

**Immigrant Doctors Practising Non-
Western Medicine:
A Study of Self-Employed Immigrant
Chinese and Indian Doctors Practising
Non-Biomedical Traditions of Medicine**

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This project is part of the New Settlers Programme at Massey University, supported by funding (1997-2004) from the Foundation for Research, Science and Technology. The NSP is designed to reduce the difficulties experienced by immigrants in the process of settlement, and increase the benefits accruing to New Zealand from its targeted immigration programme. The programme encompassed 3 main objectives: (1) a longitudinal study of new settlers; (2) determining host society context: policies and practices; and (3) determining the wider immigrant context and experience. This study is part of objective 3 with the aim to collect information on clinics offering Chinese medicine/therapy and Ayurvedic medicine using 12 –15 case studies from Auckland, Wellington and Palmerston North. Objective 2 is also addressed in the responses of the host society to the doctors and their practices.

EXECUTIVE SUMMARY

A comparative case study of recent immigrant doctors practising traditional Chinese medicine, Ayurvedic and homeopathic medicine was conducted in Auckland, Palmerston North and Wellington between July 2004 and February 2005, in which data were systematically collected via personal interviews with 14 immigrant doctors running private clinics. The study expanded on a previous investigation into the self-employment of immigrants as an alternative to employment, specifically to explore self-employment by these doctors in complementary and alternative medicine' as a response to known barriers experienced by overseas trained doctors in becoming registered as doctors in New Zealand.

Aims and Objectives

The broad aims of the study were: to illuminate the context and experiences of one group of skilled immigrants – doctors - settling in New Zealand and running clinics offering non-Western medicine, and; to illuminate the effects on their clinical practices of relevant New Zealand policies and practices. Reflecting the participants and the clinics they ran, the investigation shed light on the contribution of these skilled immigrants to New Zealand health services, and the response of the wider New Zealand society to these immigrants and their services. In order to meet the aims, the specific objectives of the study were to determine the following issues from clinic owners offering Chinese medicine/therapy, Ayurvedic and homeopathic medicine:

- The role and importance of meeting the needs of both immigrants and others in the general community;
- Relationships with local GPs and other health services;
- Experience in areas such as staff recruitment;
- Issues related to health regulations, and the effect on the operations of clinics, and other compliance requirements.

Results

The study provided a window to investigate the settlement experiences of a group of highly skilled professionals who encountered barriers to practising in their profession of medicine in the mainstream health sector. None of the participants engaged explicitly with their immigrant community in the promotion of the business, for example in seeking financial support, sponsorship or advertising. Indeed, the picture that emerged was that the focus of the participants was on

improving the range and quality of health services as an adjunct to Western medicine in New Zealand. The results are reported under three themes:

1. The doctors, clients and business operations:

A key finding of this study is that in many cases, the doctors set up practices in the respective traditions because of barriers to their registration as medical doctors in New Zealand. This was in spite of the fact that all except one had at least a bachelor degree (5 years of study), several with Masters and PhD degrees, that they said were equivalent to a degree in medicine. Indeed, most had studied along with students of Western medicine with parts of the curriculum common to both disciplines of medicine; and in the case of Chinese doctors most had qualified in Western medicine in programmes that included traditional Chinese medicine. The barriers to registration as medical doctors in New Zealand included English language, cost, and reputed difficulties; most did not attempt registration. A number of participants said that even in the country of origin, they preferred non-Western medicine and were motivated by their desire to introduce the therapy to New Zealanders. Most participants had opened their clinic soon after arriving in New Zealand.

On the positive side, the participants were able to make a good living. The appreciation of their clients compensated for the lack of recognition from medical professions. These clients were described as mainly 'Kiwi' (that is, New Zealand European, Maori and Pacific peoples); on average 10-15 percent of the clients in a given clinic were immigrants from the doctor's country of origin. All ages were reflected in the client base, with adults making up the majority, a large proportion of whom were suffering from chronic disorders that mainstream medicine had not adequately relieved. In view of the fact that many clients were unfamiliar with the underlying theories of non-Western medicine, participants emphasised the importance of explanations, and over half had prepared written information. Many participants worked flexible hours to suit their clients' requirements and over half employed other staff.

2. Interactions with New Zealand's health system

Although the clinical services were marginal to the mainstream health system, the doctors nonetheless were affected by legislation and statutes, e.g. Health and Disability Commissioner Act. An important implication of the marginal status is that with the exception of ACC-funded acupuncture, the services are not subsidised, and clients must pay out of their own pocket for services. Currently the medical practices they were engaged in were not regulated and all participants wished to see greater regulation for the protection of clients and to restrict access to poorly trained practitioners. Participants reported that collegial relationships with their counterparts working in mainstream health services was limited and usually informal. However, clients were sometimes advised by their general practitioners (GP) or other health professional to consult clinics offering alternatives, such as TCM,

to Western medicine, and participants likewise would advise their clients to consult their GP. In addition to their clinical work, a number of doctors were actively engaged in educational programmes, training others in the tradition and its therapeutic techniques, and most were active in professional development and continuing education in their respective professional associations.

3. Professional practice in New Zealand

Participants compared practising non-Western medicine in New Zealand compared with the country of origin, where all the doctors had been very active in their professional organisations, and some had been teaching and engaged in research, professional activities no longer possible. In New Zealand, the practice was marginalised as alternative and complementary, which contrasted sharply with a status equal to Western medicine in the country of origin. Compounding their difficulties, the doctors could not access diagnostic services as they could in the country of origin, nor formally refer patients to other services, and had little engagement with the medical profession in New Zealand. All belonged to the relevant professional association in New Zealand, and through their membership had gained some knowledge necessary to practising in the New Zealand environment. This was particularly the case for acupuncturists; all Chinese doctors were ACC registered and therefore had access to some funding of services.

Conclusions

Immigrant doctors from non-traditional countries and programmes provides a window on the settlement experiences of highly skilled professionals, immigrants who encounter particular difficulty in finding employment in their professional area or expertise and at a level appropriate to their experience. TCM, Ayurvedic and homeopathic medicine are in New Zealand, as in other Western countries, categorised as complementary and alternative medicine. For the participants, this marginal position created a range of difficulties in their practice and contrasted sharply with their status and practice in their country of origin. In addition, whereas many participants had previously been respected hospital specialists, in New Zealand hospital-based practice was not available. All participants practised in the primary level of health services. Participants, therefore, needed to make major adjustments to their professional practice as well as adapt to an unaccustomed marginal status in the health system. At the same time as they adjusted to living in New Zealand society, they needed to learn new ways of interacting with the health system and getting the required support for their clients. Added to this, these doctors were also grappling with issues common to many skilled immigrants. While many conveyed their disappointment with the reality of being a skilled immigrant in New Zealand compared with their expectations, most were also positive about the futures

of their families. In the present, however, they were struggling with loss of status as a highly regarded doctor with a high status in society; their realities were the low and marginal status of 'alternative' practitioner compounded with the marginal status of 'immigrant'.

In spite of the negative side to being marginalised professionally, no participant gave the impression they might return to the country of origin to resume practice there. Rather, the participants conveyed a strong commitment to New Zealand: they were positive about the futures of their families; they were keen to establish high quality health services in the tradition in New Zealand; they spoke of being motivated by their compassion for the suffering, many of whom were poor; were confident in the efficacy and safety of the therapies; and offered opinions on how to improve and integrate health services New Zealand. In addition to their clinical work, a number of doctors were actively engaged in educational programmes, training and mentoring others in the modality, and most were active in professional development and continuing education in their respective professional associations.

Recommendations

Recommendations arising from the study fall into two areas: immigrant doctors practising non-Western medical traditions; and for users, including immigrants and New Zealanders.

1. Recommendations arising from the experiences and perspectives of the immigrant doctors:

- New Zealand could learn from immigrant doctors' experiences and perspectives on integrated medical traditions and pluralistic health systems in order to broaden access to effective therapies and increase efficiency and equity of the health system.
- The evidence for effectiveness and safety of interventions for particular conditions established in international research needs to be compiled, and subsidised treatment available to those that meet the required standards.
- New Zealand can investigate international best practice specifically in other OECD countries and their experiences of integrating and improving access to TCM, Ayurvedic and homeopathic medicine.
- Practitioners' calls for improved regulation need to be investigated and appropriate action taken.
- Further research is needed on the barriers experienced by highly skilled professional immigrants and barriers to employment in their professional area of expertise.

2. Recommendations arising from the descriptions of users:

- The needs of the Asian immigrant communities for better access to the medical traditions from their countries of origin offered in New Zealand to be further investigated and the findings used to inform policy.
- The effectiveness of non-Western medical traditions to ease the burden of symptoms of those with chronic conditions (where Western medicine is ineffective) needs to be investigated and findings used to inform policy.
- Further research is needed on the experiences and perspectives of all New Zealanders, including recent immigrants, on health service use, access and preferences.

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INTRODUCTION

Major changes to New Zealand immigration policy in the context of an extensive process of deregulation and liberalisation of the economy over the past two decades has led to an ethnic and culturally diverse society. Immigration policy has encouraged an inflow of highly qualified and skilled working age immigrants from non-traditional sources, i.e. from countries other than the U.K. and Europe (see Trlin, 1988; 1992; 1997). Two consequences of the liberalisation of immigration policy are, on the one hand, the difficulties encountered by skilled immigrants in finding employment in their field and, on the other hand, the demand created by recent immigrants for the ranges of goods and services they were accustomed to in their countries of origin.

In relation to employment of skilled migrants, the difficulties experienced by highly qualified immigrants in securing satisfactory employment has been well-documented both in New Zealand (e.g. Boyer, 1996 & 1998; Department of Internal Affairs, 1996; Frieson & Ip, 1997; Ho, Goodwin, Bedford & Spragg, 1997; Ho & Lidgard, 1997; Ho, Lidgard, Bedford & Spoonley, 1997; Lidgard & Yoon, 1998; North, 2007; North & Trlin, 2004; Trlin, Henderson & North, 1999 and 2004), and in Australia (e.g. Miller & Neo, 1997). Medical doctors are one professional group that encounters particular barriers in practising in New Zealand, particularly those who qualified in non-traditional source countries, in medical programmes not included in an approved list, and in languages other than English. The Medical Council of New Zealand requires such medical doctors to be registered in New Zealand, a process commonly involving medical and English communication examinations and professional supervision, a process with a reputation among immigrant doctors as being costly and difficult to achieve (North, Trlin & Singh, 1999).

Turning now to the issue of the demand created by immigration. In the last two decades, New Zealand has experienced large scale Asian migration, in particular from China and India. New Zealand's population profile has undergone considerable shifts demographically over the period, with Asian peoples in particular having increased rapidly relative to Pacific Island peoples. According to the 2001 census, Asian peoples comprised 6.6 percent (237,459) of the population of New Zealand and at the time Statistics New Zealand projected that the percentage would increase to 13 percent (667,000) by the year 2021. The Asian population had increased by almost 50 percent to 354,552 by the 2006 census, making it the fastest growing ethnic group (Statistics NZ, 2007). Within the broad category of 'Asian', there are many different ethnic groups, the largest being the Chinese, accounting for 44 percent of the Asian population. Other ethnic groups, ranked in order of size, are Indian, Korean, Filipino, Japanese, Sri Lankan, Cambodian and Thai (Statistics New

Zealand, 2002a; 2002b; 2007). As a consequence of increases in Asian and other ethnicities, the proportion of the population identified as European has declined from 80 percent in 2001 to 67.6 percent in 2006, and is lowest at 56.5 percent in Auckland, the country's most ethnically diverse city.

Increasing diversity of the population has been linked to the growing demand for complementary/alternative medicine (CAM). Traditional Chinese medicine (TCM), in particular acupuncture and, to a lesser extent Indian Ayurvedic treatments and techniques, have been added to alternative therapies developed in Western cultures such as chiropractic, osteopathy and homeopathy. By offering these therapies and medical systems, immigrant Chinese and Indian medical practitioners are finding niches in a society that has historically used predominantly Western medicines and techniques, and provides an alternative to seeking registration as medical practitioners with the New Zealand Medical Council. The following background discussion focuses on the emergence of medical therapies from the East (China and India) in the West.

Complementary and Alternative Medicine in New Zealand and the West

Western biomedicine has, since the early days of European settlement, been dominant in New Zealand and regarded as mainstream in policy, funding and delivery. Beginning with Maori medicine (it was illegal to practice for decades after the 1907 Tohunga Suppression Act), healing theories and techniques not condoned by Western biomedical institutions have not been encouraged. Evidence for the official support of Western biomedicine can be found on Immigration New Zealand's website that provides advice of what a prospective immigrant may expect, and specifies that a general practitioner (GP) is likely to be the first contact with the health system (Immigration New Zealand, 2005). A list on the site of publicly funded health services includes free public hospital treatment, subsidies on prescription items, subsidised fees for visits to GPs, subsidised fees through ACC for post-injury visits to physiotherapists, chiropractors and osteopaths when referred by a GP, free or subsidised health care for those suffering from acute or chronic medical conditions, and no charge for laboratory tests and X-rays (except at privately operated clinics).

Complementary and alternative medicine (CAM) has always been the less accepted and less utilised alternative. However, according to Murray and Shepherd (1993) and Botting and Cook (2000), CAM has enjoyed steady growth over the last 20 years as people use it as an adjunct to conventional medicine, a trend that is likely to influence the health care industry. Terminology used shows how attitudes to CAM

have softened over the years: labelled 'lunatic fringe' in 1975, then 'fringe', by the 1980s, it became 'alternative', then 'complementary'. By the mid-1990s, 'integrated' or 'integrative' medicine became the preferred terminology (Chan, 2001). As an example of the growing acknowledgement of the place of CAM, New Zealand's Ministry of Health prepared a report on CAM in 2002. This report defined CAM as "a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period" (O'Connor, Calabrese, Cardena et al., 1997 cited in MOH, 2003, p 2). Using this definition, traditional Chinese medicine (TCM) including acupuncture, and Ayurvedic medicine are categorised as CAM in New Zealand and other Western countries, although they are regarded as mainstream in China and India respectively.

Many patients suffering from symptoms of chronic pain, allergic, musculoskeletal, psychosomatic and functional conditions have not experienced adequate relief by the treatment they get from orthodox medicine; a large portion of such patients turn to traditional or alternative medicines. Murray and Shepherd (1993) comment that "perhaps the most attractive aspect of many of these treatments is the 'holistic' approach and the orientation towards the individual's 'felt needs' rather than the clinically determined need for health care" (Murray & Shepherd, 1993, p983). The study revealed that high proportions of people claim to have experimented with alternative medicines at some stage (27 – 29 percent of men and 33 percent of women; see Murray & Shepherd, 1993, p983). Medical practitioners and academics have expressed concern over the abandonment of conventional practice for largely untested traditional therapies. Despite a lack of scientific evidence supporting CAM, a reported 42 percent of the population of the United States have experimented with alternative treatment in some form. Other studies (e.g. Eisenberg et al, 1983; Berger, 1993; Yates et al, 1993; Northcott & Bachynsky, 1993; Hedley, 1992; and Saks, 1995) show that increasing numbers of people in North America and Europe are turning to alternative forms of health care, particularly those that have emerged from the East. Therapies not tested to the same extent nor using the same methods as the scientific evidence underpinning biomedicine can nonetheless help calm a patient, relax their mind and so aid in healing their body. In addition, holistic integrated approaches to healing foster the patient taking control of broader lifestyle issues that enhance health and wellness.

The growth of CAM is also increasingly relevant in New Zealand, largely because of an increasingly diverse culture. For example, in a longitudinal study (North, Trlin & Henderson, 2004), Chinese and Indian participants often commented they were not registered with a GP as they preferred CAM treatments. When asked how participants treated illness, responses included: a GP was unnecessary; TCM or homeopathy medicine were preferred; they preferred self care; they used Western

medicine for their children only; didn't 'believe' in Western medicine; and they used a combination of both Eastern and Western remedies. Recognising the growing diversity of New Zealand's population and that injury rehabilitation services were not accessed to the same extent by the Chinese population, ACC commissioned a literature review on the use of TCM, including acupuncture in the treatment and rehabilitation of injuries. This review was limited because of its exclusion of Chinese language literature, literature that was most likely to report on scientific research. Nevertheless, a number of randomised controlled trials conducted in the West on the efficacy of acupuncture did provide evidence for its usefulness in relieving acute pain, and in the case of chronic pain syndromes, noting that generally these patients have responded poorly to conventional interventions. In addition, acupuncture was shown to be a very safe treatment, but studies into cost-effectiveness were not found (see North, Lim & Ward, 2005, for a comprehensive review of that literature.)

There has been minimal research published in New Zealand on the topic. Helen Chan (2001) found only four published studies on CAM in New Zealand from 1988 to 2000. She claimed that CAM has received little attention from medical researchers and there is insufficient funding available for such research. As early as 1987 the then Department of health published a monograph on complementary therapies (Leibrich, Hickling & Pitt, 1987). In 2001, the Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) was set up (in a three year scheme) to provide the Minister of Health with information and advice on CAM in New Zealand, partly to safeguard consumer safety (Ministry of Health, 2003). In New Zealand at present, no organisation has overall responsibility for providing consumer information on CAM and so consumers may be ill-advised, exposed to risk, mix medications or not enjoy the full benefits of CAM. New Zealand development regarding CAM reflects initiatives in other Western countries, such as in the United States where in 2000, President Clinton signed an order establishing the White House Commission on Complementary and Alternative Medicine, with the aim of increasing knowledge and research so as to maximise the benefits of complementary and alternative therapies received by Americans (Boozang, 2003).

