Regulating Traditional Medicine Professionals in the Public Interest: A Case Study of Chinese Medicine and Acupuncture Regulation in Ontario, Canada

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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Abstract

Many complementary and alternative medicine (CAM) interventions, such as acupuncture and herbal medicines, are rooted in traditional medicine (TM) systems indigenous to particular cultures and lands. The World Health Organization has recommended that nations take steps to regulate both TM and CAM practitioners worldwide, with the aim of enhancing their ‘safety, quality and effectiveness’. Several United Nations bodies have moreover recommended that nations take steps to protect TM knowledge, and prevent further misappropriation of TM practices. However, to date, very few studies have investigated or discussed how regulators may address the unique complexities of regulating TM practitioners and TM-rooted practices. This PhD dissertation – a qualitative case study of traditional Chinese medicine and acupuncture regulation in the province of Ontario, Canada: a) explores the range of factors that distinguish the regulation of traditional medicine practices and professionals from biomedical professionals; and b) considers how the ‘public interest’ may be conceptualized to appropriately address these distinguishing factors in regulatory context. Data for the study was generated from several sources, including mixed methods survey, documentary review, and 32 key informant interviews. Analytic approaches included thematic and critical discourse analyses using the principle of ‘regulatory equity’ as a guiding concept. Postcolonial, multiculturalism, and boundary work theories, as well as legal principles of disparate impact discrimination and reasonable accommodation, were applied across the study. This body of work
points to ways in which regulatory structures in Western liberal democracies may systemically privilege biomedical and non-immigrant practitioners by examining state risk discourses and the construction of regulatory boundaries for acupuncture; the issue of English-language fluency for immigrant practitioners; and the negotiation of safety, quality and epistemology in acupuncture standard-setting across professions. In this light, a series of strategies is proposed to assist regulators in negotiating equitable approaches to CAM and TM regulation. Emphasizing a broad conception of the ‘public interest,’ these strategies prioritize protection of traditional knowledge frameworks, while seeking to accommodate biomedical practitioners’ safe and skilled adoption of TM-rooted health care approaches.
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A Reflexive Prelude

Thus the researcher appears to us not as an invisible, anonymous voice of authority, but as a real, historical individual with concrete, specific desires and interests.

(Harding, 1987, p. 9)
In 2002 and 2003, I was a student of traditional Chinese medicine (TCM) and acupuncture in the province of British Columbia (BC). In 2000, BC had become Canada’s first jurisdiction to regulate the TCM profession, although traditional acupuncturists had been regulated in other provinces before that time. Some of my TCM teachers had been involved in the regulatory process, and I became peripherally aware that the implementation of these new TCM regulations had not been uncontroversial. As I worked to complete my coursework and clinical hours, one dimension of my province’s TCM regulatory requirements came into focus for me: the practical registration examination. At the time, if I recall correctly, applicants for TCM professional registration were required - in addition to completing a written examination - to locate a specified number of acupuncture points on a live model. Accurate point location, I learned, would be evaluated in relation to specific anatomical landmarks on the body. As a shiatsu therapist, I was taken aback.

Prior to studying TCM and acupuncture, I had trained in shiatsu, a form of traditional Japanese acupressure massage that shares historical roots and an epistemic basis with traditional Chinese medicine. As a shiatsu student, I learned to perceive and adjust the qi, or energy flows, along the body’s meridian system. My teachers had guided me to perceive for myself that the classically-documented acupuncture ‘points’ represented guidelines, rather than fixed landmarks; their precise location might vary slightly according to the patient’s state of health. I had been taught a range of traditional methods for point location, which included hands-on touch, visual observation, verbal communication with the patient, strategic body positioning, and proportional body measurement. Although I had also learned to locate acupoints in line with anatomical location (such as in relation to particular bones, muscles and tendons), I understood that such an approach was contemporary, a hybrid of East Asian medical practice with biomedical epistemology and methodology.

That the practical examination implemented for practitioners seeking to join BC’s newly-regulated TCM profession would privilege anatomical acupoint location methods over more traditional approaches disturbed me. It was, I felt, both a signal and a symbol of the compromises inherent in the professional regulation of health care practices and professions rooted in traditional/Indigenous medicine, within a biomedically-dominant health care system. This was not the only reason I decided, in 2004, to leave behind my goal of becoming a registered TCM practitioner in BC, although it certainly affected me.
I had been thinking about the professional regulation of traditional and complementary medicine since the mid-1990s when I was a shiatsu student. Although the BC government had denied shiatsu therapists’ request to be regulated, it had granted us exclusive authority to use the title of Registered Shiatsu Therapist (RST), which I eventually earned. As I started my own shiatsu practice, I explained to new clients somewhat apologetically that I was not a Registered Massage Therapist (RMT). Massage therapists had recently become regulated in BC, and their services — unlike my own — were increasingly eligible for private health insurance coverage. My RST colleagues and I sharply debated whether our occupation should follow the RMT profession’s lead and offer a longer, 4-year training program, bolstered with more and more biomedical curricular content. In quieter tones, we asked each other how and why a Swedish style of massage had gained professional regulatory status while our own Japanese form remained so marginal.

Along the way, I took an interest in food. I spent a lot of time in the kitchen, on farms and at markets, reading books and talking to grandmothers, making sense of the many dimensions of nourishment. I went to California to apprentice with a well-known alternative health guru, whose landmark book on therapeutic nutrition had affected me deeply. I went back to university and finished my interdisciplinary bachelor’s degree, if only to gain access to the library and read everything I could about dietetics. I milked cows and goats, kept sheep and organic laying hens, milled grain to flour and cultivated sourdough for bread, arranged for halal slaughter, fermented all manner of plant foods, learned to cook my ancestors’ traditional meals, and processed crates full of fresh local fruit.

Someone believed in what I knew and hired me to teach at a private post-secondary school of holistic nutrition, where I worked over a 12-year period. I had no formal food-related credentials. Students at the school enjoyed my classes but wondered why I didn’t carry the professional designation they were earning: a proprietary title granted registered trademark status in our province, but which carried little meaning in the mainstream health care world. When I was invited to speak at a conference at my local university, some Registered Dieticians — members of my province’s regulated nutrition profession — heckled me, calling me a charlatan and quack. But then I was hired as staff nutritionist at an integrative cancer care centre. There, working alongside biomedical doctors and a range of health care providers from across the regulated and unregulated spectrum, I counselled cancer patients and their families, and taught therapeutic
cooking classes. To my surprise, not a single patient asked about my qualifications. What did this all mean?

At some point between, I became a mother and an herbalist, both of which got me thinking yet more deeply about the professionalization of traditional and complementary health care practitioners. In 1997, nine years before my son was born and part-way through my shiatsu training, I had gone with a friend to the book launch of The New Midwifery, an edited scholarly collection that awakened me to issues of epistemology, power and co-optation in the context of professional regulation. My friend and I, short on money, bought a copy together that we shared. As I read through the volume, I was struck by Shroff and colleagues’ account of vigorous but unsuccessful efforts to grandparent experienced midwives of colour trained in the global South into Ontario, Canada’s newly regulated midwifery profession (Shroff, Hlaing, & Wu-Lawrence, 1997).

The overwhelming whiteness of the complementary medicine trend in Canada was something that had disturbed me for some time. I was intellectually aware of biomedicine’s historical position as a colonial form of medicine; and my interest in traditional medicine as a young woman of mixed Pakistani and German ethnicity had arisen as part of a desire to decolonize my own epistemic conditioning. It bothered me when I became pregnant in 2005 that so few registered midwives in my city were of non-European ancestry. At the same time, I felt fortunate to have secured access to state-funded, woman-centred care amidst lengthy waiting lists, and was grateful that my team of registered midwives supported my vision of a home birth. Regardless, as my pregnancy progressed, I began to dread my midwifery appointments, even though I liked my midwives as people. Something wasn’t right. My friend from the book launch, who had just had a baby herself, knew what I was talking about. We commiserated about what others have written about – the biomedicalization of regulated midwifery.

This same friend connected me with an ‘underground’ birth attendant who had assisted at her recent birth: a woman with decades of lay midwifery experience, who had declined to apply for membership in the province’s regulated midwifery profession, for fear that her work would lose its soul in the process. I cancelled my midwife appointments and spent a fair bit of time in my late pregnancy in conversation with this practitioner, and with two other unregulated birth attendants whom I hired to assist at my son’s birth. These women were diverse in their origins.
and training backgrounds, and as far as I could tell they were skilled, knowledgeable and experienced. They loved their work, waxed poetic about humanistic care and civil disobedience, and tried not to worry too much about the law, which prohibited them from openly doing what they were doing. I was so grateful for their companionship.

I had gradually incorporated nutritional counselling and herbal therapeutics into my private clinical practice over the years before my son was born, as shiatsu became less of a focus for me. My herbal training had been eclectic, involving formal trainings, a great deal of self-study, hands-on medicine making, and mentorship experiences with more senior practitioners. During these years, what consistently struck me about herbalists is how markedly different one might be from the next. We use different plants from different regions, in so many different ways. Of course there are sub-communities of practitioners who work in similar ways, some of whom represent particular lineages or ethno-cultural traditions, and others who have been institutionally trained. But there is no singular herbalism, no one way to practice.

Herbal medicine became a more and more important component of my private practice. With a well-stocked dispensary of herbal extracts and loose dried plants, my clinic became a resource for other herbalists in my city, who sent their clients my way to get their medicines compounded. I thought of joining my province’s professional herbalist association as had some of my colleagues, but my eclectic training did not fit into the association’s boxes, modelled on a British style of institutionalized, standardized education in ‘Western’ herbal medicine. Then I learned about the American Herbalists’ Guild (AHG), and decided to apply for professional membership. Like other professional associations, the AHG seeks to:

Encourage the development of high standards of education that promote well-trained professional practitioners who offer high quality herbal care; [and] [f]oster high standards of ethics and integrity in the education and the practice of therapeutic herbalism (American Herbalists Guild, 2017, p. 1).

But, the AHG is notably different from other associations in the details of its mission, and its professional membership model.

The AHG explicitly aims to to “honor diversity in the practice of herbal medicine,” that is, to “equally recognize the validity” of “traditional indigenous models of herbalism” and “modern science-based clinical phytotherapy” (American Herbalists Guild, 2017, p. 1). Applicants for professional membership are not required to demonstrate adherence to a standardized training
curriculum or competency set, nor to document completion of specific “diplomas and licensing examinations” (American Herbalists Guild, 2013, p. 1). Rather, the AHG “honors competency no matter how it is attained” (American Herbalists Guild, 2013, p. 1). Competency is evaluated through professional peer review of an extensive application package that requires documentation of training and clinical experience determined equivalent to four years of post-secondary herbal medicine training, as well as a demonstrated knowledge of safety-related issues in clinical practice. AHG professional members are diverse, representing a wide range of herbal healing lineages, bioregional plant wisdoms, institutional and informal training backgrounds, culturally-situated approaches, and clinical epistemologies.

Joining the AHG in 2007 was satisfying, as I felt aligned with the organization’s mission. This new alliance kept me thinking about the complexities of professionalization, and the position of traditional and complementary therapies within broader health systems. I found it ironic that AHG professional membership – situated so far from the ivory tower - was the qualification that subsequently opened the door to my entry into an MSc degree program in herbal medicine. There, my dissertation addressed what I had increasingly come to see as a core equity issue in North American health care: financially-accessible, culturally-safe traditional and complementary medicine clinics. I was also interested to learn that the AHG had once advocated for the statutory regulation of professional herbalists in the United States (where the majority of the organization’s members reside), but had eventually abandoned this goal owing to a lack of consensus within its membership.

Over the decade since I was first granted AHG professional membership, I have often wondered whether the principles underpinning the organization’s certification approach might not be applied on a larger scale, across other occupational groups, or in the context of statutory regulation. Could BC’s Chinese medicine regulator, for instance, have implemented practical examination requirements for professional entry that equally honoured traditional and anatomical/biomedical approaches to acupuncture point location? Was the creation of an illegal underclass of long-standing midwifery practitioners – whether from the global South or Canadian-trained - an inevitable consequence of statutory regulation? Such questions, and my range of experiences in the field of traditional and complementary medicine, have deeply informed the work that follows. Although academic discourse can easily obscure the personal, I trust the reader knows that I am here.
References


Chapter 1
Introduction

Over the last two decades, the World Health Organization (WHO) has called on governments worldwide to regulate practitioners of traditional, complementary and alternative medicine (TCAM), with the aim of enhancing “safety, quality and effectiveness” of care (WHO, 2002, 2014). An increasing number of nations across the globe are responding to this call. The WHO has characterized state health care systems worldwide as falling under one of four types with respect to TCAM: “integrative” systems in which biomedicine and TCAM are both funded and recognized; “inclusive” systems, where TCAM has some recognition but is only partially regulated or integrated into public care; “tolerant” systems” where some TCAM practices are “tolerated by law” but poorly integrated; and biomedically “exclusive” systems, where TCAM practices are outlawed (WHO, 2002). Two global reviews of the range of TCAM professional regulations have been undertaken in recent decades (Dixon, 2008, WHO 2001), and a comprehensive descriptive European account was published in 2010 (CAMDOC Alliance, 2010).

Professional Regulation, Traditional Medicine and the Public Interest

Saks (2002) has described professional regulation in the public interest as having three primary objectives, the most widely cited of which involves protecting members of the public from safety hazards. In addition, regulation aims to enhance practitioner conduct in terms of professionalism and ethics, and to harmonize qualifications across the marketplace. However, as elsewhere emphasized, the public interest in professional regulation is a contested concept that in itself carries “little specific meaning” (Saks, 1995, p. 34), requiring theoretical specification in order to gain utility (Baggott, 2002, Saks 1995).

Early liberal democratic theorists of the concept, such as Sorauf (1957), guarded against singular or “absolute” (p. 637) characterizations of the public interest, noting: “Any critical evaluation of the idea of a public interest must begin with a definition, but whose definition?” (p. 618). Implied in this question is an acknowledgment of the multiple publics, and range of interests, which regulators must invariably negotiate (King et al., 2010, Moroni, 2004). The public interest concept may furthermore be deployed, as discourse, by stakeholders to influence policy (Saks, 1995, Baggott, 2002); by “politicians and civil servants [who] seem to use it as a smokescreen to conceal decisions based on the groups that most effectively deploy their resources” (Saks, 1995, p. 35); and by stakeholders seeking to influence particular regulatory processes (Baggott, 2002).

Defining the public interest has been a long-contentious challenge for regulators and scholars alike (King et al., 2010). Saks (1995, p. 48) proposes that a useful definition should have four primary characteristics, that is, it should: 1) be “easy to operationalize and apply to a wide range of situations”; 2) permit “empirical assessment” of the “extent to which decisions are shaped by the self-interests of professional groups rather than the common good”; 3) be “normative”, that is, “prescrib[e] what people ought to do rather than simply reflecting a preponderance of opinion or utility”; and 4) attend to considerations of location and historicity.

Furthermore, as Baggott observes, pluralist conceptions of the public interest which give importance to multiple public stakeholder perspectives are increasingly emerging in liberal democratic regulatory processes. This is evidently a “recent development” (Baggott, 2002, p. 7),
displacing previous public interest conceptions that were predominantly paternalistic (i.e., centralizing so-called expert voices) or, in some cases populist (i.e., emphasizing a singular “view of the majority”).

With respect to the statutory regulation of traditional medicine professionals and practices, there remains a distinct gap in the literature as to how the public interest may be appropriately defined. However, safety – that is, the protection of patients from potential harms - remains a commonly-cited state rationale for regulating TCAM practitioners and practices (Dixon, 2008). Moreover, an increasing body of literature (Cant and Sharma, 1995, Wiese and Oster, 2010, Gilmour et al., 2002, Welsh et al., 2004) describes the pursuit of regulatory legitimation (rather than public protection, ethics or market harmonization) as a primary underlying impulse for many TCAM practitioner groups, who frequently find themselves in socio-politically marginal positions within the broader framework of health care. In addition, several features clearly distinguish TCAM professions from biomedical health professions, suggesting that an appropriate specification of the ‘public interest’ concept as it pertains to TCAM professional regulation may require careful theoretical attention.

Such distinguishing features are particularly evident when comparing traditional/Indigenous medicine systems, practices and practitioners to their biomedical counterparts. For example, whereas biomedicine (despite its historical and cultural roots in the European scientific revolution, is widely - if not falsely - universalized as ‘culturally neutral’ (Harding, 1998), traditional/Indigenous medicine systems (such as traditional Chinese medicine, Ayurveda or Unani Tibb) remain deeply and explicitly rooted in particular cultural and geographical contexts (Hardiman, 2009, Janes, 1999, Hsu, 1999). In addition, whereas a wide range of biomedical health professions operate within the parameters of a bioscientific (‘Euroscientific’) paradigm (Hollenberg and Muzzin, 2010), the world’s diverse traditional/Indigenous medicine systems work from within a range of culturally-situated epistemic frameworks notably distinct from and historically subjugated to biomedicine (Harding, 1998, Janes, 1999, Hardiman, 2009).

Standardization and the institutionalized transfer of knowledge and skills have come to represent essential conditions for professional regulation in the contemporary world (Abbott, 1988, Maroto, 2011). However, traditional/ Indigenous medical knowledges are internally diverse rather than standard (Kovach, 2009), and continue to be transmitted informally - through family
lineages and apprenticeships between senior and junior practitioners, as well as in more formal institutional settings (WHO, 2014). Further complicating these points in regulatory context is increasing adoption of traditional medicine rooted practices, such as acupuncture, as complementary practices by biomedically-trained practitioner groups, who in many cases divorce such practices from their traditional epistemic frameworks (Dommerholt, 2011, Janz and Adams, 2011, Hollenberg and Muzzin, 2010).

Each of these features, clearly distinguishing traditional / Indigenous medicine from biomedicine in contemporary context, is likely to have significant regulatory consequences. However, how regulators may effectively navigate such specific regulatory complexities, in the public interest, has to date received very little scholarly attention. This PhD dissertation – a qualitative case study of traditional Chinese medicine (TCM) and acupuncture regulation in Ontario, Canada, aims to: a) explore the range of factors that distinguish the regulation of traditional medicine practices and professionals from biomedical professionals; and b) consider how the public interest, a contested concept, may be theorized to appropriately address these distinguishing factors in regulatory context.

China’s traditional medicine: diverse and dynamic histories

China’s indigenous medical traditions date back more than two millennia to Eastern Asia, and include such practices as: herbal medicine, acupuncture and moxibustion (the burning of Artemesia vulgaris herb), therapeutic nutrition, qi gong movement, cupping and gua sha (scraping) therapies, and tuina massage (Scheid, 2002). While these practices have been widely transmitted through family lineage and apprenticeship (Hsu, 1999), their diverse and evolving theoretical and practical dimensions have also long been documented in such canonic Chinese medical texts as the Huang Di Nei Jing and Nan Jing (Unschuld and Wiseman, 1998).

Although significant plurality has characterized particular, local Chinese medicine therapeutics over time (Unschuld, 1992, Scheid, 2002), what Chinese medicine practitioners appear to have shared over the centuries is an epistemological basis in Taoism’s yin-yang cosmology, adapted for therapeutic usage (Maciocia, 1989). Regardless, notable variations appear – across time, locale and schools of thought – between distinct theoretical and practical treatment approaches (Scheid, 2002, Hsu, 1999, Hsu, 2001, Unschuld, 1992). Some areas of China, for example, have historically emphasized moxibustion more than other areas (Scheid, 2002). Overall, however,
Chinese herbal treatments have commonly been delivered in association with acupuncture, as part of a broader system of Chinese medicine (Scheid, 2002, Maciocia, 1989).

Various historical efforts to standardize and institutionalize Chinese medicine have been documented (Hsu, 1999). The globalized system known today as ‘traditional Chinese medicine’ (TCM) emerged in the 1950s-60s under Mao Zedong’s communist governance (Hsu, 1999, Taylor, 2005). Mao’s government strategically standardized aspects of Chinese medical theory and practice to craft a so-called ‘TCM’ system suitable for its political goals, and compatible with the globally-privileged biomedical scientific approach (Taylor, 2005, Hsu, 1999). TCM’s standardization, which included acupuncture practice, unfolded as part of Mao’s national modernization project (Taylor, 2005), and is widely understood as an anti-imperialist response to the ‘semi-colonial’ conditions produced in China via ‘unequal treaties’ with European powers beginning in the 1840s (Murphey, 1969, Wang, 2003, Childs and Williams, 1996).

Historically speaking, Chinese medicine practitioners practicing outside of the state medicine (Hsu, 1999) framework experienced significant marginalization under TCM’s statutory regulation in China. In 1952, compelled with TCM examinations infused with biomedical perspectives, hundreds of thousands of Chinese medicine practitioners failed and were “banned from practice” (Taylor, 2005, p. 40). Regardless, ‘unofficial’ transmission and practice of Chinese medicine (as distinct from ‘TCM’) via family lineages, apprenticeships and community networks continues in China today (Hsu, 1999), as well as elsewhere in Eastern Asia (Dixon et al., 2007) and overseas (Carlton and Bensoussan, 2002). With today’s extensive globalization of Chinese medicine’s theories and practices, one of its constituent therapies – acupuncture – has become the world’s “most widely used traditional medicine”, with 80% of nations surveyed recognizing its usage (WHO, 2001, p. 2).

**Acupuncture: one component of Chinese medicine**

Acupuncture involves the insertion and manipulation of thin (‘filiform’) needles at specified locations on the body to produce a therapeutic effect (Maciocia, 1989). A 2002 WHO review of high quality clinical trials involving acupuncture showed the practice had been “proven effective” for 28 disorders, and showed promise in treating another 64 conditions (WHO, 2002). In 2012, the United Nations Educational, Scientific and Cultural Organization (UNESCO) inscribed ‘acupuncture and moxibustion of traditional Chinese medicine’ on its Representative
List of the Intangible Cultural Heritage of Humanity (UNESCO, 2010). Across these nations, traditional acupuncture remains in widespread usage, alongside more biomedicalized versions of the technique.

For decades, a minority of medical doctors have taken interest in acupuncture, although it remains a relatively marginal component of conventional medical practice (Almeida, 2012, Crumley, 2012). Physiotherapists, chiropractors and other occupational groups have also brought acupuncture techniques into their treatment toolkits across many jurisdictions (Janz and Adams, 2011, Morris, 2011). Considerable evidence has been produced as to traditional acupuncture’s clinical effectiveness; and significant interest in acupuncture’s ‘physiological mechanism of action’ has prompted extensive, biomedical-style research into the practice over the last decades (WHO, 1999, WHO, 2002).

**Acupuncture regulation: approaches and controversies**

Currently, 29 nations regulate acupuncture practitioner groups (WHO, 2014); and regulations vary considerably across these jurisdictions as far as how regulations define the practice, and which professions may perform it. In China, acupuncture, as a component of professional TCM practice, is well-integrated into the public medical system alongside biomedicine (Schroeder, 2002). TCM (which includes acupuncture) is also a regulated profession in two Canadian provinces (BC and Ontario), several US states, and nationwide in Singapore, Hong Kong and Australia (NZMOH, 2011). Japan and Korea regulate medical systems closely related to Chinese medicine, and TCM regulation is pending in Malaysia (NZMOH, 2011).

However, elsewhere, such as in Germany (Birch, 2007), France (Almeida, 2012) and Argentina (Freidin, 2007), only conventional biomedical doctors may legally perform acupuncture. In a number of Western countries including Canada, the United States, Denmark and Australia, physiotherapists, chiropractors and other professional groups (including nurses, midwives and naturopaths) are additionally authorized to practice acupuncture, sometimes using alternate terminology such as ‘dry needling’ (Court of Appeals of the State of Oregon, 2014, Miller, 2012, Janz and Adams, 2011, Rittig-Rasmussen, 2011).

The Canadian province of British Columbia (BC) exemplifies a hybrid model in which acupuncture is regulated simultaneously as a profession, discipline, and modality. Members of a
range of BC professions, including physicians and physiotherapists, are permitted to perform acupuncture as a ‘modality’ within their broader scopes. In addition, three occupational titles are reserved for regulated Chinese medicine professionals, whose scope includes traditional acupuncture. For members authorized as Registered Acupuncturists, acupuncture (as ‘profession’) constitutes its entire professional scope. For members of the other two TCM-licensed groups, Registered TCM Practitioners and Registered TCM doctors (Government of British Columbia, 2008), acupuncture functions (alongside herbal medicine) as a ‘discipline’ within a broader system of TCM.

Across several biomedically-based professions, a ‘neuro-physiological’ or ‘anatomical’ approach to acupuncture treatment has been increasingly adopted in favour of more traditional/indigenous epistemological approaches (WHO, 2002, 1999, Kohut et al., 2011). Amongst physiotherapists and chiropractors, the phrase ‘trigger point dry needling’ has increasingly replaced ‘acupuncture’ as a descriptor of the practice (Kohut et al., 2011, FitzGibbon, 2011, Brady et al., 2013, Dommerholt, 2011). Competing knowledge claims over what constitutes ‘authentic’ or ‘effective’ acupuncture practice have characterized regulatory processes across several jurisdictions (Welsh et al., 2004, Janz and Adams, 2011, Court of Appeals of the State of Oregon, 2014).

**Controversies over standards**

Further complicating this issue is the approach to acupuncture standard-setting taken across a number of Western world nations. In 1999, the World Health Organization (WHO) published international “safety and training guidelines” for acupuncture practitioners that included recommended standards for traditional medicine practitioners practising acupuncture as a profession or discipline within a broader East Asian medicine system, and two sets of standards for physicians seeking to adopt acupuncture as their clinical mainstay or an adjunct modality with their broader clinical practices (WHO, 1999). The WHO also recommended that some curricular content in all such courses refer to the East Asian medical context and epistemic framework from which acupuncture has historically emerged.
However, the WHO’s 1999 guidelines did not provide training guidelines for non-physician professionals (such as chiropractors or physiotherapists) seeking to incorporate acupuncture as a clinical modality within their scope. This policy making void has given rise to a wide range of standards (and in some cases none at all) being stipulated in jurisdictions (in particular in the United States and Australia) in which non-physicians have begun to legally perform biomedicalized styles of acupuncture, sometimes under the name of dry needling (Kohut et al., 2011, Amaro, 1997, Janz and Adams, 2011, FitzGibbon, 2011). Across such jurisdictions, a trend has emerged in which dry needling practitioners seek to distance themselves discursively from traditional acupuncture’s cultural and epistemic roots, arguing that their own needling activities are entirely biomedical in character (APTA, 2012, 2016, FSBPT, 2015, AAAOM, 2012).

In some cases, East Asian medicine practitioner groups have attempted to delegitimize chiropractors’ and physiotherapists’ claims to include therapeutic needling within their scope (AAAOM, 2012, 2016). In the American states of Oregon and Washington, court challenges to this effect have been successful (AAAOM, 2016; Court of Appeals of the State of Oregon, 2014). In 2016, the American Medical Association, a professional association of physicians in the United States, recommended that “physical therapists and other non-physicians practicing dry needling should – at a minimum – have standards that are similar to the ones for training, certification and continuing education that exist for acupuncture” (AMA, 2016, p. 2). They cited “lax regulation and non existent standards”, as well as “patient safety” as the rationale behind this policy statement. Others, particularly from within East Asian medicine practitioner communities, have contended that the dry needling phenomenon exemplifies cultural misappropriation, and should be additionally contested on these grounds (AAAOM, 2012, Janz and Adams, 2011). The controversy continues.

**Linguistic policy controversies**

Another acupuncture-related policy controversy that has taken hold in Canada, the United States and Australia in recent years pertains to linguistic regulatory requirements for traditional acupuncture practitioners, many of whom are East Asian immigrants, and some of whom have limited English language proficiency. In about two thirds of American states (NCCAOM, 2012)
and one Canadian province (CTCMA, 2011) where traditional acupuncturists are currently regulated, regulators permit that registrants complete certification examinations in English or an East Asian language, stipulate no language fluency requirements, and permit patient records to be kept in any language. However, elsewhere, stricter English language policies have been proposed or implemented, giving rise to significant objections from practitioners and regulators who support the implementation of multilingual policy frameworks within the context of traditional acupuncture regulation in English language dominant jurisdictions (CMBA, 2012, California Acupuncture Board, 2012, NCCAOM, 2013). Such stakeholders contend that English-only requirements unfairly discriminate against East Asian immigrant practitioners, and fail to honour acupuncture’s East Asian cultural and linguistic roots (Qi, 2013, CMASA, 2013).

The controversies over biomedical acupuncture scope and standards, and linguistic regulatory policies for traditional acupuncture practitioners, arguably exemplify some of the unique complexities associated with the statutory regulation of traditional medicine practitioners and practices. In the first controversy, epistemic considerations as well as concerns over health care quality, safety and intellectual property intersect. In the second, the concurrently clinical and cultural dynamics at play in traditional acupuncture regulation become evident. In both cases, conceptualizations of the public interest typically applied to biomedical professional regulation, which emphasize safety and quality, ethics, and market harmonization as paramount (Saks, 1995), fall short in addressing core epistemic and cultural considerations.

As the statutory regulation of traditional medicine practitioners and practices becomes more widespread, scholars and regulators will increasingly require theoretical tools with which to craft and evaluate such policy as it relates to the public interest concept. The development of a theoretical public interest framework for such purposes is the primary focus of this PhD dissertation, unfolded through a case study of acupuncture and traditional Chinese medicine (TCM) regulation in the province of Ontario, Canada.

The Ontario case of TCM and acupuncture regulation
In 2006, the province of Ontario announced that it would regulate the practice of acupuncture, and a new profession of TCM, for the first time (Government of Ontario, 2006b). Over the two decades prior, TCM practitioners, as well as biomedical acupuncture practitioners, had lobbied
the Ontario government for self-regulatory status. In 1983, the provincial government
determined in a review that acupuncture was not sufficiently risky to regulate (Gilmour et al.,
2002, HPRAC, 1996), and the practice remained unregulated in the public domain until 2013,
when the new TCM and acupuncture regulations were implemented. In the interim, successive
Ontario governments conducted studies to revisit the issue of acupuncture regulation (HPRAC,
1996, HPRAC, 2001), eventually determining that it was indeed a practice that warranted
statutory controls.

Through the consultation periods that preceded the province’s announcement to regulate,
considerable debate and acrimony characterized the relationships between different TCM and
acupuncture practitioner organizations in the province. What united these groups, however, was
a common desire to see acupuncture regulated. (Kelner et al., 2004a, Welsh et al., 2004, Gilmour
et al., 2002) As Gilmour and colleagues have previously noted, over 50% of Chinese medicine
and acupuncture community leaders had been “trained in China before coming to Canada”
(Gilmour et al., 2002, p. 159), suggesting a high proportion of East Asian immigrants within the
practitioner community. Other subgroups within the acupuncture professional lobby included
practitioners from biomedical professions who sought to gain jurisdiction over the practice
themselves. Considerable controversy over the degree of biomedical versus East Asian training
sufficient for the professional practice of acupuncture characterized interactions between such
subgroups in the pre-regulatory period. (Welsh et al., 2004)

Like other health care acts and professions regulated in Ontario, acupuncture and TCM would
eventually be governed under the Regulated Health Professions Act (RHPA), a piece of umbrella
legislation characterized by three signature features: a) occupational title protection; b) restricted
health care acts; and c) the potential for overlapping scopes of practice across professions
(O’Reilly, 1999). Under the province’s new acupuncture regulations, a total of 10 professions,
including TCM practitioners, were authorized to perform acupuncture within their scope (1996),
representing a globally unprecedented number of occupational groups authorized in a single
jurisdiction to use this clinical intervention. Furthermore, under the new regulations, each
profession would be responsible for setting its own acupuncture-related practice standards, in
line with its preferred epistemic stance.

The new regulations, predictably, did not come into effect without controversy. In 2006, just before
the Ontario government gave final legislative approval to Bill 50, which would ultimately govern
TCM practitioners, one high-profile TCM practitioner – who had long been a proponent of regulation – spoke at a government consultation meeting:

In our belief, Bill 50 is fundamentally flawed. As you will see from what we have put on the top of our presentation, we call Bill 50 the “Traditional Chinese medicine discrimination act.” In Bill 50, all traditional Chinese medicine practitioners, mainly Chinese, are subject to stringent licensing and regulation procedures before entering the practice, while existing health care professionals - mainly white-collar Caucasians - will be privileged to practice acupuncture with virtually no training, or weekend crash courses. (Government of Ontario, 2006a)

Bill 50 was, regardless, approved by the government. A transitional regulatory period ensued over the next seven years, until the new regulations were enacted in 2013.

Just days after the new regulations came into effect, a subgroup of Ontario’s TCM practitioners initiated court proceedings intended to have the province’s new regulations overturned (Superior Court of Justice, 2014). One major allegation in the case was that the new TCM regulations discriminated against immigrant East Asian practitioners by requiring that they complete registration examinations in, keep patient records in, and ultimately demonstrate proficiency in the English language. The case was ultimately dismissed, but objections to these policies from within the TCM practitioner community, as well as from Canada’s federal government (Artuso, 2015), continued.

The Ontario case presents a scenario in which some of the key global controversies in acupuncture regulation are exemplified, and thus Ontario presents a unique setting to conduct research aimed at producing transferable policy insights. As in other jurisdictions in which similar controversies have unfolded, Ontario’s acupuncture and TCM regulation story draws attention to the concurrently clinical, cultural and epistemic complexities at play in the professional regulation of traditional medicine practitioners and practices. Undertaken as PhD research in 2013 just as Ontario’s TCM and acupuncture regulations came into effect, the qualitative case study of these regulations presented here is aimed at investigating and analysing such specific traditional medicine-related policy complexities, ultimately producing recommendations as to how the public interest principle may be relevantly theorized and deployed in such contexts.
OVERVIEW OF METHODS

Qualitative Case Study

Case study (Yin, 2009, Stake, 1995, Merriam, 1998) is a qualitative research approach in which a current phenomenon - here, the statutory regulation of Ontario’s TCM/acupuncture practitioners - is investigated within its real-world context. A qualitative (rather than quantitative) approach is suitable for the proposed study in that I study issues in depth and detail “without being constrained by predetermined categories of analysis” (Patton, 2002 p. 14). Case study furthermore represents a constructivist research methodology (Baxter and Jack, 2008, Stake, 1995, Merriam, 1998), in the sense that the ‘reality’ of the social phenomenon of interest is neither considered singular nor able to be ‘objectively’ described. Rather, accounts arising from varied experiences, theoretical perspectives or worldviews may produce distinct accounts of the complex dynamics of a situation (Patton, 2002).

Case study methodologists have categorized cases with distinct characteristics and aims into various subtypes. Yin (2009) and Stake (1995) distinguish single from multiple case studies, in which one or more phenomena may be studied alone or comparatively; the PhD research presented here constitutes a single case study of TCM and acupuncture regulation in Ontario. Stake (1995) differentiates single case studies into intrinsic and instrumental subtypes. Instrumental cases aim to better understand a theoretical question rather than simply illuminate the particulars of the specific case, the latter termed intrinsic (Stake, 1995) or descriptive (Yin, 2009) cases. This dissertation’s case study is instrumental in its pursuit of generalizable insights with respect to the statutory regulation of traditional medicine professionals and practices.

Binding the case, that is, defining boundaries around the phenomenon under study, is considered a critical step in designing a realistic or manageable case study research project. Cases may be bound in relation to temporal, locational or other contextual factors (Baxter and Jack, 2008, Yin, 2009, Huberman and Miles, 2002, Stake, 1995, Merriam, 1998). The current study of TCM/acupuncture regulation has been bound by location (the province of Ontario); and by time (from the onset of substantive government responses to regulatory lobbying efforts for acupuncture in the mid 1990s (HPRAC, 1996) until mid-2016, three years after implementation of statutory self-regulation). I have furthermore bound the case study contextually in the sense that I focused my investigation on key issues of concern.
The articulation of *issues* (Stake, 1995) or *propositions* (Yin, 2009) is commonly described as an integral component of case study research design. Issues or propositions contribute to the development of conceptual frameworks for case studies, and help to keep research focused around a clearly articulated purpose. They may emerge from review of the pertinent literature, from theoretical perspectives, from the researcher’s own experience, or from existing empirical data (Yin, 2009, Stake, 1995). Stake (1995, p. 17) defines issues as key factors, problems or questions around which the study may revolve; he describes them as “intricately wired to political, social, historical, and especially personal contexts”. The core issue underpinning this PhD dissertation is the concept of the *public interest* as it pertains to traditional medicine professional regulation.

As I elaborate in the pages that follow, the data generation and analytic / interpretive processes engaged in my dissertation work represent an iterative process through which the public interest concept took shape as a central consideration. To contextualize this discussion, I provide below a brief explanation of my research paradigm, and of the position I occupy as researcher.

**Research Paradigm and Researcher Positionality**

As Willis (2007) notes, case study methodology is widely used by researchers, like myself, who work from within a *critical* paradigm. *Critical* research is focused on the illumination of inequitable sociocultural and/or economic power relations, and is driven by an “emancipatory imperative” (Underwood 1998). A critical research paradigm is evident in the work of Harding (1997, 1998), which has exerted a significant influence on my own thinking.

Situating her work within the parameters of “postcolonial science and technology studies” Harding (1998, p. 4) positions biomedicine’s globalized dominance within the history of European colonization. She documents the colonial and neo-colonial misappropriation and co-optation of diverse traditional and Indigenous knowledges and practices into the biomedical paradigm, and contests discourses of biomedicine’s ‘superiority’ as fundamentally Eurocentric. Although Harding’s work does not address questions of professional regulation in detail, she notes (1998, p. 13):

> Institutional eurocentrism occurs when medical associations do not admit trained
acupuncturists or herbal pharmacologists, medical and pharmacology schools do not include training in such treatments. ...Here, institutional practices have eurocentric effects upon both Europeans and non-Europeans. In such cases, perfectly well-intentioned individuals, even ones who understand the health value of such nonmodern European practices, advance institutional eurocentrism to the extent that they fail to challenge the conceptual frameworks that legitimate such discriminatory practices in these institutions.

Postcolonial theoretical perspectives such as those advanced by Harding and others have increasingly been applied across a range of TCAM-related studies in recent years (see Gale, 2014), an approach that I follow in this dissertation.

Harding (1998, p. 10) poignantly asks:

*Why should a cultural practice have value only if it can be squeezed into categories designed by Europeans to appreciate European institutions, their cultures and practices?*

This question carries particular significance for me, both as a person of mixed South Asian and European ancestry, and as a long-standing TCAM practitioner myself. However, despite my training in acupuncture and East Asian medicine, I do not claim to occupy an entirely *emic* (i.e., ‘cultural insider’) (Willis, 2007) stance with respect to my research area. I am not a person of East Asian origins, and I speak no East Asian languages. I do not, for the record, practice acupuncture – although I have undergone training to do so. I have never been a member of a state-regulated profession, nor have I made any attempt to join a state professional regulatory body. That said, as expressed in my Reflective Prelude, this dissertation’s substantive focus, and the commitment to equity that underpins it, represent issues close to my heart.

I now turn to the data generation and analytic / interpretive strategies engaged in this work, and provide an overview of the chapters that follow.

**Data Generation**

A distinctive characteristic of case study research is its reliance on multiple data sources (Yin, 2009, Baxter and Jack, 2008). The integration of data from various sources both facilitates holistic interpretation of the phenomenon of interest, and contributes to the study’s reliability (Baxter and Jack, 2008, Yin, 2009, Stake, 1995). Common methods of data generation in case
study research involve document identification, fieldwork observations, and interviews (Stake, 1995, Merriam, 1998, Yin, 2009), each of which I have undertaken in this dissertation research. In addition, my work engages with qualitative data collected in a mixed-methods survey. Below, I provide a broad overview of the data generation methods undertaken as part of my PhD research; additional details on all methods are included in subsequent chapters.

Mixed Methods Survey

In 2011 and 2012, Drs. Boon and Welsh, members of my supervisory committee, distributed a mixed quantitative/qualitative, census-style survey to naturopaths, homeopaths and Chinese medicine / acupuncture practitioners across Ontario. I was not involved in the design or distribution of the survey, which received ethical approval from the University of Toronto’s Research Ethics Board. This survey aimed to collect data around the demographic, practice and educational characteristics of these practitioners just prior to the implementation of new regulations governing each of these groups, and to interrogate the range of views from these practitioners as to the upcoming regulatory changes. Chapter 2 of this dissertation provides additional details about the survey methods applied. The predominant body of survey-sourced data that I analysed for this dissertation derived from a single qualitative question as to practitioner views on regulation.

Document Identification

Document identification represented another core component of my data generation approach, and progressed iteratively across all stages of the study. Initial documents identified included government reports and legislative transcripts that documented the history of Ontario’s TCM and acupuncture regulatory process. Additional documents identified included the texts of various relevant Acts and Regulations; press releases and media reports; court documents; petitions; and content from occupational groups’ and regulatory colleges’ websites. My document identification process initially pertained exclusively to Ontario’s TCM and acupuncture regulations but expanded to include documents from other Canadian, American and Australian jurisdictions on the subject of linguistic regulatory policies for traditional acupuncture
practitioners. Additional details on the specific documents identified and analysed across this dissertation are provided in Chapters 3, 4, and 5.

Key Informant Interviews

Over the period 2014–2017, I conducted qualitative interviews with 32 key informants known to have been involved, in a range of capacities, with Ontario’s TCM and acupuncture regulatory process. Approval to conduct these interviews was secured from the University of Toronto’s Research Ethics Board. The application for ethics board approval addressed the issues of informed consent, compensation, confidentiality and anonymity, language of interview, as well as the potential benefits and risks associated with study participation. The analysed results of these interviews are presented in Chapters 4 and 5 of this dissertation.

Recruitment and Informed Consent

Names of key informants were largely identified from a range of public documents pertaining to the regulations under study; however, a smaller number of informants were referred to me by previous interviewees as the study progressed. Prospective informants whom I contacted included state actors (such as regulators and policy makers), as well as acupuncture and Chinese medicine practitioners who had been actively involved in some aspect of the province’s TCM/acupuncture regulatory process. I initially contacted all prospective interviewees either by email or hardcopy mail, with a letter of information providing information about the study (see Appendices A – D). I made subsequent follow-up contact with these persons either by email, telephone or both. Those who agreed to be interviewed were provided with informed consent materials (see Appendices E through H) for completion in advance of the interview. Informational and informed consent materials were provided to all potential informants in English, although Chinese-language translations were also sent to a number of prospective interviewees known to have low English proficiency.

Confidentiality and Anonymity

As part of the informed consent process, I reiterated verbally to informants prior to beginning interviews that I would endeavour to protect their identities when reporting the study findings by anonymising and removing key identifying features from their narratives. This was particularly important in the case of practitioners who were practicing illegally (i.e., those who had declined
to join Ontario’s TCM regulatory body), and for state actors who wanted to speak openly about their perspectives as to how the regulatory process had unfolded. However, I also informed interviewees that I could not guarantee their anonymity, particularly where their involvement in the regulatory process had been particularly unique.

Participant Compensation

Chinese medicine practitioner-interviewees were offered an honorarium of $75 for participation, in order to partially compensate them for potential income losses associated with their time. State actors, who were interviewed during regulator business hours, were not offered compensation for their participation in the study.

Interview Style and Structure

Interviews were conducted in person, lasted between 60 and 90 minutes, and proceeded on the basis of a semi-structured interview guide (included as Appendix I) that included questions about informants’ experiences with, and perspectives on, various aspects of Ontario’s TCM/acupuncture regulations. Interview questions were additionally individualized to account for each informant’s particular involvement in the regulatory process.

Language of Interviews

All but three of the interviews were conducted entirely in English; the remainder were conducted in English with the assistance of a Chinese-language interpreter of the informant’s choosing, who was also compensated in the amount of $75 per interview.

Disclosure and Reflexivity

With the aim of building trust and reducing distance between myself and my interviewees, I chose to variously disclose my background and training in, and/or knowledge of East Asian medicine, or herbal medicine, to study participants. For example, in some interviews with senior TCM practitioners, I included in my self-introduction a mention of the Chinese medicine schools I had previously attended, anticipating that these informants would likely be familiar with these institutions and the practitioners running them. These informants commonly appeared to appreciate this disclosure, and on some occasions inquired whether particular colleagues of theirs...
had been my teachers. I was sure to emphasize in introducing myself that I was not a registered TCM practitioner or acupuncturist in any jurisdiction.

In interviews with acupuncture practitioners, I would also frequently provide non-verbal indications, such as a nod, or verbal indications such as use of TCM-specific terminology, to convey my *emic* understanding of TCM theory if an informant was speaking about their work. This appeared in most cases to act as an encouraging cue to the interviewee to continue speaking. On several occasions, participants made comments recognizing that I seemed to understand their standpoint, such as, “Oh you know about about *sanyinjiao*! [an acupoint also known as Spleen 6]!” or “You understand *yin deficiency*!”.

**Transcription**

All interviews were transcribed in English by an external transcriptionist from my digital audio recordings. Only the English-language portions of bilingual (Chinese-English) interviews were transcribed. I reviewed each transcript for accuracy as soon as I received it, returning to the original audio recordings to fill in gaps as needed. Two types of gaps would commonly occur: a) those in which specialized TCM terminology was being used; and b) those arising when the transcriptionist could not understand an informant speaking Chinese-accented English. In most was I was able to decipher and fill in these gaps by listening to the audio recording again.

**Observational Field Notes**

In addition to the aforementioned data generation approaches, I attended several public meetings of Ontario’s TCM regulatory body over the period 2013 – 2015, as well as court proceedings related to the province’s TCM regulations. On these occasions, I made field notes both during and subsequent to the events in question, to record my observations and impressions surrounding the proceedings. These notes, alongside the data generated via each of the aforementioned approaches, subsequently informed my data analytic/interpretive process, detailed below.

**Overview of Analytic / Interpretive Approaches**

With the exception of the mixed-methods survey data (which were collected prior to my entry into the PhD program), data generation, analysis and interpretation proceeded concurrently and
iteratively over the course of my dissertation research and writing process, as is common in critical qualitative research (Willis 2007). In fact, even the study aims evolved considerably after I had begun analysis and interpretation of the initial study data. Over the course of my work, I applied three primary analytic approaches to engage with my data in various ways: **descriptive content analysis, thematic analysis, and critical discourse analysis.**

At the study’s outset, I began to collect and review a wide range of historical and current documents I had gathered pertaining to Ontario’s TCM and acupuncture regulatory process, as well as parallel regulations in other contexts. My initial analytic aim in reviewing these documents was to assemble, using **descriptive analytic methods** (Vaismoradi, Turunen, & Bondas, 2013), a chronological account of key events and policy details, and a list of potential key informants for subsequent interview recruitment. In reviewing these documents, I was also developing initial impressions of the core issues at play in the case under study, which I recorded in a growing set of analytic memos (Patton, 2002). These initial analyses assisted me in preparing my dissertation proposal, as well as my university ethics review board application, which enabled me to begin recruiting interview participants.

Early on in the project, I also began thematic analysis of qualitative survey data. The results of this analysis provided me with valuable insights as to the broader policy considerations at play in regulating TCAM practitioners - and TCM/acupuncture practitioners more specifically - in the Ontario context. I continued to apply this method to other portions of my dataset as the study progressed. **Thematic analysis**, as described by Braun and Clarke (2006, p. 87), is a multi-step qualitative analytic process, in which data are repeatedly reviewed and coded to characterize recurrent features across the texts under study. The method unfolds as follows: 1) “reading and re-reading the data” to identify initial concepts; 2) systematically “generating initial codes” reflecting recurrent features of the data, gathering relevant excerpts relating to each code; 3) grouping codes, along with their associated data excerpts into initial themes; 4) “reviewing themes” to ensure that they rigorously reflect their concomitant codes; 5) further refining themes through ongoing analysis of the original data; and 6) reporting these themes with a selection of textual excerpts evidencing their relevance to the initial research focus.

