in cases of emergency 'when symptoms become acute or when I want to stop symptoms quickly', 'in emergency crisis situations', 'when I am very sick', or for 'something to be cured immediately'. Respondents claimed to use Western medicine for 'most sicknesses except when I know the side effects of applying Western medicine are great'. A number of respondents said they would use Western medicine for surgery 'disease requiring surgery', 'anything serious' 'serious illness'. Quite a few respondents also mentioned

using Western medicine for female health issues such as ‘child birth’ and ‘period pain’. One respondent wrote ‘when there is a need to examine internal problems’, while quite a few respondents mentioned using Western medicine for ‘medical examinations’.

It was interesting to observe respondents commenting on how they would utilise Western medicine for mental health related problems ‘especially where counselling is needed’. Some respondents associated Western medicine with going to visit the ‘dentist and optician’ while another respondent claimed to ‘try not to use’ Western medicine. Some claimed to use Western medicine ‘only when really ill’ whilst others named specific illnesses when they would utilise Western medicine such as ‘heart disease or cancer’, ‘inflammation’, ‘stomach problems’, ‘chest infections’, ‘flu’, or ‘heart burn’.

Table 2: CHBVS Frequencies

Question	A	VO	O	S	N	M
Read Chinese newspapers and/or magazines	51	26	42	45	20	1
Follow Chinese events	27	41	40	47	29	1
Use TCM	7	18	31	88	40	1
Use Western medicine	32	52	53	42	5	1
Trust TCM	23	47	66	37	9	3
Trust Western medicine	36	77	56	13	2	1
TCM helpful when you are ill	13	35	53	53	23	8
Western medicine helpful when you are ill	30	88	47	15	4	1
Cultural beliefs influence your health-seeking behaviour and choice of medicine	20	47	37	25	55	1
Cultural values influence your health-seeking behaviour and choice of medicine	19	44	28	30	62	2
Friends and family influence your health-seeking behaviour and choice of medicine	16	35	41	40	50	3
Religious beliefs influence your health-seeking behaviour and choice of medicine	3	9	17	21	133	2
Being British Chinese influences your health-seeking behaviour and choice of medicine	15	25	33	27	66	19

Question	A	VO	O	S	N	M
Generally pleased with the care you receive from GPs	17	40	71	42	12	3
Generally pleased with the care you receive from TCMPs	7	27	66	44	27	14
Generally pleased with the quality of health care you have received in the UK	9	48	73	30	25	9
Agree with the explanations GPs give you for your illness when you are unwell	12	60	75	23	13	2
Agree with the explanations TCMPs give you for your illness when you are unwell	5	41	61	35	26	17
Agree with/conform to treatment plans GPs prescribe you when you are unwell	16	53	75	28	7	6
Agree with/conform to treatment plans TCMPs prescribe you when you are unwell	7	42	66	25	24	21
Your GP understands your health concerns	11	39	86	30	10	9
Your TCMP understands your health concerns	6	44	61	30	23	21
An adequate health service is available to you	6	42	84	27	20	6

Key: A = Always VO = Very Often O = Often S = Sometimes
 N = Never M = Missing

Chinese news and events: Just over 27% of respondents claimed to 'always' read Chinese newspapers or magazines, just over 11% of respondents claimed to 'never' read Chinese newspapers and magazines. Respondents in the 16-29 age group were most likely to 'always' follow Chinese news while the 75+ age group was the least likely to follow Chinese news. Only 14.5% of respondents claimed to 'always' follow Chinese events, while over 15% claimed 'never' to follow Chinese events. Respondents aged 50-74 were most likely to follow Chinese events 'very often'. Respondents born overseas in either China or Hong Kong were more likely to follow Chinese news and events than UK born respondents. Only a small number of UK born respondents claimed to 'always' follow Chinese news and events, UK respondents were most likely to answer 'sometimes' or 'never' in response to following Chinese news and events.

TCM Utilisation: Regarding utilisation of TCM 78% of respondents claimed to have used TCM. 4% of respondents claimed to 'always' use TCM. 48% claimed to use TCM 'sometimes' while 21% of respondents claimed 'never' to use TCM. Respondents from all age groups were most likely to rate that they use TCM 'sometimes'. Only 12% of respondents trust TCM 'always', 61% of respondents claimed to trust TCM 'often' or 'very often'. Respondents born overseas were more likely to report using and trusting TCM than UK born respondents. Respondents born overseas were also most likely to report using TCM 'sometimes' and trusting TCM 'often' or 'very often'.

In relation to TCMP care, 4% of respondents claimed to be 'always' satisfied with TCMP care, 50% of respondents stated that they were 'often' or 'very often' satisfied with care given by their TCMP. 14.5% claimed to 'never' be satisfied with the care given by the TCMP. 55% of respondents claimed to be 'often' or 'very often' satisfied with TCMP explanations. 69% of respondents claimed to 'often' or 'very often' conform to GP advice while 58% claimed to 'often' or 'very often' conform to TCMP advice. 57% of respondents believed that TCMPs understood their health concerns. British-born respondents were just as likely to profess satisfaction with the care and explanations given by TCMPs than those respondents born overseas.

Utilisation of Western Medicine: 3% of respondents claimed 'never' to have used Western medicine while 97% of respondents claimed to have used Western medicine. 17% of respondents admitted using Western medicine 'always', only one British-born respondent claimed to use Western medicine 'always'. 57% of respondents claimed to use Western medicine 'often' or 'very often'. 71% of respondents claimed to trust Western medicine 'often' or 'very often', only 1% of respondents claimed to 'never' trust Western medicine. Respondents born overseas were most likely to cite trusting Western medicine 'often' or 'very often'. 73% of respondents found Western medicine helpful 'often' or 'very often'. British-born respondents were more likely to find Western medicine helpful than those born overseas.

With regard to satisfaction with GP care, 9% of respondents claimed to be 'always' satisfied with the care given by the GP, 60% are 'often' or 'very often' satisfied with GP care while only 6.5% claimed 'never' to be satisfied with the care given by their GP. With regard to GP explanations, 72% of respondents claimed to be 'often' or 'very often' satisfied with the explanations given by GPs in consultations. 67% of respondents felt that GPs 'often' understood their health concerns. There was no difference in satisfaction with GP care and explanations when taking into account respondents' birthplace. 68% of respondents believed that an adequate health service is 'often' available to them in the UK. 66% of respondents claimed to be 'often' or 'very often' satisfied with the quality of healthcare they receive in the UK, 13% claimed 'never' to be satisfied with UK healthcare while 16% claimed to be 'sometimes' satisfied, one third of British-born respondents are only 'sometimes' satisfied with UK healthcare.

Health-Seeking Behaviours: With regard to the influence of culture on health-seeking behaviours, 30% of respondents maintained that their cultural beliefs 'never' influence their health behaviours or choice of medicine, 35% of respondents claimed that their health behaviours are 'often' or 'very often' influenced by their cultural beliefs while 11% of respondents stated that their cultural beliefs 'always' influence their health behaviour. UK born respondents were most likely to rate that their cultural beliefs 'often' influence health-seeking behaviours (40%), while respondents born overseas were more likely to rate cultural beliefs influencing health-seeking behaviours 'very often' (15%). Only 10% of respondents maintained that their cultural values 'always' influenced their health behaviours, 34% claimed that their cultural values 'never' influenced their health behaviours, while 39% claimed that their cultural values 'often' or 'very often' influenced their health behaviours. Interestingly, 30% of respondents born overseas rated their health-seeking behaviours as 'never' being influenced by their cultural values whereas 40% of UK born respondents rated their cultural values as 'very often' influencing their health-seeking behaviours.

Friends and family were seen to have some influence over health behaviours as 40% of respondents maintained that their friends and family 'often' or 'very often' influence their

health behaviours. 28% of respondents asserted that their friends and family 'never' influence their health behaviours while 9% of respondents claimed their friends and family always influence their health behaviours. Nearly one third (30%) of respondents born overseas stated that their friends and family 'never' influence their health behaviours while 47% of British-born respondents claimed their friends and family 'very often' influence their health behaviours. Religious beliefs were shown to have little impact upon the influence of health behaviours with a resounding 72% of respondents claiming that their religious beliefs 'never' influence their health behaviours, 11% of respondents claimed that their religious beliefs 'sometimes' influence their health behaviours. There were no real differences between those respondents born overseas and in the UK.

36% of respondents claimed that being British Chinese had no influence over their health-seeking behaviours or choice of medicine. While over 30% of respondents claimed their health behaviours are 'often' or 'very often' influenced by being British Chinese. 20% of British-born respondents claimed their health behaviours are 'always' influenced by the fact that they are British Chinese, while 41% of respondents overseas claimed their health behaviours are 'never' influenced by being British Chinese. Interestingly, a number of respondents chose not to answer this question claiming not to consider themselves as British Chinese.

Factor Analysis: The factor structure of the Chinese Value Survey was tested using principal components analysis on SPSS. Prior to performing principal components analysis the suitability of the data for factor analysis was tested. Inspection of the correlation matrix revealed the presence of many coefficients of .3 and above. The Kaiser-Meyer-Okin value was .93, exceeding the recommended value of .6 (Kaiser, 1970, 1974) and the Bartlett's Test of Sphericity (Bartlett, 1954) reached statistical significance ($p=.000$) supporting the factorability of the correlation matrix.

Principal components analysis revealed the presence of seven Eigenvalues greater than one which accounted for 69% of the variance, 45%, 6%, 5%, 4%, 3%, 3% and 3% of the

matrix of variance, respectively. An inspection of the screeplot revealed a break after the fifth component. Using Cattell's scree test (Cattell, 1966), it was decided to retain five components for further investigation. To aid in the interpretation of these five components, Varimax rotation was performed. The rotated solution revealed the presence of simple structure (Thurston, 1947), with all five components showing a number of strong loadings. The five factor solution explained a total of 63% of the variance, 20%, 13%, 11%, 10% and 9% respectively.

The reliabilities of these factors were assessed by Cronbach's alpha coefficient and the results demonstrate that all seven factor reliabilities are over 0.5 and therefore satisfy the exploratory research norm set by Nunally (1978). Factor loadings greater than 0.33 were considered to meet the minimal level of practical significance (Kaiser, 1958), factor loadings $>.33$ are listed under their preliminary factor names in Table 3 below.

Table 3: Value loadings $>.33$ on the Factor Analysis of the Chinese Value Survey

CVS 1 - INTEGRATION
5) Humbleness (.74) 4) Harmony (.74) 21) Sincerity (.73) 2) Working hard (.71) 3) Tolerance of others (.68) 1) Obedience towards parents (.65) 19) Resistance to corruption (.64) 16) Benevolent authority (.63) 23) Thrift (.62) 32) Courtesy (.61) 15) Sense of righteousness (.60) 20) Patriotism (.58) 28) Adaptability (.55) 14) Ordering relationships by status (.46)
% of variance accounted for before rotation: 45.1 % of variance accounted for after rotation: 20.1 Reliability: 0.94
CVS 2 – DEVELOPMENT OF SELF
24) Persistence (.70) 29) Prudence (.64) 13) Self-cultivation (.61) 33) Contentedness (.60) 18) Personal steadiness and stability (.58) 17) Non-competitiveness (.57) 25) Patience (.56) 30) Trustworthiness (.53)

<p>% of variance accounted for before rotation: 6.1 % of variance accounted for after rotation: 13.1 Reliability: 0.91</p>
<p>CVS 3 – SOCIAL RESPONSIBILITY & DISCIPLINE</p>
<p>7) Observation of rites and social rituals (.72) 6) Loyalty to superiors (.70) 11) Solidarity with others (.69) 12) Moderation (.64) 10) Knowledge (.55) 9) Kindness (.49) 8) Reciprocation of greetings, gifts and favours (.45)</p>
<p>% of variance accounted for before rotation: 4.7 % of variance accounted for after rotation: 10.9 Reliability: 0.89</p>
<p>CVS 4 – CONFUCIAN CONSERVATION</p>
<p>27) Sense of cultural superiority (.71) 35) Protecting 'face' (.67) 34) Being conservative (.67) 39) Respect for tradition (.62) 22) Disinterested and pure (.48) 31) Having a sense of shame (.46) 37) Chastity in women (.45) 26) Repayment of good and evil (.41)</p>
<p>% of variance accounted for before rotation: 3.7 % of variance accounted for after rotation: 10.1 Reliability: 0.85</p>
<p>CVS 5 - VIRTUE & COMPANIONSHIP</p>
<p>36) Close, intimate friend (.72) 38) Having few desires (.67) 40) Wealth (.55)</p>
<p>% of variance accounted for before rotation: 3.4 % of variance accounted for after rotation: 8.9 Reliability: 0.79</p>

CVS I: There were 13 values in this factor by the .33 criteria all with positive loadings. These values seem to reflect a broad emphasis on integration, conformity and social harmony with values such as 'tolerance of others', 'adaptability', and 'courtesy' loaded together in one factor. The highest loadings were 'humbleness', 'harmony', 'sincerity', and 'working hard' respectively. This factor has been labelled 'Integration'.

CVS II: There were 8 values in this factor grouping all positively loaded. The values in this grouping seem to reflect a shrewd development of the self with the inclusion of values 'contentedness with ones position in life' and 'personal steadiness and stability' grouped together with values such as 'patience' and 'trustworthiness'. The highest loadings were on 'persistence', 'prudence' and 'self-cultivation' respectively. This factor has been labelled 'Development of Self'.

CVS III: There were 7 values in this grouping by the .33 criteria once again all positively loaded. The values in this factor seem to reflect a sense of social responsibility with values such as 'moderation', 'knowledge' and 'reciprocation of gifts'. 'Observation of rites and rituals', 'loyalty to superiors', and 'solidarity with others' were all particularly highly inter-correlated. This factor has been labelled 'Social Responsibility'.

CVS IV: There were 8 positively loaded values in this factor. The eight values reflect the element of Confucian influence on Chinese respondents with values such as 'respect for tradition' and 'having a sense of shame'. The highest loadings were for 'cultural superiority', 'protecting face' and 'being conservative' respectively, these values were particularly highly inter-correlated. This factor has been labelled 'Confucian Conservation'.

CVS V: There were 3 values in this factor, all with positive loadings. Each of the values seems to reflect the importance of virtue, such as 'close and intimate friend' and 'having few desires'. This factor has been labelled 'Virtue and Companionship'.

The factor structure of the Cultural Health Belief and Value Survey was also tested using principal components analysis. Prior to performing principal components analysis the suitability of the data for factor analysis was tested. Inspection of the correlation matrix revealed the presence of many coefficients of .3 and above. The Kaiser-Meyer-Okin value was .79, exceeding the recommended value of .6 (Kaiser, 1970, 1974) and Bartlett's Test of Sphericity (Bartlett, 1954) reached statistical significance ($p=.000$) supporting the factorability of the correlation matrix.

Principal components analysis revealed the presence of five Eigenvalues greater than one which accounted for 65% of the variance 26%, 15%, 11%, 8% and 5% respectively. An inspection of the screeplot revealed a break after the fourth component. Using Cattell's scree test (Cattell, 1966), it was decided to retain four components for further investigation. To aid in the interpretation of these four components Varimax rotation was performed. The rotation solution revealed the presence of simple structure (Thurston, 1947) with all four components showing a number of strong loadings. The four-factor solution explained a total of 60% of the variance 20%, 17%, 13% and 10% respectively. The reliabilities of these factors were again assessed by Cronbach's alpha coefficient. The results show that all factor reliabilities were over 0.5.

Table 4: Value loadings $>.33$ on the Factor Analysis of the Cultural Health Belief and Value Survey

Factor 1: Orientation towards TCM
36) TCMP explanations (.85)
40) TCMP understands health concerns (.83)
25) TCM helpful (.82)
38) TCMP conform (.80)
33) TCMP care (.78)
23) Trust TCM (.77)
21) Use TCM (.61)

<p>% of variance accounted for before rotation: 25.7 % of variance accounted for after rotation: 20.3 Reliability: 0.88</p>
<p>Factor 2: Conforming with Western health services</p>
<p>35) GP explanations (.78) 39) GP understands health concerns (.78) 41) Adequate health service (.77) 34) UK healthcare (.76) 32) GP care (.75) 37) GP conform (.71)</p>
<p>% of variance accounted for before rotation: 15.3 % of variance accounted for after rotation: 17.3 Reliability: 0.88</p>
<p>Factor 3: Cultural Influences</p>
<p>28) Cultural values (.89) 27) Cultural beliefs (.87) 29) Friends and family (.71) 31) British Chinese (.67) 30) Religious beliefs (.54)</p>
<p>% of variance accounted for before rotation: 11.3 % of variance accounted for after rotation: 12.7 Reliability: 0.82</p>
<p>Factor 4: Orientation towards Western Medicine</p>
<p>24) Trust Western medicine (.80) 26) Western medicine helpful (.76) 22) Use Western medicine (.69) 19) Follow Chinese News (.51)</p>
<p>% of variance accounted for before rotation: 7.8 % of variance accounted for after rotation: 9.9 Reliability: 0.64</p>

Factor 1: There were 8 items in this factor by the >.33 criteria all with positive loadings. Each of the 8 items suggests strong associations with the utilisation of traditional Chinese

medicine such as 'use TCM', 'trust TCM' and 'satisfied with care of TCMPs'. The highest loadings were for 'agree with TCMP explanations', 'TCMP understand health concerns' and 'TCM helpful'. This factor has been labelled 'Orientation towards TCM'.

Factor 2: There were 6 positively loaded items in this second factor. All items seemed to relate specifically to the Western health system such as 'satisfaction with UK health care' and 'conform to GP treatment plans'. The highest loadings in this factor were 'GP explanations', 'GP understands health concerns' and 'adequate health service provision' respectively. This factor has been labelled 'Conforming with Western Health Services'.

Factor 3: This factor had 5 positively loaded items the items in this factor were all particularly highly correlated with each other. These items seem to reflect the influences of cultural beliefs and values on one's health behaviours with values such as 'friends and family', 'religious beliefs' and 'being British Chinese' all being considered influencing factors to ones' health behaviours. 'Cultural values' and 'cultural beliefs' were the two highest correlating items in this component. The factor has been labelled 'Cultural Influences'.

Factor 4: There were 4 values in this factor, again all positively loaded. The values clustered together in this grouping suggest an orientation towards Western medicine, this is reflected through the inclusion of values such as 'use Western medicine', 'trust Western medicine' and 'Western medicine helpful'. Interestingly, 'follow Chinese events' was also loaded into this factor, suggesting the retention of the element of Eastern influences. This factor has been labelled 'Orientation towards Western Medicine'.

Logistic Regression:

Logistic regression analysis was used to estimate both crude and adjusted odds ratios (and corresponding 95% confidence intervals) of the association of individual variables with TCM use. Univariate analysis was conducted with simple logistic regression for continuous and categorical (please refer to table 5). Multiple logistic regression models were used to model probability of TCM use amongst British Chinese respondents in

terms of all explanatory variables (see tables 6 and 7 below for further details).

As the data from the CHBVS was in an ordinal format, before logistic analysis could be conducted the data had to be transformed from ordinal to binary data to ensure compatibility to the analysis. Logistic regression was felt to be the most appropriate form of analysis to use in order to explore predictors of TCM use among the sample.

In univariate analyses crude odds ratios were initially obtained for the association of TCM use with each of the following variables: age (age group), gender (male /female), marital status (whether married/single), religion (whether respondents follow a Chinese religion), GP (whether respondents were registered with a GP), language (whether respondents' first language was Chinese), birthplace (born Hong Kong/China), length of UK residency, health status, following Chinese news (whether respondents follow Chinese news), following Chinese events (whether respondents follow Chinese events), cultural beliefs (whether respondents feel their cultural beliefs influence health behaviours), cultural values (whether respondents feel cultural values influence health behaviours), friends and family (whether respondents feel friends and family influence health behaviour), religious beliefs (whether respondents feel religious beliefs influence health behaviour), UK Chinese (whether respondents feel being British Chinese influences their health behaviour), GP care (satisfaction with GP care), TCMP care (satisfaction with TCMP care), UK health care (satisfaction with UK health care), agreeing with GP explanations, agreeing with TCMP explanations, conforming to GP treatment plan, conforming to TCMP treatment plans, GP understanding health concerns, TCMP understanding health concerns, and finally adequate health service.

Table 5: Univariate analysis: Factors associated with TCM use amongst British Chinese individuals (n=185)

	Odds ratio	95% CI Lower	95% CI Upper	P value
Age	1.02	0.99	1.04	0.23
Sex	1.51	0.74	3.08	0.26

Marital Status	1.21	0.86	1.72	0.28
Religion	1.55	1.37	16.10	0.01
GP	0.46	0.19	1.12	0.09
Language	2.16	1.04	4.48	0.04
Birthplace	0.55	0.24	1.25	0.15
UK Resident	1.24	0.97	1.60	0.09
Health	0.53	0.34	0.83	0.01
Follow Chinese news	3.22	1.25	8.31	0.02
Follow Chinese events	3.23	1.39	7.51	0.01
Cultural beliefs	2.30	1.12	4.76	0.02
Cultural values	2.68	1.31	5.50	0.01
Friends and family	1.78	0.85	3.75	0.13
Religious beliefs	1.65	0.70	3.87	0.25
UK Chinese	1.43	0.67	3.05	0.36
GP care	2.22	0.62	8.01	0.22
TCMP care	9.41	3.78	23.44	0.001
UK health care	1.60	0.61	4.17	0.34
GP explanations	4.18	1.27	13.80	0.02
TCMP explanations	18.89	7.03	50.78	0.001
GP treatment conform	2.85	0.61	13.33	0.18
TCMP treatment conform	18.14	6.59	49.93	0.001
GP understand	2.71	0.72	10.15	0.14
TCMP understand	14.77	5.41	40.28	0.001
Adequate health service	1.65	0.59	4.62	0.34

The variables religion, language, health status, following Chinese news, following Chinese events, cultural beliefs, cultural values, TCMP care, GP explanations, TCMP explanations, conforming to TCMP treatment plans and believing that TCMPs understand health concerns were all shown to be significant indicators of TCM use in univariate analysis.

In univariate analysis, odds of using TCM were shown to increase 2% for each increase in age group (OR 1.02), though this result was not significant ($p=0.23$). There was no difference in the prevalence of TCM use between men and women. Married respondents were more likely to use TCM (OR 1.21) though this result did not reach statistical significance. Religion was a significant indicator of TCM use with respondents who followed a religion being 1.5 times more likely to use TCM than those who did not follow a religion ($p=0.01$). The prevalence of TCM use was revealed to have particularly strong associations with agreeing with TCMP explanations ($p=0.001$) and conforming to TCMP treatment plans ($p=0.001$). Respondents who agree with TCMP explanations or conform to TCMP treatment plans are more than 18 times more likely to use TCM.

Respondents whose first language was Chinese were twice as likely to use TCM ($p=0.04$). Following Chinese news and Chinese events were both shown to be significant predictors of TCM utilisation ($p=0.02$ and $p=0.01$ respectively), increasing the odds of TCM use threefold. Cultural beliefs and cultural values were both shown to be significant predictors of TCM use, the prevalence of TCM use is demonstrated to have strong associations with the presence of cultural values and beliefs. Respondents who believe their cultural beliefs ($p=0.03$) and cultural values ($p=0.01$) influence their health behaviour are more than twice as likely to use TCM.

Respondents who are satisfied with the care received from TCMPs are significantly more than nine times more likely to use TCM ($p=0.001$), while those who agree with GP explanations are also shown to be four times more likely to use TCM ($p=0.02$). Prevalence of TCM use showed strongest associations with agreeing with TCMP explanations, respondents who agree with TCMP explanations are more than 18 times more likely to use TCM ($p=0.001$). Odds of TCM utilisation are also shown to increase 18 times for respondents who conform to TCMP treatment plans ($p=0.001$). Individuals who believe TCMPs understand their health concerns are over 14 times more likely to use TCM ($p=0.001$).

Multivariate analysis was conducted on all significant variables (please see table 6 for further details)

Table 6. Multivariate analysis (logistic regression modelling): Significant predictors of TCM use amongst British Chinese individuals

	Odds ratio	95% CI Lower	95% CI Upper	P value
Age	1.04	1.00	1.09	0.08
Sex	0.92	0.27	3.18	0.89
Language	4.02	1.24	13.06	0.02
TCMP explanations	67.54	13.34	341.98	0.001
Cultural Values	8.46	1.94	36.84	0.004
Religious beliefs	1.11	0.02	0.59	0.01

Hosmer : 0.98 Chiz: 1.97 (df=8)

In a multiple logistic regression model that adjusts for all the variables (see table 6 above), language (p=0.02), TCMP explanations (p=0.001) and cultural values (p=0.004) all retained statistical significance. The Hosmer and Lemeshow test demonstrates that the model had a good fit with the data, chiz (df=8) 1.97(p=0.98). Religious beliefs (p=0.01) also showed statistical significance in a multivariate model. Though the result was insignificant (p=0.08), odds of TCM use were shown to increase one time for each increase in age group (OR: 1.04); the prevalence of TCM use increased fourfold (OR: 4.02) for respondents whose first language was Chinese (p=0.02).

The probability of TCM use was shown to have strongest associations with those who agree with TCMP explanations, respondents who agree with TCMP explanations were shown to be incredibly over 67 times more likely to use TCM (p=0.001). The prevalence of TCM use was also shown to have strong associations with cultural values, respondents who believed their cultural values influenced their health behaviours were more than 8 times more likely to use TCM (p=0.004). Religious beliefs were also shown to be a significant indicator of TCM utilisation (OR: 1.11), odds of TCM use increase one time

for respondents who believe their religious beliefs influence their health behaviours (p=0.01).

A second multivariate analysis (logistic regression modelling) was conducted to explore interactions between variables of significance, in addition to exploring interactions between variables of significance. Exploring interactions between respondents' age and agreeing with TCMP explanations, and respondents' first language and agreeing with TCMP explanations, revealed both significant and interesting findings (please refer to table 7 below).

Table 7. Multivariate analysis (logistic regression modelling): Significant predictors of TCM use amongst British Chinese individuals

	Odds ratio	95% CI Lower	95% CI Upper	P value
Age	0.99	0.93	1.07	0.88
Sex	0.73	0.21	2.62	0.63
Language	0.83	0.08	8.30	0.88
TCMP explanations	0.12	0.001	12.34	0.37
Cultural Values	7.66	1.72	34.15	0.01
Religious beliefs	0.15	0.03	0.78	0.02
Age by TCMP expl	1.13	1.01	1.26	0.04
Lang by TCMP expl	18.76	0.82	427.47	0.07

Hosmer = 0.92 Chi2 = 3.2 (df=8)

In a multiple logistic regression model that adjusts for all the variables (see table 7 above) cultural values (p=0.01) retained statistical significance. The Hosmer and Lemeshow test demonstrates that the second multiple model had a good fit with the data, chi2(df=8) 3.2 (p=0.92). In a multiple model, odds of TCM use were shown to decrease 0.01% for each increase in age group, though this result was not found to be significant (p=0.88). Cultural values were shown to be a significant indicator of TCM utilisation, those respondents who believed their cultural values influenced their health behaviour were

more than 7 times (OR: 7.66) more likely to use TCM ($p=0.01$). Presence of religious beliefs was also a significant factor in TCM use; odds of TCM use were demonstrated to decrease 85% for each unit increase in religious beliefs (OR: 0.15). In other words, those respondents who did not feel their religious beliefs influenced their health behaviours were 85% more likely to use TCM ($p=0.02$).

In the original multiple model the variables language ($p=0.02$) and TCMP explanations ($p=0.001$) were both important indicators of TCM use. However, when interactions were explored between variables of importance in the original model, in particular it was found that there was a significant interaction between age and agreeing with TCMP explanations, and between language and agreeing with TCMP explanations. Looking at the interaction between age and agreeing with TCMP explanations, it can be seen that for each increase in age group and each unit increase in agreeing with TCMP explanations, odds of using TCM increase one time ($p=0.04$). Thus, odds of TCM use increase 13% with each increase in age group for those who agree with TCMP explanations (OR: 1.13). There was also a significant interaction between language and agreeing with TCMP explanations (OR: 18.76). It can also be seen from the interaction between language and agreeing with TCMP explanations that, if the individual's first language is a Chinese dialect and they agree with TCMP explanations, these individuals are significantly more than 18 times more likely to use TCM ($p=0.07$).

Culture and religion were two highly significant and interesting variables. In the current study, religion and culture were perceived by respondents to have little impact on health-seeking behaviour and choice of medicine. A large majority of respondents (72%) claimed their religious beliefs never influence their health behaviours or choice of medicine, while 34% of respondents claimed their cultural values never influence their health behaviours. Yet cultural values were shown to be a significant indicator of TCM use amongst British Chinese in logistic regression analyses. In addition to this, according to the logistic regression analyses, religious beliefs are shown to play an important role in British Chinese health behaviours.

CHAPTER THREE - DISCUSSION OF STUDY ONE

This study aimed to explore the health beliefs and health behaviours of the British Chinese community and also to look at the influence that culture may have on health behaviours. Quantitative research methods were used because it was believed that these methods would permit a greater number of respondents' views to be taken into account. The results of the study demonstrate that cultural beliefs and cultural values do have some influence over the health seeking behaviour of British Chinese communities.

By understanding British Chinese views on Western and Traditional Chinese medicine it is hoped that this could perhaps encourage medical practitioners to be more aware of the influence that culture may have on health behaviours. Culture plays an important part in the health behaviours of respondents in the current study. Respondents considered TCM and Western medicine to each have their own individual strengths and weaknesses.

Chinese health beliefs are derived from Chinese culture and are firmly grounded in the contexts within which people live. Their influence is inevitable particularly with a traditional culture such as the Chinese culture, which is of great importance to its people. The Chinese have been shown to adopt a healthy and stable lifestyle especially regarding diet, however, a considerable proportion also seldom seek advice from doctors or practice exercise (Wu et al., 2004). These findings are supported in the current study where respondents rarely mentioned the practice of exercise, though frequently mentioned how a good healthy diet is an important contributing factor to health status.

The results of this study demonstrate that British Chinese health-seeking behaviours cover a broad variety of diverse health resources. This was due in part to the open-ended design of selected questions in the CHBVS. This diversity ranges from high rates of utilisation of integrated Western and Traditional Chinese health services, medium rates of exclusive utilisation of Western health care services, and low rates of exclusive utilisation of TCM, self-care and home remedies coupled also with the occasional treatment in one's

country of birth. The results demonstrate that many British Chinese regularly use both TCM and Western medicine when unwell.

The study also shows religious beliefs and cultural values are often seen as a way of life by many British Chinese and are not specifically identified as religious or cultural values. Evidence of this can be seen through the failure of respondents in the current study to identify the role of culture and religion in their health-seeking behaviour and choice of medicine, in fact many respondents did not feel their cultural or religious values influenced their health behaviours at all. However, when quantitative analyses was conducted, it was clear to see from the results that culture and religion are both highly significant factors and play a considerable role in the health-seeking behaviours of British Chinese individuals.

The reasons behind this could lie in the fact that Chinese religion and culture are so deeply rooted in Chinese people's lives that they are seen as an integral part of everyday life and are not viewed as separate entities. Confucian beliefs and values are not viewed as part of Chinese culture or religion, these beliefs and values are simply viewed as a way of life.

Overall, the results demonstrate that the influence of cultural orientation on health-seeking behaviours is both direct and indirect; cultural orientation has an effect on health-seeking behaviours both indirectly through illness beliefs as well as independently of these beliefs. These findings emphasise the importance of considering both cultural orientation and illness beliefs and also suggest the importance of examining variables such as cost, convenience and other psychosocial variables that could have an influence upon selection of medical treatment (Quah & Bishop, 1996).

In the current study, variables such as cost, convenience and speed of recovery were important influencing factors in the choice of Western or traditional Chinese medicine for British Chinese individuals when suffering from ill health. Most respondents chose to use Western medicine to alleviate symptoms of ill health when unwell. The results

revealed that cost was a major influencing factor in the decision to use TCM or Western medicine, TCM was considered by respondents to be more expensive than Western medicine and more difficult to get hold of a good practitioner. Additionally, TCM was viewed as being slower to alleviate symptoms therefore Western medicine was viewed as more practical than TCM, in terms of a quick recovery and a speedy return to work.

Availability and accessibility of health services were other important contributing factors in choice of medicine amongst British Chinese respondents, as were cost, convenience and perceived social barriers. One important barrier experienced by some British Chinese respondents in seeking British health care is the language barrier. Despite frequently utilising Western health care when unwell, a number of respondents highlighted the problems they are faced with when attempting to describe their symptoms of ill health to their GP.

It is important to remember that these problems in explaining symptoms of ill health are not necessarily primarily a result of the language barrier, but could also be related to the cultural differences between Chinese and British culture in describing and explaining symptoms of ill health. Older respondents in particular were quick to comment on the language problems they encounter when seeking health care, despite the fact that many first generation respondents have resided in the UK for more than 20 years, many still continue to have a very limited use of the English language.