The growth of CAM in the Western world and increasing acceptance as potentially worthwhile has largely increased the level of research on the topic. The majority of research introduces CAM as a system to run parallel to, as opposed to replacing, conventional methods. Reflecting this, many medical schools in the United States, including Harvard (see Schneiderman, 2003) have established programmes in alternative therapy. Reflecting the growth in research, there is an emerging literature on various aspects of this phenomenon with hundreds of articles and dozens of texts already on the market. The *Journal of American Medical Association* and associated Archives journals chose alternative medicine for their 1998 theme issue. Some research has explored physicians' attitudes and practices regarding this increasingly prevalent phenomenon (Barrett, Marchand, Scheder, Appelbaum, Chapman, Jacobs,

Westergaard & St Clair, 2000, p235). Despite a growing interest in alternative treatments they are still not recognised as significant therapies for serious illness in some Western countries. For example, in Canada, where a sizable proportion of the population use alternative therapy in some form, the health system, which provides monetary support on other areas of health, does not supplement those who seek out alternative therapies (with the exception of those using chiropractic services who receive small reimbursements from the government). Kelner and Wellman (1997, p204) observed:

Thus, people who venture beyond the medical system are not making neutral decisions. If they remain within the system they are assured that their health care costs will be covered by government insurance and if they go elsewhere they must be prepared to bear the costs of their cure.

With the emergence of alternative therapy in the West the question has also arisen as to why patients select traditional medicine over scientifically proven conventional medicine that their particular culture has had faith in for centuries. Some researchers believe that the shift signifies a fundamental change in values, a move away from a materialistic lifestyle and toward a more 'naturalistic' existence, running parallel with CAM theory that a state of health is achievable through personal preventative actions. Others have chosen to use alternative health methods as opposed to orthodox medicine due to negative past experiences with Western medicine. Scholars such as Fulder (1998) and Furnham and Smith (1988) agree that people who use alternative practitioners 'are mostly refugees from conventional medicine' (Fulder, 1998, p30). Researchers Kelner and Wellman (1997) also note that the use of alternative therapy does not necessitate the complete abandonment of conventional treatments as often the treatments can be used in tandem to complement each other. This is often the case in examples such as cancer sufferers who undergo Western medical treatments but may use complementary methods to help aid the body in the physical and mental recovery often needed after harsh chemical and radiographic therapy treatments. Other patients may choose chiropractors for backaches, naturopaths for colds and Reiki practitioners for emotional stress. Sometimes they use a combination of treatments for a specific problem. They may see both a family physician and an acupuncturist for allergies or skin disease. In fact, many use multiple therapies concurrently. Other scholars put forward claims that a decision to seek care from alternative practitioners was part of a deliberate strategy reflecting a belief in an "alternative therapy ideology" (Pawluch, Cain & Gillett, 1994). Vincent and Furnham's (1996) suggest four principal reasons for people choosing alternative care as opposed to conventional medicine: belief in the positive value of alternative care; the ineffectiveness of conventional medicine; concern about adverse side effects of conventional medicine; and poor communication between patients and medical practitioners.

The Medical Traditions of China and India

In both China and, to a lesser extent, the Indian sub-continent, hospitals specialise in both Eastern and Western methods. In some cases, especially for those suffering from chronic illnesses, Eastern traditional medicines may replace Western techniques, although more commonly, a combination of the two is employed. In China, acupuncture and Chinese herbal medicines and supplements compete with, provide an alternative to, or complement Western medicine available from hospitals and licensed physicians' offices. And in India, homeopathic and Ayurvedic medicine run parallel to, and are sometimes integrated with, Western medicine. The harmony and integration of what in the West are competing systems of healing are in China and India reflected in medical education. Frequently, medical programmes in Western and Chinese medicine, in the case of China, and Western, homeopathic and Ayurvedic medicine, in India, take place together in the same medical school. Students study a common curriculum where appropriate such as in anatomy, biochemistry, maternity and surgery, and separate curricula such as in medicine and pharmaceuticals. Traditional Chinese and Indian medicine works by healing and balancing a patient's entire being. Traditional practitioners encourage a patient to make significant lifestyle changes to their diet, exercise regimen and relaxation methods (Liu, 1998; see also Appendix 1- participants' explanations in present study, and summaries from published sources).

Scheid (1999) commented that in an effort to heighten TCM's appeal abroad, changes have appeared including the use of research acceptable internationally. Leading Chinese medical schools and research organisations in 2003 formed a consortium, with its headquarters at the University of Hong Kong, to promote traditional treatments worldwide. The Consortium for Globalization of Chinese Medicine has as its mission to "advance the field of Chinese herbal medicine to benefit human kind through joint efforts of academic institutions, industries and regulatory agencies around the world" (Consortium for Globalization of Chinese Medicine, 2005; Yeung, 2003). Another issue for some Asian countries is the different levels of regulation of Western medicine and TCM, with TCM practitioners traditionally not being licensed, with the conversant risks to public safety. For example the Singapore government has recently introduced a system of registration and licensing for TCM practitioners, bringing Singapore in line with other countries in the Asia-Pacific region, most of which had recently officially recognised TCM practice (Lim, Sadarangani, Chan & Heng, 2005).

Hong Kong and Singapore are examples of previous British colonies with predominantly Chinese populations where Western medicine was introduced and became the dominant system. In spite of the hegemony of Western medicine, the practice of TCM has survived and its use continues. In Hong Kong, the local

population also uses Chinese herbal medicine and most people probably use Chinese concepts to explain and understand their health problems (Lam, 2001). Lam (2001) showed, in a study in Hong Kong, that although Western medicine was used when a speedy recovery was required, patients used TCM for milder illnesses such as coughs and colds, and also to supplement Western medicine, to “clear the root of the disease” and to manage the side effects of Western medicines. However, both types of medical systems were considered to have strengths and weaknesses and the decision on which system to choose depended on the type of illness the person was suffering from. Further, Western medicine was often less expensive for employees as it was covered by their medical insurance schemes but participants felt it was too strong and not good for the body. Chinese medicine was also seen to have shortcomings: Chinese herbal remedies were less convenient, slower to take effect and not as easily ingested as Western medicines and, during treatment, certain foods often had to be avoided. A Singapore study by Lim, Sadarangani, Chan and Heng (2005) found that Chinese (84 percent) were the most frequent users of CAM over a 12-month period and TCM (88 percent) was the most widely utilised form of CAM. In line with other studies, the study found that the majority of all of the CAM users (95 percent) were also users of Western medicine, CAM was more likely to be used for maintaining health rather than the treatment of illness, and 74 percent of participants did not discuss their use of CAM with doctors of Western medicine (Lim et al, 2005).

Sri Lanka differs from Hong Kong and Singapore where TCM is not integrated formally. In Sri Lanka, both formally organised systems of medicine, Ayurvedic and Western medicine, flourish (Waxler-Morrison, 1988). In a study in Sri Lanka, patients were sent to both Ayurvedic and Western practitioners. The study found that out of the 82 percent of Western medicine physicians who did prescribe medicines, 99 percent gave Western medicine only; just two Western doctors prescribed Ayurvedic treatments. Among the 83 percent of Ayurvedic practitioners who prescribed treatment, 86 percent prescribed Western medicine only, with the remainder being divided between those prescribing a combination of conventional and traditional medicine (7 percent) and those only prescribing Ayurvedic treatment (7 percent). These results illustrate pluralistic practices among doctors as well as consumers.

Immigration and the Global Emergence of TCM and Ayurveda

Large scale immigration from countries including but not limited to the above (China, Hong Kong, Singapore, Sri Lanka and India) to New Zealand and other destination countries introduces practices and practitioners of different systems of healing and different ways of utilising health services. Some researchers attribute the diffusion of health care systems and practices to the global movement of knowledge and peoples e.g. through the internet and migration, along with the support of international organisations such as the WHO, UNESCO and the International

Committee Red Cross (see Bettcher & Lee, 2002; Kalekin-Fishman, 1996; World Health Organisation, 2003). An assumption is that migrants moving to a new country seek health treatments with which they are familiar or choose practitioners who speak their language and understand their culture. For example, a Chinese immigrant used to both Western and Chinese medicine is likely to seek out a combination of Western and Chinese medicine. This assumption was supported in a study on how 42 first generation Chinese migrant women living in England engaged with Western and Chinese health care systems (Green, Bradby, Chan & Lee, 2006). The researchers concluded that migration created a demand for alternative health care in the country of settlement and also included practitioners of a range of alternatives to Western medicine. A health system that recognised and embraced medical pluralism would, they believed, assist the development of culturally appropriate health care provision.

A Canadian qualitative study of 19 Chinese immigrants with arthritis found that the immigrants' preference for one health care system over another depended on the disease, personal and cultural factors (Zhang & Verhoef, 2002). A pattern of illness management was observed, where self-care remedies were used for mild symptoms, and Western medicine accessed when symptoms interfered with daily life and work. A TCM practitioner would be consulted when negative experiences of Western medicine, including adverse reactions to drugs and communication difficulties, were encountered. However, worsening health, the cost of the unsubsidised TCM and poor quality of the Chinese practitioners might lead to a return to Western medicine. Another Canadian study found Chinese patients suffering from chronic conditions such as rheumatologic diseases tended to use TCM after repeated consultations with their family doctor (Wong et al., 1998).

An American study (Ma, 1999) involving 75 American Chinese from China and Taiwan found that less than half of the Chinese participants had used Western health services in the preceding 12 months and 20 percent had never used them. As with other studies reviewed, Chinese immigrants' health-seeking behaviours in the USA were consistent with those in their countries of origin where a mix of health service use was preferred: self-treatment and home remedies (94.6 percent), both Western and traditional Chinese clinics in the USA (45.3 percent), travel to China or Taiwan for health care (32 percent), principally using TCM clinics in the USA (25.3 percent), principally using USA Western medicine (21.3 percent) and hospitalisation in the USA (16 percent). Ma (1999) considered that the Chinese population in the USA, though the fastest growing ethnic minority, was poorly understood, invisible and neglected, and that America lagged behind Europe, Asia and Africa in integrating Western and traditional medicine. Ma (1999) described the Chinese as mostly foreign-born, tending to adhere to Chinese cultural values, beliefs and health practices, who did not understand the American health system and therefore

underutilised health services. Respondents tended to consult Western medicine for acute diseases and TCM for health promotion.

There have been a small number of New Zealand studies on the health utilisation patterns of immigrants from Asia. These studies indicated that while Asians tended to visit GPs for acute illnesses, many sought the advice of complementary or alternative practitioners for chronic problems or those for which western medicine had not been effective (Asian Public Health Project Team, 2003; Baxter, 1997; Chan, 2001; Liu, 1998; MacGregor-Reid, 2001) The 2002/2003 National Health Survey showed a lower prevalence of most chronic diseases (diabetes was an exception) among Asian people but those with chronic diseases were not accessing health services to the same degree as Europeans (Scragg & Maitra, 2005). However Scragg and Maitra (2005) found that while Asian people were very satisfied (92 percent) with their last GP visit, similar to the proportion of all New Zealanders, 12 percent of all Asian people surveyed had also visited an alternative health provider in the last 12 months. A reason postulated was that Asian migrants were unfamiliar with the mainstream health care system in New Zealand, combined with their English language limitations and poor understanding of Western medical concepts and terminology (Ho et al., 2002). The few studies on the prevalence of mental illness among Asian ethnic groups suggest that rates were no different from those of the general population, but factors related to the immigration experience that negatively impact on wellbeing included language difficulties, employment problems, disruption of family and social networks and acculturation attitudes (Ho et al., 2002).

Although many physicians, in both the East and West, now practice other traditions of medicine as well as Western medicine, there has been considerable controversy and concern over its growth in the West. The most popular and frequently used form of CAM in both ancient times and today is acupuncture, now practiced by traditional and conventional doctors alike. TCM can now be found worldwide, an achievement given the worldwide hegemony of biomedicine (Scheid, 1999), and perceptions of Chinese medicine as a complementary health practice (Wiseman, 2001). However, the global expansion of Chinese medicine has had a major impact on the practice of Chinese medicine as it has adapted to new settings with practices being modified for consumption in the new country (Hare, 1993). In the late 1990s, TCM was practised in various forms by more than 300,000 practitioners in over 140 countries. Germany, for example, opened the first hospital for Chinese medicine in Europe in 1990. Several British universities offered degree programmes in Chinese medicine and there were over 1000 TCM clinics offering acupuncture therapy. In France, acupuncture was a widely accepted part of health care provision. In the United States, there were approximately 10,000 Chinese medicine practitioners treating around one million consumers annually (Cassidy, 1998; Chan, 2005; Scheid, 1999). Other popular treatments in the Western world include herbal remedies and massage. Research by Waxler-Morison (1988) suggests that therapies such as

Ayurveda may continue to gain popularity due to the self-limiting nature of many illnesses and fewer iatrogenic illnesses resulting.

New Zealand Research on TCM

Like other forms of alternative and complementary medicine, TCM was widely viewed with suspicion until the 1970s when a delegation of medical professionals from the United States was sent to the People's Republic of China to observe acupuncture. In 1974, New Zealand sent its own delegation to China to investigate the practice, a visit that created division within the New Zealand Medical Association. While many doctors were dismissive of acupuncture, some began using acupuncture as an adjunct to their usual practice. 'Medical acupuncture' has been used to describe the practice as performed by mainstream medical professionals (GPs and physiotherapists) who tend to treat mainly injuries and musculo-skeletal problems rather than the range of health issues treated by TCM practitioners and seldom base practice on the philosophy and concepts that underlie the practice of TCM. However, in recent years, some medical professionals have become more tolerant of acupuncture, a change in attitude largely consumer-driven as patients sought treatment from TCM practitioners. Today, both practitioners and consumers are much more open to considering acupuncture as a possible intervention, especially in the treatment of injuries and chronic conditions. New Zealand research has found that some TCM practitioners, over 70 percent of whom were European, themselves viewed Chinese medicine as a complementary medicine and advocated a combination of Western and Chinese medicines (Baxter, 1997).

MacGregor-Reid (2001) investigated the diffusion of TCM into New Zealand from interviews with practitioners of TCM along with a few articles published in popular media and associated policy documents. TCM was first introduced to New Zealand by Chinese migrants who took part in the Otago gold rushes of the late 1800s. Recent excavations of a Chinese mining camp on the outskirts of Lawrence showed that Chinese doctors and pharmacies were providing services in the 1860s. By the 1900s, a small number of clinics had become established in Auckland treating members of the Chinese community (MacGregor-Reid, 2001). A century later, European New Zealanders, who tended to view TCM as complementary rather than an alternative to mainstream medicine, were seeking TCM treatments, particularly acupuncture, in increasing numbers (MacGregor-Reid, 2001). Historically, TCM and mainstream medicine have had an uneasy relationship, described by MacGregor-Reid (2001) as 'contestation'. Tension between mainstream health professionals and TCM practitioners has centred on attempts to rebrand acupuncture as 'medical acupuncture' and so control the practice of acupuncture. For example, had a proposed Amendment Bill to the Health Act 1966 been passed, the practice of acupuncture would have been restricted to mainstream medical practitioners such

as doctors, physiotherapists and dentists with New Zealand recognised qualifications (MacGregor-Reid, 2001). According to MacGregor-Reid (2001), TCM practitioners sought to distinguish themselves from 'medical acupuncturists' by implying that the traditional form of acupuncture was 'real' acupuncture. Nevertheless, as Baxter (1997) pointed out, TCM has undergone changes as it has moved from one cultural context to another, often without direct contact with Chinese people or culture. She described TCM in New Zealand as retaining a family resemblance to the TCM as practised in China but with a character and emphasis of its own.

TCM services are now widely available throughout New Zealand as demonstrated by the few previous New Zealand studies. In her survey, Baxter (1997) interviewed practitioners from Kaitaia in the North to Invercargill in the South. Liu (1998) selected the four clinics for her research from Auckland, Wellington and 'a small provincial town'. TCM practitioners can be found in a variety of clinic settings e.g. in centres dedicated to the practice of TCM therapies as well as in medical centres and physiotherapy practices, and with other practitioners such as osteopaths and chiropractors (Baxter, 1997). Consumers from different ethnic groups were catered for. Asian migrants may prefer consulting a practitioner who speaks their mother tongue and understands their culture. Likewise, a European may choose a practitioner whose first language is English and explains TCM therapies using concepts with which they are familiar. There are now many TCM clinics, particularly in Auckland where there is a high concentration of Chinese migrants, with the Auckland Yellow Pages 2005 carrying over two pages of advertisements for acupuncturists and TCM practitioners. MacGregor-Reid (2001), using data from the directories showed that between 1990 and 2000 clinic numbers almost doubled in the period to nearly 70. By 2005, the number of clinics advertising in the Auckland 2005 Yellow Pages had climbed to about 100 and, as not all advertise in the Yellow Pages, even this under-estimates the number of services.

New Zealand research suggests that practitioners of TCM were varied in ethnicity, background, training and practice. MacGregor-Reid (2001) developed three practitioner categories from a review of literature: biomedical practitioners, usually GPs and physiotherapists who practised medical acupuncture; 'lay' practitioners who offered only acupuncture alone or together with other CAM therapies; and Chinese medicine providers who offered traditional Chinese treatments and adhered to the underlying philosophy of TCM. Most of the 15 TCM practitioners MacGregor-Reid interviewed had trained in TCM as a whole system, not just acupuncture, though they did not necessarily offer all forms of traditional treatment. Liu (1998) pointed out that Chinese medical university degrees included a compulsory paper on TCM, and all seven in her study held medical qualifications in either TCM or Western medicine. Chinese doctors who had trained in Western medicine and TCM and chose to practise TCM in New Zealand often did so in response to difficulties

experienced passing the examinations to register as doctors in New Zealand as their English was often limited. Most of these had chosen to practice acupuncture rather than herbalism when in New Zealand as acupuncture was 'simpler' and more acceptable to the general population.