I began interviews about one year into the project, once I had received ethics approval to do so. I continued to undertake interviews throughout the duration of my study, exploring policy themes
using thematic analysis as I moved analytically between documents, field notes, and interview transcripts.

As my work progressed, I also began to use critical discourse analytic methods to identify and characterize, in progressively greater depth and dimensionality, two key controversies at play in Ontario’s TCM and acupuncture regulatory process, namely: a) which professional groups would be permitted to practice acupuncture within their regulatory scope, and using what standards of practice; b) linguistic regulatory entry requirements for East Asian immigrant TCM practitioners.

**Critical discourse analysis** (CDA) as conceptualized by Fairclough (1992), which I apply in the earlier portions of the dissertation, aims to examine the content and form of texts to expose the broader sociopolitical context and implications of specific linguistic usage (Fairclough, 1992, Bacchi, 2009). An ‘intertextual’ approach to CDA may draw upon external ‘texts’ to better contextualize particular discourses (Fairclough, 1992). More specifically, I engaged with Bacchi’s CDA approach (2009), which aims to illuminate the epistemic underpinnings, origins, and of particular policy-related discourses. Bacchi’s analytic method interrogates: a) the representation of a particular ‘problem’ in a specific policy approach; b) the assumptions and historical origins underlying this representation; c) silences and gaps implicit in the representation; d) the representation’s potential sociopolitical impacts; and e) ways in which the representation may be secured, reproduced, contested or replaced (Bacchi, 2009, Pereira, 2014). As my work progressed into the dissertation’s final substantive chapter, I shifted my conceptualization of discourse analysis to align with Foucaultian approaches, in which discourse is conceived more broadly “social structure and… social practice”, rather than in exclusively linguistic terms (Diaz-Bone et al., 2007, p. 1).

As I analysed the TCM – and acupuncture-related regulatory controversies in Ontario, and situated them within a broader literature, I recognized that Ontario’s challenges were not jurisdictionally-unique. Delving iteratively into these issues, I began to better understand that what I was studying were issues specific to the statutory regulation of practitioners and practices rooted in traditional/Indigenous knowledges. As I differentiated some of the features of traditional medicine practices that distinguished them from biomedical practice in regulatory context, I realized that I needed a central conceptual parameter around which to discuss these issues. It gradually became clear to me as I reviewed the scholarly literature around professional
regulation that this concept, the central issue (Stake, 1995) around which my doctoral case study revolved, was the public interest. As noted earlier, the public interest is a contested concept: that is, it has no absolute or fixed significance, but may take on a range of theoretically-specified, contextual, political and/or stakeholder-driven meanings (Saks, 1995, Baggott, 2002). To engage rigorously with this concept, I understood that I would need to adopt clear theoretical underpinnings across my work, as I now discuss.

**Postcolonial theoretical approach**

The overarching theoretical framework I adopt in this work is that of postcolonial theory. Postcolonial scholarship – at times referred to as an anti-colonial approach to emphasize its action orientation - represents a broad rubric, containing many variations, sub-approaches and debates (Loomba, 1998). What unites these is a common emphasis on transforming inequities arising from the European colonial encounter, both historically and in their ongoing ‘neocolonial’ manifestations; and in the centralization of voices, histories, knowledge systems of those impacted by neo/colonialism (Loomba, 1998; Battiste, 2005).

The relevance of postcolonial theory to issues surrounding traditional knowledge systems, and traditional medicine in particular, has been detailed by various scholars (Harding, 1998; Hollenberg & Muzzin, 2010; Gale, 2014), in light of traditional medicine’s historical and ongoing political subordination to biomedicine. The contestation of discourses of biomedical superiority represents a key component of such an approach (Hollenberg & Muzzin, 2010). Across the dissertation, I apply various theoretical approaches under the broad postcolonial rubric, as I now explain.

Early on in the dissertation, in Chapter 3, I take up the conceptual issues underpinning a United Nations recommendation that regulators across the globe attend to the preservation of traditional knowledge and work to prevent further misappropriation of Indigenous knowledges (WHO, WIPO, WTO, 2013). Misappropriation is a postcolonial theoretical concept referring to the unsanctioned, harmful extraction and decontextualization of particular cultural elements or practices, from their whole cultural contexts, typically by cultural outsiders (Brown, 2005). Questions of traditional knowledge misappropriation have been extensively addressed in the literature with respect to traditional medicine products (such as herbal formulations), and have been responded to by several nations in their creation of digital knowledge repositories and
patent protection strategies. However, with respect to the misappropriation of traditional medicine *practices*, there remains a notable gap in the literature. An exception is Hollenberg and Muzzin’s 2010 anti-/post-colonial theoretical work in this regard, which I apply in Chapter 3 to illustrate ways in which particular professional regulatory approaches may on one hand protect or conversely misappropriate and threaten traditional medical knowledge. A policy-making stance that pro-actively seeks to protect traditional knowledge is, I argue, fundamental to a public interest conceptualization geared to the statutory regulation of traditional medicine practitioners and practices.

In the dissertation’s fourth chapter, I reference a body of sociological literature addressing biomedicine’s epistemic and political dominance over TM in the context of medical pluralism in nations of the global South, despite Indigenous medical practices’ widespread regulation and usage there (Sussman, 1981; Albert et al, 2015; Zhang, 2007; Prasad, 2007). I take up Khan’s 2006 suggestion to adopt critical scholarly approaches that consider history and political factors, in exploring the power dynamics inherent in medical pluralism across the globe. To this end, I address the historically-subordinated socio-political position of non-Anglo/European minority groups in the jurisdictions whose linguistic regulatory parameters for East Asian medicine practitioners I examine in this particular chapter (Canada, the US and Australia), a subordination that represents an ongoing consequence of Anglo-European colonization (Dauvergne, 2016). This stance permits me to draw attention to the position of global South immigrant TM practitioners working in the global North as situated within two intersecting sociopolitical marginalities (i.e., as TM practitioners, and as non-Anglo/European immigrants), an observation that later informs my public interest theorizing.

As I progressively develop the public interest concept in Chapter 5 of this dissertation, I apply the paired legal concepts of disparate impact discrimination (Hunter & Shoben, 1998) and reasonable accommodation (McAndrew, 2011) to a subset of my data. *Disparate impact discrimination* refers to cases in which a particular policy or practice is found to unintentionally exert a disproportionate exclusionary impact on members of a specific ‘protected’ group (e.g., gender, ethnicity, national origin, ability, age, sexual orientation) (Hunter & Shoben, 1998). *Reasonable accommodation* is a related principle in which an “exception [is] granted to a person or group of persons for whom a universal rule or practice would have a discriminatory effect” (McAndrew, 2011). Although the concepts of disparate impact discrimination and reasonable
accommodation are not uniquely associated with postcolonial theory, their equity-driven
underpinnings fit well within postcolonial theory’s parameters and support my analysis as it
unfolds.

Further developing the concepts informing my public interest framework for traditional medicine
practitioners and practices in this chapter, I draw upon the work of scholars (Milroy & Wallace,
2004; Rosenblith & Bindewald, 2014) whose theorizing addresses cultural plurality in policy-
making context. These scholars do not explicitly adopt a postcolonial theoretical orientation.
However, Milroy and Wallace’s conceptualization of the public interest concept as
fundamentally equity-based, and both research teams’ recognition of existing social inequities
that differentially privilege members of particular groups, align well with the postcolonial
scholarship of Munshi and Kurian (2005), described below, that specifically advances my
definition of the public interest in postcolonial context.

With reference to the public interest as conceived in Western liberal democracies, Munshi and
Kurian (2005, p. 514) observe that an “asymmetric hierarchy of publics” tends to privilege
“Western” publics and interests as central or “core”, while relegating “non-Western” interests to
the periphery, as marginal. This “othering” of non-Western interests, they argue, reproduces an
“inequitable distribution of power” characteristic of European colonial relations, and should be
strategically remedied, a principle I apply both with reference to traditional medicine knowledge
and East Asian immigrant knowledge keepers.

Taken as a whole, these theoretical approaches support my postcolonial theoretical
conceptualization of the public interest in Chapter 6 as it pertains to the statutory regulation of
traditional medicine practitioners and practices. Although I refer to postcolonial theorizing more
explicitly in some of the dissertation’s chapters (i.e., Chapters 3 and 6) than in others, the reader
may interpret this as a feature of the dissertation’s manuscript-based format, which requires that
each chapter stand alone; however, as explained, postcoloniality should be understood to
underpin this work as a whole.

Finally, as my dissertation’s substantive text comes to an end in Chapter 7, I draw upon
“boundary object” theorizing (Star and Griesemer, 1989), an approach from science and
technology studies, to comprehensively discuss the discursive mechanisms underpinning my
findings as a whole. While not specifically geared to discussion of equity issues in postcolonial
context, boundary object theory accommodates such perspectives well; and permits a detailed
analysis of the ways in which neocolonial regulatory approaches may be both justified and
deployed.

**Research Rigour**

Four key principles have been identified in the literature as key in demonstrating research rigour
in qualitative research, including in the case study format: **credibility, dependability,**
**confirmability** and **transferability.** Across my dissertation, I demonstrate these four attributes
through a variety of means, in line with key strategies described in the qualitative research
literature. (Houghton, Casey, Shaw, & Murphy, 2013; Shenton, 2004)

First, I unfold my findings across a range of data sources (interview, document, survey, field
notes), enhancing their credibility and dependability. Prior to undertaking interviews, I
established ‘familiarity with the culture’ surrounding prospective key informants by carefully
analyzing a range of documents surrounding the regulation of Chinese medicine and acupuncture
in Ontario. Further increasing my work’s credibility, I debriefed my preliminary analytic
findings with my dissertation committee members on an ongoing basis, and presented these at
several academic conferences, where I received considerable feedback as my work progressed.

My use of NVivo software to code and categorize my data over the course of the study
contributed to this work’s dependability and confirmability, creating an audit trail for my case
study. Bolstering my dissertation’s dependability further, I made my personal engagement with
the study issues explicit in the Reflexive Prelude to this work, communicated my previous
background and training to study interviewees as appropriate, and further note this background in
the methods sections of some study Chapters. My clear articulation of my adopted
methodological approaches in the Introduction and Chapters 2 through 7, and a discussion of the
study limitations in the Discussion / Conclusion, further enhance the study’s confirmability and
dependability.

With respect to transferability, I provide a thick description of my study findings, supported by
raw data (such as quotes, tables and figures, and statistics as appropriate); and clearly convey the
boundaries of my study to the reader. I moreover demonstrate a high degree of methodological
and theoretical congruence across the dissertation’s analytic chapters, progressively developing
the public interest concept by analyzing the study data in light of my identified postcolonial theoretical approach.

**Dissertation Format**

I have structured this PhD dissertation in a paper-based (rather than a book-style) format. Across the six following chapters, each of which represents a stand-alone publishable (or already-published) paper, I ask a range of questions of my diverse dataset. Focusing on the core controversies in Ontario’s TCM and acupuncture regulatory process, I aim to progressively elaborate the concept of the public interest as it pertains to the statutory regulation of traditional medicine practitioners and practices. As discussed above, I engage variously with my data using a range of qualitative analytic methods within the theoretical framework described above.
Chapter Overview

Chapter #2: Supportive but “worried”: perceptions of naturopaths, homeopaths and Chinese medicine practitioners through a regulatory transition in Ontario, Canada

In 2006 and 2007, the province of Ontario, Canada announced it would grant self-regulatory status to three TCAM practitioner groups - homeopaths, naturopaths and Chinese medicine practitioners/acupuncturists under the Registered Health Professions Act, under which the province’s biomedical health professions are also governed. In 2011 and 2012, as these groups’ respective regulatory processes were underway, a census-style survey was conducted using mixed qualitative/quantitative methods. In this paper, I apply thematic analytic strategies as described by Braun and Clarke (2006) to the responses generated from a single qualitative question in this survey. This question was meant to interrogate the regulation-related opinions of Ontario Chinese medicine practitioners / acupuncturists, naturopaths and homeopaths as to the emerging regulations affecting their occupational groups.

This chapter represents an important bridge between previous work on TCAM professionalization undertaken by an Ontario, Canada research team over the last 15 years (Gilmour et al., 2002, Kelner et al., 2004a, 2004b, 2004c, 2006; Welsh et al., 2004), and my own dissertation work. As a new member of this group’s long-standing research team, I contextualize my analysis of the survey’s qualitative results in light of quantitative findings analysed by others on the team. The chapter highlights key TCAM regulatory considerations specific to the Ontario context, as well as more broadly with respect to TCAM professional regulation in global context.

The core regulatory considerations that I investigate in later chapters are initially identified in this chapter. In particular, I begin to characterize some features that distinguish the statutory regulation of TCAM occupational groups from that of biomedical professionals.
Chapter #3: State risk discourse and the regulatory preservation of traditional medicine knowledge: The case of acupuncture in Ontario, Canada

The third chapter in my dissertation shifts tone from the second chapter’s broad consideration of TCAM-specific regulatory issues, focusing on the way in which health care epistemology and risk discourse may intersect in a traditional medicine regulatory process. This chapter also begins a detailed examination of Ontario’s TCM and acupuncture regulations by critically analyzing safety-related discourses in two acupuncture-related government reports that preceded the province’s announcement that it would regulate the practice. These reports address the question of whether acupuncture is sufficiently risky to regulate; and, if so, which of Ontario’s health professions should be authorized to perform the practice within their scope, and under what conditions.

In this chapter, I uniquely position the issue of traditional medicine regulation within the historical context of European colonial dominance, in which indigenous knowledges and practices have long been subordinated to Western scientific approaches (see Harding, 1998; Hollenberg and Muzzin, 2010). Using critical policy discourse analytic methods as specified by Bacchi (2009), I highlight the key role that risk discourse may play in a TCAM professional regulatory process, at times masking other issues. Tracking the historical and epistemic conditions under which the province of Ontario ultimately decided to regulate acupuncture, I raise key questions about the role of Indigenous vs. biomedical knowledges in traditional medicine regulation. Framing traditional knowledge protection as a regulatory priority, I theoretically differentiate equality- vs equity-based policy conceptualizations, thus beginning a process of theorizing the public interest in TCAM professional regulatory context.
Chapter 4: Medical pluralism and the state: regulatory language requirements for traditional acupuncturists in English-dominant diaspora jurisdictions

Taking a step back from an exclusive focus on the Ontario context, this chapter presents an in-depth examination of a key regulatory issue facing immigrant traditional medicine professionals working in diaspora settings: linguistic regulatory entry and practice requirements. With reference to a range of linguistic policy frameworks implemented for traditional acupuncture practitioners in Canada, the United States and Australia, this paper uses thematic analysis (Braun and Clarke, 2006) as well critical discourse analysis (Bacchi, 2009) to evaluate contrasting policy discourses surrounding recent related controversies.

Drawing on the results of my document review and 28 of the qualitative interviews conducted, this work unfolds in three parts. Part A describes the range of policies in place across these jurisdictions. Part B reports on five notable related controversies that unfolded over the period 2012-14. Part C, the most substantial portion of the work, critically analyses the competing policy discourses at play in the acupuncture language debate, and positions them more broadly within the context of other linguistic policy controversies in English-dominant diaspora jurisdictions. Echoing conceptual findings from Chapter 3, I further differentiate the concepts of equality and equity in relation to TCAM professional regulation, as I build towards a comprehensive public interest conceptualization that addresses both clinical and cultural considerations.

Chapter 5: Lost in translation: language proficiency, ‘reasonable accommodation’ and Chinese medicine regulation in Ontario, Canada

Resuming thematically where Chapter 4 ended, this chapter returns to the Ontario context to examine the aims, conceptual underpinnings, and impacts of the province’s linguistic registration policies for newly-regulated traditional Chinese medicine practitioners over the period 2012-2014. With theoretical reference to the legal principles of disparate impact discrimination (see Hunter & Shoben, 1998) and reasonable accommodation (see McAndrew, 2011), and to a broader literature around culturally-inclusive policy making, this paper draws on documentary
and interview-based data to compare official written accounts of the policy’s aims and impacts with the narratives of key state and practitioner informants. My analysis in this chapter establishes that Ontario’s TCM linguistic regulatory entry policies exerted significant (if not inadvertent) barriers to professional entry for some of the province’s most senior, Chinese immigrant TCM practitioners.

It is not enough, the chapter argues, that fair regulatory outcomes be vaguely sought in a piecemeal manner; rather, equity should be conceptualized as a foundational public interest principle underpinning the statutory regulation of TCAM in the public interest. In such regulatory projects, traditional knowledge protection should be furthermore emphasized, providing a framework within which to address other public interest considerations in a culturally-sensitive and -inclusive manner.

Chapter 6: Regulating traditional medicine professionals in the public interest: a principle-based framework

Building on the findings and theorizing from Chapters 2 through 5, the sixth chapter in this dissertation presents a principle-based public interest framework to guide the statutory regulation of TCAM practitioners and practices in liberal democracies. Drawing attention to several key features that differentiate traditional medicine systems, practices and practitioners from their biomedical counterparts, this framework takes the principle of equity as the axiomatic basis upon which such regulations should be crafted. Traditional knowledge protection, as also emphasized in previous chapters, is taken as a secondary pillar of this regulatory framework. Drawing upon a broad set of global literatures related to traditional medicine, health professional regulation, and educational standards, and supported by findings from previous chapters, the framework takes postcolonial theorizing (as in Chapter 3) as the basis around which other key public interest considerations (safety, health care quality, and accessibility) may be conceptualized in TCAM professional regulatory projects.
Chapter 7: Safety as boundary-object: the case of acupuncture and Chinese medicine regulation in Ontario, Canada

In this seventh chapter, I apply a theoretical concept from science and technology studies, that of the boundary object (see Star and Griesemer, 1989; Derkatch, 2008), to the area of TCAM professional regulation. Reinterpreting data and previous analyses presented across the previous chapters, and introducing additional document-based data pertaining to acupuncture training standards in Ontario, I use the boundary object concept to highlight the disproportionate role that safety-related discourse may play in TCAM professional regulatory projects. To illustrate this point, I demonstrate several ways in which safety appears as a shape-shifting discursive boundary object that disproportionately dominates Ontario’s TCM and acupuncture’s regulatory process in Ontario to the exclusion of other public interest parameters.

Such a discursive focus, I show, acts as a mechanism by which biomedicine’s epistemic and health systems structural dominance are reinforced, even as a traditional medicine system and practice (i.e., TCM/acupuncture) previously excluded from mainstream health appear to disrupt biomedicine’s hegemony by entering the regulatory system. The observations made in this paper further underscore the significance of the public interest framework elaborated in Chapter 6, in which safety – in both a biomedical and cultural sense - is theorized as one among several principles of importance in the professional regulation of traditional medicine, rather than as the primary, dominant policy driver.

Some of the six discussed chapters have already been published, others currently remain under peer review; I provide notes to this effect at the beginning of each chapter. I have assembled the chapters in a chronology that reflects the overall progression of my analysis of the study data towards a cohesive theoretical contribution to the field of TCAM professionalization studies. This contribution is further discussed in the dissertation’s Discussion and Conclusion section, where I synthesize my overall PhD findings, emphasizing the thematic and theoretical progression across all chapters. I also draw attention to my work’s broader significance in the scholarly literature, and highlight important areas for future research.
Stylistic Note

The vast majority of the analysis, conceptualization and writing in this dissertation are my own. However, as is the convention in the health sciences, members of my PhD supervisory committee are variously listed as co-authors on the already-published papers (see Appendices J and K), and on the manuscripts currently under review, in recognition of their supervisory contributions. Consistent with the principle of formal co-authorship, I consistently employ the plural “we” in all chapters of this dissertation excepting the first (Introduction) and last (Discussion and Conclusion). It should be noted that there are slight stylistic variations across the chapters that follow, reflecting the fact that some have already been published, or submitted for review, in journals with specific style requirements.
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Chapter 2

Supportive But “Worried”: Perceptions of Naturopaths, Homeopaths and Chinese Medicine Practitioners Through a Regulatory Transition in Ontario, Canada

This paper has been published in the peer-reviewed journal, BMC Complementary and Alternative Medicine\(^1\) under the following citation (and included as Appendix J):


For this paper, I carried out analysis of qualitative data and drafted the manuscript. HB conceived of the study, participated in its design and coordination, participated in qualitative analysis, and helped to draft the manuscript. SW conceived of the study, participated in its design and coordination, participated in statistical analysis, and helped to draft the manuscript. AM performed the statistical analysis and helped to draft the manuscript. All authors read and approved the final manuscript.

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ABSTRACT

Background: In line with recent World Health Organization recommendations, many jurisdictions are taking steps to regulate practitioners of traditional, complementary and alternative medicine (TCAM). Previous studies have examined TCAM practitioners’ generally-supportive views about professional regulation; however, little research has been conducted on TCAM practitioners’ experiences and perspectives amidst an active regulatory process. In 2006 and 2007, the province of Ontario, Canada announced it would grant self-regulatory status to three TCAM practitioner groups - homeopaths, naturopaths and Chinese medicine practitioners/acupuncturists.

Methods: In 2011 and 2012, part-way through each group’s regulatory process, we surveyed all practitioners from these three groups (n=1047) that could be identified from public registries and professional associations. The data presented here are derived from the sub-sample of homeopaths (n=234), naturopaths (n=273) and Chinese medicine practitioners/acupuncturists (n=181) who provided answers to an open-ended question about their opinions of the regulatory process at the end of the survey. An inductive, thematic analysis of qualitative survey responses was conducted.

Results: Survey responses affirmed a pro-regulatory stance across all groups, but revealed considerable ‘worry’ amongst practitioners as to how the regulations might be implemented. Four primary ‘worry-related’ themes emerged: a) regulation’s potential administrative and financial burden on practitioners; b) scope-related concerns; c) implementation of fair registration standards; and d) whether regulation might erode the groups’ distinctive worldviews. Some occupationally-specific concerns appeared related to each group’s particular stage of professionalization. Other ‘worries’ may be related to the relative marginality of TCAM practitioner groups within biomedically-dominant national health care systems, and the possibility that inter-professional hierarchies may be emerging between particular TCAM groups. Specific concerns around overlapping practice scopes between TCAM and other professions raised questions about the implementation of non-monopolistic regulatory models such as Ontario’s.

Conclusions: Overall, this study will help inform regulators and TCAM practitioner groups to navigate the unique challenge of regulating health care providers long excluded from national health care systems, who frequently work from within paradigms distinct from mainstream biomedicine.
Background

The World Health Organization has called for member countries to increasingly regulate practitioners of traditional, complementary and alternative medicine (TCAM), with the aim of increasing safety, quality and effectiveness of TCAM therapies worldwide (WHO, 2014). Many nations continue to grapple with how to regulate TCAM practitioners and practices, which have historically fallen outside of the purview of biomedicine’s globalized dominance in government-sanctioned health care systems, and which, as such, are characterized by relative sociopolitical marginality (Baer, 2010). TCAM practices are, furthermore, characterized by paradigmatic features distinct from biomedicine’s underpinnings; this poses additional regulatory challenges in that many regulatory systems have been designed to accommodate biomedical-style health care (Cant and Sharma, 1995, Gilmour et al., 2002). Regardless, several nations - including some jurisdictions within Canada (Boon, 2002) - continue to make significant headway in regulating TCAM practitioner groups. Lessons learned from these jurisdictions may ease the process for others.

In some jurisdictions, governments are taking pro-active steps in support of the WHO’s call for increased integration of TCAM practitioners into their national health care systems. In 2013, for instance, several southeast Asian countries co-signed the Delhi Declaration on Traditional Medicine, agreeing to collaborate towards a ‘harmonized approach… [to] regulation of traditional medicine and involvement of traditional medicine practitioners in health services’ (WHO-SEA 2014). In many cases, however, the impulse to lobby governments to regulate TCAM practitioners has arisen from within the occupational groups themselves, as exemplified in our previous studies involving naturopaths, homeopaths and Chinese medicine practitioners in the Canadian province of Ontario (Gilmour et al., 2002, Kelner et al., 2004a, Kelner et al., 2004b, Kelner et al., 2006, Welsh et al., 2004). As we and others (Cant and Sharma, 1995, Canaway, 2009, Wiese and Oster, 2010) have noted, some of the principal drivers behind such

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2 As Boon and Welsh, who have long been publishing research on these issues in Ontario, collected the data analysed for this published chapter, the manuscript was written to indicate continuity with a series of “previous studies” on which they were co-authors.
groups’ professionalization projects include: the pursuit of increased occupational credibility, more extensive inclusion within third party and/or public health insurance programs, and the promotion of higher or more consistent training standards.

Despite widespread support for professionalization - and with it, regulation - within many TCAM practitioner groups, some issues continue to prove contentious within these communities. Standardization of educational requirements can, for instance, prove challenging for groups characterized by significant inter-occupational diversity in terms of both practice style and training background (Shahjahan, 2004). While TCAM practitioner training is increasingly institutionalized worldwide, traditional apprenticeship or mentorship-based training models continue to carry importance globally (Hsu, 1999). How much biomedical-style training should be included in TCAM practitioners’ training continues to be contentious within some groups (Welsh et al., 2004, Villanueva-Russell, 2011); and some practitioners fear long-term co-optation into a biomedically-dominant model (Cant and Sharma, 1995, Stone, 2005). In some cases, these issues have proven so controversial within practitioner communities that statutory regulation has been largely abandoned as a common goal (Stone, 2005). Herbalists in the United States, for instance, organize within a professional ‘guild’ model which explicitly recognizes multiple practice styles and diverse training pathways, rather than pursue state regulation (American Herbalists Guild, 2013). Regardless, many TCAM practitioner groups, as well as an increasing number of nations, remain committed to a regulatory pursuit, in line with the WHO’s call.

The case of naturopaths, homeopaths and Chinese medicine practitioners in Ontario, Canada

In 2006 and 2007, the Ontario (Canada) government announced that it would move forward in regulating practitioners of naturopathy, homeopathy and traditional Chinese medicine / acupuncture under the Regulated Health Professions Act (College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario, 2014). Two points should be noted about Ontario’s health professions regulatory structure. First, the province’s health professions are self-regulated with government oversight, in contrast with various types of state regulation and co-regulation more typical in other jurisdictions (such as Europe and Australia). Second, the provincial government does not authorize exclusive practice scopes to particular professions (as is more common in other jurisdictions) (Kelner et al., 2004a, O'Reilly, 1999). In Ontario’s
‘overlapping-scopes’ model, professions are granted specific, protected occupational titles, and in some cases may be authorized to perform one or more health-related ‘controlled acts’ within their scope; controlled acts may be shared across professions (O’Reilly, 1999).

In line with new legislation intended to govern each of the three professions, the Ontario government appointed a regulatory Transitional Council for each group, with the intention of laying the framework for each profession’s regulation in the public interest. In all cases, members of Transitional Councils were ‘chosen from individuals who responded to a public call for members advertised across Ontario’; Council members consisted of both practitioners from within the profession being regulated, as well as ‘general’ members who were not practitioners (Ontario Ministry of Health and Long Term Care, 2009b, Ontario Ministry of Health and Long Term Care, 2009a, Transitional Council of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario, 2013). In the case of naturopaths, who had been previously regulated under another piece of provincial legislation, all Directors of the previous regulatory Board were included in the profession’s new Transitional Council (Ontario Ministry of Health and Long Term Care, 2009b).

We have previously characterized each of the three occupational groups as being at notably different stages of professionalization (Welsh et al., 2004), which has contributed to different trajectories for each group’s regulatory process. Ontario’s naturopaths were the most tightly organized of the three, had achieved standardization in their training requirements many years earlier, and as noted above had been previously regulated in the province. Chinese medicine practitioners (whose practices include traditional acupuncture) had long lobbied for regulation, but were considerably divided as a community over the issue of professional standards. Homeopaths were similarly heterogeneous as a group, but were internally divided in terms of regulation as a goal, and had lobbied comparatively little for regulation.

Despite the significant differences in each group’s professional evolution, the Ontario government accepted the recommendations of the Health Professions Regulatory Advisory Council (http://www.hprac.org/en/index.asp) to take the step of regulating each of these groups around the same time. Regardless, the work of each group’s regulatory Transitional Council has been distinct, informed by the group’s specific needs moving forward. To date, Ontario’s Chinese medicine practitioners are the only group of the three that has fully implemented its new
regulations (in April of 2013); naturopaths and homeopaths are expected to complete this process some time in 2015.3

The current study

Although the literature has extensively detailed TCAM practitioner groups’ interest in seeking professional legitimation, including some retrospective studies of such groups’ regulatory entry, we are unaware of studies detailing the transition of these groups through an active regulatory process. In an effort to capture the experiences and perspectives of Ontario naturopaths, homeopaths and Chinese medicine practitioners (including acupuncturists) as they passed through the transition to being regulated under the Regulated Health Professions Act, we initiated a cross-sectional survey in 2011, while all three groups’ regulatory Transitional Councils were part-way through their work. Our census-style surveys were mixed in methodological design: alongside numerous quantitative questions, they included one qualitative question inviting respondents to further expand their views on the emerging regulatory changes.

As will be elaborated elsewhere, and perhaps unsurprisingly given the three groups’ previously stated motives for pursuing regulation, the quantitative aspects of the survey demonstrated a widespread overall support for the proposed new regulations across all three practitioner groups; we intend to detail these results elsewhere. Across the three groups, many respondents also offered lengthy and, at times, impassioned written responses to our qualitative survey question, in some cases even attaching letters and newspaper clippings to their surveys in an effort to communicate their perspectives. What was notable across the responses was that, despite overwhelming support for the regulatory changes, members of all three groups felt ‘worried’ to varying degrees about the proposed regulations. In particular, such concerns pertained to issues of professional scope, fair registration standards, and a potential compromise to their groups’ underlying paradigmatic principles.

3 This manuscript was written and published early on in my PhD research process before Ontario’s new naturopathic and homeopathic regulations had been implemented.
While some concerns were shared across the three TCAM practitioner groups, others were occupationally-distinct. This suggests that each group may have been facing particular but predictable challenges (e.g. consensus building around common standards) related to its current stage of professionalization. However, a number of the worries raised across the three groups appeared specifically related to the groups’ distinct identities as TCAM occupations; for example, some concerns appeared rooted in the groups’ relative marginality within the broader system of biomedical health professions. In addition, some concerns raised may be related to the implementation of Ontario’s overlapping practice scopes regulatory model, as will be discussed further on.

Regardless, the practitioner ‘worries’ raised in our study hold perhaps greatest significance in relation to the palpable challenge of regulating TCAM practitioners and practices hitherto largely excluded from national health care systems worldwide. As our study respondents clearly point out, it is one thing for a government to ‘decide’ to regulate, and quite another to unfold the details of such regulations in a way that is satisfying to various stakeholders. Any professional regulatory project will, for instance, invariably exclude some practitioners from entry; how to do so fairly and consistently may pose particular challenges in regulating TCAM practitioner groups. Cross-jurisdictional differences in regulatory scope may pose an additional challenge for some groups. The logistics of ‘grandparenting’ long-standing practitioners, navigation of cultural alongside clinical issues present in regulating traditional medicine practitioners, and the potential for producing new inter-professional hierarchies are additional issues which study respondents raised in Ontario’s context. Many such issues will likely arise in other jurisdictions as well. As such, this work may inform the global conversation on TCAM regulatory initiatives, while raising important questions for further scholarly investigation.

Methods

In 2011 and 2012, we distributed an online survey to naturopaths (n= 882), homeopaths (n=784), and both online and print surveys to Chinese medicine practitioners or acupuncturists (n=1286) across Ontario using a census model whereby we aimed to reach as many practitioners as possible. Prior to sending out the surveys, we had undertaken an extensive process to gather practitioner names and contact information. The naturopath practitioner population was contracted through the membership lists from the Ontario Association of Naturopathic Doctors
(OAND), the largest professional association for NDs in Ontario. The OAND sent an email with a link to the survey to their members (n=882). The Transitional Council of the College of Homeopaths of Ontario (TC-CHO) provided a list of homeopathic practitioners interested in receiving information about regulation and we supplemented this with further contacts generated through personal connections and internet searches (n=784). Finally, Chinese medicine practitioners were identified from practitioner organizations’ publicly-accessible member lists, internet searches using Google and online indexes, such as the Yellow Pages, Chinese newspapers, and personal visits to Chinese business centres in the greater Toronto area. Based on pre-test information, we determined that the survey should be offered in both English and Chinese languages, as well as accessible in both online and paper versions. The questionnaire, introductory letters, and reminders were translated into Chinese by a professional translator and then back translated to check for accuracy. Respondents were then contacted by email to fill out the online survey (n=659) and post mail for the paper survey (n=627). Initial response rates across the three groups were 50% (naturopaths), 56% (homeopaths), and 37.5% (Chinese medicine practitioners).

Because both Chinese medicine practitioners and homeopaths were not regulated at the time of our study, any individual self-identifying as a practicing Chinese medicine practitioner or homeopath was included in the original sampling frame, regardless of their current education or work status. However, once our sample was compiled, the data were limited to include only those practicing in Ontario on a full or part-time basis (this also excluded some naturopaths). Furthermore, for Chinese medicine practitioners, respondents already registered in Ontario under another regulated health profession (physiotherapists, nurses, MDs, etc.) where acupuncture is included as part of their scope of practice were excluded from our study (n=111), given our focus on those who must register as a Chinese medicine practitioner to practice acupuncture. These exclusions left us with a final sample of 1047, broken down as 427 naturopaths, 329 homeopaths and 291 Chinese medicine practitioners. Of these respondents, a sub-sample of 273 naturopaths (64%), 234 homeopaths (71%) and 181 Chinese medicine practitioners (63%) provided responses to the qualitative question in our study, which is the focus of this paper. The study received ethical approval from the Research Ethics Board at the University of Toronto.
The key demographics describing the groups are presented in Table 1\(^4\). From these results, we can see that women are most predominant among naturopaths (79\%) and least so among Chinese medicine practitioners (57\%). Additionally, naturopaths report an average age of approximately 38 years, while homeopaths and Chinese medicine practitioners have mean ages of 47 and 49 years, respectively. With respect to years in practice, Chinese medicine practitioners have been practicing the longest at approximately 17 years, while naturopaths report an average of eight years of experience and homeopaths nine. Finally, a little over half of naturopaths report working part-time compared to 65\% of homeopaths and 34\% of Chinese medicine practitioners\(^5\).

**Table I.** Demographic characteristics by group for qualitative respondents

<table>
<thead>
<tr>
<th></th>
<th>Naturopaths (n=273)</th>
<th>S.D.</th>
<th>Response Rate</th>
<th>Homeopaths (n=234)</th>
<th>S.D.</th>
<th>Response Rate</th>
<th>CMP’s (n=181)</th>
<th>S.D.</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender(^6)</td>
<td>0.793</td>
<td>-</td>
<td>99%</td>
<td>0.740</td>
<td>-</td>
<td>99%</td>
<td>0.572</td>
<td>-</td>
<td>99%</td>
</tr>
<tr>
<td>Age</td>
<td>38.3</td>
<td>9.79</td>
<td>97%</td>
<td>47.1</td>
<td>10.6</td>
<td>99%</td>
<td>48.7</td>
<td>11.6</td>
<td>96%</td>
</tr>
<tr>
<td>Years in practice</td>
<td>8.06</td>
<td>7.49</td>
<td>100%</td>
<td>9.29</td>
<td>8.89</td>
<td>99%</td>
<td>17.3</td>
<td>12.01</td>
<td>99%</td>
</tr>
<tr>
<td>Part-time(^7)</td>
<td>0.520</td>
<td>0.501</td>
<td>100%</td>
<td>0.645</td>
<td>0.479</td>
<td>100%</td>
<td>0.337</td>
<td>0.474</td>
<td>100%</td>
</tr>
</tbody>
</table>

The surveys contained a range of questions focused on the demographic, practice and educational characteristics of practitioners, with some questions common across surveys and some reflecting particular aspects of each group. After a series of closed-ended questions related

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\(^4\) Not all qualitative respondents provided demographic data for all key variables, so within group response rates are listed for each demographic variable in Table 1.

\(^5\) Post-hoc tests were conducted within each group to determine whether those who responded to the qualitative question differed significantly on these key demographic characteristics as compared to those who did not answer the qualitative question. For naturopaths, these results showed that qualitative respondents are older and less likely to be women than non-respondents. For both homeopaths and Chinese medicine practitioners, the only difference is with respect to age: qualitative respondents are older than non-qualitative respondents. There are no differences in any group with respect to years in practice or part-time versus full-time status.

\(^6\) 0=Men, 1=Women.

\(^7\) Reference category is full-time
to regulation, respondents were asked a broad question to solicit their views on the regulatory changes facing their occupational group. Homeopaths, for instance, were asked: *Finally, what are your thoughts about the decision to regulate homeopaths under the Regulated Health Practitioners Act in Ontario?* Questions posed to the other groups were very similar, with the practitioner group name appropriate replaced. Qualitative responses from across the three surveys were inductively coded by two independent coders for emergent themes. The two coders compared and corroborated coded findings for consistency and reliability. Themes emerging across the three groups were then compared to find areas of overlap and uniqueness.

### Results

Overall, written responses from across the three surveyed groups affirmed quantitative findings showing significant support for regulation from about three-quarters of all respondents across the three groups. A more extensive analysis of quantitative findings will be reported elsewhere. Written survey responses suggested that this support reflected respondents’ perceptions that the regulatory changes would enhance their occupations’ credibility, increase availability of third party insurance coverage for their services, and help protect the public from untrained practitioners. However, despite this widespread support for the regulatory changes in principle, quantitative findings across the naturopathic, homeopathic and Chinese medicine practitioner groups also showed that a considerable proportion of respondents (48%, 44% and 33% respectively) agreed or strongly agreed when asked to respond to the following statement: “I am worried about regulation”.

The substance of such ‘worries’ is difficult to evaluate from the quantitative findings alone, results of which are limited by the specific questions asked. However, thematic analysis of written survey responses from naturopathic [N], homeopathic [H] and Chinese medicine [CM] practitioners proved useful in drawing out a number of key regulation-related concerns, some of which were common across the three groups, and others being occupation-specific.

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8 I was the primary coder/analyst of this data; Boon was the secondary coder.
Some respondents who expressed concerns about the regulatory changes were in fact opposed to these changes, characterizing them, for instance, as “not a good idea” [CM]. A small number of practitioners argued that a discourse emphasizing public safety was being disingenuously bandied about as a political pretext for increased regulatory control over low-risk clinical activities, for instance:

One regulates activities that are dangerous. Homeopathy is not dangerous. [H]

Others felt poorly informed about the regulatory changes, and had difficulty understanding how it would affect them:

I feel that I am uninformed about the change in regulation and find the information that is provided to be confusing [N].

However, the majority of those expressing ‘worries’ did in fact support the new regulations, but had concerns or felt unsure about the way in which these were being implemented:

I do support it but don't know what will be the real outcome. Hopefully it will be a positive one to both public and practitioners. [CM]

I feel this regulation has been long overdue. Now that the opportunity has come about I am disappointed in the quality of the regulations proposed. [N]

More specifically, respondents from all three groups expressed concerns with the actions of the Transitional Councils responsible for drafting their respective new regulations:

After reviewing the Draft regulation put out by the Transitional council, my support for regulation diminished almost immediately. [H]

I am not confident that all of those who are representing my profession are acting appropriately on my behalf. [N]
Within the Chinese medicine group, respondents raised concerns about the composition of their particular Transitional Council:

My only wish is to have authentic TCM and acupuncture professionals involved in the regulations to ensure fairness, equitableness [sic], and openness. [CM]

Overall, respondents’ ‘worries’ cut across four primary themes, most of which were broadly shared across the three groups, though with occupationally-specific components. These four themes involved concerns that the new regulations might: a) produce an unwanted financial and administrative burden on practitioners; b) detrimentally affect groups’ practice scopes; c) implement inappropriate or unfair registration standards; and d) compromise occupational groups’ paradigmatic foundations.

**Increased administrative and financial burden**

A number of respondents who otherwise supported the regulatory changes raised concerns that these changes might increase administrative work for practitioners, and potentially cause negative financial impacts:

Worried about added costs, bureaucracy and paper work headaches but am generally supportive of this measure to further professionalize our profession. [CM]

Several respondents raised financial concerns within the broader context of monetary struggles within their occupational group:

It will…likely raise my registration dues, which will make practicing unaffordable to myself who is a newer practitioner. [N]

Others concurrently connected such concerns with the issue of providing financially accessible services to patients:
Regulation will cause more expenses for the Homeopath, thus making it more and more difficult for a Homeopath to make a viable living. Regulation will cause rate increases thus reducing affordability to the average family / public. [H]

Some respondents even predicted that ‘regulation costs’ (amongst other factors) could ‘cause a lot of practicing homeopaths to go underground/practice without licensing’ [H].

**Negative impact on practice scopes**

Respondents from all three groups worried that the new regulations might have detrimental impacts related to their specific practice scopes. Where concerns about *reduced scope* predominated in naturopaths’ comments, it was a concern around *overlapping* scopes that repeatedly appeared in homeopaths’ and Chinese medicine practitioners’ responses. Common across all three groups’ scope-related concerns were allusions to both inter- and intra-occupational turf battles.

As noted above, naturopathic respondents repeatedly expressed concern that their existing practice scope would be reduced under the new regulations:

> If the intent of the regulations is to evolve into a better regulated profession it cannot be at the cost of decreasing our scope of practice. [N]

Furthermore, several naturopaths expressed a concern that the new regulations might not expand their scope adequately. Specifically, such respondents hoped that naturopaths’ diagnostic rights would be broadened to include particular biomedical tests (such as “Xray, MRI, CT scans” [N]), and the ability to deliver “intravenous therapies” and “prescribe base-line pharmaceuticals” as well as specialized supplements such as “hesperidin” [N] and “L-carnitine” [N].

Some naturopaths connected their scope-related concerns to a goal of practising as independent, primary care practitioners, on par with biomedical physicians:
My inability to directly order lab tests [sic] or prescribe base-line pharmaceuticals inhibits me from being a one stop shop for primary care. I have to rely on walk-in clinic MDs to offer complete care to my patients. [N]

Others felt that the practice scope proposed in Ontario’s emerging naturopathic regulatory structure would disadvantage the province’s naturopaths in relation to other North American jurisdictions:

I feel the change will make us the laughing stock of medical providers in Ontario and we are already being scoffed at by other ND’s across the country. It’s time for a national Naturopathic Regulation at the level of British Columbia and with the scope of Arizona. [N]

However, not all respondents favoured all aspects of a regulatory scope of practice, particularly with respect to pharmaceutical drugs:

I have no desire to prescribe drugs and giving us this right invalidates the meaning behind our profession and principles. [N]

Like naturopaths, some Chinese medicine practitioners - who otherwise supported the regulatory changes - also expressed concern that their scope would be limited under the new regulations:

[Regulation] is necessary. I am looking forward to my services being covered under supplementary health insurance. I am very concerned about restrictions in my practice. [CM]

More specifically, such concerns related to particular components of Chinese massage practice (Tuina), which involve techniques similar to spinal manipulations used by chiropractors, which are restricted under Ontario’s ‘controlled acts’ model.

Amongst homeopaths and Chinese medicine practitioners, qualitative scope-related responses largely reflected a concern that the regulations would continue to permit other occupational groups to perform their respective core practices. Homeopaths specifically raised concerns about naturopaths’ continued authority to practice homeopathy:
I do not understand how homeopaths with extensive training in homeopathic remedies are not able to prescribe "restricted" remedies, yet naturopaths that only study 28 hours of homeopathics have license to prescribe these restricted remedies when they have little understanding of how these remedies work. [H]

Several homeopaths furthermore deplored that unlike naturopaths, they were not expecting to be granted a ‘doctor’ title in their professional legislation, presumably further undermining their relative credibility:

I am upset that we will be deemed as secondary health care practitioners underneath naturopaths, with our designation of Doctor of Homeopathy being withdrawn to Homeopath. [H]

Similarly, numerous Chinese medicine practitioners raised concerns that non-Chinese medicine based health care professionals (such as physiotherapists, chiropractors and naturopaths) would retain the right to practise acupuncture within their professional scope. Many expressed a perception that such professionals were less qualified to practise acupuncture so than traditionally acupuncture practitioners:

I am in favor of regulation for the profession, I wish that it was also more restricted to fully qualified/future fully registered with the college practitioners instead of being allowed to be practiced in other fields as Chirop[ractic] ... who do not receive or are required to have proper education and yet will be able to practice acupuncture within their scope of practice and profession. [CM]

Evidently such concerns around overlapping practice scopes relate to the issue of training standards, which will be discussed in greater detail further on. However, the question of regulatory turf repeatedly emerged as well, with several homeopaths and Chinese medicine practitioners expressing a wish - as described above - to see their core practice scopes more exclusively restricted.
Some Chinese medicine practitioners accepted that they would continue, within Ontario’s regulatory context, to share some core practices such as acupuncture with other professions. However, they wished to see the term ‘acupuncture’ protected for Chinese medicine practitioners under the regulations, thus differentiating traditional acupuncture from more biomedically-informed needling techniques, which one Chinese medicine respondent proposed be termed “intramuscular stimulation or dry needling” [CM] instead of ‘acupuncture’.

**Inappropriate or unfair registration standards**

Amongst homeopaths and Chinese medicine practitioners, groups for whom there were (at the time) no national educational or regulatory standards, considerable concerns were raised as to how the new regulations might assess practitioners’ qualifications for professional entry. Respondents across the two groups tended to agree in principle that some practitioners’ current training within their occupational groups were “not high enough” [H]; and that the enforcement of standards would likely “improve the quality of care to patients” by increasing “the practitioners’ level of treatment” [CM]. However, a concern around how such standards might be set - particularly in light of significant intra-occupational diversity - permeated many respondents’ comments:

> I am hoping that there will be a fair way of assessing each of our training as there are many ways to practice that benefit the patient. [H]

In particular, respondents across both homeopathic and Chinese medicine groups raised concern that various practitioner subgroups might be *inappropriately* excluded from registration, depending on how the standards were set. However, each group’s individual concerns in this regard were more occupationally-specific.

**Homeopaths**

Amongst homeopathic respondents, standards-related comments were dominated by the question of how much biomedical scientific training should be required of practitioners in the forthcoming registration standards. Those advocating for more extensive biomedical training argued it would produce higher competency within, and greater credibility for, the homeopathic community:
[U]ntil we come together as a scientific community where those who wish to practice homeopathy are required to attain a significant and competent knowledge of the hard sciences and even the soft sciences (biology, nutrition, physiology, etc..), credibility will suffer whether we regulate or not. [H]

Others de-emphasized the importance of biomedical scientific training in the professional development of competent homeopaths:

I think regulation is good in that, only those homeopaths who have been properly trained will be permitted to practice. I don't think, however, that rigorous training in the health sciences is necessary to be a good homeopath. [H]

Overall, such comments illustrated a clear lack of consensus on this issue, and worry within disparate homeopathic ‘camps’ as to how the standards would eventually emerge to determine what - or who - would be included. Several respondents feared that those representing a more “classical, Hahnemannian homeopathy” [H] would not get their voices heard in this regard, perceiving that the regulatory process had thus far been dominated by “a minority of homeopaths” [H].