Much research conducted with the British Chinese community points to the problems, both psychological and social, that many British Chinese are faced with as a result of the language barrier (Sproston et al., 1999; Wong & Cochrane, 1989; Furnham & Li, 1993; Prior et al., 1997). There is evidence that British Chinese fail to obtain full benefit from the health services as a direct result of the language difficulties that a number of the community are faced with. It has been found in previous research that the inability to communicate effectively in English can affect consultations with health workers and can also prevent individuals from using health services effectively (Watt et al., 1993).

Relationships have been identified between the ability to speak English and frequency of GP consultations (Sproston et al., 1999), psychosocial factors have also been shown to influence frequency of GP consultations. Sproston et al. (1999) reported that the Chinese respondents in their sample were less likely to consult their GP if they had a limited command of the English language, and conversely those with improved English would be more likely to visit their GP. This finding was not supported in the current study where respondents reported regularly consulting their GP when unwell despite their ability or inability to speak English. Language problems alone did not appear to be a deterrent from utilising Western health services.

Health care professionals can potentially play an important role in influencing the health habits of Chinese, this can be identified through the Chinese tendency to be highly sensitive and accepting towards figures of authority (Yang, 1993). This cultural authoritarianism may be manifested in the Chinese belief that health professionals have the ability to control various health outcomes (Wu et al., 2004). However, despite a tendency towards cultural authoritarianism, this does not explain why so many respondents in the current study admitted to failing to adhere to instructions or treatment programmes prescribed by their health practitioner.

A good doctor-patient relationship has been shown to be an important influencing factor for successful treatment and patient satisfaction (Williams et al., 1998). The main means of achieving this is effective doctor-patient communication, thus difficulties will emerge when the patient and doctor do not speak the same language. Lack of knowledge of the language of the host country creates boundaries in access to and use of health care services. Past experiences of difficulties can also lead to reluctance in seeking health care in the future (Blais & Maiga, 1999; Jang et al., 1998; Free et al., 1999).

Respondents showed considerable variation in health-seeking behaviours for different types of illnesses. Thus seemingly demonstrating a relationship of some sort between type of illness and type of medical assistance sought by respondents. In general participants seem to consult Western doctors for most illnesses with the exception of

specific illnesses where TCM is well known to treat a particular illness better than Western medicine; for example, in the case of eczema. Respondents were likely to use traditional Chinese home-remedies for chronic illnesses and illnesses not considered serious or life threatening, such as lack of energy. There seemed to be a relationship between severity of illness and seeking the advice of a GP. Similar findings have been found in other research (Tan & Bishop, 1996).

The two largest contributing factors to choice of medicine were cost and effectiveness of the medicine. For serious illnesses respondents were more likely to consult a Western practitioner as the main aim is to relieve the discomfort of the symptoms and Western medicine seemed to be acknowledged by respondents as working quicker to kill the symptoms of illnesses than TCM. However, once symptoms are alleviated many respondents reported that they would then go on to consult a TCM practitioner in order to repair and restore their health restoring balance to the body. This result is supported by other research conducted in this area (Tan & Bishop, 1996; Quah & Bishop, 1996; Sproston et al., 1999).

Both TCM and Western medicine were used concurrently by many respondents when unwell, respondents made the decision of whether they preferred to see a Western GP or a TCM practitioner based on the specific illness they are suffering from. TCM was generally considered to be good for some minor illnesses such as coughs and colds, TCM was also popularly considered to be better at eradicating the 'root' of the illness. TCM is also often used as a supplement to Western medicine after consulting a GP for quick recovery; it is often used to 'cure the root of the problem'.

Respondents commented on the high strength of Western medication, many respondents considered Western medicine to have significant side effects. However, the belief that Western medication acts faster than TCM to kill symptoms leads many individuals to choose Western medicine over TCM despite the reported awareness of the dangers of the chemical strength of the medicine. Some respondents commented on the fear of over-dependence on Western medication if taking substantial amounts over long periods of

time. Respondents seemed to have a higher expectation of Western medicine and subsequently a lower expectation of TCM in relation to its strength and speed in killing symptoms of disease.

In other research conducted with the British Chinese community consistently low rates of utilisation of Western health services have often been found (Gill et al., 2004; Aspinall & Jacobson, 2004). The majority of respondents in the current study described regularly using Western medicine when unwell only a small number of respondents claimed to exclusively use TCM. Still, it must be remembered that the majority of respondents were recruited from Chinese health and community centres where respondents may be deemed to be more likely to gain information on accessing health services and also may perhaps be more inclined to take an interest in their own health.

In this UK sample, respondents identified cost as a major contributing factor to the frequent use of Western medicine and the relatively low use of TCM. One of the single largest influencing factors influencing choice of medicine when unwell was cost of health care this was an important factor contributing to the high utilisation of Western medicine by British Chinese respondents in this sample. Respondents identified Western medicine as being cheaper than TCM in the UK as it is subsidised under the NHS, TCM is not subsidised and is therefore seen as being more expensive than Western medicine.

Respondents mentioned that it is cheaper for them to bring back herbal remedies from their home countries when on holiday. A substantial number of the sample admitted to bringing back various traditional medicines from their home countries when on holiday. Respondents emphasised the difficulties they often face in trying to find a reputable TCM practitioner in the UK. Many observed how the increasing number of TCM shops on the high streets recently is merely to cater for the Western market and that many of these shops contain practitioners who do not have proper medical training. All these factors contribute somewhat to the increased utilisation of Western medicine by British Chinese individuals and the relatively infrequent use of TCM practitioners in the UK by British Chinese in this sample.

Although Chinese people may accept the theory of and frequently utilise Western medicine, one cannot underestimate the influence of traditional Chinese health beliefs because medical systems are both social and cultural systems. In the healing process, culture shapes illness as a psychosocial experience under the influence of cultural rules that govern the perception, valuation and expression of behaviours (Kleinman, 1978). This study demonstrates that culture plays a very important role in the health-seeking behaviours of British Chinese respondents this can be seen through the utilisation of Western medicine for treatment whilst often using TCM theory to interpret illness causation.

Another important factor influencing choice of medicine for British Chinese is the speed of the recovery process. A number of respondents claim one of the reasons they utilise Western medicine so frequently is because the recovery process is quicker than if they were to use TCM for the same health problem. TCM is viewed by respondents as being slower at treating illnesses, yet respondents were quick to point out that despite Western medicine working quicker to speed up the recovery of ill health, Western medicine was not seen as being good for one's health. Many respondents commented on the increased speed of the recovery process when using Western medicine for an illness, but equally, a great number of respondents also commented on the detrimental effect that Western medicine was believed to have on the body internally.

Religious beliefs did not seem to have an influence on health behaviours. Most respondents claimed that their religious beliefs never influenced their health behaviours, this could be related to the fact that over one third of respondents claimed to have no religion. Friends and family, on the other hand, seem to have some influence on health behaviours as respondents frequently mentioned seeking the advice of a family member for treatment when experiencing ill health. This is seen as fairly common behaviour amongst Chinese communities (Kua, 2004).

The results point to some interesting findings in terms of the illness cognitions of British Chinese. The results demonstrate that respondents frequently use traditional Chinese terminology to describe ill health despite using Western medicine for the majority of illnesses. This suggests respondents' illness cognition combine Chinese and Western health concepts and that respondents tend to use aspects of both health systems simultaneously.

Contrary to predictions no generational differences were found in the emphasis placed on different cognitive dimensions, older respondents did not seem to place more weight on traditional illness concepts and younger generation respondents did not seem to place more weight on Western illness concepts. The lack of differences found between the older and younger generation could perhaps indicate evidence of the merging of Chinese and Western illness concepts that could potentially be an established aspect of British Chinese illness cognition. These findings support previous research conducted in relation to illness cognitions with a Chinese sample in Singapore (Tan & Bishop, 1996).

It is important to consider that many more of the younger generation Chinese than ever before have been born and raised in the UK by parents who were raised with a traditional Chinese culture and beliefs in China or Hong Kong. From the results of the current study it is evident that Chinese culture continues to be held highly amongst British Chinese communities with no evidence of this fading with the younger generation. There is no doubt of the importance placed on the family within Chinese culture or of the influence of family within Chinese culture and so it should come as no surprise that this merging of Eastern and Western concepts is taking place, with the continuous influence of both Eastern and Western cultures on younger generation Chinese, this would seem to be inevitable progression.

The majority of respondents in the current study were seen to value the strengths of both Traditional Chinese and Western medicine. One determining factor in the health care choices of Chinese respondents was the belief and perception of illness causation and health management, many respondents consciously choose either TCM or Western

medicine, or both, depending on the condition of their illness (acute or chronic). A common belief amongst respondents is that Western medicine is more effective in tackling the acute stage of certain diseases, such as heart diseases, cancer, surgery and operations, among others. TCM is viewed as being more effective for chronic conditions and illnesses, such as asthma and rheumatism. In general, for many health problems respondents seem quite convinced of the efficacy of Western medical treatment.

Regarding the relationship between disease representations and health-seeking behaviour, British Chinese communities adopt behaviour primarily in line with the severity of the illness, with only secondary regard to other illness concepts. Behaviours such as consulting a GP or a TCMP, as well as using TCM or home remedies, all seem to be strongly linked to the severity of the illness. Participants were more likely to say that they would seek the advice of a TCMP or utilise TCM home remedies when the illness was not considered too serious or painful. Similar results have been found elsewhere in other research (Tan & Bishop, 1996).

Chinese people view health as a property requiring continuous individual action rather than as a state punctuated by episodes of 'illness' requiring clinical intervention, as in Western beliefs (Kleinman et al., 1975). This could perhaps be one possible explanation as to why British Chinese are seen to use health services less than other communities in the UK (Aspinall & Jacobson, 2004). Kleinman et al., have emphasised the complexity of pathways between biomedical and traditional care among various Chinese populations, demonstrating that serial or concurrent use is commonplace (Kleinman et al., 1975). This finding has been supported in the current study, where concurrent use of both Western and Chinese medicine continues to be commonplace among many respondents.

In a study conducted by Quah, it was discovered that in selecting health care individuals base their decisions on their perception of which health care option is perceived to be the most cost effective for a particular illness (Quah & Bishop, 1996). This supports findings in the current study where respondents often based their health care decisions on cost-effective factors. TCM, as the more expensive option in the UK, is thus most likely to be

used less frequently than Western medicine, which is more cost effective and convenient to get hold of than TCM.

The current study revealed that Chinese respondents in the sample relied almost exclusively on their GPs as their first point of contact in the health service, with respect to Western health care services there was no indication of use being made of other primary care workers. Possible reasons for this could include a lack of knowledge or awareness of the function and availability of other primary care staff.

Respondents' demonstrated confidence in Western medicine through regular use of Western medication when unwell for most acute problems respondents expressed no hesitation about seeing a Western GP. This may explain why despite the fact that respondents frequently explained the cause of a health problem in a culturally traditional way (such as 'hot' energy), respondents were still most likely to seek the care of a GP, who may not necessarily recognise these culturally traditional beliefs and views of the causes of their ill health. An awareness of the imbalance of subscribing to one medical tradition (TCM) for understanding causation and another for treatment (WM) did not seem to be conscious amongst the respondents, their primary and main concern was to seek relief from the symptoms of ill health that interfered with daily activities.

Despite the regular use of Western medicine when unwell, respondents also highlighted the fact that although Western medicine may treat an illness much quicker than TCM, it was also seen to create more adverse side effects than TCM. There seemed to be some issues of concern relating to the strength of Western medicine and the worry this may cause when taking Western medicine over a period of time. Despite respondents regularly using Western medicine when ill, many felt that it is not good for one's health to take Western medicine too frequently. Some described the effects that the medication can have on the liver if taken for long periods of time, while others mentioned the risk of reliance or addiction to the medication if taken too often.

Despite the popularity of GPs for the treatment of ill health, another popular remedy was the use of food by eating specific foods or herbs to regain health status, many respondents mentioned using foods and herbs to help treat illnesses. This is in line with other research where subjects commonly mentioned using foods and herbal remedies to treat illnesses (Koo, 1984; Hwu et al., 2001). This demonstrates respondent's confidence in using Chinese herbs and TCM, in spite of also regularly using Western medicine to treat illnesses. Food and herbal remedies or tonics seem to be used most commonly by respondents early in the illness, before symptoms are considered serious enough to seek professional help, as an addition to Western medicine, or to speed up the recovery process after using Western medicine for an illness. Respondents commonly described how they would use Western medicine to initially gain relief from the symptoms of their illness and then use go on to use TCM until they are fully recovered this was commonplace behaviour amongst respondents.

One factor that could influence adjustment is differences in values. It has been reported that immigrants may experience stress when confronted with the host culture's values if they are perceived to contradict their own (Parker et al., 1995). Young people and older people of the first generation are affected differently by cultural adaptation. Young people who adapt to and identify with the host culture are perhaps more protected, while protection for older immigrants lies in remaining within the original culture (Furnham and Li, 1993).

Chinese culture emphasises the importance of obedience to superiors and filial piety, whereas often in the West, an individual is encouraged to exercise freedom of choice. The second generation (younger generation) Chinese are the individuals who would seem to be likely to be more exposed to the values of the host culture and therefore the most likely to be influenced by them. Evidence of this can be seen through the current study where the younger generation are viewed as being more westernised than the older generation, exercising evidence of the influence of Western culture.

Sproston et al. (2001) discovered that levels of GP consultation are related to a number of factors, of which they found the strongest ability to be the ability to speak English. Chinese people who did not speak English were considerably less likely than those who did speak English to visit their general practitioner. However, these findings have not been consistently supported in the current study where ability to speak English did not seem to be a significant contributing factor in GP consultation levels amongst British Chinese. Respondents in the current study were seen to regularly utilise GP services regardless of their command of English.

Many British Chinese draw on knowledge based on traditional Chinese health concepts and not just the Western biomedical model. It was interesting to observe cultural differences between British and Chinese people in terms of illness prevention. Many respondents believed that health was their own personal responsibility, to eat the right foods and look after oneself in order to keep illness at bay; “Personal discipline and responsibility in taking care of the self, by a strict healthy diet, organic food and regular exercise etc.”

Looking at the factor analysis of the Chinese Value Survey it can be seen that the factors found in the current study are relatively similar to factors established previously in other research (CCC, 1987; Matthews, 2000). In the CVS, all forty items correlated at the .33 level and all items in each factor correlated positively with each other. All forty items in the CVS correlated with each other revealing that the British Chinese respondents are still managing to maintain a strong hold on their Chinese cultural values despite over one third of respondents residing in the UK for more than twenty years. The forty CVS items formed five factors the first and largest of these was named ‘integration’. Integration contained the three highest correlating values; humbleness, harmony, and sincerity; three traditionally Chinese virtues. The results from these analyses demonstrate that it is possible for the British Chinese population to integrate with Western society in the UK whilst still managing to maintain a strong hold on their Chinese cultural identity.

Interestingly, in the analysis of the CHBVS all items correlated at the .33 level with the exception of one item 'following Chinese events', this was the only item that did not correlate at the .33 level all other items from the CHBVS correlated particularly highly with each other. In the CHBVS only a small number of respondents confessed to always follow Chinese events though a large majority of the sample did claim to frequently read Chinese newspapers and magazines, this could be related to the fact that the British Chinese population is widely dispersed across the country perhaps making it less convenient to celebrate Chinese events collectively as a result of work commitments and diverse geographical location across the country. However, it is much easier to keep abreast of Chinese news by reading Chinese newspapers daily, reading local news on a regular basis can be seen as an important way of keeping up to date with local Chinese news.

One of the more important strengths of TCM in the eyes of some respondents was its' natural qualities. Many respondents felt confident and comfortable using TCM when unwell because felt they could identify with TCM through its theory, which many believe relates closely to Chinese cultural beliefs, values and traditions. With this in mind it seems strange that respondents would choose to utilise Western medicine more frequently than TCM, though it must be remembered that cost was also a contributing factor of great importance in terms of choice of medicine.

Rapid social changes in the last few decades, with particular reference to younger generation British Chinese, has resulted in more highly educated younger British Chinese who are more Westernised in their attitudes and are often viewed as perhaps not as Chinese in a culturally oriented way as their parents and grandparents. Nevertheless, as the results in the current study have demonstrated this does not necessarily mean that younger generation British Chinese lose their Chinese culture, if anything, the results of the current study demonstrate that younger generation British Chinese are managing to be suitably influenced by the British culture of the environment they live in whilst simultaneously continuing to successfully retain many important aspects of their heritage Chinese culture.

In previous research it has been emphasised that adaptation to a new culture is a function of orientation towards both the individual's culture of origin and the culture of current residence (Ward & Kennedy, 1993, 1994). This is true in light of the current results where individuals seem to be able to hold on to their culture of origin whilst also managing to successfully combine this with British culture certainly in terms of health-seeking behaviours.

A limitation of the current study was an omission by the researcher to include questions on demographic details such as education and occupational status in the CHBVS. The results revealed that cost was an important factor in choice of medicine for British Chinese individuals and thus CHBVS questions asking more about demographic details could have been rather valuable in the current research. However, the researcher is looking into the prospect of designing a further study looking the effect of psychosocial variables on the health behaviours of British Chinese communities. Another potential limitation of the study was the fact that respondents were recruited from Chinese health and community centres, where it is argued, that these respondents may be more inclined to take an interest in their own health.

In conclusion, the results of the study emphasise the importance of individual differences within different cultures (Landrine & Klonoff, 1992). The results obtained here demonstrate that it is not only a matter of an individual's culture that influences health-seeking behaviour but the individual's orientation towards that particular culture.

CHAPTER FOUR - METHODOLOGY OF STUDY TWO

Focus groups were used to develop areas of particular interest that were covered only briefly in the CHBVS questionnaire of study one. Two focus groups were organised, one with lay members of the Chinese community and one with Chinese health and community workers who work closely with the Chinese community. It was felt that group interviewing would utilise the group dynamics created in a focus group to generate results and insights that may otherwise have been less accessible.

Focus groups provide valuable information on interactions, realities and interpretations of realities that reflect the dynamics of the group they also demonstrate how identities, social representations, beliefs and shared cultural norms all contribute to structure interaction and social communication (Burgess et al., 1988). The focus group discussions with members of the Chinese community were thought to be of particular use in overcoming language limitations associated with individual interviewing.

The researcher could not speak Chinese fluently enough to conduct individual interviews with members of the community who were non-English speakers. Therefore, focus groups though conducted in English were considered to be a worthy alternative, an effective and influential way of rapidly gathering a wide range of views and opinions regarding the health behaviours of the British Chinese community. This particular method of data collection is hoped will prove the richest. It was hoped that focus groups would serve to reveal specific and precise patterns of behaviour among Chinese participants in terms of, for example, their health behaviour when they are suffering from an illness; whether they use TCM, Western medicine, or a combination of the two.

Participants for the focus groups were recruited through contacts the researcher made with various Chinese centres that had initially agreed to help with the distribution of the Cultural Health Belief and Value Survey of study one. The researcher ensured that the informants were from varied backgrounds of expertise and experience. The two focus groups were set up to reflect expected differences in the knowledge of the British Chinese

community as a whole (through people working closely with the Chinese community), and the invaluable worth of the Chinese layman's belief and knowledge of traditional practices and behaviours in Chinese culture.

The focus groups were conducted at a Chinese Health Centre in Central London. The focus groups were conducted in English, the common language between the participants and moderator. The focus groups were conducted between May and June 2004. Prior to the focus group discussions, the participants each signed consent forms the duration of each focus group was approximately two hours, each participant in the lay member focus group received £15 as an incentive, each participant in the health and community worker focus group received a free meal as an incentive (for a full list of the focus group schedules please see Appendices 6 and 7).

The focus group data was analysed according to content and process. The content analysis of focus group interview data was guided by the research questions, an abbreviated version of Grounded theory was used to qualitatively analyse the transcripts from both focus group discussions in the hope of gaining a deeper understanding of the health beliefs, health behaviours and health concerns of the British Chinese community. Themes and sub-themes were extracted from the focus group transcripts in the hope that this would allow the researcher to identify key issues and categories emerging from the data, and to establish how these are structured by identity and cultural processes.

Focus Group with Chinese health and community workers

Chinese health and community workers were recruited through the researcher's voluntary work with Chinese health centres. The researcher ensured that the workers had varying spheres of expertise. The workers were recruited in the Greater London area. The focus group was held in a private room in a Chinese Health Centre in Central London, and was conducted in English. The researcher was present in the focus group in the role of both a moderator and observer. This first focus group took place at the end of May 2004.

Themes addressed in the Chinese health and community worker focus group include:

Section 1: Characteristics of the British Chinese community

Section 2: Theories of health and illness

Section 3: Provision and adequacy of health services

Focus Group with lay Chinese people

Lay members of the Chinese community were also recruited through the researcher's links with various Chinese health and community centres, made through networking and voluntary work with the centres. All lay members were recruited in the Greater London area. The focus group was held in a private room in a Chinese Health Centre in Central London, the discussion was conducted in English and the researcher was present in the focus group as both moderator and observer. This second focus group took place at the beginning of June 2004.

Themes addressed in the focus group include:

Section 1: The dynamics of mixed identity

Section 2: Health at home

Section 3: Attitudes towards Traditional Chinese medicine

Section 4: Attitude towards Western medicine, and access to, and experience of health services

CHAPTER FIVE - RESULTS AND DISCUSSION

STUDY TWO

Characteristics of the British Chinese Community

Chinese culture is complex and far from being homogeneous (Gervais & Jovchelovitch, 1998) attempting to understand a small part of what Chinese culture is about may help people to better appreciate issues relating to Chinese health attitudes, beliefs and behaviours. If health beliefs and behaviours are related to cultural values, beliefs and identities then it is therefore important to take account of these values and beliefs in addressing the health issues of this community. The findings from the current study provide ample evidence of how different health beliefs and practices from Western and Chinese culture are combined as Chinese people negotiate their identity in a non-Chinese society.

Despite the diversity of British Chinese communities and the distribution of these communities across the UK, a number of shared characteristics are still evident (Tu, 1994). These derive predominantly from the constant influence of Confucian philosophy on Chinese culture (King & Bond, 1985) and are believed to be a central part of Chinese identity (Gervais & Jovchelovitch, 1998). Indeed, since Confucian thought has dominated the Chinese way of life for over 2000 years it seems unlikely to cease its influence on Chinese migrants over the space of two generations of participation in British society. However, this is not to say that British culture has no influence over Chinese migrants or indeed that over time British culture may begin to have more of an influence over British Chinese communities as they reside in the UK for longer periods of time.

The contributions reviewed emphasise the importance of family, the cultivation of morality and also highlight the importance of hard work and achievement, it is evident that the Chinese take a lot of pride in their culture. The data collected will be used in an attempt to explore the influence of British Chinese cultural beliefs and values on health

beliefs and behaviours of the British Chinese community.

“We are the third largest minority ethnic group here in the UK, but in terms of numbers we are not that great. The Chinese population is virtually everywhere...in that case you can become very isolated and your voice will not be heard because you are so small, in terms of numbers”

Focus group, community worker

One member of the focus groups warns that people should describe the Chinese community with caution, suggesting that people should be careful not to make generalisations with the British Chinese population.

“People have got to be very careful to look at how you label the Chinese community as it is dependent on the background and where they come from... You can't generalise so much because the characteristics are very different, apart from their background it depends on what they do as well”

Focus group, community worker

Attempting to describe the Chinese community is quite a complex task, it is now over a decade since the 1991 Census, which for the very first time provided information on the British Chinese community. Although the Chinese community now constitutes the third largest minority ethnic group in the UK (House of Commons, 1985) the 2001 Census revealed that the current UK Chinese population is nearing 250,000, which constitutes a mere 0.4% of the UK population (National Statistics Bureau, 2004).

The Chinese are well known for being a widely dispersed community within the UK, with Chinese takeaways a common site in most towns and cities across the country.

“Go anywhere, any town or large villages, and they will be there setting up their fish and chip shop, or their takeaway stores”

Focus group, community worker

The Chinese also have a reputation for being an obedient and self-restrained community, which 'keep itself to itself' (House of Commons, 1985).

"I think that when you compare us (ethnic minority groups) we are not as strong as they (other minority groups) are to show, I mean we put everything inside us as Chinese...More of the coloured people they tend to be more outspoken, make a fuss about things"

Focus group, lay member

The Chinese are not known for stirring up trouble and are often viewed as being a hard-working community. One focus group member went on to comment on how the Chinese community being known for keeping themselves to themselves can often be a hindrance to the community. Not wanting to create a fuss can lead to problems of isolation and also problems accessing different mainstream services due to a lack of knowledge and/or information about these services.

"If you ask any Westerner what their image of Chinese is, the first thing they will say is that the Chinese are hard working. The second thing they will say is that the Chinese are not trouble-makers...now because of that they become labelled as the 'invisible' and also the 'unheard' community"

Focus group, community worker

The British Chinese community is quite a diverse group consisting of British-born individuals, more recent immigrants, the older generation who immigrated to the UK many years ago and also young Chinese students coming to the UK to complete their education at universities across the UK. While perhaps ten years ago or more there were more Chinese students choosing to stay and reside in the UK when they finished their education, it is now becoming increasingly more commonplace for these Chinese students to return to their homeland once they have completed their studies.

“There are lots of young Chinese, when they finish their education in England well some of them go back to Hong Kong and have a job”

Focus group, lay member

This increase in the number of Chinese students choosing to return to their homeland when they have finished their studies in the UK is believed to be related to the recent economic success in China, which is continuing to grow. This means that there are now potentially more opportunities of successful jobs for many individuals when they return to their homeland and this is proving to be an incentive. Students are learning more that it can benefit them to gain the experience of studying and working in the UK for a few years then using this experience to return to their home countries with more experience and better opportunities for themselves.

“Friends I know that work and have really good jobs, the reason they choose to stay is that they think that it will really benefit them in the future and eventually they will like to go back home”

Focus group, lay member

The division of the Chinese community is closely related to the social, economic and cultural circumstances (both in the country of origin and the host society) and to the traditional Chinese family structure and cultural values. In addition to this, the variety of life experiences lead to the creation of a heterogeneous community with differing degrees of traditionalism, modernism, aspirations, beliefs and needs; yet despite this, the Chinese depict themselves as a proud community. Shared feelings and a sense of identity are no doubt reinforced by the experience of being Chinese in a Western land with a different society and culture and the issues of integration involved.

The older and the younger generation

The contributions demonstrate how the Chinese often think of and describe their community as two groups: the “older” and “younger” generation. One of the main

differences identified between these two generations is related to the language barrier and the difficulties experienced by the older generation and new immigrants in relation to their proficiency of the English language. It was identified that problems with the language barrier and integration are a concern mainly for the older generation and recently arrived immigrants:

“For the older generation, as well as the new immigrants...there is the language barrier”

Focus group, community worker

Studies have demonstrated that language contributes to integration with the host society and that this in turn can have an impact upon well-being previous studies have shown that migration can have a significantly negative effect on psychological well-being (Furnham & Bochner, 1990; Furnham & Li, 1993). In the current study informants believe that English language proficiency has a contributing role towards integration into Western society supporting previous research findings conducted in this area.

One suggestion for the language difficulties experienced by new immigrants and the older generation in particular, was in relation to the number of years individuals may have spent in their home country before immigrating to the UK. Living longer in ones' home country means that these individuals could already have established practices in relation to their identity and culture, in which case these individuals may find it more difficult to integrate with a new culture and society. Findings from the current study demonstrate that many British Chinese individuals continue to uphold many traditional Chinese cultural health practices and beliefs.

“The first generation have spent a lot longer in their home country before they come to England”.

Focus group, community worker

Informants also suggested that proficiency of the English language could also depend on

educational background.

“Obviously, the more educated you are the easier it will be for you to integrate yourself into society... If they actually have a good education, qualifications and background they tend to pick things up much quicker”

Focus group, community worker

Many of the older generation were employed and continue to be employed in the catering trade, for many this meant leaving school to start work in the family business and not bothering to continue with their education, or coming over from China or Hong Kong to work in the catering trade. The main aim was to earn money for their families and for themselves, there was less necessity to speak good English as most catering colleagues would speak Chinese and also Chinese would be spoken in the home.

Nowadays, more of the younger generation are being educated at English schools where they speak English and have Western friends. They are also more likely than the older generation to have jobs in more mainstream services and are more likely to have been exposed to a Western culture from a much younger age than many of their parents.

Informants were keen to stress that if there was no language barrier the older generation “would very much like to join in with mainstream society”. Some informants talked about the differences in opportunities available for education and development to the older generation when they first arrived in the UK, compared to the larger number of opportunities now available to the younger generation.

One informant referred to the younger generation as getting opportunities “just like anybody else”, this is quite significant in that it suggests that some older Chinese view the younger generation Chinese as having more opportunities than the older generation, not only in terms of their education, but also in terms of being identified as a British citizen and participating in more aspects of Western life and Western culture, in a way

that perhaps the first generation do not feel that they are able to do so, or were able to do so when they arrived in the UK.

“They (younger generation) are the generation that has integrated themselves fairly well. We have the group that is the first generation Chinese and these are the group of people that need a lot of our help, and also the new immigrants from China.”

Focus group, community worker

There was a certain amount of pride being demonstrated amongst members of the focus groups in describing the growing success of the younger generation in continuing with further and higher education and finding more high-powered or mainstream services jobs. This is in contrast to the popular portrait of the Chinese community as being eternally linked with the catering and restaurant trade.

“More and more of the younger Chinese, particularly British born Chinese, are now involved in mainstream services...being able to do what normal Westerners do here in the UK.”

Focus group, community worker

Informants observed that the older generation and new immigrants are more likely to practice Chinese traditions and a Chinese lifestyle and thus identify themselves more as Chinese than British. This was seen by some informants one way of excluding themselves from participation in Western culture.

“The older generation as well as the new immigrants, they tend to stick with Chinese traditions...they live a Chinese lifestyle so in a way they kind of exclude themselves from any kind of Western services”

Focus group, community worker

Identity

Participants suggested that a person's identity as either Chinese or British is dependent upon the individual and their need or want to lose their original identity and lifestyle. It is also suggested that people's attitude towards identifying themselves with British culture could be connected to the reasons behind why the individual has chosen to move to the UK.

“If you really want to abolish your way of lifestyle, then whether you've been in your original country for long or not; you are going to lose it if you do not want to live like that. It really depends on the person and how they would like to live their lifestyle in the country”.

Focus group, community worker

When asked 'Do you think of yourselves as Chinese or British?' Only one member of the focus group failed to answer that they thought of themselves as Chinese, this was a member of the younger generation. The thoughts and feelings of many of the older and younger generation Chinese are often towards their homeland generation has been found to be a good determinant of achieved cultural, structural and identificational assimilation (Wong & Cochrane, 1989).

The family is seen as a central part of the Chinese identity. Participants suggest that an individual relating to their Chinese cultural identity could also be linked to their upbringing and whether the parents practise Chinese cultural habits and traditions; such as whether Chinese is always spoken in the home.

“It also depends on how the family brought the child up”

Focus group, community worker

Participants observed that there are two types of British-born Chinese, those who choose to live a more Western lifestyle and those who choose to follow a more traditional

Chinese lifestyle. Those who choose to identify more with their Chinese identity emphasise the importance of Chinese culture in the younger generation who are British-born and have been perhaps less exposed to Chinese culture in contrast to their parents who are more likely to be born overseas.

“Quite a few BBC I know they really like being Chinese, doing things like any other Chinese would do in Hong Kong or China. Whereas there are some that don't even want to be considered as Chinese, even though they are Chinese on the outside they would rather live like a Westerner”

Focus group, community worker

This could be related to issues of identity and wanting to hold on to, or lose, one's cultural identity. There was talk of changes in opinion regarding Chinese identity and being labelled as Chinese. One focus group member mentioned how previously many British Chinese used to distance themselves from being labelled as Chinese, whereas people are seen to distance themselves less so nowadays.

“In the past 30-40 years ago when we had the 'Cultural Revolution'...lots of younger Chinese then actually distanced themselves from being labelled as 'Chinese' because they feel ashamed. They'd think 'I'm British, not Chinese' ”

Focus group, community worker

The comments reviewed by the informants suggest that nowadays people seem to distance themselves less and feel much prouder to label themselves as Chinese. This was viewed as being related to the recent economic success and prosperity that China has currently been experiencing.

“These days with the situation...the development and the opportunities in China, ...this is now affecting the younger generation of Chinese that have been brought up here because they no longer feel ashamed to be Chinese”.

Focus group, community worker

Conversely it was revealed that there are also many of the younger generation who are choosing to identify themselves as British rather than as Chinese. This increasingly British identification demonstrates signs of successful integration amongst the younger generation of Chinese in the UK.