Liu's (1998) study included an interview with the President of the New Zealand Federation of Chinese Medical Science who indicated that TCM practitioners in New Zealand came from mainland China, Taiwan, Hong Kong, Korea, Singapore and the Philippines, as well as including some New Zealanders. Most practitioners who came from Asian countries had received training in mainland China and held Bachelors or Masters degrees in TCM or Western medicine. The practitioners in Liu's study practised a variety of therapies – herbalism, acupuncture, acupressure, Chinese massage and reflexology. Sometimes they combined therapies. All the herbalists practised acupuncture but not all the acupuncturists practised herbalism. The herbalists were also pharmacists, preparing their own prescriptions. In contrast, of the 38 practitioners interviewed in Baxter's study (1997), 71.1 percent were of European descent; 60.5 percent had either a Bachelors degree in TCM or a Diploma in Acupuncture, while the remainder had qualifications in physiotherapy acupuncture, Western medicine and those from Asia had completed medical school training in China and Taiwan. Practitioners had been engaged in other occupations before practising TCM and those who were qualified in physiotherapy or Western medicine continued to practice that modality alongside TCM. With only five practitioners practising a range of TCM treatments only, and a significant number (36.8 percent) reporting they never used herbal medicine, Baxter (1997) observed that the variety of practitioners and their modes of practice were central to the understanding of Chinese medicine in New Zealand.

A review of the few New Zealand studies showed that the users of TCM were more likely to be European, female and adult. However, Baxter (1997) reported that practitioners' descriptions of their patients were so broad that it was difficult to identify a predominance of a certain 'type' of person, and that the patient base was representative of the area in which they practised. In the studies of Baxter (1997) and MacGregor-Reid (2001), the majority of consumers who participated in consumer surveys were of European descent. As Europeans may be more willing to participate in a questionnaire survey, it cannot be concluded from participant data from three New Zealand studies that the majority of patients visiting TCM clinics are European. Liu (1998) found that in the view of practitioners, mainly Europeans and tourists frequented acupuncture clinics whereas more people of Chinese ethnicity consulted herbalists. A possible explanation of this pattern is that Europeans are generally far more accepting of acupuncture than other TCM treatments due its early rise in popularity and that the biomedical profession is more tolerant of it than other TCM therapies. Liu (1998) added that some clinics seemed to attract one ethnicity more than the other. It should also be noted that practitioners in MacGregor-Reid's study

commented that a 'large proportion' of their clients were Maori or Pacific peoples (MacGregor-Reid, 2001).

Over 70 percent of those who participated in Baxter's (1997) survey were female. MacGregor-Reid (2001) also found that most of the clientele seeking TCM treatments were female: over half the participants in her sample were women, and two of the practitioners she interviewed said that 80 percent of their patients were female. MacGregor-Reid added that according to practitioners more European females attended their clinics, while similar numbers of Chinese male and female patients did so. Liu (1998) found that males and females were represented in similar numbers, although one clinic reported that 70 percent of its patients were female, attributed to fact that the clinic treated more chronic disease affecting mainly females. Moreover, these largely female consumers were predominantly middle-aged and older, attributed to the fact that older consumers were more likely to suffer from chronic diseases and muscular and joint problems than younger people and these were the sorts of health problems that consumers considered TCM practitioners were particularly successful at treating (Liu, 1998). Baxter (1997) found that patients ranged broadly in age, predominantly 30 to 60 year olds.

All three previous New Zealand studies agreed that many consumers of TCM suffered from chronic illnesses. In MacGregor-Reid's (2001) study, consumers consulted TCM practitioners for help with chronic conditions that Western doctors could not help them with, including a knee injury, OOS (Occupational Overuse Syndrome), stress, psoriasis, high blood pressure and hormone imbalances. The patients in Liu's (1998) study were mostly older, therefore suffered more than the young from chronic conditions, for which herbal medicine was most effective, and musculo-skeletal and joint problems, best treated with acupuncture. Baxter (1997) found that 45 percent of the consumers in her study indicated that the conditions for which they were receiving treatment were chronic; only 24 of the 120 consumers said they were being treated for a problem related to an accident or injury. Users of TCM frequently pay for treatment out of their own pocket. Based on the consumer profiles reported above, many consumers are likely to fall into low income groups. The combination of older age and chronic illness may be related to low income. Low income may also be related to ethnicity. For example, in MacGregor-Reid's (2001) study in some clinics, Maori and Pacific peoples, both groups over-represented in lower income households, were high users. It is reasonable to assume also that a significant proportion of Asian TCM consumers would be in lower income households as statistically, Asian people were more likely to live in a lower income household than other New Zealanders (Scragg & Maitra, 2005). Data from the 2001 Census revealed that the median annual income of the Asian population aged 15 years and over in 2001 was \$10,400, relatively low compared with the national median of \$18,500 (Statistics New Zealand, 2002b). ACC has stated that an important focus for the Corporation had been identifying and addressing barriers to access and

entitlements, particularly for groups including Maori, Pacific peoples, Asian peoples and older and disabled persons, all represented in the usership of TCM (Accident Compensation Corporation, 2005).

New Zealand research broadly agreed with overseas research on the reasons which led consumers to use TCM in biomedically dominated health systems. The 2002/2003 New Zealand Health Survey included face-to-face interviews with more than 12,000 adults. Provisional analysis indicates that 4.8 percent of Asians had visited a TCM practitioner in the last 12 months, followed by 1.7 percent of Pacific people, 1.4 percent of Europeans and 1.1 percent of Maori (Ministerial Advisory Committee on Complementary and Alternative Health, 2004). The main reasons why Asian peoples visited TCM practitioners included: the health system was familiar to them and if English was limited they felt more at ease consulting a practitioner who shared the same language. MacGregor-Reid's (2001) study indicated a fascination among some Europeans with Chinese culture and a belief that TCM, with its origins in antiquity, must be beneficial; and among Maori and Pacific users, an affinity with the holistic approach taken. Added to this was concern about the adverse effects of pharmaceutical medicines and a belief that herbal remedies used in TCM were natural, safer and gentler in terms of side effects (Baxter, 1997; Chan, 2001; MacGregor-Reid, 2001). Also important to consumers was the holistic approach perceived to be taken, seen as treating the person, not the disease, and taking account of factors including age, sex, emotional state, environment and the like (Baxter, 1998; MacGregor-Reid, 2001; Chan, 2001). The consultation was regarded favourably: the practitioner's personal manner and holistic approach, combined with longer consultations when compared with conventional medical consultations, served to support positive client-practitioner relationships (Baxter, 1997; Liu, 1998; MacGregor-Reid, 2001). Satisfied consumers then went on to encourage their family members and friends in choosing TCM (Baxter, 1997; Liu, 1998; MacGregor-Reid, 2001).

The Regulation of Complementary and Alternative Medicines in New Zealand

MacGregor-Reid (2001) has noted that anyone could set themselves up as an acupuncturist or provider of TCM. The tension between 'medical' and 'traditional' (or 'real') acupuncture has been played out in relation to the issue of regulation, with the medical profession since the late 1970s being concerned about the lack of statutory regulation of TCM, including both acupuncture and herbal medicines. However, traditional TCM practitioners have also called for greater regulation of their practice along the lines of established regulated health professions, to protect consumers and safeguard their own reputations. Medicine, dentistry, pharmacy, physiotherapy, midwifery, nursing and osteopathy are examples of regulated health professions: practitioners are educated in approved and accredited programmes,

registered by the relevant council or board, subject to credentialing and competency reviews. These provisions safeguard public safety and confidence. However no such safeguards exist in the case of practitioners of alternative modalities. The Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) in 2004 has suggested that practitioners be required to complete minimum standards of training specific to each of the modalities they practise. Regulatory provisions affecting CAM practitioners include the Fair Trading Act 1996, the Medical Practitioners Act 1995, the Medicines Act 1981, the Health and Disability Commissioner Act 1994, and the Code of Health and Disability Consumers' Rights (Ministerial Advisory Committee on Complementary and Alternative Health, 2005). Liu (1998) pointed out that while some of the legislative provisions would apply to TCM practitioners, they may not be aware of their existence and hence their obligations to comply with, for example, the Code of Health and Disability Consumers' Rights.

In the case of TCM, some courses are quality assured by the New Zealand Qualifications Authority (NZQA). Examples are the National Diploma in Acupuncture (Level 7) which has strands in Traditional Chinese medicine, and Western Medical Science; the Auckland College of Natural Medicine that offers the Diploma of Chinese Herbal Medicine (Level 7) (New Zealand Qualifications Authority, 2005). However, mainstream medicine questions the quality of TCM training, particularly of acupuncture. Concerns expressed include inadequately trained TCM practitioners, unacceptable hygiene standards including the use of unsterile needles, and adverse interactions between herbal remedies and prescription medicines. The Medical Council of New Zealand (2005) has strict guidelines for its own members who practice CAM therapies and/or have patients who consult CAM practitioners, and a consumer website edited by a team of doctors warns patients to choose accredited or certified acupuncturists and advises them to talk to their doctor about their symptoms first.

TCM practitioners without New Zealand recognised qualifications pose difficulties for consumers in assessing and verifying their professional competence, a concern also for Chinese consumers in the USA (Ma, 1999), Singapore (Lam, 2001) and Hong Kong (Lim et al, 2005). According to MacGregor-Reid (2001), TCM practitioners with New Zealand qualifications favour introducing standards in their profession as they fear that with the growing influx of Chinese migrants and the increasing popularity of TCM, practitioners operating outside the jurisdiction of the three main associations could pose a threat to consumer safety and the reputation of the profession. Two New Zealand studies indicate consumer support for greater regulation. MacGregor-Reid's (2001) study, in which 42 consumer participants expressed their views on their experiences of traditional Chinese medicine, revealed that all would like to see TCM gain more official recognition and be subject to some form of standards control, but at the same time they did not want TCM to have to

conform to the biomedical profession. Similarly, the respondents in Baxter's (1997) study, both practitioners and patients, agreed overwhelmingly (89 and 86 percent respectively) that there should be more legislation to discourage 'quacks' and underqualified practitioners in order to protect consumers.

To this end, the government established the Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH). Formed in July 2001 to provide independent advice to the Minister of Health on matters related to complementary and alternative medicine in New Zealand, a key task was to provide advice on the need, or otherwise, to regulate complementary and alternative health care practitioners in order to protect consumers who use CAM. In a discussion document published in 2003, submissions were called for from the public on MACCAH's terms of reference: regulation; consumer information needs; research; evidence and efficacy; and integration. The analysis of the 315 submissions received together with reviews of international literature and experiences of other countries were published in the document, *Complementary and Alternative Health Care in New Zealand* (Ministerial Advisory Committee on Complementary and Alternative Health, 2004). A key recommendation was to regulate practitioners of 'high risk' treatments by law while 'lower risk' groups could be self-regulated through professional organisations. The two CAM modalities regulated by law under the Health Practitioner Competency Act 2003 are chiropractic and osteopathy. Groups such as the NZ Register of Acupuncturists, whose members specialise in the field of TCM, lobbied to have acupuncture included but were unsuccessful. However, other mechanisms exist to protect the public from suspect practitioners so long as a third party is paying in full or in part for the treatment. ACC recognises two groups of acupuncturists - the New Zealand Register of Acupuncturists and the New Zealand Acupuncturists Standards Authority. However, ACC will not accept a claim lodged by an acupuncturist; though a patient can go directly to an acupuncturist who can lodge a claim, the claimant will receive a letter from ACC requiring him/her to go to a medical practitioner for diagnosis. Similarly, the largest private health insurer, Southern Cross, offered the option of add-on cover for acupuncture provided it was performed by an acupuncturist registered with the New Zealand Register of Acupuncturists who had to be in private practice (Southern Cross Healthcare, 2005).

A second area of TCM is the herbal and patented medicines regulated by an array of legislation covered by the following: Consumer Guarantees Act 1993, Fair Trading Act 1986, the Food Act 1981, Food Regulations 1984, Dietary Supplements Regulations 1985, Australia New Zealand Food Standards, Medicines Act 1981 and the New Zealand Code of Good Manufacturing Practice for Manufacture and Distribution of Therapeutic Goods (Ministerial Advisory Committee on Complementary and Alternative Health, 2005). Provisional data from the 2002/2003 Health Survey showed that 1.4 percent of all New Zealand adults and 4.8 percent of Asian New Zealander adults visited a TCM practitioner at least once during the

previous 12-month period (Ministerial Advisory Committee on Complementary and Alternative Health, 2004). Herbal medicines are often viewed by consumers as a natural and non-toxic alternative to prescription medicines. Baxter's (1997) study of TCM in 1995 surveyed 130 predominantly European participants, and found that 58.5 percent of them reported having had problems with Western-style medications including adverse side effects. MacGregor-Reid's (2001) study involving 42 European respondents made similar comments and conveyed a perception that TCM was gentler and there were fewer side effects. However, Chinese herbal remedies are not always 'natural' or safe; in early 2000, two natural Chinese herbal products, Cheung Kum and Shen Loon, were found by Medsafe (a unit of the Ministry of Health) to contain undeclared steroids and a pharmacy-only antihistamine and were recalled (Reti, 2002). In 2003, the Director-General of Health, Dr Karen Poutasi, issued a statement warning people to stop taking 11 traditional Chinese medicines sold as herbal remedies that contained undeclared scheduled medicines such as sildenafil (Viagra), ephedrine, arsenic and aristolochia.

In the absence of Government regulation of acupuncture since the 1970s, practitioners have taken upon themselves the role of self-regulation, a number of organisations having been formed by various groups of TCM and acupuncture practitioners. Their purposes being to self-regulate and protect the interests of members, these organisations have offered monitoring and the quality assurance of practice, further education, the sharing of ideas and skills, and promotion of the profession represented. Detail about these professional associations is provided in Appendix 3. Some associations serve cultural functions in addition to professional: some of the practitioners in MacGregor-Reid's study (2001) believed that the New Zealand Chinese Acupuncture Association and Register was established because Chinese acupuncturists with poor English were not able to join the New Zealand Register of Acupuncturists, and the members' need for a sense of community, understanding and solidarity were also a factor. Submissions to MACCAH supported regulation of CAM health practitioners but opinions were divided on whether regulation should be statutory or voluntary, the latter being regarded as more effective in ensuring safety if the process were owned by and managed by professional organisations. MACCAH considered therefore that consumers would receive adequate protection from the risks involved with CAM treatment through strong self-regulation of the professional bodies (Ministerial Advisory Committee on Complementary and Alternative Health, 2004).

Conclusions

A brief review of selected international and the limited New Zealand literature indicates that New Zealand developments related to CAM in general, and traditional Chinese and Ayurvedic medicine in particular, are broadly similar to those of other

Western countries. Although TCM and Ayurvedic medicines have been employed in societies influenced by China and India respectively for thousands of years, it is only in more recent decades they have become accepted by a wider public as therapies in the West. A combination of disillusionment with institutionalised medicine, increased access to alternative theories and techniques of healing and the global movement of peoples have together fostered the introduction and growing acceptance of the ancient medical traditions of China and India along with a host of other therapies that have developed in the West and elsewhere. In addition, the growing diversity of New Zealand society through immigration has created a demand for TCM and Ayurvedic medicine among immigrant communities. As doctors educated in Asian countries encounter barriers to registering and practising as medical practitioners in New Zealand, an option for them is to establish themselves as TCM and Ayurvedic practitioners respectively. However, these developments have thrown up a range of concerns around public safety, competency assurance and regulation, concerns which established conventional medical practitioners and organisations have been quick to voice. As such, the phenomenon of contested medicine provides a window to further explore the experiences on skilled immigrants to New Zealand, already documented in other research on the settlement experiences of skilled immigrants. The present study reports on the practice, experiences and views of immigrant doctors who, in New Zealand, are providing TCM and two systems of medicine widely used as an alternative to Western medicine in the Indian sub-continent, Ayurvedic and homeopathic medicine.

METHODS

The study set out to investigate the experiences of immigrant doctors engaged in providing non-Western medical services in New Zealand. The study expanded on a previous investigation into the self-employment of immigrants as an alternative to employment, specifically to explore self-employment by these doctors in 'complementary and alternative' medicine as a response to known barriers experienced by overseas trained doctors in becoming registered as doctors in New Zealand. Specifically, the study involved doctors from China, practising traditional Chinese medicine (TCM) including acupuncture, and doctors from India, practising Ayurvedic and homeopathic medicine. In New Zealand, all three, TCM, Ayurveda, and homeopathy, are considered to fall into the category of complementary and alternative medicine (CAM), largely outside the publicly supported and funded Western medicine-based health system. Unlike TCM and Ayurvedic medicine, both ancient traditions of medicine embedded in the respective Chinese and Indian cultures, homeopathic medicine was developed in Germany and introduced into India, where it has become very popular. Homeopathic practices run by Indian immigrant doctors were included in order to explore the experiences of those immigrant doctors generally and, in particular, to investigate the relationship with the Indian immigrant community.

Aims

The broad aims of the study were: to illuminate the context and experiences of one group of skilled immigrants – doctors - settling in New Zealand and running clinics offering non-Western medicine, and; to illuminate the effects on their clinical practices of relevant New Zealand policies and practices. Reflecting the participants and the clinics they ran, the investigation shed light on the contribution of these skilled immigrants to New Zealand health services, and the response of the wider New Zealand society to these immigrants and their services.

Objectives

As well as the responses of immigrants to settlement encounters, the study also shed light on the contribution of immigrants to New Zealand society generally and the response of the wider New Zealand society to these immigrants and their services. The specific objectives of the study were to determine from clinic owners offering Chinese medicine/therapy, Ayurvedic and homeopathic medicine:

- The role and importance of meeting the needs of both immigrants and others in the general community.
- Relationships with local GPs and other health services.
- Experience in areas such as staff recruitment.
- Issues related to health regulations, and the effect on the operations of clinics, and other compliance requirements.