A number of homeopaths also raised concern that the standards proposed for ‘grandparenting’ long-standing practitioners under the new regulations might inappropriately exclude those practising part-time and in rural areas, new graduates, and practitioners with overseas training:

[T]he number of hours proposed as a minimum to qualify for registration are unrealistically high and not reflective of the difficulties of introducing this unknown form of medicine to the public - particularly in semi-rural and rural areas. [H]

...the drafts as prepared to date... will likely preclude the possibility of the majority of recent homeopathic graduates from becoming registered. [H]

I am concerned if I will be accepted by the Act because I studied in South Africa. [H]
Chinese medicine practitioners

Some Chinese medicine practitioners, by contrast, worried that the standards had been too-narrowly set, excluding those practising East Asian varieties of traditional acupuncture falling outside of the Chinese tradition:

My understanding is that [the regulation] focuses only on the Chinese tradition which is a mistake. It should include all Qi-based medicine and specialties like Korean and Japanese acupuncture. [CM]

Others worried that those who had been trained via apprenticeship or family lineage, which one respondent termed “the special path of studying TCM and acupuncture” [CM] might not be eligible for registration. Also raised were the potential challenges long-standing practitioners might face in collecting documentation of their training for the grandparented registration process:

Asking for transcripts or study reports may [create] great difficulties for those old practitioners, for these schools, or professors may not exist anymore [sic]. [CM]

A small number of respondents opposed the grandparented registration process outright, arguing that all registrants should be required to

[W]rite an exam in order to have a legal license!…no Grandfather law. [CM]

However, Chinese medicine practitioners’ most pronounced concern around grandparented registration pertained to the issue of language. Numerous practitioners asserted that the regulations should permit practitioners not only to conduct their clinical practices in a Chinese language, but also to complete registration examinations and keep patient records exclusively in Chinese. Several respondents raised significant alarm that they might be excluded from registration if the regulations enforced English (or French) as the profession’s primary language. For some individuals, such concerns had entirely dissuaded them for supporting the regulations as currently proposed:
Current legislation is biased towards eliminating TCM doctors, ousting TCM doctors. I oppose. Was taught TCM by grandfather. I don’t know English. Grandfathered regulation requires English testing. I am on the verge of being eliminated. [CM]

The potential compromise that the new regulations posed in terms of occupationally-specific values - whether cultural or otherwise - was an issue raised by practitioners across the three surveyed groups.

**Compromise to occupational paradigm**

A subgroup of respondents from across all three groups expressed concern that the regulatory changes threatened to compromise their respective occupations’ underlying paradigmatic foundations, despite the changes being perceived as positive in other respects. Within the Chinese medicine and homeopathy groups, practitioners expressed concern that their paradigmatically-distinct practices were being forced into a regulatory structure designed to accommodate professions more fundamentally rooted in biomedicine:

We should not try to ‘fit homeopathy’ into a set of regulations designed for other professions. [H]

Regulation of TCM/acupuncture should be based on TCM/acupuncture’s unique Chinese medical nuances. It should not blindly follow the regulatory methods of Western medicine. [CM]

Several homeopathic respondents expressed concern that under the new regulations, their profession would become “more medical and less homeopathic” [H], thereby compromising the “spirit of homeopathy” [H]. Similarly, a number of naturopaths characterized the regulatory changes as part of a trend “moving away from our true purpose as nature doctors” [N], and “treating more like Green MDs” [N]. They described a shift within naturopathy away from a “drugless therapy” [N] scope of practice to “more of an allopathic medical scope of practice” [N], which emphasized “treating the disease, instead of the individual” [N]. According to some
practitioners, such shifts in naturopathy’s focus were arising from a regrettable “need for approval from the conventional medical world” [N].

Within the Chinese medicine group, several respondents expressed concern that regulators were not adequately taking into account factors related to “culture and tradition” [CM], ultimately threatening to erode the occupation’s paradigmatic foundations, and with it the quality of Chinese medicine care. These effects would, they argued, detrimentally impact patients, especially people of East Asian origin using Chinese medicine as their predominant form of health care. For example:

[Decision makers] don't know this professional field so their decisions cannot reflect real TCM [traditional Chinese medicine] practitioners’ thought and practice. If this regulation is passed it will definitely kill TCM's long-term practice in Ontario. The public who heavily depend on Chinese medicine will suffer. [CM]

It is clear that respondents from across all three occupational groups - naturopaths, homeopaths and Chinese medicine practitioners - expressed multiple ‘worries’ about the way in which Ontario’s new regulations governing their work would be implemented. Some concerns reflected fundamental issues relating to each group’s underlying worldview and core practices; others pertained to more immediate financial or administrative concerns. It is important to note that for the majority of practitioners surveyed, such ‘worries’ appeared notably secondary to an overarching spirit of support for Ontario’s new regulations governing each of them. Nevertheless, the expressed ‘worries’ do warrant careful consideration in relation to the broader global issues surrounding regulation of traditional, complementary and alternative medicine (TCAM) practitioner groups.

**Discussion**

In several ways, practitioners’ accounts of moving towards regulatory inclusion in this study appear to describe a less idealized experience than many might have hoped, echoing previous studies pointing to the tradeoffs inherent in TCAM groups’ professionalization projects (Cant and Sharma, 1995, Gilmour et al., 2002, Baer, 2010). Some respondents’ concerns that
regulation might compromise their occupations’ paradigmatic foundations are not new: the threats of occupational co-optation within a biomedically-dominant health care system (in which institutionalized training is highly valued) have been extensively discussed (Cant and Sharma, 1995, Adams et al., 2009, Baer, 2010, Hollenberg and Muzzin, 2010). Whereas some recent studies suggest that institutionalization of some TCAM practitioner trainings may permit considerable inclusion of holistic philosophical content at odds with biomedical epistemologies (Brosnan, 2015, Wardle et al., 2012), other work has noted that institutionalization tends to promote increased biomedicalization of TCAM training (van Teiklingen, 2000, Flesh, 2013). Regardless, another potential challenge for TCAM practitioners to face is that any regulatory process designed to implement stringent registration standards will necessarily exclude some applicants. However, the varied ‘worries’ raised in our study appear in several ways to move beyond such previously reported issues.

Of particular relevance in our findings are practitioner fears about unjust exclusion of specific practitioner subgroups, whether part-time or foreign-trained practitioners, immigrants, those lacking English fluency, or those trained through traditional apprenticeship. The professions literature does indeed document inequities inherent in many regulatory bodies’ registration practices (Ngo and Este, 2006, Sakamoto et al., 2010), and it remains to be seen how effectively Ontario’s TCAM professional regulatory bodies are able to first define, and subsequently implement, fair registration practices. As Ontario’s provincial Fairness Commissioner - a government body responsible for ensuring equitable registration requirements across the health professions - has noted, regulation of professions like homeopathy and Chinese medicine, ‘that have their roots in traditional ways of knowing,’ raises unique challenges from a regulatory equity perspective (Office of the Fairness Commissioner, 2012). In particular, the issue of regulatory grandparenting strategies - a commonly engaged short-term strategy for bringing long-standing practitioners under the auspices of a new professional regulatory structure (Aldridge, 2008) - may warrant significant additional research in relation to TCAM practitioners groups. Indeed, while some studies have described the details of grandparenting strategies for TCAM practitioner groups (Dixon et al., 2007, Aldridge, 2008, Zhou et al., 2012), little sociological analysis has been applied to such approaches.

In addition to such equity-related points, our findings highlight the significant internal diversity characterizing particular TCAM occupational groups, in which distinct subgroups may hold
notably different views about regulation and its implementation, as well – in particular – as appropriate educational standards. Although such internal diversity has been previously pointed out (Cant and Sharma, 1995, Villanueva-Russell, 2011, Welsh et al., 2004), its dimensions and implications within and across various TCAM practitioner groups may warrant further scholarly exploration.

Moving to the distinct ways in which each occupational group framed its particular ‘worries’ about regulation, it is possible that such distinctions may have been influenced by each group’s stage of professionalization at the time when they were granted regulatory status. As we noted in our earlier study of the same occupations, naturopaths represented the most advanced stage of professionalization of the three groups, having previously established clear, cross-jurisdictional standards and a distinct professional identity. That naturopaths surveyed in the current study articulated few standards-related concerns but focused instead on achieving a broad regulatory practice scope on par with other North American jurisdictions is thus not surprising.

Chinese medicine practitioners, whom we characterized in our 2004 study as internally fragmented over the degree of biomedical sciences that should be included in occupational standards, appeared to have since moved beyond this concern as a community, instead focusing on a more nuanced set of tensions between acupuncture as a clinical practice, and the importance of Chinese medicine’s cultural/historical dimensions. This focus is reflected in practitioner concerns around language proficiency requirements, recognition of practitioners trained by apprenticeship, and the question of ‘which’ East Asian acupuncture styles should be explicitly validated in Ontario's regulations. These issues – which our research team is currently investigating further – raise a number of complex regulatory questions which may be unique to traditional medicine occupational groups, for whom both clinical and cultural concerns may hold parallel importance. As several survey respondents suggest, the question of regulatory English proficiency requirements may not, for instance, be adequately addressed as a public safety issue alone, but appears to raise a range of complex historical and cultural dimensions related to preserving the traditional East Asian medicine system’s roots within a western liberal democratic regulatory structure.

Homeopaths, who in our previous study were the smallest and least organized of the three groups, and arguably the least ‘ready’ for regulation, continued to struggle internally over the
issue of biomedical scientific training even as Ontario granted them self-regulatory status: a concern which had similarly dominated our earlier discussions with community leaders. It is perhaps self-evident that biomedicine is currently the ‘lingua franca’ in widespread usage between regulated health professions, and that TCAM professions’ adoption of biomedical language and perspectives may indeed facilitate their participation in mainstream health care systems. However, as Hollenberg and Muzzin have pointed out (Hollenberg and Muzzin, 2010), the increased biomedicalization of TCAM professions is neither socially nor politically neutral, but may better be understood within the related historical contexts of increased biomedical dominance in health care worldwide. As such, the process of TCAM professions ‘integrating’ into mainstream health care necessarily raises complex questions of power; and TCAM groups’ concerns that they may be losing their core identities in a process of ‘enforced assimilation’ should be further investigated in this light. Furthermore, it is worth noting that some TCAM occupations (e.g. naturopathy, chiropractic) appear to have more enthusiastically adopted biomedical theory and terminology as essential to implementation of their therapeutic systems than have others (e.g. Chinese medicine, homeopathy, Ayurveda), which may have considerable sociological and political consequences. As Hollenberg and Muzzin (2010: 53) have observed, some TCAM groups’ propensity to biomedicalize may result in a further ‘co-opt[ation], marginalis[ation], appropriate[ion], and/or assimilate[ion]’ of these health care approaches into an expanded biomedical hegemony. Alternately, or concurrently, it may permit these groups’ to expediate a process of sociopolitical legitimation.

Homeopaths’ and Chinese medicine practitioners’ concerns around having to ‘share’ some of their key clinical practices with other professions had not appeared in our earlier studies. These concerns may have simply reflected some practitioners’ poor understanding of Ontario’s health professions regulatory structure, which governs ‘controlled acts’ but does not authorize exclusive practice scopes. This in itself is an important issue, emphasizing a potential challenge regulators may face in effectively communicating with TCAM practitioners through a regulatory process. It is unclear whether such communication challenges are similar to those otherwise faced by government bodies in other pursuits, or if there are more TCAM-specific issues at play in this regard. However, more broadly contextualized, the concerns raised by members of both of these occupational groups about overlapping practice scopes may also speak to larger trends at play in the field of TCAM professional regulation.
For example, some Ontario Chinese medicine practitioners’ concern that under the new regulations they would continue to ‘share acupuncture’ with other professions significantly echoes ongoing professional turf battles over acupuncture across the non-East Asian world (Chiu, 2005). In the United States, for example, two recent court cases launched by traditional East Asian medicine practitioners in the states of Oregon (Court of Appeals of the State of Oregon, 2014) and Washington (Griffin, 2014), have ruled that chiropractors and physiotherapists, respectively, may no longer engage in acupuncture-like ‘needling’ practices within their scopes. Although these states’ regulatory structures are certainly different from Ontario’s in that they employ licensure models with exclusive practice scopes, it remains noteworthy that such inter-occupational turf battles over acupuncture are increasingly common.

Elsewhere, in Australia, where Chinese medicine practitioners have recently been granted the protected title of ‘acupuncturist’ and exclusive professional authority to describe their work as ‘acupuncture’, the act of inserting thin needles for therapeutic purposes remains in the public domain, that is, not exclusive to this occupational group. As such, members of several other professions have ‘rebranded’ their needling activities using such nomenclature as ‘dry needling’ and ‘intramuscular stimulation’ (Janz and Adams, 2011), raising the ire of East Asian acupuncturists. Although an Australian regulatory impact analysis had previously determined that limiting acupuncture practice to East Asian medicine practitioners was unlikely to produce public benefit (Australian Health Workforce Ministerial Council, 2009), an early Ontario analysis of similar issues (which was later abandoned) had reached considerably different conclusions (HPRAC, 1996). Aside from the vital question of public safety in this regard, there are several additional dimensions warranting consideration in this regard. For instance, various occupations will not only occupy distinct positions within an inter-professional hierarchy / ecology (Abbott, 2005, Abbott, 1988), but will also approach a particular practice (such as acupuncture) from distinct epistemological foundations.

Of similar interest is the concern raised by several homeopaths that they would be sharing the practice scope of homeopathy with Ontario’s naturopaths. To be clear, the practice of recommending homeopathic remedies has not been designated as a ‘controlled act’ under Ontario’s Regulated Health Professions Act. As such, the practice remains in public domain; and no limitations exist in Canada on the sale of homeopathic remedies themselves, as long as they meet the country’s federal requirements governing natural health products. Regardless, what is
poignant in some homeopaths’ accounts is a perception that the new regulations may secure for the homeopathic group a subordinate sociopolitical position in relation to the naturopathic profession. Indeed, the regulations will at once permit both naturopaths and homeopaths to ‘practice homeopathy’ within their professional scopes, while requiring less homeopathy-specific training for naturopaths, and granting the coveted ‘doctor title’ to naturopaths and not homeopaths, the apparent ‘homeopathy experts’. Two points are significant in this regard.

First, in terms of regulatory structures, these claims raise questions about what constitutes competency in relation to Ontario’s ‘overlapping-scopes’ regulatory structure. This question, which arose both in relation to ‘homeopathic scope’ and with regards ‘acupuncture scope’ across various professions in our study, is important from a policy perspective. Indeed, an overlapping-scopes regulatory model has been increasingly adopted across Canadian jurisdictions, but little research has explored the nuances of its implementation or impacts since O’Reilly’s pioneering study describing the model’s emergence in Ontario (O’Reilly, 1999). Furthermore, interest in adopting overlapping-scopes regulatory models has been growing in the United States since the publication of the 1995 Pew Report on Reforming Health Care Regulation (Ameringer, 2002). The Pew Report recommended phasing out regulatory structures based on exclusive practice scopes which promote professional monopolies that ‘unnecessarily restrict other professions from providing competent, effective and accessible care’ (Pew Health Professions Commission, 1995).

If overlapping-scopes regulatory models are to become more normative in North America, it may become important for regulators to engage more directly with clear criteria for what constitutes competent or effective care for specific practices. Such engagement may present several challenges. Within a self-regulatory context such as Ontario’s, it is typically professions themselves – rather than the state – which establish training standards. Moreover, even outside of a self-regulatory context, any state engagement with standards would likely require considerable input from those with expertise in the relevant fields – namely members of the scope-overlapping professions themselves. The challenge of balancing each profession’s self-interest with the range of public interests through this process may require considerable negotiation. This may be particularly challenging in regulating TCAM professions and practices within biomedically-dominant regulatory frameworks, as high quality scientific evidence for TCAM therapies is in some cases just emerging; and because some practitioner groups may draw in varying degrees on
non-biomedical evidentiary paradigms. Governments may consider adopting the World Health Organization’s educational standards guidelines for various TCAM practices to assist in this type of groundbreaking regulatory work.

The second point of interest around the homeopathy/naturopathy tension suggested in some respondents’ comments in our study is the issue of inter-professional stratification under a regulatory model that was originally intended to ‘level the playing field’ between professions, rather than fortify additional hierarchies between them (O'Reilly, 1999). The sociological professions literature has detailed the subordination of TCAM practitioner groups in relation to biomedical physicians (Cant and Sharma, 1995, Kelner et al., 2004a, Wiese and Oster, 2010), but to date little work has addressed the unequal power relations that may be emerging between TCAM groups as they move to professionalize.

Conclusions
In conclusion, the current study raises several key theoretical and practical points while providing a unique snapshot of practitioner perspectives across three distinct TCAM professions as they pass through a long-awaited transition into state-regulated status. The advantage of our study’s census survey model is that it offered a broad cross-section of respondents with an opportunity to contribute their perspectives. Having undertaken an extensive process to gather practitioner names and contact information across multiple media, our search was quite comprehensive. Nevertheless, some practitioners may have been inadvertently missed. That said, the broad range of perspectives exposed through inductive analysis of participants’ responses to an open-ended question in a predominantly quantitative survey (quantitative findings discussed elsewhere) represent an important series of insights, which may not have otherwise been exposed (Rich et al., 2013), thus highlighting the potential scholarly value of a rigorous, mixed-methods approach.

Regardless, this work does have limitations. Some respondents’ opinions, for instance, may have been based on incorrect information either about Ontario’s regulatory structure, about the details of their occupation’s regulatory process, or both. We furthermore recognize the limitations of collecting robust qualitative data using a survey format as compared, for example, to conducting in-depth interviews, which invariably provide more detailed information with greater nuance.
Regardless, that so many survey respondents gave lengthy and detailed written comments in response to a single qualitative question posed in a predominantly quantitative survey, suggested a high level of practitioner engagement in the regulatory project, which we considered significant.

It remains to be seen to what degree the diverse ‘worries’ described by Ontario homeopaths, naturopaths and Chinese medicine practitioners experiencing an important milestone in their professional projects shall endure as the regulations take effect; or whether such concerns more simply reflect the inevitable transitional discomforts that may be expected to accompany the impacts of a significant regulatory change. We will continue to follow these issues as these groups evolve into established regulated professionals in the province of Ontario. In the interim, it is our hope that the perspectives explored in this work may help to illuminate the internal struggles faced globally by TCAM practitioner groups passing through regulatory transitions, and to inform further investigation around how such regulations may be more effectively and seamlessly implemented, in the public interest, across nations.
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Chapter 3

State Risk Discourse and the Regulatory Preservation of Traditional Medicine Knowledge: The Case of Acupuncture in Ontario, Canada

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For this chapter, I conducted the analysis, conceptualized the text, and drafted the full manuscript. The co-authors provided valuable feedback in their roles as members of my PhD dissertation committee.

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Abstract

Several United Nations bodies have advised countries to actively preserve Traditional Medicine (TM) knowledge and prevent its misappropriation in regulatory structures. To help advance decision-making around this complex regulatory issue, we examine the relationship between risk discourse, epistemology and policy. This study presents a critical, postcolonial analysis of divergent risk discourses elaborated in two contrasting Ontario (Canada) government reports preceding that jurisdiction’s regulation of acupuncture, the world’s most widely practised TM therapy. The earlier (1996) report, produced when Ontario’s regulatory lobby was largely comprised of Chinese medicine practitioners, presents a risk discourse inclusive of biomedical and TM knowledge claims, emphasizing the principle of regulatory ‘equity’ as well as historical and sociocultural considerations. Reflecting the interests of an increasingly biomedical practitioner lobby, the later (2001) report uses implicit discursive means to exclusively privilege Western scientific perspectives on risk. This report’s policy recommendations, we argue, suggest misappropriation of TM knowledge. We advise regulators to consider equitable adaptations to existing policy structures, and to explicitly include TM evidentiary perspectives in their pre-regulatory assessments.
Traditional medicine (TM) systems, such as Chinese medicine and India’s Ayurveda, are based in Indigenous knowledge systems. In 2013, the World Health Organization (WHO) called on nations to regulate TM, with the aim of enhancing “safety, quality and effectiveness” of health care across the many nations where TM remains in widespread usage (WHO 2014: 7). Policy makers are faced with the unique challenge of incorporating such practices within health professional regulatory models typically designed to govern biomedically-trained occupational groups. In our era of ‘evidence-based’ decision-making - which typically privileges Western scientific knowledge - how may regulators contend with evidentiary perspectives from within TM systems? This question gains gravity in light of a recent United Nations (UN) recommendation directing nations to implement policies protecting traditional knowledge (WHO et al., 2013).

The significance of Indigenous medical practices (e.g., acupuncture) and remedies (e.g., herbal medicines), go well beyond the technicalities of their performance. These practices carry profound cultural significance within their communities of origin, a point recognized by the United Nations Educational, Scientific and Cultural Organization (UNESCO), which in 2010 positioned Chinese medicine’s acupuncture on its Representative List of the Intangible Cultural Heritage of Humanity (UNESCO, 2010). Furthermore, as Janes (1999: 1805) asserts, the Indigenous “epistemological tenets” that shape diagnosis and TM therapy usage represent critical alternative models for resolving health crises on a global scale where biomedical and technological solutions fall increasingly short. The preservation of TM products and practices within their Indigenous epistemic frameworks thus carries multilayered significance.

Even within their nations and cultures of origin, Janes (1999:1808) observes that, “indigenous medical systems appear suspended in a web of countervailing powers and influences”. Foremost among these, Janes (1999:1808) explains, are Western scientific pressures, compelling “rationalization of traditional medicine along biomedical lines”. This is evident, for instance, with respect to acupuncture, an Indigenous East Asian medical practice in use today across 80 percent of nations (WHO, 2001) and regulated in 29 countries (WHO, 2014). Traditional acupuncture’s “living and social context” (WHO et al., 2013: 92) have long been preserved via family lineages, apprenticeship-style training and study of Chinese medical classics such as the *Huang Di Nei Jing* (Ni, 1995). However, as Flesh (2013) notes, traditional acupuncture training programs have become increasingly institutionalized and biomedical in approach and content.
In recent decades, a subset of practitioners from particular biomedically-trained professions have begun to practice acupuncture as an adjunct therapy to their existing practice scopes (e.g., Janz and Adams, 2011). (In the United States, for example, chiropractic regulatory bodies in thirty-three states have explicitly permitted their members to use the practice (ABCA, 2016).) Over the same period, biomedical researchers have substantiated acupuncture’s clinical efficacy for a range of conditions. In 1999, the WHO proposed training guidelines for acupuncture practitioners across professions, recommending that their education include some degree of Chinese medicine content (WHO, 1999). This strategy might, if enforced by regulators, have helped stabilize acupuncture’s global position as a health care practice rooted in a TM conceptual model. Instead, across the globe, the practice - and regulation - of acupuncture from within a biomedical epistemic framework is on the rise (Kohut et al., 2011).

Several East Asian nations - including China, Japan, Singapore and Korea - have governed acupuncture within the framework of those nations’ respective regulated TM systems (Schroeder, 2002, NZMOH, 2011), legally entrenching the practice in its Indigenous epistemology. However, regulations in several other jurisdictions reflect the globalized trend towards acupuncture’s biomedicalization. For example, in Germany (Birch, 2007), France (Ramsey, 1999) and Argentina (Freidin, 2007), it is exclusively medical doctors who may legally perform acupuncture. In several English-language dominant states characterized by considerable ethnocultural diversity, and high levels of immigration (including Canada, the United States and Australia) (Gozdecka et al., 2014) governments have simultaneously regulated acupuncturists working within traditional East Asian frameworks, while permitting a range of biomedical professionals to perform the practice (AAAOM, 2001, Janz and Adams, 2011).

The case of Ontario, Canada presents a striking example of such a regulatory model. There, Chinese medicine practitioners and nine biomedically-trained professions, were authorized in 2013 to perform acupuncture within their scopes of practice. Ontario’s provincial acupuncture regulations are unusual both inter- and intra-jurisdictionally. Within the province of Ontario, Traditional Chinese Medicine (TCM) is the first TM profession to have been granted statutory regulation; although the province has also regulated other ‘complementary’ therapy professions (including chiropractic, naturopathy and homeopathy). Acupuncture moreover represents the only TM therapy to have been explicitly included under the province’s list of restricted health care acts. Globally speaking, Ontario’s acupuncture regulations are distinct in their explicit
inclusion of acupuncture within the practice scopes of such a large number of professions.

Further at odds with other jurisdictions using hybrid regulatory models to regulate TM practices, Ontario’s regulations explicitly divorce acupuncture from its Indigenous epistemic framework. These distinct features of Ontario’s acupuncture regulatory structure capture the current tensions regarding regulation and the protection of traditional knowledge.

As Hollenberg and Muzzin (2010) have noted, the regulatory separation of acupuncture from its Chinese medicine roots exemplifies cultural misappropriation (a postcolonial theoretical concept). ‘Misappropriation’ occurs when particular cultural components are extracted and decontextualized from their broader cultural frameworks, typically by cultural outsiders, unsanctioned by the source community, thus causing harm (Brown, 2005). Prevention of misappropriation is a key component of UN recommendations surrounding traditional knowledge protection (WHO et al., 2013), and represents an equity-driven regulatory approach within the increasingly pluralistic context of health care worldwide.

Equity, a principle concerned with producing fair outcomes for diverse parties (Arnaud, 2001, Stone, 2012), has been increasingly characterized as an important driving principle in producing socially-just state policies around non-biomedical healing systems and practices (Baer, 1989, Khan, 2006, Marian, 2007, Prasad, 2007). Equity as a policy-driving principle contrasts starkly with the notion of ‘equality’, the premise that distinct groups should be treated equivalently, that is, in the same way. Equity-informed approaches, by contrast, permit flexibility, non-equivalence and innovation in crafting regulatory approaches to redress injustices arising from broader contextual conditions (Arnaud, 2001, Stone, 2012).

With the aim of exploring equity-informed policy approaches that actively prevent misappropriation of TM knowledges, we report on a critical discourse analysis of two Ontario government reports, completed in 1996 and 2001 respectively, on the subject of acupuncture regulation. The 2001 report’s recommendations provided the key conceptual parameters around which Ontario’s acupuncture regulations were ultimately crafted. The recommendations in the 1996 report, whose conceptual approach we find more protective of TM knowledge - were largely discarded by regulators. Critically engaging the notion of risk discourse within a postcolonial theoretical framework, we illustrate how each report engages with distinct evidence types, producing contrasting risk discourses – and in turn, divergent policy recommendations.
Our findings thus draw attention to the mechanics by which state actors may deploy risk discourses in ways that either protect, or may lead to policies that create the possibility for misappropriation of TM knowledge in a regulatory process.

**Epistemology, Risk Discourse and TM Regulation**

Regulators across the globe commonly justify policy decisions with reference to the ‘public interest’ principle (Baggott, 2002, Saks, 1995). As regards health professional regulation, public safety – along with the principle of health care quality - is widely characterized as an important public interest consideration (Baggott, 2002). It is uncontestable that some degree of potential risk (e.g., lung puncture) will accompany delivery of acupuncture (Janz and Adams, 2011).

However, governments in different jurisdictions have produced distinct risk characterizations for the practice, resulting in divergent policy approaches.

The Danish government, for example, deregulated acupuncture (previously authorized exclusively to medical doctors) in 2007 on the basis that it “was considered non-harmful” (Rittig-Rasmussen, 2011: 114). 2001 regulations restricting use of the term ‘acupuncture’ to Chinese medicine practitioners in the Australian state of Victoria, were by contrast, justified on ‘safety’ grounds. Notably, the practice of acupuncture remained in the public domain under this regulatory scheme, enabling a range of providers with little training to continue performing it using alternate terminology (e.g., dry needling). (Janz and Adams, 2011)

Risk, as these examples suggest, is not a politically neutral concept. Risk assessment may be undertaken from various epistemic stances, taking into consideration distinct types of ‘evidence’ (Gostin, 2008, Wilson and Keelan, 2013). Two primary epistemic approaches to policy-related risk assessment have been characterized (using various terminology) in the literature. We propose use of the terms ‘technical’ and ‘contextual’ to characterize these two approaches. What we term ‘technical’ risk assessments are those underpinned by a view of “scientific knowledge as composed of objective facts” (Bradbury, 1989: 381), primarily employing quantitative risk evaluation measures (Weinberg, 1972). ‘Contextual’ risk assessments, by contrast, incorporate a broad range of quantitative and qualitative, as well as sociocultural and ethical factors; and frequently make explicit the underlying values engaged in the use of various evidence types (Bradbury, 1989, Dake, 1992, Lupton, 1993).
Various actors engaged in policy processes may construct strategic, risk-informed discourses to substantiate particular political and market-related aims (Dake, 1992, Lupton, 1993, Wynne, 1980). O’Neill (1994) has pointed to biomedical professionals’ strategic risk discourse construction surrounding once-marginal health care practices (such as acupuncture), as they increasingly seek regulatory jurisdiction over such practices. Such strategic discourses, O’Neill notes, gain in political strength as biomedical evidence surrounding these practices progressively emerges. However, we are unaware of studies to date that engage either with the question of risk discourse construction or traditional knowledge preservation through a TM professional regulatory process. These are the primary objectives of this paper. This work is also a contextual precursor to our broader study of Ontario’s implemented acupuncture regulations (forthcoming), a core portion of which involves development of a normative, TM-specific ‘public interest’ conceptualization.

Methods

We undertake a critical analysis of ‘risk’-informed discourses in two contrasting Ontario government reports preceding implementation of the Province’s 2006 acupuncture regulations. Examining these risk discourses within a postcolonial framework (detailed below), our analysis exposes, contrasts and unpacks the two reports’ risk discourses and their broader implications for TM regulation across jurisdictions.

Analysis of the two reports was performed primarily by the first author as part of a larger PhD study of Ontario’s acupuncture regulations, informed by her training in East Asian medical theory as well as critical qualitative methodologies. It was reviewed and corroborated by the other authors, long-standing scholars in the field of traditional and complementary health professional regulation. The third author, whose postcolonial theoretical work in this field informs the current analysis, provided key insights to deepen our comparative analysis.

Methodologically, we situate this work within the parameters of critical discourse analysis (CDA), examining the content and form of texts to expose the broader sociopolitical context and implications of specific linguistic usage (Fairclough, 1992, Bacchi, 2009). An ‘intertextual’ approach to CDA –which we engage in this study - may draw upon external ‘texts’ to better contextualize particular discourses (Fairclough, 1992).
More specifically, we engage Bacchi’s CDA approach (2009), which aims to illuminate the epistemic underpinnings, origins, and benefactors of particular policy-related discourses. Bacchi’s analytic method interrogates: a) the representation of a particular ‘problem’ in a specific policy approach; b) the assumptions and historical origins underlying this representation; c) silences and gaps implicit in the representation; d) the representation’s potential sociopolitical impacts; and e) ways in which the representation may be secured, reproduced, contested or replaced (Bacchi, 2009, Pereira, 2014).

Our analysis of the two reports unfolded in several phases. First, we coded the text of each report systematically, searching for passages pertaining to acupuncture’s risk profile. Then, using Bacchi’s approach as a guide, and in line with our articulated theoretical parameters (elaborated below), we used an intertextual and comparative approach to examine the identified report excerpts in relation to the preservation of traditional knowledge and the concept of misappropriation.

**Postcolonial theory**

Aimed at transforming inequities arising from European colonialism, postcolonial theoretical approaches contest the ‘superiority’ of Eurocentric worldviews in relation to those of historically colonized peoples, and centralize the voices, histories and knowledge systems of the colonized (Battiste, 2005, Loomba, 1998). In light of TM’s historical subordination to biomedicine worldwide as an integral component of European colonization (Harding, 1998), postcolonial theoretical models provide a suitable, equity-informed lens for the study of TM systems and practices. Postcolonial theories have been previously applied to studies of TM occupational groups (see Gale, 2014), and they align well with United Nations directives (WHO et al., 2013) to prevent further misappropriation of TM knowledge. Our analysis relies specifically on Hollenberg and Muzzin’s (2010: 48) theoretical concept of “paradigm appropriation”, in which biomedicine appropriates certain aspects from other healing systems or traditions without fully acknowledging the paradigmatic worldview from which the particular treatment aspect was taken.

For clarity’s sake, we note that hybridity, characterized by cultural ‘integration’ between colonizer and colonized, may represent another important postcolonial theoretical concept (Loomba, 1998) relevant to TM-related policy issues (Gale, 2014). As we intend to discuss
elsewhere, we recognize that not all hybrid ‘mixings’ of biomedical and TM knowledge, are equally problematic from an equity-informed perspective. It is misappropriated TM knowledges, as conceptualized by Hollenberg and Muzzin’s theorizing, that are a particular focus in this work.

**Context**

The province of Ontario, Canada is characterized by considerable ethno-cultural diversity. Twelve percent of the population in Toronto, Ontario’s primary urban centre, report Chinese as their ethnicity (City of Toronto, 2013), which rises to 38% in some suburban areas surrounding the city (City of Markham, 2011). In addition, a recent population-based survey reported 12% of Canada’s general population to have consulted a ‘complementary and alternative medicine’ practitioner in the twelve months prior, 18% of whom claimed to have received acupuncture (Metcalfe et al, 2010). It is in this broad context that Ontario recently regulated acupuncture and the profession of Chinese medicine. In what follows, we provide relevant background about the pre-regulatory reports under study, as well as the evidentiary and political climates of the time.

**Background on the reports under study**

In 2013, after years of lobbying from several practitioner groups, Ontario’s provincial government restricted acupuncture practice to a newly-regulated profession of Chinese medicine, and nine additional (biomedically-trained) health care professions. These regulatory changes were preceded by two formal government studies, published in report form in 1996 and 2001 respectively. These two reports, whose risk-informed discourses we analyse in this work, were prepared by Ontario’s Health Professions Regulatory Advisory Council (HPRAC), a government agency at arms-length with Ontario (Canada)’s provincial Ministry of Health. Guided by a set of ‘public interest’ principles – foremost among which is ‘protection of the public from harm’ – HPRAC’s mandate is to guide Ontario’s Health Minister on matters related to the provincial regulation of health professions (HPRAC, 2014). Made public in reports, HPRAC’s studies typically include a period of stakeholder consultation.

In 1984, during a health professions regulatory review that informed HPRAC’s formation,
dozens of occupational groups – including Chinese medicine practitioners - petitioned Ontario’s provincial government for self-regulatory status. At the time, the Province determined that acupuncture did not warrant regulation; the practice remained unregulated for another two decades. Ontario’s Health Minister’s 1994 request that HPRAC study the issue of acupuncture regulation followed formal requests for regulation from three acupuncture practitioner organizations in the Province. The resulting 1996 report recommended that Ontario formally define acupuncture as a Chinese medicine-based health care act; and that it also restrict its practice – on safety grounds – to regulated professionals. While the 1996 report recommended future regulation of Chinese medicine practitioners in the Province, it did not address this issue in detail. The report did, however, propose that the term acupuncture not be permitted to describe non-Chinese medicine based therapeutic ‘needling’; rather, biomedical professionals seeking to perform such ‘needling’ should be authorized to do so under a separate regulatory stipulation.

In 1997-98, HPRAC’s membership underwent a “complete turnover” (HPRAC, 2001a: i). Under the same elected government, a new provincial Health Minister requested in 1999 that HPRAC study the issue of Chinese medicine professional regulation. The Minister also requested additional advice from HPRAC on the issues surrounding acupuncture regulation, which the 1996 report had previously addressed. As in 1996, HPRAC’s 2001 report advised that acupuncture (and Chinese medicine) be regulated. However, in contrast to the 1996 report’s proposal, HPRAC recommended in 2001 that acupuncture’s regulatory definition be strictly physical (i.e. as a ‘procedure beneath the dermis’) rather than epistemic (i.e., as a Chinese medicine based practice). Following the 2001 report’s recommendations, the Ontario government passed legislation in 2006 – implemented in 2013 - to regulate Chinese medicine professionals, and remove acupuncture from the public domain.

Evidentiary landscape

When the Ontario government first considered acupuncture’s regulation in 1983, the body of biomedical evidence supporting the practice was in its infancy. In 1979, the World Health Organization (WHO) had published a ‘provisional’ list detailing 43 health disorders for which acupuncture might prove effective, emphasizing the need for high quality clinical trials (WHO,
1979). By 1999, mid-way between HPRAC’s two acupuncture reviews, the WHO had undertaken a new review of this evidence, finally published in 2003, detailing the results of 255 relevant trials (WHO, 2002). As we detail further on, the progressive emergence of this body of evidence might – in line with O’Neill’s (1994) theoretical observations - have fuelled biomedical occupational groups’ zeal to frame their pursuit of regulatory jurisdiction over acupuncture in Ontario in evidentiary terms. It may, furthermore, have played a role in guiding the political directives issued to HPRAC’s 2001 report team, by the province’s Minister of Health.

Political climate
Ontario’s Chinese medicine practitioners had begun, in the 1980s, an active political lobby towards acupuncture regulation. By the mid-1990s, they had been joined by a lobby of biomedical professionals performing acupuncture. The key biomedical stakeholders informing the 1996 report process were members of the Acupuncture Foundation of Canada, a group of Ontario acupuncture practitioners formed by a group of medical doctors in the 1970s. These doctors – later joined by a range of biomedical health professionals - had been trained in Chinese medicine based acupuncture; but biomedical theories around the practice’s mechanism of action increasingly informed their work. Despite this group’s professed practice of ‘anatomical’ acupuncture, their training programs included both biomedical and Chinese-medicine based courses. Not surprisingly, HPRAC’s 1996 report is clear that “there was considerable agreement among respondents that acupuncture is philosophically rooted in TCM.” (HPRAC, 1996: 10). It was in this epistemic climate that HPRAC’s 1996 report took shape.

By 2001, the body of biomedical evidence surrounding acupuncture had grown considerably. In this light, another subgroup of Ontario’s biomedical professionals arguably sought, as O’Neill (1994: 503) has theorized as occurring in similar circumstances, to “confin[e] acupuncture to established medical practitioners… promoting them as a safe alternative to the alternatives”. The Ontario Physiotherapy Association’s presentation to HPRAC, for instance, has been summarized as follows:

Acupuncture should be a controlled act because there is a risk of harm. …The [Ontario Physiotherapy Association] questions whether the regulation of TCM [traditional Chinese medicine] and acupuncture…would amount to endorsement of its efficacy. The major deficiency in the [TCM practitioners’] submissions is their failure to demonstrate the
efficacy of TCM to the scientific thresholds that are generally accepted in health care. (HPRAC, 2001b: 7)

Such views were echoed by others, such as the Ontario Podiatric Medical Association, whose representatives argued that “a lack of scientific evidence is problematic for TCM and acupuncture”, while themselves seeking regulatory jurisdiction over acupuncture (HPRAC, 2001b: 5).

It was not, however, stakeholder pressures alone – but also political pressures from the government - that shaped HPRAC’s later report. These are made evident in the Ontario Health Minister’s 1999 letter to HPRAC, leading to the 2001 report. This letter explicitly encouraged HPRAC to reconsider its 1996 recommendations in light of “developments in the research in support of acupuncture”; and “increased interest on the part of some regulated health professionals in using acupuncture as an adjunct to other forms of treatment” (HPRAC, 2001a: 3). The Minister thus appeared to signal that HPRAC should place greater weight than previously on the perspectives of a subgroup of biomedical acupuncturists who, empowered by increasing biomedical evidence of acupuncture’s efficacy, had – in an inter-occupational turf battle - expressed increasing hostility towards Chinese medicine knowledge. Each of these power relations appears to have played a key role in shaping the risk discourses and related policy recommendations that appeared in HPRAC’s 1996 and 2001 reports.

Results

In what follows, we review the linguistic and argumentative strategies engaged by HPRAC in developing its divergent 1996 and 2001 risk discourses surrounding acupuncture. At cursory glance, it would appear that the 1996 and 2001 HPRAC reports share a common analysis of acupuncture’s risk profile (as potentially harmful), and a common policy recommendation (that is, to regulate the practice in the province). However, closer examination of the discursive strategies engaged in each report reveals profoundly distinct epistemic underpinnings in each. These, in turn, give rise to contrasting policy recommendations, each substantiated largely on safety grounds.
Epistemic foundations: what is acupuncture?

HPRAC’s 2001 text accurately notes that “the most fundamental disagreement” between its recommendations and those presented in the 1996 report relate to their respective stances on “the essential nature of acupuncture” (HPRAC, 2001a: 19). Indeed, the two reports’ conflicting policy recommendations - informed by distinct risk discourses - are underpinned by a stark epistemic divergence.

Positioning acupuncture securely within its historical context, the 1996 report notes that acupuncture was “developed over thousands of years, in China”, and is “rooted in TCM [traditional Chinese medicine]” (HPRAC, 1996: ii-iii). The text further affirms that Chinese medicine’s theoretical parameters comprise an essential component of acupuncture:

> [I]n reality, acupuncture is about balancing Qi, or vital energy, i.e. it is not about “inserting acupuncture needles”. …acupuncture is much more than an activity or act, it is a whole different way of thinking and approaching health care. (HPRAC, 1996: 26)

Positioning biomedical acupuncture research in historical context, HPRAC’s 1996 report further validates Chinese medicine perspectives surrounding acupuncture:

> Western-based research has been conducted on acupuncture. …This research has provided an explanation of how or why acupuncture works only in a small number of cases [and so] …it is possible that acupuncture may never be completely explained in Western terms. (HPRAC, 1996: 17-18)

The 2001 report takes a markedly different stance on acupuncture’s essential character, framing it as a fundamentally physical practice, disassociated from its Chinese medicine roots:

> Regardless of its theoretical basis, acupuncture is principally a ‘procedure on tissue below the dermis’. (HPRAC, 2001a: 41)

As we now demonstrate, the 2001 definition, which presents itself as theoretically neutral, implicitly privileges a biomedical epistemic stance as to acupuncture’s defining attributes.

The 2001 report recognizes that acupuncture performed in a Chinese medicine context relies fundamentally on a Chinese medicine based diagnostic process:
TCM [traditional Chinese medicine]-based acupuncture does not have a body of knowledge that…can be separated from the TCM body of knowledge. (HPRAC, 2001a:10)

As the 2001 report furthermore acknowledges, Chinese medicine diagnosis rests firmly on ‘energetic’ theoretical principles - that is, on concepts that cannot be described in exclusively physical terms:

The [Chinese medicine diagnostic] process is a cognitive one, and the theoretical system may be internally consistent, but its components (e.g., meridians and Qi) are not physically observable [our emphasis]. (HPRAC, 2001a: 39)

It is clear, then, that an exclusively physical definition for acupuncture (as a ‘procedure beneath the dermis’) neither reflects nor includes Chinese medicine based perspectives surrounding the practice. Rather, this definition implicitly reproduces a biomedical epistemic construct of the human organism as an essentially physical entity (Marcum, 2008). The epistemic divergences underlying HPRAC’s 1996 and 2001 acupuncture definitions shape the two reports’ contrasting risk discourses.

**Evidence of direct harms**

With respect to safety, HPRAC’s 1996 and 2001 reports both characterize acupuncture as potentially presenting a significant risk of harm to the public, and propose regulation as an appropriate means of mitigating this risk. The reports further concur that the practice of acupuncture may pose a risk of “direct physical harm” (HPRAC, 1996: 20) to patients; and use similar language to describe such risks:

- broken, bent, or stuck needles
- injuries to internal organs
- risk of infection (HPRAC, 1996: 20)
- stuck, broken or bent needles
- traumatic injury to important organs
- transmitting infection (HPRAC, 2001a:12-13)

In support of this point, both reports cite English-language, biomedically-informed literature - more specifically, quantitative analyses of both case reports and practitioner surveys. The 2001 report, adopting a technical risk assessment approach, does so to the exclusion of other types of evidence (whether qualitative or rooted in TM knowledge). The 1996 report by contrast also cites two Chinese medicine textbooks to support this risk characterization. It thus positions Chinese medicine knowledge alongside biomedical knowledge as a valid form of evidence,
signaling adoption of a more contextual approach to risk assessment; and recognizing that acupuncture’s direct physical risks have long been understood in Chinese medicine.

**Indirect harm: a Chinese medicine concept**

Direct physical harm is not the only risk historically associated with acupuncture in the Chinese medicine tradition. As the two-thousand year old Chinese medicine classic, *Huang Di Nei Jing* (Yellow Emperor’s Classic of Medicine, or *Nei Jing*) affirms, skilled application of traditional diagnostic principles is considered critical to safe practice:

> By utilizing incorrect procedures, one can easily exacerbate a problem. If one does not understand these principles, and correctly remedy the cause of disease, the consequences can be devastating. (Ni, 1995: 188)

Poorly executed treatments, reflecting poor understanding of Chinese medicine’s theoretical principles, are furthermore considered a “violation of practice” (Ni, 1995: 192), potentially causing unnecessary harm to the patient. Notably, HPRAC’s 1996 report devotes considerable space to discussing such risks, which it characterizes as “indirect harm”. The 1996 report reads:

> Although there is no question that an untrained practitioner can cause direct physical harm while performing acupuncture…, there may be a number of consequences that constitute indirect harm to the patient. (HPRAC, 1996: 20-21)

Like the *Nei Jing*, HPRAC’s 1996 report characterizes “indirect” harm as “result[ing] largely from lack of adequate training” (HPRAC, 1996: 21). Examples of indirect harm provided in the 1996 report echo those described in the *Nei Jing*. For example, “masking symptoms” (HPRAC, 1996: 21) is traditionally considered to occur when the root cause of a disease, or (to use Chinese medical terminology, *ben*) is not appropriately addressed (Ni 1995). “Ineffective treatments” (HPRAC, 1996: 21) are seen as resulting from acupuncture in which the body’s *qi* is inappropriately directed along the bodily *meridians* (Ni 1995). “Aggravation of symptoms” is another form of acupuncture-related indirect harm discussed in HPRAC’s 1996 report (21), equally discussed in the *Nei Jing* (Ni 1995).

It is not, however, Chinese medicine texts that HPRAC’s 1996 report cites in support of its
“indirect harm” assertions. Rather, it indicates that it “learned” about this concept from stakeholder “participants” (HPRAC, 1996: 20). This further signals that HPRAC’s contextual risk assessment approach in 1996 not only integrates perspectives gleaned from biomedical and traditional medical texts, but also from stakeholder input. We find in our analysis that the 2001 report’s technical risk assessment approach, by contrast, validates stakeholder views only when they correspond with biomedical evidence; and, as shown below, discounts traditional knowledge perspectives, including those underpinning the concept of indirect harm.

Dismissal of traditional knowledge perspectives

As in 1996, the 2001 report explicitly describes stakeholders as having identified “a wide range of potential reactions and injuries” from acupuncture, including direct physical harms as well as more indirect risks including “aggravated symptoms…and improper technique” (HPRAC, 2001a: 12). Elsewhere, however, the 2001 report discursively invalidates the indirect harm concept. In the first step of a complex linguistic strategy, HPRAC appears to give credence to the principle of ‘indirect harm’:

HPRAC does recognize that there is a risk associated with basing acupuncture treatments on an improper assessment and diagnosis resulting in inappropriate treatment. (HPRAC, 2001a: 13)

The passage continues by strategically isolating indirect harm as relevant only to Chinese medicine practitioners. (Of note, these are the acupuncturists characterized in the 1996 report as less likely to inflict indirect harm, due to their extensive knowledge of Chinese medicine’s theoretical principles.)