“When you ask children, like my children who were born over here, if you ask them they will say, ‘I’m not Chinese, I’m British’”

Focus group, community worker

This identification with being British is thought to be related to the fact that many of the younger generation are now British-born and so are therefore more likely to consider and identify themselves as being British rather than Chinese. Many have attended a British school with Western friends, so even if these children speak Chinese in their homes and continue to practice Chinese cultural traditions with their families, there is still a pervading influence of Western culture.

“I’m not saying that these people do not keep their values or traditions because a lot of their family and their parents, a lot of them still practice a lot of their traditions and cultures at home. Some of them can read Chinese and speak Chinese because of this and lots of Chinese parents still send their children to Chinese language schools and so on.”

Focus group, community worker

This is not to say that Chinese culture does not continue to have a dominant influence over British Chinese individuals. Respondents talked of children being taught by their parents to practice Chinese traditions in the home there was also mention of parents sending their children to Chinese language schools at weekends. This demonstrates evidence that the Chinese feel it important to pass on traditions from their Chinese culture and heritage onto their children.

The case for being a 'real' Chinese

Participants went on to discuss issues concerning the definition of being 'real' Chinese. Informants recited a saying relayed to them by a client at their centre, a recent immigrant from China.

"If you've lived here longer than 5 years then you're probably not Chinese, not 'real' Chinese"

Focus group, community worker

Interestingly when the moderator went on to probe the informants on what they felt about this and whether they considered this to be true, the response came that *"most people sat round this table now would disagree"*. This could perhaps be related to the fact that all members of the focus group had resided in the UK for more than five years and the majority of the focus group members still strongly considered themselves to be Chinese. The informants felt that Chinese immigrants who may have recently moved to the UK from Hong Kong or China may have a different view of the identity of Chinese individuals in relation to their Chinese culture and practices.

"For someone who has just arrived in this country...do consider the 'Chineseness' has got to be related to the traditions".

Focus group, community worker

It was suggested that perhaps when one has lived in another country for a while they become more influenced by their surrounding environment. An interesting analogy of a dilution of the mind was used to describe the way that individuals eventually become more similar to the surroundings they inhabit.

"It's like a dilution of your way of thinking, your way of judging things. Your way of assessing things tends to change with the environment you actually stay in".

Focus group, community worker

Nevertheless most focus group members were adamant in the fact that regardless of how many years they may reside in the UK they would still continue to identify themselves as being part of the Chinese culture.

“Even if you give me another ten, twenty years over here. I would be keeping to the same way that I am thinking and my ways of practice, like my culture”

Focus group, community worker

This strong identification with Chinese culture supports the view that identification with both Chinese and British cultural identity can depend a great deal on the individual and whether they actually wish to make an effort to hold on to or lose their Chinese culture, practices, and traditions from their homeland.

Culture and values – Cohesion and fragmentation

One can never underestimate the influence of culture in people’s beliefs and practices. Chinese culture in particular has enjoyed a dominant role in Chinese communities for a substantial amount of years. It is evident from the commentaries reviewed that the influence of Chinese culture continues to be a consistent and pervasive force in the lives of British Chinese individuals.

“Culture does play a big part in what we are”

Focus group, lay member

“I think my cultural beliefs and values decided the whole reason why I am here. They decide everything”

Focus group, lay member

Focus group informants emphasised that there are many differences between Chinese and British communities and their worldview.

“It’s your (British) culture and your way of looking at things that are different”

Focus group, lay member

Some informants believed that this difference between British and Chinese communities is related to culture and the importance that is placed upon culture in Chinese societies. In contrast to the comparative perceived lack of importance placed upon culture in British societies.

“Culture plays quite an important part in what we do because we are slightly different and traditionally they (English) do things differently”

Focus group, lay member

One of the main differences identified between Chinese and Western culture by one member of the focus groups was related to family and the importance that Chinese culture places on the family. Western culture is viewed as placing less importance on the family than Chinese culture, it was also suggested that Western culture places less respect on the family than Chinese culture.

“The way they (English) treat their parents and the way we (Chinese) treat our parents is totally different they have this scheme whereby once you are past 18 years old, they don’t care and you have to go and live by yourself and look after yourself, but from our point of view, we are always thinking about what’s going to happen to our children... even if they are 50 years old”

Focus group, lay member

Another major difference between Western and Chinese culture is identified as being related to the ideas of collectivism and individualism. The Chinese are perceived as more of a collectivist culture this is in contrast to the more individualistic culture that is identified as dominating life in the West (Hui & Triandis, 1986). These two ideologies consist of very different senses of identity, relationships to others, approaches to knowledge, learning and traditions, and ways of life. The collectivist ideology may go

further to explain the importance of the family to Chinese communities and their culture it may also go further to explain the oft-quoted disparate differences between the cultures of the Chinese and the West.

Unlike individualist cultures, collectivist cultures tend to favour traditional knowledge and practices over the pursuit of something new. The value placed upon tradition and experience accounts for the revered and genuine respect subscribed to the elderly. This collectivist ideology also forms both the content of knowledge and also the method of transference of this knowledge across the generations. Knowledge is passed on through gestures, habits and rituals, it is less important to understand *why* one does something than to know *what* to do and *how* and *when* to do it (Gervais & Jovchelovitch, 1998), it is generally assumed that knowledge is acquired with age. This respect for tradition so characteristic of Chinese culture has an immediate over people's health beliefs and consequently, their choice of medicine.

Despite the cultural differences identified between Chinese and Western culture in the current study, there is little mention of any disharmony amongst Chinese with British society in the UK. There is also mention amongst informants of the more tolerant nature of British society.

“There are a number of cultural differences, but now the English seem to be more accepting of us which I think is a good thing”

Focus group, lay member

However, there was also some mention of the negative aspects of being a minority ethnic group and hints at social exclusion. One informant felt that no matter how British a Chinese person may feel they will always be identified by Westerners, as being foreign or Chinese.

“You know that there are certain circles that you can never ever get in, no matter how good your English could be, or no matter how good your understanding of

this culture is”

Focus group, lay member

“The colour and the race make a lot of difference even nowadays it still exists”

Focus group, lay member

Opinions were also voiced from informants stating that integration with British society is also related to peoples’ attitudes and individual choice, thus emphasising that integration is not just about one’s culture where some people are able to successfully integrate themselves with a British lifestyle whilst managing to continue to hold onto their traditional Chinese culture and practices.

“Yes, culture’s a big thing but it also depends on the individual choice I mean we have the same people and yet we have different groups within the same culture. We all say that this culture is different and we all say that we find that it is difficult, but some people will be more open-minded and try other things...”

Focus group, lay member

There was a mention of the difficulties some of the younger generation experience when they arrive in the UK from China or Hong Kong as young adults to continue their education. Focus group members described how some of these individuals experience a confusing conflict of cultures and identity when they return to their home country having completed their studies and having become acculturated to the UK and to a British lifestyle.

“The culture is different. They get used to the culture over in England”

Focus group, lay member

There was discussion of the fears of problems of isolation, finding a partner and finding friends they could relate to, someone who has shared similar experiences.

“You have to think about things like; ‘will I be able to find a girlfriend for myself over there?’ and I’m getting older, and you’ve got friends but not like friends friends. It’s slightly different, you know”

Focus group, Lay member

There was a feeling that some individuals experience confusion in trying to continue to maintain an integrated Western and Chinese lifestyle when they return to their homeland.

“One of my friend’s children, he was born over here and then emigrated back to Hong Kong for a few years... He would try and not to speak any Chinese at home and outside with his friends. He would always say ‘speak English to me I am British’.”

Focus group, community worker

Studies have shown that when children of Chinese parents adapt to life in Western society their traditional values and lifestyle can often change (Pang & Sung, 2000), this also seems to be evident in the current study.

“When they finish their education in England some of them go back to Hong Kong and have a job but they don’t mix with the local Chinese you see because they can’t.... When they finish work those BBC go to the pub whereas the real Chinese go to the Chinese restaurants and have a meal”

Focus group, Lay member

Changing reasons behind the Chinese choosing to live in the UK

“Before Chinese people used to come over here to make a living, now they come over here for money, for position”.

Focus group, lay member

“In the old days, I mean 10-20 years ago, people did just come for jobs, work for money, but not as many now”

Focus group, lay member

In the past few years there seems to be slight changes taking place within the UK Chinese community. It appears to be more common for younger generation Chinese from China and Hong Kong to contemplate moving back to their home country in the future. This is perceived to be related to the changing economic climate in China in recent years. After stagnating for two decades under the rigid authoritarianism of early communist rule, China is currently experiencing rapid economic progress. China now has the world's fastest-growing economy and is undergoing what has been described as a second industrial revolution.

“China is so big, like the city where I come from, people earn much more money than in England so people tend to go back now. Like myself, I always want to go back because you can easily earn more money than here”

Focus group, lay member

However, there is evidence that the recent success of China is not filtering through to all its citizens. Focus group members commented on how China people from more rural villages are still continuing to apply for immigration to the UK, while China people from more prosperous cities are thinking more and more about the possibilities of moving back to their homeland where there are now more opportunities for making money and obtaining a successful career than before these Chinese immigrants moved to the UK.

“I don't think people still have enough money for living; like the people from the villages or provinces. We must remember that China is just so big it's huge. I think it's the village people who want to come out of the country... but nowadays the situation is getting better”

Focus group, lay member

This is not to say that there are not still many Chinese families coming to the UK in the hope of a better lifestyle and the chance to earn more money and gain a better education

for their children in order to increase the opportunities for their children later in life.

“I know a guy, he comes from China. He wants to bring his children up here, that’s the main reason that he’s over here he doesn’t want his children to end up in the same place that he is... I can see he wants to do more possibly he wants his children to move from China to the UK because better education.”

Focus group, lay member

TCM and Western medicine

The commentaries reviewed revealed patterns of health resources used by Chinese informants based on their cultural background and adaptation to their experiences as British Chinese citizens include self care, home remedies, TCM alone, integrated TCM and Western medicine, and Western medicine alone.

“The theory of treatment in TCM is very different to Western medicine...TCM theory is to do with the harmony of the body inside particularly the internal of the body. You probably hear the Chinese saying ‘I am too cold’, or ‘I am too hot’, the well-being is based on being just right, neither too hot, or too cold. If you say that to your GP they would not understand what you are talking about because it is something that cannot be explained.”

Focus group, community worker

Traditional Chinese concepts of health and illness dominate the health and illness representations held by members of the British Chinese community this is clear from the findings of the current study. What biomedical knowledge Chinese informants possess is often integrated with their knowledge of TCM so that their Western health beliefs are compatible with their own Chinese outlook, beliefs and cultural identity.

Notions of balance and harmony are central to Chinese representations of health and illness as is the surrounding environment that an individual inhabits. The Chinese view

balance and harmony as an essential element for well-being. There is also the assumption that the mind and body are linked to one another and are not separate entities, as is the case with the biomedical model of medicine. The majority of the current sample explained and understood their illnesses in traditional medical concepts rather than Western medical principles.

Chinese immigrants are known to have a complex knowledge and understanding of illnesses and home remedies as a direct result of having been exposed to a uniquely modern orientation towards health care that integrates TCM and Western medicine in their home countries (Guo, 2000).

In China and Hong Kong an integrated approach to medicine is applied where TCM and Western medicine run parallel to each other. This is perhaps one of the reasons why so many British Chinese choose to utilise both TCM and Western medicine when experiencing ill health. They may be continuing with health behaviours practised in their home countries while the younger generation are often copying cultural practices upheld and learnt in the family home that they have been brought up with and observed through the practices of their families.

It was emphasised by informants that health and illness are the functions of behaviours, lifestyles and emotions. The concept of having a holistic view of health appears to dominate the line of thought of Chinese individuals their holistic concept of health reflects Chinese cultural values and the philosophy of traditional Chinese medical diagnosis and treatment. Natural phenomena and social and physical environments, including emotions, changes in weather and temperature, are perceived to affect all parts of the body. In addition to being a competent remedy for treating ill health TCM is also acknowledged as being good to use for everyday prevention of ill health.

“TCM as a whole is quite good at help people to prevent illnesses”

Focus group, community worker

An orientation towards others is a deeply rooted part of the historical and cultural traditions of the Chinese community continuing to express itself in their value and belief system. In the cultural values of health and well-being there is a strong sense of importance placed on the family, kinship and affiliation are traditionally more valued than individualism in Chinese culture and respect and care of the elderly is always emphasised. The Chinese community can be seen to actively preserve many aspects of their Chinese cultural traditions. The informants in the focus groups expressed a strong sense of kinship and often spoke of turning to their families for health needs, advice and care.

A popular notion of TCM amongst Chinese communities is that it tackles the 'root', or cause of the disease. The Chinese predominantly view Western medicine as being able to tackle only the symptoms of the disease and not the actual cause of the disease itself. Western medicine is acknowledged amongst focus group members as having more of a scientific and clinical grounding than TCM, which is viewed as being more based on experience.

"The treatment from Western medicine, from my understanding, is tackling the symptoms of the disease rather than the cause of the disease. TCM usually tackles the causes"

Focus group, community worker

Informants confirmed that both TCM and Western medicine are used concurrently by many British Chinese individuals, patients do nonetheless often make decisions on which type of practitioner they want to consult depending on the illness they are suffering from. TCM is considered to be good for some milder illnesses, for example, coughs or colds, or for chronic illnesses. It is also considered to be better for 'clearing' the disease. TCM is often used as a supplement to Western medication-that is, after consulting a GP for quick recovery TCM is then used to 'clear the root of the disease'. This seems to be a common occurrence for Chinese communities not just in the UK but also native Chinese in Hong Kong or China (Lam, 2001).

“TCM is quite good but it just takes a bit of time if you want a speedy recovery you use Western medicine”

Focus group, lay member

Sometimes TCM was reported to be used as an ‘alternative’, when Western medicine fails or when the individual is so desperate they will try anything. Informants also considered TCM to be milder than Western medicine and did not consider TCM to have strong side effects, unlike Western medicine. TCM is however seen to have a number of specific weaknesses; it is viewed as less convenient than Western medicine to prepare and administer because you have to boil the herbs to make the medicine. Herbal medicine is also seen as almost always tasting very bitter which makes it an unpopular choice with some patients, particularly children. TCM is also considered to be slower at tackling the illness than Western medicine.

“It’s the benefits you are looking for that will really influence your choice to choose different types of medicine. For me I believe it’s about convenience and the taste of the medicine. TCM is more natural but I just can’t accept it, it tastes awful it looks awful it smells awful. I simply can’t take it”

Focus group, lay member

Informants considered Western medicine to have specific strengths, it was considered more convenient than TCM herbal tonics because there is no need to cook the ingredients beforehand. Western medicine was also viewed as producing a faster recovery, which was one of the main influencing factors for patients. Western medicine was also viewed as being better to cure some diseases immediately. It was mentioned that patients would sometimes use Western medicine to control the symptoms first and then use TCM in an attempt to cure the disease by banishing the symptoms.

The choice of using either Western medicine or TCM is revealed as often being dependent on the type of illness for many focus group participants. Informants believed

that there are particular illnesses for which TCM is believed to be more effective at treatment than Western medicine, in these cases, if a respondent experiences this illness they would choose to use TCM over Western medicine. There was also an acknowledgement by respondents that the older generation are more likely to be making Chinese herbal tonics, soups and remedies.

“The older generation, they make a lot of soups... people believe that if they drink these type of tonics it will help them to resist infection”

Focus group, lay member

Although Western medicine is considered to have a number of strengths it is also considered to have a number of distinct weaknesses informants considered Western medicine to have strong side effects. Respondents commented how it is not good for one's health to take Western medicine over prolonged periods of time, some informants commented that despite using Western medicine when suffering from ill health they believed the side effects of Western medication are too strong, often leaving the individual feeling weak. Respondents also mentioned a fear of becoming addicted to medication if taken over long periods of time taking tablets too frequently was observed by informants as being destructive to the health and not good for the body.

“There is less side-effects from using TCM because most of the TCM is dried ingredients and there is no chemicals in them. TCM can go with most things, it's more healthy”

Focus group, lay member

Informants pointed out that Western medicine focuses on the symptoms of disease and is seen to be more efficacious than TCM in the treatment of acute diseases, while chronic illness, prevention, nutritional care and the promotion and maintenance of health are viewed as being more responsive to a traditional Chinese medical approach.

“TCM is quite strong in certain areas it can actually cure certain diseases that

Western medicine can't do or finds difficult to put right"

Focus group, community worker

It was revealed that members of the British Chinese community commonly use TCM in the form of self-medication. Self-medication home remedies are often in the form of tonics or soups where the ingredients are obtained from a TCM herbalist and are boiled together in a pot of boiling water. These home remedies and self-medication seem to be one of the more common ways of utilising TCM by British Chinese communities.

"My family do cook soups and stuff but it's harder over here to cook the stuff you need because you don't have the right medicine, and if you go to a Chinese herbalist over here it will be really expensive"

Focus group, lay member

TCM has an important role in Chinese culture and most members of the Chinese community have used some form of TCM at some point in their lives. All members of the focus group admitted to having utilised both TCM and Western medicine there was an agreement between informants that TCM and alternative and complementary medicines are beginning to become more popular in the UK, where there is now seen to be more of a market for TCM than ever before.

"I think TCM is becoming more popular because more people are starting to study TCM over here"

Focus group, lay member

Respondents' contributions often emphasised the negative aspects of TCM and problems related to the practice of TCM in the UK, these problems are believed to be related to the lack of regulations for TCM here in the UK. Many informants expressed a lack of confidence with the UK TCM system and a preference to stick to using TCM in their homeland or using TCM herbalists in Chinatown that are perhaps more reputable than other TCM herbalists in addition to the common home remedies and self-medication of

TCM using TCM brought over from individuals' homelands.

"I prefer TCM when it's from home, but not from the UK"

Focus group, lay member

"I would never trust those herbalists outside of Chinatown. You don't feel safe because you don't know if there is any regulations over here"

Focus group, lay member

One reason for this lack of trust of TCM practices in the UK could be related to the fact that in their home countries the TCM doctor usually treats many members of the same family. The TCM doctor generally has a long established relationship with the family so there is the development of a trusting relationship between the patient and the TCM doctor. In addition to this, if a TCM doctor treats the family over a long period of time the TCM doctor will also be familiar with an individual's ailments.

"If I had a choice that my TCM doctor could move from Hong Kong to here I would use TCM because I do know this TCM doctor and I do trust him... He's really very good he's been treating my family for 10-20 years"

Focus group, lay member

Despite respondents having a high regard and respect for TCM individually as a form of medicine and collectively as an important part of Chinese culture. Respondents also acknowledged that TCM is slower to cure diseases informants admitted that Western medicine is more useful in the case of acute illnesses TCM is more commonly used with minor illnesses and also to aid with recovery once the symptoms of the illness has been dealt with.

"For the acute illnesses I would go for the modern medicine because it will stop the symptoms then afterwards I will go and see the TCM doctor to try to cure the cause"

Focus group, community worker

The natural ingredients of TCM are seen as one of its strengths TCM is viewed as being closely inter-linked with Chinese culture, it is viewed as a crucial part of the Chinese culture. Therefore it is only natural that the Chinese may feel that they can relate to TCM more so than with Western medicine, some individuals may find it easier and more natural to relate to TCM as it is already a familiar part of their lives, culture and beliefs TCM has been a part of Chinese culture for a substantial amount of years.

It is evident from the contributions that there is a great deal of mistrust towards TCM shops and TCM doctors in the UK. Many members of the British Chinese community are suspicious of these services as a result of hearing of past experiences of friends or family dealing with counterfeit TCM doctors in the UK in the past.

“I never, ever use TCM over here unless I know the TCM doctor unless I know that person quite well”

Focus group, lay member

Focus group members also commented on the expensive prices of TCM in the UK, compared to the cost of TCM in their homelands. Informants also mentioned the inconvenience of not having all medicines and herbs available over here in the UK, suggesting that these could be additional factors further contributing to the relatively low utilisation of TCM by the Chinese community in this country.

The primary concern of most respondents is to recover in the shortest time so as to avoid having to take days off work to recover and thus lose money. Speed of recovery and cost of care were the two strongest influencing factors related to choice of medicine by the British Chinese community in this sample, convenience was also a confounding variable influencing choice of medicine.

Members of the focus groups frequently referred to problems that are beginning to arise as a result of the recent wave of popularity with TCM and alternative medicine in the UK among British consumers as TCM is not yet properly regulated in the UK. Focus group

members intimated that there may sometimes be Chinese people opening Chinese herbal medicine shops who do not actually have any experience in the field of TCM and have had no formal training or qualifications. These individuals are not seen to be interested in the welfare of their patients their primary concern is seen by many British Chinese as being to make a lot of money and take advantage of the recent wave of popularity within the field of alternative and complementary medicines.

“You need to be very careful with a TCM doctor, for instance you need to make sure that this TCM doctor has the right sort of training and the right sort of experience”

Focus group, community worker

“At the moment with the whole business of TCM in this country, you could go tomorrow to any high street or shopping mall and open up a herbal or acupuncture shop and Westerners might think that you can do it because you look Chinese, but in fact you don't know what you're doing”

Focus group, community worker

TCM shops in the UK were often observed by respondents as being designed to attract British consumers and not designed for the Chinese consumer market. One informant even went on to make a comparison of a TCM shop being like a Chinese takeaway in that they are designed to attract growing interest from Westerners in alternative medicine and complementary therapies.

“If I were ill I'd rather go to Hong Kong to find a TCM doctor that I have used before instead of using someone over here because obviously, most of the TCM shops over here are designed for British people, not for Chinese people. It's just like some takeaways”

Focus group, lay member

It is interesting to note that despite it being clear from the results that respondents are

seen to relate more to the traditional Chinese model of medicine as opposed to the Western biomedical model of medicine, most respondents still continue to choose to use Western medicine when they are unwell as opposed to TCM. This is related to the speed of the recovery process for Chinese individuals, which is believed to be quicker when using Western medicine than when using TCM, another contributing factor is that it is cheaper to use Western medicine in the UK, as TCM is not available on the NHS in the same way that Western medicine is. TCM is more expensive to use than Western medicine in the UK as a result of the cost of the consultation with the TCM practitioner, in addition to the cost of the herbs and medicine, there is also a prevalent lack of trust amongst the Chinese community of TCM shops and herbalists. All of these factors contribute somewhat to the increased use of Western medicine amongst the British Chinese community.

One informant observed that if TCM were available on the NHS in the same way that Western medicine is, there would be an increase in the amount of people utilising TCM on a more regular basis.

“If TCM was available for free or subsidised like Western medicine then it would increase its popularity”

Focus group, community worker

Although British Chinese do utilise Western health services, there are a number of issues still prevalent, which impede on the full use of these health services by the Chinese community. Lack of information about the functioning of the NHS and the services available still continues to be widespread (Gervais & Jovchelovitch, 1998).

“I’ve got a poster saying about if you are an asylum seeker what to do if you get sick or if you want to register with a GP, but the poster is in English so it’s no good. They do the stuff but they don’t think about whether the people they are trying to reach can benefit from it”

Focus group, community worker

There was suggestion that foreign-born Chinese, who are accustomed to a different medical system before they arrive in the UK, may assume that the Western medical system is the same as the system in their own countries.

“Those people who first arrive in this country many of them assume that it is the same system as their own country”

Focus group, community worker

“Places in Hong Kong and China, you can just go and see the pharmacist and tell them ‘I’ve got this type of illness, what medicine can I take?’ Whereas a lot of drugs in this country you need a prescription most of the time, for people who have just arrived, they probably think like ‘why do we have to wait so long when we are over here to get treatment? Or ‘why can’t we just buy the medicine over the counter?’”

Focus group, community worker

Prior experience of medical systems is bound to have a contributing influence as to what shapes foreign-born Chinese expectations of the British health system. Evidently from the responses it can be seen that many Chinese are likely to expect similar health practices to take place in the UK.

Chinese informants in the current sample did not generally consider their knowledge and beliefs of the traditional Chinese medical to clash with their knowledge and understanding of the Western biomedical model, in fact, it seems evident that the Chinese strive to integrate the two medical systems drawing on what they believe to be their respective strengths. This is an issue commonly reported of Chinese communities (Koo, 1987; Gervais & Jovchelovitch, 1998).

“For Chinese people we have the knowledge that TCM works more for some specific illness which Western medicine can’t really do anything about. If Western people knew

that type of information they would probably use it as part of their main treatment programme”

Focus group, community worker

The current study demonstrates that Chinese people are able to integrate two different health systems of knowledge and incorporate new information deriving from different traditions and cultures. This appears to be a familiar function of the Chinese manner of thinking, the idea of concurrent use of both Western and traditional Chinese health systems allows the Chinese to cope with a different culture and lifestyle while still managing to hold onto elements of their traditional cultural practices in the UK.

This ability to integrate health beliefs and behaviours seems to vary according to age and degrees of acculturation into mainstream British society. However, this ability to integrate health beliefs and behaviours is evident through the informants' involved in the current sample. British Chinese communities seem to have the ability to learn new health beliefs and behaviours and either combine these with their current traditional Chinese health beliefs and behaviours system, or allow the two belief systems to co-exist together. This is made possible because, according to the Chinese line of thought, Chinese and Western health beliefs are very different to one another and thus do not compete with each other. It is therefore possible for these two health belief systems to successfully co-exist side by side, the Chinese use these two systems mutually in order to suit their different purposes and needs.

One clear feature of Chinese health behaviours is that the Chinese are seen to combine health resources available to them, regardless of whether they are related to Western medicine or TCM. TCM and TCM rituals are used in day to day life in order to maintain good health and prevent ill health they are also used to treat minor illnesses for which TCM is popularly used e.g.: fractures, rheumatic pain and skin diseases etc. The Chinese believe that TCM is better at tackling the 'root' of the disease while the Chinese will be more likely to utilise Western medicine for more acute illnesses and also to reduce painful symptoms, in addition to this, both systems will often be used to compensate for the

limitations and weaknesses of the other medicine.

Health beliefs and health behaviours

Before the current findings are presented it is important to emphasise that many of the descriptions of Chinese health practices and health beliefs emerged through storytelling and the description of experiences and practices of individuals when suffering from ill health they were often expressed in a fragmentary form. One possible reason for this could be that the way information is habitually passed on in Chinese culture often relies more on traditional rituals and observation of these rituals than through explanations. In Chinese culture knowledge is often passed on through observation of traditional habits and rituals.

The transference of health knowledge is an important finding in the current study. Although language is deeply involved in the transference of knowledge, language is not actively used to explain practices and beliefs. The Chinese transfer their health beliefs and behaviours into rituals and these rituals are passed down from generation to generation through the observance of rituals, behaviours and practices. The Chinese often learn much from one another through the power of observation transference of knowledge is handed down and learnt through the observance of rituals, behaviours and practices mostly within the home.

The representations of health and illness discovered in the current study are deeply related to issues concerning the maintenance, the transmission and the transformation of a cultural identity. The Chinese abroad, as with other ethnic groups, 'seek to create some continuity between past and present, between old selves imprinted by the mother tongue and the new ones invented with painful freedom' (Schwartz, 1992). A complex interaction takes place between the shared history social memory and common practices of the Chinese combined with the new social knowledge and conventions that the Chinese community are exposed to in the UK.

The experiences of non-British-born informants when they arrive in the UK, requires them to adapt to a change in their health status and to cultural change. Their adaptations to changes in health behaviours are embedded in their cultural perspectives of health and well-being and are associated with their health concerns. Respondents believe that good health is related to balance and harmony within the body and that often when one is experiencing ill health, this is a result of the internal body being imbalanced which will then go on to affect the harmony in the body.

“It’s all about balance and harmony, and about the ‘qi’ in your body”

Focus group, community worker

Chinese health care practices are quite different from Western health care practices to the extent that compliance is not a familiar concept to either Chinese health professionals or patients. In Chinese culture people are expected to make their own decisions regarding health behaviours (Hwu et al., 2001). Chinese health beliefs are derived from the culture and are firmly grounded within the context in which people live, their influence is inevitable, in the current study most informants mentioned using food and herbs to correct the imbalance in the body and restore health from their perspective it is obvious that food can bring internal strength.

Food is key to prevention and the Chinese believe that food plays a fundamental role in curing disease, this is displayed through respondents’ talk of using traditional foods and herbs to cure ill health and prevent disease. Respondents referred to food as a regulator of health as well as vehicle to prevent ill health the correct use of food is a dominant source of health prevention amongst the Chinese.

“When I have flu...my mum went to the TCM herbalist and bought some TCM she made me a big bowl of black soup and what you do is you drink it and then lay down with as many duvets as possible to cover you when you sweat it all out and then you get rid of all the germs”

Focus group, lay member

An important health belief of the Chinese community is related to the power of prevention Chinese participants involved in the current sample felt that their individual role of preventing ill health by looking after and being responsible for ones' own body and health was an important part of their culture.

“Morning sickness is an example, TCM is extremely good at treating morning sickness by putting needles in the right places of the body it is very effective”

Focus group, community worker

A popular lay Chinese belief of TCM is that you should eat a specific part of an animal's body if you are having an illness in this part of your body. This also applies to improving the condition of the particular body part. For example:

“One of the lay beliefs by Chinese older people is that if you want to strengthen your leg strength then you will drink some soup with chicken legs. If you want to be more intelligent you will eat some soup with pig's brain”

Focus group, community worker

The Chinese view food as a vital component to health and illness, eating is a particularly social act with Chinese communities, since health is conceived to be the product of sufficient flow of 'qi' or energy around the body then it is only natural that food will be seen as a central part of good health. The manipulation of food nutrition is still in place today in order to maintain good health and prevent or cure illness (Koo, 1984; 1987).

Many respondents emphasised the importance of the role of food in relation to health together with language, food is seen as being one of the most important vehicles for the transportation of traditional health beliefs (Gervais & Jovchelovitch, 1998). Food is seen as a vital part of prevention and plays a fundamental role in curing disease, informants often referred to food as a general regulator in everyday life, the Chinese community

views the correct use of food as a major source of illness prevention. Food is also seen to have curative properties and is thus utilised in a concoction of tonics.

“If you have some hard skin...just take a small piece of garlic and smash it up, put the juice over it (hard skin) and rub it several times then after a while it will dry out and then disappear”

Focus group, lay member

Food is a major vehicle for health beliefs in the Chinese community it comprises the practice of a number of concepts and rituals that continue to keep the cultural system of the community alive. Through food, the Chinese continue to pass down through the generations, traditional knowledge express care and maintain fundamental relations. Through self-management of their health the Chinese have developed many health behaviours to suit their conditions lifestyles and belief patterns. The constructs of respect trust and control within healthcare relationships are clearly of critical importance to the quality of life of the Chinese community.

The Chinese individuals used in the current sample believe that health and illness are functions of behaviour lifestyle and emotions, emphasising the importance of nutrition, physical activity, mental health and social activity as components in health and illness. It is evident from the comments reviewed that cost of healthcare is a major influencing factor despite the dominant force of Chinese culture and traditions over British Chinese communities.

“If you want to go for TCM you have to pay for it, but if you access the UK health system the NHS provides a free system so people just tend to use their local GP or walk-in centre”

Focus group, community worker

“It depends how important my time is I mean money does buy you time. If you recover in 2-3 days then you can go back to work straight away but if it takes you

longer to recover than you could lose more money from not working”

Focus group, lay member

This method of using the best treatment for a particular illness can be interpreted as the pragmatic nature of the Chinese culture. It is frequently noted that the Chinese alternate between Western and Chinese systems of healthcare and will try many different medical paths until they recover from the illness (Sproston et al., 1999; Quah & Bishop, 1996) this finding has been further confirmed in the results of the current study. Koo (1987) has described the common practice of ‘doctor shopping’ in Hong Kong in previous research identifying the reasoning behind the ‘as long as it works’ approach.

“Apart from going to see the normal GP people also tend to go to see the TCM doctor because that’s what they can relate to, they can explain better”

Focus group, community worker

“When you have the TCM especially in the liquid form they say it’s to water your internal system to clear you internally, that’s what they believe”

Focus group, lay member

The concept of balance reflects Chinese life, health promotion and health-seeking behaviours, the Chinese community view holistic balance and harmony as essential elements for long life and well-being. The Chinese continue to view health from their traditional Chinese perspective while collating newly acquired Western knowledge thereby adapting to the new structures while continuing to maintain valued Chinese cultural traditions.

When questioned about the influence of family and friends on the health beliefs and behaviours of informants one responded:

“Family is one of the main influences”

Focus group, community worker

Slow forms of Chinese cultural exercises continue to be practised, though the regularity of these practices for Chinese in Britain was not stated. These slow forms of exercise seem to be particularly popular amongst the elderly as a way of attempting to maintain good health.

“If you look at tai chi and chi gong, these type of exercises are slow exercises which is one of the more common types of exercise. People will get up very early in the morning and start to do what they call ‘walk up the hill, walk down the mountain’. They consider because the air in the city is quite highly polluted and so by getting up early and going up the mountain, the air will be cleaner and so it will be good for them”.