Design

A comparative case study of recent immigrant doctors' practices offering traditional Chinese medicine (in the case of Chinese doctors) and Ayurvedic and homeopathic medicine (in the case of doctors from India) was conducted in Auckland, Palmerston North and Wellington between July 2004 and February 2005. Using a semi-structured interview schedule comprised of structured and open-ended questions (see Appendix 3), data were systematically collected via personal interviews with 14 immigrant doctors running private clinics.

Ethical issues, participants and recruitment

The design was approved by the Human Research Ethics Committee of The University of Auckland. Potential participants who appeared to be linked to Chinese and Indian communities and who were advertising themselves as practising TCM, Ayurvedic medicine and homeopathic medicine in Auckland, Wellington and Palmerston North were identified through the Yellow Pages. Additional participants were recruited through networking. Information about the study, a consent form and an invitation to contact the researcher if interested in participating were posted, and arrangements made to visit them at the time and place of their choosing. Participants needed to be able to complete the interview in English. This was not anticipated as constituting a problem because their application for immigration was approved under the General/General Skills categories where English language standards required. The aim was to collect information on clinics offering Chinese medicine/therapy and Ayurvedic medicine using 12 –15 case studies from Auckland, Wellington and Palmerston North. Very few Ayurvedic clinics run by immigrant doctors from India were identified and because of the widespread use of homeopathy in India, two of these clinics were later included. Fifteen immigrant doctors were recruited in this way, among whom one subsequently was unable to participate, leaving a final sample of fourteen.

Data collection and analysis

Using the questionnaire (Appendix 3), interviews lasting 1-2 hours were conducted and the responses recorded. Responses were collated separately for the practice of TCM, Ayurvedic and homeopathic medicine to produce a descriptive comparative account. The results reflect the following three themes:

- participants' accounts of the business they operated;
- the relationship with mainstream health services in New Zealand; and
- how the participants see themselves professionally compared to their professional lives in the countries of origin.

FINDINGS

In response to questions put to them, participants described their practice in the non-Western medical practice in which they were educated. First, descriptive profiles of the doctors themselves, their patients and the running of the clinics are given. Then, the interactions between these services and mainstream health services in New Zealand, particularly with general practitioners, are reported. Finally insights into the impact on the professional status and activities of the participating doctors are reported. Far from being able to simply transfer their skills gained in one country's health system to a different country's health system, and among a different set of clients and colleagues, these findings indicate that immigrant doctors who were practising traditional Chinese, Ayurvedic and homeopathic medicine encountered significant challenges as they reinvented themselves professionally. Nevertheless the opportunity for these immigrant doctors to establish and to operate the clinics in the respective discipline, with few bureaucratic barriers, provided them with generally satisfying employment and the ability to support their families. The accounts of the participants also illustrate that the decision-making around establishing a business and self-employment is intertwined with the settlement process of skilled immigrants, as the imperatives of supporting one's family in some cases precluded pursuing the costly and protracted process of registration as a medical practitioner.

1. The Doctors, Clients and Business Operations

The data were collected in Auckland, Wellington and Palmerston North between July 2004 and January 2005 from 14 doctors who recently immigrated from the People's Republic of China and India, all of whom were qualified as doctors in their respective countries.

First, the profile of the participating doctors is described including their reasons for self-employment, their qualifications and their perspectives on practising in New Zealand compared with the country of origin. Next, the profile of the clientele is described. Finding that the main usership is members of society in general and not recent immigrants, how these immigrant doctors practising an alternative form of medicine interacted with their New Zealander clients was explored. Challenges encountered in operating their businesses are described including employing skilled personnel and procuring supplies not locally available and how the doctors related to their immigrant community in relation to the business reported.

Profile and Qualifications of the Immigrant Doctors

There were ten Chinese-born practitioners of traditional Chinese medicine (TCM) and four Indian-born doctors, two of whom practised Ayurvedic medicine and two homeopathic medicine. All were male except one Indian and two Chinese practitioners. The majority took up residency in New Zealand in the mid-1990s, with another two having arrived earlier, in 1988, and one as recently as 2001.

The doctors described their qualifications as being equal to a Western medical degree. Indeed, many had studied at medical schools along with their peers studying Western medicine. They had thus completed at least five years of medical education at a university based on a curriculum that included Western medicine, followed by clinical practice in teaching hospitals or private clinics. There was one exception only, a doctor who attended a private college for three years in the “classical” version of the modality. The professional experience of these doctors prior to settling in New Zealand included having been a consultant in a WHO centre for acupuncture, being clinical tutors and university professors in their respective fields, having up to 20 years clinical experience and engaged in research.

In India, doctors could qualify in Ayurvedic, homeopathic or Western medicine; some parts of each curriculum were common across the disciplines (e.g. surgery, maternity, biochemistry), but medicine and pharmacology differed. Most Chinese doctors explained that at the universities they attended for a 5-year degree, the curriculum for all medical students included both Western and Chinese medicine. However, the mix differed, described as a 60/40 or 80/20 ratio, and most participants in the present study said they took a higher proportion of TCM than Western medicine. For six of the Chinese doctors studying at a general medical school, TCM was limited to acupuncture. Another said he had been trained only in Western medicine, and had then undertaken a 3-year course in acupuncture in his specialist area of orthopaedics. Three had been educated in institutions of Chinese medicine where Western medicine was a smaller component, and these three practised Chinese herbal medicine as well acupuncture and related therapies. In the opinion of one, many Chinese doctors practising Chinese medicine in New Zealand were educated mainly in Western medicine and had limited training in acupuncture. Five of the Chinese doctors held Masters degrees (8-9 years of university education). Two had specialised (in gynaecology and orthopaedics respectively). And one Indian doctor had gone on to complete a PhD in Ayurvedic medicine.

The credentials of these 14 immigrant doctors in both qualifications and experience, and the fact a large proportion have been educated in Western medicine as well as in Chinese or Indian medical traditions, raise the question: why did they not seek registration as doctors and practice medicine in New Zealand? Most had not

attempted to seek medical registration, and in the case of many Chinese, their self-assessed English language ability was a factor in that decision. There were other reasons: the expense, the fact that it was possible to make a good living practising in 'complementary and alternative' medicine traditions, and in the case of those predominantly trained and experienced in TCM or Ayurvedic medicine, that it was not appropriate to seek registration as a (Western) medical practitioner. Some commented that even in China, where they could have practised Western as well as Chinese medicine, they preferred using TCM as it was less toxic and safer. There were exceptions, however. An Indian doctor now regrets having missed an earlier opportunity, because of financial constraints, of study with a view to medical registration. A Chinese doctor, a specialist in China, described '11 months of frustration' in attempting to register as a medical practitioner before abandoning the quest, while another Chinese doctor who was undertaking English and other courses to prepare for applying for registration had to abandon the process for financial and also family reasons, and likewise regrets his present situation.

All participants, however, were members of the relevant professional association in New Zealand (e.g. New Zealand Register of Acupuncturists, New Zealand Charter of Natural Health Practitioners, New Zealand Homeopathic Society). All practitioners of acupuncture were also ACC registered. Many displayed the framed certificate in their waiting rooms or specified professional recognition in printed information or on websites.

Opening the clinic

The majority of these clinics were opened between 1995-1999. The earliest three began in 1989-91, and the most recent two began in 2003. In all cases, the doctors opened their clinic soon after arrival in New Zealand, some in the same year, others later after first having studied English and investigated employment opportunities. A few who opened their clinic 2-4 years after arrival in New Zealand first undertook other employment or other study programmes. Studying nursing was mentioned by one; two worked as caregivers, two were employed in TCM by another clinic operator and two first taught in tertiary institutions teaching complementary and alternative medicine (CAM).

The doctors were asked why they opened the clinic. Many gave more than one reason. For four (two Indians and two Chinese) the main reason was simply to make a living, and for others in addition to making a living was the opportunity to be self-employed. One did so because there was not the opportunity to practice as a medical doctor. A larger number said they were motivated by their love of their work and profession: two Indians and five Chinese spoke of wanting to apply their skills and knowledge and to maintain experience. Furthermore, these doctors expressed a

desire to help and heal people through therapies that in their experience were beneficial and effective, especially for those who suffered chronic illness, had not been helped with conventional medicine and were poor. An Ayurvedic doctor and a Chinese herbal medicine doctor said their motivation was to introduce to New Zealand the benefits of their respective traditions of medicine.

The Clients

Based on findings of studies among communities of recent immigrants from Asia in New Zealand that TCM and similar therapies were desired and used (e.g. Asian Public Health Project Team, 2003; Ho et al, 2002; North, Trlin & Henderson, 2004; Scragg & Maitra, 2005), an expectation of the study was that these immigrant doctors would meet a need by immigrants from the same countries of origin for medical services widely available in the country of origin but not delivered by mainstream health services in New Zealand. Contrary to expectations, but in line with the few studies previously conducted on TCM in New Zealand, the study found that the participating doctors described the majority of their clients as 'Kiwi'. While TCM clinics not included in this study may well primarily serve Chinese communities, in the case of those clinics participating in this study the main users of the services were described by participants as 'Kiwi'.

The patients referred to as 'Kiwi', the principal users of the clinics, included New Zealand European/Pakeha, Maori and Pacific peoples. Depending on where the clinic was located, the term 'Kiwi' also included South African and European immigrants. Both Chinese and Indian doctors observed that New Zealand-born Chinese and Indian clients were no different to 'Kiwi' patients in their beliefs on health and medicine: this was because New Zealand-raised Asians were more familiar with Western medicine and used health services similar to their European counterparts. However, New Zealand-born Asians were not identified as a large user group and participants did not include them in the term 'Kiwi'. Most frequently, between 80-99 percent of clients of all clinics were 'Kiwi', with 50 percent as the lowest proportion for one each TCM and homeopathic clinic.

The proportion of clients of TCM clinics who were of Chinese origin ranged between <1 percent and 50 percent, with most at 10-15 percent. These 'Chinese' referred to mainly overseas born Chinese, including international students, with some commenting that New Zealand born Chinese were included. Half of the Chinese doctors also included Asians of other origins in this group including those from Korea, Japan, Thailand and India. A similar pattern was reported by Ayurvedic doctors, who saw 'very few', at most 10 percent, of Indians. One of the homeopathic doctors saw 2-3 percent Indians and for the other up to 50 percent were Indians, mainly young children whose parents preferred homeopathy to Western medicine

that they regarded as harsh and toxic. The Indian doctors suggested a reason for low use by their immigrant compatriots was because unlike in mainstream medicine, they had to pay out of their own pocket for the service. In addition some were not prepared to make the lifestyle changes advised, or to accept the usually lengthy duration of treatment. It is noted that the proportions of Asian and other users also reflect the ethnic profile of the New Zealand population, where Asians constitute a small but growing minority.

In many clinics, males and females equally used the services. Exceptions were where a female Chinese doctor attracted more female clients and one Ayurvedic clinic that attracted a largely female clientele, possibly reflecting the rejuvenation and beauty care services also offered. It was predominantly 30-60 year old adults who used all clinics, but doctors consistently reported that they saw all ages from a few weeks to old age.

Doctors reported that many of their clients, who suffer from chronic illness, have had little or no relief using Western medicine and some demonstrate the toxic effects of the 'chemical' agents used to treat those illnesses. Indeed, several observed that their service was suited more to the treatment of chronic complaints, not acute problems. There are clients who were reported to consult non-biomedical traditions out of a preference for a more 'natural' and less toxic approach. Several of the doctors expressed sorrow at the plight of some of their clients, described as long-term ill, suffering and poor. These chronic illnesses included: musculoskeletal problems including chronic pain and arthritis (specified by eight TCM doctors, one Ayurvedic and one homeopathic doctor); mental health and neurological problems including depression, stress, fatigue, insomnia and migraines (five TCM and two homeopathic doctors); conditions linked with allergies including skin problems, asthma, sinus and cough (four TCM, two Ayurvedic and one homeopathic doctors); women's problems including menstrual problems and menopause (four TCM and one homeopathic doctors); and diseases including cancer, stroke, hypertension and heart problems (one each TCM, Ayurvedic and homeopathic doctors). A few specified no predominant conditions, saying they treated everything; a TCM doctor said he was used like a general practitioner (GP), as the first port of call. One each TCM and homeopathic doctor said their Chinese and Indian clients respectively consulted them for 'gastric' complaints. Only one participant, an Ayurvedic doctor, commented that people consult him so as to understand their body type and achieve balance or because they are wanting a holistic approach to their care including a spiritual dimension. Another commented that some people come out of curiosity. A couple of the participants said that some of their clients are unwilling to make the life-style changes prescribed, wanting only the relief from symptoms; the doctors were limited in how much they could assist these clients.

These practitioners of TCM, Ayurvedic and homeopathic medicine, themselves recent immigrants to New Zealand, and in the case of a number of Chinese (by their own assessment) limited in using English conversationally, were treating predominantly 'Kiwi' clients. The therapeutic approach they employed was distinct from Western medicine, the system many of their clients would have been familiar with. The underlying philosophical basis of the approaches the doctors used differs in many respects from Western medicine (see Appendix 1 for descriptions from participants and published literature on TCM, Ayurvedic and homeopathic medicine). Given that the majority of clients of these clinics were described as 'Kiwi' and unfamiliar with the underlying philosophical basis and approaches to treatment, how did the doctors go about explaining the approach and its basis to clients? And how could the clients be sure the service was effective, safe and administered competently by a qualified person?

Several participants emphasised the importance of a careful and thorough explanation provided to clients; indeed, several saw this as a reason why they achieved good co-operation from clients with a different and often prolonged course of treatment and had received few complaints. Both the Ayurvedic doctors, one of the homeopathic doctors and half of the Chinese doctors had prepared written information to explain these differences, and the basis of treatment, to their clients. Participants were asked how they assessed whether the treatment was effective. Abatement of symptoms was the main indicator and the only indicator in the case of homeopathic medicine. In the case of TCM related to musculoskeletal complaints reduced pain and improved mobility were the aim of treatment and indicator of effectiveness. However bearing in mind the individualised, holistic approach characterising these medical traditions and findings of the initial assessment, other indicators were also important, and these Ayurvedic and TCM doctors re-assessed the client against the same signs used in the initial consultation. These signs included improved energy and strength, improved pulse, positive emotions, return of an appetite and the like.

Given the unfamiliarity of the services to a clientele more accustomed to Western medicine, participants were asked about the feedback received from clients. One each Chinese and Indian doctor had once conducted a formal survey of customer satisfaction. In all other cases, feedback was mainly in the form of spontaneous verbal or written comment, and such feedback was positive. For example, a number of Chinese doctors had letters and cards in a folder available for clients to read, others had notice boards covered with cards and letters of thanks and a few included excerpts on their web-sites or in printed pamphlets. Some written feedback was from specialist medical practitioners or GPs and from well-known sports-persons. A number of participants said that most of their clients come through word of mouth, itself a testimony to the effectiveness of the treatment. There were also instances of negative feedback, such as when a client did not improve, or disliked a particular

intervention, such as acupuncture or traction. Clients did sometimes cease to attend the clinic. From the points of view of doctors, this could be for reasons of cost as indicated below, but also because: the client was better, the treatment was taking too long to be effective, the client did not wish to make the advised life-style changes; and the client's GP disapproved.

Operating the business

Running a private business based on unfamiliar (to New Zealanders) treatments and requiring specialised staff and materials not widely available locally created particular challenges. Although all except two worked at least a 40 hour week Monday to Friday, hours were often flexible, e.g. taking a break during the day and extending into the evening featured. Five Chinese doctors regularly worked Saturday half days, and another two by appointment on Saturdays. Two Indian doctors did not work regular hours; they worked on average 2-3 days a week to response to demand. The flexible hours were a means of attracting clients to the clinics: many participants observed that they had a large client base, new clients came through word of mouth, and there was no need to advertise. Most commonly the Yellow Pages Directory was the main means of promoting the business.

Several clinics (6) were operated from leased business premises and, in another three cases, the business premises were privately owned. In four cases the clinic was run from a room in the family home and one from a room in a friend's business, a community pharmacy. Three operated from more than one location. The majority (11) had changed premises at least once and two began business by purchasing an existing clinic. These premises were located both in commercial and residential areas. The business was most commonly privately owned (three Indian and eight Chinese doctors), with one Indian and two Chinese clinics being limited liability companies. Doctors were asked if they had experienced problems with robberies or break-ins. Four Chinese doctors reported that their clinic had been broken into, twice in the case of two. Herbal medicines were stolen from one, cash from another, but in two cases nothing was taken.

All of the TCM doctors but none of the Indian doctors were registered with ACC (the state-owned insurance agency providing compulsory accident cover for New Zealanders and visitors to the country). For three of these TCM services, up to 70 percent of their work was paid for by ACC, with another two reporting about 50 percent of their work as ACC related. Two said that musculoskeletal work only was covered by ACC, while for the remaining three, ACC work was a small part only. Private health insurers reportedly did not cover the services of these doctors. Clients of three TCM and all Indian doctors paid mainly out of their own pocket for their consultations. All medicines dispensed by these doctors were also paid for

personally. Almost all participants said they occasionally waived or reduced the fee for some of their clients, particularly those whom they knew to be poor, or sometimes for follow-up visits; one each Chinese and Indian doctor said they often reduced the fee.

In most clinics, consultation fees were advertised either by notice or on a pamphlet. Frequently no surcharge on ACC was charged. Often an initial consultation would take longer (an hour or more) and therefore be more expensive than subsequent visits for interventions. An example of one of the higher fees charged was an Auckland clinic where an initial consultation was \$100 for adults and \$50 for a child, with follow-up visits half that amount for adults and free for children. Noting that a number of the participants were equivalent in training, experience and (in the countries of origin) status to specialist doctors, these prices compare favourably with the fees charged by specialists in private practice. Compared to general practitioner (GP) fees, the charges are more than fees of GPs, although unlike GPs, the participants did not have access to government subsidies and the clients received therapeutic interventions as well as diagnostic advice. Fees varied according to the geographical location (e.g. in Auckland were generally higher than in Palmerston North) and treatment (e.g. lengthy interventions and use of consumables were dearer). The purchase of herbal and other remedies was additional, and prices highly variable as these products needed to be imported. In some cases, the costs that must be borne personally would lead to the client stopping treatment.