This is, however, a separate issue and discussed in the context of the authorizing TCM practitioners a controlled act related to communicating a diagnosis. (HPRAC, 2001a: 13)

This interpretation is consistent with the 2001 report’s definition of acupuncture as atheoretical, relativistically characterizing a particular, TCM-rooted concept as relevant only to those practitioners who view TCM theory as instrumental to acupuncture’s practice. As the 2001 report proceeds, HPRAC appears to further discount the indirect harm principle, even with respect to its application within a Chinese medicine context. HPRAC writes:
HPRAC was not provided with evidence documenting the incidence of injury or other mishaps resulting from an inappropriate or incorrect TCM diagnosis [i.e. indirect harm]. A search of English language literature for studies specifically on the validity of TCM diagnostic approaches failed to produce articles. (HPRAC, 2001a: 27)

In this ‘technical’ discourse, HPRAC demonstrates its privileging of English-language, Western scientific ‘evidence’ over Chinese medicine knowledge; it further exemplifies the postcolonial theoretical concept of ‘paradigm appropriation’, characterized by:

knowledge devaluation and notions of superior European scientific knowledge as compared to non-European knowledges, where other knowledges only become acceptable when absorbed and employed by Euroscience. (Hollenberg and Muzzin, 2010: 49)

**Acupuncture vs. needle therapy: separate restricted practices?**

The two reports deploy their respective, contrasting risk discourses to substantiate divergent acupuncture regulatory proposals for implementation within the parameters of Ontario’s Regulated Health Professions Act (RHPA). The RHPA’s ‘controlled acts’ model removes particular health care acts from the public domain, authorizing their performance to specific regulated professions. Unlike regulatory models requiring exclusive practice scopes, Ontario’s RHPA permits overlap between different professions’ scopes. At the time of the two HPRAC report studies, acupuncture had been explicitly exempted from the RHPA’s controlled act #2 (“performing a procedure on tissue below the dermis”), leaving the practice in the public domain.

HPRAC’s 2001 report proposed that acupuncture be restricted under controlled act #2, to a range of regulated professions including Chinese medicine practitioners. Its 1996 report, by contrast, advised that such a model – which it had also considered – was “so attractive that it is deceiving”, and had “serious shortcomings” (HPRAC, 1996: 25) (described further on). The 1996 report recommended, instead, that a new controlled act be created to govern acupuncture practiced within a Chinese medicine framework. Professions seeking to practice outside of this framework, it proposed, should be authorized to perform “needling therapy” (but not “acupuncture”) under controlled act 2. We review, below, the risk-based argumentation used in each report to substantiate its respective regulatory proposals.
Risk and regulatory boundaries in HPRAC’s 1996 report

In preparing its regulatory argumentation, the 1996 report relies on the paired concepts of direct and indirect harm, but differentiates the regulatory requirements associated with mitigating each. On one hand, it points to similarities between acupuncture and venipuncture (e.g. for drawing blood or administering injections), arguing that the two practices share common risks of direct physical harm. Such risks, it argues, are relatively easy to manage:

The direct harms [associated with acupuncture] are also harms that are associated with some of the controlled acts currently regulated under the RHPA. For example, venipuncture. …The direct harms are quite straightforward and can be easily understood based on incompetent performance or lack of sterile technique. (HPRAC, 1996: 21)

Contending that indirect harm is by contrast “more subtle”, HPRAC (1996: 8) emphasizes that acupuncture requires additional regulatory parameters beyond those governing venipuncture, to ensure its safe practice. Such parameters, it argues, should address its assertion that inadequate harm “results largely from lack of adequate training”. Having defined acupuncture as essentially Chinese-medicine based, HPRAC (2001:7) proposes that training in acupuncture sufficient to prevent indirect harms ought to have a basis in Chinese medicine:

Professions that should be authorized to perform acupuncture [under a new, Chinese medicine based controlled act for acupuncture]…are those that can demonstrate sufficient training in acupuncture which includes a solid understanding of TCM theory. (HPRAC, 1996: iv)

Notably, the 1996 report does not suggest that only Chinese medicine professionals should be permitted to perform this new Chinese medicine based controlled act. Rather, it proposes that this jurisdiction be granted to any profession whose members met the World Health Organization’s articulated minimum training standards for acupuncture:

The minimum amount of TCM-based acupuncture training for a regulated health care professional should be at least 220 hours. (HPRAC 1996: iii)

However, HPRAC also makes clear that safety, as a public interest principle, is not the only factor informing its 1996 policy proposal, a point we take up next.
The public interest principle of equity

As noted earlier, public safety is foremost among the public interest principles driving HPRAC’s 1996 mandate. Moreover, HPRAC’s 1996 report refers at length to the public interest principle of ‘equity’ to substantiate its proposed policy approach. With respect to the principle of equity, HPRAC (1996: 4) summarizes its position as follows:

Equity requires that health care service providers be regulated in a manner that recognizes and respects the cultural underpinnings of the services they provide.

At the core of HPRAC’s equity-informed comments (1996: 4) are two key points. First is HPRAC’s recognition that Ontario’s health professional regulatory legislation, the RHPA, was “designed and built on western [biomedical] model of health care”. Second is HPRAC’s commitment to “accommodating forms of health care practice that are not based on the western medical model” under the RHPA. This, it argues, would permit the Province to “respond fairly and equitably” to residents’ diverse health care needs, as well as to benefit from diverse health care practitioner “skills and training”. Before discussing these points’ broader significance, we return to the 2001 report’s use of risk discourse to substantiate its contrasting policy recommendation: one which the 1996 report had argued did not adequately entrench equity-based principles.

Risk and regulatory boundaries in the 2001 report

On the basis of exclusively biomedical evidence, and a biomedicalized definition of acupuncture as an exclusively physical act, HPRAC’s 2001 report (20) divorces the notion of acupuncture-related risk from the theoretical parameters informing its practice:

[T]he risk of harm from acupuncture is rooted in it being a “procedure below the dermis” and that the risk is not related to whether acupuncture is TCM-based or anatomically-based.

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Based on these assumptions, HPRAC makes its proposal to govern all acupuncture practice under a single regulatory mechanism, in which “acupuncture should be part of the existing controlled act of performing a procedure on tissue below the dermis” (HPRAC, 2001a: 21). We interpret this proposal as paradigm appropriation, distinguished by the “separation of technique from healing paradigm” (Hollenberg and Muzzin, 2010: 49). Our analysis finds that the 2001 recommendations can neither be seen as protective of traditional knowledge, nor as favouring the principle of equity.

The 2001 HPRAC report does not explicitly cite public interest principles beyond safety to justify its policy proposal (as was done in 1996). However, the 2001 report’s text appears to implicitly be founded on the principle of regulatory ‘equality’ in its proposal to treat traditional and biomedical acupuncture as equivalent under the law.

The 2001 report’s implicit emphasis on regulatory ‘equality’ is also evident in its safety-based recommendations around training standards. Alongside its claims that “the relative safety of acupuncture is… linked with having well trained practitioners and promotion of clean needle technique”, it proposes that individual regulatory bodies governing acupuncture-practising professions “give due consideration to the competencies and training required for their members to perform acupuncture safely” (2001a: 12, 23). This proposal seems to rely on the implied premise that all professions should be ‘equally free’ to define standards relevant to their own distinct understanding and usage of acupuncture. From the 1996 report’s equity-based vantage point, however, this policy approach would likely fall short with respect to quality assurance and the protection of traditional knowledge:

There will be no way to ensure that standards of practice or consistent content and depth in education and training programs necessary to safely perform TCM-based acupuncture will be in place or enforced. …[T]here would be no assurance of maintaining or even recognizing the historical and cultural origins of acupuncture. …Any needle insertion under any model could be considered acupuncture (HPRAC, 1996: 25)
Discussion

Bacchi’s methodological approach, which emphasizes illumination of particular policy problems’ discursive representations, has enabled us to draw attention to the central role that risk discourse may play in states’ framing of public interest regulatory issues around TM professionalization. As Baggott (2002: 11) has noted, health professional regulatory policy reforms are increasingly “discussed in terms of protecting patients or reducing risks”; stakeholder discourses are likely to reflect this trend. O’Neill’s (1994) observation that biomedical health providers increasingly deploy safety-based discourses to support their jurisdictional claims over previously marginal medical practices gains new dimensionality in light of our study’s postcolonial lens.

Central to our theoretical framework in this work is contextualization of regulator responses to epistemic turf battles over TM practices within the context of historical colonial relations. This (re)contextualization of policy formulation as a set of epistemological power relations points to the normative position of biomedical knowledge, making invisible traditional knowledge. Our comparative application informed by Bacchi’s CDA approach across two contrasting policy texts has made visible important theoretical connections between risk assessment frameworks (contextual vs. technical), health care epistemology (traditional knowledge inclusive vs. exclusively biomedical), public interest conceptions (broad vs. narrow), regulatory parameters (equitable vs. equivalent, innovative vs. fixed) and the protection of traditional knowledge (or not). We suggest that regulators of TM around the world can support the WHO’s call to protect traditional knowledge if they position traditional knowledge protection as itself a key component of their public interest imperative.

To this end, regulators will need to explicitly recognize potential systemic barriers in place in their jurisdictions, and show willingness to adapt or innovate upon existing policy structures in order to equitably accommodate TM approaches. This process will furthermore require that regulators become familiar with health care related concepts arising from within traditional knowledge frameworks. A first step would involve recognition that evidentiary perspectives or concepts (e.g., acupuncture as a ‘physical’ intervention) appearing to be culturally ‘neutral’ may so appear because they are culturally normative (i.e., rooted in biomedical epistemology). The active inclusion of TM cultural insiders to regulatory processes for governing TM-rooted
practices may also mitigate such epistemic myopia to some degree.

In addition, as various health practitioner groups jockey for professional status and power by battling over jurisdiction for TM practices—as is increasingly seen in the case of acupuncture—regulators’ increased sensitivity to TM-based perspectives may assist them in differentiating between, and avoiding conflation of, stakeholders’ epistemic claims and occupational self-interest. That said, two core points need further theoretical exploration to assist regulators in this regard: a) circumstances under which hybridized (that is, biomedicalized) forms of TM knowledge and practice might not be seen as problematic misappropriations; and b) to what extent the public interest advantage of increased public access to beneficial TM-rooted therapies offered by biomedically-trained practitioners within a biomedical framework mitigates considerations around traditional knowledge protection.

Regardless, contending with the challenge of generating regulatory conditions for an equitable medical pluralism, in the public interest, is a question that extends well beyond the issue of risk discourse emphasized in this work. One such issue, which our analysis touched upon briefly, is the development of regulatory practice standards for TM-rooted practices. Other important considerations around TM professional regulation, which have become furthermore apparent in Ontario’s context, lie at the clinical/cultural intersect. These include: language of practice; accommodation of informal vs. formal training backgrounds; and the challenge of standardizing an intrinsically diverse body of TM knowledge. We intend, elsewhere, to discuss these issues in greater detail.

That said, the current work’s unique contribution lies in its critical illustration of the ways in which regulatory risk discourses surrounding a TM practice may support or counter the principle of misappropriation in policy context. The analysis of this example case may serve as a tool to support policy makers around the world as they seek to construct equitable TM regulatory frameworks. Future critical scholarship will prove vital in further specifying—for regulators’ usage—the normative but nebulous ‘public interest’ concept as it relates to TM practitioners and practices.
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Chapter 4

Medical pluralism and the state: Regulatory language requirements for traditional acupuncturists in English-dominant diaspora jurisdictions

This chapter is currently under peer review as a paper for publication. Although the chapter’s data collection, analysis and writing were primarily my own, Dr. Heather Boon is listed as co-author, to recognize her supervisory role on my PhD committee.
Abstract

Regulation of traditional acupuncturists has proven controversial in several jurisdictions. In this work, we detail and analyse the range of English-language registration, practice and record keeping requirements for regulated traditional acupuncturists across Canada, the United States and Australia. Drawing on the results of an extensive documentary review and twenty-eight qualitative interviews, we identify five primary themes underpinning policy-related discourses and debate: patient safety; standardized, integrated health care systems; economic considerations; traditional knowledge protection; and culturally-inclusive care delivery. We critically examine these policy discourses, positioning them within a broader literature related to language policies in multiculturalist states, and considering their relevance to the question of traditional medicine professional regulation in diaspora. With reference to the principle of regulatory equity, and to the concept of a pluralistic public, we present a set of recommendations for traditional medicine regulators contending simultaneously with clinical and cultural considerations.
Introduction

Medical pluralism, in which multiple “differentially designed and conceived medical systems” co-exist in a single culture or state (Janzen, 1978), is increasingly the norm worldwide (Frankel and Lewis, 1989). Global migrations have resulted in the ‘export’ of many traditional medicine (TM) systems and practices into a diverse diaspora outside of their nations of origin. Immigrant influxes between global South states and the global North (Jennings, 2005, Cant and Sharma, 1999) have brought “both a demand for, and, crucially, practitioners of a range of alternatives to biomedicine” (Green et al., 2006). Originating in the indigenous medicine systems of Eastern Asia, acupuncture is a health care practice that exemplifies the TM diaspora phenomenon. While acupuncture remains in widespread use across its geographies of origin (Scheid, 2002, Unschuld, 1992, Hsu, 1999), it is practised today in 80% of nations worldwide, and regulated in twenty-nine countries (WHO, 2014).

A considerable body of scholarship (e.g., Sussman, 1981, Albert et al., 2015, Zhang, 2007, Prasad, 2007) has examined the dynamics surrounding medical pluralism in many global South states, where indigenous TM medicine systems remain predominant (and often state-regulated) forms of health care. Although such accounts are diverse, reflecting the range of global contexts, biomedicine’s epistemic and political dominance in relation to TM systems and practices is a common theme across them. As Zhang (2007) has noted, “[m]edical pluralism … is a site of contestation and struggle.” Khan (2006) has asserted a “need to go beyond the liberal pluralist tendencies” that have previously dominated scholarly discussion around medical pluralism, and instead engage more critically with issues of “power, domination and hegemony” by locating related research within a “larger historical, social and political context”.

The concept of equity “has been increasingly characterized as an important driving principle in producing socially-just state policies around non-biomedical healing systems and practices” (see Ijaz et al., 2016, p. 99). As a policy-making principle, equity – which takes fair outcomes as its goal - may be contrasted with the notion of regulatory equality, predicated upon the notion of equivalent treatment for diverse parties, regardless of contextual or historically-related factors (Arnaud, 2001, Stone, 2012). Conceptualized as an underlying principle through which other policy-making parameters – such as ‘the public interest’ - may be illuminated, equity provides a
potent driver for “crafting regulatory approaches to redress injustices arising from broader contextual conditions” (Ijaz et al., 2016, p. 99).

Critical scholarship that addresses equity-related issues surrounding medical pluralism in the global North represents an emerging area of research (e.g., Hollenberg and Muzzin, 2010, Marian, 2007b, Marian, 2007a, Baer, 1989, Green et al., 2006, Cant and Sharma, 1999). In such settings, it is not only biomedicine’s dominance in the health care sector and the health care needs and preferences of immigrant ethnic minority patients (e.g., Han, 2000, Rochelle and Marks, 2011) that increases complexity, but also the potential for immigrant TM practitioners to be systemically disadvantaged (e.g., Ijaz et al., 2015, Chiu, 2006, Shroff et al., 1997).

In this work, we critically analyse one such equity-related controversy at the cultural/clinical intersection: linguistic regulatory requirements for East Asian immigrant practitioners of traditional acupuncture in three English-language dominant countries (Canada, the United States, and Australia). In recent years, considerable contention has surrounded the question of English-language proficiency and record keeping requirements, as well as English only versus multilingual professional entry examinations, for such practitioners. Our aims in this study are three-fold: a) to detail the range of linguistic certification and regulatory requirements for traditional acupuncturists across Canada, the United States and Australia; b) to report on recent related controversies in each of these countries; and c) to characterize and critically interpret the competing discourses at the heart of these controversies. We begin with an overview of two primary literatures relevant to the issues under study: linguistic entry requirements in regulated health professions; and multiculturalist policy frameworks in Canada, the United States and Australia.

**Professional entry and language requirements**

Many regulated occupations in English-language dominant nations require high-level English proficiency of their members, presenting barriers to immigrant professional entry (e.g., Novak and Chen, 2013, Ngo and Este, 2006, Sakamoto et al., 2010). In the case of biomedical professionals, a primary discourse used to justify such linguistic requirements involves an assertion that public safety will be protected by ensuring competent communication between clinician and patient in the jurisdiction’s dominant language (see Lynch, 2016). That said, the degree of language proficiency seen to achieve this aim is a matter of contention (Jacoby and
McNamara, 1999), and language competency requirements (e.g., for nurses in Canada, the US, Australia and New Zealand) consequently vary considerably across jurisdictions (O’Neill, 2007). Professional language proficiency requirements have furthermore been shown to be a significant disincentive to the migration of health care professionals (e.g., nurses) between nations (Kingma, 2001).

Linguistic regulatory requirements for immigrant TM practitioners

In Canada, the United States and Australia, where traditional acupuncture practitioners have been increasingly regulated, East Asian immigrants commonly represent a significant proportion of practitioners (Chiu, 2006, Ijaz et al., 2015, Zhou et al., 2012). Survey data from the province of Victoria, Australia in 2012 showed 38% of registered Chinese medicine practitioners have Chinese as their first language, a proportion that increased substantially with age, up to 80% in the over-65 age group. Over a quarter of the same jurisdiction’s practitioners surveyed self-rated their English skills as “average” rather than “fluent”, and a small proportion (~5%) “considered their spoken English to be at a minimal level” (Zhou et al., 2012, 65). Practitioner surveys of traditional acupuncture practitioners in various American states indicate that a smaller, but still significant, proportion of practitioners (~ 17 – 29%) are of Asian ethnic origins (Lee et al., 1999, Cherkin et al., 2002). Lee and colleagues (1999) further note that 23% of practitioners surveyed in one urban area had been trained in China, and that their study had under-represented acupuncturists with low English proficiency.

Chiu (2006) has briefly discussed language barriers as impeding immigrant professionals’ practice of traditional Chinese medicine in the Canadian province of British Columbia. There, she describes English-speaking patients in British Columbia, Canada as voluntarily bringing their own interpreters to sessions with particular immigrant Chinese medicine practitioners. However, Chiu’s work does not position these issues in policy context.

Cultural pluralism, multiculturalism and language policy

Canada, the United States and Australia are culturally-pluralistic nations characterized by English-language dominance. Amidst such ethno-cultural diversity, Canada’s federal government has designated both English and French as official languages. Australia and the
United States, by contrast, have no official national language, though government affairs are largely conducted in English. About half of American states, however, have designated English as their official language. As widely discussed elsewhere (e.g., Dauvergne, 2016), the three countries under discussion are all marked by the subordinate socio-political position of non-Anglo-European ethno-linguistic minority groups in relation to Anglo-European colonial settler culture.

Despite their divergent ‘official language’ approaches, all three countries under study have adopted ‘multiculturalism’ as a national policy principle (Gozdecka et al., 2014). Kymlicka (2011) has characterized state multiculturalism policies as aiming to “recognize the legitimate interests of minorities in their identity and culture without eroding core liberal-democratic values.” As one ‘multiculturalist’ mechanism to accommodate the distinct needs of minority ethno-cultural groups within these English-language dominant states, and to redress historically-situated power imbalances, governments have introduced various linguistic policy accommodations.

For example, both the Canadian and American federal governments provide voter information for state elections in 31 and 11 languages respectively, although English (and in Canada also French) are the dominant and/or official languages (Elections Canada, 2015, US Election Assistance Commission, 2015). Some Canadian and US jurisdictions similarly permit those applying for drivers’ licenses to complete knowledge tests in a range of languages (Welcome BC, 2015, NYDMV, 2016). The Australian government likewise provides translations of an extensive array of informative materials in “over 60 languages” (Department of Human Services, 2016).

**Multilingualism in pluralistic health care context**

In recent decades, state-funded medical services across many industrialized countries have been increasingly provided in multiple languages as part of a broader trend towards delivery of ‘culturally competent’ and ‘linguistically-concordant’ health care (Anderson et al., 2003, Weech-Maldonado et al., 2012). Non-English language interpreter services have for example been made widely available for 911 emergency call services in both Canada (OCASI, 2015, E-Comm 9-1-1, 2011) and the United States (NWNN, 2014, Raymond, 2014), and for the ‘Triple Zero’ emergency call service in Australia (Triple Zero, 2016). All American hospitals are now
required to make clear records documenting their patients’ linguistic communication needs (Mui et al., 2007). As Clifford and colleagues (2015) have noted with reference to these three multiculturalist states, the principles of “cultural competence ha[ve] been increasingly incorporated into health policy documents and professional accreditation standards.” Regardless, Indigenous and ethno-racial minority groups continue to face considerable health inequities (Weech-Maldonado et al., 2012, Anderson et al., 2003), some language-related.

“Language difficulties and cultural barriers” have, for instance, been identified as a contributing factor to ethnic minority Asian Americans’ disproportionate rates of many diseases (Mui et al., 2007 p. 119); and low English language proficiency has been identified as one significant barrier to East Asian immigrants accessing health services in both North America and the United Kingdom (Mui et al., 2007, Sproston et al., 2000). A study of “Chinese and Korean immigrant elders’ poor health status” in the United Kingdom has similarly characterized “inability to speak English” as a key exacerbating factor (along with “prejudice, micro-aggression, overt racism, and discrimination) (Mui et al., 2007).

In addition to the role of linguistic barriers (Chappell and Lai, 1998, Rochelle and Marks, 2011, Ma, 2000, Han, 2000), East Asian immigrants’ usage of state medical services is known to increase when their ethnic identities are reflected in the provision of care (Han, 2000). Furthermore, a significant preference for traditional East Asian medicine over biomedicine has been demonstrated both amongst East Asian immigrants with low English language proficiency (Sproston et al., 2000) and those “speaking Chinese as a first language” (Rochelle and Marks, 2011) in the United Kingdom.

‘Post-multiculturalism’ and immigrant language policy

Over the last few decades, state multiculturalism policies have been critiqued on one hand as contributing to the further “marginalisation of minorities by keeping them off serious government policy agendas” (Vertovec, 2010), and, conversely, as “prioritizing the maintenance of culture at the cost of strong national identity” (Gozdecka et al., 2014). Reflecting the latter critique, a ‘post-multicultural’ political trend (Vertovec, 2010, Kymlicka, 2010) has recently emerged in multiculturalist states, with the introduction of policies that “seek to foster both the recognition of diversity and the maintenance of collective national identities” (Vertovec, 2010). A key exemplar of this trend involves mandatory “citizenship and/or language tests” (Gozdecka
et al., 2014) for those seeking immigration in these countries.

Such tests have been implemented in Canada, Australia as well as the United States. They require that prospective citizens demonstrate a rudimentary, or in some cases vocational level of proficiency in the jurisdiction’s official or dominant language. Several critics have contested the ethical and political basis of citizenship/language tests (see McNamara and Ryan, 2011, Shohamy and McNamara, 2009, Cooke, 2009, Winter, 2014), characterizing their ‘gatekeeping’ function as keeping members of particular ethnic or religious groups – often “those perceived as being culturally very different to the host population” (Cooke, 2009) - from migrating to a particular country. Notably, exemptions to citizenship-related linguistic proficiency requirements have been implemented on the basis of advanced age in all three countries (Government of Canada, 2015, Starr, 2016, USCIS, 2015, Government of Australia, 2016).

As this paper will highlight, the question of linguistic regulatory policies for traditional acupuncture practitioners in English-dominant jurisdictions addresses key issues around the professional regulation of traditional medicine systems in culturally pluralistic societies. Some share features with other linguistic policy questions in multiculturalist states, which – as noted – have been extensively addressed in the literature to date. Other issues we raise in this work are unique to the field of traditional medicine regulation, in which clinical and cultural considerations intersect, and which very little research has to date addressed. This paper aims to begin filling this key gap in the literature. We turn now to our study methods.

**Methods**

**Data collection**

Data collection in this study was two-fold, consisting of a) the compilation of public documents; and b) qualitative, semi-structured interviews.

We collected a wide range of Canadian, American and Australian public documents related to linguistic regulatory policies for traditional acupuncturists across these jurisdictions, including the following: policy and informational documents from regulators and certification agencies; minutes of the same bodies’ public meetings; media reports; court transcripts; letters from and
statements by public officials; and public petitions. In compiling these documents, we focused on those jurisdictions where there have been recent controversies around the policies under study, while seeking to gather policy-related details from across the three countries more broadly.

We also conducted 28 qualitative interviews with a range of stakeholders involved in the policy controversies under study. These included state actors [n=6] and acupuncture practitioners [n=17] involved in the 2013 regulation of traditional Chinese medicine in the province of Ontario, Canada. Approximately one-half of the acupuncture practitioners interviewed were East Asian immigrants to Canada. We also interviewed five key informants (practitioners [n=2] and regulators [n=3]) who had been actively involved in acupuncture-related linguistic controversies in other Canadian and American jurisdictions. These interviews were conducted as part of the first author’s PhD research project pertaining to acupuncture and Chinese medicine regulations. Approval to conduct the interviews was secured from the University of Toronto’s Research Ethics Board. Using an informed consent process, and a semi-structured interview guide that included questions about regulatory language considerations, the first author interviewed informants for 60 to 90 minutes; digital audio recordings were subsequently transcribed for analysis.

Data analysis

Study findings were analytically generated in iterative stages, reflecting the three articulated study aims, and presented in three Parts in what follows.

For Parts A and B of our study, in which we describe the range of linguistic regulatory policies used by traditional acupuncture regulators in Canada, the United States and Australia, and document recent related controversies, we applied descriptive content analytic methods to the set of public documents collected. As a relatively ‘uncritical’ qualitative method, descriptive content analysis is concerned with presenting a ‘fact’-based narrative, without engaging in significant interpretive or theoretical analysis (Vaismoradi et al., 2013). Parts A and B provide important contextual information needed for the more critical/interpretive work undertaken for Part C.

The work conducted for Part C of our study, which characterizes and analyses the competing linguistic policy discourses underpinning the controversies described as Aim B, took place in two steps. First (Part C[a]), we conducted a thematic analysis of linguistic policy-related
rationale and argumentation articulated across the study documents as well as in our interview transcripts. Thematic analysis, as described by Braun and Clarke (2006), is a multi-step qualitative analytic process, in which data are repeatedly reviewed and coded to characterize recurrent features across the texts under study. Supported by illustrative textual excerpts, data-driven themes are iteratively refined to provide an account of focal concerns within the data. In this case, we aimed to identify the primary arguments used to support or contest particular linguistic policy approaches across the texts being analysed.

Next (Part C[b]), having completed this thematic analysis, we used an equity-informed theoretical stance to evaluate the policy-related discourses uncovered in our thematic analysis. To this end, we applied critical discursive analytic methods. Bacchi’s (2009) policy-focused methodology in this regard seeks to interpret the way in which a particular ‘policy problem’ is implicitly or explicitly represented in discourse, giving careful consideration to historical and contextual undercurrents, and to the policy’s potential to exert broader sociocultural or political impacts.

In what follows, we present our study results in three parts, corresponding to our articulated study aims.

Results

Part A: Policy Overview

As seen in Table I, regulators in Canada, the United States and Australia have adopted a range of regulatory approaches to English language proficiency in their traditional acupuncture practitioner regulations. Whereas some jurisdictions require English language proficiency of all new registrants, others have temporarily provided transitional (e.g., Ontario, Canada) or permanent (Australia) exemptions to such requirements for a subgroup of non-native English speakers who practice in an East Asian language. Yet elsewhere, no language proficiency requirements are articulated. Across jurisdictions where English proficiency is a requirement, the mechanisms in place for demonstrating such proficiency include English-only registration
exams, demonstration of English-language education, and completion of standardized English language proficiency tests.

Multilingual registration examinations (i.e., both in English and at least in one East Asian language) are currently made available across most of the United States, and in the Canadian province of British Columbia. In Australia, no registration examinations are currently required for traditional acupuncturists. With regards to patient records, linguistic policy approaches range from none stipulated (e.g., California and British Columbia) to English-only (e.g., Ontario, Alberta, Texas, Arizona). Several American jurisdictions, and Canada’s province of Newfoundland/Labrador instead require that practitioners make records available in English on an as-needed basis. In Australia, a patient’s identifying details and emergency contact information must be kept in English; and although the regulator has expressed “a preference that records be kept in English” (CMAB, 2012), permanent exceptions have been made for long-standing East Asian immigrant practitioners.

Table I: Regulatory Language Proficiency Requirements for Traditional Acupuncturists’ Professional Entry in the United States, Canada and Australia (US data adapted from NCCAOM, 2012)

<table>
<thead>
<tr>
<th></th>
<th>English proficiency required</th>
<th>English proficiency not required</th>
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</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Entire country; exemption for grand-parented registrants</td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>Ontario (temporary exemption for grand-parented registrants); Alberta, Quebec (French, not English)</td>
<td>British Columbia, Newfoundland/Labrador (conditional/restricted registration for registrants not proficient in English)</td>
</tr>
</tbody>
</table>
Part B: The acupuncture linguistic regulatory controversy

Our analysis of public documents has revealed a trend in recent years across several English-dominant jurisdictions, to further standardize English language requirements for traditional acupuncturists, with respect to language proficiency, examination language, and patient records. Five notable controversies took place between 2011 and 2014: two in the United States (in 2012); two in Canada (in 2011-12 and 2013-14 respectively); and another in Australia (2012-13). The descriptive account provided below provides important context for our discussion of the policy themes and discourses at play across these controversies in Parts Ca and Cb.

United States

Case I: National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)

Language proficiency requirements for traditional acupuncturists in the United States are stipulated at the state level, but most American states have adopted a common certification standard set by the NCCAOM. The NCCAOM has long offered its certification examinations in the English, Chinese, and Korean languages, but in 2012 appointed a panel to study whether these should be discontinued. In 2013, the NCCAOM proposed to “phase out” multilingual examinations, and to “require documentation of English language proficiency” for all successful applicants (NCCAOM, 2013). However, in light of practitioner feedback, the NCCAOM withdrew these proposals; multilingual examinations continue to be offered.

Case II: California Acupuncture Board

In California, where the NCCAOM exams are not used, the state acupuncture Board similarly proposed, in 2012, to abandon its decades-long practice of offering multilingual examinations. The proposal proved contentious within the Board itself, produced vocal objections from within the broader community of traditional acupuncturists and patients, and gave rise to a letter of reprimand from the California State Senate. Today, California continues to offer acupuncture licensing examinations in the English, Chinese and Korean languages, contingent on 5% demand from within the applicant pool.
Canada

Case III: College of Traditional Chinese Medicine Practitioners of British Columbia (CTCMA)

In 2011, British Columbia’s regulatory body for traditional acupuncturists, the CTCMA, passed a bylaw requiring that all patient records be kept in English. Since its inception in 2002, no linguistic requirements had been stipulated for practitioners, and registration examinations had been offered in both English and Chinese. The new record keeping bylaw proved deeply controversial both within the CTCMA executive and its professional membership, and was abandoned under significant pressure from practitioners.

Case IV: College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario (CTCMPAO)

In 2013, the province of Ontario introduced regulations governing traditional Chinese medicine practitioners, in which patient records were required to be kept in English and registration examinations were offered in English only. Although temporary linguistic accommodations were made for entry examinations, and a temporary registration class was introduced to permit practitioners without English fluency to continue practicing until 2018, English language proficiency would ultimately be required of all practitioners. A subgroup of long-standing practitioners undertook court proceedings, claiming that these linguistic regulations were discriminatory; their case was unsuccessful and the policy remains intact.

Australia

Case V: Chinese Medicine Board of Australia (CMBA)

In 2012, the CMBA made English proficiency a normative requirement across Australia’s newly regulated Chinese medicine profession, while permitting a subgroup of grand-parented registrants to indefinitely work alongside an on-site interpreter, and keep patient records in a language other than English. Australia’s professional association of medical doctors expressed strong objections to the latter portion of the policy, but the CMBA remained firm in its policy approach. In 2013, during public consultations preceding further tightening of the regulator’s English-proficiency standards, two of Australia’s three largest Chinese medicine practitioner organizations objected vocally to these requirements, arguing they were producing a “tremendous [negative] impact within the Chinese ethic practitioners’ community” (FCMA, 2013, p. 1); the policy was nevertheless implemented.
Part C(a): Thematic Analysis of Competing Policy Discourses

Our overview of linguistic regulatory approaches implemented for traditional acupuncturists across Canada, the United States and Australia makes clear that no consensus exists across jurisdictions as to the most appropriate policy approach. Indeed, policies vary considerably as to English-language proficiency requirements and record-keeping frameworks. Whereas many North American jurisdictions make available professional entry examinations in East Asian languages, others provide them exclusively in English. Our thematic analysis of policy-related documents, as well as of interview transcripts from the Ontario (Canada) context, illustrate this lack of consensus, exposing starkly contrasting policy discourses between those who support English-only versus multilingual regulatory strategies. Several sub-themes are evident in this debate, as summarized in what follows.

Notably, we found a high degree of discursive congruence across jurisdictions in the arguments made on each side of the debate, affirming that the policy controversies at play across all three countries are substantially similar. In our document and interview analysis, we found both practitioners and state actors holding views on either side of the debate. That said, community-based groups who expressed opposition to English-only policies appeared in all cases to have been led by East Asian immigrant practitioners and patients. Across our interview sample, we found over two-thirds of practitioners to be opposed to English-only policies, representing both immigrant East Asian, and North American-born practitioners. However, the majority of practitioners who supported English-only policies were not of East Asian ethnicity. In what follows, we detail our study themes, also summarized in Table II.
TABLE II: Competing discourses on English-only regulatory policies for traditional acupuncturists

<table>
<thead>
<tr>
<th>Primary themes</th>
<th>Favouring English-only policies</th>
<th>Opposing English-only policies</th>
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<tbody>
<tr>
<td>I. Patient safety</td>
<td>• Non-English proficient practitioners create unnecessary patient risks</td>
<td>• English-only policies create more significant risks by driving practitioners underground</td>
</tr>
<tr>
<td>II. Standardized, integrated health care systems</td>
<td>• Traditional acupuncturists should ‘integrate’ into English-dominant, biomedical culture</td>
<td>• Prospect of ‘integration’ raises complex issues of power</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Level of required fluency should reflect context of practice</td>
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<tr>
<td>III. Economic considerations</td>
<td>• Provision of multilingual services is too costly</td>
<td>• Economic concerns should not supercede fair regulations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• English-only policies economically disadvantage practitioners working in East Asian languages</td>
</tr>
<tr>
<td>IV. Preservation of traditional knowledge</td>
<td>• Advantages of English-only approach outweigh disadvantages</td>
<td>• Regulations should respect traditional acupuncture’s linguistic and cultural underpinnings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Language requirements produce discriminatory barriers to professional entry and practice</td>
</tr>
<tr>
<td>V. Provision of culturally-inclusive health care</td>
<td>• Recognition that English-only approach may have addressable shortcomings</td>
<td>• Multilingual policy approach is vital to foster inclusion of East Asian language practitioners who provide important ethno-specific health services</td>
</tr>
</tbody>
</table>
Theme I: Patient Safety

Practitioners and state actors who supported English-only policies generally emphasized public safety as their primary concern. They tended to argue that poor English language skills could produce a significant risk to patients, particularly in emergency situations.

If you have someone in your office and they’re experiencing cardiac arrest, and you don’t have the language skills to call 911, what are you going to do? [Canadian Regulator]

They commonly situated their safety concerns within the context of inter-professional communication (a point to which we will return further on):

We must take action that would increase patient safety by ensuring that all graduates taking the CALE [California Acupuncture Licensing Examination] are prepared to communicate with all other healthcare professions. (California Acupuncture Board, 2012)

[With a] practitioner who does not keep records in English, at a time of patient crisis or emergency … [where] a patient has to be rushed to ER [emergency room] after just seeing their [traditional acupuncture] practitioner, the patient records, if they’re not able to translate them appropriately, aren’t going to mean anything to the emergency medical practitioners who might need to save this patient’s life. [Acupuncturist, Non-East Asian, Non-Immigrant]

English-only policy opponents did not deny, but tended to minimize the potential risk to patients associated with some practitioners’ low English proficiency. Traditional acupuncturists practising exclusively in East Asian languages were, they argued, some of the most experienced within the profession, with a long history of safe practice:

We’ve been practicing, more senior traditional Chinese medicine practitioners, twenty years, thirty years they’ve been practicing this profession for so long, and never anything wrong happening. [Acupuncturist, East Asian Immigrant]

By requiring English language proficiency, they asserted, regulators would magnify the small existing language-related risk for patients, by removing statutory accountability and recourse mechanisms for patients who might otherwise be harmed:

The risk [associated with practitioners who are not fluent in English] is minimal and controllable. Manageable. We don’t need [a] policy to deal with this minimal risk, it creates a bigger risk. You know the bigger risk is that you create a category of illegal practitioners. If those doctors puncture a patient and hurt them, what would happen? If
they’re licensed, they can get malpractice insurance. [Acupuncturist, Non-East Asian, Non-Immigrant]

Some also argued that English-only registration policies might compromise delivery of safe care for East Asian immigrant patients lacking English fluency:

What about the public safety for those patients that can only speak Chinese or Korean? What if the patient has to go to a practitioner that can only speak English? (California Acupuncture Board, 2012).

There’s less risk in my perspective and in terms of safety in communication, there’s much less risk of miscommunication when you have Chinese-speaking people seeing practitioners who speak their native tongue. [Canadian Regulator]

Theme II: Standardized, integrated health care systems

English-only regulatory requirements commonly advocated for the standardization of linguistic entry requirements across health care professions. For instance, the Australian Medical Association – objecting to the transitional linguistic accommodations for long-standing immigrant practitioners proposed by that country’s Chinese medicine regulator – argued:

All health professions registered under the National Law have registrants who are from diverse cultural backgrounds. All these registrants are required to meet high standards of proficiency in the English language (Hambleton, 2011).

English-only policy proponents furthermore argued that English proficiency was necessary for traditional acupuncturists’ integration into existing (biomedical) health care systems:

If you’re going to be working with the public you need to be able to communicate with the public. You need to be able to interface. So as a practitioner who perhaps doesn’t have English language fluency, and a doctor wants to send you a patient’s medical test report, what are you going to say, send it to me in Chinese because I don’t speak English? You have to integrate them. They have to integrate themselves into the mainstream. [Acupuncturist, Non-East Asian, Non-Immigrant]

The official language is English. Especially if we want to integrate [traditional acupuncture] into our health care system, English is a must. If you don’t know English, I would say, you must. [Acupuncturist, East Asian Immigrant]

Those opposing English-only policies asserted, by contrast, that the integration of traditional
acupuncturists into mainstream health care was a complex undertaking that could not be achieved simply by enforcing language proficiency requirements. They characterized two sets of socio-political barriers as impeding such goals: a) the relative marginality of TM practitioners in relation to dominant biomedicine; and b) the ethno-linguistically disadvantaged position of East Asian immigrant practitioners:

Of course we appreciate about so-called collaboration with other regulated health professionals. But if I tell another health professional about deficiency fire, will they understand what I am saying? This is a diagnosis from traditional Chinese medicine, this is the professional language of our medicine. Don’t tell me you don’t understand and want me to translate it into English. This is already the English translation, but they don’t know our medicine. [Acupuncturist, East Asian Immigrant]

I think for people who are trained here, speak English, possibly are white, it’s easier to envision just fitting into the mainstream health and being accepted by the mainstream health care system…they can just picture being integrated much more easily than I think a practitioner who has immigrated here, still doesn’t speak a whole lot of English, or speaks with an accent, you know, works out of China town, and is still pretty marginal, has no prospect maybe of being integrated into that system as much. [Acupuncturist, East Asian Non-Immigrant]

Notably, some respondents who opposed English-only policies within the context of private clinical practice, conceded that English fluency, and a requirement to keep English language patient records, might be reasonable within the context of state-funded health care:

If it was integrated, and there was acupuncture and herbs in hospital settings, yeah, well then yeah. Then I think that those acupuncturists would have to be writing notes in English. I think that would be fair, it’s an English-speaking hospital, whatever. Private? No, I don’t think so. [Acupuncturist, Non-East Asian]

**Theme III: Economic considerations**

Some advocates of English-only policies – such as one participant at a California acupuncture regulatory board meeting - argued that the provision of multilingual regulatory examinations was too costly:

This Board spends more money on examination than in enforcement. I would suggest that the English-only test is an easy fix for this… If you are no longer paying for translation services for forms of the test, presumably that saves money that could go to enforcement (California Acupuncture Board, 2012).
The substantial cost associated with provision of multilingual examinations was affirmed by informants involved in the delivery of certification examinations in other North American jurisdictions.

“IT’s respect we do for our elders, but it’s not a profitable thing. As you can well imagine there’s a lot of cost to provide the [multilingual] exam. [American Regulator]

Regardless, those favouring multilingual policy approaches argued that this was money well spent:

Budget cost should not be a reason why we do an English-only exam. [Acupuncturist, Non-East Asian, Non-Immigrant]

English-only policy opponents furthermore tended to characterize these policies as having the potential to produce detrimental economic impacts on East Asian immigrant practitioners lacking English fluency. In a letter from California’s State Senate to its acupuncture regulator, potential income losses are highlighted:

English proficiency is not a necessary precursor to becoming a contributing citizen in California’s economy and should not be used by the Board to discriminate against talented and skilled individuals who seek to provide high-quality acupuncture services in California (Steinberg and Price, 2013).

Others emphasized the high costs associated with translating patient records into English as a disproportionate burden placed on clinicians working in East Asian languages:

Seriously, that would put me out of business. We’re talking about translators with very specific knowledge. Full stop. There’s no way any of us can afford that. That’s just ridiculous. You do not know medical language in two languages unless you have a lot of study. Those people, do you know what they cost per hour? [Acupuncturist, Non-East Asian, Non-Immigrant]

Theme IV: Preservation of traditional knowledge

Those opposing English-only policies typically characterized traditional acupuncture as a unique profession that requires unique regulatory consideration in order to preserve the profession’s associated traditional knowledge base. They consistently emphasized the historical and cultural importance of East Asian languages to the profession’s clinical work. A practitioner organization in Australia explained its position in this respect as follows:
[The] Chinese Medicine Board of Australia should also consider to have an English language standard different to other 12 National Boards in consideration of the unique cultural and historic background of Chinese medicine professional[s]… to better refle[ct] the specific nature of practice of the Chinese Medicine profession. …[The] Mandarin [language] in Chinese Medicine is not only the art, it is also the culture and philosophy of Chinese Medicine. (CMASA, 2013)

The vital role of senior practitioners (who commonly conduct their clinical practices in an East Asian language) in continuing to transmit traditional knowledge to junior practitioners, was further emphasized by those favouring multilingual regulatory policies:

By saying that they can’t continue to write in Chinese is just like, that’s something that is to me so inverted. …That’s something that should be cherished and we should be proud of them for keeping [traditional medicine] alive… All the best doctors are now in their 60s, 65 and 70s, and in the next 15, 20 years it’s over… I think while we have these things they should be honoured. [Acupuncturist, Non-East Asian, Non-Immigrant]

English-only policies, in this light, were repeatedly characterized as threatening the inclusion of such senior mentors within the regulated profession:

Almost all of the teachers of the people that are doing [traditional acupuncture] now were not speaking English confidently, a lot of them were not competent enough to write medical notes in English. The older practitioners that are not native English speaking, you know, to eliminate them from the profession, is a disservice to the profession itself. [Acupuncturist, East Asian, Non-Immigrant]

Although some English-only policy advocates recognized that some senior practitioners might be excluded as a result of these regulatory parameters, they tended to minimize these impacts as an inevitable “cost of regulation” [Acupuncturist], outweighed by the policy’s other apparent advantages.

[For] some of the older [practitioners], it’s really hard to have them upgrade to that level [of English], but … how many past practitioners are there? They’re all probably near retirement or stop[ping] practice already. I don’t have too much concern about that. If they're 75 or over 70 years old and so on, that’s okay. [Acupuncturist, East Asian Immigrant]

If it’s a Chinese practitioner treating a Chinese patient and maybe has a Chinese-speaking physician, well then in that case English might actually be a liability, so there’s no good answer to it. I don’t know the solution. I don’t know how to make it better. It just goes back to my opinion that standardized record keeping in English is only going to help improve patient safety. [Canadian Regulator]
Theme V: Provision of culturally-inclusive health care

Those opposing English-only policies and advocating multilingual policy models for traditional acupuncturist regulation repeatedly cautioned that English-only approaches might compromise delivery of culturally-appropriate TM care for and by East Asian immigrants. A patient petition for instance characterized the prospect of an English-only policy in California as follows:

> This proposal would deny all Chinese and Korean speaking people the privilege and right to be consumers and practitioners of their native medicine, alienating large numbers of immigrant, elderly and low-income communities of healthcare (Qi, 2013).

Others explained that practitioners working in languages other than English would commonly provide care to members of their specific ethno-linguistic communities. Such practitioners, they argued, did not generally require high levels of English language proficiency to serve the patients who would seek them out; but provided an important, culturally-specific health care service which should be given regulatory sanction.

> What about people that are only treating people from their community? They only treat Chinese people, why do they need to speak English? I don’t know that they do. [Acupuncturist, Non-East Asian, Non-Immigrant]

> When the [Chinese medicine] doctors don’t speak good English they take care of Chinese speaking patients. They don’t take care of English speaking patients. There are many practitioners available that speak very good English so they don’t have to go to a Chinese-speaking doctor. They have so much choice for that. …The patients are smart. They don’t choose people who don’t understand them. I speak Mandarin. Even Cantonese-speaking patients who are Chinese, they don’t come to see me. I don’t understand them. There are so many practitioners who speak fluent Cantonese, why would they come here and see me? No way. [Acupuncturist, East Asian Immigrant]

Part C(b): Critical discourse analysis of thematic findings

As our thematic findings illustrate, there are both state actors and practitioners of diverse demographic makeup on either side of the polarized debate around linguistic regulatory policies for traditional acupuncturists working in English-dominant diaspora jurisdictions. In what follows, we interpret the discourses on both sides of the debate with a view to demographic features, political philosophy, and alignment with similar linguistic policy debates.
The preponderance of non-East Asian immigrant interviewees among those favouring English-only policies in our study is, we suggest, not indicative of a strong ethno-specific polarization around this policy issue. In addition, we found in our analysis of the interview narratives of those practitioners of non-East Asian ethnicity who opposed English-only policies, that they were more likely to make explicit their reverence for and allegiance towards their East Asian immigrant teachers and clinical mentors, than did those who supported English-only policies. Put another way, opposition to English-only policies appeared to accompany a broader narrative that gave concurrent importance to the cultural and clinical aspects of traditional acupuncture as a system of therapy; and it was East Asian informants who appeared somewhat more likely to do so. In addition, we found – across both interviews and documents – an important philosophical difference underpinning the policy related discourses of English-only policy supporters and opponents, pointing to a contrasting (though not always explicit) engagement with the principles of regulatory equality and equity, respectively.