Focus group, community worker

Informants’ felt that some forms of slow exercise are good for the health in addition to being good exercise for the body they believed the exercises were beneficial for the physical and mental health of an individual these beliefs are closely related to Chinese cultural beliefs.

Common Chinese health-seeking behaviours include self-treatment or home remedies; use of a combination of Western medicine and TCM; use of Western medicine alone; use of TCM alone.

“In Chinese countries, people do very much seek self-help... they seek self-help rather than professional help... for minor illnesses”

Focus group, Community worker

The Chinese community focuses on traditional practices, a common behaviour was if the severity of an illness persisted and all resources had been exhausted a combination of WM and TCM is often sought, this is seen as being related to the fact that the Chinese are interested in the quickest form of cure for their illnesses.

“The difference in Chinese people seeking medical help is that they want to get it sorted and over and done with as quickly as possible”

Focus group, community worker

The health experiences of the Chinese community require them to adapt to a change in their health status and to cultural change. Their adaptations to these changes are grounded in their cultural perspectives of health and well-being and are associated with their health concerns.

It is apparent that the Chinese will use Chinese medicine tonics and herbs in order to maintain good health and to prevent illness, whereas they would start to use Western medicine when suffering from acute illnesses. Prevention is a matter of everyday life for the Chinese community and is generally not associated with illness. The Chinese attempt to maintain good health by balancing the social, individual, natural and supernatural realms; prevention is a matter of attaining a harmonious life.

The transference of health beliefs and customs take place through social and community rituals of many kinds, the most important ones occurring within the family. In this sense, a deeply held knowledge system is developed, most of which is taken for granted and demonstrated in the most basic elements of everyday life: language and food. Whenever the Chinese language is spoken and food is prepared traditional rituals, beliefs and customs about health are being transferred (Gervais & Jovchelovitch, 1998).

When questioned about health beliefs and health behaviours informants believed their health beliefs and behaviours were related to their rich Chinese culture and background.

“I think it depends on the cultural background...the Chinese... In a way they are more open-minded also they believe in prevention so lifestyle-wise, they probably try to eat more healthily”

Focus group, community worker

As a general rule Chinese informants in the current study tended to utilise TCM for minor conditions and ailments; to treat the 'root' of an illness; or if the condition is not considered as urgent this seems to be a common practice amongst the Chinese community.

“Older people, they already have a lot of ready medicines in their homes that they keep. Like for headache, stomach ache, for diarrhoea”

Focus group, community worker

Conversely, utilisation of Western medicine tended to be advocated in the case of 'serious' conditions; when it is deemed necessary to deal with the symptoms of an illness or to alleviate acute pain fast. On the basis of these health beliefs many informants believe it to be a matter of practicality to utilise Western medicine and TCM simultaneously while Western medicine is traditionally believed by the Chinese to alleviate painful symptoms of ill health TCM is believed to tackle the root cause of the illness thus it appears only natural that Chinese would choose to utilise both types of medicine as both TCM and Western medicine would seem to complement one another.

“They think that well ‘if we can stop diarrhoea with our own medicine then no need to go and see the doctor’ ”

Focus group, community worker

“Bring them (medicines) back from their homelands when they go back home”

Focus group, community worker

The health beliefs and behaviours revealed in this study are deeply mixed with issues concerning the maintenance and continual transference of the Chinese cultural identity. The Chinese have sought to continue to uphold their Chinese culture and combine this traditional culture with a British culture in a Western society. There are complex interactions taking place all the time between the common Chinese cultural practices and

new Western practices of Chinese individuals.

Barriers to accessing health services in the UK

There are different groups of Chinese within the British Chinese community this is clearly evident. Different members of the Chinese community will have different coping mechanisms in place to make sense of their Chinese culture and heritage in a Western society these behaviours will have an impact upon the individual. There seem to be two main groups amongst the British Chinese community, the 'isolated' individuals and the 'integrated' individuals. There are different levels of isolation and integration that do not necessarily conform to the generational differences these differences seems to conform more through the ability to use English and the willingness to engage with British culture.

“For those people that don't have the language skills that will be a problem for integration”

Focus group, community worker

The more isolated individuals feel in British society, the more reliant they may become on Chinese health beliefs and practices and seeking support from Chinese organisations or networks. The least integrated in British Chinese society tend to be the elderly, people working in the catering trade and also newly arrived immigrants. These individuals are often less educated and are united by the common characteristic of not being able to speak English very well. However, age is not the only determining variable for integration competent use of the English language is imperative for successful integration into the host society and also competent use of the English language is crucial in understanding and accessing mainstream health services. Substantial amounts of the Chinese community rely on their families or Chinese community networks, when they need to seek medical help many of these individuals do not have the means of identifying health resources and benefits that are available to them.

“The barrier is for those who cannot speak the language they definitely need an

advocate, even to do simple things like filling out a form they need an interpreter to do that or help them out”

Focus group, community worker

Proficiency of the English language is a renowned problem for the Chinese community the older generation and new immigrants are the two groups who have particular problems. Difficulties with language and communication can lead to problems of isolation lack of understanding and lack of a common knowledge of the kinds of services and benefits available to people. This means that these communities are often at a disadvantage due to the barriers they face accessing these services as a result of the lack of proficiency in English, even for some of the most basic factors, such as naming parts of the body.

“The older generation don’t have much common knowledge about the human body”

Focus group, community worker

Language and communication difficulties are seen as a major barrier to accessing health care services among the British Chinese community.

“The problem with a lot of Chinese people is that they do not know how to access these services”

Focus group, lay member

Clear communication is essential in ensuring the delivery of quality health care and yet language barriers result in poor communication between health providers and patients. This poses a serious impediment for many older generation Chinese and new immigrants in particular, without a basic grasp of the English language it may be difficult for many Chinese individuals to access health services as it will be difficult for them to understand what is available to them.

“Translation is one of the main issues. My mum doesn’t know any English and it’s quite hard to find an interpreter, I can’t go with her you know there’s certain things I can’t interpret for her. When she is sick only my father is around, my dad can speak a bit of English but if there were a Chinese family who couldn’t speak English in an emergency then they’d be in trouble”

Focus group, lay member

Nevertheless, having an interpreter at hand in an appointment does not necessarily seem to ease this difficulty as the patient is often worrying about whether the translator is translating the descriptions accurately.

“Sometimes you also worry because you’re not sure if this interpreter is interpreting the right thing for you. That is another issue because you don’t know whether what you are saying to the interpreter is being interpreted correctly into English to the GP. You just don’t know”

Focus group, lay member

Informants mentioned the impracticalities linked with trying to book an interpreter for an appointment. Often surgeries are asking for substantial notice to book an interpreter, however, it is often impractical for the patient to give lots of notice before booking an interpreter for an appointment, especially if the patient is suffering from an acute illness. There are also signs that information about services to help the Chinese community to access health care services are not reaching all the individuals who need to use those services. There seems to be a lack of awareness of the services available.

“Does the surgery where your mother attends not provide an interpreter?”

Moderator

“They don’t tell you unless you ask”

Focus group, lay member

“If you ask them for an interpreter, sometimes you have to give a lot of notice, 2 weeks or something like that... So if you have a serious illness then it’s impossible to give any notice”

Focus group, lay member

“If there were one or two interpreters in each surgery then it would make life a lot easier, but you see my parents don’t know that these services are available”

Focus group, lay member

Communication problems are renowned amongst the Chinese community. Many Chinese often express difficulty in attempting to accurately describe the sorts of pain they are experiencing. In Chinese culture, the way of describing pain in the body is often different to the Western concept of pain, it is suggested that the communication problem is not a problem that is isolated to the older generation or to the less educated in the community but perhaps more of a cultural problem.

“There’s also the communication problems isn’t there? How to describe the condition to the GP, especially for the older generation, but even for myself... When I was a university graduate, I sometimes find difficulty in trying to explain my symptoms to my GP to describe what sort of pain I am experiencing”

Focus group, community worker

Informants implied that there is corruption apparent in the interpreting trade with individuals attempting to charge substantial amounts of money for an interpreting session.

“I know some people they find themselves an interpreter and they will charge a lot of money, like £60-70, just for that appointment... but sometimes if you’re feeling quite ill and you’ve managed to book a GP appointment for that day then you’re really quite desperate”

Focus group, lay member

There is evidence that new migrants and members of the older generation have problems accessing health services and understanding the structure of these services (Sproston et al., 2001). There was also mention there is not enough information available on mainstream health services and also that new migrants may become confused as the Western health service available is often very different to the health services available in individuals' homeland.

"I think that there is also limited information to these services structure. I think for people from mainland China you can go to the hospital to see the outpatient clinic to get seen straight away if you want to, whereas here, you can only go if it's a real emergency"

Focus group, community worker

Some contributions stated that one of the reasons some of the older generation are reluctant to see Western GPs is that they feel uncomfortable and frustrated about not being able to communicate with them freely and not having the opportunity to express the concerns of their health problems.

"The older generation, especially for women, they prefer to see a lady GP instead of male because of the whole culture you see they think 'oh, I don't want those men looking at me'... The younger generation is different they can see because we live in the UK we must accept the British way of life"

Focus group, lay member

There are many examples in informants' contributions of instances where informants talk about the difficulties they experience in communicating their preoccupations to the GP. Actual or anticipated misunderstandings are often enough to deter some Chinese patients from consulting their GP. Confidence in the competence of the GP could even potentially decrease if the GP fails to take seriously the lay aetiology and diagnosis put forward by

the patient. The Chinese strongly believe in their own understanding and a failure on the part of the health professionals to recognise the validity of their assessments raises significant communication barriers, which may not easily be overcome (Gervais & Jovchelovitch, 1998).

Some respondents mentioned the difference in the doctor-patient relationship between the UK and in Chinese countries. The Chinese are perhaps more accustomed to a better relationship with their doctor in their homeland and so there seems to be a feeling over here that there is a lack of time available in GP consultations, there seems to also be a feeling of a lack of trust towards GPs.

“There is no doctor-patient experience, one surgery may have many different doctors and each time you go back to the surgery you may see a different doctor he doesn't know you at all, doesn't know the casework, the background. At home the relationship is different, when you go to see the doctor he knows your whole family, your whole history, everything”

Focus group, community worker

Prior experience of healthcare systems are also seen to have an influence over an individual's choice of healthcare. Familiarity with a particular health system usually means greater trust past experiences also determine to a large extent the patients' expectations and therefore their degree of satisfaction with the service. Trust in the qualifications of the doctors is another factor; word of mouth is of vital importance in the choice of TCM doctor but this means being a part of the community thus fears of 'pirate' TCM doctors counteract against the use of TCM doctors in the UK, just as standard qualifications across the NHS instils confidence in the doctor's qualifications, if not necessarily in the doctor's treatment.

Some informants went on to describe the rising popularity of Chinese speaking GPs. Chinese speaking GPs are a popular choice of GP amongst the Chinese community, particularly with members of the older generation who may find difficulty in explaining

their symptoms to their Western GPs.

“Upstairs from where I work there is a Chinese GP who works there many Chinese people really like to use him because they can speak the same dialect”

Focus group, community worker

Chinese speaking GPs seem to relieve a lot of the anxiety and worries that many members of the Chinese community have a problem with in Western GP related to issues of trust, understanding what the GP is saying to them, in addition to not having to worry that their GP understands everything that they are saying.

“If they had a choice they would much rather register with a Chinese GP, then they don't need an interpreter. They know that when they go there they can get treated and get the right diagnosis and they don't have to arrange for an interpreter because sometimes arranging an interpreter can be quite stressful for them”

Focus group, community worker

Those informants working with the Chinese community observed that they often have 'lots and lots of requests' for Chinese GPs. There was a general feeling that there are not enough Chinese GPs for the demand that is placed on them, that demand exceeds supply. One focus group member pointed out that there are many Asian GPs based in areas where there are lots of Asian people but the same cannot be said for Chinese GPs. Another informant observed that the lack of Chinese GPs may be more closely related to the wide dispersal of the Chinese population across the UK.

“It's funny because there are quite a few Chinese GPs they just serve in different areas of the country so I don't think that they are utilised in the best possible way... I think it's got more to do with the system and also with the Chinese population in this country”

Focus group, community worker

Anxiety and cultural differences are reflected in the expressed unfamiliarity and distrust of the Western health system by the older generation in particular. Some informants, for example, stated that they would go to visit their GP only after traditional treatments had failed, while some patients believe that the Chinese have a different body constitution than Westerners and thus Western GPs are not familiar with their biological functions. On the other hand, there were also informants who chose to initially utilise Western medicine and then go on to consult a TCM doctor only after Western treatments have failed.

Reluctance to seek help from outsiders is another barrier that is especially prevalent in the older generation. Nonetheless, it would be unfair to assume that all the British Chinese community feel this way, it is evident from the current study that there are a great number of Chinese who choose to utilise British health services.

Language is one of the aspects of culture that facilitates assimilation, it is evident that the older generation Chinese will find more difficulty to redefine themselves as a consequence of their exposure to British society and culture, they are more likely to have spent longer in their homeland before moving to the UK and may be more reluctant to enter into a British culture and lifestyle having their own established practices and beliefs.

When people seek medical help in multicultural societies they choose services and health personnel in the health care system which not only best address their own lay assessments of their conditions but which assume and reflect their culture. Choices of healthcare and evaluations of individual experiences of health services are therefore shaped by cultural and social understandings (Gervais & Jovchelovitch, 1998).

When questioned about whether the informants felt that Chinese people have confidence in the British health care system, most of the respondents answered “no”. When asked for the reasons behind this lack of confidence in the British healthcare system informants revealed that this lack of trust was related to the language barrier.

“It’s probably because of the language barrier, it might be a very straightforward case for the Chinese patient because they don’t understand they might easily have misunderstandings”

Focus group, community member

CHAPTER SIX - CONCLUSIONS & RECOMMENDATIONS

Chinese cultural beliefs and practices play an important role in the health-seeking behaviours of British Chinese communities therefore traditional health beliefs and culture as well as socioeconomic and environmental factors related to Chinese health-seeking behaviours should be incorporated in to the design and implementation of culturally appropriate health interventions for British Chinese communities.

The use of both qualitative and quantitative methods served to strengthen the internal validity of the study. Similar trends were found in both analyses, the qualitative study emphasised the importance of obtaining in-depth assessments since additional issues such as specific traditional cultural health beliefs and practices such as bulk buying TCM in the respondents' native country, which might not otherwise have been considered if a quantitative study alone had been undertaken. In addition to this, the value of using community networks in sampling ethnic minority groups in the UK was reinforced (Kwan & Williams, 1998).

The acculturation of respondents participating in the research, judged in terms of respondents' English-speaking abilities and number of years in the UK, varied greatly. The British health care system was generally perceived as difficult to use, particularly with a view to concerns over the language barrier and concerns about communicating with health providers and being able to trust them. Although none of these points are unique to British Chinese communities, their previous experience with different approaches of medicine to treat ill health may make the experience of such barriers more extreme.

A better understanding of the influence of traditional cultural and health beliefs and social and environmental factors on the health-seeking practices of the British Chinese could help enable the design and implementation of culturally appropriate and effective health

promotion and intervention programs. Since Chinese people are often likely to have their own health beliefs, an understanding of these health beliefs and associated behaviours must be fully explored in order to meet identified needs and provide effective health care.

From the results of the current research it is clear to see that British Chinese communities display different approaches to health-seeking behaviours compared to other communities in the UK. It is also clear that there are a multitude of issues and variables that must be examined in order for one to truly understand health service under-utilisation by British Chinese.

When immigrants first arrive in the UK they consider themselves Chinese, being Chinese is a central part of their self-concept. In comparison, being British is something individuals must learn in order for them to survive in the UK. Therefore, although they live in the UK, many may continue to perceive themselves as Chinese across a number of social contexts (Tsai et al., 2000).

After spending more time in the UK the meaning of being British and being Chinese may change for immigrants, notions of being British may become less contextualised as immigrants have increased exposure to, and experience in, British culture. Thus being British may be based on respondents' engagement with both British and Chinese cultures. Notions of being Chinese, however, may become more contextualised as contact with Chinese culture decreases, though this hardly seems realistic if one looks back on how British Chinese communities have successfully managed to retain their Chinese culture and identity despite living in the UK for a substantial number of years.

Important differences emerged among immigrant Chinese, suggesting that the meaning of being Chinese and being British may change with increased exposure to, and experience with, British culture. These differences may be related to the extent to which cultural orientation is internalised in one's self-concept (Baumeister, 1998).

Alternative medicine deserves more attention in the biomedical-oriented health care

system, while some Western health professionals may view this as an intrusion of traditional medicine in Western health care systems. Incorporation of alternative medicine into these systems should be viewed as complementary rather than competitive (Ma, 1999).

With demands for alternative approaches to healthcare now becoming increasingly commonplace in the UK, traditional health professions should receive equal recognition and acceptance at least in the communities where there are demonstrable demands for these approaches. For example, regulating traditional practitioners such as acupuncturists, as an independent profession will benefit both health professionals and consumers and protect patients against medical 'cowboys'. Professional licensure enables alternative practitioners to improve their current status and gives them the opportunity to negotiate their professional boundaries with other health professionals in a pluralistic health system (Ma, 1999).

This study raised an important issue in the source of health care for British Chinese communities – TCM. For some respondents it was the sole source of health care, to others it was used to complement or integrate with Western medicine. It is thus vital to consider patterns of utilisation of TCM and Western medicine rather than focus primarily on Western medicine. Many British Chinese individuals have a complex knowledge of illnesses and home remedies because they have been exposed to a uniquely modern orientation towards health care that integrates TCM and Western medicine. In order to improve the quality of health care for Chinese communities in the UK it is important to sensitise health providers to TCM, because of their accessibility to British Chinese communities TCM practitioners are a valuable and important resource.

The results of this research indicate that British Chinese communities are not making full use of health services, reasons for this include language difficulties, Chinese cultural beliefs and Chinese health beliefs as well as a lack of awareness of available services (Watt et al., 1993). In order for British Chinese to overcome barriers they face accessing health care services, health providers need to have an accurate understanding of the

health beliefs of the British Chinese in addition to an up-to-date knowledge of the social and cultural factors influencing their behaviour.

Both educational levels and in particular ability to speak English, are associated with absorption and adoption of aspects of UK culture. Elderly Chinese most notably appear to have remained relatively insulated from the prevailing culture and retained their cultural beliefs and value systems, together with the cultural preference for self-help and self-sufficiency these beliefs remain a significant barrier to access of health services for British Chinese (Kwan & Holmes, 1999).

The results of the current study emphasise the role of culture as a major underlying influence on the choice of medical care and especially for seeking traditional health care, furthermore, they point to the individual differences in cultural orientation (Quah & Bishop, 1996).

Added to language barriers, cultural incongruence between patient and health provider may discourage patient from seeking consultations for medication use. Some individuals may become bicultural or acculturated whereas others may keep their own tradition and cultural practices. More recent immigrants may hold strong cultural beliefs and therefore practice medication according to such beliefs (Zhan & Chen, 2004). Two major factors language difficulties and cultural barriers were related to poor medication practices.

A limitation of the study was that the sample of respondents used may not be considered entirely representative of all members of the British Chinese community. It has been argued previously that people who attend Chinese community and health centres, from which the majority of respondents were recruited, may be biased towards those who have the strongest self-identification as Chinese (Li et al., 1999).

Another limitation of the study was that the focus groups were conducted in English and not Chinese. The decision to conduct the focus groups in English and not in Chinese was a very difficult decision for the researcher to make. However, one of the problems was

that the researcher (who could not communicate fluently in Chinese) did not want any information to be lost in the translational process of the focus group transcripts. As this could not be guaranteed, the researcher felt it would perhaps be more effective to conduct the focus groups personally rather than rely on other people to conduct the interviews, transcribe and translate all the interview data. Although this then meant that the researcher was excluding potential focus group candidates on the grounds that they could not speak English, this was felt to be the most feasible and effective way of gathering the data.

Health behaviour is the result of many complex interactions effective communication with British Chinese communities is not just a matter of language; effective health education and promotion can only be achieved by a knowledge of cultural patterns and health behaviours (Fong & Watt, 1994). Although language difficulties have been identified as a major problem other barriers include poor knowledge of health service provision and lack of Chinese-speaking health worker, the relatively scattered settlement pattern of British Chinese may also cause problems (Smaje & Le Grand, 1997).

Further research into British Chinese health behaviours may enhance health providers' understanding of the health behaviours of British Chinese individuals.

Table 8: Comparison of findings from studies one and two:

STUDY ONE	STUDY TWO
<ul style="list-style-type: none"> • Health info obtained from Chinese health and community centres. • 2 greatest influencing factors: cost of treatment and effectiveness of medicine to clear illness. • Convenience also another important influencing factor. • TCM viewed as expensive in UK. WM viewed as cheaper than TCM in UK. • WM/TCM utilisation based on type of illness individual suffering from. • TCM used more often for chronic diseases, WM used more for acute illnesses. • Bad practising TCM doctors reflect badly on UK TCM practice. Lack of confidence in UK TCM due to bad practitioners. • Higher expectation of WM and lower expectation of TCM in relation to strength and speed of medicine to get rid of symptoms. • Widespread regular use of WM. Only small number exclusively using TCM. • Concurrent use of TCM and WM widespread amongst British Chinese. Many use TCM when WM fails to work, or use TCM once finished taking WM, to restore balance to body. • TCM good for well-being, maintains health and wellness. Works to root of disease, not just symptoms. • Overuse of WM not good. Too many chemicals in WM, believed to weaken immune system over time. Cannot cure root of problem, only symptoms. • WM fast acting with fast recovery speed. TCM slow to see the results. WM lack of holistic properties. • Cultural beliefs influence health-seeking behaviours. • Difficult to find good, reputable TCM practitioner in UK. TCM herbal remedies expensive in UK. 	<ul style="list-style-type: none"> • UK Chinese viewed as quite isolated resulting from wide dispersal of community across UK. • UK Chinese community viewed as quiet, not making a fuss, leading to voices not being heard, labelled as ‘unheard’ or ‘invisible’ community. • Acknowledged language barrier for older generation and new immigrants. • The more educated one is, the easier it will be to integrate into society. • Younger generation viewed as being more integrated into British society than the older generation. • Older generation and newer immigrants viewed as upholding Chinese traditions and a Chinese lifestyle. Seen to exclude themselves from Western services. • Identity dependent upon individual and how they choose to live their lives in the host country. • Family viewed as central part of a person’s identity. • More people prouder to be identified nowadays; compared to twenty years ago. More people now likely to return to their homeland due to the economic prosperity of China. • Some individuals choose to live like Westerners, others choose to identify more with the Chinese part of their identity. • Only considered ‘real’ Chinese, if lived in UK for less than 5 years. • Culture seen to play an important role in identity. British seen as doing ‘things differently’. • Colour and race continue to be seen to make a difference. • Theory of WM and TCM very different. TCM all to do with harmony and balance in life and body. • TCM viewed as good at prevention.

SECTION C: CHAPTER SEVEN - ABSTRACT

Low back pain affects a large proportion of people in the western world and despite its widespread availability and use the effectiveness of acupuncture for chronic pain remains in question. The aim of this systematic review is to determine the efficacy of acupuncture in the treatment of low back pain.

Only randomised controlled trials of acupuncture involving needling in the treatment of patients with low back pain were included in this review. Two reviewers independently assessed the methodological quality of the studies using a methodological quality criterion assessment recommended by the Cochrane Back Review Group. As a result of the data being statistically and clinically heterogeneous the analysis was split; a meta-analysis was performed on data that was not considered statistically heterogeneous while a qualitative analysis was also performed on all of the studies included in the review.

Twelve randomised controlled trials were included in the review with a total of 640 subjects randomised to either a placebo group or an experimental group. On the whole, the methodological quality of the randomised controlled trials was reasonable; five studies met the pre-set quality threshold for this review.

The results reveal that there was no evidence showing acupuncture to be more effective than no treatment. There was moderate evidence suggesting that acupuncture is not more effective than trigger point injection or transcutaneous electrical nerve stimulation; there was limited evidence indicating that acupuncture was not more effective than placebo or sham acupuncture for the management of chronic low back pain, there was also no evidence indicating acupuncture to be more effective than physiotherapy and limited evidence indicating acupuncture to be superior to standard therapy.

Because this systematic review failed to clearly indicate whether or not acupuncture is effective in the management of low back pain, the author would not recommend acupuncture as a reliable source of treatment for low back pain.

CHAPTER EIGHT - INTRODUCTION

Chronic low back pain is one of the commonest causes of long-term disability in middle age across the globe. Recent surveys in the UK suggest that low back pain is the largest single cause of work absenteeism and is responsible for around 119 million days of sick leave each year (BackCare, 2004). Chronic low back pain is resistant to treatment and patients are often referred for multidisciplinary treatment (Fishbain et al., 1995). Despite greater knowledge expertise and health care resources for spinal pathologies, chronic disability resulting from non-specific low back pain continues to rapidly rise (BackCare, 2004).

There is no historical evidence demonstrating that low back pain is any different, any more common, or any more severe than it always has been (Allan & Waddell, 1989). The only annual population survey that has consistently used the same questions and methodological approach over time (Leino et al., 1994) has shown no change in the prevalence of low back pain during the past 20 years. However, this is the period in which chronic low back pain has dramatically increased.

Back pain is one of the most popular reasons for turning to complementary and alternative medical therapies (Ernst, 2000) it is also one of the most common indications for referral to acupuncturists (Wadlow & Peringer, 1996). There does, however, seem to be a lack of evidence supporting acupuncture as an effective treatment for chronic back pain.

Originating in the Far East around 2000 years ago, in its original form acupuncture is based on the principles of traditional Chinese medicine (TCM). Acupuncture is the best-known technique of TCM and is one of the oldest forms of therapy, it can be used for many conditions and is thought to be especially well suited to the treatment of pain both acute and chronic.

Traditional Chinese medicine is based on a number of philosophical beliefs traditional acupuncture theory is based on the Daoist concept of yin and yang, any manifestation of disease is believed to be a sign of imbalance between the yin and yang forces in the body. The workings of the body are believed to be controlled by qi, a life force energy that circulates between the organs along channels called meridians. Qi energy must flow smoothly through the meridians and organs to maintain good health acupuncture points are located along meridians and provide a way of altering the flow of qi (Vickers & Zollman, 1999).

There are 361 traditional acupuncture points located on the meridians, correct choice in needling is believed to restore the balance of yin and yang in the body. When the needles have been placed correctly and successfully, the patient is supposed to experience a sensation of *te chi*, a subjective feeling of numbness, fullness, tingling, and warmth with a little soreness and sensitivity around the acupuncture point. There is no agreement among acupuncturists regarding the necessity of reaching *te chi* for acupuncture to be effective. In addition to needling, acupuncture also includes techniques such as cupping and moxibustion (Vickers & Zollman, 1999).

Since acupuncture first infiltrated Western societies many centuries ago a variety of different styles have developed such as Japanese meridian therapy, involving mainly shallow needle insertion; French energetic acupuncture; Korean constitutional acupuncture and Lemington 5-element acupuncture. Although these are all similar to traditional acupuncture they each have distinct and different characteristics in recent decades, new forms of acupuncture have developed such as auricular (ear) acupuncture, scalp acupuncture, hand acupuncture, and foot acupuncture (Lao, 1996).

Acupuncture is divided into two categories the classical theory and its application and also modern acupuncture, which consists of a gradual extension of the ancient theories. Modern acupuncturists use traditional meridian acupuncture points in addition to non-meridian or extra-meridian points, which are fixed points not necessarily associated with

meridians. Acupuncturists also use trigger points that have no fixed locations and are found by eliciting tenderness at the site of most pain.

While few barriers to research complementary and alternative medicine exist in principle there are many in practice. Complementary and alternative medicine lacks both a research tradition and a research infrastructure (Ernst & White, 1997) the orthodox attitude remains highly sceptical. A recent telephone survey on the use of complementary and alternative medicine in the United Kingdom yielded a one-year prevalence of 20% (Ernst & White, 2000). The lack of thorough, high quality research in complementary medicine is considerable (Ernst, 1996) the reasons for this are diverse, however lack of funding due to scepticism could be an important contributing factor.

Despite scientific evidence documenting a biological basis of acupuncture analgesia and the increasing use of acupuncture by people suffering from pain, the effectiveness of acupuncture for the relief of chronic pain remains in question. Although many viable mechanisms exist to explain its analgesic actions (Han & Terenius, 1982), reviews of acupuncture as a treatment for painful conditions invariably conclude that the published data are insufficient to judge it as effective or ineffective (Ter Riet et al., 1990).

Despite many reviews having been published convincing evidence of pain relief, a consensus of opinion is still lacking (Ezzo et al., 2000; Smith et al., 2000; van Tulder et al., 1999; Ernst & White, 1998). Results from individual randomised controlled trials (RCTs) vary considerably from no effect to a significant improvement. Trials of acupuncture suffer problems of poor quality, which leads to bias; one review concluded that most studies of acupuncture to date were scientifically flawed and that the benefit of acupuncture in chronic pain continues to remain unproven (Ter Riet et al., 1990).

One review has focused specifically on the effectiveness of acupuncture for low back pain (van Tulder et al., 1999). However, this review was conducted quite a few years ago now, in which time more relevant research in this area may have developed. The current

review summarises the available scientific evidence on the effectiveness of acupuncture for both acute and chronic low back pain.

The objective of the systematic review is to determine whether or not acupuncture is an effective method of management for non-specific low back pain. The following comparisons are investigated:

1. Acupuncture compared with no treatment
 - a) Acupuncture in addition to baseline medication or treatment compared with baseline medication or treatment alone.
 - b) Acupuncture treatment only in comparison with a group not receiving any intervention.
2. Acupuncture compared with placebo or sham treatment
 - a) Acupuncture compared with needle attachment skin surface (placebo: needle that does not penetrate the skin).
 - b) Acupuncture compared with needling prick on skin surface (sham: needles placed in area close to but not in acupuncture points).
3. Acupuncture compared with conventional treatment
4. Acupuncture compared with physiotherapy
5. Acupuncture compared with standard therapy

CHAPTER NINE - METHODOLOGY

Study Inclusion Criteria:

Studies: Only randomised controlled trials (RCTs) were included in the review.

Participants: RCTs involving patients with non-specific low back pain (LBP) were included. RCTs including LBP patients caused by specific illnesses such as arthritis and self-inflicted injuries or diseases were excluded. Patients aged >18 years, with LBP > 3 months.

Interventions: Reviews assessing acupuncture treatment involving needle insertion to the skin were included in the review. Both methods of acupuncture were used in the review; traditional acupuncture where the needles are inserted at classical meridian points and contemporary acupuncture where needles are inserted at non-meridian/trigger points. Studies were included regardless of whether the source of stimulation was manual or electrical. Studies where the acupuncture treatment did not involve needling such as acupressure and laser acupuncture were not included. The control interventions were placebo acupuncture, physiotherapy, standard treatment, or no treatment.

Outcome measures: Randomised controlled trials were included if they used at least one of the following four primary outcome measures: pain intensity (VAS); a global measure (overall improvement, proportion of patients recovered, subjective improvement of symptoms); functional status (Roland Morris Disability Questionnaire, Oswestry Scale); and return to work (return to work status, number of days off work). Physiological outcomes of physical examination (eg. Range of motion, spinal flexion, muscle strength etc), generic health status (as assessed by the Medical Outcome Study Short Form – 36 [SF-36], Nottingham Health Profile, Sickness Impact Profile) and other symptoms such as medication use and side effects were considered secondary outcomes.

Exclusion criteria: Studies not reported in English were excluded. This was due to financial constraints. Patients aged <18 years were also excluded.

Search strategy: One reviewer (TLR) conducted the search for full, published reports of randomised controlled trials of traditional and non-traditional acupuncture treatment for low back pain. A number of different search strategies were used to identify relevant reports included in the review. Searches on electrical databases such as: Medline (up to Feb 2004); EMBASE (up to Feb 2004); CINAHL (up to Feb 2004); DARE (up to Feb 2004); PsychLit (up to Feb 2004); BMJ (up to Feb 2004); PubMed (Up To Feb 2004); and the Cochrane Library (up to Feb 2004). Hand searches were also carried out in relevant journals such as Pain.

A broad free text search restricted to the English language was undertaken using all variants of the following terms: acupuncture, complementary medicine, complementary therapy, alternative medicine, alternative therapy, Chinese medicine, traditional Chinese medicine, randomised control trials, chronic pain, back pain. Reference lists of retrieved papers and reviews were searched for additional reports. Authors were not contacted for original data.

Methods of the review

Study selection: One reviewer (TLR) generated the database search strategies then reviewed the information independently to identify trials to be potentially included in the review. Full articles describing the trials were obtained from the British Library and the reviewer independently applied the selection criteria to the studies. The reviewer was not blinded to the journal or authors.

Methodological quality assessment: The methodological quality of each RCT was assessed independently by one reviewer (TLR), the methodological quality of the RCTs was assessed according to the criteria list (recommended in the method guidelines of the Cochrane Back Review Group for systematic reviews). Each criteria was scored as “yes”, “no”, or “don’t know” (Please refer to Appendix 15 for full listed results).