Over half the doctors employed staff. Six (two Indian and four Chinese) had no staff. However, one of these has in the past had up to five staff at any one time, ten employees in all, and another previously had three staff and is currently seeking to recruit two. (In both cases former employees had gone on to open their own clinics.) The remaining eight had at least one staff, of whom six had two or more, and up to four staff. These staff were employed in some cases to work in the same clinical work as the participant, e.g. acupuncture. In other cases, they were employed in a complementary role, including dispensing herbal medicines, massage, carrying out other alternative therapies and instructing in yoga, or nutrition and cooking. Two were employed not in a clinical role but as a business manager and receptionist. In addition to staff who were similarly qualified to the participant, some staff had engaged in a range of other occupations before joining the clinic, including as a psychologist, pharmacist, nurse, teacher, alternative therapist or naturalist, homemaker, and in business. In five cases, these staff included a spouse of the participant and another four were from the same country of origin; two were students of the participant. Another was New Zealand-born of the same ethnicity. However, five staff were of European descent and of these, three were students, past or present, of the participant. Two staff were recruited from China in order to work in the clinic. Another participant has in the past recruited a number of doctors from China, all of whom are now working in the same field for themselves. However, the

Chinese doctors agreed that there are numerous Chinese doctors in New Zealand, trained like them in both Western medicine and acupuncture, and generally staff are recruited from this pool. The Indian doctors also agreed that there were similarly qualified Indian doctors in New Zealand, but these were not being recruited to work in existing clinics as were Chinese doctors.

A particular challenge for immigrant doctors delivering TCM and Ayurvedic services was the procurement of herbal and other medicines, and some equipment not used in mainstream health services. Homeopathic doctors did not encounter this difficulty as they could procure European-manufactured homeopathic medicines from suppliers in New Zealand. The Ayurvedic doctors regularly imported herbs, teas and oils from India, along with one-off acquisitions of special equipment including massage tables (made from a special wood believed to be therapeutic) and steam chambers.

All TCM doctors used disposable acupuncture needles and these were generally sourced from an importer. Some ear acupressure balls, patented medicines, mentholated plasters, liniments and moxa (herbal substances that are lit and left to smoulder on acupuncture points) could also be sourced from importers, themselves frequently Chinese immigrants. Many also used equipment including an acupuncture machine, cupping equipment, magnetic and laser therapy equipment, many of which were brought into the country as personal luggage. Some equipment including treatment beds and traction equipment could be purchased locally.

Only four TCM doctors sourced all their materials from a New Zealand supplier and these practised acupuncture and related techniques but not herbal treatment. A few TCM doctors preferred to source their material from an established importer; another said that for small quantities less than a certain value, an import licence was unnecessary. For other supplies, including some (listed above) that were available from an importer, participants preferred to personally import the material. Importing could be through using a supplier in China or personally: one mentioned having made several trips to China so far; another said he returned to China every couple of years. Both Ayurvedic and six TCM doctors directly import the medicinal products they use; some import 3-4 times a year. Permits are needed from the Ministry of Agriculture and Forestry (MAF) and from Customs. With the correct permits, no difficulties were reported. Questions that may be raised are easily answered. However, one reported difficulties, including the confiscation of material; another said that some material was not permitted to enter New Zealand. 'Funny stories' were mentioned in relation to restricted drugs that are used medicinally in TCM, when the Custom's Drug Division is involved. Both Ayurvedic doctors anticipated future problems under the Trans-Tasman agreement on herbal remedies. Asked whether Chinese immigrant friends assisted by bringing material back, only two said that they occasionally brought in material this way and then only in small quantities.

Regarding confidence in the quality of consumables such as acupuncture needles, and herbal medicines, the doctors said they generally purchased material from a reputable source either in the country of origin or New Zealand, with many relying on their familiarity with processors, suppliers and products in assuring the quality, or relying on the importer's guarantee. One said he knew by the smell of the herbs. Another maintained contact with colleagues in China to advise him. Only one stated in his publicity that the products used were approved by the code of Good Manufacturing Practices.

Finally, doctors were asked what was important for them as far as business success was concerned. Financial health was important, with five Chinese and three Indians saying it was important that the clinic paid for itself and there was an adequate income for their families; a few added that they earned a very adequate income and some said the business was profitable. However, a Chinese and an Indian, both women, said that money was not important as their husbands' income supported the family; one of these said she worked a lot of uncharged time in consultations. Five (three Chinese and two Indian) used growth in their client base as an indicator of business success; one said annual client growth met his targets. However the majority referred to non-financial indications of a healthy business: the professionalism with which they ran the business, the benefits to their clients and seeing people's health improve, their personal enjoyment of work, and their role in introducing 'Eastern' medicine to the West, believing that the two working together was important. A few expressed the view that when they worked in a caring and competent way and were busy clinically, the financial aspect would take care of itself.

Business relationships with the immigrant communities, an issue explored in the interviews, did not feature. First, there was no evidence of initiatives such as community provision of start-up finance, or community funding to facilitate a requested service to be established in an area of demand. While both Ayurvedic doctors provided information of their services through associations of Indian immigrants and, in one case, through Access radio (a station dedicated to minority listeners), only four TCM doctors said they communicated through Chinese associations, and one occasionally placed advertisements in Chinese media. However, another four TCM doctors reported that Chinese clients living in suburbs or regions other than where the clinic was located had requested they set up clinics in those areas, suggesting there might be an unmet need. The remainder did not target their compatriots. Similarly, participants tended not to recruit staff through community links, with the exception of three TCM doctors who had advertised for staff in Chinese media. However, one of these observed that the English language ability of qualified TCM doctors identified in this way was inadequate, and he would not use that approach in the future. The single area in which compatriot assistance

was occasionally used (see above) was in the procurement of equipment and supplies that were produced mainly in the country of origin: three TCM doctors, but neither of the Ayurvedic doctors, did occasionally request friends to bring in small items such as equipment or herbal medicines.

2. Interactions with New Zealand's Health System

Working in the context of the New Zealand health sector is the focus of this section, including professional relationships with medical and other practitioners, funding, policy and legislation. Although the immigrant doctors practising TCM, Ayurvedic and homeopathic medicine were largely outside New Zealand's mainstream health sector, an exception being TCM doctors providing acupuncture covered by ACC, they nonetheless interacted with it. An important aspect of the relationships was reflected in referral patterns between these immigrant doctors and other health service providers. Further, all providers of health services in New Zealand fall under the Health and Disability Commissioner Act (1994).

Relationships with GPs and specialist doctors

Although most participants advised their clients to continue to use GP and other medical services, and they themselves received referrals from GPs and other doctors, a tension between the established tradition of Western medicine and the traditions of medicine introduced by immigrant doctors was nonetheless evident. All participants referred their clients back to the client's GP when necessary. Referrals were most commonly because: diagnostic tests needed to be organised (the most frequent reason); there had been no improvement with treatment; the client's complaint is not in the doctor's area of expertise; Ayurvedic or TCM isn't effective in the particular condition (e.g. it is an acute problem, or an infection); the doctor believes the medical regimen needs to be reviewed (e.g. after Ayurvedic or TCM treatment); the doctor suspects a serious problem such as a malignancy. In most cases, these referrals were not a formal written referral; rather the client was advised to consult their GP.

Was the practice of cross-referral reciprocated? Both homeopathic doctors and an Ayurvedic doctor agreed that certain GPs referred patients to them, particularly in cases of treatment failure and if the GP was sympathetic to complementary medicine. All TCM doctors said that GPs and sometimes specialists and other health professionals referred patients to them. Examples were: GPs requested acupuncture for injury or chronic conditions; oncologists referred for the treatment of side-effects of aggressive therapy; midwives referred for treatment of morning sickness and other reasons related to pregnancy and post-childbirth; doctors referred in cases of treatment failure. A few Chinese TCM doctors observed that some GPs who do not

refer 'do not believe in acupuncture'. Participants of all three medical traditions treated GPs, specialists and other health professionals among their clients, and these satisfied medical professionals would then refer their patients to them.

In view of their dependence on the client's GP for organising diagnostic tests, the doctors were asked about their relationship with local GPs. A number did not know local GPs at all and, of these, a few thought meeting them was desirable. Two mentioned they had made an effort to do so, such as distributing information and a business card, but their efforts had not been reciprocated. Five, three Chinese and two Indians, said they knew local GPs by name and some – particularly their compatriots- were good friends. An example of a close working relationship was a local New Zealand European GP who was formerly a student of an Ayurvedic doctor; they worked together collegially in their respective practices, referring patients to each other.

All Chinese TCM doctors were registered ACC providers of acupuncture. Clients receiving acupuncture under ACC needed to have the diagnosis confirmed by a medical practitioner, and in all cases it was the GP who generally did so or referred clients. Three said they also received referrals from physiotherapists. One thought that clients who had an ACC number could self-refer and he could administer up to 10 treatments. Considerable frustration was expressed regarding ACC. For example, doctors found the paperwork onerous. Also criticised was the frequent change of regulations, e.g. formerly ACC providers could register patients for ACC cover, but now may not do so without the involvement of a GP. Many participants complained at the increased restrictiveness of ACC in terms of not being able to directly register clients and being restricted as to the number of treatments they could administer; relief could not always be obtained with the small number of treatments permitted, observed one.

Relationships with other health professionals and services

Given that many interventions in Ayurvedic and TCM medicine involved physical therapeutic techniques, participants were asked about their professional relationship with physiotherapists. An Ayurvedic doctor and four TCM doctors said that they have received clients referred by physiotherapists and in a few cases, by osteopaths and chiropractors, usually for specific treatment such as acupuncture. Similarly, some participants refer clients to these professionals (e.g. because they have specific equipment or techniques that may help, or so that the therapist can instruct the client in an exercise regime). A TCM doctor commented that often clients who see him have already received physiotherapy, without success; another observed that in the case of musculoskeletal complaints, there are a range of physical therapeutic techniques in TCM, inferring that physiotherapy was redundant in those situations.

Participants were also asked about whether they referred clients to emergency services. Neither Ayurvedic doctor did so, as their clients suffered from chronic, rather than serious and acute, conditions. However, both homeopathic doctors said they did so refer in such instances as clients with chest pain or breathing difficulties. Likewise, most TCM doctors said they referred for similar reasons; in addition the examples given included suspected fracture or infection as a cause of musculoskeletal pain, suspected tumour and suspected obstruction. Generally, however, the need for such referrals is infrequent.

Compatibility of herbal and patented medicines and biomedical pharmaceuticals

In the light of clients of these immigrant doctors generally continuing to use mainstream health services, the issue arises of the compatibility of medicinal products. Participants claimed there is no incompatibility or contraindications between Ayurvedic, TCM or homeopathic medicine and pharmaceutical products. Doctors of all three traditions also said that they recommended that clients continue to take their prescribed pharmaceutical medicines, and several encouraged their clients to discuss the fact they were taking herbal or homeopathic remedies with their GP. TCM doctors observed that the two are frequently used together in China, where TCM is integrated with Western medicine. However, clients of both TCM and homeopathic medicine are generally advised to allow a gap of an hour or two between the two types of medicine. Some doctors said that they ask the client to bring their prescribed medicines so they can ensure safety. One TCM doctor said that she asks clients about the pharmaceutical medicines they are taking, as she can offer herbal medicines to relieve side-effects. A homeopathic doctor pointed out to clients that the two work in opposite ways, e.g. an anti-inflammatory product or antibiotic suppresses the inflammation, while homeopathic remedies stimulate the problem and thereby the body's healing response. Regarding acupuncture, the only precaution in relation to pharmaceutical products concerns anticoagulant agents, where there could be a bleeding problem.

Complaints about the practice

All providers of health services in New Zealand fall under the Health and Disability Commissioner Act (1994); some of the participants had copies of the code of patient rights in their waiting rooms. Registered acupuncturists in particular were aware of patient rights under the act. Doctors were asked whether they had encountered any complaints from clients or generated from the mainstream health system. Six TCM doctors and both Ayurvedic doctors reported no complaints. The question generated several comments that the TCM doctors registered in New Zealand as acupuncturists

have been trained about patient rights, informed consent for treatment and confidentiality. One of these TCM doctors went on to describe the care taken in explaining the treatment and its rationale, and the importance of being aware of cultural aspects of the interaction as well as therapeutic aspects. Another TCM doctor said that if there had been complaints about his practice, none had come to his ears. The other four TCM doctors gave examples of complaints: a treatment had not benefited the client; acupuncture or acupressure had caused pain; and a dissatisfied client who demanded his money back. One doctor told of a GP who telephoned the acupuncturist in relation to a patient's complaint that she was bruised after treatment. The GP was satisfied with the explanation that bruising did no long-term harm but advised the acupuncturist to inform the client of a risk of bruising. However, overall such complaints were few and infrequent.

Only two examples were given of higher level complaints. In one, a TCM doctor was visited by the police investigating whether he was using marijuana; in fact, he was using moxibustion, a technique where a herbal therapeutic material smoulders on acupuncture points and the client had suspected that this material was a restricted substance. The other concerned a homeopathic doctor whose advertisements placed in a community newspaper and signs advertising his service triggered complaints by local GPs. He reported receiving three letters from the Medical Council of New Zealand, a warning he would be fined if he persisted and was visited by an official in response to these complaints. The doctor no longer advertises his business.

Contribution to meeting health needs of all New Zealanders

The health care services offered by the doctors, outside of the mainstream Western health care services, were used mainly by persons of Anglo-Celtic, European, Maori and Pacific descent, with recent immigrants from the same source countries most frequently comprising 10-15 percent of clientele. Indications were that many people resorted to TCM, Ayurvedic and homeopathic medicine where Western medicine had failed, particularly in the case of chronic conditions. As the prevalence of chronic diseases grows, arguably a range of therapies to ease symptoms is important. A reason offered for compatriots not using the services was that these were not subsidised, and immigrants preferred to use Government supported services. Nevertheless, between 10-15 percent, at most 50 percent, of users of most TCM clinics were Asians, indicating the importance of the services for the new immigrant community. Given the increasing diversity of New Zealand society, the services offered by these immigrant doctors fill a need. New Zealanders are increasingly exposed to and demand alternatives, including in health care, driven through travel, the media and other sources in a global community. In addition, the participants observed that in their countries of origin where the different medical traditions are integrated in the health system, users become skilled in choosing which traditions to

use for different symptoms and illnesses. However, participants expressed some frustration at the lack of interest and support from the mainstream medical profession generally (individual doctors may be supportive) and from bureaucracies approached including the Ministry of Health.

A few doctors also supply herbal medicines and material to New Zealander practitioners. During one interview, the participant doctor several times left to make up a prescription prepared by New Zealand European colleagues operating their own clinics. And an Ayurvedic doctor also supplied materials to former students now operating their own clinics.

Looking to the future

Invited to add other comments, a large number of participants commented on their desire to see greater official recognition of their tradition of medicine, and coupled with this was widespread agreement on the need for improved regulation. A TCM doctor observed that some health professions outside of the mainstream, such as chiropractic and osteopathy that have a comparable educational preparation, are regulated. According to participants, anyone wishing to practice alternative medicine in New Zealand, including homeopathy, TCM and Ayurvedic medicine, can open a clinic; only acupuncture is affected by regulation in relation to access to ACC coverage. A doctor who expressed high satisfaction with the way his practice had developed also spoke of his 'shock' at discovering just how easy it was to set oneself up as a health practitioner, and outlined his concern at how easy it was to potentially abuse clients and bring disrepute upon the health tradition through the lack of regulation and oversight. He displayed a large file of correspondence with such Government departments as the Ministry of Health and New Zealand Qualifications Authority in the course of his active lobbying to improve regulations, standards and monitoring. Similarly, a number of participants wished to see their disciplines taught in public institutions, including universities and polytechnics, as in their countries of origin but have found little interest. Participants believed that this lack of regulation potentially gives rise to bad press about alternative and natural therapies. Regulation and the compulsory registration of practitioners would make doctors subject to greater scrutiny, a possibility participants welcomed as a measure to expose unscrupulous practitioners.

Benefits of improved regulation were several. First and most important was the protection of the public. Participants were concerned about the public being exposed to therapists whose knowledge and skill base was questionable; examples were given of courses of dubious quality sometimes teaching multiple modalities in a short time frame. Compared with the rigorous and lengthy education these doctors had undergone, participants feared that the therapies may not be effective, or at worse

risky, and bring TCM, Ayurvedic and homeopathic medicine into disrepute. At present, the public had no way of distinguishing between acupuncture delivered by a TCM doctor who had completed a 5 year degree (or longer) in TCM and a natural therapist or medical practitioner who had been instructed only for a short period. Regulation would bring with it the possibility of improved public education.

A second group of benefits were those accruing to the doctors. They believed that regulation would give them access to diagnostic services, services that they were trained and experienced in using; they would no longer have to rely on their clients persuading the GP to arrange such tests. Clients would also benefit by not needing to consult a GP to arrange tests and pay the additional fee. Regulation could also potentially open the way to coverage by health insurance and, in the case of ACC, provide for clients to self-refer to acupuncturists rather than needing a referral from the GP or a physiotherapist. Some participants felt that with official recognition, other benefits such as research funding will follow.

Integrating TCM, particularly acupuncture, into health services presumes official government recognition. With recognition and regulation, participants anticipated an official acknowledgement of their discipline of medicine as a proven therapy would follow. In this respect, comments were made that New Zealand has much to learn from other Western countries such as France, the U.K. and Australia where TCM, including acupuncture, is better incorporated into the health system. A Chinese doctor wondered if hospitals could have a department where alternatives to biomedicine were offered, as in China. However, although all participants were operating their clinics at the primary care level, none identified primary health organisations as a potential environment for integrating their traditions with mainstream Western medicine.