Those advocating for English-only policies for traditional acupuncturists regulated in English-dominant diaspora regions rely implicitly on the notion of ‘equality’ to shape their policy-related discourses. English language proficiency, registration examinations, and patient records, they assert, have been implemented for all other regulated health professionals; and the principle of equality calls for regulatory standardization. All traditional acupuncturists, they argue, must be able to equally serve ‘the public,’ which they singularly conceptualize as English-speaking. Safety and access to care for this English-speaking ‘public’ are, they suggest, of utmost concern, overriding other considerations. Although English-only proponents tend to recognize some detrimental impacts as potentially arising from the policies they advocate, these are normalized as inevitable consequences of statutory regulation: unfortunate, but acceptable. Any accommodations proposed by regulators to alleviate such impacts should therefore be seen as generous, rather than necessary, and dispensable, if costs prove too high.

Opponents of English-only policies, by contrast, predicate their arguments upon the notion of regulatory equity, emphasizing fair outcomes (rather than equivalent treatment). They underscore a range of factors that differentiate the traditional acupuncture profession from biomedical health professions, arguing for a set of unique linguistic regulatory parameters in response. Such parameters include consideration for the historical importance of East Asian languages in the traditional acupuncture profession; the systemic subordination of non-biomedical forms of health
care and socio-cultural subordination of immigrant professionals; the traditional medical expertise of senior practitioners lacking English fluency; and the ways in which linguistically concordant traditional acupuncture care addresses the culturally-specific needs of East Asian immigrant patients. Minimizing safety-related concerns, those favouring multilingual policies ultimately characterize English-only policies as inequitably discriminating against, and rendering professional licensure and disproportionately difficult and costly for senior East Asian immigrant practitioners. Conceptualizing the public of traditional acupuncture patients as diverse rather than singular, they assert that linguistic diversity within the profession should be honoured, in policy, as an asset.

In addition to these equality- and equity-discourse observations, we suggest that the recent trend towards more widespread mandatory English language requirements for regulated traditional acupuncturists may roughly correspond - not only temporally but discursively - to the ‘post-multiculturalist’ trend (see Gozdecka et al., 2014) towards linguistic citizenship testing requirements in several culturally pluralistic, industrialized states. Indeed, as we now illustrate, discourses on both sides of the acupuncture language debate appear to parallel the political narratives of those favouring and opposing language proficiency tests for aspiring citizens in a number of Western world jurisdictions.

For example, where supporters of English-only traditional acupuncture regulatory requirements cite inter-professional collaboration and trans-professional standardization as key imperatives, proponents of linguistic citizenship requirements argue that such will position immigrants on a more ‘level (i.e., standardized) playing field’ within which to better ‘integrate’ (i.e., collaborate) into the dominant culture (Vertovec, 2010, Cooke, 2009). Opponents of English-only linguistic policies for traditional acupuncturists by contrast— in parallel with those opposing linguistic citizenship tests (Cooke, 2009, McNamara and Ryan, 2011) – characterize such policies as discriminatory gatekeeping mechanisms which unjustly exclude particular groups from the domains in question. Whereas citizenship tests are frequently justified as mechanisms to preserve national security (Vertovec, 2010, McNamara and Ryan, 2011, Cooke, 2009), ‘patient safety’ is commonly invoked by English-only policy supporters in our analysis. Those lacking dominant-language proficiency are in both debates furthermore characterized as posing an economic burden upon the statutory infrastructure (Vertovec, 2010).
Taken as a whole, our findings highlight the conceptual overlap between the linguistic policy controversy involving traditional acupuncture regulations, and other language-related policy controversies in which marginalized or minority ethnic groups struggle for equitable treatment under the law. Despite our explicit commitment to equity-informed scholarship and policy, we do not suggest that the discursive claims of English-only policy opponents be adopted wholesale simply because their arguments take the notion of equity as axiomatic. Rather, with a view to recommending equitable policy frameworks for such cases, we further discuss, below, the claims put forward on either side of the debate.

Discussion and Conclusions

Hill and colleagues (2008, p. 671) have characterized the long-standing debate over English-only workplace policies in the United States as reflecting “a tension between demands for assimilation and respect for cultural differences.” Young and colleagues (1995, p. 511) similarly describe the primary tension or “dilemma” surrounding medical pluralism and statutory regulation in global context as follows:

[H]ow to balance the demands of minority groups who wish to practise their own healing traditions (as well as individuals to have the freedom to choose their own healers) with the desire of central governments to promote the interests of the nation-state and set general standards of health care for everyone.

However, the issue of regulatory linguistic requirements for traditional acupuncturists is in several ways distinct from other language policy questions.

In contrast, for example, to other regulated health professions for which English-language proficiency requirements have been implemented, the services of traditional acupuncture practitioners are not generally funded by the state. Moreover, the proportion of immigrant members of the traditional acupuncture profession in English language dominant jurisdictions may at present be higher than for other health professions. Finally, in contrast to biomedical health professions (which, despite their cultural roots in the European scientific revolution (Harding, 1998) ), are today not strongly aligned with particular linguistic or ethnic communities), the traditional acupuncture profession today remains integrally linked to its East Asian epistemic, cultural and linguistic origins. As elsewhere argued (Ijaz et al., 2016), these
(and other) factors require that the statutory regulation of traditional medicine practitioners – whether in diaspora or not – be considered as a unique policy issue requiring careful contextual consideration.

In our analysis, we found that safety, an important public interest consideration in regulating health care professionals across many jurisdictions (Baggott, 2002, Saks, 1995), was repeatedly invoked by English-only policy supporters as the primary rationale behind their support for English language proficiency requirements, registration examinations and patient records in the traditional acupuncture profession. As noted earlier, multilingual interpreters are now widely available in 911 emergency call centres across the continent. As such, it is unlikely that practitioners’ low English fluency would impede emergency care delivery for a patient. It is furthermore difficult to imagine how traditional acupuncturists’ patient records might prove urgently useful to emergency medical workers even if they were composed in English.

Traditional acupuncturists commonly use specialized East Asian medical terminology to describe their diagnoses (e.g., ‘Liver Qi Stagnation’, or ‘Damp Heat in the Lower Burner’), and the locations of the acupuncture points they select for needling (e.g., Stomach 36, or Kidney 3) (Maciocia, 1989). This is terminology that would be difficult for most biomedical professionals to decipher.

That having been said, it is certainly conceivable that lack of practitioner proficiency in a jurisdiction’s dominant language – English, in this case – might result in clinical miscommunications, or worse, harmful errors. Across the extensive document review and set of interviews that inform this study, we encountered just one account of patient harm associated with a traditional acupuncturist’s low English proficiency (Wells, 2014). Although our document review was not designed to systematically collect reports of language-related clinical errors across the jurisdictions under study, the fact that few such cases were made public amidst considerable policy controversy suggests, as some study informants asserted, that such cases are quite rare. Thus, while safety concerns may not be a major consideration in this context, we suggest that the potential for linguistic miscommunications between practitioner and patient produces a risk of harm that policy makers should not altogether ignore.

Aside from safety-based arguments focused on English-speaking patients, some of our study informants emphasized that access to safe, culturally-appropriate care for some East Asian
immigrant patients who themselves lack English proficiency might be compromised should a subgroup of non-English proficient practitioners be barred from practice. Moreover, a new set of safety considerations might arise should such practitioners continue to practice, illegally, to persist in their occupation while meeting patient care demands from within their ethno-linguistic communities. Indeed, patients potentially harmed within the context of such illegal care would have difficulty securing legal recourse for physical or psychosocial injuries incurred.

In our study, English-only policy opponents emphasized East Asian languages’ historical and cultural importance to the traditional acupuncture profession, notably echoing United Nations policy imperatives on such matters. For example, a 2013 report co-authored by the WHO, World Trade Organization and World Intellectual Property Organization, advised regulators to place focus on “preserving the living cultural and social context of TK [traditional knowledge], and maintaining the customary framework for developing, passing on and governing access to TK” (WHO et al., 2013), including in the health care context. Multilingual policy advocates repeatedly expressed concern that senior practitioners with low English proficiency might be excluded from professional entry under English-only regulatory requirements, thus potentially compromising the continued transmission of traditional East Asian medical knowledge. In the same way that prevention of clinical harms to patients must be considered a public interest imperative, we argue that regulatory inclusion of practitioners who act as repositories of traditional medical knowledge should be prioritized.

We suggest that two other discursive themes identified in our study – standardized, integrated health care systems, and the provision of culturally-inclusive health care – pertain more broadly to the principle of accessible health care delivery. In line with our explicit stance that TM regulation be conceptualized as an equity-informed project, we reject outright the suggestion – typified in English-only policy advocates’ discourse – that English language proficiency, examination and record-keeping requirements should be required of traditional acupuncturists simply because these are normative requirements across other, biomedical health care professions. Instead, we contend, each of these policy considerations should be examined for its own merits as it pertains specifically to the regulation of traditional acupuncturists.

Across Canada, the United States and Australia, traditional acupuncture care is currently delivered primarily within the context of private clinical enterprises. That is, they are outside of
state-funded health care institutions, and are typically paid for by the patient (and/or a privately-held insurance company) rather than reimbursed within public health care systems. Within the context of private clinical practice, we see no pressing public interest as being served by requiring that patient records be kept in English, nor that the practitioner demonstrate high level English proficiency – as long as the patient has consented to receiving care without an expectation of English language care or documentation. Within a state-funded context (e.g., a hospital), by contrast, where health care providers are expected to interface seamlessly with one another in the jurisdiction’s dominant/official language, it may be reasonable to expect that practitioners both demonstrate high level proficiency and keep patient records in that language.

We furthermore see no clear reason why *all* privately-operating traditional acupuncturists in a particular English-dominant jurisdiction should be required to be available for serving patients in the English language. Demographic data characterizing traditional acupuncture practitioners in the jurisdictions under study suggests that it is a small proportion of East Asian immigrant practitioners who self-identify as having minimal English fluency. It is, therefore, the vast majority of practitioners who are available to serve patients seeking English-language care, suggesting no accessibility concerns for this particular ‘public’.

That said, senior practitioners offering traditional acupuncture services in East Asian languages may be seen as providing skilled, culturally-appropriate and linguistically-concordant TM care for a members of an ethno-linguistic minority ‘public’ known to be underserved by mainstream biomedical health care systems. A regulatory approach that threatens to exclude such practitioners may thus significantly compromise health care accessibility (while reinforcing systemic barriers to immigrant professional entry that have been extensively documented). As such, an equitable regulatory linguistic approach for traditional acupuncture practitioners working in English-dominant diaspora jurisdictions should: a) be predicated upon a conception of the ‘public’ that is multiple and diversified rather than singular and monolithic; and b) attend specifically to the distinct needs of both majority and marginal publics.

While we have made some broad policy recommendations here, it is evident that additional work will be needed to further establish the specifics of such an equitable linguistic policy approach. Economic considerations – raised by stakeholders on both sides of the traditional acupuncture language debate – will for instance need to be evaluated, perhaps on a jurisdiction-specific basis.
The degree of English language proficiency needed to ensure patient safety within private policy mechanisms may best enable a subgroup of practitioners lacking English proficiency to continue their clinical work within their language communities, should be furthermore examined. Also warranting closer scrutiny is whether linguistic policy strategies applied in other contexts – such age-based exemptions used in federal immigration tests – might prove relevant to this particular policy area. Our analysis to this point has been largely conceptual and, while theoretically valuable, would ideally be complemented with research documenting the lived impacts on patients and practitioners – respecting safety, traditional knowledge protection, or accessibility – of specific policy approaches implemented across the jurisdictions under study.

As states continue to regulate TM practitioners across the globe, both in their indigenous geographies and in diaspora, innovative policy approaches will become increasingly important, in pursuit of a more equitable medical pluralism. We emphasize that TM professional regulations should not necessarily be modeled to mirror those created for biomedical professionals; nor should they serve to further disenfranchise ethnic minority practitioners who steward these systems’ longevity. Rather, policy approaches should be flexible enough to meet the needs of multiple publics, attend to the health care needs of ethnic minority patients, redress historical inequities, and accommodate TM professions’ culturally-situated features. To better enable critical examination of such emerging regulatory models, we strongly affirm Marian’s (2007b, 2007a) call for regulatory transparency and accountability in such policy projects, particularly when issues of social justice are at stake.
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Chapter 5

Lost in Translation: Language Proficiency, ‘Reasonable Accommodation’ and Chinese Medicine Regulation in Ontario, Canada

This chapter is currently under peer review as a paper for journal publication. Although the chapter data collection, analysis and writing were primarily my own, Dr. Heather Boon is listed as co-author on the paper under review, to recognize her supervisory role on my PhD committee.
Abstract

This work uses the legal principles of *disparate impact discrimination* and *reasonable accommodation* to evaluate a set of controversial linguistic professional entry requirements for traditional Chinese medicine (TCM) practitioners newly regulated in the province of Ontario, Canada. We conducted an extensive document analysis, and 23 key informant interviews with TCM practitioners/leaders and state actors. Our findings strongly suggest that the policies under study produced disproportionate professional registration barriers for East Asian immigrant practitioners with low English language proficiency. We provide recommendations for regulatory redress, and propose theoretical parameters for the culturally-inclusive professional regulation of traditional medicine practitioners.
Introduction

In 2013, the province of Ontario (Canada) implemented regulations granting self-regulatory status to the profession of traditional Chinese medicine (TCM), whose clinical scope includes acupuncture and herbal medicine (CTCMPAO, 2014). Acupuncture is an indigenous health care practice originating in traditional East Asian medicine, practiced in 80% of nations worldwide and regulated in 29 countries (WHO, 2014). Ontario’s TCM and acupuncture practitioners had lobbied their provincial government for regulation since the mid-1980s (O’Reilly, 1999), and the prospect of regulation had been supported by a significant majority of the province’s practitioners (Ijaz et al., 2015) However, in March 2013, just days before Ontario’s new TCM regulations were to come into effect, a subgroup of Ontario TCM practitioners sought to have the regulations overturned in court. At the heart of the case that ensued was a claim that the linguistic registration requirements set out for TCM practitioners in the province were discriminatory, positioning some of the province’s most senior, Chinese immigrant practitioners at a significant disadvantage (CTCMPAO, 2013g).

The regulator’s English or French “language fluency requirements,” the claimants argued, amounted to discrimination under Canada’s Charter of Rights and Freedoms. They argued that the linguistic accommodations provided by the regulator were not “sufficient to overcome the discrimination they alleged which they suggested might bar them and other qualified practitioners from practice, or discourage qualified practitioners from even trying to register” (Yuan, Li v. CTCMPAO, 2014). In January 2014, the judge dismissed the case, on several grounds. He characterized the contested linguistic professional requirements as “common to all other health professions in Ontario,” and necessary for patient safety and inter-professional communication (Yuan, Li v. CTCMPAO, 2014). He noted that Canada’s Charter did not apply to “language rights beyond the [official] English and French languages,” cited “no evidence of any discriminatory impact” on practitioners, and deemed the regulator’s temporary linguistic “accommodation to assist those with language difficulties” to be “reasonable” (Yuan, Li v. CTCMPAO, 2014).

The issue of linguistic proficiency requirements for traditional acupuncture practitioners has proven controversial in a number of English-language dominant jurisdictions, across which a wide range of policy approaches have been implemented (see Chapter 4). This regulatory
problem raises issues common to a range of linguistic policy controversies in multiculturalist states, while also exemplifying the unique challenges associated with regulating traditional medicine professionals. Traditional acupuncture’s diagnostic and treatment approaches are, for example, intimately connected with East Asian culture and history, have long been transmitted in East Asian languages, and have in many cases been globally exported by East Asian immigrants. How indeed may regulators address such issues in policy? To date, few scholars have examined the distinct challenges of regulating traditional medicine occupational groups, or investigated the lived impacts of specific policy approaches that address such professions’ important cultural dimensions.

Drawing on 23 key informant interviews, and a wide range of public documents, this work presents a critical analysis of Ontario’s TCM regulatory language policy over the period 2013 – 2016. With reference to the concepts of equality and equity, the legal principles of ‘reasonable accommodation’ and ‘disparate impact discrimination’, and a United Nations policy instrument addressing linguistic rights, we evaluate the Ontario TCM policy’s reported aims and impacts. Ultimately, this work aims to provide insights for traditional medicine regulators contending concurrently with clinical and cultural considerations, within biomedically-dominant health systems. We begin with an overview of related policies in other jurisdictions, followed by some key conceptual parameters.

Linguistic regulatory policies for traditional acupuncturists in diaspora: an overview

A significant proportion of traditional acupuncture practitioners regulated in the non-East Asian diaspora (such as Canada, the United States and Australia) are immigrants from East Asian countries (Chiu, 2006, Ijaz et al., 2015, Zhou et al., 2012, Lee et al., 1999, Cherkin et al., 2002). A small percentage of practitioners in such jurisdictions have been reported to have low proficiency in the jurisdiction’s dominant or official language (usually English) (Zhou et al., 2012, Lee et al., 1999). State regulators across these jurisdictions have taken a wide range of policy approaches to the issue of language proficiency. For example, in 14 American states and two Canadian provinces, proficiency in the jurisdiction’s dominant language (i.e., English [Province of Alberta, 1988, NCCAOM, 2012], French [LegisQuebec, 2016]) has been made a
non-negotiable condition for professional entry. In the remaining majority of American states (NCCAOM, 2012), and in the province of British Columbia (CTCMA, 2015), regulators have by contrast stipulated no linguistic proficiency requirements for registrants.

Elsewhere, language-proficiency requirements for traditional acupuncture practitioners co-exist with permanent exemptions to these same requirements. In Australia, for example, where all new TCM registrants must today rigorously demonstrate English-language proficiency to enter the profession, long-standing practitioners with low English proficiency were permitted to become permanently registered under an exemption granted during the profession’s initial ‘grandparenting’ period (CMBA, 2012, 2015, 2012). In the Canadian province of Newfoundland and Labrador, English language proficiency is similarly considered a normative registration requirement, but a registration class for non-English fluent practitioners permits their continued practice with language-related conditions (Government of Newfoundland, 2012).

In our previous analysis of political discourses surrounding these linguistic policies, we characterized the range of related views as exemplifying one of two primary political perspectives: equality or equity (See Paper 3). An ethic of regulatory equality, emphasizing “equivalent treatment for diverse parties, regardless of contextual or historically-related factors” (p. 85) predominated among those arguing for mandatory dominant-language proficiency policies. Such arguments (like the Ontario court judgment) typically emphasized public safety, as well as standardized, integrated health systems, as key considerations. Arguments opposing such policies (like the stance taken by Canada’s multiculturalism minister) appear predicated upon the principle of regulatory ‘equity’, which emphasizes context-specific factors, and takes equality of outcomes (rather than equal treatment) as its aim. These equity-based arguments typically focused on the professional inclusion of senior, East Asian immigrant practitioners, and the delivery of culturally appropriate care, as key regulatory priorities.

The current study, which examines in detail the accommodations implemented by Ontario’s TCM regulator, presents a nuanced analysis of the culturally-situated policy tensions at play in traditional medicine professional regulation. We begin with the theoretical parameters that underpin this work.
Disparate impact discrimination and the ‘reasonable accommodation’ principle

A legal principle known as *disparate impact discrimination* has been widely used in evaluating cases in which particular policy or practice is alleged to have *unintentionally* exerted a “disproportionate exclusion of individuals on a protected basis” (Hunter and Shoben, 1998, p. 109). Although language is not a protected class under human rights laws in Canada (OHRC, 2009), the United States (Hill et al., 2008, Thorpe-Lopez, 2007), or Australia (AHRC, 2006) (as it is in the European Union [(Thorpe-Lopez, 2007)])), disparate impact theory has been applied within many language-related cases of alleged discrimination with reference to ethnic or national origin (Hill et al., 2008). In the Canadian context, the related legal concept of *reasonable accommodation* refers to an “exception granted to a person or group of persons for whom a universal rule or practice would have a discriminatory effect” (McAndrew, 2011).

McAndrew notes (2011, p. 47):

> The normative foundations of reasonable accommodation are based on the recognition that, even without the intent to discriminate, a rule or practice that *appears neutral* and that is applied equally to everyone may constitute an infringement on the right to equality.

The legal principle of reasonable accommodation may thus be viewed as fundamentally equity-based, in its pursuit of equal outcomes rather than equivalent treatment, in the face of cultural diversity (Qadeer and Agrawal, 2011). “One talks of equity,” note Qadeer and Agrawal (2011, p. 135) “when referring to the policies and programmes through which the principle of equality is implemented.”

Although the reasonable accommodation principle has been critiqued from across the political spectrum (Qadeer and Agrawal, 2011, McAndrew, 2011, Caron, 2014), the current study rests on the proposition that this approach “increases justice and equality among individuals”, rather than representing “a privilege that provides more rights to some individuals” (Caron, 2014). In cases where a practice or policy has been formally demonstrated - typically using numeric data and/or “qualitative forms of evidence” (Hill et al., 2008, p. 718) - to have exerted a disparate (discriminatory) effect, two steps towards redress typically follow. First, the degree to which the existing policy or practice is required to meet its enactor’s business or institutional mandate must be demonstrated; and second, the problematic policy or practice must be removed, modified or
replaced to correct its discriminatory impact while retaining dimensions of the policy determined to be essential (McAndrew, 2011, Hill et al., 2008).

**Relevant policy-making frameworks**

Regulators crafting statutory measures to govern traditional medicine professionals are certainly not the first to contend with how complex cultural considerations may be addressed in policy. Writing with reference to urban planning policy in the Canadian context, Milroy and Wallace (2004) theorize that there are “three ways of understanding the connection between ethnoracial diversity and planning”. One, they explain, is “to see planning as a technical, neutral activity” in which “there is no place for culture,” an approach that may retain normative “ethnocentric assumptions” (p. 3). This approach, we suggest, aligns with what Rosenblith and Bindewald (2014, p. 595), addressing education policy in culturally pluralistic democratic context, have termed “mere tolerance”: an approach which “renders the least powerful invisible, particularly when it comes to developing or changing policies… allow[ing] for the persistence of social and political inequality.”

According to Milroy and Wallace, a second way of addressing culture in policy is to “recognize ethnoracial diversity as a factor” in the policy process, but not “to treat any one group differently”. This is, we argue, an approach that coincides with what Rosenblith and Bindewald (2014) have termed “tolerance as mutuality,” in which a “shared decision making process” between stakeholders across a range of cultural groups “takes relationality and an acceptance of plurality as its starting points”. Such an equality-based policy approach, however, is clearly distinct from Milroy and Wallace’s third (and recommended) policy-making strategy, which takes equity (i.e., the context-specific, fair treatment of diverse groups) as its structural hallmark.

In such an approach, “ethnoracial diversity is not a separate environmental condition that must be processed through the planning framework. It is the framework, and planning sits within it” (Milroy and Wallace, 2004, p. 4, emphasis in original). In such a process, Milroy and Wallace advise (2004, p. 4), the concept of the “public interest,” which is commonly said to drive state policy making, must be “redefined” to centralize the principle of equity, echoing a regulatory ethic that Rosenblith and Bindewald (2014) call “robust respect”.
With reference to questions around language-related state policies in particular, a 1998 United Nations policy instrument known as the Oslo Recommendations Regarding the Linguistic Rights of National Minorities (UNESCO, 1998) provides additional guidance. The Oslo Recommendations propose that policy questions related to official/dominant language requirements, whether referring to Indigenous ‘national minority’ groups or “other types of [linguistic] minorities” (UNESCO, 1998), be evaluated on a case-specific basis to determine their statutory importance:

In keeping with the logic of legitimate public interest, any requirement(s) for the use of language which may be prescribed by the State must be proportional to the public interest to be served. The proportionality of any requirement is to be determined by the extent to which it is necessary (UNESCO, 1998).

Although the public interest concept has just begun to be theorized as it relates to the professional regulation of traditional medicine practitioners, the World Health Organization has recommended that the principles of safety, quality and accessibility of care be emphasized in such projects (WHO, 2014). More recently, we have proposed that the principles of equity and traditional knowledge protection be additionally taken as core public interest parameters in regulating traditional medicine professionals (Ijaz et al., 2016): a position we take up here.

**Methods**

Our primary aim in this study is to evaluate the degree to which the linguistic communications and accommodations enacted by Ontario’s TCM regulator over its grandparented registration period (2012 – 2014) reflect the principle of ‘reasonable accommodation’, with reference to Chinese immigrant TCM practitioners with low English proficiency. To this end, we have assembled a critical, thematic account of the policy’s reported aims and impacts, using the following methods:

**Public documents**

We collected a wide range of public documents published by Ontario’s TCM regulator between 2013 and 2016, selected for content relevant to the province’s linguistic regulatory policy’s aims and impacts. These documents included the following: minutes of regulatory body meetings; the
regulator’s website and annual reports; yearly reports submitted by the regulator to Ontario’s Fairness Commissioner; court proceedings; and a range of guides and forms related to the process of grandparented registration, written language plans, and linguistic accommodations for safety and jurisprudence testing. Using NVivo software as an organizational tool, we read and re-read these documents, applying thematic analysis methods as described by Braun and Clarke (2006) to extract, code and thematically organize excerpts from these texts that pertained specifically to our research aims. Analysis was conducted primarily by the first author, but confirmed and corroborated by the co-author.

**Interviews**

Over the period 2014 – 2017, the first author conducted qualitative interviews with 23 key informants known to have been involved, in a range of capacities, with Ontario’s TCM regulatory process. These interviews, for which approval was secured from the University of Toronto’s Research Ethics Board, were undertaken as part of a larger PhD research project pertaining to Ontario’s recently implemented TCM and acupuncture regulations. Interviews typically lasted between 60 and 90 minutes each, and proceeded on the basis of a semi-structured interview guide that included questions about informants’ experiences with, and perspectives on, regulatory language considerations. Practitioners were initially approached by email or by hardcopy letter, using Chinese-translated invitations where informants were known to have low English proficiency.

Informants included members of the former TCM regulatory Transitional Council and government staffers (n=6), as well as TCM/acupuncture practitioners and community leaders (n=17). At the time of interview, all practitioners interviewed continued to have active TCM practices; three had elected not to join Ontario’s new TCM regulatory body, and were therefore practising illegally. About half of the practitioners interviewed were East Asian-born immigrants to Canada. Practitioner-informants were offered an honorarium of $75 for participation, in order to partially compensate them for potential income losses associated with their time.

All but three of the interviews were conducted entirely in English; the remainder were conducted in English with the assistance of a Chinese-language interpreter of the informant’s choosing, who was also compensated. Using an iterative thematic analytic approach aligned with that applied to
documents, we reviewed interview transcripts for content pertinent to our study aims, paying close attention to areas of intersection with and/or at odds with document-based findings.

Requests for additional data

On two occasions – in 2014, and again in 2016 - we formally requested that Ontario’s TCM regulator participate in our study, in order to fill gaps left by our analysis of public documents and other interviews. The regulatory leadership explicitly declined to be interviewed on both occasions, and declined to respond to our specific written requests for additional information about the policies under study. Characterizing our inquiry as “very much related to matters in several litigation proceedings,” the regulator noted that it had been “advised by our counsel to refrain from discussing these matters” (Mak, 2017).

Results

What follows is an account of our study findings, in two parts. We begin with an account of Ontario’s TCM linguistic regulatory communication and policy approaches, as represented in a range of public documents. Then, we present a parallel account as reported by the range of key informants interviewed.

Part I: Documentary Analysis

The context of Ontario’s TCM language policy

In November 2006, the Ontario government passed the TCM Act, legislation that would for the first time grant self-regulatory status to the province’s Chinese medicine practitioners (Government of Ontario, 2015). Ontario would be the second Canadian province to regulate the TCM profession - which includes traditional acupuncture as well as Chinese herbal medicine within its scope - after British Columbia (where regulations were implemented in 2008) (Government of British Columbia, 2008). The Canadian provinces of Alberta, Quebec and Newfoundland and Labrador had also previously regulated TCM acupuncturists (but not herbal medicine practitioners) in 1994, 1998 and 2012 respectively (Province of Alberta, 1988, LegisQuebec, 2016, Government of Newfoundland, 2012).
In 2008, a transitional regulatory council was formed in Ontario, mandated “to develop the regulations, standards of practice, policies and guidelines” that would ultimately govern the province’s TCM practitioners (TC-CTCMPAO, 2008). From the outset, the transitional council took a bilingual (i.e., English and Chinese) approach to communicating, in print, with prospective members (although public meetings were conducted exclusively in English). Newsletters, brochures, posters, and minutes of the council’s meetings were disseminated in both languages until the new regulations came into effect in 2013 (e.g., see Figure A).

In 2009, as the transitional council moved towards drafting its registration regulations, policies and standards of practice, it briefly addressed linguistic issues in a bilingual (English-Chinese) newsletter for prospective members:

> Discussions on the use of the Chinese language for communication and record keeping are ongoing. No recommendations have been made as of today’s date. However, it is important to note that to communicate with patients from different cultures, other health professionals, health institutions and insurance carriers, English or French is necessary. (TC-CTCMPAO, 2009)

By 2011, the transitional council had drafted registration regulations that included the linguistic policy stipulations ultimately implemented by the province’s new TCM regulator in 2013 (TC-CTCMPAO, 2011), as detailed below.

Figure A: Pre-regulatory poster, circa 2008
Ontario’s TCM linguistic regulatory policy

In 2013, when Ontario’s TCM professional regulations came into effect, two primary registration classes were introduced for practitioners seeking professional entry. The first, termed ‘general class’ registration, represented a permanent class of membership. Applicants for general class registration would be required to document completion of a relevant three-year, full-time education program, and successfully complete English-language, national entry examinations geared to testing their professional knowledge and skill (CTCMPAO, 2013b). The second ‘grandparented’ registration class, membership in which would expire after a five-year period ending April 2018 (CTCMPAO, 2013c), was geared to facilitating professional entry of long-standing TCM practitioners. Grandparented registration required that the practitioner document at least 2000 TCM patient visits within the five years preceding regulation. As we will discuss further on, applicants for both general and grandparented registration were also mandated to complete registration requirements related to safety and jurisprudence\textsuperscript{11} subjects.

In 2012, prior to the regulations being enacted, Ontario’s TCM regulatory transitional council confirmed to the province’s practitioners – who were now preparing in large numbers to submit their applications for professional registration – that all registered practitioners would ultimately be required to “speak, read and write either English or French\textsuperscript{12} with reasonable fluency” (CTCMPAO, 2013a). Applicants for both the general and grandparented registration classes would be considered sufficiently language-proficient if they could “understand communications coming from” the regulatory body, “complete registration application form,” and achieve a passing grade on the required safety and jurisprudence examinations (CTCMPAO, 2013a, p. 28). All of these registration materials and tests were made available exclusively in English (CTCMPAO, 2013a). The province’s new TCM regulator, like the transitional council before it, would justify its long-term linguistic registration policies on the basis that all practitioners should

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\textsuperscript{11} Jurisprudence tests were meant to test applicants’ “knowledge in the context of practice within Ontario’s healthcare system including the legislative framework, regulatory requirements, etc.” (CTCMPAO 2013a).

\textsuperscript{12} While English and French are Ontario’s official languages, English is the province’s dominant language. Although the province’s TCM regulator has equally designated English and French as the profession’s formally-recognized languages, to date all official TCM professional correspondence and examinations have taken place exclusively in English.
ultimately prove able to communicate effectively (i.e., in English) with patients, other regulated health care professionals, and emergency care providers (CTCMPAO, 2013a).

That said, “in recognition of the language challenges that some applicants for [the] Grandparented class of certificate of registration may encounter,” a temporary exemption from such a language fluency requirement was implemented, to enable some grandparented applicants to “effectively deal with inter-professional collaboration and continuity of care” (CTCMPAO, 2013a) by alternate means (see #1, below). Moreover, three additional temporary linguistic accommodations were implemented to facilitate grandparented applicants’ successful completion of the mandatory safety and jurisprudence examination requirements. Below, we detail the four transitional linguistic policy accommodations implemented by Ontario’s TCM regulator over the grandparented registration period.

Transitional linguistic policy accommodations

1. Written language plan

The first of Ontario’s TCM linguistic accommodation measures, announced by the transitional council in 2012, consisted of a ‘written language plan’ that would enable practitioners with low English proficiency to continue practice over a five-year period ending in 2018. In their written language plans, practitioners were required to “demonstrate how they can effectively fulfill their obligations of inter-professional collaboration and continuity of patient care” (CTCMPAO, 2013h, p. 1). The regulator’s articulated expectation was that such practitioners would make two key commitments. First they would either host “an interpreter/translator/family member on site … during practice hours who is competent… in speaking, reading and writing English or French,” or practise “with another member of the [regulatory body] who is fluent in English or French.” Second, they would enrol in classes to improve their language skills over the transitional period (CTCMPAO, 2013h, p. 1). Ultimately, these practitioners would also be expected to complete an English language general registration transitional process by 2017 if they wished to remain registered (CTCMPAO, 2013c).
2. Use of a bilingual dictionary

The second linguistic accommodation measure, also introduced by the transitional council, permitted grandparented applicants (whether applying to work with a written language plan or not) to bring a bilingual dictionary along to assist them in completing open-book jurisprudence and safety examinations for which the regulator had provided English-language study guides.

3. Take-home safety program

In early May 2013, two months after the regulations had come into effect, and many practitioners had applied for registration, Ontario’s new TCM regulator approved its third linguistic accommodation. This involved “a process to accommodate [g]randparented applicants who failed the Safety Program test because he/she [sic] cannot speak, read and write English or French” (CTCMPAO, 2013d, p. 2) To be eligible for this accommodation, applicants must have submitted a written language plan to the regulator, and have previously failed the English language safety test. The accommodated program required that such applicants prepare a written, safety-related submission “at home with the assistance of a translator retained by the applicant” (CTCMPAO, 2013a, p. 18). The fee associated with usage of the safety test accommodation plan would be $200, twice the cost of the English language safety test (CTCMPAO, 2015).

4. Jurisprudence test with an interpreter

In late October 2013, one year after the regulator had begun offering jurisprudence examinations, it approved its fourth and final accommodation, a “Jurisprudence Course Accommodation Plan for Grandparented applicants lacking in English language fluency” (CTCMPAO, 2013f, p. 1). Eligibility for this accommodation was, as in #3 above, limited to practitioners who had submitted a written language plan (CTCMPAO, 2013e). In implementing this accommodation, the regulator initially “recruited invigilators” fluent in “English and either Mandarin or Cantonese” to staff a series of dedicated, English-language jurisprudence test sessions. Later, the regulator “revised” the accommodation arrangement to “allow applicants to bring their [own] interpreters to the test” (CTCMPAO, 2013a, p. 18). Aside from a bilingual dictionary and English-language study guide, no additional materials would be permitted at the exam. As in #3 above, applicants opting for this accommodation would be levied a $200 fee, twice that associated with the test taken without an interpreter (CTCMPAO, 2015).
Changes in the regulator’s linguistic communication strategy

It was not only the provincial regulator’s approach to linguistic accommodations for grandparented TCM applicants that evolved over time, but also its linguistic communication strategy. Whereas the transitional council had disseminated bilingual public communications in English and Chinese through its term, Chinese-language communications all but disappeared as the new regulations came into effect. As with the mandatory safety and jurisprudence examinations, application guides and forms for professional registration were provided exclusively in English (CTCMPAO, 2013a). The regulator’s logo, which had featured Chinese lettering through the transitional period and into the first year after regulation, changed in 2015 to include a French translation of the regulator’s name alongside the original English, and exclude the original Chinese (see Figures Bi and Bii). The graphic portion of the logo, which featured an acronym of the regulator’s name in English lettering, and Chinese lettering representing the words ‘Chinese medicine’ remained intact in the new logo.

Figure Bi: Logo of Ontario’s TCM regulator, circa 2009

Figure Bii: Logo of Ontario’s TCM regulator, circa 2015

The French language also began to feature more prominently in other aspects of the regulator’s communications as time went on. In 2015, the regulator announced that it would begin “offering a French language services plan”, meant “to better assist the diverse need[s] of applicants” (CTCMPAO, 2015, p. 13). Having “evaluated its resources and compared it to the service demand,” the regulator “decided to build capacity in phases with the first phase being that certain pages of the website be available in French” (p. 13).
In addition to this French language focus, the linguistic communication strategy would shift, within the first year after regulation, towards a less Chinese-focused approach. For instance, in 2014, as the grandparented registration period was coming to a close, the regulator used a two-fold multilingual communication strategy to “reach out to all eligible candidates” (CTCMPAO, 2014b, p. 1). First, it “posted a notice on its website in five different language groups: English, Chinese, Russian, French and Korean” (CTCMPAO, 2014a, p. 8). Second, it:

placed over 50 advertisements in local and mainstream newspapers targeting nine different language groups: English, Cantonese, Mandarin, Russian, French, Korean, Vietnamese, Indian13, and Iranian (CTCMPAO, 2014a, p. 8).

We turn now to the regulator’s account surrounding uptake of its linguistic policy accommodations.

Uptake of language accommodations

Over the period 2013 – 2015, the regulator received no “request for services or communications in French” (CTCMPAO, 2015, p. 13); data about requests for service in other languages were not reported. Jurisprudence exams began to be offered in October 2012, and safety tests in January 2013 (TC-CTCMPAO, 2013), but it is unknown what proportion of applicants elected to use a bilingual dictionary to complete these tests. Soon after Ontario’s TCM regulations came into effect in April 2013, however, anecdotal reports published in Canadian national print media suggested that a number of practitioners may have failed safety and/or jurisprudence examinations for reasons related to language proficiency (Canadian Press, 2013), despite being permitted to use a dictionary.

That year’s reported pass rates on the jurisprudence and safety exams were 98% and 92% respectively; and the provincial TCM regulator indicated that it “has not been faced with a situation where [safety and jurisprudence] test results were below desired levels” (CTCMPAO, 2013a, p. 33). However, the regulator reported having made a series of “email[s] and phone

13 “Indian” is a national identifier but not a language group. It is unclear in which South Asian language(s) the regulator published its notices.
calls” to contact applicants who had initially failed the tests for linguistic reasons, inviting them to retake the tests with additional accommodations (CTCMPAO, 2014b, p. 18).

It is unknown what proportion of reported failures may have been associated with an applicant’s low English language proficiency. That said, the number of applicants who enrolled in the take-home safety test accommodation program over the first year it was offered was 94; the same number of applicants are recorded as having failed the dictionary-accommodated safety test the previous year (TC-CTCMPAO, 2013). Thirty-three practitioners enrolled in the interpreter-accommodated jurisprudence exam in the first year it was offered, in contrast to 30 who had failed the dictionary-accommodated test the previous year (TC-CTCMPAO, 2013).

By 2015, 234 practitioners, representing 8% of the total active membership in Ontario’s TCM regulatory body, had been registered to practice with a written language plan (CTCMPAO, 2016), signalling a self-disclosed lack of English or French proficiency. Of the 234 practitioners with a written language plan reported to achieve professional entry, 47% (n=111) achieved professional entry using the take-home safety test and 22% (n=52) using the interpreter-assisted jurisprudence exam (CTCMPAO, 2014a, 2015, 2016). The remainder may be presumed to have completed these requirements without interpreter assistance.

**Demographic registration data**

The regulator has additionally made public a range of registration-related data that relate either directly or indirectly to issues surrounding language proficiency. With respect to the languages spoken by the TCM regulator’s professional members, the only data released are in narrative form, as follows:

> We know our practitioners are a very diverse group, hailing from all over the world and speaking 78 languages. Forty-five percent of our members speak two languages, 27% speak three languages, 6% speak four languages and we have members that can speak up to seven languages (CTCMPAO, 2014a, p. 4).

Although not directly related to language, Ontario’s TCM regulator has also released data pertaining to the country in which applicants for TCM professional entry received their initial TCM training, as well as the age of its professional members. As detailed in Table I below, over
the period 2013 – 2015, about half of all applicants were known to have been trained in Canada, one third in China or another East Asian country, and the majority of those remaining in an unknown or undisclosed location. As seen in Table II, almost half of all TCM practitioners registered over this same period were over the age of 50. The potential relevance of these particular demographics will be discussed below.

TABLE I: Ontario applications for TCM professional registration by country of training, 2013-2015

<table>
<thead>
<tr>
<th>Country of training</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>1188</td>
<td>667</td>
<td>48</td>
<td>1903</td>
</tr>
<tr>
<td>China</td>
<td>885</td>
<td>301</td>
<td>5</td>
<td>1191</td>
</tr>
<tr>
<td>USA</td>
<td>40</td>
<td>46</td>
<td>1</td>
<td>87</td>
</tr>
<tr>
<td>Korea</td>
<td>34</td>
<td>14</td>
<td>0</td>
<td>48</td>
</tr>
<tr>
<td>Russia</td>
<td>28</td>
<td>10</td>
<td>0</td>
<td>38</td>
</tr>
<tr>
<td>Japan</td>
<td>23</td>
<td>0</td>
<td>0</td>
<td>23</td>
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<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>235</td>
<td>196</td>
<td>3</td>
<td>434</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>2433</td>
<td>1239</td>
<td>58</td>
<td>3730</td>
</tr>
</tbody>
</table>

(Adapted from CTCMPAO, 2013a, 2014b, 2015)

TABLE II: Age range of Ontario TCM registrants

<table>
<thead>
<tr>
<th>Age range</th>
<th>% of registrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 30</td>
<td>2.2</td>
</tr>
<tr>
<td>31 – 40</td>
<td>17.6</td>
</tr>
<tr>
<td>41 – 50</td>
<td>32.7</td>
</tr>
<tr>
<td>51-60</td>
<td>33.7</td>
</tr>
<tr>
<td>&gt; 60</td>
<td>13.8</td>
</tr>
</tbody>
</table>

(Adapted from CTCMPAO, 2016)
Part II: Interview-based findings

Below, are the results of our 23 interviews with members of Ontario’s TCM regulatory transitional council, provincial government staffers involved in the TCM regulatory file, and finally with TCM practitioner/leaders.

State actor accounts

Regulating in the ‘public interest’

In describing the development of Ontario’s TCM linguistic policy approaches, government staffers and former transitional council members alike referred to the ‘public interest’ principle as a driving conceptual parameter. These informants emphasized protection of the public, and quality of TCM care, as core public interest dimensions:

The role of the regulatory body in Ontario is about protecting the public, it’s not about protecting the profession. …So the question was, how would you balance [the profession’s unique features with] the public interest and public safety. (Provincial government staffer)

Many practitioners are well-versed with Chinese medicine but are not well-versed with English. If the practitioner [is] not allowed to practice because of the limitation of English ability, then the public will not be benefited. …It comes [down] to the quality of the treatment. Public interest is the quality of the treatment. (Former Transitional Council Member)

TCM as a unique profession

State actors also consistently emphasized several features that distinguished Ontario’s new TCM profession from the province’s other regulated professions, including the TCM group’s distinct medical epistemology, modes of associated training, and ethno-linguistic make-up:

What was very unique, which is not the case for other professions, is that some TCM practitioners will not be learning in Canada, practitioners who will practice in traditional Chinese medicine obviously know the language, and it’s a philosophy of its own. (Provincial government staffer)

This is one of the more unique professions in Ontario. Certainly every other regulated profession has a portion of internationally-educated [members], and a portion of those
that don’t speak English or French as a first language, but in terms of it being the majority, I’m not aware of another example. (Provincial government staffer)

The TCM regulator had, we were told, carefully taken these unique occupational features into account alongside the articulated public interest considerations, as it negotiated its linguistic policy development:

My impression when dealing with the transitional [council] registrar and the current [regulatory] staff is that they took all of those issues into account when they were developing their procedures. …They were working around being flexible in order to have a language fluency requirement but enable practitioners to have time, especially those in the grandparented class, to be able to demonstrate fluency. I do recall that they were taking measures to be able to bring people in, and not leave people without a livelihood. I think it [the language issue] was taken very seriously, but certainly it’s a very difficult issue for them. I’m not aware of another profession that has had to grapple with it to this degree. (Provincial government staffer)

Range of perspectives in the policy process

Over the course of our study, we spoke with individuals who had previously been transitional council members, who provided additional details as to how the regulator’s linguistic communication and policy strategies unfolded. According to one such informant, the decision to initially provide bilingual information materials about regulation (such as newsletters) in both English and Chinese languages through the pre-regulatory period had been uncontroversial within the council: “Everyone agreed, we should have both English and Chinese”. Two of the three transitional council members we spoke with were clear that they had also advocated for long-standing, skilled practitioners with low English language proficiency to be ultimately granted permanent registration without necessarily having to learn English. For example:

Some individuals, they’re over 70 years old, over 80 years old, even near 90, they’re still very, very valuable to the community and to the profession but their language is lacking. I always felt it would be really, really bad to have them drop practicing because of the language barrier. (Former Transitional Council Member)
However, the third member we interviewed expressed ambivalence around this point, ultimately advocating English proficiency for all TCM practitioners while permitting temporary, transitional linguistic accommodations for those with low-English proficiency:

Ideally I wanted to see those really qualified TCM practitioners to continue their practice while we are encouraging them to update and to upgrade their language. On the other hand, for the new practitioners we have to make sure that we are at the same level with all of the other regulated health care professions in Ontario, including our professionalism, our language and the standard of care and service and so on. Personally, I feel that [an English] language requirement is very essential. (Former Transitional Council Member)

We heard that a range of views as to how to best craft linguistic proficiency and entry policies for the new TCM profession had been present within the council, and that these issues had at times proven contentious:

I was a strong advocate to include the Chinese language in addition to English and French. But I had difficulty to get full support from my colleagues in the [transitional] council and we finally came to compromise [with the eventual policy]. …Some shared my view, but not the majority. (Former Transitional Council Member)

There were members of the [transitional] council who wanted to have the [registration] exams in Chinese [as well as in English] and then that was just said [to be] impossible. There was maybe [a] couple of people who were a bit strong about it but their language was very limited. (Former Transitional Council Member)

**Polarization along ethnic and epistemic lines**

One previous transitional council member, who said she had advocated for a permanent language exemption for senior Chinese immigrant practitioners, described a polarization as having been present within the transitional council along both ethnic (i.e., Chinese vs. non-Chinese) and epistemic (TCM vs. biomedical) lines:

[Ethnic] Chinese practitioners inside the [transitional] council, they had the same view as me, [but those with a] different background and different upbringing may not share my view. That’s the key point. Some council member[s] were very strong in Western medicine background, not very strong in Chinese medicine background. I would say very few council members have [a] really strong Chinese medicine background. (Former Transitional Council Member)
Cost as a policy determinant

One transitional council member recounted that cost had been a deciding factor in determining whether regulatory application materials should be made available in both English and Chinese:

We had discussions about translating the documents to Chinese and some of the council members suggested or requested to have essential materials be translated to Chinese. This suggestion was denied because of the cost. (Former Transitional Council Member)

Pressure from the provincial health ministry

Notably more than one former transitional council member indicated that the language policies ultimately adopted by the council had been shaped in light of political pressures from Ontario’s provincial Health Ministry:

When I was in the Transitional Council, I felt that everything was under the control of the government, the Ministry of Health. We were told at the time that [on] the language issue, there was no negotiation, period. I had no idea why the [Council leadership] was saying this but always the lawyer just backed [the leadership] up saying that according to the law, that is not allowed, our official language in Canada is English and French. But… you probably know that in BC [the province of British Columbia] they do offer the examinations in Chinese. (Former Transitional Council Member)

The Minister of Health wanted it that way. Because they say they recognize English and French. It was with the Ministry of Health, they have to agree with the regulation and the procedure. (Former Transitional Council Member)

One provincial government staffer noted that Ontario’s self-regulating professions would typically set their own professional entry requirements in consultation with their governing Ministry:

The procedure normally when a profession is drafting regulations [is] they have to work with the Ministry of Health and Long Term Care on that. But the professions themselves are expected to be the experts in their field and to have a rationale for the requirements that they set. (Provincial government staffer)
Another provincial staffer with close involvement in the TCM professional regulations alluded to some linguistic policy expectations implied from the ministerial side:

There was an expectation that, as part of a regulated profession, you would be accessible to the public fairly broadly. I think there was probably a bit of an expectation [in terms of language policy], but I don’t think, I don’t remember it ever being very crisply articulated. (Provincial government staffer)

Summary

Overall, our interviews with state actors suggested that the province’s TCM regulator had worked to negotiate multiple policy priorities and demands within the context of a notably distinct traditional medicine profession. It was also clear that a range of perspectives had been expressed within the TCM transitional council as it developed its linguistic professional entry policies. Some transitional council members did not feel that their voices had been sufficiently represented in the policy making process, and indicated that various factors (including cost and political pressure) may have been at play in shaping the regulator's linguistic communication strategies and registration requirements.