Table 9: Methodological Quality Criterion List

Patient selection:			
a) Were the eligibility criteria specified?	Y	N	?
b) Treatment allocation			
i. Was the method of randomisation described and adequate?	Y	N	?
ii. Was the treatment allocation concealed?			
c) Were the groups similar at baseline regarding the most important prognostic indicators?	Y	N	?
Intervention:			
d) Were therapeutic and control interventions operationalised?	Y	N	?
e) Was the care provider blinded?	Y	N	?
f) Was controlled for co-interventions which could explain the results?	Y	N	?
g) Was the compliance rate (in each group) unlikely to cause bias?	Y	N	?
h) Was the patient blinded?	Y	N	?
Outcome Measurement:			
i) Was the outcome assessor blinded?	Y	N	?
j) Was at least one of the primary outcome measures applied?	Y	N	?
k) Was there a description of adverse effects?	Y	N	?
l) Was the withdrawal/drop-out rate unlikely to cause bias?	Y	N	?
m) Timing of follow-up measurements			
i. Was a short-term follow-up measurement performed?	Y	N	?
ii. Was a long-term follow-up measurement performed?	Y	N	?
n) Was the timing of the outcome assessment in all groups comparable?	Y	N	?
Statistics:			
o) Was the sample size for each group described?	Y	N	?
p) Did the analysis include an intention-to-treat analysis?	Y	N	?
q) Were the point estimates and measures of variability presented for the primary outcome measure?	Y	N	?

Data extraction: One reviewer (TLR) extracted the data on the primary outcome

measures (pain intensity, a global measure, functional status, and return to work) and secondary outcome measures (physical measures, generic health status, and other symptoms such as medication use and side effects). Data on the characteristics of the study population were extracted as follows: data, participants, duration of LBP, interventions, outcome measures and results.

A second reviewer (EE) was enlisted to independently apply the criteria list to each study in order to extract the relevant details, differences between the reviewers regarding data extraction were resolved by referring back to the original article and establishing consensus. The authors of the original studies were not contacted for more information with the exception of one study (Leibing et al., 2002), since many of the studies were published over ten years ago, the reviewer felt that it would not be appropriate to contact the authors. Unfortunately, despite contacting the authors of one study (Leibing et al., 2002), the reviewer was unsuccessful in receiving a reply for the request for additional data for the study.

Analysis: The studies included in the systematic review were clinically heterogeneous with respect to the type and duration of the disorder, the interventions and the outcomes. Furthermore, the outcomes were poorly presented in 4 of the 12 studies in such a way that pooling was not possible for these particular studies (MacDonald et al., 1983; Lehman et al., 1983; Lehman et al., 1986; Thomas & Lundberg, 1994; Leibing et al., 2002). Therefore a decision was made to conduct a meta-analysis on those studies where pooling was possible, in addition to this a qualitative review was performed on all studies included in the review. This was conducted by attributing various levels of evidence to the effectiveness of acupuncture taking into account the methodological quality and the outcome of the original studies. A meta-analysis was conducted on the eight studies (Edelist et al., 1976; Mendelson et al., 1978; Mendelson et al., 1983; Coan et al., 1980; Gunn et al., 1980; Garvey et al., 1989; Carlsson & Sjolund, 2001; Kerr et al., 2003; Meng et al., 2003) where the reviewer (TLR) deemed pooling possible.

With respect to the qualitative analysis an RCT was considered to be of higher quality if

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it had a validity score of 6, or above, out of a possible 10 on the internal validity items (BI, BII, C, E, F, G, H, I, L, N). Please refer to appendix 16 for further details.

CHAPTER TEN - RESULTS

Study Selection: Through literature searches on various databases such as Medline, EMBASE, BMJ, PubMed and hand searches in relevant journals such as ‘Pain’, a number of studies were identified as being potentially eligible. Thorough reviews of the full articles of the potentially eligible studies resulted in agreement between the reviewers of fourteen studies meeting the eligibility criteria. All studies excluded were done so for reasons such as acupuncture treatments not involving needling, no reporting of randomised controlled trials and studies not reported in English (Please see Table 10). A search of the Cochrane Complementary Medicine Field Database and the Cochrane Library identified no additional studies. In summary, a total of twelve randomised controlled trials on acupuncture for low back pain were identified that met the criteria for inclusion in this particular review.

Table 10: Studies excluded

Author and Date	Reasons for exclusion
Lopacz & Gralowski (1979)	Written in Polish language
Duplan et al. (1983)	Written in French
Von Mencke et al. (1988, 1989)	Written in German
Grant et al. (1999)	Uncontrolled
MacPherson et al. (1999)	Uncontrolled
Cherkin et al. (2001)	Uncontrolled
Molsberger et al. (2002)	History of LBP >6 weeks
Tsukayama et al. (2002)	History of LBP >2 weeks
Yeung et al. (2003)	Uncontrolled

Methodological Quality: Tables 11 – 14 display the scores on the methodological criteria list. The number of validity items with a positive score was relatively high. Five studies (Garvey et al., 1989; Carlsson & Sjolund, 2001; Leibing et al., 2002; Kerr et al., 2003; Meng et al., 2003) out of twelve met the pre-set high quality level requiring a score of 60% or greater. Some of the earlier studies lacked information on one or more validity items, in particular, information was lacking on items B₂, C, E, F, and I. This resulted in

it being unclear as to whether or not the treatment was concealed and also led to confusion as to whether the groups were similar at baseline.

Information was also lacking in some of the earlier studies on the descriptive and statistical items, specifically items K, M₂, and Q. This indicated that adverse effects were not described there was no long-term follow up measurement in addition to poorly presented results.

Table 11: Patient Selection

Reference	A	B ₁	B ₂	C
1)Edelist et al. (1976)	N	?	?	?
2) Mendelson et al. (1978, 1983)	Y	Y	Y	N
3)Coan et al. (1980)	Y	N	N	Y
4)Gunn et al. (1980)	Y	?	?	Y
5) Lehmann et al. (1983, 1986)	N	Y	?	?
6)MacDonald et al. (1983)	Y	?	?	?
7)Garvey et al. (1989)	Y	Y	?	?
8)Thomas & Lundberg (1994)	Y	?	?	Y
9)Carlsson & Sjolund (2001)	Y	Y	Y	Y
10)Leibing et al. (2002)	Y	Y	N	Y
11)Kerr et al. (2003)	Y	Y	Y	Y
12)Meng et al. (2003)	Y	Y	N	Y

Study Characteristics: The study details are presented in greater detail in table 16. There were three studies comparing acupuncture to no treatment (Coan et al., 1980; Gunn et al., 1980; Thomas & Lundberg, 1994). There were two studies comparing acupuncture to conventional treatment (Lehmann et al., 1983; Lehmann et al., 1986; Garvey et al., 1989). Eight studies compared acupuncture to a placebo or sham acupuncture treatment (Edelist et al., 1976; Mendelson et al., 1978; Mendelson et al., 1983; MacDonald et al., 1983; Lehmann et al., 1983; Lehmann et al., 1986; Garvey et al., 1989; Carlsson & Sjolund, 2001; Leibing et al., 2002; Kerr et al., 2003).

Five studies took place in a secondary care setting (Edelist et al., 1976; Gunn et al., 1980; Lehmann et al., 1983; Lehmann et al., 1986; MacDonald et al., 1983; Kerr et al., 2002). In three studies the setting was not specified (Coan et al., 1980; Garvey et al., 1989; Mendelson et al., 1978; Mendelson et al., 1983). Ten studies included patients with chronic low back pain (Coan et al., 1980; Gunn et al., 1980; Lehmann et al., 1983; Lehmann et al., 1986; MacDonald et al., 1983; Mendelson et al., 1978; Mendelson et al., 1983; Thomas & Lundberg, 1994; Carlsson & Sjolund, 2001; Leibing et al., 2002; Kerr et al., 2002; Meng et al., 2002). Two studies did not specify the duration of the reported conditions (Edelist et al., 1976; Garvey et al., 1989).

Five studies included a combination of low back pain patients with and without radiation (Gunn et al., 1980; Lehmann et al., 1983; Lehmann et al., 1986; MacDonald et al., 1983; Thomas & Lundberg, 1994; Carlsson & Sjolund, 2001). In four studies there was no indication as to whether patients with or without radiating symptoms were included (Edelist et al., 1976; Coan et al., 1980; Mendelson et al., 1978; Mendelson et al., 1983; Kerr et al., 2003). Only two studies reported on low back pain with or without radiation (Garvey et al., 1989; Leibing et al., 2002).

Sample sizes were unsatisfactorily small in most of the studies particularly the earlier studies, with sample sizes ranging from 17-131 subjects. Basic information on age and gender of the study population was severely lacking in five of the twelve studies (Edelist et al., 1976; MacDonald et al., 1983; Lehmann et al., 1983; Lehmann et al., 1986; Garvey et al., 1989; Thomas & Lundberg, 1994).

The acupuncture treatment varied widely in type and length; in only six of the studies was needle stimulation performed until 'teh chi' was reached (Edelist et al., 1976; Mendelson et al., 1978; Mendelson et al., 1983; Carlsson & Sjolund, 2001; Leibing et al., 2002; Kerr et al., 2003; Meng et al., 2003). A description of the training and experience of the acupuncturists was given in nine of the twelve studies (Mendelson et al., 1978; Mendelson et al., 1983; Coan et al., 1980; Lehmann et al., 1983; Lehmann et al., 1986; Thomas & Lundberg, 1994; Carlsson & Sjolund, 2001; Leibing et al., 2002; Kerr et al.,

2003; Meng et al., 2003).

Table 12: Intervention

Reference	D	E	F	G	H
1)Edelist et al. (1976)	Y	N	N	Y	Y
2) Mendelson et al. (1978, 1983)	N	N	N	N	N
3)Coan et al. (1980)	Y	N	N	Y	N
4)Gunn et al. (1980)	Y	N	N	Y	Y
5) Lehmann et al. (1983, 1986)	Y	N	N	Y	Y
6)MacDonald et al. (1983)	Y	N	Y	Y	N
7)Garvey et al. (1989)	Y	Y	N	Y	Y
8)Thomas & Lundberg (1994)	Y	N	N	Y	N
9)Carlsson & Sjolund (2001)	Y	Y	Y	Y	Y
10)Leibing et al. (2002)	Y	N	Y	Y	Y
11)Kerr et al. (2003)	Y	N	Y	Y	Y
12)Meng et al. (2003)	Y	N	Y	Y	N

Split analysis: The reviewer discovered that sub-group analyses could not be performed completely as no study clearly and effectively managed to successfully evaluate acute low back pain. In addition to this, many of the studies included either a mixed population of low back pain patients with and without radiation, or did not specify whether or not the subjects had radiating symptoms. In spite of this, there were enough similarities in the outcomes of some studies to the extent that a meta-analysis could be performed on a selected number of studies (please see table 15 for full details).

Table 13: Outcome Measurement

Reference	I	J	K	L	MI	MII	N
1)Edelist et al. (1976)	Y	Y	N	Y	Y	N	?
2) Mendelson et al. (1978, 1983)	N	Y	N	N	Y	Y	N
3)Coan et al. (1980)	N	Y	N	N	Y	Y	N
4)Gunn et al. (1980)	?	Y	N	Y	Y	N	?
5) Lehmann et al. (1983, 1986)	Y	Y	N	N	Y	N	Y
6)MacDonald et al. (1983)	N	Y	Y	N	Y	Y	Y
7)Garvey et al. (1989)	Y	Y	Y	Y	Y	N	Y
8)Thomas & Lundberg (1994)	?	Y	N	?	Y	Y	Y
9)Carlsson & Sjolund (2001)	Y	Y	Y	Y	Y	Y	Y
10)Leibing et al. (2002)	Y	Y	Y	Y	Y	Y	Y
11)Kerr et al. (2003)	Y	Y	Y	Y	Y	Y	Y
12)Meng et al. (2003)	N	Y	Y	Y	Y	N	Y

Acupuncture Versus No Treatment: Three studies were identified comparing the effects of acupuncture with no treatment (Edelist et al., 1976; Gunn et al., 1980; Thomas & Lundberg, 1994). In two of the studies the reference group was made up largely of patients on a waiting list (Edelist et al., 1976; Thomas & Lundberg, 1994), while in another study the additional value of acupuncture over a standard clinical regime was compared only with the standard clinical routine. All three studies were of low methodological quality and the conclusions of the reviewers were contradictory. This lead to conflicting evidence on the effectiveness of acupuncture compared with no treatment.

Acupuncture Versus Conventional Treatment: Two studies were identified comparing the effects of acupuncture with conventional treatment (Lehmann et al., 1983; Lehmann et al., 1986; Garvey et al., 1989). The Garvey study was of higher methodological quality while the Lehmann study was of lower methodological quality. The overall conclusion of the reviewers concerning each study was neutral indicating that there was moderate evidence demonstrating that acupuncture is not more effective than trigger point injections or TENS.

Table 14: Statistics

Reference	O	P	Q
1)Edelist et al. (1976)	Y	Y	N
2) Mendelson et al. (1978, 1983)	Y	N	N
3)Coan et al. (1980)	Y	Y	Y
4)Gunn et al. (1980)	Y	Y	N
5) Lehmann et al. (1983, 1986)	N	N	Y
6)MacDonald et al. (1983)	Y	Y	N
7)Garvey et al. (1989)	Y	Y	N
8)Thomas & Lundberg (1994)	N	Y	Y
9)Carlsson & Sjolund (2001)	Y	Y	Y
10)Leibing et al. (2002)	Y	Y	Y
11)Kerr et al. (2003)	Y	Y	Y
12)Meng et al. (2003)	Y	Y	Y

Acupuncture Versus Placebo or Sham Acupuncture: Eight studies were identified comparing acupuncture to placebo or sham acupuncture (Edelist et a., 1976; Mendelson et al., 1978; Mendelson et al., 1983; MecDonald et al., 1983; Lehmann et al., 1983; Lehmann et al., 1986; Garvey et al., 1989; Carlsson & Sjolund, 2001; Leibing et al., 2002; Kerr et al., 2003). Of these eight studies, four were considered to be of higher methodological quality (Garvey et al., 1989; Carlsson & Sjolund, 2001; Leibing et al., 2002; Kerr et al., 2003). The other four studies (Edelist et al., 1976; Mendelson et al., 1978; Mendelson et al., 1983; MacDonald et al., 1983; Lehmann et al., 1983; Lehmann et al., 1986) were considered to be of lower methodological quality. The reviewers' overall conclusion concerning the studies of Garvey, Leibing and Kerr was neutral, though it should be highlighted that the usefulness of the non-traditional acupuncture treatment used in the Garvey study is questionable; in only one study was both the author and reviewer conclusion in a positive agreement (Carlsson & Sjolund, 2001). The reviewers' overall conclusion concerning three of the four low quality studies was also neutral, while in one study the overall conclusion was unclear. Thus suggesting that acupuncture is in fact no more effective than placebo or sham acupuncture.

Acupuncture Versus Physiotherapy: One study was identified comparing acupuncture to physiotherapy (Leibing et al., 2002) this study was considered to be of high methodological quality. The authors' conclusion was that acupuncture was superior to physiotherapy however, the reviewers' overall conclusion was neutral the Leibing et al. study only mentioned the superiority of acupuncture at the end of treatment and failed to mention this for the nine-month follow-up.

Acupuncture Versus Standard Therapy: One study was identified comparing acupuncture to standard therapy (Meng et al., 2003), this study was considered to be of relatively high methodological quality. The reviewers' overall conclusion was positive acupuncture was shown to be superior to standard therapy however this was the only study comparing acupuncture to standard therapy.

Table 15: Meta-analysis of the number of patients in each group showing improvement in pain levels

Study	Experimental grp	Control grp
1)Edelist et al. (1976)	7/15 – 46.7%	6/15 – 40%
2) Mendelson et al. (1978, 1983)	44/77 – 57.1%	41/77 – 53.2%
3)Coan et al. (1980)	19/23 – 82.6%	5/16 – 31.3%
4)Gunn et al. (1980)	18/29 – 62.1%	4/27 – 14.8%
5) Lehmann et al. (1983, 1986)	No % score	Available
6)MacDonald et al. (1983)	No % score	Available
7)Garvey et al. (1989)	11/18 – 61.1%	4/10 – 14.8%
8)Thomas & Lundberg (1994)	No % score	Available
9)Carlsson & Sjolund (2001)	14/34 – 41.2%	2/16 – 12.5%
10)Leibing et al. (2002)	No % score	Available
11)Kerr et al. (2003)	21/23 – 91.3%	13/17 – 76.5%
12)Meng et al. (2003)	7/22 – 31.8%	1/23 – 0.04%
Total	141/241 – 58.5%	76/201 – 37.8%

A meta-analysis was performed on selected studies that demonstrated similarities in their reported outcomes. In eight (Edelist et al., 1976; Mendelson et al., 1978; Mendelson et

al., 1983; Coan et al., 1980; Gunn et al., 1980; Garvey et al., 1989; Carlsson & Sjolund, 2001; Kerr et al., 2003; Meng et al., 2003) of the twelve studies data was given on the number of patients showing improvement in their levels of pain in each of the control and experimental groups. From this the reviewer was able to calculate the crude percentage of patients in each of the control and experimental groups that demonstrated an improvement in their levels of pain.

As can be seen in table 15 above, the experimental (acupuncture) groups performed considerably better in terms of improvement in levels of pain, than the control (placebo) groups. This was true for all of the studies included in the analysis, the acupuncture group attained an overall improvement rate of 58.5% compared to a 37.8% overall improvement rate in the placebo group.

Table 16: Study Details

Study	Methods	Participants	Interventions	Outcomes	Notes
Edelist et al. (1976)	RCT; randomisation procedure not described.	30 patients. <u>Inclusion criteria:</u> no improvement after conventional therapy Inc. physiotherapy, analgesics. Patients felt to have disc disease.	<u>Acupuncture grp:</u> Manual insertion of 4 sterile needles into traditional acupuncture points until reaching 'teh chi', then 3-10Hz electroacupuncture for 30 mins. 3 treatments in max 2 wks. <u>Sham acupuncture grp:</u> 4 needles placed on non-classical acupuncture points, 'teh chi' not reached. Training and experience of acupuncturist unknown.	<u>Results:</u> No of patients improved post-treatment on global measure (subjective) and physical examination (objective): acupuncture 7 (47%), 6 (40%) vs. sham acupuncture 6 (40%), 5 (33%). Not significant.	<u>Author conclusion:</u> Neutral. <u>Reviewer conclusion:</u> Neutral. Small sample size and no description of patient randomisation.
Mendelson et al. (1978, 1983)	RCT; random number method	100 patients. <u>Inclusion criteria:</u> Chronic LBP, no compensation or litigation pending, no overt psychiatric disease.	<u>Acupuncture grp:</u> Traditional Chinese acupuncture, meridian, 8 needles, manual stimulation until 'teh chi' reached. 30 min sessions. Twice weekly for 4 wks. <u>Placebo acupuncture grp:</u> Intradermal injection of 2% lidocaine at non-acupuncture points, then acupuncture needles for 30mins without stimulation. Twice weekly for 4 wks. Acknowledged acupuncturist.	<u>Results:</u> Reduction in pain (VAS) score after 4 wks in acupuncture grp 40% vs placebo acupuncture grp 26%. Not significant. Crossover: Reduction in pain score now acupuncture 19%, placebo 40%. Significant. Overall mean % decrease in pain score 26.1 for acupuncture and 21.8 for placebo. Not significant.	<u>Author conclusion:</u> Neutral. <u>Reviewer conclusion:</u> Unclear. Many patients failed to complete treatment.

Study	Methods	Participants	Interventions	Outcomes	Notes
Coan et al. (1980)	RCT; randomisation method-box with 50 papers folded and labelled A&B. Box shaken and papers removed randomly.	50 patients recruited via public service announcement in newspapers. <u>Inclusion criteria:</u> LBP >6mths, no prior acupuncture treatment or history of diabetes, infection or cancer, not more than 2 back surgeries	<u>Acupuncture grp:</u> Following classical Oriental meridian theory. Electrical acupuncture in some patients. <u>Waiting list grp:</u> Waiting list controls, no treatment. Acknowledged acupuncturists.	<u>Results:</u> After 10wks in acupuncture and 15wks in waiting list grp: reduction in pain score (11 point scale), global improvement and ADL (4 point scale): acupuncture grp 51%, 83% and 19% vs waiting list grp 2%, 31% and 0%. Inadequate treatment in 11 of 50 patients treated with acupuncture.	<u>Author conclusion:</u> Positive. <u>Reviewer conclusion:</u> Unclear. Large drop out rates, different follow up times between the two grps.
Gunn et al. (1980)	RCT; randomised blocks defined by age and operation status; first from each block allocated to acupuncture grp.	56 patients. <u>Inclusion criteria:</u> males LBP. 12wks, who have had 8wks of standard clinical regime. Persistent disabling pain despite medical or surgical therapy. <u>Exclusion criteria:</u> Psychosomatic or psychological problems.	<u>Acupuncture grp:</u> Standard clinical routine (physiotherapy, remedial exercises, occupational therapy, industrial assessment) plus non-meridian acupuncture, muscle motor points, mechanical stimulation. 9V low electrical stimulation interrupted direct current. <u>Non-acupuncture group:</u> Standard clinical routine. No sessions varied, max 15 sessions, twice weekly. Training and experience of acupuncturists unknown.	<u>Results:</u> Global improvement (4 point scale); no patients with good or total improvement at discharge and after 12 wks in acupuncture grp 18, 17 vs 4, 4 in non-acupuncture grp. Significant. At final follow-up (12-61 wks) in acupuncture group 18 (62%) had returned to work and in non-acupuncture grp 4 (15%).	<u>Author conclusion:</u> Positive. <u>Reviewer conclusion:</u> Neutral.

Study	Methods	Participants	Interventions	Outcomes	Notes
MacDonald et al. (1983)	RCT; stratified random process to divide sexes as equally as possible between two groups.	17 patients referred from orthopaedic clinic. <u>Inclusion criteria:</u> Chronic LBP >1yr. No relief from conventional treatments.	<u>Acupuncture grp:</u> subcutaneous (4mm) 30 gauge needle insertion at trigger points, 5-20mins, max of 10 sessions in 10wks. Electroacupuncture if manual stimulation failed. <u>Placebo acupuncture grp:</u> Electrodes connected to dummy apparatus. Max 10 sessions in 10wks. Training and experience of acupuncturists unknown.	<u>Results:</u> Mean % reduction post-treatment in (VAS) pain score, (VAS) pain relief score, physical examination and (VAS) ADL; acupuncture grp 57%, 77%, 97% and 52% vs placebo acupuncture 23%, 30%, 29%, and 6%. Significant.	<u>Author conclusion:</u> Positive <u>Reviewer conclusion:</u> Neutral. Small sample size, no of sessions and follow-up times unknown.
Lehmann et al. (1983, 1986)	RCT; block randomisation, blocks defined by prior lumbar surgery	54 patients screened at orthopaedic clinic. <u>Inclusion criteria:</u> Chronic disabling LBP warranting expense of inpatient treatment. <u>Exclusion criteria:</u> Awaiting lumbar surgery, pain <3mths, pregnancy, osteomyelitis of spine, tumour etc.	<u>Acupuncture grp:</u> Electroacupuncture, biphasic wave 2-4Hz, meridian, Hoku points and additional points stimulated according to patient's pattern of pain. Twice weekly for 3wks. <u>TENS grp:</u> pulse width 250/sec at 60Hz. 15 sessions in 3wks sub-threshold intensity, points of stimulation over centre of pain, experienced physiotherapist. <u>Placebo TENS grp:</u> Same as TENS but dead battery. Acknowledged acupuncturists.	<u>Results:</u> Acupuncture significantly more relief of average pain post-treatment & after 6mths (36%, 43%) than both TENS and placebo TENS grps. No difference between TENS and placebo TENS grps. Return to work after 6mths 53% in acupuncture grp, 61% in TENS grp, and 44% in placebo TENS grp.	<u>Author conclusion:</u> Positive for pain, neutral for global measure and return to work. Overall conclusion positive. <u>Reviewer conclusion:</u> Neutral.

Study	Methods	Participants	Interventions	Outcomes	Notes
Garvey et al. (1989)	RCT; computer generated four tier list entry.	63 patients. <u>Inclusion criteria:</u> Non-radiating LBP, normal neurological examination, absence of tension signs, normal x-ray, persistent pain despite initial 4wk treatment. Able to localise point of max tenderness.	<u>Acupuncture grp:</u> Single dry needle stick with 21 gauge needle after isopropyl alcohol wipe. <u>Reference grps:</u> 1) Injection 1.5ml 1% lidocaine, 21 gauge needle after isopropyl alcohol wipe. 2) Injection 0.75ml 1% lidocaine and 0.75ml Aristospan using 1.5 inch, 21 gauge needle after isopropyl alcohol wipe. 3) 10-sec ethyl chloride spray, followed by 20 sec acupuncture using plastic needle guard after isopropyl alcohol wipe.	<u>Results:</u> Global improvement (improved or not improved): no. (%) patients improved after 2wks: acupuncture 11 (55%), lidocaine injection 4 (31%), lidocaine+steroid 5 (26%), acupuncture 8 (50%).	<u>Author conclusion:</u> Neutral. <u>Reviewer conclusion:</u> Neutral. Not traditional acupuncture.
Thomas & Lundberg (1994)	RCT; randomisation procedure not described.	43 patients from 2 clinics. <u>Inclusion criteria:</u> nociceptive LBP >6mths, restriction of trunk or hip movement due to pain, restriction of ADL, muscle spasm.	<u>Acupuncture grp:</u> Manual stimulation of needles, 2Hz and 80Hz electrical stimulation of needles. 3 paraspinal points & 3-4 distal points, rotation until 'teh chi' reached. 10, 30min sessions. <u>Waiting list grp:</u> Waiting list controls, no treatment. Acknowledged acupuncturists.	<u>Results:</u> Randomisation only for 3 modes of acupuncture vs waiting list grp. Improvement in pain (no of words from chart with 83 words describing pain intensity), global improvement (3 point scale) and functional status (VAS on 12 ADL) was in the acupuncture grp after 6wks2, 0.6, and 0.7. In waiting list grp -0.1, -0.1 and -0.8. After 6mths 2.1, 0.2, 1.0 vs -0.2, 0 and 0.3.	<u>Author conclusion:</u> Positive for pain on global measure and physical examination neutral for functional status. Overall conclusion positive. <u>Reviewer conclusion:</u> Neutral.

Study	Methods	Participants	Interventions	Outcomes	Notes
Carlsson & Sjolund (2001)	RCT; randomisation produced from computer-generated list.	50 patients <u>Inclusion criteria:</u> Lumbar or lumbosacral LBP >6mths. No radiation of pain below knee level. Normal neurological examination findings. <u>Exclusion criteria:</u> Major trauma or systemic disease, ongoing pregnancy and history of acupuncture treatment.	<u>Acupuncture grp:</u> Needle acupuncture given to points on lower back. Needles increased from 8 to 14-18 during first 3-4 sessions. 'the chi' sensation sought in all instances. One session per wk for 8wks. <u>Electroacupuncture grp:</u> 2-3 manual sessions given, followed by electrical stimulation sessions using 4 needles in lower back. 2Hz frequency interrupted by 15Hz. One session per wk for 8wks. <u>Placebo grp:</u> Mock TENS machine, electrodes attached to dummy apparatus.	<u>Results:</u> 1mth follow-up: 16 of 34 in acupuncture grps and 2 of 16 in placebo grp showed improvement. 6mth follow-up: 14 of 34 in acupuncture grps and 2 of 16 in placebo grp showed improvement. (acknowledged acupuncturists)	<u>Author conclusion:</u> Positive. <u>Reviewer conclusion:</u> Positive.
Leibing et al. (2002)	RCT; used a computer-based randomisation process.	131 outpatients from an orthopaedics dept. <u>Inclusion criteria:</u> Non-radiating LBP >6mths. <u>Exclusion criteria:</u> Abnormal neurological status, concomitant severe disease, psychiatric illness, current psychotherapy, pathological lumbosacral anterior-	<u>Acupuncture grp:</u> 20, 30min sessions of traditional and standardised acupuncture. 20 fixed body acupoints and 6 ear points were selected according to their TCM function. 'teh chi' sensation elicited. <u>Sham acupuncture grp:</u> 20, 30min sessions of minimal acupuncture. Needles inserted superficially. <u>Physiotherapy grp:</u> Patients received active physiotherapy and no other treatment.	<u>Results:</u> Acupuncture was superior to the physio grp regarding pain intensity (P=0.000), pain disability (P=0.000), and psychological stress (P=0.020). 9mth follow-up: Superiority of acupuncture compared to sham acupuncture became less distinct. Acupuncture was no different to sham acupuncture.	<u>Author conclusion:</u> Neutral. <u>Reviewer conclusion:</u> Neutral.

Study	Methods	Participants	Interventions	Outcomes	Notes
Leibing et al. (2002) continued		Posterior and lateral x-rays, rheumatic inflammatory disease.	Acknowledged acupuncturists		
Kerr et al. (2003)	RCT; patients randomised using computer-generated randomisation.	46 patients. <u>Inclusion criteria:</u> LBP >6mths, with or without leg pain and with no neurological deficits. <u>Exclusion criteria:</u> Pregnancy, underlying systemic disorders, and diagnoses of rheumatoid arthritis, osteoarthritis of the spine, or cancer.	<u>Acupuncture grp:</u> Set acupuncture points. 11 needles per patient per 30min session. Needles inserted until 'teh chi' sensation elicited. 6 sessions over 6wks. Patients also given a leaflet on 'healthy activities for looking after your back'. <u>Placebo TENS:</u> 6, 30min sessions over 6wks. Treatment administered using a non-functioning TENS machine attached to 4 electrodes placed over the lumbar spine. Acknowledged acupuncturists.	<u>Results:</u> SF36 scores in the placebo-TENS grp highly significant (P=0.004). 91% from acupuncture grp experienced pain relief said they experienced pain relief compared to 75% of the placebo-TENS grp. 43% of patients had between 1-6mths' pain relief following acupuncture compared with 33% of the placebo-TENS grp.	<u>Author conclusion:</u> Unclear. <u>Reviewer conclusion:</u> Unclear.

Study	Methods	Participants	Interventions	Outcomes	Notes
Meng et al. (2003)	RCT; computer generated random allocation sequence prepared	47 patients <u>Inclusion criteria:</u> Chronic LBP >12wks, >60 yrs, having imaging study of lumbar spine in past 12 mths.	<u>Acu Grp:</u> Standard therapy as directed by primary physician during 5wk intervention period plus 2 weekly acupuncture for 5wks. 10-14 needles used per session. 'the chi' sensation elicited. <u>Standard therapy grp:</u> Patients continued standard therapy as directed by primary physician during 5wks. <u>Cross-over grp:</u> Patients randomised to physio grp were offered the opportunity, at completion of their time in physio grp, to cross-over and receive acupuncture. Acknowledged acupuncturists	<u>Results:</u> Significant decrease of RDQ scores in acupuncture grp compared with physio grp (p=0.001). This effect was maintained for up to 4 wks after treatment. Mean global transition score was higher in acupuncture grp suggesting greater improvement.	<u>Author conclusion:</u> Positive <u>Reviewer conclusion:</u> Positive

CHAPTER ELEVEN - DISCUSSION

Twelve RCTs were included in this systematic review on the whole the number of validity items (used to assess methodological quality) with a positive score was reasonable. Five studies managed to reach the pre-set high quality standards requiring a score of 60% or greater (Garvey et al., 1989; Carlsson & Sjolund, 2001; Leibing et al., 2002; Meng et al., 2003).

According to the results and in line with findings from other acupuncture reviews (Ter Riet et al., 1990; van Tulder et al., 1999) there was no evidence demonstrating that acupuncture was more effective than no treatment. There was limited evidence showing acupuncture to be superior to standard therapy or physiotherapy, there was moderate evidence demonstrating that acupuncture is no more effective than trigger point injection or TENS and there was limited evidence illustrating that acupuncture is not more effective than placebo or sham acupuncture for the management of chronic low back pain.

Selection Bias: Despite every effort being made to discover all published RCTs some relevant trials could have been missed. All twelve of the included RCTs were published in the English language empirical evidence has suggested that exclusion of trials published in non-English languages could be associated with bias (Moher et al., 1996). However the actual number of studies published in languages other than English, that are currently listed in electronic databases such as MEDLINE and EMBASE is limited. Due to time and financial constraints the current review only contains studies published in the English language.

Blinding: Although there is some empirical evidence supporting the use of blinded assessment in the methodological quality of RCTs (with regards to authors, journal and institution) to prevent bias amongst reviewers, there is also evidence demonstrating that blinding has no effect on results (Berlin et al., 1997). True blinding would be rather difficult to achieve as a result of the reviewers becoming too deeply involved in the reviewing process (van Tulder et al., 1999). As a result of this both the selection and reviewing process in the current review were carried out non-blinded by the reviewers.