3. Professional Practice in New Zealand

Participants' accounts highlighted important differences in the professional contexts experienced in their countries of origin and in New Zealand that impacted on their professional status and future. Medical practice in non-Western medical traditions in countries with pluralistic health systems is compared with practising in a health system where different traditions are not integrated. Impacts included: where in the health system one may practice; the techniques and facilities commonly used in the country of origin that can no longer be accessed; the availability and relevance of continuing education; the opportunity to conduct research. In combination, these differences militated against the participants enjoying a professional status and opportunities equal to those they enjoyed in their countries of origin.

Practising in a pluralistic health system

In their countries of origin, most participants were educated and conversant in both Western medicine and the other medical traditions in China or India. TCM and Ayurvedic medicine were ancient medical traditions in China and India respectively, while homeopathy, developed in Europe, was embraced by Indians, who refer to Western medicine as allopathic medicine. Also common to all participants, the health care sectors in both India and China were characterised by pluralism, where Western and the respective medical traditions of the countries were used side-by-side and in the case of China, were fully integrated. While the Ayurvedic and homeopathic doctors of India had practised primarily in the respective branches of medicine, a number of the Chinese doctors had practised mainly Western medicine augmented by TCM. However, all of them were able to and did use certain techniques of Western medicine, particularly diagnostic and surgical techniques. The pluralistic health systems were characterised by a full range of health services being offered in each medical tradition including primary care and hospital services. Further, a single hospital may offer both Western and the other discipline of medicine traditional in the country and patients were treated with either or both according to medical need.

In the New Zealand health system, where Western medicine is the officially supported system (the focus of policy, funding and regulation), the participant doctors faced major differences. All the participants who in the country of origin had practised in hospital settings - many had been hospital specialists and some were surgeons – could practise only at the primary level in New Zealand. In their primary health care service, they were unable to use many of the techniques of Western medicine in their practice, including the laboratory and imaging diagnostic techniques that most had previously incorporated into their practice. Almost all the participants had been accustomed to using standard medical laboratory tests and x-rays and other imaging in making the diagnosis. Indeed, several of the Chinese doctors expressed considerable frustration at being unable to order diagnostic tests, a practice in which they were trained and carried out in their countries of origin. In contrast, when practising in New Zealand the doctor was dependent on the client arranging such tests through their GP, and bringing the result and in some cases the x-ray to the participant doctor. To have tests organised was in fact a common reason for suggesting that the client consult their GP (none of the participants directly requested the clients' GPs to arrange the tests). Only an Ayurvedic doctor and a homeopathic doctor were not as reliant on diagnostic tests.

Maintaining and advancing their clinical knowledge

The issue of continuing education in New Zealand was explored. In all cases, participants agreed that there were no courses or opportunities for higher education in their respective fields, a situation contributing to the intellectual wilderness they found themselves in. Several were endeavouring to rectify the lack of educational opportunities by teaching in, and in some cases establishing, educational institutes, and this will be discussed further below. For the participants themselves, however, their existing knowledge and expertise was, they felt, far in advance of continuing education opportunities in New Zealand, such as they were. A homeopathic doctor compared his five year full-time university degree in India with New Zealand's part-time four year (equivalent to two years full-time) diploma courses. Ayurvedic doctors compared their five year degrees with the short certificate or diploma courses offered in New Zealand, including courses run by 'holistic' health colleges or as a single component in courses in CAM. (As argued above, the matter of difference between the educational levels preparing practitioners in New Zealand and in the countries of origin had implications not only for continuing education of participants and their colleagues; it was also a factor in the recognition of the expertise and status of practitioners of such disciplines in general.) While neither the Ayurvedic nor homeopathic doctors were required to complete an assessed course in order to register in New Zealand, the TCM doctors needed to complete an assessed course before being registered to practice acupuncture. The NZQA-approved diploma course, based on a reading list for personal study, was administered and examined by the New Zealand Register of Acupuncturists. Participants said the content did not advance the Chinese immigrant doctors' knowledge of the science of acupuncture but focused on technical and regulatory matters including the code of patient rights and sterile needle use and disposal.

In the absence of advanced and continuing educational opportunities for highly trained and experienced immigrant doctors, participants were asked about access to current publications on research and scholarship. Two TCM doctors reported returning to China regularly, where they maintained contact with colleagues in their specialty areas, worked and sometimes attended conferences. One Ayurvedic doctor said he subscribed to an English language journal produced in India, the other did not; and one homeopathic doctor occasionally purchased an Indian journal; the other did not. Both the New Zealand Homeopathic Society and the New Zealand Registered Acupuncturist Association produce journals and the latter maintains a library. In addition, half the TCM doctors subscribed to Chinese journals and purchased books and five described themselves as heavy users of the internet to access current material. As a participant observed, continuing education and advancing knowledge was not impossible, but required more effort.

Lacking advanced educational opportunities for themselves, some participants had contributed to continuing education activities in their respective professions, such as addressing professional meetings, seminars and conducting workshops. A few others were registration board assessors. One described speaking at service organisations such as Lions in order to inform the public about the healing system; others referred to similar speaking engagements to service groups, such as the well-child health care organisation Plunket, and to professionals, such as midwives. In addition, there were those who had taught courses in the respective medical science and healing in health educational programmes, including both Ayurvedic doctors having taught Ayurveda in a holistic health college, and a TCM doctor being a guest lecturer on acupuncture at a polytechnic health sciences programme. Two TCM doctors working in the same clinic lectured for a full-time equivalent at a school of acupuncture. Finally, where there was no available school, a participant had established an NZQA-approved educational institute to teach Ayurvedic medicine; he was the CEO and there were colleges in Auckland, Gold Coast and Melbourne where certificate and diploma programmes were delivered. Those participants who engaged in formal teaching activities in New Zealand also talked of the ongoing support and mentoring they provided to former students. Some participants taught other classes on subjects related to their tradition of medicine including yoga and tai chi. A few participants had been invited guest teachers at colleges in other countries, such as in Canada and the USA.

Research

Prior to migrating to New Zealand, the participants described a very stimulating and active professional life in their countries of origin. Participants of all three medical traditions referred to the clinical research they were engaged in and said that they regularly submitted scientific papers to journals and conferences. A TCM doctor said he previously undertook significant funded research in China. Another described TCM research in China as having been developed to a 'deep level' involving biochemical and genetic research. A number referred to working in an environment of case-based research and discussing cases, exchanging knowledge, and generally advancing knowledge and experience collectively.

Unlike in their countries of origin, in New Zealand none was actively engaged in research, although a few thought they may do so in the future. Impediments to conducting research were noted, including: the distance from an active research environment; lack of intellectual stimulation; lack of access to funding and sponsorship in New Zealand; the present practice does not comply with regulations in China for undertaking research (a TCM doctor); insufficient time and other resources; inadequate English; and New Zealand's privacy laws. One participant observed that life as a new immigrant is characterised by the struggle to make a

living, to survive, leaving no energy for research. For many of these doctors, treating clients at a primary level for chronic but not life-threatening complaints contrasted strongly with their pre-immigration working lives in specialist research-active teaching hospitals. A few doctors, however, described growing research interests in the treatment of conditions they frequently encountered in New Zealand; cancer, chronic fatigue syndrome and depression were mentioned. An Ayurvedic doctor and four TCM doctors described case-based studies, as they documented clinical responses to their treatment and discussed their findings in professional circles; one said he had published such work in a professional journal, another used these cases in discussions with former colleagues who were leaders in their fields in the countries of origin and some used them in teaching and continuing educational contexts.

Professional activity and status in New Zealand

Doctors generally had belonged to the respective professional associations, where some had been very active as office-holders. A TCM doctor said that membership was required for those working in hospitals; another said he had belonged to six such associations; a number had belonged to the prestigious Chinese Medical Association. Moreover, having come from countries with pluralistic medical systems, this active professional life also involved medical professionals engaged in Western medicine. With the exception of a homeopathic doctor, the participants no longer belonged to those associations in the countries of origin.

Now in New Zealand, participants belonged to the respective local professional associations. These included the New Zealand Register of Acupuncturists, New Zealand Acupuncturist and Chinese Medicine Practitioner Association, New Zealand Charter of Natural Health Practitioners, Australasian Ayurvedic Practitioners Association Inc., and the New Zealand Homeopathic Society. Most displayed framed copies of their registration or membership certificate in their premises. Several of these associations organised regular meetings, seminars and lectures, and participants attended and sometimes addressed such gatherings. In the case of acupuncturists, the Association requires 20 hours of continuing education per year. Occasional conferences were also organised, that participants attended when they could; cost could be a restricting factor. Both Ayurvedic doctors and one TCM doctor, but neither homeopathic doctor, were current or former presidents or executive members of the respective associations. A TCM doctor complained that the association 'belonged to Westerners', militating against it being a means of delivering continuing education at an advanced level. In the case of Ayurveda, there were no professional associations in New Zealand until established by a study participant; he established the Australasian Ayurvedic Practitioners Association Inc. in 1997 and in

2003, was a founding member of the International Council of Ayurvedic Medicine (he is currently its CEO).

The level of societal respect participants had enjoyed in the country of origin, where a few had travelled overseas as expert consultants and a number had been specialist clinicians in teaching hospitals and lecturers at the respective medical schools, was not matched in New Zealand. A few TCM doctors, however, who had only recently qualified before migrating to New Zealand, had not been as professionally active nor accustomed to such respect. Moreover, participants found themselves on the margins of medicine, commonly termed 'alternative' or 'complementary', a novel experience for these doctors and one that was widely resented. Participants felt that by being regarded as 'alternative' therapists, they were relegated to a marginal status that contrasted poignantly with the high status and professional respect enjoyed in the country of origin; one spoke of being 'hurt' by the fact that his practice was dismissed as 'quackery'. Not only did the participants find themselves on the margins of medicine. The high level of professional engagement in their respective specialties was not evident in New Zealand where Ayurvedic, homeopathic and TCM doctors all spoke of their professional isolation. The appreciation clients expressed compensated to some extent for the negative professional experiences and the motivation to help clients that led to the establishment of the clinics in the first place gave rise to ideas as to how health services could be improved in New Zealand by addressing some of the restrictions and attitudes.

Conclusions

While many of the participating immigrant doctors would have been eligible (based on their medical education) to apply for registration to practice medicine in New Zealand, the majority did not attempt to do so. The opportunity to instead establish and run their own clinics offering alternatives to Western medicine enabled the participants to make a living and support themselves and their families as self-employed business men and women. Only two expressed regrets; the remainder indicated that they were positive about their work, in particular their ability to assist their clients.

In spite of the contribution by all participants to the range of health care services available in New Zealand, and the contribution of a sub-set to education and workforce development, some participants indicated that their expertise was under-recognised and underused. In particular the medical establishment and the Government bureaucracies that supported mainstream medicine were regarded as unsympathetic and unhelpful. Included among the participants, as noted above, were PhD qualified doctors, specialists, university academics and clinical teachers, active clinical researchers, experts who had been invited to speak internationally

gatherings. These doctors who had before migration worked autonomously in general and specialist capacities, in some cases drawing from diagnostic and therapeutic techniques of Western medicine as well as the traditional medical science, now were dependent on, for example, their clients requesting their GPs to organise diagnostic tests, or sometimes to prescribe a medicine. They were restricted in what therapeutic techniques they could use.

Notwithstanding the professional isolation and the lack of intellectual stimulation experienced, participants conveyed an enthusiasm for their work in New Zealand with few exceptions. The reasons were several. A large number were convinced of the benefits of the treatment they offered, which frequently was described as safer, less toxic and more beneficial than Western medicine. Doctors of all three traditions spoke of their desire to introduce genuine practice to New Zealand, setting their practice apart from 'complementary' and 'alternative' medicine and establishing it as a medical science comparable to biomedicine, but with a different theoretical basis.

CONCLUSIONS AND RECOMMENDATIONS

A comparative case study of recent immigrant doctors practising traditional Chinese medicine, Ayurvedic and homeopathic medicine was conducted in Auckland, Palmerston North and Wellington between July 2004 and February 2005, in which data were systematically collected via personal interviews with 14 immigrant doctors running private clinics. The broad aims of the study were: to illuminate the context and experiences of one group of skilled immigrants – doctors - settling in New Zealand and running clinics offering non-Western medicine, and; to illuminate the effects on their clinical practices of relevant New Zealand policies and practices. Reflecting the participants and the clinics they ran, the investigation shed light on the contribution of these skilled immigrants to New Zealand health services, and the response of the wider New Zealand society to these immigrants and their services.

On Being an ‘Alternative’ Practitioner and an Immigrant

Immigrant doctors from non-traditional countries and programmes provides a window on the settlement experiences of highly skilled professionals, immigrants who encounter particular difficulty in finding employment in their professional area or expertise and at a level appropriate to their experience. Previous research on immigrant medical doctors has found high levels of frustration in registering and practising as doctors in New Zealand (Department of Internal Affairs, 1996; North, Trlin and Singh, 1999). A key finding of the present study is that in many cases, although many of the Chinese doctors in particular had been trained and previously practised mainly in Western medicine with TCM as an adjunct, the participants set up practices in the respective traditions of TCM, Ayurvedic and homeopathic medicine because of barriers to registering as medical doctors to practice medicine in New Zealand. The barriers that influenced most of these immigrant doctors not to attempt registration as doctors in New Zealand included English language and cost, and the reputed difficulties. However the participants were able to make a good living in the respective traditions, as shown in an earlier study on self-employed immigrants (North and Trlin, 2004).

TCM, Ayurvedic and homeopathic medicine are in New Zealand, as in other Western countries, categorised as complementary and alternative medicine. For the participants, this marginal position created a range of difficulties in their practice and contrasted sharply with their status and practice in their country of origin. In their country of origin, Western medicine was integrated with other traditions of medicine, reflected in their education and practice, where the status of Western and other doctors was equal and all had access to diagnostic and other services. In New Zealand, status was marginal and low and they had no access to diagnostic services,

nor could they practice collegially with other medical practitioners and, except in the case of acupuncture post-injury, there was no access to subsidies for services. In addition, whereas many participants had previously been respected hospital specialists, in New Zealand, hospital-based practice was not available. All participants practised in the primary level of health services. Participants, therefore, needed to make major adjustments to their professional practice as well as adapt to an unaccustomed marginal status in the health system. At the same time as they adjusted to living in New Zealand society, they needed to learn new ways of interacting with the health system and getting the required support for their clients.

Participants compared active, intellectually stimulating professional context in which they engaged in their country of origin with an intellectual wilderness in New Zealand. Notwithstanding the professional isolation and the lack of intellectual stimulation experienced, participants, with few exceptions, conveyed an enthusiasm for their work in New Zealand. The reasons were several. A large number were convinced of the benefits of the treatment they offered, which they frequently as described as safer, less toxic and more beneficial than Western medicine. Doctors of all three traditions spoke of their desire to introduce genuine practice to New Zealand, thus setting their practice apart from 'complementary' and 'alternative' medicine and establishing it as a medical science comparable to biomedicine, but with a different theoretical basis. An Ayurvedic doctor said that he loved the challenge of introducing Ayurveda to New Zealanders, marketing the discipline and creating the professional and educational support structures needed. Several TCM doctors spoke of their love of their work, and their compassion for the suffering, especially those who had not benefited from mainstream medicine or were suffering from toxic effects of powerful medicines such as anti-cancer medications.

In their comments, the doctors reflected concern about their perceived status as 'alternative', a status they had not formerly occupied or considered. While many operated busy clinics and were highly appreciated by their clients, their loss of status relative to their circumstances prior to migrating was frequently commented on. One participant described being 'hurt' that his discipline was dismissed by the medical profession as 'quackery'. A Chinese doctor conveyed considerable frustration with ACC that, he said, regarded acupuncture as 'low'. He referred to an ACC report that concluded acupuncture helped some musculoskeletal problems but not others. He would like to know how that conclusion was reached and by whom? Where is the evidence? Did the authors draw on the wealth of research done in China? What was the expertise of the authors? These questions reflect the concerns of many doctors about the general lack of understanding of TCM, acupuncture, Ayurvedic and homeopathic medicine by society in general and health professionals and bureaucracies in particular. A doctor felt that the New Zealand public were generally ignorant about the discipline, and public education is needed.

Added to this, these doctors were also grappling with issues common to many skilled immigrants. One remarked on the frustrations related to 'being an immigrant'. He did not wish to discuss the issue in depth, but alluded to talent not being realised, daily frustrations and disappointments, lost hope, illness in the family, and financial struggles. While many conveyed their disappointment with the reality of being a skilled immigrant in New Zealand compared with their expectations, most were also positive about the futures of their families. In the present, however, they were struggling with loss of status as a highly regarded doctor with a high status in society; their realities were the low and marginal status of 'alternative' practitioner compounded with the marginal status of 'immigrant'.

Contributions to New Zealand society and health services

The appreciation of their clients compensated for the lack of recognition from medical professions. Generally not more than 10-15 percent of clients were immigrants from the same country of origin. Like previous New Zealand research (Baxter, 1997; Liu, 1998; MacGregor-Reid, 2001), the clientele were drawn mainly from the general New Zealand society. A large proportion of these clients were suffering from chronic disorders that mainstream medicine had not adequately relieved, and clients paid out of their own pocket to complement mainstream medicine. Although the clinical services were marginal to the mainstream health system, the doctors nonetheless were affected by some legislation and statutes (e.g. Health and Disability Commissioner Act). In response to a largely New Zealand European, Maori and Pacific clientele, the participants went to considerable lengths to explain the therapies. All belonged to the appropriate professional association in New Zealand, and through their membership had gained some knowledge necessary to practising in the New Zealand environment. In addition, many articulated their ambitions to improve the range and quality of health services other than Western medicine to New Zealanders. Currently, the traditions they were engaged in were not regulated and all participants wished to see greater regulation for the protection of clients and to restrict access to poorly trained practitioners; Liu (1998) also conveyed this desire.