TCM Practitioner Accounts

Across our interviews with TCM practitioners, many of whom were community leaders, we heard that the linguistic policy approach taken by their provincial regulator has proven insufficient in several respects. Practitioners with low English proficiency who successfully registered using one or more accommodations expressed a sense of dissatisfaction with these accommodations. Several informants indicated that the accommodations provided by the regulator had been insufficient. Some informants reported having relied on translated resources prepared by TCM practitioner organizations in order to successfully register. Others did not attempt registration for linguistic reasons, reportedly retiring prematurely or practising illegally after the regulations came into effect. The non-registration of many experienced, immigrant TCM practitioners who acted as mentors to many junior practitioners would, we heard, significantly impact the ongoing transmission of important TCM knowledge and, ultimately, erode the integrity of the profession itself.
Practitioners joined with difficulty

Some study informants told us about immigrant Chinese practitioners with limited English proficiency who, despite linguistic barriers, had achieved TCM professional registration; for example:

I’ve seen a lot of people do the exams, even our own [practitioner association’s executive member], she’s over eighty. Her English is not very good, but she studied, and she did the jurisprudence and safety program tests in English, you know. It was a struggle for her but she did it. It’s kind of insulting… that takes a lot of courage to do it. (Practitioner)

However, as in the previous excerpt, these accounts commonly alluded to practitioners’ dissatisfaction with the regulator’s linguistic regulatory approach. Another practitioner we interviewed through an interpreter, who was registered to practice with a written language plan, described his experience availing himself of the regulator’s linguistic accommodations for the safety and jurisprudence test requirements. Again, a sense of the practitioner’s distaste with the registration process is evident:

We waste[d] a lot of money. So the first thing is that you have to write a safety test in English, and pay $100 for that. And then after not passing you request a language plan, the safety accommodation plan, another $200. And then you have to translate it so you hire a translator, another money for there. So it’s like wasting, he felt like he had to pay a lot just to pass the safety. You had to pay the money twice. And for the jurisprudence test the translator version is actually more expensive than the regular one. (Practitioner)

Accommodations provided by the regulator were insufficient

One practitioner, who had been active within one of the province’s larger TCM practitioner associations, indicated that her association had lobbied the regulator for additional safety- and jurisprudence-testing accommodations (beyond the use of a dictionary). She reported that the second set of linguistic accommodations implemented by the regulator, in which practitioners were permitted to complete these tests with the assistance of a translator, may have been implemented as a result:

We [have] an association, so at the [time of the] safety and [juris]prudence entrance tests, we requested, we don't speak English, what can we do. Our association is mainly non-English speakers so they have sent in a request to see if we can write it in Chinese or have it translated. Okay, and then we signed the request and our association president spoke to the college registrar. And then they have agreed upon having [use of a] Chinese translator [permitted for these two tests]. (Practitioner)
Another informant explained that two different professional associations also produced and disseminated Chinese language translations of the jurisprudence- and safety-test study guides to hundreds of TCM practitioners with a wide range of English proficiency levels, to assist them in studying for these tests:

[Name of association] went and translated [the jurisprudence and safety test handbooks] into Chinese for the membership. The original is English, it's [from] the [regulator]. We charge for the copy cost, to Chinese people. We order five hundred [of each translated handbook]. Safety, we only have a few copies left. [Jurisprudence], those are all gone - that went faster. And we're not the only one who translated this. There was another association, they also translated [the handbooks]. (Practitioner)

We heard from several practitioners who maintained that they (and/or others they knew) would not have felt adequately prepared for the mandatory safety and jurisprudence exams if they had only had access to the resources provided by the regulator. One informant, interviewed through an interpreter, described his experience:

Our association translated the jurisprudence [handbook] into Chinese, so he read [it] many times. He wouldn’t have been able to do it without this translation. He says, if I understand the English of the jurisprudence book then I wouldn’t need a translator. Without the Chinese version, he would not even know what’s going to be tested. (Practitioner)

### Practitioners did not attempt registration

We heard that many long-standing practitioners had found the prospect of attempting English-language safety and jurisprudence examinations too daunting to undertake. Some of our practitioner-informants described the regulator’s provision of English-only registration materials as having dissuaded some of their colleagues from applying for regulatory membership:

I know a group [of practitioners] that did not even register for the grandparented. Too difficult. Because the forms [were] in English. Now first they don’t even understand English, so how can they fill out the form? (Practitioner)

Across such accounts, informants characterized the regulator’s linguistic registration policies and accommodations as culturally insensitive, unjust, and disrespectful to the position of senior TCM practitioners.
So many qualified people who don’t speak very good English do not go register or cannot go register because they could not pass the test. They feel insulted because they’re being discriminated [against], like, I’ve been practicing for twenty, thirty years, why am I being asked to do this, for what? … This tells me they’re trying to push us out. (Practitioner)

People with experience, years of experience, they won’t go to the test. They’re not registered. There are many, there are hundreds. Some will be forced to do underground, you know. And, if they have to make a living, they have no choice. … Things are not fair to them. There’s no respect there for the profession. (Practitioner)

**Loss of senior professional mentors**

Several informants emphasized that the premature retirement, or underground status of senior practitioners who had not joined the new profession for language-related reasons would significantly compromise the transmission of important, experience-based TCM knowledge from one generation of practitioners to the next:

If the senior doctors are still practicing, then the new student[s] can learn from them. But now because of this [regulatory stipulation], many of the senior practitioners have retired and they cannot teach. (Practitioner)

It’s kind of sad that a lot of the senior masters, they just gave up and left. They decided to leave the country or the province. They say they don’t think they can make it in Ontario, so they left. And I feel like it’s sad because you’re supposed to be our mentors, you know, you have a lot of clinical experience that you could teach the next generation. (Practitioner)

One senior practitioner we interviewed, who had long lobbied for TCM regulation, drew attention to the broader historical context of the policy’s reported negative impacts, and called for immediate policy measures to redress them:

I’ve been practicing for over 40 years. At the beginning I went underground because the law does not allow me to practice. I received many calls from the [Ontario regulator for physicians and surgeons]. They say you should not practice Chinese medicine because you are not licensed. … They try to bring me to court. Today the [TCM regulator] need[s] to understand for instance that hundreds of practitioners went underground. Why they went underground. I have mentioned that [to the regulator], but they don’t seem to take it serious. What’s important is the change of the policy. If the policy change[s], then these people will come out.
Discussion and Conclusions

Our account of Ontario’s TCM linguistic policy approach over its transitional and grandparented regulatory period – as we will argue in what follows - tells the story of a traditional medicine regulator torn between competing policy priorities and contrasting regulatory epistemologies. It is also a tale of political irony, in which a marginal community of traditional medicine practitioners once deemed illegal by the state successfully pursued the statutory aim of self-regulation, eventually achieving this goal but with the ‘side effect’ of producing a new category of experienced illegal practitioners from within. But before proceeding with our conceptual analysis, it is important to draw attention to three key points.

First, dominant or official language proficiency has been consistently characterized as a barrier to immigrant professional entry across a range of occupational groups (Novak and Chen, 2013, Ngo and Este, 2006, Sakamoto et al., 2010, Kingma, 2001). Second, while institutional modes of training are increasingly becoming the norm in the TCM field (Flesh, 2013), the fact remains across many traditional medicine systems that “non-codified traditional medicinal knowledge which has not been fixed in writing” is frequently “passed on in oral traditions from generation to generation” as part of “the customary framework for developing, passing on and governing access to TK [traditional knowledge]” (WHO, WIPO, & WTO, 2013). Finally, the principle of ‘filial piety,’ or respect for elders, is widely recognized as a core cultural value across East Asian societies, often attributed to the influence of Confucian, Taoist and/or Buddhist thought (Smith and Hung, 2012, Lan, 2002, Laidlaw et al., 2010, Lai, 2011).

In this light, and on the basis of our study findings, we argue below that the linguistic communication approach and grandparented registration parameters implemented by Ontario’s TCM regulator has exerted a discriminatory disparate impact upon a significant subset of the province’s senior, Chinese immigrant practitioners. This impact, we find, is not clear in official data that appear to indicate that the temporary linguistic accommodations implemented by the regulator were significantly effective. These accommodations, while certainly used by many applicants for professional registration, do not (we argue) represent ‘reasonable accommodations’ to adequately address the needs of a key constituency within the province’s TCM occupational group. We theorize that a key conceptual feature underpinning the inadequacy of the linguistic accommodations crafted involves the regulator’s (perhaps
inadvertent) subordination of the principle of regulatory equity to that of equality as described above. With reference to the ‘public interest’ and the concept of ‘robust respect’, we present a set of recommendations for redressing the specific impacts of the policy under study, while drawing broader conclusions with regards the statutory regulation of traditional medicine professionals more generally.

A convincing case of disparate impact discrimination

The legal principle of disparate impact discrimination, as noted earlier, is predicated on the absence of intent (in the presence of impact) to disproportionately exclude or harm members of a protected group. State actors’ accounts, as well as the fact that several linguistic registration accommodations were offered, affirm that Ontario’s TCM regulator made considerable efforts to inclusively address the occupational group’s unique ethno-linguistic makeup. As such, the evidence suggests there was no intent to discriminate on the regulator’s part. Practitioner informants, however, provide an account that sharply contrasts with the official record, that rendered professional registration unfairly difficult or daunting for an unconfirmed but not insignificant number of the occupational group’s most respected senior Chinese immigrant practitioners. As we now discuss, we find practitioner accounts from our study to convincingly demonstrate a case of disparate impact discrimination in need of redress.

Over its grandparented registration period (2012-2014), Ontario’s TCM regulator implemented four types of linguistic accommodations to facilitate the temporary professional entry of long-standing practitioners with low English proficiency. These involved, initially, a ‘written language plan’ registration option and permission to use a bilingual dictionary at mandatory safety and jurisprudence examinations; and, subsequently, the option of completing the aforementioned examination requirements with an interpreter. In principle, these accommodations, representing alternate or supplementary routes to ‘standard’ professional registration requirements on the basis of linguistic need, appear aligned with the legal principle of reasonable accommodation.

These accommodations were evidently used by a considerable number of applicants for TCM professional registration. Those who used them appear to have been largely successful in achieving professional entry. However, our practitioner interviews raise the suspicion that these
accommodations were not sufficient to address the needs of all TCM practitioners for whom they were crafted.

For example, practitioner informants repeatedly indicated that Chinese-translations of the regulator’s safety- and jurisprudence-exam handbooks made available by community-based practitioner associations played an important role in many (perhaps hundreds) of applicants’ completion of these tests. We spoke, furthermore, with practitioners who indicated that they – and others they knew - would not have felt able to successfully prepare for these exams without the Chinese-translated handbooks. A disproportionate onus, we argue, was thus placed on non-English proficient applicants to seek out community-based resources to facilitate their professional entry in the absence of relevant support from the regulator. For some practitioners, our study informants made clear, this burden was experienced as being so heavy as to prevent them from attempting to register, precipitating their premature retirement or illegal practice.

The judge in a related Ontario court case argued, in dismissing claims of related discrimination, that “none of the practitioner Applicants have attempted to take the exams, even with the accommodations offered and consequently there is no evidence of any discriminatory impact” (Yuan v. Li, 2014). The case judge, of course, cannot be held accountable for evidence not presented in the legal proceedings (i.e., the accounts of our study informants). We are moreover aware that it is not the court’s place to negotiate policy solutions. That said, we contend that in the current context, the aforementioned legal argumentation does not sufficiently address the range of factors at play. In particular, such argumentation inappropriately places the burden of ‘reasonable accommodation’ not on the regulator, where it belongs, but on members of the group in need of such accommodation.

As is evident from historical documentation of Ontario’s TCM regulatory process, the claimants in the language-related TCM court cases were persons who had long lobbied for statutory self-regulation (Government of Ontario, 2006). Similarly, a survey of Ontario’s TCM practitioners prior to the regulations coming into effect made two points clear: a) the vast majority of practitioners, across demographic groups, supported regulation in principle; and b) a considerable proportion were concerned about the way that regulation was to be implemented, including with respect to linguistic registration requirements (see Paper 3). One may conclude on this basis that for both the court claimants, and for those practitioners reported to have
prematurely retired or continued to practice underground rather than attempt registration with the province’s new TCM regulator, their decisions in this regard were not due to their not wanting to become registered. Rather, these practitioners’ decision not to attempt registration may be seen as reflecting the insufficiency, that is, the unintentional cultural insensitivity, of the accommodations provided (as previously suggested by Canada’s federal multiculturalism minister (Artuso, 2015).

Practitioner informants interviewed in our study repeatedly characterized their regulator’s linguistic entry requirements as ‘insulting’ and ‘disrespectful’, arguably reflecting a widely-felt, and culturally-situated sentiment within the TCM practitioner community. This stance, we suggest, not only reflects the principle of ‘filial piety’ that is endemic across East Asian cultures, but also the critical and revered position of senior practitioner mentors within traditional medicine systems such as TCM. That our study informants consistently depicted the linguistic accommodations offered by the regulator as having trespassed these important cultural values is a clear signal that these accommodations should not be considered to have been reasonably or sensitively crafted. To hold practitioners accountable for such cultural insensitivity, in policy, represents a step away from, rather than towards, setting up reasonable accommodations.

In order to reliably conclude whether disparate impact discrimination has indeed occurred in the current context, and whether the accommodations provided were indeed reasonable, it is important to address the available demographic evidence. The regulator has indicated that at least one-third of applicants for professional registration over the grandparenting period had trained in China, a statistic that (in the absence of more precise data) may be roughly viewed as a proxy for the proportion of Chinese immigrant applicants. Moreover, that the regulator is known to have exclusively enlisted Chinese language interpreters to staff a limited series of accommodated jurisprudence examinations, strongly suggests that it was primarily Chinese speakers (and thus likely Chinese immigrants) who struggled to complete registration requirements for linguistic reasons.

Unfortunately, while practitioner informants consistently indicated that senior Chinese immigrant practitioners of advanced age were most severely impacted by the regulator’s linguistic policies, no demographic data are currently available that would permit a statistical exploration of such an age-related correlation. In the absence of data, however, this suggestion is
historically consistent with the well-documented point that widespread English language education would have been virtually absent in China until the late 1970s, after the death of Mao Zedong (Hu, 2004). If, as our study findings strongly suggest, it is indeed Chinese immigrant practitioners, likely over the age of 50, who have struggled disproportionately to register (or did not attempt registration because it appeared too daunting), then the regulator’s temporary linguistic accommodations should not be seen as ‘reasonable’. We thus make the case that disparate impact discrimination has likely occurred.

Such discrimination, we posit, is particularly significant in light of the role of senior Chinese immigrant practitioners are known to play within the occupational group as a whole. Those disadvantaged by the process, we argue, should be compensated if only to preserve the integrity of Ontario’s TCM profession. In order to propose potential mechanisms of redress that may prove advantageous in Ontario’s context, and theoretically illuminating more broadly with respect to the question of traditional medicine professional regulation, we shift our focus to a more conceptual analysis of the accommodations provided by the regulator.

Competing policy imperatives

As has been repeatedly demonstrated within other policy contexts, competing or even contradictory philosophical or political imperatives commonly co-exist in state accounts of particular policies (Norwich, 1996, Ball, 1994, Marshall and Patterson, 2002). Such “ideological impurity” (Norwich, 1996) is suggested in our study of Ontario’s TCM language-related policy approach. In fact, Ontario’s TCM regulator appears to have been both sequentially and concurrently driven by equity- and equality-based impulses in its linguistic communication strategies and grandparented registration requirements. Ultimately, however, it is the principle of regulatory equality that underpins the policy process, giving rise to a series of detrimental impacts. The sequential character of these impulses is particularly evident as we examine the linguistic communication strategies engaged by Ontario's TCM regulator over time.

We would characterize the transitional council’s earlier, Chinese-English communication approach as equity-based, in its attempt to inclusively target the TCM practitioner community’s preponderance of Chinese immigrant practitioners. But, later communications no longer respond
to the context-specific conditions of the occupation, instead emphasizing Canada’s official languages, while ‘equally’ targeting a wide range of language groups. State actors interviewed have variously alluded to political pressures from within the provincial health ministry, and demographic features of the transitional council makeup, as potential contributors to this shift towards more equality-based communication strategies. But, for whatever reasons, an important conceptual change occurred.

Parallel discourses of equity and equality principles are evident in the transitional council and regulators’ linguistic registration policies. In contrast to the sequential shift that is evident in regulatory communications, the principles of equity and equality appear concurrently at odds in the policies adopted. On one hand, our interviews with state actors suggest that the regulator had taken an equity-informed approach to developing its range of linguistic policy accommodations, emphasizing fair outcomes (as compared to identical treatment) for all practitioners. Indeed, the narratives of these study informants seem to echo equity-based discourses identified in a previous related study, focused on crafting a “a set of unique … regulatory parameters” for Ontario’s unique TCM profession, with a particular emphasis on preserving the “traditional medical expertise of senior practitioners lacking English fluency” (citation removed for anonymity).

On the other hand, the regulator’s long-term linguistic policy framework exemplifies the notion of regulatory standardization, which is a hallmark of equality-based thinking. Indeed, the regulator made clear from the outset that despite its provision of temporary linguistic accommodation options, all registered TCM practitioners would ultimately be required to demonstrate proficiency in one of the jurisdiction’s official languages (English or French) at the end of the grandparenting period. The policy rationale made explicit by the regulator in this regard echoes the discursive themes commonly cited in equality-based policy argumentation across other jurisdictions regulating traditional acupuncture practitioners, emphasizing patient safety and standardized, integrated health care systems (see Chapter 4). Nowhere does the regulator make clear how or why a permanent adoption of its temporary accommodations might be understood to compromise these regulatory priorities of standardization and safety. Further, the most experienced mentors in TCM might be assumed to be its leaders, who therefore promote safety through their superior knowledge.
This point begins to expose how equality – rather than equity – was the driving conceptual force underpinning these accommodations. A more equity-driven approach, we suggest, would have made such accommodations not only more permanent, but also would not have constructed and idealized English proficiency as the normative, or normalized condition for registered TCM practitioners. The regulator’s approach implicitly constructs as ‘Other’ or ‘deviant’ the subset of East Asian immigrant practitioners who – despite their senior status within the occupational group as a whole – have low English proficiency. Such ‘Othering’ is also evident in the piecemeal fashion through which the Ontario accommodations were implemented (i.e., as ‘addons’ rather than as normative options), and the additional fees associated with them. By construing low English proficiency as something in need of long-term correction or rehabilitation for practitioners grandparented to work with a ‘written language plan’, such a problematic implied deviance is made yet more explicit. Further, no value is placed on the linguistic and cultural connection between TCM Chinese speakers and diaspora of patients with which they might be associated.

We suggest that this case calls for additional investigation by provincial government bodies, in collaboration with TCM practitioner organizations, to determine the extent to which the province’s TCM practitioners may have been detrimentally impacted by the policies under study. Predicated upon our existing study conclusions, we address below – both practically and conceptually – how appropriate redress for the policy problems examined in this work may be crafted, and discuss the relevance of our study findings to the statutory regulation of traditional medicine professionals more broadly.

Reconciliation of disparate policy impacts

We see two primary aims as key in addressing the disparate impacts suggested in our study to have resulted from Ontario’s TCM linguistic regulatory policies: first, reconciliation of existing harms; and second, prevention of further harms. Overall, we recommend that Ontario’s TCM regulator implement the following urgent policy changes:

1. Undertake a campaign to recruit long-standing Chinese-speaking immigrant practitioners with low English proficiency who did not register during the grandparented registration process, without penalizing practitioners. Provide these practitioners, and new East Asian
immigrant practitioners over age 50, with the option to register into the grandparented class over a three-year period.

2. Revise registration policy so that grandparented practitioners over age 50, with a written language plan, are not required to transfer to general class membership but may stay permanently in the grandparented class.

3. Make registration materials and all mandatory examinations available in both English and Chinese moving forward, as in the province of British Columbia.

4. Permit all practitioners over age 50 to register to work with a written language plan, including new registrants who complete Chinese language examinations.

5. For practitioners with a ‘written language plan’ revise policy stipulations so that:
   a. Practitioners are not required to host an English-language translator onsite.
   b. Patients sign informed consent documents confirming their awareness of the practitioner’s linguistic limitations. Such documents should be standardized and made available in English and Chinese by the regulator.
   c. Patient identifying information and emergency contacts be kept in English on such documents to facilitate health systems continuity in emergencies.
   d. Patients are responsible for arranging and/or funding the services of language interpreters on an as-needed basis.

In line with Milroy and Wallace’s culturally-inclusive policy-making framework, our recommendations take the principle of equity as the central axis around which the statutory regulation of traditional medicine professionals be conceptualized. Aligned with the Ontario government’s mandate to implement fair registration practices across its regulated professions (Office of the Fairness Commissioner, 2012), our recommendations also prioritize the principle of traditional knowledge protection to honour the TCM profession’s Chinese cultural roots. Our analysis to this point has made evident the detrimental policy impacts that may occur when equity – and traditional knowledge protection - are not taken as primary driving principles underpinning such regulations, even when these principles are applied as secondary policy aims.

By actively recruiting practitioners for whom previous linguistic accommodations may not have proved sufficient, and by implementing a permanent mechanism through which Chinese immigrant practitioners may both register professionally and continue to practice in the Chinese language, the principles of equity and traditional knowledge protection are centred, consistent
with the TCM healing tradition. The intersecting public interests of facilitating patient culturally-appropriate access to high quality TCM care from across the occupational group’s most senior practitioners are also served by our recommendations. As advised in the Oslo Recommendations Regarding the Linguistic Rights of National Minorities, the various public interests at play in a particular language policy issue should be proportionally addressed in relation to their respective necessity. In this regard, the issue of patient safety warrants some attention.

As noted in a previous work on linguistic regulatory policies for traditional acupuncture practitioners, “the potential for linguistic miscommunications between practitioner and patient produces a risk of harm that policy makers should not altogether ignore” (see Chapter 3). However, the study authors also point out that a “new set of safety considerations might arise should [some] practitioners continue practice, illegally … [as] patients potentially harmed within the context of such illegal care would have difficulty securing legal recourse” (see Chapter 3). Our recommendations aim to concurrently address both of these safety concerns by bringing underground practitioners into the regulatory fold, while entrenching accountability mechanisms to facilitate safe, skilled and consented-to communications between practitioner and patient.

As McAndrew (2011) has noted with respect to the process of crafting reasonable accommodations to address discriminatory policies or practices:

> The main limit that can be invoked by the corporate or public sector leaders, either to justify the denial of certain requests or in a more positive manner to propose an alternative solution, is that of undue hardship [emphasis in original]. This is to demonstrate that the given request challenges the very capabilities of the institution to carry out its mandates… [including] elements such as financial costs, organizational factors, or the magnitude of risks.

As one state actor interviewed in our study suggested, the regulator’s decisions as to whether it should provide Chinese-language examinations and registration materials may have at least partly been based on economic considerations. In Ontario’s context, should this have indeed been the case, such a decision might retrospectively be re-evaluated with reference to the following financial points: a) the considerable legal costs undoubtedly borne by the regulator with reference to language-related court proceedings; and b) the cash surplus of $1.35 million reported by the TCM transitional council during the fiscal year (2012-13) leading up to the regulations coming into effect (TC-CTCMPAO, 2013), followed by cash surpluses of $2.8 million, $3 million, and $3.5 million in each of the years following (CTCMPAO, 2014a, 2015,
2016). It may be difficult in this light for the regulator to convincingly argue that the implementation of our policy recommendations moving would constitute ‘undue hardship’ at the financial level.

Ultimately, the recommendations we propose are consistent with what Rosenblith and Bindewald (2014) have termed a “robust respect” approach. Notably, these authors characterize such an approach, in the context of public education policy, as excessively “exacting” or “demanding” in its focus on cultural inclusion (p. 590). However, in the context of traditional medicine professional regulation, we contend that “robust respect” represents precisely the type of policy framework needed to fairly address (and redress) such groups’ intersecting cultural and clinical dimensions.

Such a regulatory strategy, we argue, is of particular importance in diaspora settings, where senior traditional knowledge keepers are likely to experience an intersection of marginalities represented by their concurrent immigrant status, and by their work in a health care field widely subordinated to mainstream biomedicine. To conceptualise the public interest in this way - fundamentally predicated upon the equity principle, and attending explicitly to traditional knowledge protection – is (as our work here suggests) likely to prove advantageous in promoting patient safety, as well as access to high quality care, as traditional medicine professional regulations become increasingly widespread across the globe.
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Chapter 6
Regulating Traditional Medicine Professionals in the Public Interest: A Principle-Based Framework

This chapter is currently under peer review as a paper for journal publication. Although the chapter’s conceptualization and writing were primarily my own, Dr. Heather Boon and Dr. Linda Muzzin are listed as co-authors on the paper under review, to recognize their supervisory role on my PhD committee, and the important insights they contributed to this particular work.
ABSTRACT

This work presents a principle-based public interest framework to guide the statutory regulation of traditional (Indigenous) medicine (TM) practitioners and practices in liberal democracies. Several features distinguish TM professional regulation from that of biomedical health professions: epistemic and evidentiary considerations; TM’s concurrent clinical and cultural importance; the internal diversity of so-called TM ‘systems’; and the historically-situated differential power relations between TM and biomedicine. Underpinned by the principle of regulatory equity, our framework prioritizes traditional knowledge protection alongside more widely-discussed public interest considerations of patient safety, quality of care, and accessibility. We invite scholars, practitioner groups and regulators to engage with this framework to foster a more robust debate around an area of professional regulation that to date has been scantly theorized.
This work presents a principle-based, public interest framework pertaining to the statutory regulation of traditional and complementary medicine (TCAM) practitioners and practices in liberal democratic states. In its 2013 Traditional Medicine Strategy, the World Health Organization (WHO) has recommended that nations take steps to regulate TCAM “practices and practitioners”. Traditional medicine systems, such as Chinese medicine and India’s Ayurveda, have “a long history” and represent “the sum total of the knowledge, skill, and practices” related to health maintenance, diagnosis and treatment rooted in particular Indigenous cultures and geographies (WHO, 2014 p. 15). As the WHO further notes, “[i]n some countries, traditional medicine or non-conventional medicine may be termed complementary medicine,” (p. 7), a term that we reserve in this work for health care practices that originate in traditional medicine systems but are not indigenous to the jurisdiction of the world where they are being practiced (e.g., acupuncture practiced outside of Eastern Asia).

Among the principles underlying the WHO’s regulatory recommendations are the enhancement of “safety, quality and effectiveness” in the delivery of TCAM care; and TCAM’s “global integration… into health systems”. Such aims, the Strategy suggests, should be addressed with reference to “protect[ing] the intellectual property rights of indigenous people and local communities and their health care heritage” (p. 18). The WHO has furthermore characterized state health care systems worldwide as falling under one of four types with respect to TCAM: “integrative” systems in which biomedicine and TCAM are both funded and recognized; “inclusive” systems, where TCAM has some recognition but is only partially regulated or integrated into public care; “tolerant” systems” where some TCAM practices are “tolerated by law” but poorly integrated; and biomedically, “exclusive” systems, where TCAM practices are outlawed (WHO, 2002, p. 2).

As Dixon has noted (2008, p. 2), a range of TCAM professional regulatory models have been implemented worldwide. These include models of “direct government-administered regulation, … government-sanctioned self-regulation, … and independent self-regulation”. Particular regulations may apply to TCAM practices (e.g., acupuncture, herbal medicine) or professions as a whole (e.g., Chinese medicine). Regulations may furthermore protect occupational titles (e.g., ‘Acupuncturist’), and/or restrict particular practices (e.g., acupuncture), for specified groups’ usage. TCAM professional regulations worldwide are most often implemented at the national/federal level, but in some countries are governed at the regional/provincial/state level.
To date, Dixon notes (2008, p. 3), “there has been little research into the relative merits of different approaches to the regulation of practitioners of traditional/complementary medicine, particularly against specified objectives.”

The focus of the current work is to specify, within a principle-based framework, a set of priorities and guidelines against which TCAM professional regulations may be crafted, operationalized and evaluated. Benton and colleagues (2013) have characterized principle-based regulatory frameworks as those in which regulators, “instead of using a set of detailed and prescriptive rules[,] describe in more general and flexible terms higher level processes and desired outcomes that guide regulatory system design” (p. 14). Well-designed, principle-based regulatory approaches have the advantage of potential applicability across contexts and jurisdictions; and have become more common in recent years. To our knowledge, the framework presented here represents a first systematic attempt to elaborate a detailed set of conceptual guidelines to guide the evaluation, formulation and negotiation of policy approaches for the regulation of TCAM practitioners and practices.

No singular approach to TCAM professional regulation is likely to be relevant across all jurisdictions, whether at the practitioner level or more broadly at the health care system level. For example, policy frameworks for the traditional East Asian practice of acupuncture vary considerably across the globe. Some jurisdictions (e.g., Germany, Argentina, France) permit only medical doctors to perform the practice (Birch, 2007, Freidin, 2007, Ramsey, 1999), whereas others (e.g., China, Japan, Korea) regulate acupuncture as part of their nations’ respective Indigenous medical systems (NZMOH, 2011, Schroeder, 2002). By focusing on regulatory principles rather than specific structures or practices, the public interest framework for TCAM professional regulation presented in this work is meant to be flexible enough to inform regulation across diverse contexts.

Background and Rationale

We undertook the development of this framework in light of several analytic challenges we recently encountered in our research surrounding the regulation of acupuncture and traditional
Chinese medicine, as well as other TCAM occupations, in the province of Ontario. In our team’s previous work we engaged neo-Weberian professionalization theories (Abbott, 1988, 2005), and concepts of boundary work surrounding occupational knowledge claims (e.g., Witz, 1992) to analyse the dynamics surrounding the professionalization of these groups. More recently, it became apparent that these theories did not fully address important issues that arose in the statutory regulation of acupuncture and traditional Chinese medicine in Ontario; these issues included traditional knowledge preservation, linguistic policy requirements, and questions of cultural misappropriation. TCAM practitioner regulation presents a unique range of historical, political and epistemic issues whose nuanced analysis requires pointed theoretical specification.

Our choice to position such theoretical work within a public interest framework also arose from our ongoing study of Chinese medicine and acupuncture regulation in Ontario’s context. Ontario’s Health Ministry relies on advice from an arms-length provincial advisory council in making decisions around health professional regulation in the jurisdiction. Informed by research and stakeholder consultation, this advisory council uses the Ontario’s own principle-based, public interest framework to guide its health professional regulatory recommendations. In our recent study of the council’s regulatory recommendations around acupuncture, we found – on one hand – that the Ontario’s public interest framework had considerable utility in examining and communicating complex policy issues. Conversely, we also noted that the framework – designed to address biomedical practitioner regulation - did not attend explicitly to a number of TCAM-specific policy concerns in Ontario.

We also found, as we investigated a linguistic policy controversy at play in Ontario’s Chinese medicine regulatory process, echoing similar controversies involving traditional acupuncture regulators elsewhere in the United States, Canada and Australia, that various stakeholders’ policy discourses framed competing arguments based in conceptualizations of the public interest. Across our studies, we found that few guidelines existed to help regulators discern between stakeholder claims representing occupational self-interest, and matters of broader public concern, producing a policy-making void for regulators in the TCAM field. The framework we present in this work is meant to begin filling this void.

We do not take a stance as to whether TCAM care should be regulated in a given jurisdiction. There are both advantages and disadvantages to regulating TCAM practitioners and practices -
whether for the state, the ‘public’, or practitioner groups. That having been said, the concept of
the ‘public interest’ frequently plays a central discursive role in professional regulatory debates
and negotiations. To better enable diverse TCAM regulatory stakeholders to communicate using
a shared set of concepts, we felt it important to articulate our theorizing around the ‘public
interest’ concept. Much of this theorizing has arisen progressively in direct response to our
analysis of Chinese medicine and acupuncture regulation in Ontario. Rather than reiterate these
analyses here, we direct readers to our previous work in this regard (Chapters 2, 3, 4, 5) and
focus in the current work on contextualizing our proposed framework within a broader set of
relevant global literatures.

Based on post-colonial theoretical principles, and informed by Saks’ (1995) public interest
model pertaining to health professionalization, our principle-based framework for the regulation
of TCAM practitioners and practices consists of five public interest principles (as seen in Figure
I). As its overarching principle, equity provides a foundational concept around which we shape
our discussion of the other principles. Traditional knowledge protection is the second major
pillar we elaborate, providing an important conceptual lens through which to address our other
three public interest principles. These are patient safety, quality of care, and accessibility. This
work is meant to be primarily theoretical, as a resource for future application, debate and further
development.

In what follows, we delineate a group of unique regulatory challenges pertaining to TCAM
professional regulation. We then engage post-colonial theoretical principles, whose relevance to
the question of TCAM professional regulation we have discussed elsewhere [Chapter 3]. Post-
colonialism is engaged to situate the concept of ‘the public interest’ in service of a TCAM-
specific professional regulatory framework. Next, we present and discuss the details of our
public interest framework for TCAM professional regulation, exploring the potential application
of the framework as well as its possible limitations. It is ultimately our hope that the ideas we
discuss here might catalyze a more nuanced scholarly and regulatory engagement around the
complexities of regulating health care practices and practitioners whose work has indigenous or
traditional roots. At this point, we will shift our terminology from an emphasis on ‘TCAM’
professional regulation, to one that centralizes traditional medicine (TM), from which many
(although not all) TCAM practices are historically derived.
Unique challenges in regulating TCAM practitioners and practices

The primary features of TCAM practitioner and practice regulation that require a distinct set of conceptual guidelines to drive both policy and policy analysis pertain to the following:

a) concurrent clinical and cultural characteristics of traditional medicine (TM) systems;

b) the historical circumstances (and resulting evidentiary tensions) that surround TM’s political subjugation to Western biomedical knowledge systems;

c) challenges (and/or incongruity) of accommodating internally-diverse Indigenous knowledges and practices into models of regulatory standardization; and

d) the increasing biomedicalization of TM worldwide.

We discuss each of these in turn.

TM as culturally-situated health care

In line with its globally dominant position, biomedicine, whose historical and cultural roots lie in the European scientific revolution, is widely and falsely universalized as ‘culturally neutral’ (Harding, 1998). In contrast, many traditional medicine systems and practices today remain explicitly entrenched in their Indigenous cultural and linguistic contexts. In 2012, for instance, the United Nations Educational, Scientific and Cultural Organization (UNESCO) inscribed “acupuncture and moxibustion of traditional Chinese medicine” on its Representative List of the Intangible Cultural Heritage of Humanity (UNESCO, 2010), attesting to its ongoing cultural – as well as clinical - importance. The cultural importance of particular TM treatments for members of their source ethno-cultural communities furthermore raises challenging regulatory questions around access to culturally-appropriate health care.
Evidentiary considerations

Questions around what ‘counts’ as evidence of clinical merit, which are increasingly debated in the scholarly literature (e.g., Haraway, 1988, Harding, 1998, Greenhalgh et al., 2014, Verhoef et al., 2005) continue to emerge as regulators aim to determine what constitutes safe and effective TM care in their specific jurisdictions. TM systems operate from within epistemic frameworks distinct from the Western biomedical sciences (Harding, 1998, Janes, 1999, Hardiman, 2009), whose evidentiary parameters widely inform health professional regulatory decisions across the globe. This issue is especially complex given the long history of political subjugation of traditional knowledge systems’ to Western scientific knowledge, rooted in European colonization – and the consequent, ongoing differential power relations between biomedical and traditional medical frameworks (Hollenberg and Muzzin, 2010). To date, few tools exist to assist policy makers in navigating the intersection of TM epistemologies with biomedical universality claims in regulatory context.

Professional standardization

Standardization and the institutionalized transfer of knowledge and skills - have come to represent an essential condition for professional regulation in the contemporary world (Abbott, 1988, Maroto, 2011). Across the globe, however, TM knowledge continues to be transmitted informally, through family lineages and apprenticeships between senior and junior practitioners, as well as in more formal, institutional settings. Kovach (2009), a Canadian Indigenous scholar, has noted that “Indigenous knowledges can never be standardized” (p. 56), due to their inherent internal diversity and living, dynamic character (Hsu, 2001). Indeed, even for an apparently singular TM practice – such as traditional East Asian acupuncture – a wide range of theoretical and practical approaches co-exist across the globe, which carry specific cultural significance for particular communities (Hsu, 1999, Scheid, 2002). Regulators may be accustomed to contending with competing knowledge claims as particular occupational factions lobby for exclusive regulatory privileges; however, the internal diversity of TM approaches raises particular regulatory complexities when standardization becomes associated with regulation.
Biomedicalization of TM care

The study and reframing of TM systems and practices using biomedical conceptual frameworks and language has been used, for many decades, arguably as a strategy to increase their perceived legitimacy within biomedically-dominant health care systems (Janes, 1999). This has included the increased adoption of biomedical subject areas in the curricula of institutionalized training programs for codified TM systems such as Chinese medicine, Ayurveda and Unani; as well as an increasing body of biomedical-style research conducted on particular TM therapies. Further complicating this biomedicalization is the increasing adoption of TM practices, such as acupuncture, by biomedically-trained practitioner groups, who divorce such practices from their traditional epistemic frameworks (Dommerholt, 2011, Janz and Adams, 2011).

Conceptualizing the public interest with reference to TM professional regulation

The public interest: a core regulatory concept

The imperative to serve the ‘public interest’ is a common starting point around which regulators craft particular policy approaches, including regulation of professionals. The public interest is also a central notion around which scholars may evaluate the altruistic impacts of specific policies, particularly where political or economic motivators (whether on the part of regulators, occupational groups or other interests) are at play (Saks, 1995). That having been said, defining the public interest has been a long-contentious challenge for regulators and scholars alike (King et al., 2010). Even early liberal democratic theorists of the concept, such as Sorauf (1957), guarded against singular or “absolute” (p. 637) characterizations of the public interest, noting: “Any critical evaluation of the idea of a public interest must begin with a definition, but whose
definition?” (p. 618). Implied in this question is an acknowledgment of the multiple publics, and range of interests, which regulators must invariably negotiate (King et al., 2010, Moroni, 2004).

With respect to the statutory regulation of TCAM practitioners and practices, our team’s previous work has drawn attention to some specific contested claims around the public interest that render complex the separation of ‘public’ or altruistic state interests from the professional self-interests of occupational groups, as well as other stakeholders. These include challenges in navigating epistemic and evidentiary claims around the regulatory definition of TCAM practices (Chapter 3), determining how far regulatory boundaries may extend into the private realm (Chapter 4), examining what constitutes professional self-interest vs. the common good (Chapter 3, 4, 5), and the ways in which state and stakeholders’ deployment of safety-related discourses may mask a range of political imperatives in need of critical examination (Chapters 3, 4, 5, 7). The differential power relations at play between different occupational groups (such as between TCAM and biomedical groups), and pressures (whether implicit or explicit) from the state, have also been key factors at play (Chapters 3, 4, 5, 7). In our analyses, we found each of these contentious public interest-related issues to carry within it a tension around the degree to which TCAM professional regulations should structurally mirror those applied to biomedical professional groups. Our conceptual stance has consistently been one that emphasizes the principle of regulatory equity, that is, one focused on fair outcomes rather than equivalent regulatory treatment.

Conceptions of the public interest have varied across jurisdictions, changing over time (Saks, 1995, Adams, 2013), and are theoretically driven (Saks, 1995, Moroni, 2004, Baker, 2005). Saks (1995) has proposed four key attributes of a public interest definition to use in evaluating “the activities of the professions” in Western liberal democracies (p. 37). Such a definition, Saks proposes, should: a) be broadly applicable and easily operationalized; b) enable evaluation of “the extent to which decisions are shaped by the self-interests of professional groups rather than the common good”; c) prescribe “what people ought to do rather than simply reflecting a preponderance of opinion or utility”; and d) reflect considerations of “time and place”, that is, location and historicity (p. 48).

In this work, we have adopted Saks’s broad public interest conception to inform the parameters for our public interest framework. However, as Saks and others (e.g., Baker, 2005) have noted,
the meaning of the public interest is largely contingent upon the theoretical lens through which it is interpreted. In particularizing our public interest framework to meet the TM-specific challenges discussed earlier, we diverge from Saks’s work and employ a postcolonial theoretical framework.

**Theorizing the public interest in postcolonial context**

As documented and discussed in detail elsewhere (Harding, 1998, Shiva, 1997, Battiste, 2005, Banerji, 1981), TM knowledges and practices have long been subjugated, devalued, and co-opted across the globe within the context of European colonization. Today’s ongoing, differential power relations between biomedicine and TM may be seen as representing a neo-colonial phenomenon, whose intricacies may be illuminated through post-colonial theoretical approaches, which have begun to be variously applied in studies of TM occupational groups (see Gale, 2014). Post-colonial theoretical approaches, which are diverse, share an action-orientation geared to transforming socio-political inequities and oppressive power structures arising from European colonialism and its ongoing neo-colonial manifestations (Loomba, 1988, Battiste, 2005). In contrast to other critical theoretical approaches applied to this area of study - e.g., Foucauldian analyses (Fries, 2008), and critical relativism (as implied in Saks, 1995), we find, echoing Hollenberg and Muzzin (2010), that critical analyses of neo-colonial power relations permit a close examination of the historical and epistemological factors at play in the power relations between biomedicine and TM.

Our post-colonial approach, evident in the framework described, seeks to redress such power imbalances by re-centering those publics and interests marginalized under colonial and neo-colonial conditions. This approach has several key dimensions. First, we begin from a stance that contests discourses of biomedical superiority, values traditional and Indigenous knowledges; and pro-actively seeks to protect the latter, and prevent misappropriations thereof. We furthermore draw ongoing attention to the concurrently cultural and clinical character of traditional medicine knowledges, systems, and practices; and centralize the social justice principle in our consideration of cultural factors. We recognize the internal diversity of traditional medicine
systems as representing their fundamentally living character; and our work resists the trend towards imposition of standardizing concepts upon such internal diversity.

We also draw specifically on the work of Munshi and Kurian (2005), in which they refer to an “asymmetric hierarchy of publics” (p. 514) within Western liberal democracies: a concept we find to be of significance in negotiating the interests of various publics with respect to TM professional regulation. Munshi and Kurian argue that unless actively contested, such an asymmetric hierarchy reproduces the “inequitable distribution of power” (p. 514) characteristic of historical colonial relations. As such, they explain, “Western” interests become associated with “core” perspectives, and “non-Western” perspectives become “othered” on the periphery. In this light, we now present our framework.

The Framework

We elaborate, below, our public interest regulatory framework for TM practitioners and practices, beginning with the principles of equity and traditional knowledge protection. Our conceptualization of these principles informs our discussion of the latter three principles: accessibility, quality of care, and safety (see Fig. 1).

Equity

Equity is the fundamental regulatory principle around which the statutory regulation of TM practices and practitioners should be conceptualized (citations removed). The principle of equity, extensively discussed across the social and political science literature, must first and foremost be distinguished from the principle of regulatory equality. Whereas the aim of equity-based policy is socially-just, or “fair” outcomes, proponents of regulatory equality demand equivalence, or “sameness” in regulatory treatment (Stone, 2012, Arnaud, 2001). Equality-based TCAM professional regulatory approaches, i.e., those requiring that TCAM practitioners and practices be treated in the ‘same’ way as biomedical practitioners and practices under the law, are not justifiable for two key reasons.
First, a majority of health professional regulatory structures worldwide have biomedicine, the globally-dominant health care model, informing their underlying ontological and epistemic framework (WHO, 2002), though this is unlikely to be made explicit by the regulating state. As discussed elsewhere (e.g., Chapter 3) such biomedical underpinnings may for instance be seen in governments’ conceptualization of ‘high quality evidence’ as being essentially biomedical evidence. As noted earlier, traditional medicine systems have several core characteristics (e.g., simultaneous importance of cultural and clinical factors; unique epistemologies; internally diverse knowledges) that distinguish them from biomedicine. Regulatory structures based in biomedical conceptual underpinnings are thus unlikely to readily accommodate such aspects of TCAM practice without considerable adjustment. Forcing TCAM practitioners and practices to fit within an unmodified biomedical regulatory framework is unlikely to facilitate protection of traditional knowledges. However, such protection is a key WHO regulatory priority, and important for several reasons which we have elsewhere discussed (see Chapter 3).

Second, a primary aim of TCAM professional regulation, also articulated by the WHO, is integration of TCAM care into national health care systems. TCAM remains relatively marginal in state-sanctioned health care systems across most of the globe, successful integration without further marginalization will require disruption of biomedicine’s hegemonic dominance. It is highly unlikely that an equality-based regulatory approach – one that fails to a) recognize the differential power relations between biomedicine and TCAM, and b) permit innovative regulatory mechanisms that make space for TCAM professionals as partners in health care delivery – can facilitate harmonious integration.

An equity-informed regulatory approach – that is, one that innovates or adapts professional regulatory structures to reflect the intrinsic features of TCAM systems, and that aims to redress historical inequalities across health care epistemologies – is an attractive alternative and should thus be considered a first priority for TCAM professional regulators. In what follows, we elaborate various ways in which the equity principle should be seen to underpin other public interest dimensions at play in TCAM professional regulation. Inevitably, equity will mean different things across distinct jurisdictional contexts. As we elaborate below, this equity principle should be considered the primary concept around which traditional knowledge protection – our second public interest principle – and the three others (safety, accessibility and quality) - ultimately take shape.
Traditional knowledge protection

Traditional knowledge protection, or put another way, the preservation of Indigenous intellectual and cultural property, is fundamentally an equity-related issue: one that requires focused attention with respect to TCAM professional regulation. Its importance arises from the historical context of European colonial domination of global South nations, as well as Indigenous peoples in the global North, wherein traditional knowledges, languages and cultural practices have been systematically devalued, subsumed and at times decimated over the last few centuries (Harding, 1998). As the WHO affirms in its 2013 Traditional Medicine Strategy, “issues related to intellectual property (IP) can have an impact on products, practices and even practitioners (p. 34)”, thus characterizing the protection of traditional medical knowledge as a global regulatory priority.

To date, the issues surrounding intellectual property and misappropriation of traditional knowledge have been extensively explored in relation to protecting products (such as traditional herbal formulations) from unwarranted patents (Shiva, 1997, Srinivas, 2007, WHO et al., 2013). However, with a few exceptions (Ijaz et al., 2016, Srinivas, 2007), little has been said in the literature to date about the regulatory protection of traditional knowledge as it pertains to Indigenous health care practices (such as acupuncture, yoga or manual therapies). To this end, we draw upon Merryman’s (1989) public interest-driven conceptualization of three points “central to the development of cultural property policy: preservation, truth, and access” (p. 345).