Methodological Quality: The methodological quality of the RCTs included in the current review was of mixed quality. Many of the earlier studies were of particularly low quality (Edelist et al., 1976; Coan et al., 1980; Gunn et al., 1980; MacDonald et al., 1983; Lehmann et al., 1983; Lehmann et al., 1986; Thomas & Lundberg, 1994), while studies included that were conducted within the last five years (Carlsson & Sjolund, 2001; Leibing et al., 2002; Kerr et al., 2003; Meng et al., 2003) were of much higher methodological quality. The methodological quality of this review was defined by the internal validity criteria referring to characteristics of the study that could be affected by selection, performance, and attrition and detection bias. Studies with lower methodological quality are expected to have biased findings (van Tulder et al., 1999). Although the split analysis used in this review may not have been ideal it seems unlikely that alternative forms of analysis would have resulted in different conclusions. There is no strong evidence in favour of acupuncture although many randomised controlled trials of TCM have been published, most contain small sample sizes and are methodologically weak (Tang et al., 1999).

Split analysis: Since the reviewers found the studies included in the review to be particularly clinically diverse a split analysis was conducted. There was much diversity in the type, location and duration of the low back pain conditions, the acupuncture interventions and the outcomes measured. In addition to this, the outcomes were poorly presented in many studies to such an extent that pooling was only possible in a select number of studies. A meta-analysis was conducted in the studies where pooling was possible, qualitative analysis was conducted on all of the studies included in the review. The levels of evidence used in the review were subjective because there is still no consensus on how to assess the strength of the evidence (van Tulder et al., 1999).

Validity of Treatment: The training and expertise of the acupuncturists used to administer the acupuncture treatments was mentioned in nine of the studies. Compared to the original review, a number of studies managed to inform the reader about the expertise of the practitioner in terms of years of practice whether they were qualified etc. However, in the majority of studies authors failed to specify the number of needles, number and duration of sessions and the duration of the intervention

period. Selected studies reported that the acupuncture points, number of sessions and duration of treatment were dependent and changeable according to the patient's pain pattern.

The inadequate description of acupuncture treatment included in most of the studies makes it rather difficult to evaluate whether the acupuncture treatment is indeed valid or not. Additionally, the validity of the acupuncture treatment may be associated with its safety in addition to its effectiveness.

Serious adverse effects such as infections have been known to occur with acupuncture caused by non-sterile needles or other complications. However, although the incidence of adverse effects is unknown (Ernst & White, 1997) a recent consensus report stated that one advantage of acupuncture is that the incidence of adverse effects is lower than that of many other accepted medical interventions.

Summary: The effectiveness of acupuncture for the treatment of low back pain remains in question. The results of this current systematic review confirm that there continues to be insufficient clinical evidence demonstrating that acupuncture is both useful and effective in the management of acute and chronic low back pain. However, given that the earlier studies used in this particular review were of poorer quality than more recent studies included, which were of higher methodological quality, it is hoped that sometime in the near future a clearer consensus on the effectiveness of acupuncture for chronic low back pain will be achieved.

- **Conclusions:**

Implications for Practice: This systematic review failed to clearly demonstrate that acupuncture is an effective intervention in the management of low back pain. The effectiveness of acupuncture for the treatment of low back pain remains in question there is no clear rigorous evidence to support its use as a regular treatment for LBP. Therefore acupuncture, as a regular treatment for patients with chronic low back pain, cannot be recommended.

Implications for Research: Future studies need to be more thorough in overcoming

the limitations of the RCTs presented in the current review, future studies also need to have larger sample sizes RCTs presented in the current review contained mostly unsatisfactorily low sample sizes. Prospective RCTs using consistent and appropriate high quality methodology and experienced practitioners (where valid acupuncture treatments are used) are clearly needed in order to make an evidence-based judgement on the effectiveness of acupuncture as an intervention for LBP.

CHAPTER TWELVE - REFLECTIVE ANALYSIS

This case study reports the findings of a piece of consultancy undertaken for the head office of a Chinese Health Centre in Central London's Chinatown, between October 2004 and February 2005. It is the design of an evaluation measuring outcomes of the Chinese National Healthy Living Centre's Traditional Chinese Medicine Sunday Surgery Clinic.

An opportune contact with the Chinese National Healthy Living Centre (CNHLC) emphasised the importance of the role of networking in being offered consultancy. I had been loosely involved with CNHLC since mid 2000, when I approached the centre about the possibility of becoming more involved with the Chinese community by becoming a voluntary worker at their centre. In mid 2004, the director of CNHLC contacted me; my contact was someone I had previously worked with as a result of my voluntary work and also my research with the British Chinese community. My contact informed me that the CNHLC head office were interested in approaching me as a consultant to become involved in an evaluation of the Centre's Traditional Chinese Medicine Sunday Surgery Clinic.

The Chinese National Healthy Living Centre is a registered charity and is funded through a series of grants. CNHLC was founded in 1987, to promote healthy living and provide access to health services for the UK Chinese community. CNHLC's Sunday Surgery provides traditional Chinese herbal medicine in its drop-in clinic as well as acupuncture treatments. The Centre's main funders provided the capital for the TCM Sunday Surgery Clinic, this funding was due to expire in 2005, and it was therefore necessary for CNHLC to write a report for their funders on the progress of the TCM service.

My contact explained that CNHLC had decided to approach me as a result of my prior involvement and experience with the centre whilst conducting my research on 'Health-Seeking Behaviours and Use of Traditional Chinese Medicine Among the British Chinese'. It was felt that I would be a suitable candidate to become involved with the evaluation as I had worked quite closely with the centre over the past few

years whilst conducting my research and also in my role as a voluntary worker. CNHLC felt that I had the relevant skills and knowledge necessary for the job in hand in addition to a sound understanding of CNHLC itself, its history, its staff and the way the centre was run on a day-to-day basis. I was invited to submit a proposal (please see appendix 17) detailing my ideas and plans for the evaluation.

Prior to submitting my proposal for the evaluation I arranged an informal meeting with the director of CNHLC. I felt that it was important for me to gain more of an understanding about what my role as consultant would involve and what would be expected of me. I needed to know what undertaking the work would mean to me in terms of what effect it would have on my regular workload bearing in mind that I was already studying in addition to being in full-time employment.

It was in this particular meeting that I learnt more about what CNHLC wanted to gain from the evaluation; what CNHLC wanted to find out, what was the purpose of the evaluation. Before I attended the meeting I prepared some notes with some questions I wanted to find the answers to. I used the meeting as an opportunity to find out as much as I could about what was expected of me in addition to what I could expect from CNHLC in return. I was informed that CNHLC would like me to become involved in the design and implementation of an evaluation of their TCM Sunday Surgery Clinic.

I requested and was provided with information regarding the centre's Sunday Surgery Clinic. In this meeting I was also introduced to the centre's evaluation officer who would be overseeing all the work I would undertake, if I were to be the successful candidate. At the end of this informal meeting we arranged another meeting at a mutually convenient time for myself and both the director and the evaluation officer, for a fortnight's time.

I went away and thought about what had been discussed in the meeting; what would be expected of me, what skills and knowledge I felt I would be able to provide in terms of my role as consultant in addition to how much time I felt I would realistically be able to dedicate to the project. I took the time to assess the skills I felt I had as a professional for the job I was being asked to become involved with and my other

commitments to my studies and my employment, I started to make a broad plan of how I would go about the design of the evaluation, if I were to be the successful candidate, how much time my role in the evaluation would involve, whether I thought it was feasible for me to complete the work along with the other commitments I was currently undertaking at the time.

In the weeks preceding my next meeting with CNHLC, while I was planning the work and negotiating the contract inside my own head, I made the difficult decision to risk losing the offer of consultancy made by CNHLC. I determined that due to my other work and educational commitments it would not be possible for me to complete the evaluation in full, as CNHLC had preferred. I really wanted to become involved in the project however, I was also aware of the fact that I didn't want to bite off more than I could chew when I already had a heavy workload. I felt that it was important for me to be able to successfully conduct the work I was being invited to become involved in, I therefore didn't want to promise to carry out work that I did not think I would realistically be able to successfully deliver. It was important to me that I was both open and honest with my potential clients.

I weighed up the possibilities, the pros and cons of being a part of the evaluation and my potential involvement in the project. It simply was not feasible for me to undertake the whole evaluation I just did not have the time spare when considering my normal workload. I decided to stick firm with my original decision if acceptable with CNHLC, I would like to become involved with the planning and design of the evaluation. I made the decision to be involved in the evaluation free of charge as a good will gesture and a show of appreciation for all the help and support I had received from the centre over recent times in relation to conducting my research on the Chinese community. I also felt that my involvement free of charge in the project might go some way to help soften the blow of my not being able to become fully involved in evaluation.

Before the next arranged meeting with my clients I composed a proposal for the consultancy to bring along with me to the meeting. I began to brainstorm exactly what it was CNHLC were aiming to find out I started with the organisational context of the centre as a whole, the aims of the TCM Sunday surgery and then on to the aims

of the evaluation I referred to information my clients had initially provided me with regarding the TCM clinic to help me with my initial plan I also referred to notes I had made myself while attending the Sunday TCM clinic. In my proposal I detailed what I felt would be the most appropriate and effective forms of evaluation for CNHLC and its service users, I made a draft plan of action regarding the methodology of the evaluation. I used the initial brainstorming session as the start of my evaluation proposal plan and worked on the ideas I had to further develop the proposal.

I examined the types of evaluation method I felt would be most appropriate to use and looked at what sort of methods had been used in past evaluations conducted at the centre. I was aware that there was a pressure for time for the evaluation as I had been informed in my previous meeting with my clients that they would need the data to write their report by mid 2005. I was considering using semi-structured interviews as a data collection technique for the evaluation but I was beginning to have second thoughts about this method of data collection. There was no budget available for the evaluation and I was mindful of the fact that if I was potentially only going to be available for the planning and design of the evaluation, there would be no one available to conduct the interviews or the analysis. Conducting interviews and then qualitatively analysing the data would also be more time consuming than the alternative data collection technique of questionnaires and quantitative analysis.

A quantitative questionnaire would be an effective means of data collection. I felt it would be able to gather all the information necessary for CNHLC to write their report, I was also aware of the potential problems I may encounter along the way in the evaluation design as a result of my limited ability with the Chinese language. I believed that by designing a questionnaire, this would also be less time consuming to analyse, design and conduct compared to interviews. There would also be less language issues involved in the design and implementation of a questionnaire in contrast to interviews where there were likely to be more language-related issues. In addition to this, less manpower would be necessary to conduct the evaluation if I were to design a questionnaire, this was an important factor when making the decision to use questionnaires. I had previous experience of designing questionnaires in the past and so had some confidence in the area I set to work on starting to design a potential questionnaire for the evaluation.

In the next meeting arranged with my potential clients, I submitted my draft proposal with a loose timeframe attached. The director, evaluation officer and myself all attended the meeting, the same attendees present at the previous meeting. I prepared three copies of my proposal: one copy for myself, one for the director, and a copy for the evaluation officer.

In my proposal I identified what I believed to be the aims of the TCM Sunday Surgery. I also identified the aims of the evaluation. In the proposal I loosely detailed the methodology I intended to use in practice for the evaluation practical issues of the work and my involvement. I stated what I saw as my role as consultant in the evaluation. I tried to make it clear what my role would involve to prevent any misunderstandings further down the line, were I to be the successful candidate. Finally, I detailed my projected estimations of the timing involved in the evaluation design and lastly I confirmed the lack of cost for my involvement and also the lack of budget.

In the meeting I explained to the director and evaluation officer that despite wanting very much to become involved with the evaluation and being flattered to be invited to work on the project, it simply would not be feasible for me to be involved in the evaluation as much as CNHLC would like me to be. I explained that this was due to other employment and educational commitments and suggested that if CNHLC would still like me to become involved in the evaluation, I could be involved in the design of the evaluation (an area that I knew I would be able to fulfil without impinging too much on my other commitments to my work and studies). I then suggested that I could be available after this purely on a practical level for advice, emphasising that my work and educational commitments prevented me from being of further assistance to the project.

In the proposal I submitted to CNHLC I suggested that throughout my work on the evaluation I could work at CNHLC one day per week. CNHLC's evaluation officer was to oversee all the work that I was to carry out for the evaluation so I suggested that all other contact between the evaluation officer and myself could be made via email or telephone if necessary. I established a loosely projected timeframe detailing

when I expected (approximately) to complete the various stages of the evaluation. It was important for me that my potential clients were to have a good idea of how I intended to conduct the evaluation I felt that they would then be in a clearer mind to decide whether my proposal was to their liking and whether I had designed the evaluation to be carried out in the way CNHLC would like the consultancy to be conducted.

I also made it clear to my clients once again that I would be working free of charge on the project and that I would only be able to be fully involved in the project as far as designing the evaluation was concerned. In order for CNHLC to have a clearer picture of work I was willing to undertake and my designs for the evaluation I had drafted a loose time frame (please see appendix 18) that could be altered if firmer plans were to be made I attached this timeframe to the proposal and distributed it before the start of the meeting.

I had agreed to become involved in the consultation free of charge as a result of all the invaluable help and support I had received from CNHLC over the past few years in relation to conducting my empirical research. I felt that it would be a nice gesture of goodwill and show of gratitude to a charity-run organisation with limited funds that had provided me with invaluable help and support throughout the time when I was conducting my own research.

I felt it was important not to over-commit myself as I was fully aware of my other pressures and commitments with my full time job as a research officer in a London hospital, a job in which I was being paid. I had to remember that I was becoming involved in the CNHLC evaluation as a gesture of goodwill whereas I had other more permanent commitments to my full-time employment. In the meeting I attempted to explain to CNHLC that as much as I wanted to become as involved as I could in the work I was being offered, I also had to be realistic about the amount of spare time I had free to be involved in the consultation without jeopardising any of the other commitments I had to my employment and my studies.

I felt that it was really important to be realistic about the amount of work I was able to take on, I didn't want to promise to do more than I was able to or to find myself

struggling to balance an extra large workload. At least if I agreed a realistic workload I knew I would be guaranteed to complete the work successfully and not let anybody down, I was conscious of the fact that as I was new in the field of consultancy I was eager to please and did not want to disappoint in my work and find that no one would ask for my skills again I wanted to make the right impression and also more importantly, to ensure that I was able to complete the work successfully and complete it to my highest standards.

Despite my resolve, I found it an equally difficult decision to make to attempt to negotiate the contract I had been offered by my potential clients, remembering that this was my first foray into the field of consultancy and had no prior experience to guide me. Nevertheless, though I did not have any previous experience of being offered or conducting consultancy, I did have the experience of a working relationship with CNHLC and felt that this could work to my advantage. I believe that this established relationship with my client gave me the extra confidence to attempt to negotiate the contract for myself it gave me an extra sense of assurance in that I had some sort of idea of how my clients would react to the proposal. Our relationship was not completely new and so I knew a little of what to expect.

Later the next week I was delighted to be informed by the director that CNHLC would be happy for me to play the limited role I agreed that I was able to commit to the evaluation of the TCM Sunday Surgery project. One of the first things I did when discovering that my proposal had been successful was to draft out a new timetable for myself encompassing all my work and educational commitments and the timeframe available to each of my pieces of work. I felt it was essential to establish a timetable for myself so that I was aware of how much time I would have available to spend on each piece of work.

Before I properly started to prepare my work on the project in earnest it was important for me to identify and clarify who my clients were. I identified CNHLC's evaluation officer as my primary client and the director of CNHLC as my contact and also my sponsor CNHLC as an organisation, I identified as the ultimate client. One of the advantages I had in agreeing to become involved in the project was that I had worked with my clients previously. I already had an idea of the way in which the organisation

was run, I had established relationships with staff at the centre and thus I had an idea of what to expect from the organisation and my clients. I believe that this helped to make my first experience in my role as a consultant perhaps a little less daunting.

Once informed by my clients that my proposal had been successful I immediately began working on firmer plans for the design of the evaluation and the kind of approach I felt would be more effective for the evaluation. I attended CNHLC once a week as agreed in my proposal and initially began to get myself more involved in the project by reading up the information provided to me by my clients and trying to discover more about the history behind the TCM clinic; what the clinic consisted of, how long the clinic had been running and other such details.

One factor I was aware of early on in the design of the evaluation before I submitted my proposal were issues surrounding my inability to read or write Chinese. I knew that this issue obviously wasn't a problem for my clients as they were aware of my inability to read and write Chinese, and yet they still wished for my involvement in the project. I recognised that for me to become effectively involved in the project I would have to find a reliable and sustainable way around this language problem.

I attended the TCM Sunday clinic over the first few weeks of the consultancy in order to gain more awareness of the services available and provided for at the clinic and the running of the clinic, its popularity, a profile of its service users etc. I set about examining the different types of evaluation that had been conducted in the past at the centre and how these evaluations had been carried out I made an effort to try to stand back and take a look at myself and the relevant skills I felt I possessed for the job in hand I also looked at the issues involved in the designing of the evaluation with my lack of Chinese language skills and how I could potentially overcome these issues.

I identified two methods of evaluation for measuring outcomes that I felt would be effective and appropriate for the clinic and its users; interviews with service users and/or questionnaires distributed to clinic users. I was aware that CNHLC did not have much manpower with respect to staff that could become involved in the project. It had been clear to me from the start that no budget was available for the project I

was also aware that I was the only person involved in the design and planning of the work, the only other person involved in the evaluation was the evaluation officer.

After attending the TCM clinic a number of times to gain a profile of the clinic and its service users I discovered that most of the clinic users were ethnic Chinese and many had limited ability to speak English. The lack of manpower and budget would potentially make conducting interviews both complex and long-winded and also rather costly, particularly if a bilingual (Chinese & English) person would be needed to conduct the interviews, transcribe the interviews and then someone to analyse all the data. After much discussion with the director and evaluation officer, it was agreed that as a result of time constraints and lack of staff to work on the project a questionnaire would be both a feasible and effective way of gaining the information necessary to write a report.

After consulting with the director and evaluation officer over issues of language I was reassured that my clients would be able to organise the translation of the designed questionnaire into the appropriate language by a voluntary worker at the centre. This was a great relief to me as it meant that I did not have the arduous task of trying to find a translator, it also meant that I knew I could rely on the translation being of a high standard as I knew my clients would oversee the translation and ensure a member of staff would proof-read the questionnaire and look for any mistakes in the translated text.

All these factors worked in my favour as this meant that by using a voluntary worker and also getting a voluntary worker to translate the document, no costs would be entailed. I was also aware that the evaluation officer had the skills to analyse the questionnaire data, in my absence and this ensured that I was successfully maintaining the evaluation whilst incurring no costs, importantly managing to keep to the 'no budget' agreement of the consultation.

I set to work immediately on the design of a questionnaire. Between October and December 2004, I designed both a pre and post consultation questionnaire (please see appendix) for CNHLC to distribute to its TCM clinic service users. In all the time

that I was working on the design of the evaluation I was in regular contact with my clients. I attended the centre once a week as agreed in the proposal I had submitted.

It seemed to me that throughout my involvement with the consultancy, my clients seemed to be comfortable with me taking the lead in the evaluation there were only a few occasions when amendments and changes were suggested to my work.

There was one occasion in the consultation process when a suggestion was made by my clients, related to the design of the evaluation this was when the evaluation officer discussed with me the possibility of designing two questionnaires. The first to distribute before a patients' TCM appointment and the second to be posted out to the patient a month after their TCM treatment, we discussed what we thought would be the best plan of action, I then set to work on adjusting the initial questionnaire and designing a second post-consultation questionnaire.

Whilst in the process of designing the questionnaires for the evaluation I was in close contact with the evaluation officer and ensured that all my work was passed through the evaluation officer first. The evaluation officer was relatively new to the organisation and was a member of staff that I did not already have an established relationship with. I felt it was vital for us to establish a good working relationship and for there to be good communication between us, after all, we would be in regular contact with each other throughout the entirety of my involvement in the project. This was why I felt it would help if I presented my progress each week, it was important that we both knew where I was up to with the evaluation and what was left of my part in the evaluation to undertake.

One issue I encountered in my work on the CNHLC evaluation was with different levels of urgency in relation to communication between the client and myself. I had agreed to attend CNHLC once a week and all other communication made during the week was to be via email or telephone. Despite this agreement I was rarely contacted by my clients outside of my weekly day of attendance, I found on some occasions that I would agree work with my clients one week then I would go away and work on this through the following week. I would then attend CNHLC the next week to be informed me that my client had changed their mind on the work agreed or wanted

alterations to be made to the work we had agreed on the previous week. I would normally only be informed of these changes on my agreed day of work at CNHLC.

I found this lack of communication quite frustrating to deal with as this often meant that I would have wasted some of my time during the week working on the design of the evaluation that would become invalid by the time of my day of work at CNHLC. I understood there was nothing personal in these problems that they were due to a lack of organisation. Nevertheless, this did nothing to ease my frustrations regarding the situation, particularly as I already had a heavy workload to contend with and did not welcome the idea of wasting any time concerning my work.

We had initially agreed that I design one questionnaire asking the TCM clinic users their views on the treatments provided, what clients thought of the service provided and what they thought of the treatments they had received. It was agreed that we wanted to examine whether patients were satisfied with the treatments provided and received at the CNHLC TCM clinic and if not, why not. In addition to discovering whether the treatments had any effect on the quality of life of the users and whether the treatments had improved the condition of the complaint the patient had come to the clinic presenting.

After discussion with the evaluation officer, mid-way through designing the initial questionnaire, we came to a decision to have both a pre-consultation and a post-consultation questionnaire. It was around this point that I learnt the importance of close and regular contact with my client in consultations. I realised that if I had not been in close and regular contact with my client, instigating weekly meetings, I may not have been informed of the idea of a second questionnaire until later on in the project. As I already had a full timetable, work-wise, I was fully aware of how important it was for me to try as much as I could to keep within the limits of the time frame I had set for myself otherwise, I was aware of how easy it could become for me to slip behind schedule on pieces of work.

My client informed me that they had been thinking that it may be better to have two questionnaires for the evaluation; a pre and post consultation questionnaire. They

mentioned that they had been thinking of this for a while I enquired why I had not been informed of this idea earlier. It was revealed that they did not consider it that important as I was still working on the first questionnaire.

I was aware that I was becoming frustrated with my clients' more relaxed attitude towards communicating work with me so I took it upon myself to discuss this issue with the evaluation officer. I was a little nervous at first at the prospect of raising this issue with my client on the other hand I felt it was important to raise the issue early on to prevent a repeat of the same situation, and to prevent the issue becoming a bigger problem. I convinced myself there was nothing to be nervous about, that it was just about clearing up a small matter with my client. I knew that if I approached the situation in the right way the matter would be resolved. I viewed it as being related to communication and organisation and believed that if we improved the communication and organisation this could only serve us better in terms of our working relationship.

When I approached the evaluation officer about this issue, it was clear that I had been worrying about nothing. One thing I was conscious of was that I didn't want to appear to be being bossy and trying to control the project. The evaluation officer understood my issues much to my relief and this led to an improvement in our levels of communication and organisation. After raising this issue I found that the evaluation officer would often contact me via email during the week to touch base on the evaluation.

My clients seemed very relaxed in their attitude to leave a lot of the work and responsibility down to myself. Perhaps this was as a result of my having an established relationship with my clients this meant that they perhaps already knew a little of what to expect in terms of my workload, work pattern and my attitude towards my work. They may have felt happy and confident leaving the work to me in the knowledge that I would be capable of completing the work I had agreed to undertake. This could also have been related to the fact that I presented my work to my clients on a weekly basis, so they always knew where I was up to with the consultation, and where they stood.

I felt no pressure whatsoever from my clients in terms of completing the work I had agreed to take on in the project, also in terms of the quality and style of my work. It gave me some pleasure and satisfaction knowing that in my first experience in consultancy, I was being given so much creative freedom. On the majority of occasions when I presented the work I had completed so far for the project to my clients their reaction seemed to generally be one of relaxed agreement. I made a routine of presenting the progress of the work to my clients each week on my allocated day of work at the organisation. This way there would be no room for misunderstandings to occur, it also gave my clients the opportunity to see for themselves each week how much progress I had made with the evaluation and where I was up to with the work.

I believe that one of the reasons I encountered so few problems along the way with my first experience of consultancy was partly due to the fact that I was organised and strict with my timetable when it came to my workload. I always made sure I was up to speed with all my work and knew where I was up to with each piece of work. Organisation of my work gave me a sense of control over the work I was conducting this organisation and pressure of disciplining myself also ultimately meant that I actually managed to complete my part of the bargain ahead of schedule, it also meant that I was more prepared in the case of a setback.

One factor that made the consultancy a little easier to conduct was that I made a great effort to keep up to date with all the work I was committed to at that time, including my regular workload in my job. This contributed to me feeling not as panicked and pressured as I may otherwise have been, had I been running behind on other pieces of work I feel that this would have only added to the frustration of the situation.

I felt fortunate that I had been so organised, both in my planning for the evaluation and the management of my job and study workload this resulted in helping me to feel more in control of my work and the consultancy situation, I also felt less pressure than I potentially could have done when things didn't turn out exactly how I expected them to. As a result of my organisation and discipline concerning my workload, this allowed me time spare for changes and alterations to be made throughout the

consultancy process. I learnt that organisation and communication are two of the most important skills to possess when it comes to consultancy.

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APPENDIX 1

TCM RESEARCH PROTOCOL

Title: The influence of cultural beliefs and cultural values on the health-seeking behaviours of the Chinese community in Britain

Aims & Objectives:

The objectives of the study are as follows:

To investigate the health-seeking behaviours of the British Chinese community

To explore the relationship between cultural beliefs and values and the influences these may have upon a person's health-seeking behaviours

To explore the relationship between cultural orientation, cultural values and utilisation of TCM and/or Western medicine

To examine the relationship between age, choice of medicine, nature of illness and country of origin

To assess whether having a strong affiliation to Chinese values and culture will influence Chinese peoples' decision to utilise TCM

Research Questions:

Are Chinese born overseas more likely to utilise Chinese medicine than British born Chinese?

Are people who are more affiliated to Chinese culture and values more likely to utilise TCM?

Are people who are less affiliated to Chinese culture and values more likely to utilise Western medicine?

Is there any relationship between the nature of illness and choice of medicine?

Is there any relationship between age, country of origin and choice of medicine?

Background:

In multicultural societies, where many ethnic communities live side by side with the cultural system of the host country, cultural backgrounds and the corresponding representations attached regarding health and illness are emerging as important factors in planning the delivery of health care (Chi, 1994). The UK is characterised by its cultural diversity. Migrants from diverse socio-cultural and linguistic backgrounds have been found to possess varying perceptions of health and illness. Given the multi-cultural nature of contemporary British society, and that health and illness are culturally constructed experiences, it is important to include the perspectives of people from different ethnic cultures in health related research, in order to provide culturally sensitive health care during an illness. Moreover, as one's experience of health and illness is likely to be influenced by one's culture, culture may affect and have implications on a patient's recovery process.

The Chinese are one of the least understood of all of Britain's immigrant minorities despite constituting Britain's third largest ethnic minority. Remarkably little research has been carried out into the Chinese community in Britain.

A significant change taking place within the Chinese community is linked to the increasing proportion of British-born Chinese, which now constitutes over 60% of Chinese in Britain (Sproston et al, 1999). As more and more British-born Chinese are emerging from the British education system the character of the Chinese community is beginning to change. More Chinese are now British born and English speakers, less are now involved in the catering trade, and more now see themselves as British Chinese than ever before. As a result of the changes in the community come the problems associated with intergenerational relations, communication problems and the generation gap between Chinese-born parents and British-born children.

Research Strategy:

Quantitative Questionnaire:

Conduct my own questionnaire in combination with the Chinese Value Survey (Chinese Culture Connection, 1987) and distribute to lay members of the Chinese community via various Chinese health and community centres nationwide. Get details of these health and community centres via the 'UK Chinese Community Service Directory'. Translate the questionnaire booklet, combining my questionnaire and the Chinese Value Survey into Chinese. Need to translate into Chinese to ensure a response from a wide-ranging audience of the Chinese community. Distribute by networking with Chinese community and health centres in the UK Chinese Community Service Directory. Send letters and emails to the centres asking for their help in distributing my questionnaire to their members. Attach a copy of the questionnaire booklet to the letter/email. Encourage CNHLC staff and members that I know and get on with, to distribute to family and friends. Analyse the questionnaire booklet using factor analysis. Aim for a minimum of 250 questionnaire responses.

Qualitative Focus Group Discussions:

Set up and arrange for two focus groups to occur. Focus groups will be a good way of gathering a wide range of information from different perspectives of the same community. It will be better and more effective than individual interviewing, which can be potentially limiting and also more time consuming. It also saves the complications of individual interviewing with problems of recruiting and language barriers with certain sections of the Chinese community. It is also an effective way of gathering more information in a shorter time period. Facilitate two separate focus groups to reflect views of lay members of the Chinese community in one focus group in addition to another focus group consisting of Chinese professionals. It will be more effective with fewer people instead of too many people, where not many people in the group will get an opportunity to talk. The focus groups will take place in English. Focus groups to take a maximum of 1.5-2 hrs each. Both focus groups to be tape-recorded and then transcribed accordingly by myself, with myself as facilitator in each focus group.

Themes to address in the focus groups:

CHINESE HEALTH & COMMUNITY WORKERS

Section 1: Characteristics of the British Chinese community

- Similarities and differences of the Chinese community in England
- Cohesion and fragmentation. The dynamics of identity
- Integration in, and exclusion from, mainstream society

Section 2: Theories of health and illness

- Differences and similarities between Traditional Chinese Medicine and Western medicine
- Chinese lay theories of health and illness. Notions of balance and harmony
- Health and lifestyle
- Cultural beliefs and cultural values and how these can influence health behaviours and health-seeking behaviours

Section 3: Provision and adequacy of health services

- Chinese patterns in seeking medical help
- Access to healthcare (facilitators and barriers)
- Availability and adequacy of service provisions. Main health-related concerns

LAY MEMBERS OF THE CHINESE COMMUNITY

Section 1: The dynamics of mixed identity

- What is it like to be a Chinese person living in Britain?
- Could you tell me about the similarities and differences between the generation of Chinese who emigrated to England and those who were born in England?

Section 2: Health at home

- When you were younger, did your parents teach you about how to be healthy, and how to lead a healthy life? In what ways?
- In what ways do you think your health behaviours are influenced by the fact that you are a Chinese person in Britain?
- In what ways do you feel that your cultural beliefs and values are influenced by the fact that you are a Chinese person in Britain?

Section 3: Attitudes towards Traditional Chinese medicine

- What do you think about Traditional Chinese medicine?
- Do you use TCM? If so, why do use TCM? If not, why not?
- If you have used TCM, for what conditions would you normally use TCM?
- Are there some conditions to which TCM is more suited?

Section 4: Attitude towards Western medicine, and access to, and experience of health services

- What do you think of Western medicine?
- I'd like to hear your views about your experiences of the health service
- Do you think the health service is sensitive to the needs of Chinese people? In what ways?

- If there was one thing that could be improved, in terms of health service provision for Chinese people, what would you like this to be? / What do you feel could be done to improve health service provision for Chinese people in England?

Participant Sample:

Chinese population with a minimum age of 18. No maximum age. Use members of Chinese Health and Community Centres in London and Manchester.

APPENDIX 2

Research information sheet, consent form and CHBVS distributed to respondents.

The Influence of Cultural Beliefs and Values on the Health-Seeking Behaviours of Chinese Communities in Britain

英國華人社區在尋找醫療服務時文化信仰和價值觀所帶來的影響

Tina Rochelle: Research Officer, University Hospital Lewisham

The UK is characterised by its cultural diversity and the corresponding representations attached regarding health and illness are emerging as important factors in planning the delivery of health care. It is important to include the perspectives of people from different ethnic cultures in health related research in order to provide culturally sensitive health care. Moreover, as one's experience of health and illness is likely to be influenced by one's culture, culture may affect and have implications for a patient's treatment and recovery.

The purpose of this study is to learn more about British Chinese communities' health behaviours through structured questionnaires and focus groups. This could potentially help health services, providers and planners to be more aware of cultural differences, which could hopefully lead to a more culturally competent health service being provided. Your views as lay members of the British Chinese public are invaluable to this project. Your interest and participation in this project would be greatly appreciated.

英國是一個多民族的國家，要建立一個健全和完善的醫療制度並不容易，所以設計了以下問卷，希望收集和聽取不同文化背景人士的意見，從而建立一個更適合英國國情的醫療保健制度。

這份問卷主要是探討在英國的華人社會裏，華人是怎樣看待英國的醫療服務，它可以幫助英國醫療衛生服務部在制訂計劃時留意文化區別從而導致一個更高質數包含文化因素的醫療保健服務，所以你的意見和參與是非常重要的，希望各位華人大力支持。

Title of Project: The Influence of Cultural Beliefs and Values on the Health-Seeking Behaviours of Chinese Communities in Britain

**Name of Researcher: Tina Rochelle
Research Officer, University Hospital Lewisham**

Please tick each box.