In spite of the negative side to being marginalised professionally, no participant gave the impression they might return to the country of origin to resume practice there. Rather, the participants conveyed a strong commitment to New Zealand: they were positive about the futures of their families; they were keen to establish high quality health services in the tradition in New Zealand; they spoke of being motivated by their compassion for the suffering, many of whom were poor; were confident in the efficacy and safety of the therapies; and offered opinions on how to improve and integrate health services New Zealand. In addition to their clinical work, a number of doctors were actively engaged in educational programmes, training and mentoring

others in the modality, and most were active in professional development and continuing education in their respective professional associations.

In the light of research among Asian immigrants indicating difficulties engaging with mainstream medicine and higher rates of use of Asian medical traditions (Asian Public Health Project Team, 2003; Baxter, 1997; Chan, 2001; Ho et al., 2002; Liu, 1998; MacGregor-Reid, 2001; Scragg & Maitra, 2005) an expectation of this study was that demand by immigrants would drive the expansion of TCM, Ayurvedic and homeopathic medical services. Indeed, the 2002/2003 National Health Survey showed that 12 percent of Asian people surveyed had visited an alternative health provider in the last 12 months, considerably higher than the general population (Scragg & Maitra, 2005). The present study indicates that expansion is indeed driven by immigration but it is the suppliers of services, not the consumers, who are the key drivers.

Recommendations

Recommendations arising from the study fall into two areas: immigrant doctors practising non-Western medical traditions; and for users, including immigrants and New Zealanders.

Recommendations arising from the experiences and perspectives of the immigrant doctors:

- New Zealand could learn from immigrant doctors' experiences and perspectives on integrated medical traditions and pluralistic health systems in order to broaden access to effective therapies and increase efficiency and equity of the health system.
- The evidence for effectiveness and safety of interventions for particular conditions established in international research needs to be compiled, and subsidised treatment available to those that meet the required standards.
- New Zealand can investigate international best practice specifically in other OECD countries and their experiences of integrating and improving access to TCM, Ayurvedic and homeopathic medicine.
- Practitioners' calls for improved regulation need to be investigated and appropriate action taken.
- Further research is needed on the barriers experienced by highly skilled professional immigrants and barriers to employment in their professional area of expertise.

Recommendations arising from the descriptions of users:

- The needs of the Asian immigrant communities for better access to the medical traditions from their countries of origin offered in New Zealand need to be further investigated and the findings used to inform policy.
- The effectiveness of non-Western medical traditions to ease the burden of symptoms of those with chronic conditions (where Western medicine is ineffective) needs to be investigated and findings used to inform policy.
- Further research is needed on the experiences and perspectives of all New Zealanders, including recent immigrants, on health service use, access and preferences.

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APPENDICES

Appendix 1: Notes on the Medical Traditions Practised by Participants

Appendix 2: Associations of Practitioners and Self-Regulation

Appendix 3: The Questionnaire

Appendix 1: Notes on the Medical Traditions Practised by Participants

1. Participants' Descriptions

The participants' descriptions of the basis of their practices and the therapies they employed is summarised in order to provide an understanding of the practitioners' perspectives and understanding.

Doctors of both TCM and Ayurvedic medicine described their approaches as holistic, concerned with the root cause of illness, rather than the symptoms and patient's complaint. Individualised consultation and treatment are carried out with a view to restoring 'balance'. Thus, for the same disorder or complaint, the treatment may differ because of personal differences between patients. Treatment often involves lifestyle and nutritional advice in addition to medicines and interventions, and is concerned with prevention, health promotion and wellbeing. Homeopathy also treats the person, not the disease, but the underlying philosophy of 'like cures like', not 'balance', is the basis of treatment. There was general agreement among participants that these systems of medicine were particularly suited to the treatment of chronic conditions and supported the body's natural healing ability. As such, a longer course of treatment is likely before benefits are apparent. However, as a Chinese doctor pointed out, like Western medicine, TCM works better in some conditions than others.

While restoration of balance is central to both TCM and Ayurvedic medicine, from explanations given by participants, the focus of balance differs. The aim of treatment in Ayurveda involves achieving a balance of primary energies of air, fire and water, energies that are held to regulate all physiological processes. It is believed that harmony between body, mind and soul is also necessary for health. Ayurveda employs techniques to purify, to enhance harmony, to rejuvenate. TCM also refers to balance – of yin and yang. According to TCM, energy or life force, known as Qi (Chi), flows along meridian pathways and when these are blocked, symptoms appear; acupuncture, it is argued, unblocks the pathways and allows Qi to flow, restoring the balance of yin and yang. The five elements of fire, wood, earth, water and metal are also important. It follows, then, that from this perspective an unbalanced life and environment can lead to illness, as for example wrong food, climate change, emotional disturbance, overwork and the like can upset balance. While acupuncture is believed to unblock meridians, Chinese herbal medicine is used to restore the balance of internal organs, strengthen the body's constitution and cleanse the body of toxins. Two Chinese doctors made a distinction in the case of treating soft tissue and musculoskeletal injury: in these cases, their approach in diagnosing and treating did not differ from Western medicine except that acupuncture was a standard

intervention. One said he draws mainly from Western medicine to diagnose musculoskeletal complaints, and from both Western and TCM traditions to treat.

From the accounts of participants, it appears that TCM and Ayurvedic medicine share philosophical similarities and contrast with homeopathic and especially Western medicine. How the underlying theories affect practice is evident in the consultations, particularly in terms of the diagnostic techniques and treatments used. As with similarities in the underlying philosophical basis, both TCM and Ayurvedic medicine shared some common approaches to the consultation. TCM and Ayurvedic practitioners emphasised that the approach was holistic and comprehensive, resulting in an assessment of the state of balance. Imbalances and blockages of meridian channels resulted in symptoms, and the focus of treatment was restoration of balance. The importance of taking a very detailed history was emphasised by both TCM and Ayurvedic practitioners, involving not only a history of the complaint but also a personal and family history, and information on such matters as emotions, relationships, lifestyle, nutrition and climate change. A few TCM doctors commented that in the case of musculoskeletal injuries, the history taking is limited to the complaint.

Homeopathic practitioners also emphasised the importance of a detailed history, but described their approach to the clinical examination as similar to biomedicine. In contrast, both TCM and Ayurvedic practitioners relied on “pulse diagnosis”, a technique not reflected in biomedicine nor homeopathic medicine. Physical examinations involved observing the tongue, facial colour and expression, and bodily posture; smelling breathe and secretions; listening to the voice tone and energy; and palpation. A Chinese doctor summarised the process as “Look-Feel-Touch”; another as “Asking, Smelling, Hearing, and Watching”.

Having arrived at a diagnosis of the root cause of symptoms, agreed as the most important element of practice, treatment was focussed on the root cause, not the localised symptoms. The homeopathic doctors described their approach as treating ‘like with like’ to stimulate the body’s healing; tinctures of ultra-diluted medicines were used. Both Ayurvedic doctors and 7 TCM doctors also used medicinal treatments. In Ayurveda, herbal supplements, teas and tonics were prescribed. TCM doctors used both raw herbal and processed herbal medicines. One explained that herbal medicines were used for conditions other than musculoskeletal complaints. All practitioners agreed that the medicine regimens prescribed were tailored to the individual, not standardised for the complaint, and saw this as a key point of departure from biomedicine.

Ayurvedic doctors relied also on physical treatments, with Ayurvedic massage central to restoring balance and for rejuvenating. Indicating the specialised nature of massage therapy, the types of massage specified by the two doctors varied and

included katibasti, synchronised massage and vibrational massage. Another technique used by both was panchakarma for detoxification, or purification. The Chinese TCM doctors all used acupuncture and its variants (acupressure, cupping, moxibustion, and ear acupuncture) said to be a mainstay for the localised treatment of musculoskeletal complaints. In addition are the use of deep tissue massage, traction, reflexology (not traditionally part of TCM), use of heat lamps and magnetic therapy. This group of treatments are based on meridian principles, aimed at unblocking energy channels. Only homeopathic doctors did not use physical techniques in treatment.

In addition to medicinal and physical treatments, nutritional and cooking instruction was used therapeutically by one Ayurvedic doctor who commented that 'the kitchen is the key to good health'. Another offered a beauty programme. Both homeopathic and Ayurvedic doctors offered lifestyle counselling. Some Chinese TCM doctors specified advising clients on exercise, meditation and nutrition (important to the balance of Yin-Yang). An Ayurvedic doctor taught yoga and a TCM doctor Tai Chi.

2. Traditional Chinese Medicine

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Underlying theory

The ancient practice of traditional Chinese medicine is an integral part of the Chinese culture and has been practiced in some form for over 5000 years. Ancient Chinese physicians believed disease in the body was caused by an imbalance in the internal forces of Yin and Yang¹ which, as polar opposites must work together, relying on each other to maintain health. The aim of traditional Chinese medicine (TCM) was to recreate balance within the body, creating even amounts of Yin and Yang and thereby returning the body to a healthy state. Yin represents the structural and substantive qualities and Yang represents the functional energetic qualities of the universe. 'In modern terms, yang corresponds to all that is active, expansive, centrifugal, aggressive, demanding, (polar) negative and yin implies all that is structural, substantive, contractive, centripetal, responsive, conservative, (polar) positive' (Gao, 1997, p.12). The theory of Yin and Yang is paramount in almost all aspects of Chinese history, 'the Yin/Yang doctrine is simple but its influence has been

¹ 'Yin/Yang are the way of Heaven and Earth, the great principle and outline of everything, the parents of change, the roots and source of life, death, the palace of the gods. Treatment of disease should be based upon the roots (of Yin/Yang).' (Nei Jing First century BC, cited in Gao, 1997, p.12.)

very extensive. No aspect of Chinese civilisation – metaphysics, medicine, government or art – has escaped its imprint' (Gao, 1997, p.12).

One of the more significant aspects of TCM is its belief in the importance of prevention as opposed to cure. Doctrines of Chinese medicine maintain that by keeping the body balanced by regularly practising the doctrines of TCM, a person is able to avoid illness and disease rather than having to cure such ailments. This is illustrated in the practice of wealthy Chinese citizens who, in ancient times, would pay a doctor in advance to maintain the health of their body and mind. If a patient then fell ill, the doctor was required to refund the fee. Although the delicate balance of Yin and Yang (governing the body's well-being and emotions) must be kept at correct proportions, the two properties may change to certain extents within the body. Although it is normal for the balance to constantly change, if a serious imbalance occurs then disease or illness is formed. The essential principle of TCM is to decide the exact nature of the imbalance between Yin and Yang, and the pathogen causing trouble, and then to correct these pathological processes. As the natural forces of the body return to the normal balance, the disease is cured.

The Chinese believed that the force behind all living tissue was 'Qi' and therefore the role of Chinese medicine is to keep the 'Qi' of the body strong so it is able to keep the body strong and able to resist pathogens (disease-causing factors). Methods included specific breathing exercises combined with meditation to develop the strength of 'Qi'² in the body. In TCM, the factors that disrupt the balance in our bodies are the causes of disease (Tu, 2004b). Three general categories of causes have been developed. The first category refers to external causes including climatic influences. The six external causes of disease are wind, heat/fire, summer-heat, dampness, dryness, cold. The second category refers to internal causes. Internal causes include emotional distresses that damage the visceral organs, thus causing disease, and these are internal wind, internal heat/fire, internal dampness, internal dryness and internal cold. The third category is neither external nor internal causes, but those other factors that impact on health such as diet, trauma and sexual activity.

² 'Qi' represents the energy throughout the universe and that which pervades and flows within the human body. The Chinese 'Qi' is very similar to the Greek idea of 'pneuma' and the Indian 'prana.' (Gao, 1997, p.20). Manfred Porkert (cited in Gao, p.20) as 'energy of definite (or definable) quality, energy of definite direction in space, of a definite arrangement, quality of structure.' Paul Unschuld also describes 'Qi' and states the importance of its existence. He refers to 'Qi' as the "'finest matter'" and emphasizes that, even though it is invisible and without form, it is still referred to as a substance in the ancient literature and this is an important consideration when interpreting ancient medical texts.' (cited in Gao, 1997, p.20).

Diagnosis

In TCM, the diagnostic process is conducted using the Four Examinations. The first area is “looking”: at the complexion, eyes, tongue, nails, hair, gait, stature and affect. The second area is “hearing and smelling; the sound of the voice and breath, odour of the breath and skin The third area involves “questioning”: complaints, symptoms, health history and family health history, patterns of sleep, diet, digestion, pain, emotional features, lifestyle features etc. And finally is “touching”: palpation of the body to ascertain temperature, body moisture, pain; and taking of the pulse (NIH, 2005). The diagnosis is the most complex part of the treatment; in ancient times this was achieved by a refined form of pulse diagnosis.³ This method of diagnosis allows the whole body to be assessed and it also defines the relative balance between each of the organs. In addition, pulse diagnosis is said to give a clear idea of the type of disease process, whether it is acute or chronic, and to give the prognosis for that disease on that individual patient.

Treatments

When illness does occur, the Chinese physician will select a method to treat the disorder. By first diagnosing the area of the body and organ that is causing the problem, a physician will then target this area using acupuncture.

Acupuncture

Acupuncture, first used more than 5,000 years ago, is used to treat and prevent disease. Very fine needles (today these are sterile stainless steel needles) are inserted into selected acupoints along the different meridians (Tu, 2004a). There are more than 2,000 acupuncture points on the body that connect with the 12 main and eight secondary pathways or meridians. The meridians conduct energy or Qi between the surface of the body and the internal organs. Qi regulates an individual’s spiritual, physical, emotional and mental balance and is influenced by Yin and Yang. Acupuncture is believed to balance Yin and Yang, ensuring that Qi flows freely around the body, thereby restoring health to the body and mind (Nestler & Dovey, 2001). Sometimes, small amounts of electric current are used to enhance the effect of the treatment. The number of points where acupuncture needles are inserted has also increased, usually discovered as a result of the integration of TCM meridian theories and Western medicine anatomy and physiology knowledge (Tu, 2004a).

³ The palpitation of the pulse enables the acupuncturist to assess which organ is diseased, whether the organ is over – or under-active, and the pathogen causing the damage. This is achieved by feeling the pulse at three positions at each wrist and by feeling the pulse at the superficial and deep positions at each end of three positions on the wrist. It is unclear how this system of pulse diagnosis came into existence but it was refined and very important system by the time the Nei Ching Su Wen was written (Lewith, 2004).

Acupuncture is used to treat a wide variety of conditions with few side-effects and is also used in analgesia. Acupressure uses the same acupuncture points on the body but different therapeutic techniques including superficial rubbing pressure method, the press and release method, the tapping method and the meridian method (Chung, 2004). Also applied to the acupoints, moxa (or mugwort) is a dried herb that, when lit, has a warming and energising effect and activates the channels (Tu, 2004a).

Exercise therapy

Qi Gong, developed on the basis of the channels and collaterals (the meridian system) of TCM, is a combination of exercises and meditation with the aim to build up Qi in the body, promote health and fitness and prolong life. The goal is to enable the Qi to ascend, descend, open, close and circulate freely through the 12 main channels, the Ren and Du channels and the eight extra channels and collaterals. Tai Chi is a martial art that developed out of Qi Gong that strengthens the body and promotes inner relaxation. Tai Chi is a combination of the meditation associated with Qi Gong and an exercise system that involves a series of slow, fluid movements (Jialing Yu, 2004a). Tai Chi is considered useful for maintaining the mobility and flexibility of the musculo-skeletal system.

Diet and Chinese herbal medicine

In addition to acupuncture and exercise, diet and herbal remedies have always played an important role in TCM. The giving of dietary advice has a long history in China. The *Shen Nong Ben Cao Jing Herbal Classic*, written about 200BC, lists certain foods as having therapeutic qualities, for example, Chinese date and yam, ginger, grape and lily bulb (Jialing Yu, 2004b). Foods are classified as either Yin, Yang or neutral. The diagnostic process employed is similar to that for herbal therapy. Rather than following western eating patterns of counting calories and levels of nutrients, vitamins or fats to create a balanced diet, the Chinese believe that who we are determines what is most beneficial for us to eat. For example, foods are selected on the basis of their correspondence with individual patterns, modified by the climate, the season and acute illness. Different foods are used to cure different symptoms, and although a specific food group may relieve one person's symptoms those same food groups may exacerbate symptoms of another person. Once an individual has had their patterns of dysfunction diagnosed, they will know if they need more Yin or Yang foods to balance their body. A Chinese doctor, before recommending a therapeutic diet, studies the patient's constitution, the nature of the patient's illness and even the season and climate. A therapeutic diet can also be used to maintain an individual's good health. The flavour of a food influences the type of action it has on the body and which organ(s) it affects. The season and climate must also be taken into account e.g. in autumn which is drying, a person should eat foods, such as honey, bananas, pears, lotus root, dairy products, that nourish Yin and moisten the lungs.