With respect to the preservation of traditional medical knowledge, TCAM professional regulations should first and foremost accommodate a range of routes to practitioner training that include informal (i.e., non-institutional) knowledge transmission. As UNESCO has for instance recognized with respect to traditional acupuncture and moxibustion, these practices may be “taught through verbal instruction and demonstration, transmitted through master-disciple relations or through members of a clan” in addition to being “transmitted through formal academic education” (UNESCO, 2010, p.1). Regulations that threaten to weaken, displace or eliminate informal traditional knowledge transmission paths – or threaten the ongoing practice of traditional knowledge keepers and/or senior traditional medicine practitioners - should not be
considered in the public interest defined as above. In addition, regulators should explicitly aim to preserve the cultural and linguistic context of traditional knowledge in crafting TCAM professionalization policies: a consideration that pertains additionally to Merryman’s conception of *truth* as an important cultural property-related policy parameter.

As regards *truth*, Merryman identifies two primary policy considerations: ‘decontextualization’ and the production of ‘counterfeits’. Regulators should take an active stance against the ‘decontextualization’ (or, as Hollenberg and Muzzin [2010] term it, ‘paradigm appropriation’) of traditional knowledge. This may be achieved by ensuring that TCAM practices remain explicitly linked, in policy, to their Indigenous epistemic and cultural frameworks or communities (rather than subsumed by biomedical or Eurocentric cultural conceptions). To prevent the regulatory propagation of ‘counterfeit’ forms of traditional medicine practice (or, in Hollenberg and Muzzin’s words, ‘paradigm assimilation’), which as Merryman notes (p. 360) “falsify history, misrepresent the culture [and] distort the human record,” regulators should similarly take a strong ethical position limiting non-traditional medicine practitioner groups seeking primary regulatory jurisdiction over traditional medicine-rooted practices. This may specifically apply to cases where traditional medicine practices have been re-conceptualized in biomedical terms as ‘complementary’ medicine practices, without reference to the practices’ indigenous roots.

Below, we discuss *access*, Merryman’s final policy parameter relating to cultural property (and in our view a public interest principle in its own right) more broadly in relation to TCAM regulation and knowledge protection, and then move on to quality and safety parameters.

**Accessibility**

A primary aim of TCAM professional regulation should be, as the WHO has emphasized, improved public access to high quality, safe TCAM care. In order to better conceptualize quality and safety as they pertain to TCAM practitioners and practices, it is important to first unpack the notion of public access. As emphasized earlier on, and elsewhere detailed in traditional medicine regulatory context [citation removed], there inevitably exist multiple ‘publics’ at play with respect to a given policy project, representing divergent (and at times competing) interests. That said, and as recognized by the WHO, traditional medicine is a form of health care that is
“culturally acceptable and trusted [on this basis] by large numbers of people” (WHO, 2014, p. 13). A key equity-driven imperative in TCAM professional regulation should, then, be helping to redress the asymmetrical power dynamics that frequently characterize the neo-colonial relations between ‘Western’ and ‘non-Western’ publics. More specifically, we propose that for regulatory purposes, those ethno-cultural communities from which particular traditional medicine systems and practices emerge should be conceptualized as ‘core’ publics of concern, regardless of whether such publics constitute the majority population in a given jurisdiction.

In its discussion of the access principle, the WHO (2014, p. 11) furthermore places strong emphasis on “increasing the availability and affordability of TM [traditional medicine], with an emphasis on access for poor populations.” In this light, lower-income and impoverished populations might be characterized as a second ‘priority public’ for professional regulators. The primary mechanism by which the WHO proposes this access-related priority should be implemented is through the integration of TCAM into mainstream health care via increased state funding. However, as research undertaken by Hollenberg and Muzzin (2010) suggests, some initiatives aimed at integrating traditional medicine into mainstream healthcare reinforce the subordination and misappropriation of Indigenous health care approaches. Furthermore, Indigenous stewards of TM knowledge may not consider it in their communities’ interests to make their ancestral practices accessible to all. As such, we explicitly characterize access in terms of both TM protection, and the concept of priority publics.

Our above conceptualization of access is not intended to suggest that people who are not members of particular ethno-cultural communities and/or lower-income people should not have access to TCAM care: but rather, that such broadened access be considered a secondary public interest priority, once implementation of the primary priorities for TM have been secured. Furthermore, the impulse to regulatory integration and increased accessibility should thus be carefully balanced with – if not subordinated to - traditional knowledge protection aims. Regulators may seek to do so by crafting policy that increasingly positions traditional medicine practitioners and the epistemologies in which their work is rooted on par with biomedical practitioners and perspectives. This is undoubtedly a daunting prospect given biomedicine’s dominance in state-sanctioned health care across the globe. We begin to explore, in our discussion of quality and safety below, tangible ways in which more equitable integration may occur.
Quality of Care

Under any professional regulatory regime, assurance that patients receive quality care pertains largely to the locally-accepted and enforced standards of training and practice. To help negotiate the regulatory complexities that may arise, we present some quality-related issues for consideration. Donabedian (1990) has characterized health care quality as having seven core attributes, which we propose may be grouped into three primary categories: clinical factors (to include Donabedian’s attributes of efficacy and effectiveness); economic factors (efficiency and optimality); and interpersonal/sociocultural factors (acceptability, legitimacy, equity). We set aside discussion of economic factors on the presumption that these are likely to be jurisdictionally-dependent; an example of how economic considerations may be interrogated in TM regulatory context has elsewhere been briefly presented [citation removed]. However, with respect to clinical factors and interpersonal/sociocultural factors, we raise several important issues relevant to regulation of TCAM practitioners and practices below.

These issues, we argue, may best be seen in light of the post-colonial theoretical lens discussed earlier (including equity and TM protection), as well as changing, global, quality-related health-care policy trends over the last century. We draw the reader’s attention again to our previous work, in which the relationship between quality care, equity and traditional knowledge protection are more explicitly elaborated in one particular regulatory context [citation removed].

As Madison (2012) has noted, liberal democratic states (and a broader community of scientific and health policy scholars) have undergone a considerable conceptual shift in recent decades with respect to notions of health care quality. Over this time period, biomedical notions of ‘evidence-based’ health care have now taken a complementary position alongside the previous, primary emphasis on preventing incompetent or dangerous practice. Notions of what constitutes specialist expertise have furthermore become increasingly tied to the possession of formal credentials (Collins and Evans, 2007, Collins, 1979) associated with standardized, codified knowledge (Collins and Evans, 2007, Weinstein, 1993). Formal credentials have become ubiquitous requirements for professional entry, even across occupations in which more informal methods of demonstrating competency were previously accepted as evidence of high skill and
knowledge (Lambert, 2012). Health professionalization trends for TCAM practitioners and practices across the globe increasingly are impacted by these epistemic, regulatory shifts, a point which we argue should not be uncritically accepted in discussing the issue of quality care parameters.

The WHO, for example, has in recent years produced a set of benchmark documents to help guide regulators in setting standards for TCAM practitioner groups (WHO, 2016). These benchmark documents reflect contemporary biomedical professionalization trends in their deference to institutional training modes, exemplified in the WHO’s lists of recommended competencies and calculated hours of formal education. While the theoretical and diagnostic frameworks indigenous to particular traditional medicine systems and practices form the underlying basis of the WHO training benchmarks, biomedical competencies are also included, presumably to facilitate the aim of ‘integration’. It is furthermore noteworthy that the benchmark documents that have to date been produced pertain largely to those ‘systems’ of traditional medicine (i.e., Traditional Chinese, Ayurveda and Unani Medicine) that have been extensively codified and institutionalized, as well as increasingly the object of biomedical study in recent decades.

This is not to say that these benchmarks do not have value. They should, we suggest, be carefully examined for relevance to the issue of quality care in jurisdictions seeking to regulate these particular systems or their concomitant practices (such as acupuncture, or Ayurvedic panchakarma and dietary therapies, each of which incidentally also have associated benchmark documents). However, the WHO benchmarks should also be understood as historically-situated documents reflecting incorrect conceptualizations of traditional medicine systems as static - that is, as health care approaches ‘fixed’ in ancient history. In fact, as medical historians and social scientists have carefully shown (see Hardiman, 2009, Langford, 2002, Hsu, 1999, Hsu, 2001, Scheid, 2002, Taylor, 2005, Lambert, 2012) the three aforementioned traditional medicine systems – while historically and epistemically rooted in older, Indigenous knowledges – are in fact thoroughly modern systems of medicine. As Langford (2002), Hardiman (2009) and Taylor (2005) demonstrate, the codification and institutionalization of these systems’ have occurred over the last century as nationalistic responses to colonial conditions and biomedical dominance, effectively increasing political capital surrounding Indigenous health care epistemologies and practices.
That having been said, the standardization of Ayurvedic, Unani and TCM ‘systems’ (an idea that essentializes their variations) has simultaneously served to exclude many diverse bodies of knowledge and styles of practices endemic to South and East Asian regions and cultures. As Lambert has elaborated, the “selective processes of legitimation… whereby particular traditions of indigenous medicine undergo reformulation into professionalized and accredited knowledge systems” (Lambert, 2012, p. 1030) has produced “hierarchies of legitimacy” (p. 1029), thus marginalizing a wide range of indigenous medical practitioner groups that continue to “practice without official sanction” (p. 1034).

Policy makers contending with the question of quality in regulating TCAM practitioners and practices thus face complex, historicized inter- and intra-occupational considerations in ensuring equitable policy approaches. Equity requires that contemporary conceptions of “the grounds for legitimating medical expertise” (Lambert, 2012, p. 1033) be troubled and re-envisioned, in order to avoid the ongoing, neo-colonial subjugation of TM practitioners and practices resisting configuration as para-biomedical occupations. “Formal qualifications,” asserts Lambert (2012, p. 1035) in the context of TCAM professionalization policy, “do not necessarily equate to the acquisition of genuine therapeutic expertise or ensure the provision of high quality care.” Rather, as Collins and Evans explain (pp. 52, 142), “it is possible to have expertise, including specialist expertise, in the absence of qualifications. …[T]here are kinds of expertise that are not captured by traditional forms of accreditation.”

Weinstein (1993) has for instance differentiated ‘epistemic’ expertise (which is typically codified, and knowledge of which is confirmed via written testing) from ‘performative’ expertise (demonstrated by competent performance of a skill within the accepted parameters of a particular field). As Lambert (2012) has suggested, such ‘performative’ expertise may serve but as a starting point for the innovative professionalization of TCAM approaches not characterized by codification, as well as for practitioners not trained via institutional means. It is an accepted practice in transitional regulatory entry processes for long-standing traditional medicine practitioners in jurisdictions newly regulating them, that practitioners with significant clinical experience who were previously trained via family lineage or apprenticeship models are permitted to become licensed (e.g., Dixon et al., 2007, Carlton and Bensoussan, 2002).
Such models, which validate informal rather than exclusively formal training modes, and which honour extensive practice experience, should be considered a potential mainstay of TCAM regulatory approaches, both as part of transitional (grandparented) professional registration processes and beyond. Non-textual means of evaluating clinical knowledge and skill should be carefully examined – via close collaboration between regulators and TCAM practitioners - as potential methods of accreditation (see for instance Lambert’s 2012 account of mid-20th century Indian regulation of traditional medicine practitioners). Models of non-standardized, peer-review-based professional certification, such as that adopted by the contemporary American Herbalists’ Guild (2013), should also be considered.

Returning to our initial proposed parameters surrounding quality of care (clinical factors and interpersonal/sociocultural factors) it is evident that TCAM professional regulators will be tasked with negotiating a range of issues surrounding TCAM quality of care that go well beyond those typically arising within the context of biomedical professional regulation. As noted, there exist a wide range of sociocultural factors at play. At the interpersonal level, we have emphasized culturally-appropriate health care delivery as a key consideration (an issue we discuss further on with respect to the theoretical concept of ‘cultural safety’). To judge clinical quality, it will be incumbent on regulators to familiarize themselves with the global debate around what constitutes ‘evidence’ (e.g., Haraway, 1988, Harding, 1998, Greenhalgh et al., 2014, Verhoef et al., 2005). As we have elsewhere suggested [citations removed] regulators should take steps to ensure that evidentiary perspectives adopted in the TCAM professional regulatory process centre traditional knowledges, both codified and oral, depending on context. Such considerations will become increasingly important as particular TM therapies become popular outside of their nations of origin. Finally, in evaluating the jurisdictional claims of diverse practitioner groups’ over such therapies, including claims by biomedical practitioner groups, regulators should remain vigilant that the historical, cultural and epistemic origins, and epistemically/culturally appropriate assessments of quality, become and remain central considerations.
Safety

Patient safety, the final public interest principle in Fig. 1, is a key policy parameter around which regulators of professional groups and practices frequently conceptualize the ‘public interest’. The concept of safety (or, put another way, the prevention of harm) is not a neutral concept but rather one that relies on theoretical parameters to be clearly defined (Ijaz et al., 2016). Elsewhere [citation removed], we have discussed the way in which safety-related discourses may disproportionately dominate TCAM professional regulatory negotiations, at times acting as political camouflage for a wide range of non-safety related issues. As such, regulators should apply particular vigilance in evaluating various stakeholders’ safety-related claims.

We have elaborated, earlier, our position that the principle of safety, as it pertains to TCAM professional regulation, be interpreted in light of evidentiary contributions from within both TM and biomedical frameworks, rather than on the basis of biomedical evidence alone. The risk of harm should furthermore be understood as not only representing the possibility that members of the public might experience direct physical harms from accidents or incompetently-applied TCAM therapies, and ‘adverse events’ that occur unexpectedly even when care is competently delivered (Hayward et al., 2005). It should also include, as we have elsewhere discussed (Ijaz et al., 2016), the concept of indirect harms, which is present in many traditional medicine systems, wherein ‘balance’ of body systems is an overall aim; and wherein poorly elaborated treatments may aggravate ‘imbalance’ in the organism (Maciocia, 1989, Chishti, 1988, Lad, 2002). Indirect harms may thus arise from the application of poorly-understood diagnostic or therapeutic principles, and are considered a marker of unskilled practice.

Two additional forms of potential harm may be represented by the concepts of omission and harmful interaction. Omission refers to the unintentional or intentional failure to offer or provide a timely treatment known to be beneficial for a particular condition (Hayward et al., 2005). In the context of TCAM care, omission is commonly discussed with reference to the need for timely referral to a biomedical physician (WHO, 2014). However, with the advance of TCAM care’s integration into mainstream health care, as well as the increasing body of codified evidence as to the effectiveness of particular TCAM treatments, TCAM-related education for biomedical health providers will become increasingly important. This may permit more patients to receive more effective, safe and economical treatments for particular conditions. Preferable care options may,
in some cases, involve TM-rooted therapies. Keeping in mind the importance of traditional knowledge protection, and Indigenous’ peoples authority to control the transmission of their heritage (Battiste and Youngblood Henderson, 2000), overall may supercede the value of transplanting some TM therapies into biomedically-dominant settings.

The potential for both harmful (Goldman et al., 2008, Girard and Vohra, 2011) and beneficial (Lin, 2014, Edwards, 2012) interactions between particular traditional and biomedical therapies has furthermore emerged as a safety issue of significance. It is, we argue, the responsibility of both traditional medical and biomedical health care providers to address the potential for such clinical interactions (such as between traditional herbal medicines and pharmaceutical medications). Regulatory training requirements will increasingly need to be articulated in this regard across the range of health professions.

Finally, as with quality, safety considerations should not be understood as relating exclusively to the clinical dimensions of health care practice but also to interpersonal and cultural matters. As has historically been the case in health professional regulation in liberal democratic states (Abbott, 1988), TCAM professionalization policies should be engaged to enforce a high degree of professionalism, whether related to misrepresentation of one’s work, practising within one’s legal scope, or involving mechanisms of recourse for interpersonal and/or economic abuses. Moreover, the concept of cultural safety, developed in New Zealand within the context of indigenous Maori nurses’ work (Anderson et al., 2003, Ramsden, 1993, Ramsden, 2000, Reimer Kirkham et al., 2002), holds significance for the regulatory negotiation of interpersonal relations in the context of traditional medicine care. The cultural safety concept (and the more widely discussed notion of ‘cultural competency’), emphasize cultural sensitivity and the delivery of linguistically-concordant, culturally-appropriate health care (Clifford et al., 2015). However, the cultural safety concept contextualizes the health care experiences of individuals’ more broadly in a postcolonial context, “mak[ing] visible the historical, social and political situatedness of health care relations” (Anderson et al., 2003, p. 199).

We propose that regulators, in constructing TCAM professionalization policies, attend to cultural safety as a key pillar with reference to members of historically marginalized populations. This principle should be applied both to relations between health care professionals and patients, as well as between different types of health care providers, where historically-situated power
differentials become visible. We echo Anderson and colleagues’ call (2003, p. 211) to extend the cultural safety concept beyond the binary “polarized politics between the colonized and the colonizer,” with the aim of creating “hybrid, cultural spaces for transformative practice”. Anderson et al (2003, p. 211) propose that the cultural safety concept be used to socially contextualize, and thereby attend to the health experiences of “not only those who have historically been oppressed, but also those who are seen to occupy positions of privilege”: an idea we find compelling with respect to the delivery of particular types of TM care to members of (minority as well as majority) ethnocultural groups for whom such practices are not Indigenous or culturally-familiar.

For many people worldwide, biomedicine has become the normative cultural framework within which they have come to conceptualize healing practice. Delivering traditionally-rooted care within biomedical frameworks (such as acupuncture by medical doctors or physiotherapists) may indeed increase widespread accessibility of a range of effective therapeutic options not currently available to patients, in a form that many patients may find culturally-safe. As such, this type of health care hybridization should not, we argue, be opposed in principle. Rather, in constructing policy frameworks that permit such practices, regulators should attend carefully to the principles of traditional knowledge protection and equity to ensure that state-sanctioned, biomedicalized TCAM care: a) preserves and recognizes a connection to the practices’ traditional epistemic and cultural source; and b) does not further displace or marginalize traditional medicine practitioner groups, whether at the epistemic or economic level, or both.

**Applying the framework**

We have discussed, in detail, a set of parameters around which regulators and policy analysts should aim to address the unique challenges associated with TCAM professional regulation across the globe. It has not been our aim to exhaustively explore all aspects of TCAM professional regulation, but rather to suggest guidelines as to how certain TCAM-specific challenges that have hitherto been underexplored might be addressed in regulatory context. Each jurisdiction will have its own particular context, history and requirements; and the framework presented will need to be interpreted in line with these. In order to supplement its scope and
nuance its application, it is likely that this principle-based framework may be effectively complemented by other theoretical models or international policy documents. Of central importance are the voices of Indigenous medicine practitioners themselves, which should be be at the table when examining regulatory questions that involve their culturally-specific healing traditions.

Ultimately, the approach we present here is intended to enhance global discussion of the unique issues surrounding statutory regulation of TCAM practitioners and practices. We encourage transparent application of this framework both by scholars and regulators, in order to develop a more robust knowledge base highlighting challenges and facilitators associated with TCAM professional regulation across contexts. With the aim of further developing this area of scholarship, we thus welcome constructive evaluation of this framework both in general and with reference to particular regulatory contexts.
Figure I: Public Interest Framework for Professional Regulation of Traditional Medicine

- **EQUITY**
  - Situate regulation in historical context
  - Innovate appropriate regulatory frameworks
  - Account for unequal power relations

- **TRADITIONAL KNOWLEDGE PROTECTION**
  - Attend to both clinical and cultural considerations
  - Protect intellectual property and prevent misappropriation

- **SAFETY**
  - Evaluate diverse evidence types to reduce direct and indirect harm, omission and problematic interactions
  - Promote professionalism and cultural safety

- **QUALITY**
  - Preserve epistemic and technical diversity of care
  - Validate codified and non-codified knowledges
  - Incorporate multiple modes of evaluating expertise

- **ACCESSIBILITY**
  - Identify and prioritize access for key publics
  - Conceptualise and enact equity-based integration strategies
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Abstract

This chapter applies a theoretical concept from science and technology studies, that of the boundary object, to the field of professional regulation as it pertains to traditional, complementary and alternative medicine (TCAM). By examining state risk discourses and the construction of regulatory parameters for acupuncture, the issue of English-language fluency for immigrant practitioners, and the negotiation of standard-setting across professions, our analysis points to ways in which safety-related discourse may play a disproportionate role in TCAM regulatory processes. This discursive emphasis on safety, aligned with biomedicine’s ‘evidence-based’ conceptual underpinnings, deflects attention from other important regulatory considerations. It also serves to reinforce the subordination of non-biomedical epistemologies and practitioners even while these become newly integrated into mainstream health care. Regulators of TCAM professionals and practices should bring careful awareness to the difference between safety as discourse, and safety as policy consideration.
In this chapter, we apply a theoretical concept from science and technology studies, that of the *boundary object*, to the field of professional regulation as it pertains to traditional, complementary and alternative medicine (TCAM). With reference to our recent case study of acupuncture and Chinese medicine regulation in the province of Ontario, Canada, we use the ‘boundary object’ concept as a mechanism to highlight the disproportionate role that safety-related discourse may play in TCAM professional regulatory projects. We then discuss possible implications of our observations with respect to TCAM professionalization studies more broadly.

**Boundary objects and TCAM research**

The *boundary object* concept was first theorized by Star and Griesemer (1989), and relies on the *social worlds framework*, elaborated over multiple decades within the symbolic interactionist tradition of sociology and widely used in studies of science and technology. (Clarke and Star, 2008). Social worlds are conceptualized as ‘shared discursive spaces’ in which ‘multiple collective actors’ engage in particular primary activities, at specific locations or sites, in particular ways; and ultimately aim to promote or propagate some aspect of these activities (p. 114). ‘Over time,’ note Clarke and Star (p. 113), ‘social worlds typically segment into multiple worlds, intersect with other worlds… and merge.’ They use the term ‘arena’ to describe an ecology in which multiple social worlds organize ‘around issues of mutual concern and commitment to action’ (p. 113). The social worlds framework has been extensively used to study occupations and professions, as well as a wide range of other groups and settings.

In their 1989 case study of the Berkeley Museum of Vertebrate Zoology, Star and Griesemer advanced social worlds theory by introducing to it the boundary object concept. They characterized boundary objects, which may be ‘abstract or concrete’, as having ‘different meanings in different social worlds,’ while preserving a structure ‘common enough to more than one world to make them recognizable, a means of translation…[for] developing and maintaining coherence across intersecting social worlds’ (Star & Griesemer, 1989, p. 393). Examples of boundary objects in Star and Griesemer’s original study included ‘species and subspecies of mammals and birds’, as well as ‘the habitats of collected animal species’, which carried distinct...
meanings across the social worlds of (among others) the museum’s ‘research scientists, curators, amateur collectors, private sponsors and patrons’ (p. 392). Although members of the aforementioned social worlds shared a common goal of ‘preserving California’s nature’ in Star and Griesemer’s study (p. 408), they brought to this endeavour a range of different perspectives and approaches, made evident in their distinct conceptualizations of, and engagement with, the identified boundary objects.

Star and Griesemer’s original boundary object concept has been applied and theoretically nuanced across a range of scholarly fields, including in TCAM-related research (Derkatch, 2008, Keshet et al., 2013, Owens, 2015). In contrast to Star and Griesemer’s early characterization of boundary objects as operating within mutually advantageous collaborative settings, TCAM scholars’ application of the boundary object concept has specifically addressed the differential power dynamics typically at play in TCAM/biomedical encounters. Owens, for example, points to the effective deployment of the sterile needle as a boundary object from within the social world of American acupuncturists, who sought to facilitate traditional acupuncture’s increased entry into the politically-dominant social world of mainstream U.S. health care. She notes (2015, p. 21):

The sterile needle “worked” as a boundary object during this period due to its cohesion with two major trends in the early 1990s: the concern over infectious disease transmission through needles and the increased call for evidence-based medicine.

In this chapter, we similarly use the boundary object concept to explore acupuncture’s increased integration into mainstream health care, but in this case with reference to professional regulation. In our analysis, we shift focus from the needle itself to the concept of safety as a rhetorical boundary object, echoing Derkatch’s work (2008) about evidentiary debates around traditional, complementary and alternative medicine (TCAM). There, Derkatch theoretically extends the boundary object concept to include rhetorical strategy, referring to the concept of efficacy, one of evidence-based medicine’s core principles. With reference to the reification of randomized control trials in biomedicine, Derkatch (2008, p. 379) analyses efficacy as a shape-shifting, rhetorical boundary object through which ‘a given health practice or study’ may be positioned ‘within or beyond the borders of science’. As Derkatch notes within the context of research:
Efficacy, and its sister term, safety, are cited, mantra-like, throughout the medical literature as the chief motivations behind research… [A]s keywords, safety and efficacy are so flexible that they can function as gatekeepers (p. 381).

In this work, we use a similar theoretical approach as Derkatch, this time to demonstrate how evidence-based medicine’s cardinal virtue of safety may act, somewhat problematically, as a central discursive boundary object in defining regulatory parameters for TCAM practices and practitioners. With reference to the case of acupuncture and Chinese medicine regulation in Ontario, Canada, and to the arena of intersecting social worlds at play in that process, we point to three areas in which safety has played a key discursive role as a regulatory boundary object: a) in establishing the need for acupuncture’s regulation; b) in formulating training standards across the professions; and c) in defining policy to address the distinct ethno-linguistic features of the Chinese medicine profession.

The data we interpret in this study were collected as part of a qualitative case study we conducted on the statutory regulation of acupuncture and traditional Chinese medicine in Ontario, Canada. Case study data included an extensive body of public documents from the period 1984 through 2017, including consultative documents from regulators, transcripts of court proceedings and government hearings, minutes of public meetings, regulations, public petitions, statements by public officials, websites of professional organizations, and media reports. We also conducted thirty-two qualitative interviews with key informants including Chinese medicine and acupuncture community leaders and practitioners, and state officials who had been involved in the Chinese medicine / acupuncture regulatory process.

In this chapter, we engage with boundary object theory to reinterpret previously reported findings from this case study (Chapters 2, 3, 4, 5, 6). Using the boundary object lens to discuss the prominence of safety discourse in the case under study permits a meta-level interpretation of our diverse study findings. This chapter references previous study findings as well as primary documents in some cases, but does not cite any interview-based findings directly as they have been reported elsewhere (Chapters 5 and 6). We now turn to our analysis.
Shifting safety discourse across social worlds: Establishing the need for acupuncture’s regulation

Ontario’s Chinese medicine practitioners had lobbied for statutory self-regulatory status over three decades before the profession – and with it, the practice of acupuncture – were regulated in 2013. Until that time, the insertion of acupuncture needles for therapeutic purposes was not subject to any statutory limitations. In 1984, the Ontario government – one key social world in our study - undertook to redesign its health professional regulatory framework in an effort to ‘level the playing field’ across a range of health care occupations, by governing all regulated groups under a single piece of umbrella legislation. Primary among the province’s nine identified criteria for self-regulation in 1984 was demonstration of a substantial potential ‘risk of harm…to individual patients’ (O'Reilly, 1999, p. 359). In other words, the Ontario government constituted safety as a key gatekeeping factor in determining which health care practices or occupations required regulatory boundaries around them.

At the time, Chinese medicine practitioners – another social world at play in our analysis - were among over one hundred health care occupational groups requesting to be newly regulated. However, the provincial government determined that acupuncture - one of Chinese medicine’s central practices - was ‘not inherently hazardous’ (HPRAC, 1996, p. 1), that is, not sufficiently risky to warrant regulatory controls. The practice of acupuncture thus remained in the public domain, and Ontario’s Chinese medicine practitioners remained unregulated. However, the Ontario government’s stance as to acupuncture’s associated risk profile would change twice more over the decades leading up to the province’s 2013 acupuncture and Chinese medicine regulations. During this period, the arena of intersecting social worlds engaged with the issue of acupuncture’s statutory regulation would become progressively larger and more differentiated into complex and intersecting sub-groupings.

In 1995, the Ontario government received three formal requests for new regulations involving the practice of acupuncture from three separate groups (each of which we characterize as a distinct social world): one from a Chinese medicine practitioner association, another from the province’s naturopathic profession, and the third from a provincial coalition of acupuncture-practising biomedical health professionals. Whereas the Chinese medicine group requested that a
profession of Chinese medicine be regulated (with acupuncture as a central therapeutic intervention), the other two groups were exclusively concerned with seeing the practice of acupuncture regulated as a practice within their own professions’ broader scopes. Ontario’s health Minister tasked an arms-length provincial body, the Health Professions Advisory Council, with studying these three requests. The Council decided to focus a single study on what was shared across these requests: the question of acupuncture regulation (HPRAC, 1996).

Noting that ‘risk of harm’ constituted ‘the threshold for regulating a new activity’ under Ontario’s health professional regulatory structure (HPRAC, 1996, p. 4), the Council undertook a ‘public review… to generate a fuller understanding of acupuncture including its risk of harm’ (p. 8). Among the stakeholders who contributed written documents and oral presentations during this review were representatives of the social worlds identified earlier. How to characterize acupuncture’s safety profile was central among the core questions the Council posed of stakeholders. Stakeholders represented a range of individuals, as well as representatives of multiple social worlds including medical doctors, Chinese medicine practitioners and naturopaths, as well as chiropractors, nurses and physiotherapists. What was shared across these worlds was a common interest in seeing acupuncture regulated in the province, discursively expressed as a characterization of acupuncture as sufficiently unsafe to warrant statutory controls.

In this light, the Council determined that acupuncture did indeed carry inherent risks when performed by ‘untrained or incompetent practitioners’ (HPRAC, 1996), and recommended that acupuncture be regulated in the province. The Council’s 1996 report emphasized that there had been ‘considerable agreement among respondents that acupuncture is philosophically rooted in [traditional Chinese medicine]’ (p. 10). This was, ultimately, a position the Council also took, advising that some degree of Chinese-medicine based training should be a regulatory requirement for its safe practice. The ‘needling practices’ of health professionals seeking to use acupuncture needles from an exclusively biomedical perspective, the report concluded, should be separately evaluated and governed. These recommendations, which set out – using safety as a central discursive object - to construct regulatory boundaries around acupuncture that validated indigenous Chinese medical knowledge as legitimate science (see Ijaz et al., 2016), were, however, shelved rather than implemented.
In 2001, a renewed political will to regulate acupuncture and Chinese medicine emerged in the province; and the same provincial Council (which had undergone a significant turnover of members) undertook a second study of the issue. As in 1996, the Council concluded that acupuncture and Chinese medicine should be regulated in order to protect the public from potential harms. Similar stakeholders were involved in this second investigation, and again used safety-based discourse to substantiate a commonly-held view among the occupational groups involved that acupuncture should be regulated in the province. The specifics of the risk discourses deployed differed, however, across occupational groups, reflecting the ways in which safety as boundary object carried contrasting discursive subtexts across social worlds.

Some, such as Ontario’s physiotherapists and podiatrists, bolstered their safety-based argumentation in support of acupuncture’s regulation by turf-related claims over the practice, as well as efficacy-based discourse geared to invalidating the epistemic claims of Chinese medicine based practitioners. For example:

Acupuncture [should be] a controlled act because there is a risk of harm. Acupuncture is within the scope of practice of physiotherapy to treat pain and neuromuscular disorders. The [Ontario Physiotherapy Association] questions whether the regulation of [traditional Chinese medicine] and acupuncture under the [Regulated Health Professions Act] would amount to endorsement of its efficacy. (HPRAC, 2001 Appendix H, p. 7)

Chinese medicine practitioners by contrast used safety discourse to argue that their government should limit the practice of acupuncture to those with some Chinese medicine based training. ‘The improper practice of acupuncture may cause side effects,’ they argued, alluding to argumentation that had been foregrounded in the Council’s 1996 report, which strongly distinguished the practice of biomedical needling from traditional acupuncture.

Ultimately, the Council sided with biomedical stakeholders, noting that it

...did not receive convincing evidence that adhering to any philosophical or theoretical basis for the procedure affected the risk of harm (and hence the need for regulation) for acupuncture (HPRAC, 2001, p. 20).

Chinese medicine knowledge, the Council’s 2001 report discursively concluded (in contrast to its 1996 recommendations), was irrelevant to the safe performance of acupuncture, a practice the Council now redefined in biomedical terms as strictly involving the physical insertion of needles ‘below the dermis’ (HPRAC, 2001, p. iii).
As we have elsewhere discussed at length (Ijaz et al., 2016), these later recommendations were conceptually predicated on a discourse of safety that privileged biomedical science in policy, implicitly excluding Chinese medicine’s indigenous knowledge perspectives from within the boundaries of state-recognized knowledge. Notably, Ontario’s eventual acupuncture regulations would closely reflect the exclusively biomedical epistemic position underpinning the 2001 report’s recommendations. In separating acupuncture from its traditional Chinese roots, these regulations’ conceptual underpinnings exemplify the cultural misappropriation of traditional knowledge. Such misappropriation, we find, was made possible through the state’s adoption of risk-based discourses by stakeholders from biomedically-trained occupational social worlds.

That said, the province’s concurrent regulation of Chinese medicine practitioners as one acupuncture-practising group could also be argued to raise this group of traditional medicine practitioners’ sociocultural status, somewhat complicating biomedicine’s hegemonic position within the broader health care system. Regardless of such multidimensional power dynamics, our analysis of safety as a discursive boundary object in the state’s establishment of whether, and how, to regulate acupuncture makes three points clear. First, safety is not a neutral concept, but rather a principle upon which a range of epistemic perspectives and political motives may be superimposed from across diverse social worlds. Second, and related, the safety principle may be deployed as state discourse to give greater or lesser weight to particular epistemic or political stances. Finally (see Ijaz et al, 2016), the subjugation of traditional/indigenous knowledges to biomedical evidentiary perspectives is a historically situated phenomenon, rooted in European colonization (Harding, 1998, Shiva, 1997). As such, state risk discourses around TCAM professional regulation may serve – as seen in Ontario’s case – to contest and/or advance traditional medicine’s neo-colonial misappropriation, whether intentionally or not.

However, as we now discuss, it is not only in establishing TCAM practices’ eligibility for inclusion within professional regulatory structures that the safety principle may play the role of boundary object, but also with respect to practice standards and professional entry requirements implemented.
Differential application of the safety principle: Acupuncture training standards across the professions

In its 2001 study report recommending the future regulation of acupuncture, Ontario’s Health Professions Advisory Council had proposed that five professions – a new Chinese medicine profession, as well as dentistry, medicine, naturopathy and nursing – be authorized to perform the practice within their scope moving forward. It furthermore recommended that these professions ‘be required… to establish through regulation the appropriate educational standard needed to provide safe and effective [our emphasis] acupuncture treatment’ (HPRAC, 2001, p. 52). Any other professions seeking similar ‘authority to perform acupuncture,’ the report advised (p. 23), should be required to formally apply for ‘an expansion of scope of practice’, and similarly produce appropriate training standards.

It would initially appear that the Council constructed safety and efficacy as core boundary objects around which individual professions might develop standards for acupuncture. However, given the evidentiary conditions of the time period, the Council also noted that ‘the strongest evidence available to show that acupuncture is efficacious for the treatment of certain conditions is empirical evidence’ (HPRAC, 2001, p. 20). As such, the Council implied that safety would be the primary locus around which a limited number of Ontario professions might craft future acupuncture training standards. However, as we now discuss, when the province’s acupuncture regulations eventually came into effect, the concept of safety would serve less as a tangible guide to standards production, and more as a discursive principle differentially applied across the province’s acupuncture-practising occupational social worlds.

In 2006, the Ontario government announced that it would: a) add acupuncture to its list of health care activities restricted to regulated professionals; and b) regulate a new Chinese medicine profession, under whose scope acupuncture would specifically fall. As recommended in the 2001 report, the province’s dentists, medical doctors, naturopaths and nurses would also be permitted to perform the practice. Diverging from its 2001 recommendations, the province also created a regulatory exemption through which the province’s chiropractors, physiotherapists, occupational therapists, massage therapists and chiropodists, would be automatically authorized to include acupuncture within their existing scope. Within Ontario’s system of self-regulation for health
professionals, individual professions are tasked with developing their own practice standards within their statutory scopes. Across the ten professions authorized to perform acupuncture, four disparate types of acupuncture training standards were ultimately implemented. Viewed as a whole, these standards tell a story about risk, professional regulation and inter-occupational stratification across social worlds. This story echoes in regulatory context Derkatch’s observation (which we discuss further on), made in the context of research, that “biomedical studies so routinely fail to meet the same standards to which CAM studies are held” (2008, p. 379). More specifically, we draw attention to these standards’ relationship with a) their associated professions’ respective positioning within the broader arena, or health systems ecology (see Abbott, 2005); b) the safety principle, previously construed by the Ontario government as a key regulatory boundary object aimed at governing professional authority over acupuncture; and c) the question of medical epistemology.

As the only profession within whose scope acupuncture constitutes a primary component, the competency-based standards for acupuncture implemented by Ontario’s Chinese medicine profession would be the most rigorous in the province, equivalent to approximately 2000 hours of training. These standards – which emphasize traditional Chinese medical theory and practice, but include training in the biomedical sciences - align substantially with the World Health Organization’s training guidelines for traditional acupuncture practitioners (WHO, 1999), and with parallel standards governing traditional acupuncture practitioners across other jurisdictions (see Birch, 2007).

The acupuncture training requirements implemented across three other Ontario complementary medicine professions (naturopathy, massage therapy and chiropractic) mandate that practitioners wishing to perform acupuncture document, at a minimum, a training standard that adheres roughly to the 200-hour World Health Organization guidelines for health professionals using acupuncture as an adjunct modality within their broader scope (WHO, 1999). Echoing the recommendations of the Ontario government’s 1996 report on acupuncture, two of these three professions – chiropractic and naturopathy – furthermore require that their members’ acupuncture training include Chinese medicine theoretical approaches.
Like the aforementioned complementary medicine professions, two of the province’s three allied (biomedical) health professions, physiotherapy and occupational therapy, keep a register of their acupuncture-practising members\(^1\). However, while being listed on such a roster requires that these allied health professionals document ‘some’ theoretical and practical learning in the field of acupuncture, the specifics of such training (i.e., the number of hours, competencies, epistemic basis of training, skill of instructor) are left entirely at the individual practitioner’s discretion. Further in this vein, the province’s three longest-standing biomedical health professions (medicine, nursing and dentistry) have articulated no acupuncture standards whatsoever for their members, and do not keep a roster of practitioners who elect to use acupuncture with patients. It is clear that the approach taken by both allied and biomedical health professionals diverges considerably from the province’s safety-related recommendations in both 1996 and 2001.

As self-regulating entities, none of the province’s acupuncture-authorized professions would have been externally mandated to enforce particular acupuncture standards for its members. That said, the way each of these professions responded to being authorized to include acupuncture within its scope is suggestive of a self-imposed disparity in standard-setting practice that reflects each profession’s position in an inter-professional hierarchy. It is difficult to rationally justify why those practitioners registered as members of an allied health profession (e.g., physiotherapists) would require less documented training in order to safely perform acupuncture than regulated complementary medicine practitioners (e.g., chiropractors). Nor is it reasonable to suppose that nurses or medical doctors might be more adept at self-assessing their own competency in the field of acupuncture than, for example, occupational therapists, or naturopathic physicians.

Chinese medicine practitioners’ significantly higher acupuncture training standards may be understood as central to their claim as specialists in the field, defining them as a new profession in the province. However, the inter-professional stratification in acupuncture training standards evident across the other nine professions authorized to perform the practice may represent a kind of differential posturing through which more marginal groups seek to demonstrate their professional rigour (and their explicit adherence to the safety-based standards that are hallmarks of today’s dominant ‘evidence-based medicine’ approach) more pro-actively than do more dominant groups.
Such an observation in a regulatory context echoes the known boundary-crossing strategies of CAM research scientists, who ‘exhibit a kind of hyper-performance’ (Derkatch, 2008, p. 114) of established biomedical research methods to establish their credibility. As Polich and colleagues (2010) similarly note in their empirical study of CAM research (p. 114-5):

> Methodological rigour carried a special potency for [TCAM researchers], one extending beyond what is typical for more conventional scientific research… [They] strategically employed a scientific vocabulary in an effort to give unconventional research a more conventional guise… [T]CAM researchers also responded to professional scepticism by definitively asserting their scientific credentials.

Recalling the discursive link between safety and epistemology addressed earlier on, we furthermore note that among those relatively-marginal TCAM professions that elected to implement clear acupuncture training standards, the majority included at least some Chinese medicine theory among their required competencies. By not implementing clear acupuncture standards for their members, by contrast, the province’s more established allied and biomedical health professions conveyed an implicit message that their existing (biomedical) knowledge base represented a sufficient epistemic and practical basis for the safe performance of acupuncture. This act of omission, we suggest, echoing our earlier findings about the province’s policy recommendations for acupuncture prior to its regulation, represents another form of traditional knowledge misappropriation that may again be situated within the historical context of European colonial dominance.
Regardless, as a regulatory boundary object, it is clear that the safety concept has been differentially interpreted and applied across the social worlds of Ontario’s acupuncture practising professions, as expressed in their associated training and practice standards. It is noteworthy that those professions for which evidence-based medicine is widely characterized as axiomatic are those that would, in their response to being authorized to include acupuncture within their scope, be least likely to exemplify evidence-based medicine’s cardinal safety principle in their acupuncture training standards. As noted earlier, Ontario’s professional self-regulatory model was redesigned in 1984 in an attempt to level the playing field across regulated occupational groups by granting them each equal access to professional status under the same piece of legislation. However, our findings suggest that these groups continue to self-govern both in response to, and in preservation of, long-standing (historical and neo-colonial) power dynamics between them. The malleable safety principle, as manifest in training standards – and other professional entry requirements, as we now discuss – clearly represents a boundary object that helps to illuminate these power relationships.

Safety, language and Chinese medicine professional entry: regulatory mimicry

Derkatch (2008) and Polich and colleagues (2010) have observed that TCAM researchers’ vigilant application of biomedical research methods, in pursuit of greater credibility, commonly extends to situations where such methods (as the randomized control trial) are known to poorly accommodate the therapies being studied. A similar pattern seems apparent within the context of professionalizing TCAM occupations worldwide, wherein these groups increasingly reshape themselves to include more biomedical subjects in their educational curricula (e.g., Flesh, 2013), despite – in many cases – being at odds with the occupations’ own epistemic foundations. We have also found such a phenomenon to be evident – if not exemplified – in our previous study of English-language proficiency requirements implemented by traditional acupuncture and Chinese medicine regulators and certification bodies in two Canadian provinces (Ontario and British Columbia), two-thirds of American states, and across Australia (Chapters 4, 5). In these jurisdictions, we observe a tendency from within the occupational leadership to institute professional entry requirements that echo those implemented in biomedical professions, despite contextual factors that render such requirements very difficult to meet for some of the
occupation’s most experienced members. Notably, safety-related discourse again appears as a key boundary object invoked by a range of actors to justify these requirements.

Across the aforementioned jurisdictions, a significant proportion of traditional acupuncture and Chinese medicine practitioners are immigrants from East Asian countries, some of who conduct their clinical practices primarily in an East Asian language. A small percentage of such practitioners – who are typically over the age of 50 - are also known to have low English language proficiency. As part of our study (Chapters 4, 5) we interviewed 28 key informants involved in, or affected by, the various linguistic policy approaches discussed. Informants included regulators and other state actors, as well as traditional acupuncture practitioners (about half of whom were East Asian immigrants). In analysing the range of stakeholder views relating to these policies, we found safety-related discourses to have played a prominent role on both sides of a significantly polarized debate.

Attesting to the segmentation that may occur within particular social worlds, there were both ‘state actors and practitioners of diverse demographic [ethnic] makeup on either side’ (Chapter 4) of the debate over regulatory English language proficiency requirements. Those who supported English-only policies emphasized safety as their primary concern, arguing that ‘non-English proficient practitioners create unnecessary patient risks… particularly in emergency situations’ and in the ‘context of interprofessional communication’ (Chapters 4, 5). Those opposing such policies, by contrast, argued that ‘English-only policies create more significant risks’ by driving underground ‘some of the most experienced’ immigrant practitioners, thus removing statutory accountability and recourse mechanisms for patients who might otherwise be harmed…. and compromis[ing] delivery of safe [legal] care for East Asian immigrant patients lacking English fluency (Chapter 4).

In Ontario’s context in particular, we demonstrated that language proficiency requirements for traditional acupuncture practitioners that construct low English proficiency as a deviant trait in need of remediation may lead to the premature retirement and/or underground practice of significant numbers of senior immigrant practitioners with decades of clinical experience (Chapter 5). Such outcomes are not only of concern in terms of their impacts on these individual practitioners, but threaten the integrity of the profession as a whole. Indeed, as has been widely recognized, the oral transmission of traditional medical knowledge from senior to junior
practitioners through a mentorship relationship is an important historical, and ongoing, form of indigenous knowledge preservation (WHO, WIPO & WTO, 2013) including in East Asian medicine (Hsu, 1999). When patient safety is constructed by policy makers as the primary boundary object surrounding linguistic regulatory entry requirements for traditional East Asian medicine practitioners in English-dominant jurisdictions – as was evident in our study of the Ontario case - core historical and contextual features of the occupational groups being regulated are perilously overlooked.

What is notable in several North American jurisdictions is that English-proficiency requirements have been implemented from within Chinese medicine and traditional acupuncture regulatory or certification bodies. In Ontario, as in the United States, many of the decision-makers involved in these policy projects have been practitioners from within the Chinese medicine social world, who seemed aware that: a) the occupational group had distinct demographic features that might render English proficiency a challenging professional registration requirement to meet; and b) there was widespread opposition to language proficiency requirements from within the practitioner community itself.

In the same way as TCAM researchers commonly mimic or adopt poorly-fitting biomedical methods to fortify their studies’ mainstream credibility, our findings suggest that regulators and certification bodies governing marginal health occupations – including those comprised of cultural insiders - may be strategically using safety-based discourse as a mechanism through which to justify a mimicry of biomedical professions’ registration requirements, in order to secure their own groups’ tenuous regulatory status. Although safety is certainly not an irrelevant regulatory consideration with respect to linguistic entry requirements for traditional East Asian medicine practitioners, there are other important issues that appear to receive insufficient attention when safety-as-boundary-object dominates the regulatory debate.
Beyond a discourse of safety: regulating TCAM professionals in the public interest

Our discussion to this point shows the concept of patient safety to be a central discursive boundary object in the regulation of acupuncture and Chinese medicine in Ontario. We have pointed to three distinct regulatory issues in which actors from across a range of social worlds variously invoked the safety concept to either preface, or substantiate a particular policy position. As discussed, safety was the primary discursive consideration at play in the province’s initial decision to leave acupuncture and the profession of Chinese medicine unregulated, and subsequently to regulate both practice and profession. The rationale offered for the specific regulatory model to be applied was also framed in safety-related terms. Similarly, the Ontario government pointed to safety as a measure of primary importance in creating future acupuncture-related standards across the Ontario professions performing the practice. Finally, Ontario’s new Chinese medicine regulator positioned safety among the primary rationales behind the linguistic professional entry requirements it implemented as the new regulations came into effect. As a regulatory boundary object, the concept of safety took several guises across distinct social worlds, playing multiple roles in the drama surrounding the regulation of acupuncture and Chinese medicine in the province.