- | | |
|--|--------------------------|
| 1. I confirm I have read and understood the information sheet for the above project.
我已閱讀和明白問卷的內容。 | <input type="checkbox"/> |
| 2. I understand my participation is voluntary and I am free to withdraw at any time.
我明白我是義務參與，可隨時離開。 | <input type="checkbox"/> |
| 3. I understand that my participation in the above study will be dealt with in the strictest confidence and that all information will be held confidentially before eventually being destroyed.
我明白我的參與是絕對保密。 | <input type="checkbox"/> |
| 4. I agree to take part in the above study.
我同意參與問卷調查。 | <input type="checkbox"/> |

Signed 簽名：.....

Date 日期：.....

Print Name 名字：.....

Cultural Health Belief and Value Survey

文化背景和價值觀與健康的關係

- Please indicate your choice by ticking the box for the answer most relevant to you for each question. 請你在認為最適合的答案上√
- Key: GP = Doctor of Western medicine 西醫
TCMP = Traditional Chinese Medicine Practitioner 中醫
TCM = Traditional Chinese Medicine 中藥

1) Date of Birth 出生日期：_____

2) Sex 性別：

i. Male 男

ii. Female 女

3) Marital Status 婚姻狀況：

i. Single 單身

ii. Co-habiting 同居

iii. Married 已婚

iv. Divorce 離婚

v. Separated 分居

4) Children 孩子：

i. Yes 有

ii. No 沒有

(if yes how many) 如果有，有多少 _____

5) Religion 宗教信仰：

i. Buddhism 佛教

- ii. Christianity 基督教
- iii. Catholicism 天主教
- iv. Muslim 回教
- v. Other 其他，please specify請指出 _____

6) Registered with GP 家庭醫生：

- i. Yes 有
- ii. No 沒有

Languages 語言：

7) Which of these languages do you consider to be your 'first language', or the language you feel most able and comfortable to speak：

下面那種語言是你的母語或者是平常說得最多的：

- i. Cantonese 廣東話
- ii. Mandarin 普通話
- iii. Hakka 客家話
- iv. Vietnamese 越南話
- v. English 英文
- vi. Other 其它，please specify請指出 _____

8) Which other languages have you a good knowledge of？

你還會說以下哪一種語言？

- i. Cantonese 廣東話
- ii. Mandarin 普通話
- iii. Hakka 客家話
- iv. Vietnamese 越南話
- v. English 英文
- vi. Other 其它，please specify請指出 _____

9) Where were you born?

你在哪裏出生？

- i. China 中國
- ii. Hong Kong 香港
- iii. Malaysia 馬來西亞
- iv. Singapore 星加坡
- v. Vietnam 越南
- vi. UK 英國

(if UK please specify where your parents came from)

如果在英國，請指出父母原國籍 _____

- vii. Other 其它，please specify 請指出 _____

10) How long have you been a resident in the UK?

你在英國居住了多久？

- i. Less than 1 year 少於一年
- ii. 1-5 years 1至5年
- iii. 6-10 years 6至10年
- iv. 11-20 years 11至20年
- v. more than 20 years 超過20年

11) Self-assessment of health status:

自我評估身體狀況：

- i. Very Unhealthy 很差
- ii. Unhealthy 差
- iii. Average health 一般
- iv. Healthy 好
- v. Very healthy 很好

- 12) Where do you obtain your health-related information from?
你是從哪裏獲得有關醫學的資料？

- 13) What do you feel are the strengths of TCM?
你認為中藥有什麼好處？

- 14) What do you feel are the strengths of Western medicine?
你認為西藥有什麼好處？

- 15) What do you feel are the weaknesses of TCM?
你認為中藥有什麼不好？

16) What do you feel are the weaknesses of Western medicine?

你認為西藥有什麼不好？

17) For what illnesses would you normally use TCM?

在什麼病況下你會看中醫？

18) For what illnesses would you normally use Western medicine?

在什麼病況下你會看西醫？

Please indicate on a 5 point scale the frequency of each of the questions asked.

5 = Always. 4 = Very Often. 3 = Often. 2 = Sometimes. 1 = Never

請用下面5種指示回答問題

5=經常，4=多數，3=普通，2=有時，1=沒有

		5	4	3	2	1
19)	Do you read Chinese newspapers and/or magazines? 你有否閱讀中文報紙和雜誌?					
20)	Do you follow Chinese events? 你有否參與華人活動?					
21)	Do you use TCM? 你有否用中藥?					
22)	Do you use Western medicine? 你有否用西藥?					
23)	Do you trust TCM? 你是否相信中藥?					
24)	Do you trust Western medicine? 你是否相信西藥?					
25)	Do you find TCM helpful when you are ill? 當你有病時，中藥能萬否幫你嗎?					
26)	Is Western medicine helpful when you are ill? 當你有病時，你覺得西藥能否幫你嗎?					
27)	Do you feel your cultural beliefs influence your health-seeking behaviour and choice of medicine? 你認為文化背景會影響你對藥物的選擇嗎?					
28)	Do you feel your cultural values influence your health-seeking behaviour and choice of medicine? 你認為文化價值觀念影響你對藥物選擇嗎?					
29)	Do you feel your friends and family influence your health-seeking behaviour and choice of medicine? 你認為朋友和家庭會影響你對藥物的選擇嗎?					
30)	Do you feel your religious beliefs influence your health-seeking behaviour and choice of medicine? 你認為宗教信仰會影響你對藥物的選擇嗎?					
31)	Do you feel being British Chinese influences your health-seeking behaviour and choice of medicine? 你認為作為一個在英國長大的中國人，有否影響你對藥物的選擇嗎?					
32)	Are you generally pleased with the care you receive from GPs? 一般來說，你滿意家庭醫生的服務嗎?					
33)	Are you generally pleased with the care you receive from TCMPs? 一般來說，你滿意中醫的服務嗎?					
34)	Are you generally pleased with the quality of health care you have received in the UK? 總括來說，你滿意英國的醫療服務嗎?					

		5	4	3	2	1
35)	Do you agree with the explanations that GPs give you for your illness when you are unwell? 你看病時，同意家庭醫生對你的診斷嗎？					
36)	Do you agree with the explanations that TCMPs give you for your illness when you are unwell? 你看病時，同意中醫師對你的診斷嗎？					
37)	Do you agree with/conform to treatment plans GPs prescribe you when you are unwell? 你對你家庭醫生的治療方法同不同意？					
38)	Do you agree with/conform to treatment plans TCMPs prescribe you when you are unwell? 你對你中醫的治療方法同不同意？					
39)	Do you feel that GPs understand your health concerns? 你認為家庭醫生明白你健康需求嗎？					
40)	Do you feel that TCMPs understand your health concerns? 你認為中醫師白你的健康需求嗎？					
41)	Do you agree with/conform to treatment plans GPs prescribe you when you are unwell? 你對你家庭醫生所給予你的藥物同不同意？					
42)	Do you agree with/conform to treatment plans TCMPs prescribe you when you are unwell? 你對你中醫所給予你的藥物同不同意？					
43)	Do you feel an adequate health service is available to you? 對你來說這裡的醫療服務足夠嗎？					

Chinese Value Survey
中國價值觀問卷

Please indicate on a 9 point scale the personal importance of each of the 40 concepts.
9 = of supreme importance. 1 = of no importance at all.

9 = 非常重要。 1 = 不重要

		9	8	7	6	5	4	3	2	1
1)	Obedience to and respect of parents 服從和尊重父母									
2)	Working Hard 努力工作									
3)	Tolerance of Others 忍耐力									
4)	Harmony with others 與人相處融合									
5)	Humbleness 謙虛									
6)	Loyalty to superiors 有歸屬感									
7)	Observation of rites and social rituals 對風俗習慣的觀察									
8)	Reciprocation of greetings, favours and gifts 禮上往來									
9)	Kindness (forgiveness, compassion) 寬宏大量									
10)	Knowledge (education) 學識									
11)	Solidarity with others 合作愉快									
12)	Moderation (following the middle way) 適量宜至									
13)	Self-cultivation 自我教育培訓									
14)	Ordering relationships by status & observing this order 尊師重道									
15)	Sense of righteousness 辨別是非能力									
16)	Benevolent authority 仁心、善舉									
17)	Non-competitiveness 不喜歡比較									
18)	Personal steadiness and stability 自制能力									
19)	Resistance to corruption 抗拒貪污受賂									

		9	8	7	6	5	4	3	2	1
20)	Patriotism 愛國心									
21)	Sincerity 誠實									
22)	Keeping oneself disinterested and pure 保持純真									
23)	Thrift 節儉									
24)	Persistence (perseverance) 持續性									
25)	Patience 耐性									
26)	Repayment of both good or evil another person has caused you 恩怨分明									
27)	A sense of cultural superiority 有種族優越感									
28)	Adaptability 適應力									
29)	Prudence (carefulness) 三思而後行									
30)	Trustworthiness 可信，可靠									
31)	Having a sense of shame 羞愧感									
32)	Courtesy 禮貌									
33)	Contentedness with one's position in life 滿足感									
34)	Being conservative 保守									
35)	Protecting your 'face' 要面子									
36)	A close, intimate friend 一個親密的朋友									
37)	Chastity in women 女人的純潔									
38)	Having few desires 夢想與欲望									
39)	Respect for tradition 尊重傳統習慣									
40)	Wealth 財富									

APPENDIX 3**Table 17: Distribution of the Chinese population across regions, April 2001**

Region	Number of Chinese	% of total Chinese population
London	80,208	32.42
South East	33,078	13.37
North West	26,893	10.87
East	20,386	8.24
West Midlands	16,106	6.51
East Midlands	12,914	5.22
South West	12,717	5.14
Yorkshire & the Humber	12,345	4.99
North East	6,037	2.44
England	220,683	89.20
Scotland	16,304	6.59
Wales	6,259	2.53
Northern Ireland	4,156	1.68
England & Wales	226,942	91.73
UK Base	247,403	100

National Statistics Bureau

APPENDIX 4

An example of the letter sent to Chinese Health and Community Centres throughout the UK asking for their assistance in the recruitment of participants

December 2003

Hi

My name's Tina Rochelle I am half Chinese and originally from Manchester. I hope you don't mind me contacting you, I got your details from the 'UK Chinese Community Service Directory'.

I am currently in the middle of a Doctorate in Health Psychology at City University, London. I also work as a research officer at Lewisham Hospital, London.

For my doctorate I am currently in the process of conducting my research entitled; 'The Influence of Cultural Beliefs and Values on the Health-Seeking Behaviours of Chinese Communities in Britain'.

I am currently trying to get as many questionnaires filled in as possible by Chinese people and I was wondering if you could possibly of any help. I have enclosed a copy of my questionnaire for you to have a look at. If you would like to help with my research I could post a pack of questionnaires to you, along with free-post envelopes for people to post their completed questionnaires back to me in London.

I would really appreciate your help with this. However, if you decide not to, thank you very much for taking the time to read this letter.

Thanks very much once again and best wishes

Tina Rochelle

Junior Research Officer
R&D Unit
1st Floor Research Centre
University Hospital Lewisham
Lewisham High Street
London, SE13 6LH
England
020 8333 3030 ext 6359
e-mail tina.rochelle@uhl.nhs.uk

APPENDIX 5*Table 18: List of all the Chinese Health and Community Centres that participated in the research*

Name	Address
Advocacy and Interpreting Services	170-172 Roundhay Road. Leeds. LS8 5PL
Bishop Ho Ming Wah Association	6 St Martin's Place. London. WC2N 4JJ
Chadswell Healthy Living Centre	Harrison Street. London. WC1H 8JE
Chinese in Britain Forum	1 st Flr. Boardman House. 64 Broadway. London. E15 1NG
Chinese Information and Advice Centre	4 th Flr. 104-108 Oxford Street. London. W1D 1LP
Chinese National Healthy Living Centre	29-30 Soho Square. London. W1D 3QS
Chinese National Healthy Living Centre	6-8 Houldsworth Street. Manchester. M1 1EJ
Chinese National Healthy Living Centre	3 rd Flr. Ladywell House. 20 Hurst Street. Birmingham. B5 4BN
Islington Chinese Association	33 Giesbach Road. London. N19 3DA
Lai Yin Association	Mount Pleasant Community Centre. Sharown Lane. Sheffield. S11 8AE
Marlborough Family Service	38 Marlborough Place. London. NW8 0PJ
Milton Keynes Chinese School and Community Centre	25-27 Holyhead Crescent. Milton Keynes. MK4 3AN
Northumbria Health Care NHS Trust	Wallsend Health Centre. The Green. Tyne & Wear. NE28 7PD
Pagoda Chinese Community Centre	Henry Street. Liverpool. L1 5BU
Wai Yin Centre	1 st Flr. Fraser House. 36 Charlotte Street. Manchester. M1 4FD
Yellow Earth Theatre	10A Old Compton Street. London. W1V 5PB

APPENDIX 6

Example of focus group schedule handed to Chinese worker participants:

CHINESE HEALTH & COMMUNITY WORKERS

Section 1: Characteristics of the British Chinese community

- Similarities and differences of the Chinese community in England
- Cohesion and fragmentation. The dynamics of identity
- Integration in, and exclusion from, mainstream society

Section 2: Theories of health and illness

- Differences and similarities between Traditional Chinese Medicine and Western medicine
- Chinese lay theories of health and illness. Notions of balance and harmony
- Health and lifestyle
- Cultural beliefs and cultural values and how these can influence health behaviours and health-seeking behaviours

Section 3: Provision and adequacy of health services

- Chinese patterns in seeking medical help
- Access to healthcare (facilitators and barriers)
- Availability and adequacy of service provisions. Main health-related concerns

APPENDIX 7

Example of focus group schedule handed to lay Chinese participants:

LAY MEMBERS OF THE CHINESE COMMUNITY

Section 1: The dynamics of mixed identity

- What is it like to be a Chinese person living in Britain?
- Could you tell me about the similarities and differences between the generation of Chinese who emigrated to England and those who were born in England?

Section 2: Health at home

- When you were younger, did your parents teach you about how to be healthy, and how to lead a healthy life? In what ways?
- In what ways do you think your health behaviours are influenced by the fact that you are a Chinese person in Britain?
- In what ways do you feel that your cultural beliefs and values are influenced by the fact that you are a Chinese person in Britain?

Section 3: Attitudes towards Traditional Chinese medicine

- What do you think about Traditional Chinese medicine?
- Do you use TCM? If so, why do use TCM? If not, why not?
- If you have used TCM, for what conditions would you normally use TCM?
- Are there some conditions to which TCM is more suited?

Section 4: Attitude towards Western medicine, and access to, and experience of health services

- What do you think of Western medicine?
- I'd like to hear your views about your experiences of the health service
- Do you think the health service is sensitive to the needs of Chinese people? In what ways?

- If there was one thing that could be improved, in terms of health service provision for Chinese people, what would you like this to be? / What do you feel could be done to improve health service provision for Chinese people in England?

APPENDIX 8

Example of moderator's focus group schedule for Chinese worker group:

CHINESE HEALTH & COMMUNITY WORKERS

Section 1: Characteristics of the British Chinese community

- Similarities and differences of the Chinese community in England

*Prompts: immigration patterns, areas of settlement
Socio economic and demographic differences
Linguistic abilities, communication difficulties*

- Cohesion and fragmentation. The dynamics of identity

*Prompts: Feeling Chinese/feeling British/feeling
British Chinese, cultural identity – dependent
upon circumstances?? UK considered home?
HK/China considered home?*

- Integration in, and exclusion from, mainstream society

*Prompts: Sense of community, integrating with community,
Job in community*

Section 2: Theories of health and illness

- Differences and similarities between Traditional Chinese Medicine and Western medicine

*Prompts: holistic/localistic
Focus on person/disease
Focus on prevention/treatment*

- Chinese lay theories of health and illness.

Prompts: Notions of balance and harmony

- Health and lifestyle

*Prompts: Health as a way of life, role of food
in prevention and treatment,
Exercise, smoking*

- Cultural beliefs and cultural values and how these can influence health behaviours and health-seeking behaviours

*Prompts: Influenced by Chinese/British values. In what ways?
Do you feel that you participate in British/Chinese cultures? In what ways?*

Section 3: Provision and adequacy of health services

- Chinese patterns in seeking medical help

Prompts: self-medication, family advice, shopping around for medical advice, consulting both GP & TCMP, why some people consult both practitioners

- Access to healthcare (facilitators and barriers)

Prompts: Language, interpreters, understanding of British healthcare system, confidence in System, treatment by medical staff

- Availability and adequacy of service provisions. Main health-related concerns

Prompts: Is service adequate? Why? Why not?

APPENDIX 9

Example of moderator's focus group schedule for Chinese worker group:

LAY MEMBERS OF THE CHINESE COMMUNITY

Section 1: The dynamics of mixed identity

- What is it like to be a Chinese person living in Britain?

*Prompts: Difficulties, positive things, feelings of belonging/
Exclusion, feel more British/Chinese, is England
considered home?*

- Could you tell me about the similarities and differences between the generation of Chinese who emigrated to England and those who were born in England?

*Prompts: Differences in values, feeling more English/Chinese
Differences in beliefs,*

Section 2: Health at home

- When you were younger, did your parents teach you about how to be healthy, and how to lead a healthy life? In what ways?

*Prompts: role of food in prevention and treatment
Health and lifestyle*

- In what ways do you feel that your health behaviours are influenced by the fact that you are a Chinese person in Britain?
- In what ways do you feel that your cultural beliefs and values are influenced by the fact that you are a Chinese person in Britain?

Section 3: Attitudes towards Traditional Chinese medicine

- What do you think about Traditional Chinese medicine?
- Do you use TCM?

Prompts: If so, why do use TCM? If not, why not?

- If you have used TCM, for what conditions would you normally use TCM?
- Do you think that there may be some conditions to which TCM is more suited?

Prompts: If so, which conditions and why

Section 4: Attitude towards Western medicine, and access to, and experience of health services

- What do you think of Western medicine?

Prompts: Do you use it? Do you trust it? If not, why not.

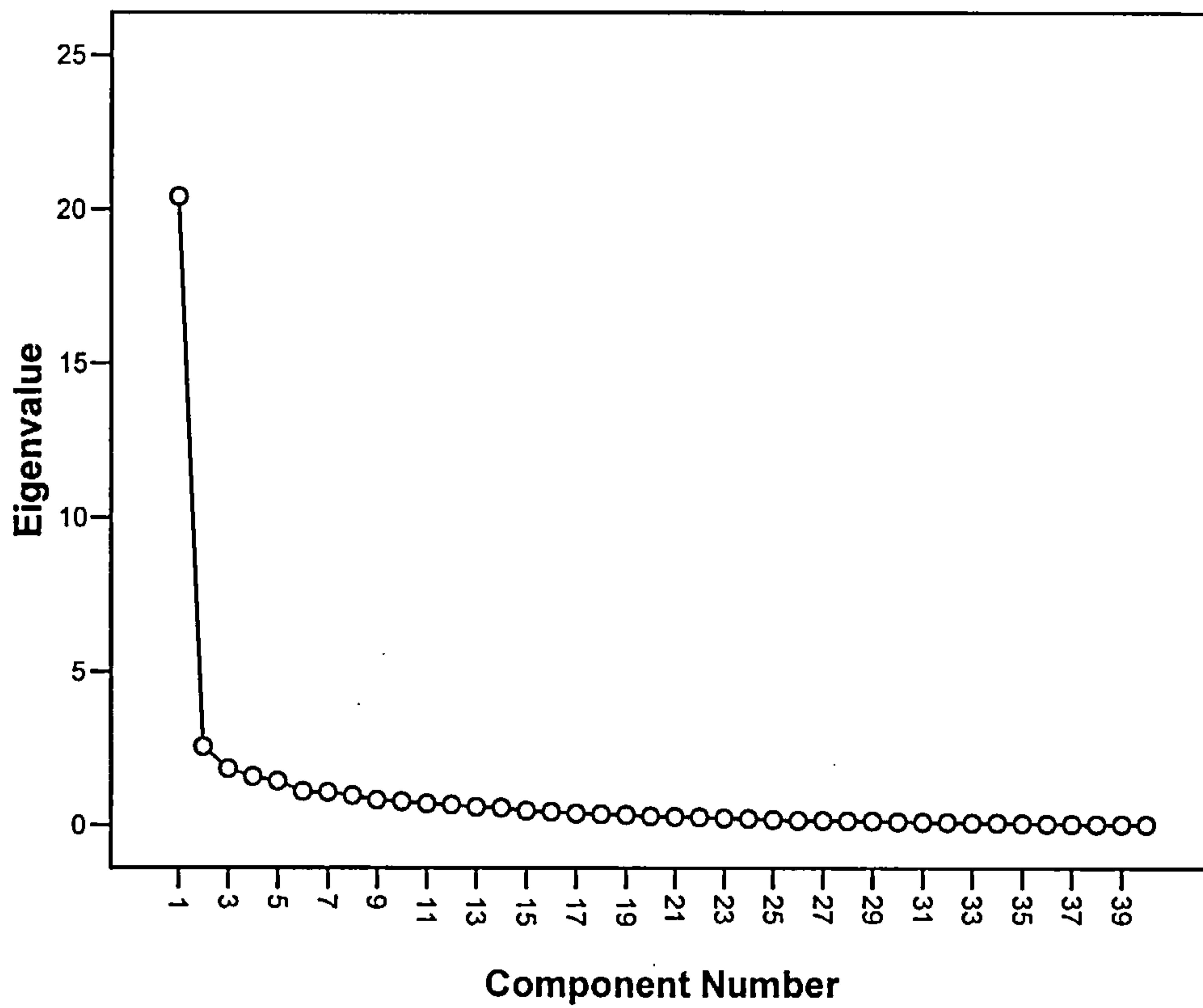
- I'd like to hear your views about your experiences of the health service
- Do you think the health service is sensitive to the needs of Chinese people? In what ways?

If there was one thing that could be improved, in terms of health service provision for Chinese people, what would you like this to be? / What do you feel could be done to improve health service provision for Chinese people in England?

APPENDIX 10

Figure 1: Chinese Value Survey

Scree Plot



APPENDIX 11**Table 19: CVS Rotated Component Matrix(a)**

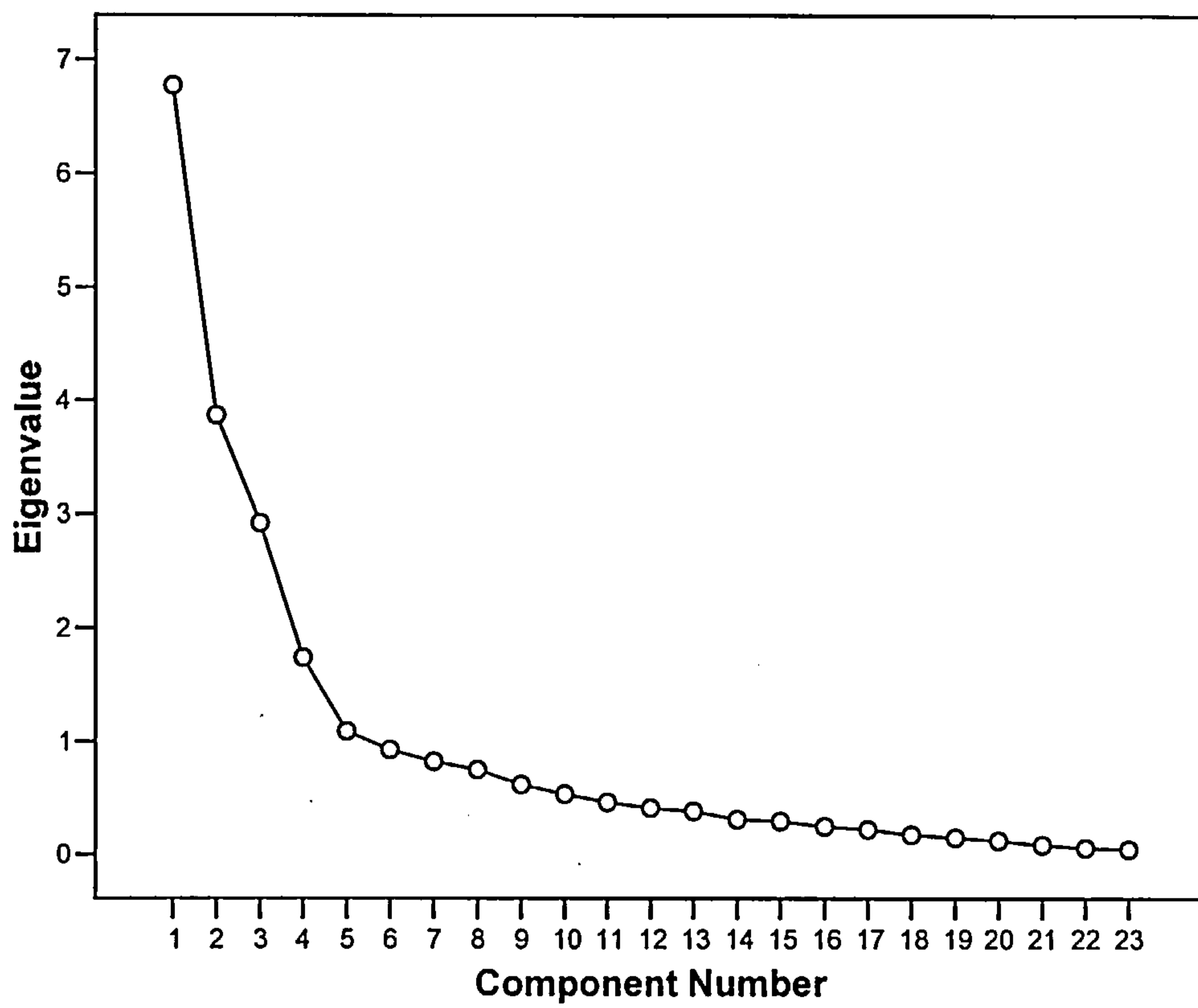
	Component				
	1	2	3	4	5
Humbleness	.743		.403		
Harmony	.737		.343		
Sincerity	.731	.304			
Working Hard	.709				
Tolerance	.680	.305			
Obedience towards parents	.652				
Resist corruption	.637	.379			
Benevolent Authority	.627				.387
Thrift	.621			.341	.371
Courtesy	.609	.440			.306
Righteousness	.604	.477	.331		
Patriotism	.579				.318
Adaptability	.545	.537			
Relationship status	.461				.445
Persistence	.334	.697		.341	
Prudence	.413	.636		.313	
Self-cultivation		.610	.395		.361
Contentedness		.603	.339	.356	
Steadiness & stability	.353	.581			
Non-competitiveness		.569			
Patience	.554	.563			.329
Trustworthiness	.486	.532			.306
Rites & Rituals			.723		
Loyalty to superiors			.695		
Solidarity		.375	.688		
Moderation		.380	.638		
Knowledge		.340	.545		
Kindness	.428	.401	.490		
Reciprocation of gifts	.356		.452	.310	.346
Cultural superiority				.715	
Protecting face				.671	
Being conservative				.666	
Respect for tradition	.384	.319		.618	
Disinterested & Pure	.309			.484	.422
Sense of shame		.335	.383	.458	
Chastity in Women	.306			.450	.419
Repayment of good & evil	.334			.414	.341
Close friend					.716
Having few desires					.672
Wealth				.308	.552

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.
a Rotation converged in 8 iterations.

APPENDIX 12

Figure 2: Chinese Health Belief and Value Survey

Scree Plot



APPENDIX 13

Table 20: CHBVS Rotated Component Matrix(a)

	Component			
	1	2	3	4
TCMP explanations	.854			
TCMP understand health concerns	.832			
TCM helpful	.822			
TCMP conform	.803			
TCMP care	.781			
Trust TCM	.771			
Use TCM	.607			
Follow Chinese Events	.312			
GP explanations		.783		
GP understand health concerns		.782		
Adequate health service		.765		
UK healthcare		.755		
GP care		.754		
GP conform		.705		.302
Cultural values			.888	
Cultural beliefs			.872	
Friends & family			.709	
UK Chinese			.673	
Religious Beliefs			.540	
Trust UK medicine				.803
UK medicine helpful				.758
Use UK med				.691
Follow Chinese News	.323			.510

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.
 a Rotation converged in 5 iterations.

APPENDIX 14

Systematic Review Protocol

Review Question: A re-examination of the effectiveness of acupuncture as an intervention for the alleviation of chronic low back pain.

Background: Back pain is a major complaint for people in the western world, particularly the large number who use acupuncture each year. In spite of the availability of acupuncture in clinics, the effectiveness of acupuncture for chronic pain continues to remain in question. This systematic review of randomised controlled trials aims to evaluate the effectiveness of acupuncture for the management of non-specific low back pain. The review is a partial replication of the van Tulder et al. (1999) systematic review on back pain. This review includes English language studies only. The procedure followed the van Tulder et al. (1999) review. Randomised controlled trials were performed to assess the effectiveness of all types of acupuncture treatment, involving needling for participants with non-specific low back pain.

Objectives:

- 1) Partial replication of the original review conducted by van Tulder et al (1999).
- 2) Various search strategies; Medline, Embase, Cinahl, PsychLit, BMJ, PubMed, and the Cochrane library in addition to hand searches to be carried out in relevant journals such as Pain etc
- 3) Reanalyse the data with any additional studies selected that meet the criteria.

Search Strategy:

- 1) All the English language articles reviewed by van Tulder et al (1999) will be re-reviewed.
- 2) Various search strategies will be searched for relevant articles reviewing the effects of acupuncture, for example; computer search engines in addition to hand searches in relevant journals from 1966-February 2004.

Search Terms:

A broad free text search restricted to the English language using all variants of the following terms: acupuncture, complementary medicine, complementary therapy, alternative medicine, alternative therapy, Chinese medicine, traditional Chinese medicine, randomised control trials, chronic pain, back pain, low back pain, chronic back pain, chronic low back pain.

Study Selection Criteria:

Participants: Patients with non-specific low back pain. Patients aged >18 years with low back pain >3 months. Low back pain caused by specific illnesses (arthritis) or self-inflicted injuries or diseases not to be included.

Interventions: Reviews assessing acupuncture treatment involving needle insertion into the skin. Traditional and contemporary acupuncture methods to be included. Do

not include reviews where acupuncture treatment doesn't involve needling (acupressure and laser acupuncture).

Outcome measures: Reviews to be included if they use one of the following four primary outcome measures in following with the van Tulder et al (1999) review:

- (i) Pain intensity (VAS)
- (ii) A global measure (overall improvement, proportion of patients recovered, subjective improvement of symptoms)
- (iii) Functional status (Roland Morris Disability Questionnaire, Oswestry Scale)
- (iv) Return to work (Return to work status, number of days off)

Considered secondary outcome measures:

- (i) Physiologic outcomes of physical examination (eg; range of spinal flexion, muscle strength etc).
- (ii) Generic health status (as assessed by the Medical Outcome Short Form 36 [SF-36], Nottingham Health Profile, Sickness Impact Profile).
- (iii) Other symptoms such as medication use and side effects.

Search Procedure:

TLR will select studies for inclusion into the review. Identified studies will then be screened for suitability using the inclusion criteria by TLR.

Study Quality Assessment Criteria:

The quality and validity of each study will be assessed using the following methodological quality criteria list.

<i>Patient selection:</i>	Y	N	?
d) Were the eligibility criteria specified?			
e) Treatment allocation	Y	N	?
iii. Was the method of randomisation described and adequate?			
iv. Was the treatment allocation concealed?			
f) Were the groups similar at baseline regarding the most important prognostic indicators?	Y	N	?
<i>Intervention:</i>			
d) Were therapeutic and control interventions operationalised?	Y	N	?
e) Was the care provider blinded?	Y	N	?
f) Was controlled for co-interventions which could explain the results?	Y	N	?
h) Was the compliance rate (in each group) unlikely to cause bias?	Y	N	?
h) Was the patient blinded?	Y	N	?
<i>Outcome Measurement:</i>			
i) Was the outcome assessor blinded?	Y	N	?
k) Was at least one of the primary outcome measures applied?	Y	N	?
k) Was there a description of adverse effects?	Y	N	?
l) Was the withdrawal/drop-out rate unlikely to cause bias?	Y	N	?
n) Timing of follow-up measurements	Y	N	?
ii. Was a short-term follow-up measurement performed?			
ii Was a long-term follow-up measurement performed?			
n) Was the timing of the outcome assessment in all groups comparable?	Y	N	?
<i>Statistics:</i>			
o) Was the sample size for each group described?	Y	N	?

q) Did the analysis include an intention-to-treat analysis?	Y	N	?
q) Were the point estimates and measures of variability presented for the primary outcome measure?	Y	N	?