Herbal medicines in TCM are made from plant parts such as roots, stems, bark, leaves, seeds, flowers and fungus, and from minerals such as talcum, kaolin, sodium sulphate and magnetic stone and animal parts. More than 3,000 species of plants and animal products have been identified. The herbs are processed using a range of methods – with water and fire, physical methods, fermenting, sprouting and ‘frosting’- to enhance their therapeutic effect, reduce or eliminate toxicity, transform the nature of the herb, remove impurities, facilitate storage etc. A typical formula contains 4 to 12 ingredients and remedies are formulated according to the individual’s needs. They may be in the form of a decoction (package of herbs boiled in water), powders (drunk with boiling water), tinctures (a dose suspended in alcohol) or as pills (Chiu, 2004). Tablets, ampoules and capsules are becoming increasingly popular due to their convenience. Sales of Chinese medicine in China increased by 52 percent between 1988 and 1992, just eclipsing the sales of Western medicines by 1 percent (Hesketh & Zhu, 1997). In contrast to Western pharmaceuticals, TCM herbs are characterised as either cold, hot, warm, cool or neutral, and these reflect Yin and Yang. Cold diseases are treated with heating herbs and hot diseases with cooling herbs. Herbs are also categorised by tastes which are more important in defining a herb’s properties than its actual taste. The tastes are sour, bitter, sweet, spicy, salty, bland and astringent. Sour, astringent, bitter and salty tastes are related to Yin and spicy, sweet and bland are attributed to Yang. The TCM herbalist looks at the location and orientation of the disease pattern in four main areas of the body to determine which herbs to prescribe. A skilled practitioner will be aware that combining certain herbs may produce toxic or adverse reactions and some herbs are contraindicated in certain circumstances, for example if a woman is pregnant. There may also be negative reactions between herbs and foods, conversely, an experienced herbalist will be able to suggest foods to eat with the herbal remedy that will enhance its effectiveness (Chiu, 2004).

3. Ayurvedic Medicine

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Briggs (2002, p.361) defines Ayurvedic medicine as ‘the traditional holistic approach to health and treatment of disease practiced in India. Its popularity (similar to TCM) in other cultures is increasing as complementary medicine becomes more widespread. Ayurveda makes extensive use of plants in conjunction with diet and lifestyle modification to promote health.’

Indian Ayurvedic techniques are also being used increasingly in the West. The holistic nature of Ayurvedic medicine supports the view that human beings are made up of multiple interacting subsystems such as mind, body, emotion and spirit. As all systems are interrelated and affect each other, they must all be involved in the treatment process. Therefore practitioners of Ayurveda and other holistic practices encourage the patient to help decide the treatment to be prescribed and spend a lot of time discussing symptoms of the overall body before treating a specific problem area. In many ways the methods and theories of Ayurveda run parallel to those of traditional Chinese medicine. They both share the absolute belief that, unlike conventional Western medicine, all patients cannot be treated in the same way, with the same therapies and medication. Both view the treatment of the human body in a holistic way by assessing the entire being, both mentally and physically, before administering treatment.

Hundreds of years of foreign rule in India resulted in a decline and the loss of knowledge of Ayurveda, but since the country regained independence, there has been a resurgence of Ayurvedic medicine. More than 100 Ayurvedic colleges are now established in India, with a number of these being supported by the Indian government. The ancient knowledge of Ayurveda includes a very complete and practical understanding of human physiology. The first recordings of Ayurvedic techniques and methods date back to 5000 years ago in the document 'The Vedas' which was compiled in Sanskrit by Srila Vyasadeva and distributed in temples and libraries throughout India. The writings were extremely detailed with procedures from herbal and dietary recommendations to descriptions of surgical operations. Later (about 3000 years ago – Shannon , 2001, p.454) authors such as Sushruta and Charaka described surgical procedures such as prosthetic surgery to replace limbs, cosmetic surgery on the nose and elsewhere, caesarean section and even brain surgery. These are supported by archaeological research which uncovers evidence that some of these operations were carried out successfully some 3000 – 5000 years ago (Bhagavat das. 'History of Ayurveda'. www.ayurveda-herbs.com).

Underlying theory

Ayurveda is based on the universal law of balancing the five elements (ether, air, fire, water and earth) that make up the physical body. The elements are kept intact by the three doshas, which must be kept balanced through lifestyle, herbs and diet. Improper diet and lifestyle can result in imbalance and lead to various diseases and mental disturbances. The three doshas are Vata or Vayu (air), Pitta (fire) and Kapha (water), which singularly or in combination make up each individual being. Most people have characteristics from two or more of the doshas. The characteristics of each dosha include the following. Someone is of a Vata disposition is of slight build

with dry skin and hair. They often have variable scanty appetites and are light sleepers. When they are balanced correctly, they are artistic and creative but have tendencies towards being hyperactive, insecure and anxious. The Pitta types have soft, oily skin, fair complexions and strong appetites, preferring to eat large meals without snacking. When they are well-balanced, Pittas are intelligent, organised, assertive and good orators. They have moderate activity levels and are very competitive. Those of the Kapha disposition are generally large, big-boned and strong. They have oily, smooth hair and skin and lotus eyes. Kaphas eat slowly and have lots of small meals throughout the day. They are not very active or as quick to understand but they are calm and loyal.

Therapies

As in traditional Chinese medicine, specific foods should be chosen in light of an individual's symptoms and other personal characteristics. All food is broken down into six sub categories or tastes: sweet, sour, salty, pungent, bitter and astringent. Each taste comprises of two elements, for example sweet, which is comprised of earth and water. In addition, to the taste of the food it is also labelled according to its heating or cooling properties and its 'post-digestive' effect (this refers to 'how foods taste to tissues' during and after assimilation.) Taste, action and post-digestive are the key to understanding foods and herbs. It is stressed throughout the teachings of Ayurveda that no food is good or bad, but food should be used according to the individual. This explains why Ayurvedic practitioners question a patient extensively about past illnesses and other problems before they prescribe medication.

As well as the correct consumption of food, Ayurveda offers many other ways of healing. There are specific methods connected with the five senses; as all people heal differently, a method of therapy can be chosen to suit an individual's needs. For taste therapy, Ayurvedic practitioners employ the use of herbs and nutrition; for smell – aromatherapy; touch – yoga, gem and massage therapy; sounds – mantras; and for sight, colour therapy is used. An illness is considered as bought on merely by an excess or deficiency of one or more elements. Examples include an excess of air, which can cause lack of concentration and physical gas and an abundance of fire leading to heat rash or a hot temper. An overabundance of water may lead to lethargy, becoming overweight or 'water illness' in the chest region. The five elements affect and are responsible for everything. By consumption of certain foods and herbs and practicing spirituality and increasing exercise, an individual can reverse the imbalance within their physical being. For example, if someone has too much Vata (ether/air/wind) they may have dry skin and bones, constipation, anxiety and worry. If they are surrounded by Pitta (fire/warmth) and Kapha (water/earth/moisture) and avoid air (drying/cold and ungrounding things), the

warmth and moisture will warm and lubricate the air and they will re-achieve balance.

4. Homeopathic Medicine

Homeopathy was developed by German physician, chemist and author, Samuel Hahnemann, MD (1755 – 1843). According to Micozzi (1998), Hahnemann observed that medicinal substances elicit a standard array of signs and symptoms in healthy people. The medicine that elicits symptoms most closely resembling the illness being treated is the one most likely to initiate a curative response. Hahnemann coined the term 'homeopathy' to describe the method of using remedies with the power to resonate with the illness as a whole, in contrast with the more conventional method of opposing symptoms with superior force. The word homeopathy is derived from the Greek 'omoios' meaning 'similar' and 'pathos' meaning 'feeling' (Micozzi, 1998).

Appendix 2: Associations of Practitioners and Self-Regulation

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TCM and acupuncture regulatory bodies

Since the 1970s, a number of associations have been established over the years to represent and advance the interests of each group of practitioners. Baxter (1997) listed these groups. Mainstream health profession groups include: the New Zealand Physiotherapy Acupuncture and Pain Modulation Association (PAPMA); the Medical Acupuncture Society of New Zealand (MASNZ) whose members were interested in medical acupuncture and had qualifications in Western medicine and were registered medical practitioners. 'Lay' acupuncturists formed. The Bill sparked discussions, mainly concerning the registration of acupuncturists, among the various groups from mainstream medicine with an interest in acupuncture. Groups representing TCM practitioners were also formed: the first in the 1970s was the New Zealand Register of Acupuncturists (NZRA) and during the 1980s and 1990s, the New Zealand Chinese Acupuncture Association and Register (1988) and the New Zealand Federation of Chinese Medical Science (1993).

The New Zealand Register of Acupuncturists

The New Zealand Register of Acupuncturists (NZRA) was incorporated as a society in 1977 to promote TCM and acupuncture and to ensure high standards of ethics and professionalism amongst its members. All new members must pass the NZRA examination and must have trained at colleges which require a minimum of four years of full-time study in TCM, including Western anatomy, physiology and pathology as well as acupuncture. Members of the Register have been trained at recognised places and/or have shown equivalent standards of proficiency through their clinical practice and by examination (The NZ Register of Acupuncturists, 2005). All practising members are approved ACC providers and are registered with the Accident Compensation Corporation to provide ACC treatment with referral from a medical practitioner.

The Medical Acupuncture Society of New Zealand

The Medical Acupuncture Society of New Zealand (MASNZ), which became an incorporated society in 1981, is a non-profit organisation whose members are

registered medical practitioners with an interest in acupuncture. The Society's purpose is to promote the knowledge of and use of acupuncture within the medical community. MASNZ maintains and runs the Register of Medical Acupuncturists. To be admitted to the register, medical practitioners must be licensed with the Medical Council of New Zealand to practice medicine and complete 150 hours of approved acupuncture training and pass an examination in acupuncture competence. In addition, MASNZ runs conferences and workshops to extend the knowledge of medical acupuncture (Medical Acupuncture Society of New Zealand). Baxter (1997) made the observation that while MASNZ appeared to represent and regulate a significant proportion of medical acupuncturists, it did not include all medical acupuncturists in New Zealand.

The Physiotherapy Acupuncture Association of New Zealand

The Physiotherapy Acupuncture Association of New Zealand (PAANZ) is a special interest group of the New Zealand Society of Physiotherapists. It changed its name from the New Zealand Physiotherapy Acupuncture and Pain Modulation Association (PAPMA) in 1998. MacGregor Reid (2001) commented that the then PAPMA was the largest group offering acupuncture in New Zealand. The aim of the PAANZ is to promote a high standard of acupuncture by physiotherapists and this is achieved through its post-basic education programme and the national conferences held jointly with the Medical Acupuncture Association of New Zealand (MASNZ). The PAANZ Register of Physiotherapy Acupuncturists helps to monitor ongoing acupuncture training. Members of the Register must attend 150 hours of education, including assessment procedures in order to qualify for this (New Zealand Society of Physiotherapists).

The New Zealand Chinese Acupuncture Association and Register

The New Zealand Chinese Acupuncture Association and Register (NZCAAR) was established in 1988. MacGregor-Reid (2001) reported that members could not register with the Accident Compensation Corporation to become ACC providers. She said that from what she could ascertain, NZCAAR members were required to submit proof of their experience and qualifications to the Association but were not required to sit examinations like those wishing to join the New Zealand Register of Acupuncturists.

The New Zealand Federation of Chinese Medical Science Inc

The New Zealand Federation of Chinese Medical Science Inc (NZFCMS) was established in 1993. Approximately half of all TCM practitioners in New Zealand are members and the majority are of Chinese ethnicity. The Federation's main goal is to organise qualified practitioners of TCM, particularly acupuncturists, herbalists, and Chinese massage therapists. The NZFCMS provides members with compulsory continuing education, holds seminars, publishes bulletins promoting contact with

other countries, disseminates health care information via Chinese newspapers and liaises with government departments which are involved in formulating policies to regulate the TCM profession. The Federation regulates and monitors the competence of its members to ensure patient safety. In about 1997, when it introduced more stringent entry criteria, which included, for instance, the requirement that members publish academic articles, membership fell significantly (Liu, 1998).

The New Zealand Institute of Acupuncture

Baxter (1997) reported that the New Zealand Institute of Acupuncture was a broad-based non-partisan organisation for those who shared an interest in acupuncture and related therapies. Established in 1994, its objectives included promoting acupuncture and related therapies, providing education to its members, fostering and promoting research and encouraging publication of findings (Baxter, 1997).

The New Zealand Institute of Chinese Acupuncture and Medicine

While a web search displayed no details of either of these organisations, it was referred to in the literature (Baxter, 1997). Verbal communication with a member of the NZICAM revealed that the NZICAM advocated a purely traditional approach to the practice of Chinese medicine in New Zealand.

The New Zealand Charter of Health Practitioners

The New Zealand Charter of Health Practitioners was formed in October 1993 to represent the varied modalities involved in the natural healthcare profession of New Zealand. The Charter's main emphasis is to uphold the welfare and health concerns of the health consumer by providing practitioners of the highest professional standard and qualification obtainable. The Charter's administration represents approximately 80 percent of the total natural healthcare practitioner population of New Zealand. There are many affiliates, including the New Zealand Federation of Chinese Medical Science, the New Zealand Register of Acupuncturists, and the New Zealand Institute of Acupuncture (The New Zealand Charter of Health Practitioners).

Appendix 3: The Questionnaire

Date:

Place [suburb and city]

A. Your Service and Business Operations

1. Please explain the professional services you provide here:
 - (a) Consultations
 - (b) Treatments
 - (c) Other

2. Tell me about the establishment and operations of the business.
 - (a) Year opened
 - (b) Business hours
 - (c) Ownership and legal status
 - (d) Any important events (e.g. year of purchase of premises, expansion)
 - (e) How do you assess business health?

3. Can we discuss the staff who provide the services:
 - (a) Yourself:
 1. When and where did you train in TCM/Ayurvedic/homeopathic medicine?
 2. What you *first* did in New Zealand– before you opened this service?
 3. Your reasons for opening this service?
 4. Any New Zealand recognition of education/qualifications?

 - (b) Your staff-#1:
 1. When and where did they train in TCM/Ayurvedic/homeopathic medicine?
 2. What they *first* did in New Zealand- before they worked here?
 3. What were their reasons for joining you?
 4. Any New Zealand recognition of education/qualifications?

(c) Your staff-#2:

5. When and where did they train in TCM/Ayurvedic/homeopathic medicine?
6. What they *first* did in New Zealand- before they worked here?
7. What were their reasons for joining you?

(d) Your staff-#3:

8. When and where did they train in TCM/Ayurvedic/homeopathic medicine?
9. What they *first* did in New Zealand- before they worked here?
10. What were their reasons for joining you?
11. Any New Zealand recognition of education/qualifications?

(e) Your staff-#4:

12. When and where did they train in TCM/Ayurvedic/homeopathic medicine?
13. What they *first* did in New Zealand- before they worked here?
14. What were their reasons for joining you?
15. Any New Zealand recognition of education/qualifications?

4. Explain how you recruit new staff (if applicable):

- (a) New Zealand availability
- (b) Sponsoring immigration, e.g. job offer
- (c) Attesting to qualification and competence
- (d) Experiences with immigration

5. Can we discuss procurement of medicines and equipment:

- (a) What is needed in this service
- (b) Sources
- (c) Experiences in importing (if applicable)
- (d) Quality control

6. Tell me about continuing and higher education for you and your staff (if applicable):

- (a) What courses are available in New Zealand?
- (b) What courses have you and/or your staff undertaken?
- (c) Journals/magazines that are available?
- (d) Research undertaken, especially joint research [e.g. with colleagues in your country of origin]
- (e) How does your experience in New Zealand compare with experience in country of origin (regarding continuing education and research)?

7. Are you involved in a professional association? Yes/No. If yes:

- (a) What is it called?
- (b) What is your role?

(c) How does your professional situation in New Zealand compare with the home country?

8. Can you tell me about the underlying theory for your service, e.g. Balance, energy flows etc.

We request copies of pamphlets and information for clients about the rationale for treatment.

9. How do you assess that the treatment is effective?

B. Your Clients

10. Please explain to me who uses your services, and the approximate percent of each:

- (a) Immigrants from country/culture of origin
- (b) Non-immigrants, same ethnic group
- (c) Non-immigrants, not from same ethnic group
- (d) Gender mix
- (e) Age mix

11. Tell me about the health problems your clients consult your service about:

12. What are the payment systems and for which conditions:

- (a) Out of the client's pocket
- (b) ACC
- (c) No charge
- (d) Other

13. What feedback do your clients give you?

- (a) Regular customer satisfaction survey
- (b) Letters from clients
- (c) Comments from clients
- (d) Clients decline a particular treatment
- (e) Clients cease to attend clinic

C. Other Health Services

14. Please tell me about your working relationship with general practitioners in this locality, and give examples:

- (a) Personal acquaintance and friendship?
- (b) Do you refer clients to GPs?
- (c) Do they refer patients to you?

(d) Do your clients consult GPs as well as you?

15. Please explain relationships between your service and other mainstream health services:

- (a) Do you refer clients to emergency centres or hospitals? If so why and when?
- (b) Do you refer clients to physiotherapists – do they refer clients to you?
- (c) If you are ACC registered, who refers the clients to you?
- (d) Please comment on the compatibility of medicines you dispense and medicines pharmacists dispense.

D. Other Issues

16. Have you encountered any difficulties or problems regarding your service in this community?

- (a) Complaints
- (b) Harassment
- (c) Robbery/break-in
- (d) Difficulties with the law

17. Please tell me about the relationship of your service with the immigrant/ethnic community in this locality:

- (a) Financial support
- (b) Use of community media (for advertising)
- (c) Recruitment of staff
- (d) Recruitment of clients
- (e) Expansion/setting up your services
- (f) Procurement of medicines, equipment, supplies.

18. Any other comments you would like to make:

AUTHOR

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The Principal Investigator for this survey, Nicola was a founding member of the New Settlers Programme and is currently Associate Professor and Post-Graduate Coordinator in the School of Nursing, Faculty of Medical and Health Sciences, University of Auckland. Having formerly lectured in the Business Studies Faculty, Massey University, where she ran the post-graduate programme in health services management, Nicola has been involved in research on health systems and health workforce issues over many years. Reflecting her enduring research interest in international migration and its impacts on both the migrant and the host society, her PhD thesis explored aspects of the health of Cambodian refugees in New Zealand. Nicola is the Principal Investigator for the New Zealand Cost of Nursing Turnover study, and a researcher in the Te Riu o Hokianga programme.

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