For instance, state actors’ discursive emphasis on patient safety masked issues not directly safety-related. This was evident between 1984 and 1996, when the Ontario government changed its official stance as to whether acupuncture was sufficiently risky to regulate, although it is clear that the practice itself (and its associated risks) would not have substantively changed over this period. The notion of safety was also deployed to construct regulatory boundaries surrounding acupuncture that would ultimately preserve biomedicine’s epistemic and positional authority in the province’s regulatory structures. In 2001, for example, the province would use the notion of safety to justify acupuncture’s regulatory separation from its Chinese medical and cultural roots, re-conceptualizing the practice in exclusively biomedical terms.

The Ontario government would, that same year, use safety-based grounds to call for stringent future training requirements across the province’s acupuncture-practising professions. However, it would become clear as the regulations came into effect in 2013 that those professions
occupying more marginal positions within the province’s overall inter-occupational hierarchy would be more likely to implement training standards for their members that directly addressed the principle of patient safety in practice. The propensity of marginal occupational groups to adopt professional entry standards typical across biomedical professions – regardless of whether such requirements in fact met the specific needs of their members – was furthermore evident in the case of Ontario’s Chinese medicine professional linguistic entry requirements.

Scholars of the professions have long analysed the jurisdictional ‘turf’ struggles over scope and standards that typify the transition from occupation to profession, frequently via statutory regulation (Parkin, 1974, Parkin, 1979, Murphy, 1988, Collins, 1990, Collins, 1979, Abbott, 1988). There is, similarly, a body of sociological literature that addresses risk as a central thematic and discursive focus in policy making across industrialized countries, including in the context of health care (Allen et al., 2016) and health professional regulation (Phipps et al., 2011). What our work here highlights are some of the specific ways in which safety discourse may be deployed within a policy context characterized by differential power relations. In particular, in relation to TCAM professional regulation, we have drawn attention to some ways in which historical colonial power relations may be reproduced through the mechanism of safety as discourse.

In the same way that Derkatch has characterized ‘efficacy’ as a rhetorical boundary object surrounding complementary and alternative medicine research, we argue that ‘safety’-related discourse may be playing a gatekeeping role in the statutory regulation (and ongoing socio-political subjugation) of TCAM practitioners and practices. In the context of research, Derkatch (2008, p. 382) has argued that the efficacy concept can be poorly suited to researching complementary and alternative medicine interventions:

CAM practices do not fit well within an efficacy model; they are much more amenable to effectiveness studies because such studies can better accommodate the sorts of patients, symptoms, treatments, and outcomes typical of CAM… But many critics of CAM hold efficacy, not effectiveness, up as the criterion for evaluating CAM, even though much significant biomedical research is effectiveness-based.

We do not contest that safety should be given careful consideration in the professional regulation of TCAM practitioners or practices. However, the safety concept is malleable, capable of
supporting a range of epistemic stances; and, in our study, shown to be unevenly applied in ways that mask a range of regulatory issues and power dynamics across the range of health professions. As such, we propose that those involved in crafting professional regulations for TCAM practitioners and practices make efforts to identify and directly address these other issues and dynamics, so that a slippery rhetoric of safety does not inappropriately dominate the policy process.

We have elsewhere proposed a principle-based public interest framework intended to inform TCAM professional regulations, which may assist those undertaking such a pursuit (Chapter 6). Situated within postcolonial theoretical parameters, our framework addresses the set of distinct regulatory challenges that accompany TCAM professional regulation, warranting an equity-driven policy approach: one that attends fairly to contextual factors surrounding TCAM professional regulation, rather than simply reproducing regulatory models implemented for biomedical professions. *Traditional knowledge protection* is one such key factor of unique importance within a TCAM professional regulatory context. Health care *quality* and *accessibility* are other core principles, positioned on equal footing with *safety* as essential public interest parameters. Regulators’ application of our framework, we hope, may be one mechanism by which the disproportionate *discursive* emphasis on safety seen in our Ontario study may be prevented in other TCAM professional regulatory contexts.

That said, this chapter’s distinct contribution lies in its demonstration of multiple means by which a discourse of safety may dominate a TCAM professional regulatory project in ways that ultimately reinforce biomedicine’s epistemic and institutional authority. As our analysis demonstrates, this type of reinforcement of dominant power dynamics may occur even as these same power relations are contested by the inclusion or entry of traditional medicine practices and professions into health care systems from which they would have previously been excluded. This type of hybrid phenomenon, characterized by multidirectional power relations amidst the blending of health care systems and approaches that were once considered distinct, is an area ripe for additional research.
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Chapter 8

Discussion and Conclusion

As noted across the preceding chapters, there has to date been relatively little research that directly addresses the unique complexities of regulating traditional medicine practitioners and practices. However, an increasing number of jurisdictions across the globe are taking steps, in line with United Nations recommendations, to regulate such practitioners. Demand for non-biomedical care across many nations appears to be on the rise. This PhD dissertation – a qualitative case study of traditional Chinese medicine and acupuncture regulation in Ontario, Canada - aimed to: a) explore ways in which the regulation of traditional medicine practices and professionals may differ from the regulation of biomedical professionals; and b) consider how the ‘public interest’ may be conceptualized to appropriately address these distinguishing factors in regulatory context.

The work presented in the preceding chapters represents a contribution to an emerging literature on the professional regulation of traditional medicine, both in its characterization of a single jurisdiction’s experience, and in its related theorizing. It is intended that regulators undertaking similar regulatory projects, and scholars analysing such projects, may look to this body of work for both conceptual and practical insight. In particular, the tangible policy cases analysed across my first four chapters interrogate the advantages and disadvantages of particular traditional medicine regulatory approaches that may prove instructive across other settings.

Theoretically, this doctoral dissertation’s contribution is five-fold, in that it: 1) identifies a set of features, contexts and conditions that clearly distinguish the statutory regulation of traditional medicine practices and professionals from biomedical professionals; 2) adds a regulatory dimension to an existing body of scholarship that positions traditional medicine research in postcolonial context; 3) reconceptualises the ‘public interest’ concept as it pertains to traditional medicine regulation; 4) proposes a detailed theoretical framework for application (and further development) in traditional medicine regulatory projects across the globe; and 5) problematizes the disproportionate dominance of biomedical safety discourse over other regulatory
considerations in the context of traditional and complementary medicine’s professionalization. In addition, this work draws attention to the ways in which: 6) regulatory boundaries may be constructed around traditional medicine professional fields; and 7) the ways in which the ways in which particular TM professional regulatory approaches may (even inadvertently) misappropriate and threaten the longevity of traditional medical knowledge. Below, I discuss the ways in which I develop each of these points across this dissertation.

Features distinguishing regulation of traditional medicine vs. biomedical health practitioners and practices

In Chapter 2, the distinct complexities of regulating practitioners of traditional, complementary and alternative medicine (TCAM) begin to become evident. Practitioners from three TCAM occupational groups undergoing a significant change in regulatory status – naturopathy, homeopathy and traditional Chinese medicine – were surveyed as to their views about regulation. Some of the concerns they raise – such as an increased administrative and financial burden on practitioners with regulation, impacts to the scope of these groups’ practices, and the potential for the regulatory exclusion of some practitioners - are common issues faced by a wide range of newly-regulated professions may face. Each of these articulated concerns, however, carried TCAM-specific nuances, related to the historical and ongoing subordination of these professions to mainstream biomedicine.

The financial costs of regulation to practitioners were, for instance, characterized as particularly burdensome in light of the three TCAM occupations’ relatively marginal sociocultural status in relation to biomedical occupations, arguably impeding their ease in achieving financial success. Practitioner concerns around regulatory practice scopes also alluded to the TCAM groups’ systemic subordination to biomedical professions. Biomedicine, for instance, is state-funded in Canada, in contrast to TCAM. Concerns around skilled practitioners’ potential regulatory exclusion raised TCAM-specific considerations around the construction of regulatory standards, whether related to biomedical knowledge requirements in the case of homeopaths, or English-language proficiency requirements in the case of Chinese medicine practitioners. Moreover, across the three TCAM groups surveyed, practitioners were significantly concerned that their
regulatory integration into biomedically-dominant health systems would compromise their occupations’ distinct, non-biomedical epistemic foundations.

The specific regulatory challenges associated with the distinct epistemic foundations of TCAM professions became further evident in Chapter 3. This chapter exposes the ways in which the biomedical underpinnings of existing health professional regulatory systems, and the politically normative character of biomedical epistemology, may ultimately serve to subordinate traditional medicine knowledge and practice in policy. The potential for such epistemic subordination within the context of health professional regulation should be an important point of awareness, I argue, for TCAM professional regulators. Another key differentiating factor between TCAM and biomedical professions in regulatory context pertains to the concurrently clinical and cultural character of the former, as elaborated at length in Chapters 4 and 5 with respect to linguistic regulatory requirements for TCM practitioners.

In Chapter 6, I draw upon my findings from Chapters 2 through 5, as well as an extensive literature review, to coherently summarize, to my knowledge for the first time in the scholarly literature, the range of features that differentiate TCAM professional regulation from that of biomedical occupations and practices.

Regulation of traditional medicine practitioners and practices as a postcolonial phenomenon

As Gale has elsewhere reviewed (2014), the application of postcolonial theory within TCAM-related research is evident in a few recent studies. Consistent with postcolonialism, a contribution of my PhD work is that I uniquely situate TCAM professional regulation as a policy project deeply impacted by the historical context of European colonial relations. As I argue in Chapter 3, this theoretical positioning aligns well with World Health Organization directives around traditional knowledge protection, and makes further sense as an explicatory model around traditional medicine’s historical and ongoing global subordination to biomedicine within state health care systems. Using postcolonial theoretical conceptualizations originally proposed by Harding and applied to TCAM by Hollenberg and Muzzin, I address the issue of traditional knowledge misappropriation in TCAM professional regulatory context. I believe that this
represents a significant scholarly contribution as to date, issues surrounding intellectual/cultural property relating to traditional medical knowledge have been primarily explored in the literature with reference to traditional medicine *products* (such as herbal formulations) rather than *practices* (such as acupuncture or yoga). In Chapter 6, I extend the scope of postcolonial theorizing in this regard well beyond the issue of cultural misappropriation, to represent the primary conceptual foundation underpinning my proposed public interest framework for TCAM professional regulatory projects. This theorizing - when engaged by scholars, regulators and/or practitioners - carries the potential to significantly reframe global conversations around TCAM professional regulation.

Reconceptualization of the ‘public interest’ in the context of traditional medicine professional regulation

The concept and discourse of the ‘public interest’ recurs as a primary theoretical consideration across chapters 2 through 6. In Chapter 2, I begin to problematize – but do not significantly elaborate – the public interest concept as it pertains to TCAM professional regulation, by pointing to distinct features of TCAM occupations in regulatory context. In Chapter 3, I make explicit my theoretical intention to develop a “normative, TM [traditional medicine]-specific ‘public interest’ conceptualization” (Ijaz et al. 2016, 99); and propose that regulatory ‘equity’, and ‘traditional knowledge protection’ – along with patient safety – be considered axiomatic in this context. In Chapter 4, I affirm and further elaborate this position. I argue that the “regulatory inclusion of practitioners who act as repositories of traditional medical knowledge” be conceptualized as a core public interest imperative (related to traditional knowledge protection) in TCAM professional regulatory context. I furthermore propose that the notion of the ‘public’ itself be conceptualized in this context as “multiple and diversified rather than singular and monolithic; and… [that regulators] attend specifically to the distinct needs of both majority and marginal publics.” In Chapter 5, I further elaborate a conception of ‘equity’, central to framing the public interest in TCAM professional regulatory context, as fundamentally aligned with principles of culturally-inclusive policy-making. This chapter, like Chapter 4, also addresses health care quality and accessibility as important public interest considerations. Chapter 6 finally
brings all of these theoretical dimensions together to propose a comprehensive public interest framework for TCAM professional regulation.

Development of a theoretical framework to guide professional regulation of traditional medicine

Having developed, across Chapter 2 through 5, the parameters for a TCAM-specific public interest conceptualization in professional regulatory context, Chapter 6 elaborates in considerable detail how regulators may deploy this newly theorized public interest conception in practice. Pointing to the unique characteristics of TCAM occupations, and emphasizing the importance of postcolonial theorizing, I draw broadly on literatures pertaining to TCAM occupations and professional regulation in this work.

I discuss tangible ways in which TCAM professional regulatory projects may be informed first and foremost by the public interest principle of equity, be driven by an imperative to protect traditional knowledge, and ultimately preserve patient safety, health care quality, and accessibility.

Problematization of ‘safety’ as a predominant discourse surrounding the professional regulation of traditional medicine

The way I position the public interest principle of safety in Chapter 6’s TCAM professional regulatory framework – on par with quality and accessibility of care, and subordinated to the overarching principle of equity, and policy driver of traditional knowledge protection – strongly reflects the discursive observations made across my dissertation work. In Chapter 3, I show how the concept of safety – as a primary regulatory discourse – may be variously deployed to reflect particular epistemic and political stances, and should thus not be considered neutral in TCAM professional regulatory context. In Chapter 4 and 5, safety again arises as a key discursive parameter around which particular TCAM regulatory considerations of cultural significance are framed by a range of stakeholders. In Chapter 7, I refer to these previous chapters to expose
multiple ways in which safety-related discourse may exert a disproportionately dominant influence within TCAM professional regulatory projects. The public interest, I ultimately argue, is likely to be better served if the concept of safety – though certainly important in its own right – is more proportionally weighted alongside other relevant considerations in the policy making process.

Construction of regulatory boundaries

My work in this dissertation has also helped to expose some ways in which state actors may construct regulatory boundaries around traditional medicine practitioners and practices in crafting statutory regulations. In Chapter 3, I pointed to contrasting ways in which such boundaries may be constructed by either incorporating or excluding epistemic perspectives from traditional medicine systems from considerations around regulatory definitions for a traditional medicine rooted practice; and how such a definition would ultimately underpin decisions as to which occupational groups might be authorized to perform such a practice. In Chapter 4, I explored the boundaries between public and private realms in traditional medicine regulatory context, in particular with respect to situations where such health care practices are or are not funded by the state. How regulators might work to distinguish stakeholder claims from professional self-interest was another boundary-related theme that appears across Chapters 3, 4 and 5. Finally, my work across the dissertation’s chapters highlights the key role of safety discourse as a key boundary object in traditional medicine regulation, and the ways in which contrasting equity- vs. equality-based thinking consistently underpinned regulatory controversies of various types.

Threats to traditional knowledge

Across this dissertation I draw attention to the ways in which specific traditional medicine regulatory approaches may ultimately serve to either protect or threaten traditional medical knowledge, either through structural misappropriation (such as described in Chapter 3 with respect to acupuncture’s regulatory definition) or through professional registration practices that (inadvertently) exclude experienced senior practitioners, who play an important role in preserving, furthering and transmitting important traditional medical knowledge (Chapters 4 and 5). In these chapters, as in the public interest framework (Chapter 6), I discuss regulatory
strategies to both prevent and redress such threats to the preservation of Indigenous medical knowledge. In particular, the premature retirement of senior traditional medicine practitioners represents a significant loss which may prove difficult to ‘undo’ in a global environment of biomedical dominance; and threatens the valuable epistemic models that underpin traditional medicine systems and practices across the globe. Theory aside, this is an area of regulatory concern that warrants urgent practical attention in order to prevent further harm to Indigenous knowledge systems and their keepers, as has long been the case in neo/colonial context.

**Limitations**

One possible limitation of the theorizing advanced across this dissertation, and in particular within the proposed public interest framework (Chapter 6), is that it has – with the exception of Chapter 4 - been substantially based on a single case study from one global North jurisdiction, where the traditional medicine system being regulated was not indigenous but an ‘import’. There are complexities involved in the regulation of traditional medicine professions within their geographies of origin involving a diasporic context as in the current study. I have tried to address this aspect of the situation by referring to a broad set of global literatures in formulating the public interest framework (Chapter 6). There may, moreover, be peculiarities in Ontario’s health professional regulatory model from which particular policy challenges arose in regulating TCM practitioners, which I may have conflated with the challenges associated with traditional medicine regulation.

One may anticipate that future applications of the framework across a range of contexts may help to illuminate these and other possible gaps in the theorizing undertaken within it, and thus help to nuance the framework’s scope and application.

Other limitations of this dissertation relate to the scope of data generated and analysed for the study. Participant recruitment for the study interviews was initially limited to key stakeholders who had been centrally involved in some aspect of Ontario’s Chinese medicine and acupuncture regulatory process. As the study progressed, I did interview a small number of individuals (e.g., TCM practitioners working with a written language plan) who had not been directly involved in the regulations, in an effort to further develop the study themes relating to linguistic policy issues. Overall, however, the non-inclusion of front-line practitioners without direct involvement in the regulations may have limited the range of perspectives represented in my analysis. That
said, my semi-structured interview guide was informed by findings from the survey discussed in Chapter 2, which did indeed include a wide range of front-line TCM and acupuncture practitioners.

Moreover, a number of key informants I contacted for interview either declined my request or did not respond to my repeated efforts at correspondence. In particular, I had difficulty securing interviews with former members of Ontario’s former TCM regulatory transitional council, or current members of the existing TCM regulatory council. These persons, who would have carried a wealth of insider knowledge as to the processes I studied, may have felt constrained in their ability to disclose confidential information by their former or current positions. I was also unsuccessful in speaking at length, on the record, with many persons involved in the language-related court cases underway as the study progressed. Regardless, I made strong efforts to supplement interview-based data with a range of textual sources.

Future Directions

There were several areas of focus that arose within my case study of Ontario’s Chinese medicine and acupuncture regulations that I have not addressed in this doctoral dissertation. I will outline these below, as areas where I intend to undertake further writing, on the basis of the data collected and analysed over the duration of the case study.

Cultural misappropriation and traditional medicine practices

As pointed out in Chapter 3, “not all hybrid ‘mixings’ of biomedical and TM knowledge are equally problematic from an equity-informed perspective” (Ijaz et al. 2016, 99), an issue that needs to be addressed and theorized. Future scholarship in this area, geared to examining the nuances of ‘cultural misappropriation’ as it pertains to the cultural hybridity of traditional medicine practices (e.g., acupuncture, yoga), will comprise an important contribution to the literature in an area that is increasingly contentious in the public sphere.

Acupuncture standards for biomedical practitioners

The issue of acupuncture standards for health care professionals who are not practitioners of East Asian medicine was raised in Chapters and 3, and emerged as a significant theme across the interviews conducted in this study. This issue, similar to the language policy issue addressed in
Chapters 4 and 5, has proven contentious well beyond the Ontario context in recent years, and warrants further analysis. In Chapter 7, I briefly discuss my analytic findings on the standards issue, which I have presented in poster and oral presentation form at academic conferences. I intend to write a thorough account of my data or findings in the future.

Educational standards for East Asian medicine practitioners

Another issue that was briefly raised in Chapter 2, but not developed further in this dissertation, pertains to the standardization of traditional medicine knowledge in regulatory context. As noted in Chapter 6, traditional medicine knowledges are internally diverse, and lend themselves with difficulty to uniform standardization without considerable losses or exclusions of particular knowledge branches. How this point was negotiated in the Ontario (and pan-Canadian) context arose repeatedly in study interviews, but was not explicitly addressed in the dissertation. It remains an area ripe for additional analysis and writing.

Implications of regulation on practice and care

One important area of concern that I did not directly address in this dissertation, but which warrants considerable further investigation, pertains to the impacts of regulation on actual practice (both for practitioners and patients), and for potential health/wellness outcomes associated with the statutory regulation of traditional medicine practitioners and practices.

Application of the public interest framework

The most significant area for future research emerging from this dissertation pertains to the application of the public interest framework presented in Chapter 6. In particular, additional published case examples of traditional medicine related professional regulatory projects that draw conceptually upon this framework, will prove invaluable in illustrating its utility. It is my hope, moving forward, that others – whether researchers, regulators or practitioners - may actively engage with this framework in their work, examining its applicability across contexts, and providing feedback as to where it may benefit from additional nuance.
Conclusion

Through a qualitative case study of traditional Chinese medicine and acupuncture regulation in Ontario Canada, this PhD dissertation has identified, analysed, theorized and discussed a wide range of complexities unique to the statutory regulation of traditional medicine practices and professionals. Aligned with my articulated aims, I developed a theoretical conceptualization of the ‘public interest’. This theorizing, which centralizes the principle of equity, and emphasizes traditional knowledge protection as a priority, takes into account a wide range of historical, epistemic, political and cultural considerations deeply relevant to traditional medicine’s professionalization in contemporary globalized context. In addition, the tangible policy examples magnified across the dissertation demonstrate the applicability of the theoretical principles discussed. Overall, this work may prove relevant for scholars, regulators and practitioners alike as they seek to study and navigate complex policy-making challenges surrounding traditional medicine practitioners and practices. It is, ultimately, my hope that this work – as a whole - gives rise to lively debate across sectors, and helps give shape to an area in need of considerable further investigation: traditional medicine professional regulatory studies.
References


APPENDIX A: Letter of information, no compensation

Study: Acupuncture practitioner regulation & the pursuit of professional legitimacy in Ontario

Dear …

I am writing to request your participation in a research study about acupuncture regulation in Ontario. As a PhD student at the University of Toronto, I am conducting a qualitative research study to investigate the many issues faced by practitioner groups and government through the recent process of regulating acupuncture practitioners in the province. I am aware that you have been involved in Ontario’s acupuncture and TCM regulatory process, and would like to speak with you to gain better understanding as to your experiences through this process, and the issues you have encountered.

What is the study’s purpose?
The purpose of the study is to explore how various practitioner groups recently attained explicit authority to continue practicing acupuncture in the province of Ontario. The study findings will be compared and contrasted with regulations across other jurisdictions worldwide. I am conducting this study to fulfill the thesis requirement for my PhD degree.

What is being requested of you?
As the principal investigator, I am requesting your formal consent to meet with me for an interview, at your convenience. The interview will last approximately 60 – 90 minutes. I will be asking you various questions about your particular involvement in the regulatory process, as well as your perspectives as to the impact of the outcomes on TCM and acupuncture practitioners. With your agreement, I will be making an audio recording of our interview for confidential transcription, which I will use in my study analysis.

Is the interview confidential?
Your name will not be associated with any of the study findings, and the identities of interviewees will be strictly protected throughout the research project. Interview recordings will be kept for up to twelve months after our interview, during which time they will be transcribed. The names of participants (as well as specific locations and organizational affiliations) will be removed from interview transcripts. A unique code will replace names on transcripts to identify each person interviewed. Throughout the study, all interview transcripts will be securely encrypted on a password protected computer, and in locked filing cabinets and offices; only the primary investigator (myself) and my thesis supervisory committee members will be able to access them.

No information will be printed or released that would disclose any personal identities. However, complete anonymity can be difficult to achieve in a study such as this one. This is particularly true for high-profile public persons, whose stories, views and activities may already be known within specific communities, or by the general public. That said, all steps will be taken to protect your identity in line with your wishes. Within six months of our interview, you may request (either in writing, in person or by phone) that your transcript, or portions of it, be deleted. However, even if your transcript (or portions of it) are destroyed at your request, it is important to understand that perspectives from your interview may be incorporated into the study analysis.

What happens to interview transcripts after the study is over?
After the study I am conducting for my PhD thesis project is complete, anonymous interview transcripts will be stored in a case study database for future reference and analysis by the study’s research team. No direct quotes will be used in the publication of further analyses. If you would prefer not to have your transcript included in this database, you may request (within six months of your interview) that the transcript be destroyed after the end of this study.

Will the study report be available to read?
You may request that I send you a copy of the final study report when my research is complete.
Will there be compensation for participating in this study?
No. However, all efforts will be made to schedule interviews at a time and location convenient to you.

What are the risks and benefits of participating in this study?
There is minimal risk associated with participating in this study. Your participation is voluntary, and you may withdraw part or all of your interview content within six weeks of our interview. Your name will not be publically associated with the study findings, and every effort will be made to keep your contribution confidential. However, complete anonymity cannot be ensured, particularly for public figures.

A benefit associated with the study is that participants will have a chance to have their perspectives represented in scholarly form alongside the views and experiences of other stakeholders to Ontario’s acupuncture regulatory process. There is a chance that study findings may influence how other jurisdictions regulate acupuncture in future. Also, a summary of the study findings will be distributed to all of those who express interest, which may help particular occupational groups to better understand their position with respect to acupuncture regulation.

What are the rights of interview participants?
If you have any other questions about your rights as an interview participant, please contact Daniel Gyewu, Research Ethics Manager, Ethics Review Office, University of Toronto, at 416-946-5606 or by email at d.gyewu@utoronto.ca.

Please keep this information letter and a copy of the informed consent for your records.
Your particular perspectives on the regulation of acupuncture are important to the study. We sincerely hope that you will agree to take part. Please contact me by email (Nadine.ijaz@mail.utoronto.ca) or by telephone (416-705-9042) to let me know if you would, or would not, like to participate. If you let me know that you would not like to participate, I will not contact you again. If I do not hear from you within approximately one week, I will contact you again to inquire about your possible involvement, and to resolve any questions or concerns you may have about this study.

If you agree to participate in this study, a consent form will be sent to you, and we will work together to find an agreeable time and location for an interview. Please do not hesitate to contact me if you have any questions at this point.

Sincerely,

Nadine Ijaz MSc, PhD Student

Supervisory Committee Members:
Dr. Heather Boon, Supervisor
(Pharmacy, U. Toronto)
Dr. Sandy Welsh (Sociology, U. Toronto)
Dr. Linda Muzzin (OISE, U. Toronto)
Dr. Tracey Adams (Sociology, U. Western Ontario)
APPENDIX B: Letter of information, with compensation

Study: Acupuncture practitioner regulation & the pursuit of professional legitimacy in Ontario

Dear …

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What is the study’s purpose?
The purpose of the study is to explore how various practitioner groups recently attained explicit authority to continue practicing acupuncture in the province of Ontario. The study findings will be compared and contrasted with regulations across other jurisdictions worldwide. I am conducting this study to fulfill the thesis requirement for my PhD degree.

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Is the interview confidential?
Your name will not be associated with any of the study findings, and the identities of interviewees will be strictly protected throughout the research project. Interview recordings will be kept for up to twelve months after our interview, during which time they will be transcribed. The names of participants (as well as specific locations and organizational affiliations) will be removed from interview transcripts. A unique code will replace names on transcripts to identify each person interviewed. Throughout the study, all interview transcripts will be securely encrypted on a password protected computer, and in locked filing cabinets and offices; only the primary investigator (myself) and my thesis supervisory committee members will be able to access them.

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After the study I am conducting for my PhD thesis project is complete, anonymous interview transcripts will be stored in a case study database for future reference and analysis by the study’s research team. No direct quotes will be used in the publication of further analyses. If you would prefer not to have your transcript included in this database, you may request (within six months of your interview) that the transcript be destroyed after the end of this study.

Will the study report be available to read?
You may request that I send you a copy of the final study report when my research is complete.

Will there be compensation for participating in this study? Yes. You will be offered $75 in cash in order to partially compensate you for potential loss of professional income arising from your participation in the study.

What are the risks and benefits of participating in this study?
There is minimal risk associated with participating in this study. Your participation is voluntary, and you may withdraw part or all of your interview content within six weeks of our interview. Your name will not be publically associated with the study findings, and every effort will be made to keep your contribution confidential. However, complete anonymity cannot be ensured, particularly for public figures.

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Please keep this information letter and a copy of the informed consent for your records.
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If you agree to participate in this study, a consent form will be sent to you, and we will work together to find an agreeable time and location for an interview. Please do not hesitate to contact me if you have any questions at this point.

Sincerely,

Nadine Ijaz MSc, PhD Student

Supervisory Committee Members:
Dr. Heather Boon, Supervisor
(Pharmacy, U. Toronto)
Dr. Sandy Welsh (Sociology, U. Toronto)
Dr. Linda Muzzin (OISE, U. Toronto)
Dr. Tracey Adams (Sociology, U. Western Ontari
Letter of Information, Chinese

信息函件

研究标题：安省针灸医师的监管与医师对专业合法性的争取

本人谨致函邀请您参与一项关于安省监管针灸的调查研究。身为多伦多大学的博士生，我现在进行一项定性研究，探讨在最近安省对针灸医师进行监管的过程中，执业者和政府所面对的许多问题。我希望与您交谈，更好地了解您在这个过程中的体验，以及您遇到的问题。

这项研究有什么目的？
这项研究的目的是探讨不同的执业群体最近如何获得明确权力，继续在安省从事针灸工作。研究结果将与世界各地其它司法管辖区的监管情况比较和对比。我进行这项研究是为了撰写论文以达到博士学位的要求。

您要面对什么要求？
作为主要研究者，我恳请您于方便时给予正式同意，同意与我会面接受访问。访问将需时约一至一个半小时。我将向您提出不同的问题，它们是关于您个人在监管过程中的参与，以及您对于中医师所受影响的看法。在我同意的情况下，我将对访问进行录音，以便进行保密的誊写，这些记录将用于我的研究分析之中。

访问是否会以华语进行？
是的，如果这是您的选择，访问可以在一名翻译员的协助下以华语进行。如果您想邀请一名您自己选择的口译员，您可以这样做。否则，口译员可以由研究团队提供。作为主要研究者，我将进行访问，以英语发问，然后由口译员向您表达问题的意思。您以华语回答后，口译员将以英语把答案告诉我。

访问是否会保密？
您的名字不会在任何研究结果中出现，而在整个研究项目进行的过程中，受访者的名字将受到严格保护。访问的录音将在访问完成后保留至多12个月，期间录音会被誊写出来。参与者（以及具体地点和所属组织）的名字将从访问记录中删除。一个独特代号取代在誊写本中出现的名字，以供识别每位受访者之用。研究进行期间，所有访问记录将被安全地加密，储存在一个有密码保护的电脑，并且有加锁的档案柜和办公室；只有主要研究者（本人）和论文监督委员会的成员能够接触它们。

任何会披露任何个人身份的资料都不会刊行或发布。可是，像这样的一项研究可能难以做到完全匿名。知名度高的公众人物尤其会有这种情况，他们的经历、意见和活动可能在特定的社区中已为人知，或者普罗大众都知道。话虽如此，我们将采取一切措施，如您所愿地保护您的身份。访问完成后6个月内，您可以要求（以书面形式、亲临或致电）把您的录音誊本或其若干部分删除。不过，即使誊本（或其若干部分）在您的要求下被毁，您要明白到，您在访问中表达的看法可能会纳入研究分析中。

访问记录于研究结束之后会怎样？
当我为了我的博士生论文项目而进行的研究结束后，匿名的访问记录将储存在个案研究数据库中，以供进行这项研究的团队将来参考和分析。进一步分析的发布中不会有任何直接引述。倘若您不想让录音誊本包括在这个数据库内，您可以要求（访问完成后6个月内）于这项研究结束后把誊本销毁。
研究报告是否可供阅读？
您可以要求我于研究完成后把最终研究报告的一份复印本发给您。

参与这项研究是否会有报酬？
是的。您将会得到现金 75 元，这是对您因为参与研究而失去的潜在专业收入，补偿一部分。此外，如果您选择邀请一名华语/英语口译员，那人也将会于访问进行时得到现金 75 元。

参与这项研究将有什么风险和好处？
参与这项研究的风险是微乎其微。您的参与是自愿性质，您可以于访问完成后6个星期内撤回访问内容的全部。您的姓名不会在研究结果中公开，而且我们将尽力对您的贡献保密。可是，完全的匿名性是不能确保，尤其是对公众人物来说。

这项研究的一个好处是参加者将有机会让他们的看法，连同其它利益相关者对安省监管针灸过程的意见和体验，从学术角度表达出来。研究结果有可能于将来可以影响其它司法管辖区如何监管针灸。此外，研究结果的摘要将分发给所有表示兴趣者，这份摘要可能会帮助某些职业群体，在针灸监管方面对他们的生活有更了解。

访问的参加者有什么权利？
如果您对身为访问参加者，您所拥有的权利有任何其它问题，请致电 416-946-5606 或发电邮 d.gyewu@utoronto.ca，联系多伦多大学伦理审查办公室 (Ethics Review Office) 的研究伦理经理 (Research Ethics Manager) Daniel Gyewu。

请保留这份信息函件和知情同意书的复印本，作为记录。

您对安省监管针灸的看法对这项研究很重要。我们真诚地希望您同意参与。请发电邮 Nadine.ijaz@mail.utoronto.ca 或致电 (416-705-9042) 给我，让我知道您愿意或不愿意参加。如果您告诉我，您不想参加，我不会再次与您联系。倘若我于一个星期内得不到您的回音，我将再次联系您，询问您是否参加，并为您提供这项研究的任何问题或疑虑予以解释。

如果您同意参加这项研究，将收到一份同意书，然后我们将一起为访问寻求一个合适的时间和地点。目前若您有任何问题，请随时与我联系。

谨此致意

多伦多大学
博士生/主要研究员
Nadine Ijaz MSc
Nadine.ijaz@mail.utoronto.ca

监督委员会成员：

Dr. Heather Boon — 监督人 (多伦多大学药学)
Dr. Sandy Welsh (多伦多大学社会学)
Dr. Linda Muzzin (多伦多大学OISE)
Dr. Tracey Adams (西安大略大学社会学)
Appendix D: English-translated Chinese letter of information

Letter of Information

**Study title:** Acupuncture practitioner regulation and the pursuit of professional legitimacy in Ontario

I am writing to request your participation in a research study about acupuncture regulation in Ontario. As a PhD candidate at the University of Toronto, I am conducting a qualitative research study to investigate the many issues faced by practitioner groups and government through the recent process of regulating acupuncture practitioners in the province. I would like to speak with you to gain better understanding as to your experiences through this process, and the issues you have encountered.

**What is the study’s purpose?**
The purpose of the study is to explore how various practitioner groups recently attained explicit authority to continue practicing acupuncture in the province of Ontario. The study findings will be compared and contrasted with regulations across other jurisdictions worldwide. I am conducting this study to fulfill the thesis requirement for my PhD degree.

**What is being requested of you?**
As the principal investigator, I am requesting your formal consent to meet with me for an interview, at your convenience. The interview will last approximately 1 to 1.5 hours. I will be asking you various questions about your particular involvement in the regulatory process, as well as your perspectives as to the impact of the outcomes on Chinese medicine practitioners. With your agreement, I will be making an audio recording of our interview for confidential transcription, which I will use in my study analysis.

**Will the interview be in Chinese?**
Yes, if you prefer, the interview may be conducted in Chinese, with a translator. If you prefer to invite an interpreter of your own choosing, you may do so. Alternately, an interpreter may be provided by the research team. As the principal investigator, I will be conducting the interview, and asking questions in English, which will then be conveyed to you by the interpreter. Then, the interpreter will convey your Chinese language responses will be back to me in English.

**Is the interview confidential?**
Your name will not be associated with any of the study findings, and the identities of interviewees will be strictly protected throughout the research project. Interview recordings will be kept for up to twelve months after our interview, during which time they will be transcribed. The names of participants (as well as specific locations and organizational affiliations) will be removed from interview transcripts. A unique code will replace names on transcripts to identify each person interviewed. Throughout the study, all interview transcripts will be securely encrypted on a password protected computer, and in locked filing cabinets and offices; only the primary investigator (myself) and my thesis supervisory committee members will be able to access them.

No information will be printed or released that would disclose any personal identities. However, complete anonymity can be difficult to achieve in a study such as this one. This is particularly true for high-profile public persons, whose stories, views and activities may already be known within specific communities, or by the general public. That said, all steps will be taken to protect your identity in line with your wishes. Within six months of our interview, you may request (either in writing, in person or by phone) that your transcript, or portions of it, be deleted. However, even if your transcript (or portions of it) are destroyed at your request, it is important to understand that perspectives from your interview may be incorporated into the study analysis.
What happens to interview transcripts after the study is over?
After the study I am conducting for my PhD thesis project is complete, anonymous interview transcripts will be stored in a case study database for future reference and analysis by the study’s research team. No direct quotes will be used in the publication of further analyses. If you would prefer not to have your transcript included in this database, you may request (within six months of your interview) that the transcript be destroyed after the end of this study.

Will the study report be available to read?
You may request that I send you a copy of the final study report when my research is complete.

Will there be compensation for participating in this study?
Yes, You will be offered $75 in cash in order to partially compensate you for potential loss of professional income arising from your participation in the study. In addition, if you choose to invite a Chinese/English interpreter to the interview, that person will also be offered $75 in cash at the time of the interview.

What are the risks and benefits of participating in this study?
There is minimal risk associated with participating in this study. Your participation is voluntary, and you may withdraw part or all of your interview content within six weeks of our interview. Your name will not be publically associated with the study findings, and every effort will be made to keep your contribution confidential. However, complete anonymity cannot be ensured, particularly for public figures.

A benefit associated with the study is that participants will have a chance to have their perspectives represented in scholarly form alongside the views and experiences of other stakeholders to Ontario’s acupuncture regulatory process. There is a chance that study findings may influence how other jurisdictions regulate acupuncture in future. Also, a summary of the study findings will be distributed to all of those who express interest, which may help particular occupational groups to better understand their position with respect to acupuncture regulation.

What are the rights of interview participants?
If you have any other questions about your rights as an interview participant, please contact Daniel Gyewu, Research Ethics Manager, Ethics Review Office, University of Toronto, at 416-946-5606 or by email at d.gyewu@utoronto.ca. Please keep this information letter and a copy of the informed consent for your records.

Your perspectives on the regulation of acupuncture in the province of Ontario are important to the study. We sincerely hope that you will agree to take part. Please contact me by email (Nadine.ijaz@mail.utoronto.ca) or by telephone (416-705-9042) to let me know if you would, or would not, like to participate. If you let me know that you would not like to participate, I will not contact you again. If I do not hear from you within approximately one week, I will contact you again to inquire about your possible involvement, and to resolve any questions or concerns you may have about this study.

If you agree to participate in this study, a consent form will be sent to you, and we will work together to find an agreeable time and location for an interview. Please do not hesitate to contact me if you have any questions at this point.

Sincerely,

Nadine Ijaz MSc  
Principal Investigator  
PhD candidate  
University of Toronto

Supervisory Committee Members:
Dr. Heather Boon, Supervisor (Pharmacy, U. Toronto)  
Dr. Sandy Welsh (Sociology, U. Toronto)  
Dr. Linda Muzzin (OISE, U. Toronto)  
Dr. Tracey Adams (Sociology, U. Western Ontario)

Nadine.ijaz@mail.utoronto.ca
Appendix E: Consent form, no compensation

Study title: Acupuncture practitioner regulation and the pursuit of professional legitimacy in Ontario

I acknowledge that I have read the letter of information accompanying this form, have had the study described to me to my satisfaction, and have had an opportunity to have my questions about my involvement in the study answered. I agree to participate in the described study.

I understand that the Principal Investigator, Nadine Ijaz (a PhD candidate in the Faculty of Pharmacy at the University of Toronto) will be interviewing me, and that this study is intended to fulfill the thesis requirements for her doctoral degree.

I understand that my interview is likely to last between 60 and 90 minutes, and that it will be audio-recorded with my consent.

I understand that the information I provide for this study over the course of my interview will be kept confidential, and that I will be identified by a unique, anonymous numerical code accessible only to the principal investigator and her doctoral thesis supervisor. Audio files will be stored exclusively on password-protected computers for up to twelve months after the interview. Transcripts will be encrypted on password-protected computers and/or in locked filing cabinets and offices accessible only to the research team.

I understand that total anonymity cannot be guaranteed in the current study, although the Principal Investigator will make all efforts to protect participant confidentiality.

I understand that my anonymous interview transcript will be stored in a research archive after the study is complete, and that it may be re-analysed in future research by the research team.

I understand that participation in this study is voluntary, and that I may end the interview at any time after it has begun. I also understand that I may withdraw my transcript from the study within six months of the interview. However, I acknowledge that the Principal Investigator – who may recall portions of our interview – may incorporate perspectives from our interview in the study even if the transcript is destroyed at my request.

Date: _____/_____/_____ (to be dated by interviewee)

D M Y

Interviewee signature: __________________________

APPENDIX F: Consent form, with compensation

Study title: Acupuncture practitioner regulation and the pursuit of professional legitimacy in Ontario

I acknowledge that I have read the letter of information accompanying this form, have had the study described to me to my satisfaction, and have had an opportunity to have my questions about my involvement in the study answered. I agree to participate in the described study.

I understand that the Principal Investigator, Nadine Ijaz (a PhD candidate in the Faculty of Pharmacy at the University of Toronto) will be interviewing me, and that this study is intended to fulfill the thesis requirements for her doctoral degree.

I understand that my interview is likely to last between 60 and 90 minutes, and that it will be audio-recorded with my consent.

I understand that the information I provide for this study over the course of my interview will be kept confidential, and that I will be identified by a unique, anonymous numerical code accessible only to the principal investigator and her doctoral thesis supervisor. Audio files will be stored exclusively on password-protected computers for up to twelve months after the interview. Transcripts will be encrypted on password-protected computers and/or in locked filing cabinets and offices accessible only to the research team.

I understand that total anonymity cannot be guaranteed in the current study, although the Principal Investigator will make all efforts to protect participant confidentiality.

I understand that my anonymous interview transcript will be stored in a research archive after the study is complete, and that it may be re-analysed in future research by the research team.

I understand that participation in this study is voluntary, and that I may end the interview at any time after it has begun. I also understand that I may withdraw my transcript from the study within six months of the interview. However, I acknowledge that the Principal Investigator – who may recall portions of our interview – may incorporate perspectives from our interview in the study even if the transcript is destroyed at my request.

Date: _____ / _____ / _____ (to be dated by interviewee)

Interviewee signature: __________________________

I have received $75 in cash as compensation for my participation in this interview.

Interviewee initials: ____________________________ Date: _______________________

Thank you for your participation in this study.
APPENDIX G: Consent form, Chinese

访问的知情同意书

研究标题：安省针灸医师的监管与医师对专业合法性的争取

我确认我已阅读随本同意书附上的信息函件，这项研究已经以令我满意的方式描述，而且我有机会对我参与研究的任何问题得到解答。我同意参加所描述的研究。

我明白到主要研究员Nadine Ijaz（多伦多大学的博士生）将访问我，而这项研究是要让她撰写论文以达到博士学位的要求。

我明白到访问可能需时60至90分钟，并且在我同意的情况下，访问会以录音方式记录。我明白到Nadine Ijaz将以英语进行访问，而她的问题和我以华语提供的答案，将于访问进行时由一名口译员来翻译，使我们的讨论顺利进行。

我明白到我在访问过程中为这项研究提供的资料将保密，而我的身份将以一个独特、无名的数字代号来识别，只有主要研究员和她的博士论文监督人得到这个代号。音频档案将仅储存在有密码保护的电脑内，于访问完成后保留至多12个月。录音的誊写本将加密储存在有密码保护的电脑及/或加锁的档案柜和办公室，只有研究团队可以接触它们。

我明白到虽然主要研究员将尽全力保护参加者的机密，但不能保证当前这项研究的完全匿名性。

我明白到我的匿名访问记录将于研究完成后，储存在一个研究档案库中，可能会供研究团队在未来的研究中重新分析。

我明白到参与这项研究是自愿性质，而我可以于访问开始进行后任何时候使它终止。我明白到我可以于访问完成后6个月内撤回誊本。可是，我确认即使誊本在我的要求下被毁，主要研究员（可能会想起访问内容的若干部分）可能会把在访问中得到的看法纳入这项研究中。

日期：_____/_____/_____（由受访者注明日期）

受访者签名：____________________  请工整书写姓名：____________________

谢谢您参与这项研究。
APPENDIX H: English-translated Chinese consent form

Informed Consent Form For Interview

Study title: Acupuncture practitioner regulation and the pursuit of professional legitimacy in Ontario

I acknowledge that I have read the letter of information accompanying this form, have had the study described to me to my satisfaction, and have had an opportunity to have my questions about my involvement in the study answered. I agree to participate in the described study. I understand that the Principal Investigator, Nadine Ijaz (a PhD candidate at the University of Toronto) will be interviewing me, and that this study is intended to fulfill the thesis requirements for her doctoral degree.

I understand that my interview is likely to last between 60 and 90 minutes, and that it will be audio-recorded with my consent. I understand that Nadine Ijaz will be conducting the interview in English, and that her questions - and my answers, in Chinese - will be translated by a language interpreter at the time of the interview to facilitate our discussion.

I understand that the information I provide for this study over the course of my interview will be kept confidential, and that I will be identified by a unique, anonymous numerical code accessible only to the principal investigator and her doctoral thesis supervisor. Audio files will be stored exclusively on password-protected computers for up to twelve months after the interview. Transcripts will be encrypted on password-protected computers and/or in locked filing cabinets and offices accessible only to the research team.

I understand that total anonymity cannot be guaranteed in the current study, although the Principal Investigator will make all efforts to protect participant confidentiality.

I understand that an anonymous interview transcript will be stored in a research archive after the study is complete, and that it may be re-analysed in future research by the research team.

I understand that participation in this study is voluntary, and that I may end the interview at any time after it has begun. I also understand that I may withdraw my transcript from the study within six months of the interview. However, I acknowledge that the Principal Investigator – who may recall portions of our interview – may incorporate perspectives from our interview in the study even if the transcript is destroyed at my request.

Date: _____/_____/_____ (to be dated by interviewee)

Interviewee signature: __________________________ Please print name: __________________________

I have received $75 in cash as compensation for my participation in this interview.

Interviewee initials: __________________________ Date: __________________________

Thank you for your participation in this study.
Appendix I: Semi-structured interview guide

Interview Guide

1. **OVERALL INVOLVEMENT**: Can you tell me about your involvement in the regulation of acupuncture in Ontario?
   a. **PROBE**: Timeframe, particular role, reason for involvement
   b. **PROBE**: Details, story of involvement

2. **TCM-BASED & BIOMEDICAL ACUPUNCTURE**: Ontario’s regulations allow for the practice of two broad categories of acupuncture: TCM-based and anatomical, or biomedical, acupuncture. What is your view on how the regulations have handled this issue?
   a. **PROBE**: What role do you think culture should or should not play in regulating acupuncture?

3. **SCOPE**: Eleven different professional groups in the province are now authorized to perform acupuncture under the new regulations. What is your view on this policy decision?
   a. **PROBE**: Personal involvement
   b. **PROBE**: Benefits, challenges associated with this policy
   c. **PROBE**: Economics, legitimation, insurance coverage

4. **STANDARDS**: Various professions in Ontario currently require different acupuncture training standards for their members. I’m interested in your views on this.
   a. **PROBE**: How does your profession handle acupuncture standards?
   b. **PROBE**: Personal involvement in standards development?
   c. **PROBE**: Do you think these standards are adequate? Inadequate?
   d. **PROBE**: Anything else you would like to add about this?

5. **GRANDPARENTING**: Each profession regulating acupuncture has handled the issue of ‘grandparenting’ existing practitioners in its own way. In your view, has this process been handled well [by your profession/overall]?
   a. **PROBE**: Successes, challenges
   b. **PROBE**: Formal training vs. apprenticeship (TCM only)
   c. **PROBE**: Language issues (TCM only)

6. **REGULATORY OBJECTIONS**: There have now been two court cases associated with the province’s acupuncture regulations. Have you had any involvement in these?
   a. **PROBE**: If so, describe, discuss...
   b. **PROBE**: If not, what are your views on some TCM practitioners’ objections to the current acupuncture regulations?

7. **OPEN-ENDED CONCLUSION**: Is there anything else you would like to add about Ontario’s acupuncture regulations are they stand today?
The province’s third acupuncture-authorized ‘allied health profession,’ chiropody, has advised our research team that it continues to work on establishing an approach to acupuncture training standards for its members. No standards, or rostering requirement, are currently in place.