The study quality assessments will be carried out independently by TLR and EE for each study.

APPENDIX 15

Methodological Quality Criteria List

Patient selection:

a) Were the eligibility criteria specified?

- 1) No.
- 2) Yes. Chronic LBP, no pending litigation or compensation claims, no overt psychiatric illness. Ability to read and write English.
- 3) Yes. LBP >6mths, no previous acupuncture, no history of diabetes, infection or cancer, no more than 2 back surgeries.
- 4) Yes. Male, chronic LBP >12wks, no response to traditional medical or surgical therapy.
- 5) Yes. Chronic LBP >1yr, failed to gain relief from appropriate conventional treatment methods.
- 6) Yes. LBP >3mths, no pregnancy, no osteomyelitis of spine, no discitis, no tumour, no ankylosing, no spondylitis, no vertebral fractures, and no structural scoliosis.
- 7) Yes. LBP, persistent pain despite initial 4wks of treatment.
- 8) Yes. LBP >6mths, muscle spasm present, numbness, diminished sensation or muscle weakness.
- 9) Yes. LBP >6mths, no radiation of pain below knee, normal neurological examination. No history of acupuncture.
- 10) Yes. Non-radiating LBP >6mths, normal neurological examination. No psychiatric illness or current psychotherapy.
- 11) Yes. LBP >6mths, with or without leg pain and with no neurological deficits. No rheumatoid arthritis or osteoarthritis of the spine.
- 12) Yes. LBP >12wks, aged >60yrs. No spinal tumour, infection or fracture, and no associated neurological symptoms.

b) Treatment allocation

I. Was the method of randomisation described and adequate?

- 1) Don't know.
- 2) Yes. Patients randomly allocated to two groups.
- 3) Yes. Small box with 50 pieces of paper, 25 group A, 25 group B.
- 4) No.
- 5) Don't know.
- 6) Don't know.
- 7) Yes. Patients divided into 4 groups, randomly assigned.
- 8) Don't know.
- 9) Yes. Random allocation. Randomisation was produced from a previously computer-generated list.
- 10) Yes. Patients randomised to one of three groups using a computer-based randomisation process.
- 11) Yes. Patients randomised to one of two groups using computer-generated randomisation.
- 12) Yes. A computer-generated random allocation sequence was prepared.

II. Was the treatment allocation concealed?

- 1) Don't know.
- 2) Don't know.
- 3) Yes.

- 4) No.
- 5) Don't know.
- 6) Don't know.
- 7) Don't know.
- 8) Don't know.
- 9) Yes.
- 10) Yes.
- 11) Yes.
- 12) No.

c) Were the groups similar at baseline regarding the most important prognostic indicators?

- 1) Don't know.
- 2) Don't know.
- 3) Yes.
- 4) Yes.
- 5) Yes.
- 6) Don't know.
- 7) Don't know.
- 8) Don't know.
- 9) Yes.
- 10) Yes.
- 11) Don't know.
- 12) Yes.

Intervention:

d) Were therapeutic and control interventions operationalised?

- 1) Yes.
- 2) Yes.
- 3) No. Some patients also received electroacupuncture.
- 4) Yes.
- 5) Yes.
- 6) Yes.
- 7) Yes.
- 8) Yes.
- 9) Yes.
- 10) Yes.
- 11) Yes.
- 12) Yes.

e) Was the care provider blinded?

- 1) No.
- 2) No.
- 3) No.
- 4) No.
- 5) No.
- 6) No.
- 7) Yes.
- 8) No.
- 9) No.
- 10) No.
- 11) No.

12) No.

f) Was there controlled for co-interventions which could explain the results?

1) No.

2) No.

3) No.

4) No.

5) No.

6) Yes. Invalid group found to have a contaminating effect on the acupuncture results.

7) No.

8) No.

9) Yes. Difference in pain estimates between placebo and acupuncture groups partially due to mean pain intensity increased in placebo group. Also, didn't control for possible mood changes among patients.

10) Yes. Possible psychological effects may have led to an overestimation of effects of acupuncture.

11) Yes. As participants were encouraged to be more aware of back pain and given handouts re: back care and exercises to perform they may have improved without any intervention.

12) Yes. No placebo group to control for the non-specific effects of acupuncture.

g) Was the compliance rate (in each group) unlikely to cause bias?

1) Yes.

2) Yes.

3) No. Low compliance and high drop out rate.

4) Yes.

5) Yes.

6) Yes.

7) Yes.

8) Yes.

9) Yes.

10) Yes.

11) Yes.

12) Yes.

h) Was the patient blinded?

1) Yes.

2) Yes.

3) No.

4) No.

5) Yes.

6) No.

7) Yes.

8) No.

9) Yes.

10) Yes.

11) Yes.

12) No.

Outcome Measurement:

i) Was the outcome assessor blinded?

1) Yes.

- 2) Yes.
- 3) No.
- 4) No.
- 5) Don't know.
- 6) No.
- 7) Yes.
- 8) Don't know.
- 9) Yes.
- 10) Yes.
- 11) Yes.
- 12) No.

j) Was at least one of the primary outcome measures applied?

- 1) Yes. Pain improvement rated by physician.
- 2) Yes. VAS.
- 3) Yes. Patients asked for pain score.
- 4) Yes. Patients asked for pain status.
- 5) Yes. VAS.
- 6) Yes. VAS.
- 7) Yes. VAS.
- 8) Yes. ADL score.
- 9) Yes. VAS.
- 10) Yes. VAS.
- 11) Yes. VAS.
- 12) Yes. Modified Roland Disability Questionnaire.

k) Was there a description of adverse effects?

- 1) No.
- 2) No.
- 3) No.
- 4) No.
- 5) No.
- 6) Yes. Inactive TENS machine may have a short-term placebo effect.
- 7) Yes. A few patients receiving dry-needling injections complained of increased pain.
- 8) No.
- 9) Yes. No complication of any kind occurred from the acupuncture treatments or during the follow-up period.
- 10) Yes. Minor, unserious events occurred in 3 patients.
- 11) Yes. In the acupuncture group, those who reported side-effects remarked that other pain had become more manifest because their back pain had subsided.
- 12) Yes. Subjects in the acupuncture group reported minor aching, bruising and light-headedness. One acupuncture subject withdrew from the study because of pain.

l) Was the withdrawal/drop-out rate unlikely to cause bias?

- 1) Yes.
- 2) No. 5 patients did not complete the first phase, 4 patients did not continue, and 9 patients failed to complete the second phase.
- 3) No. High drop out rate enforced a third treatment group to be established.
- 4) Yes.
- 5) Yes.
- 6) No. Large number did not complete follow up.

- 7) Yes.
- 8) Don't know.
- 9) Yes.
- 10) Yes.
- 11) Yes.
- 12) Yes.

m) Timing of follow-up measurements

I. Was a short-term follow-up measurement performed?

- 1) Yes. 2wk follow up applied.
- 2) Yes. 18wk follow up applied.
- 3) Yes. 10wk follow up applied.
- 4) Yes. 12wk follow up applied.
- 5) Yes. 10wk follow up applied.
- 6) Yes. 3mth follow up applied.
- 7) Yes. 2wk follow up applied.
- 8) Yes. 6wk follow up applied.
- 9) Yes. 3mth follow up applied.
- 10) Yes. 12wk follow up applied.
- 11) Yes. 6wk follow up applied.
- 12) Yes. 9wk follow up applied.

II. Was a long-term follow-up measurement performed?

- 1) No.
- 2) No.
- 3) Yes. 40wk follow up applied.
- 4) Yes. 12-61wk follow up applied.
- 5) No.
- 6) Yes. 6mth follow up applied.
- 7) No.
- 8) Yes. 6mth follow up applied.
- 9) Yes. 6mth follow up applied.
- 10) Yes. 9mth follow up applied.
- 11) Yes. 6mth follow up applied.
- 12) No.

n) Was the timing of the outcome assessment in both groups comparable?

- 1) Don't know.
- 2) No.
- 3) Yes.
- 4) Yes.
- 5) Don't know.
- 6) Yes.
- 7) Yes.
- 8) Yes.
- 9) Yes.
- 10) Yes.
- 11) Yes.
- 12) Yes.

Statistics:

o) Was the sample size for each group described?

- 1) Yes. Acupuncture grp – 15; sham acupuncture grp –15.

- 2) No.
- 3) Yes. Immediate grp –23; delayed grp – 16; inadequate grp – 11.
- 4) Yes. 29 study subjects, 27 control patients.
- 5) Yes. Acupuncture grp – 8; placebo grp – 9.
- 6) Yes. Electroacupuncture – 17; TENS – 18; TENS dead battery – 18.
- 7) Yes. Group A – 13; Group B – 14; Group C – 20; Group D – 16.
- 8) No.
- 9) Yes. Acupuncture grp – 34; Placebo grp – 16.
- 10) Yes. Acupuncture grp – 40; sham acupuncture grp – 45.
- 11) Yes. Acupuncture grp – 20; placebo TENS grp – 20.
- 12) Yes. Acupuncture grp – 24; control grp – 23.

p) Did the analysis include an intention-to-treat analysis?

- 1) Yes.
- 2) No.
- 3) No.
- 4) Yes.
- 5) Yes.
- 6) Yes.
- 7) Yes.
- 8) Yes.
- 9) Yes.
- 10) Yes.
- 11) Yes.
- 12) Yes.

q) Were the point estimates and measures of variability presented for the primary outcome measure?

- 1) No.
- 2) Yes.
- 3) No.
- 4) Yes.
- 5) No.
- 6) No.
- 7) No.
- 8) Yes.
- 9) Yes.
- 10) Yes.
- 11) Yes.
- 12) Yes

APPENDIX 16

Internal Validity Items

[Internal validity items: bi, bii, c, e, f, g, h, i, l, n]

1) Edelist et al. (1976)

Internal validity: 3/10 – 30% Low quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	N	?	?	?	Y	N	N	Y	Y	Y	Y	N	N	Y	N	?	Y	Y	N

2) Mendelson et al. (1978, 1983)

Internal validity: 5/10 – 50% Low quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	N	Y	?	?	Y	N	N	Y	Y	Y	Y	N	N	Y	N	Y	N	N	Y

3) Coan et al. (1980)

Internal validity: 2/10 – 20% Low quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	Y	Y	Y	N	N	N	N	N	N	N	Y	N	N	Y	Y	N	Y	N	N

4) Gunn et al. (1980)

Internal validity: 4/10 – 40% Low quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	Y	N	N	Y	Y	N	N	Y	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y

5) MacDonald et al. (1983)

Internal validity: 4/10 – 40% Low quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	Y	?	?	Y	Y	N	N	Y	Y	?	Y	N	Y	Y	N	?	Y	Y	N

6) Lehmann et al. (1983, 1986)

Internal validity: 3/10 – 30% Low quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	Y	?	?	?	Y	N	Y	Y	N	N	Y	Y	N	Y	Y	Y	Y	Y	N

7) Garvey et al. (1989)

Internal validity: 7/10 - 70% High quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	Y	Y	?	?	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N

- 8) Thomas & Lundberg (1994)
Internal validity: 3/10 – 30% Low quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	Y	?	?	Y	Y	N	N	Y	N	?	Y	N	?	Y	Y	Y	N	Y	Y

- 9) Carlsson & Sjolund (2001)
Internal validity: 9/10 - 90% High quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

- 10) Liebing et al. (2002)
Internal validity: 9/10 - 90% High quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

- 11) Kerr et al. (2003)
Internal validity: 8/10 - 80% High quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	Y	Y	Y	?	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

- 12) Meng et al. (2003)
Internal validity: 6/10 - 60% High quality.

Criteria	A	Bi	Bii	C	D	E	F	G	H	I	J	K	L	Mi	Mii	N	O	P	Q
Answer	Y	Y	N	Y	Y	N	Y	Y	N	N	Y	Y	Y	Y	N	Y	Y	Y	Y

APPENDIX 17

Proposal submitted to CNHLC in relation to my professional practice.

全國華人保健中心
CHINESE NATIONAL
HEALTHY LIVING CENTRE

The Lewisham Hospital 
NHS Trust

PROPOSAL FOR EVALUATION OF CNHLC TRADITIONAL CHINESE MEDICINE SUNDAY SURGERY CLINIC

Background and organisational context: CNHLC was founded in 1987 to promote healthy living, and provide access to health services, for the Chinese community in the UK. The community is widely dispersed across the country and currently makes the lowest use of health services of all Minority Ethnic groups. CNHLC aims to reduce the health inequality between the Chinese community and the general population. Language difficulties and long working hours in the catering trade present major obstacles to many Chinese people in accessing mainstream health provision. Language and cultural barriers can result in their being given inappropriate health solutions. Isolation is a common problem amongst this widely dispersed community and can lead to a range of mental illnesses. The Centre, based close to London's Chinatown, provides a range of services designed to tackle both the physical and psychological aspects of health. The Chinese National Healthy Living Centre is currently funded by the New Opportunities Fund and works closely with both statutory and community organisations in order to deliver their mission.

The TCM clinic is held every Sunday at the Soho Walk-in Centre, and holds 8 sessions per week on a pre-booked basis (although additional sessions may be provided if time allows). Trained TCM practitioners from the 'Asante Academy of Chinese Medicine' provide acupuncture treatment and herbal remedies. Practitioners often recommend a course of treatment for optimum results. The service was initially free, but now charges patients £10 per session, with additional charges for herbal remedies/medicines.

Aims of the TCM Sunday Surgery:

- To provide affordable TCM to any Chinese person requiring it
- To provide an alternative to orthodox Western medicine to any person requiring it, elderly Chinese in particular

Aims of the Evaluation:

- Find out *why* there's a need for the service – CNHLC will need to justify the need for the service to their funders.
- Profile of the people who access the service.
- Whether the clinic provides a successful TCM service for its users.

- Whether the popularity of the clinic has remained constant or changed.
- Establish the importance of the clinic for its service users.

Output indicators:

- Take up: Number of people who use the service
- Access: Profile of the people using the service

Outcomes	Outcome indicators
Treatment results in successful outcome for patient.	Patient agrees treatment has alleviated/cured symptoms presented by patient.
Patient has improved quality of life after treatment.	Patient expresses sense of improved wellbeing and QOL after treatment.
Patient receives satisfactory treatment.	Patient expresses satisfaction with the treatment they receive. Returns to re-use the service.

Methodology: The consultant will design a pre-consultation and post-consultation questionnaire. The pre-consultation questionnaire will be distributed to all patients attending the clinic before their consultation with a TCM practitioner. Patient will complete the questionnaire before attending their appointment. Approximately one month after their appointment, the patient will then be sent a post-consultation questionnaire to their home address through the post for them to complete and post back to the centre in a pre-paid envelope. The pre-consultation questionnaire will ask patients a few general demographic and health and lifestyle questions before moving on to more specific questions related to utilisation of TCM and Western medicine. Finally there will be a few questions on patients' expectations of their TCM appointment.

The post-consultation questionnaire will focus on aspects of the patients' first consultation with the clinic. Whether the TCM treatment was successful, whether the patient feels their QOL has been improved in any way, and whether the TCM service provided at the clinic met with patients' expectations and the reasons for this.

Practical Issues:

- Translations: Need to get confirmation that CNHLC will identify a translator for the questionnaires. Also need confirmation that translator will be a CNHLC voluntary work. Need to identify members of staff at CNHLC to proof read both questionnaires, once translations are complete.
- Payment: The consultant has agreed to work on the consultancy free of charge, for the good will generated, and as a favour to CNHLC. To show appreciation for the centre's help with previous research conducted by the consultant.

My Role: My role as consultant, is to plan and design an evaluation measuring outcomes of CNHLC's TCM Sunday Surgery Clinic. I shall attend the centre once a week; each Friday until my role in the consultation is complete. Once the design of the evaluation is complete I am to hand over the evaluation design to CNHLC, for their Evaluation Officer to commence with undertaking the evaluation. I will report

to CNHLC's Evaluation Officer on a regular basis. All work I carry out I shall finalise through both the Evaluation Officer and the Director before forwarding to the identified voluntary worker for translation. As I shall be attending CNHLC once a week, all other necessary contact between the Evaluation Officer and I, can be made via telephone or email at my office at Lewisham Hospital.

Time Frame: I aim to complete the design of the evaluation by the end of January 2005. By January 2005, the design of both a pre and post consultation questionnaire shall be complete and translated into Chinese and ready for CNHLC to distribute amongst its' TCM clinic users. At this point I shall hand the consultancy back over to CNHLC. In order for them to conduct the evaluation and analysis and write up their report. This means that by January 2005 the questionnaires shall be translated into Chinese, printed and ready to be distributed to new patients when they attend the TCM Sunday Surgery Clinic at CNHLC.

APPENDIX 18**Table 21. CNHLC TCM EVALUATION OBJECTIVES**

SPECIFIC MEASURABLE ACHIEVABLE REALISTIC TIMELY

Task	Detail	Date
Background research	Attend TCM clinic for 2-3 week to gain a feel of the clinic, its users and the TCM service provided.	October 2004
Background research	Read up on CNHLC literature. Enquire about other evaluations that may have been conducted at CNHLC in the past and ask for details of these. Start brainstorming a loose draft of an evaluation plan.	October/November 2004
Design	Begin work on the design of an evaluation. *Need to be aware of language and translation issues, need to take into account in evaluation design.	October/November 2004
Design	Finalise English version of pre and post consultation questionnaires.	December 2004
Translation	Forward pre and post consultation questionnaires on to voluntary worker to complete translation of questionnaires into traditional Chinese.	December 2004
Translation	Identify 2 members of staff to proof read questionnaires and finalise a final version of the questionnaire.	December 2004
Hand over	Once Chinese versions of the questionnaire have been proof read and passed, hand consultation over to evaluation officer to conduct and analyse.	End of Dec 2004

APPENDIX 19

全國華人保健中心
CHINESE NATIONAL
HEALTHY LIVING CENTRE

PRE TCM CLINIC CONSULTATION QUESTIONNAIRE

This questionnaire asks a few questions about your health and health behaviour. Please answer the questions to the best of your ability and knowledge. Unless the questions specifies, please tick only one answer per question. The questionnaire should take approximately 15 minutes to complete. The information will be used for our own evaluation purposes only. All information will be dealt with in the strictest of confidence.

BACKGROUND INFORMATION

1a. Name: _____

1b. Date of Birth: _____

1c. Sex:

- i) Male
- ii) Female

1d. Address:

2a. Which of these languages would you consider to be your 'first language'?

- i) Cantonese
- ii) Mandarin
- iii) Hakka
- iv) Hokkien
- v) Vietnamese
- vi) English
- vii) Other

Please specify _____

2b. Which other languages do you have a good knowledge of? (Can tick more

than one answer)

- i) Cantonese ()
- ii) Mandarin ()
- iii) Hakka ()
- iv) Hokkien ()
- v) Vietnamese ()
- vi) English ()
- vii) Other ()

Please specify _____

3. In which country were you born?

- i) China ()
- ii) Hong Kong ()
- iii) Malaysia ()
- iv) Vietnam ()
- v) Taiwan ()
- vi) UK ()
- vii) Other ()

4. Please specify where your parents are from: _____

5. How would you class your ethnicity?

- i) White ()
- ii) Mixed ()
- iii) Asian or Asian British ()
- iv) Black or Black British ()
- v) Chinese ()
- vi) Other ()

Please Specify _____

6. How long have you been a resident in the UK?

- i) Less than 1 year ()
- ii) 1-5 years ()
- iii) 6-10 years ()
- iv) 11-20 years ()
- v) More than 20 years ()

7. How easy or difficult do you find it to speak and communicate in English?

- i) Very Easy ()
- ii) Fairly Easy ()
- iii) Fairly Difficult ()
- iv) Very Difficult ()

HEALTH & LIFESTYLE

8a. How often do you exercise?

- i) Daily ()
- ii) Frequently ()
- iii) Rarely ()
- iv) Never ()

8b. What forms of exercise (e.g. running, swimming) do you practise most frequently?

9a. How much alcohol do you normally drink in a week?

- i) None ()
- ii) 1-7 drinks per week ()
- iii) 7-21 drinks per week ()
- iv) More than 21 drinks per week ()

9b. What type of alcoholic beverage do you normally consume?

10a. Do you smoke?

- i) Yes ()
- ii) No () Go to question 9

10b. If yes, how much do you smoke per day?

- i) Cigarettes () _____
- ii) Cigars () _____
- iii) Pipes () _____

11. How would you rate your dietary habits?

- i) Very good ()
- ii) Good ()
- iii) Average ()
- iv) Unhealthy ()
- v) Very unhealthy ()

12. How would you rate your own health?

- i) Very unhealthy ()
- ii) Unhealthy ()
- iii) Average health ()
- iv) Healthy ()
- v) Very healthy ()

UTILISATION OF GP SERVICES

13a. Are you registered with a GP clinic?

- i) Yes ()
- ii) No ()

13b. If no, why not?

14. When did you last visit your GP?

- i) Less than one week ()
- ii) One week to one month ()
- iii) Between one and two months ()
- iv) Between two and six months ()
- v) Between six and twelve months ()
- vi) More than twelve months ()
- vii) Never visited a GP ()

15a. Do you need to use an interpreter when visiting your GP or hospital doctor?

- i) Yes ()
- ii) No ()

- iii) Sometimes ()

15b. Is your interpreter normally: (Can tick more than one answer)

- i) Spouse/partner ()
- ii) Son/daughter ()
- iii) Friend ()
- iv) Relative ()
- v) Community Centre interpreter ()
- vi) Council interpreter ()
- vii) Hospital interpreter ()
- viii) Paid interpreter ()
- ix) Other ()

Please specify _____

15c. Do you feel confident that the interpreter effectively conveys your health queries to the practitioner?

- i) Yes ()
- ii) No ()
- iii) Some of the time ()
- iv) Most of the time ()
- v) Not at all ()
- vi) Don't know ()

UTILISATION OF TCM

16b. Why have you chosen to consult a TCM practitioner rather than your own GP today? (Can tick more than one answer)

- i) I have tried Western medicine but it was not successful ()
- ii) Trust in TCM ()
- iii) Language is not a barrier ()
- iv) Do not have GP ()
- v) Other ()

Please specify _____

16c. If your answer to 15b was i), in what ways was Western medicine not successful? (Can tick more than one answer)

- i) GP did not understand my problem ()
- ii) The treatment only provided temporary relief from symptoms and not a complete cure ()
- iii) I was unable to accept the treatment offered by Western medicine ()

- iv) Western medicines are not suitable for me ()
- v) Western medicines have adverse effects on the body ()
- vi) Other ()

Please specify _____

16d. If your answer to 15b was not i), do you always consult a TCM practitioner first rather than your own GP?

- i) Yes ()
- ii) No ()

17a. Have you visited other TCM Practitioners in the UK before?

- i) Yes ()
- ii) No () Go to question 16d

17b. If yes, what forms of treatment have you received in the past from TCM clinics? (Can tick more than one answer)

- i) Acupuncture ()
- ii) Herbal medicine ()
- iii) Both ()
- iv) Advice ()
- v) Other ()

Please specify _____

17c. If you have visited other TCM clinics in the past, what were the reasons behind your visits? (Can tick more than one answer)

- i) Treatment for a specific medical condition ()
- ii) To improve well-being and illness prevention ()
- iii) For general health advice ()
- iv) Other reasons ()

Please specify _____

17d. If no, why have you never visited other TCM practitioners before? (Can tick more than one answer)

- i) No opportunity ()
- ii) Too expensive ()
- iii) Uncertain of practitioner qualifications ()
- iv) Other ()

Please specify _____

18. What made you choose this particular TCM clinic today? (Can tick more than one answer)

- i) Recommended by friend/family ()

- ii) Good reputation ()
 - iii) Cheaper than other clinics ()
 - iv) Other reason ()
- Please specify _____

19. What expectations, if any, do you have about visiting this clinic today?

YOUR VIEWS ON TCM

20a. Which type of medical practitioner do you prefer to consult?

- i) TCM practitioner ()
- ii) GP ()

20b. Why?

21a. There are some health problems for which TCM is better at treating than Western medicine?

- i) Strongly Agree ()
- ii) Agree ()
- iii) Neither ()
- iv) Disagree ()
- v) Strongly Disagree ()

21b. There are some health problems for which Western medicine is better at treating than TCM?

- i) Strongly Agree ()
- ii) Agree ()
- iii) Neither ()
- iv) Disagree ()
- v) Strongly Disagree ()

22a. There are some medical conditions for which I would choose to consult a TCM practitioner?

- i) Yes
- ii) No

22b. If yes, please indicate which category of illness/disease you would choose TCM to treat. (Can circle more than one)

Heart/cardiovascular	Lung	Liver/Kidney	Ears/Nose/Throat
Bones/Joints		Gastrointestinal	Skin Cancer
Men's health		Gynaecology	Fertility

23a. There are some medical conditions for which I would choose to consult a GP?

- i) Yes
- ii) No

23b. If yes, please indicate which category of illness/disease you would use Western medicine to treat. (Can circle more than one)

Heart/cardiovascular	Lung	Liver/Kidney	Ears/Nose/Throat
Bones/Joints		Gastrointestinal	Skin Cancer
Men's health		Gynaecology	Fertility

24a. Have you used Chinese herbal medicine at home before?

- i) Yes
- ii) No

24b. If yes, what was your reason for using Chinese herbal medicine at home? (Can tick more than one answer)

- i) For general health
- ii) Prevention of illness
- iii) Treatment for a specific condition
- iv) Other

Please specify _____

24c. Do any other members of your family use TCM at home?

- i) Yes
- ii) No

24d. Do any members of your family visit TCM practitioners?

- i) Yes ()
- ii) No ()

IF YOU ARE TREATING A SPECIFIC MEDICAL CONDITION, THE FOLLOWING QUESTIONS WILL ALLOW US TO ASSESS HOW THIS CONDITION AFFECTS YOUR QUALITY OF LIFE NOW.

25. How much does your condition affect your lifestyle? Please indicate how your condition may have limited your participation in the following activities over the past 2 weeks.

	Severely limited	Limited quite a bit	Moderately limited	Slightly limited	Did not limit at all	Does not apply or did not do for other reasons
Hobbies, recreational activities						
Working or doing household chores						
Visiting family or friends out of your home						
Bathing, using the toilet						
Going shopping						

26. If your condition causes you pain, how would you describe how your pain has felt over the past 2 weeks?

The pain...

comes and goes and is very mild	is mild and does not vary much	comes and goes and is moderate	is moderate and does not vary much	is severe but comes and goes	is severe and does not vary much

27. Over the past 2 weeks, how much has your condition interfered with your enjoyment of life?

It has extremely limited my enjoyment of life	It has limited my enjoyment of life quite a bit	It has moderately limited my enjoyment of life	It has slightly limited my enjoyment of life	It has not limited my enjoyment of life at all

28. If you had to spend the rest of your life with your condition the way it is right now, how would you feel about this?

Not at all satisfied	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied

APPENDIX 20

全國華人保健中心 CHINESE NATIONAL HEALTHY LIVING CENTRE

POST TCM CONSULTATION QUESTIONNAIRE

This questionnaire asks a few questions about the treatment you received from our TCM clinic. You may remember completing a similar questionnaire at your first visit to the TCM clinic. This survey is simply a follow-up of the services you received. Please try to answer the questions to the best of your ability and knowledge. Unless the question specifies, please tick only one answer per question. This questionnaire should take approximately 15 minutes to complete. The information gathered is to be used purely for CNHLC's evaluation purposes. All information will be dealt with in the strictest of confidence.

1. When did you last visit the TCM clinic?

- i) Less than one week ()
- ii) One week to one month ()
- iii) Between one and two months ()
- iv) Between two and six months ()
- v) Between six and twelve months ()
- vi) More than twelve months ()

2. How many times have you visited the clinic?

- i) None ()
- ii) Once ()
- iii) Twice ()
- iv) Three to four times ()
- v) More than four times ()

3. What treatment(s) did you receive during your visit(s) to the TCM clinic?(Can tick more than one answer)

- i) Acupuncture ()
- ii) Herbal medicine ()
- iii) Both ()
- iv) Advice ()
- v) Other ()

Please specify _____

TCM PRACTITIONER / PATIENT RELATIONSHIP
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4. On your last visit to the TCM clinic, did you feel the time the TCM practitioner spent with you was:
- i) Long enough ()
 - ii) Too short ()
 - iii) OK ()
5. On your last visit to the TCM clinic, was the TCM practitioner:
- i) Sympathetic to your problem ()
 - ii) Unsympathetic to your problem ()
 - iii) Neither ()
6. On your last visit to the TCM clinic, did you feel that you received accurate information about your diagnosis, treatment and care plan from the TCM practitioner?
- i) Yes ()
 - ii) No ()
7. On your last visit to the TCM clinic, did you feel that information regarding your health was presented by the TCM practitioner in a way that was easy for you to understand?
- i) Yes ()
 - ii) No ()
8. On your last visit to the TCM clinic, did you feel your questions were answered satisfactorily by the TCM practitioner?
- i) Yes ()
 - ii) No ()
9. On your last visit to the TCM clinic, how did you feel that you and the TCM practitioner communicated with each other in your consultation?
- i) Very well ()
 - ii) Well ()
 - iii) OK ()
 - iv) Poorly ()
 - v) Not at all ()
10. On your last visit to the TCM clinic, did you feel the TCM practitioner listened to you when you tried to explain your health problem to him/her?
- i) Yes ()
 - ii) No ()

11. On your last visit to the TCM clinic, did you trust the TCM practitioner enough to talk openly about your health problems with him/her?

- i) Very much ()
- ii) A little ()
- iii) Not at all ()

TCM TREATMENT & SERVICE

12. Were you satisfied with the level of service you received from the CNHLC TCM clinic on your last visit?

- i) Yes ()
- ii) No ()

13a. Were you satisfied with the treatment you received from the CNHLC TCM clinic on your last visit?

- i) Yes ()
- ii) No ()

13b. If yes, which aspects of your treatment were you happy with?

13c. If no, which aspects of your treatment were you not happy with?

14a. Do you feel that the treatment you received at the CNHLC TCM clinic alleviated your symptoms?

- i) Yes ()
- ii) No ()

14b. In what ways?

15a. Do you feel that the treatment you received at the CNHLC TCM clinic cured your symptoms/illness?

- i) Yes ()
- ii) No ()

15b. In what ways?

16a. Do you feel that the treatment you received at the CNHLC TCM clinic improved your overall health?

- i) Yes ()
- ii) No ()

16b. In what ways?

17. How would you rate your own health?

- v) Very unhealthy ()
- vi) Unhealthy ()
- vii) Average health ()
- viii) Healthy ()
- v) Very healthy ()

18a. Do you feel that the service and treatment at our CNHLC TCM clinic met your expectations?

- i) Yes ()
- ii) No ()

18b. In what ways?

19. Overall, were you generally satisfied or dissatisfied with the outcome of your visit to the CNHLC TCM service?

- i) Satisfied ()
- ii) Dissatisfied ()
- iii) Neither ()

20. Overall, what is your general opinion on the quality of the TCM service provided at CNHLC?

- i) Very good ()
- ii) Good ()
- iii) OK ()
- iv) Poor ()
- v) Very poor ()

21. What would make using our services easier for you?

22. Why did you decide to use our TCM clinic rather than see your own GP?

23. What would you do if you did not use the TCM service provided by CNHLC?

24a. Would you return to use the TCM service at CNHLC again?

- i) Yes ()
- ii) No ()
- iii) Maybe ()

24b. Why?

25. Would you recommend our service to others?

- i) Yes ()
- ii) No ()

Please feel free to make further comments or suggestions about the CNHLC TCM clinic.

IF YOU RECEIVED TREATMENT FOR A SPECIFIC MEDICAL CONDITION, THE FOLLOWING QUESTIONS WILL ALLOW US TO ASSESS HOW THIS CONDITION AFFECTS YOUR QUALITY OF LIFE NOW.

26. How much does your condition affect your lifestyle? Please indicate how your condition may have limited your participation in the following activities over the past 2 weeks.

	Severely limited	Limited quite a bit	Moderately limited	Slightly limited	Did not limit at all	Does not apply or did not do for other reasons
Hobbies, recreational activities						
Working or doing household chores						
Visiting family or friends out of your home						
Bathing, using the toilet						
Going shopping						

27. If your condition causes you pain, how would you describe how your pain has felt over the past 2 weeks?

The pain...

comes and goes and is very mild	is mild and does not vary much	comes and goes and is moderate	is moderate and does not vary much	is severe but comes and goes	is severe and does not vary much

28. Over the past 2 weeks, how much has your condition interfered with your enjoyment of life?

It has extremely	It has limited my enjoyment	It has moderately	It has slightly limited my	It has not limited my

limited my enjoyment of life	of life quite a bit	limited my enjoyment of life	enjoyment of life	enjoyment of life at all

29. If you had to spend the rest of your life with your condition the way it is right now, how would you feel about this?

Not at all satisfied	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied