EXTENDING PROFESSIONAL EDUCATION AND PRACTICE IN CHINESE MEDICINE WITHIN HIGHER EDUCATION

A Case study submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Professional Studies

Henry Sim Kwong LEE
[MBA, MSc, BSc (Hons)]

National Centre for Work Based Learning Partnerships

Middlesex University

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Abstract

This case study examines the challenges facing Chinese medicine in UK; the response of Middlesex University as a leader in the provision of Chinese medicine education and training in Europe when in 1997, it added a degree in Chinese medicine into its academic portfolio; and the processes of developing and implementing two sub-strategic projects which will lay the foundation for Middlesex University to extend its professional education and practice in Chinese medicine.

Chinese medicine has always been available to the Chinese population in UK. After a long period of stable and incongruous existence, Chinese medicine began to experience rapid growth in the early 1980s, stimulated by increased consumer interest in self-sufficiency, and back-to-nature to manage their own health. There is also an increase consumer dissatisfaction with the side effects of the chemical drugs. However, in UK as it is the case in Europe, Chinese medicine is not licensed as a medicine and not accepted by orthodox medical practitioners.

The case study confirmed that Middlesex University is on course to own a sound strategy to nurture the development and growth of the professional education and practice in Chinese medicine within the higher education sector. The groundwork is being prepared by these two projects in the case study, the European Centre for Chinese Medicine and the Chinese Medicine Association of Suppliers to enable the University to be the Chinese medicine education and research "hub" for Europe.

The case study supported the notion that insider knowledge can help smooth the complex and complicated human relations to achieve collaborative partnership with different nationals with their attendant cultural beliefs, practice and values, socio-economic and political systems. The projects were neither developed nor managed as conventional projects rather the case study advocated for a flexible approach when managing innovative, collaborative and multi-nationals projects.

Abbreviations

AM	Alternative medicines
AU	Authentication wheel
BAcC	British Acupuncture Council
BMA	British Medical Association
BUTCM	Beijing University of Traditional Chinese Medicine
CDG	Curriculum Development Group
CMAS	Chinese Medicine Association of Suppliers
CM	Chinese Medicine instead of TCM
COA	Chinese, orthodox and alternative medicines wheel
CR	Clinical Research wheel
CT	Clinical Trial wheel
EBM	Evidence-based medicine wheel
ECCM	European Centre For Chinese Medicine
ECMAH	European Chinese Medicine Academic Hub
EI	Education innovations wheel
EU	European Union
HEFCE	Higher Education Funding Council for England
LM	Licensed medicine wheel
MCA	Medicines Control Agency
MU	Middlesex University
MUCMEC	Middlesex University Chinese Medicine Ethics Committee
MUCMLF	Middlesex University Chinese Medicine Learning Fund

OM	Orthodox Medicine
PNPRG	Phytochemistry Natural Product Research Group
QAK	Quality Assurance and Kite-mark wheel
QL	Quality life wheel
RCHPA	Register of Chinese Herbal Practitioners Association
SATCM	State Administration of Traditional Chinese Medicine
SACM	State Administration of Chinese Medicine
SR	Self regulation wheel
TCM	Traditional Chinese Medicine
WHO	World Health Organisation

Acknowledgement

This case study was made possible by a chance conversation with a remarkable educator. That meeting has since stayed with me very vividly. I said to him "Why not have a 'work-based doctorate'? America is full of them. You have already achieved full MA through work-base!". Typically and as expected, my question was answered by another question "Why don't you write a paper about it?" Four of us did! Since that chance conversation, I began my experiential learning journey. This remarkable educator is Professor Derek Portwood who helped Middlesex University to gain the Queens Anniversary Award in 1997 for his pioneering work at the University's National Centre for Work Base Learning Partnership where he was the Director.

I am very indebted to Professor Derek Portwood who is also my supervisor, for his understanding, stimulating guidance and encouragement in this new and pioneering doctorate programme. The student support at the NBCWBL is an example of good practice.

I also would like to acknowledge colleagues in the UK, Hong Kong, China and Europe with whom I had worked very closely. They had given me both inspiration and also challenges to breach both the academic, cultural and professional frontiers to initiate innovative and creative ideas and projects. Those were personal experiences which I shall always treasure and they are also reflected both in my previous roles and in this case study. Without those rich experiences, my case study would be a poor second. My sincere thanks to Mike Brown for reading the final draft and providing me with valuable comments

To my family for their loving support in helping me to realise my creativity at their own expense in many instances, I dedicate this work. Often their needs were unintentionally relegated to second place. I am very grateful for their silent acceptance of the inconvenience.

Introduction

Until the mid-1990s there was no higher education institution offering an undergraduate programme in traditional Chinese medicine. Therefore, when Middlesex University (MU) decided to add Chinese medicine as part of its portfolio of undergraduate programmes, it took on a major challenge. How to introduce a Chinese medicine undergraduate programme into higher education and medical practice in UK? The traditional Chinese medicine which originated in China has been practised for many thousand of years. It has a complete theoretical system which is diametrically opposed to Orthodox medicine which is also the predominant health care modality in the UK. Orthodox medicine has achieved very advanced and clear specialisations.

In 1997, Middlesex University developed a five-year full-time joint BSc(Hons) Traditional Chinese Medicine programme with Beijing University of Traditional Chinese Medicine. Since then, Middlesex University has assumed the leadership role in the traditional Chinese medicine education and training in Europe. MU has since developed a strategy to set itself as the "hub" to offer traditional Chinese medicine education, training and research in Europe. The strategy known as the European Chinese Medicine Academic Hub (ECMAH), aims to develop and offer a package of innovative and quality-based Chinese medicine academic activities across Europe to institutions which would meet MU's collaborative partnership criteria. The strategy has many sub-strategic projects, many of which have been developed and approved to provide the building blocks to achieve the ECMAH strategy.

However, there is another major and complex challenge which must be resolved in tandem with the ECMAH strategy. This explains why a series of sub-strategic projects has been put in place. The other major challenge is to enable Chinese medicine to be recognised as a medicine. This requires that the prescribed treatment must have undergone and passed clinical trials. A Chinese medicine treatment with herbs consists of a mixture of many kinds of herbs which the patient has to concoct and then drink

as an infusion. Each dose can range from a single herb to more than ten different kinds of herbs. Therefore, an infusion of Chinese herbal medicine consists of multiple pharmacological properties compared with a single chemical compound for the chemical-based drugs. To date, the conventional clinical trial processes and procedures are ill-equipped to monitor simultaneously the effects of these herbs in the body.

This paper is the final part of the Doctorate in Professional Studies programme. It focuses on a case study of two of these sub-strategic projects. The first of the two projects focuses on the development of the European Centre for Chinese Medicine (ECCM) whose membership comprises twelve organisations across Europe and China. The creation of a Chinese Medicine Association of Suppliers (CMAS) is the other project. ECCM and CMAS will promote evidence-based and quality herbs to support clinical trials respectively. The sum total of these two projects will enhance the status of Middlesex University as a university fit to lead the rest of Europe in education, training and research in Chinese medicine. To contextualise the case study and the overall strategy a critical review and reflection is offered of the major and complex task MU has undertaken to introduce traditional Chinese medicine as an academic subject in higher education. The review will also confirm that although these challenges are not abstract, they are still elusive and unpredictable because there are no data or models to follow except through personal practical experiences.

The case study examines the developmental processes of these two projects. It is primarily underpinned by action research whose processes have been in fact blended with other research models to form an eclectic model. The model offered a three-dimensional image of the processes under observation. It is capable of providing the macro-snap shots which are then examined and essential information is then selectively analysed. During the projects, the model enabled the developer to sift and search for qualitative data embedded in the complex processes of the projects. The model has also helped to enhance the overall capacity to examine the processes of interfacing different cultures, beliefs, values and practices that existed among partners from diverse and international backgrounds. Finally, the model has offered the opportunity to

compensate for the limitations of using a single model and to gain a more in-depth focus of the projects.

An attempt is made to look beyond the vision when all the sub-strategies are completed and implemented. For example, what are the implications if the general public no longer accept the state of their health and the quality of their life as developed and managed on their behalf within the present model of health and medical care model? What will be the implications if an integrated transnational medical and health care model of education and training were accepted as the core principle to pulsate through the health care education and training curricular developments, that is when the Chinese, orthodox and alternative medical students learn and work together and interchangeably?

Please note that pseudonyms are used to protect the individuals. To avoid complicated explanations and usage of she or he, her/him I have used the feminine gender where necessary throughout the paper.

Challenges facing Chinese medicine in the UK

Understand Yin and Yang,
You will understand Chinese thought.
Understand Chinese thought,
Chinese medicine you will understand.

It is easy to say that Chinese medicine (CM) faces many problems when it is introduced into UK than to delineate the actual problems. I would like to start with a quotation from Porkert(1974) who was searching for a rationale why Chinese medicine is little understood in the West. I hope this may help to promote our understanding what are the perceived problems which prevent CM being accepted outside China, particularly in cultures where orthodox medicine has monopoly status.

> "Chinese medicine, like the other Chinese sciences, defines data on the basis of the inductive and synthetic mode of cognition. In Western science prior to the development of electrodynamics and nuclear physics (which are founded essentially on inductivity), the inductive nexus was limited to subordinate uses in proto sciences such as astrology. Now Western man, as a consequence of two thousand years of intellectual tradition, persists in the habit of making causal connections first and inductive links, if at all, only as an afterthought. This habit must still be considered the biggest obstacle to an adequate appreciation of Chinese science in general and of Chinese medicine in particular. Given such different cognitive bases, many of the apparent similarities between traditional Chinese and European science which attract the admiration of positivists turn out to be spurious."

Whilst the general public are willing to "give it a try" in their search for natural medicine, the scientific community, in particular orthodox medicine (OM), is very sceptical. OM demands proofs such as evidence of data of clinical trials conducted within the Western scientific frame. It is therefore, not surprising to note that when a degree in CM was first proposed, it was met with comments from polite acknowledgement, "sounds interesting" to "does it mean that we shall all learn yin and yang? ... we shall all be able to stick needles over the sick person's body!" Despite the increasing popularity of complementary medicines and therapies outside academia,

academics knew very little about these subjects and some refer to them as "'mumbo jumbo' and . . . is it science-based?" Nevertheless, Middlesex University (MU) did remain faithful to its declared vision and mission to extend the frontier of knowledge.

Instead of labelling them as problems I consider them as challenges of different complexity and they are precipitated by the development of the BSc(Hons) Traditional Chinese Medicine (the degree programme). They have been triggered by several critical questions. What is Chinese medicine? Is it a medicine? Is it science-based and where is the supporting evidence? The degree programme does face several important, multifaceted and interdependent issues such as:

- How to maintain and enhance CM as an academic subject as well as a professional programme?
- What is the strategy to help CM to become evidence-based practice?
- How to maintain and enhance the rising public support and trust for CM?

The traditional Chinese medicine -what is it?

Every culture has its own folklores for every aspect of its life. Chinese medicine began with a mixture of myth, legend and belief. Their principal value is to preserve the way of life as observed and retold through generations until it was taken over by written records. It was said that once, more than four thousand years ago there were two emperors. One was called Yellow Emperor (Huangdi) who nominated himself as the supreme ruler of the universe and occupied the centre. The second emperor was called Fire Emperor (Yandi) who occupied the southern part of the universe. Yandi was said to have the head of a bull with a transparent belly. He was a very kind Emperor who taught men to cultivate the five grains (millet, rye, sesame and two kinds of wheat). He discovered tea in 2737BC. He was also known as the Divine Farmer (Shen'nong). He possessed a magic stick which could identify a plant and indicate whether it was poisonous or not. Yandi would even taste the plants himself to observe their effects in

his transparent belly. Should a plant be poisonous he would rub the affected part of his body with the appropriate herb to neutralise its effects. It was said that he had personally tasted more than seventy poisons in one day. One day, the poison killed him. He is regarded as the Father of Chinese medicine, and Hippocrates later as the Father of the Greek medicine. He was also credited with the first materia medica, the *Shen'nong Bencaojing* (Classic of Herbal Medicine) which consisted of 365 herbs in three volumes.

The Yellow Emperor also had many therapeutic skills. He and his ministers are said to have invented many things like pestle and mortar, the bow, chariots, boats, musical and mathematical scales and the mirror. Wu Peng, one of the ministers, pioneered the art of medicine. Whether these two Emperors were myths or not, two important medical works bear their names; the Shen'nong Bencaojing and the *Huangdi Nei Jing* (Yellow Emperor's Classic of Internal Medicine, popularly referred to as *Nei Jing*). Neijing was thought to have been written between 475-221 BC and has two parts; *Su Wen* (Plain Questions) and *Ling Shu* (Miraculous Pivot, also known as Canon of Acupuncture). The Traditional Chinese Medicine (TCM) or Chinese Medicine (CM) is based on the theories and ideas discussed in *Nei Jing*. These theories and ideas have been continuously refined through practice over the centuries. *Nei Jing* consists of:

- extensive summary and systematisation of previous experiences of treatment;
- theories of medicine;
- anatomy and physiology;
- pathology of human body;
- diagnosis, treatment and prevention of diseases.

The dang'gui (Chinese angelica, Angelica Sinensis) is recognised to be effective in treating certain gynaecological problems. According to legend, there were two brothers from a poor family. The eldest was very idle and the youngest was very diligent. On their parents' death, the young brother was banished from his parental

home by his elder brother. He was given his dead father's hunting bow and some arrows. He lived in the wood and hunted for a living. One day he saw a falcon perched on a tree. As he was aiming at the bird, the bird appealed to him in human voice not to shoot and explained that its mother was blind and it had to provide food for her. If the young brother spared its life, it would give him some seeds of medicinal herbs. The young brother took pity and urged the falcon to go and find food for its mother and that there was no need to offer the gift. Thereupon, the falcon spat a drop of blood containing the seeds of medicinal herbs and flew away. The young brother picked up a few seeds and planted them in a plot of land by his hut facing the sun. Soon, seedlings became sturdy stems with small blood coloured flowers. He broke off a root and ate it, whereupon he felt invigorated and strong. He gave the roots to the villagers to eat. Those who had been ill, soon recovered and the others gained strength. At the same time a flock of small birds with red plumage and golden beaks flew around the young brother's hut and screeched incessantly "dang'gui, dang'gui". Thus, the plant was so named!

The folklores serve to demonstrate the closeness of medicine with people's life and culture in China. The essence of Chinese philosophy and culture is the harmonious coexistence of man and nature based on the principles of yin and yang. According to the Chinese philosophy all natural phenomena in the universe are divided first into the physical compositions of plant, heat, earth, mineral and liquid, then into the five natural elements of wood, fire, earth, metal and water. All phenomena are categorised into yin and yang (negative and positive respectively), also known as vital energies which complement each other to maintain an equilibrium in spite of their apparent antagonism against each other. Yin represents negativism, passivity, darkness and coldness and Yang as positivism, activity, brightness and heat (figure 1: Yin and Yang in harmony. The black and white dots are seeds of each other which are normal and essential, demonstrating signs of life, harmony and dynamic equilibrium).

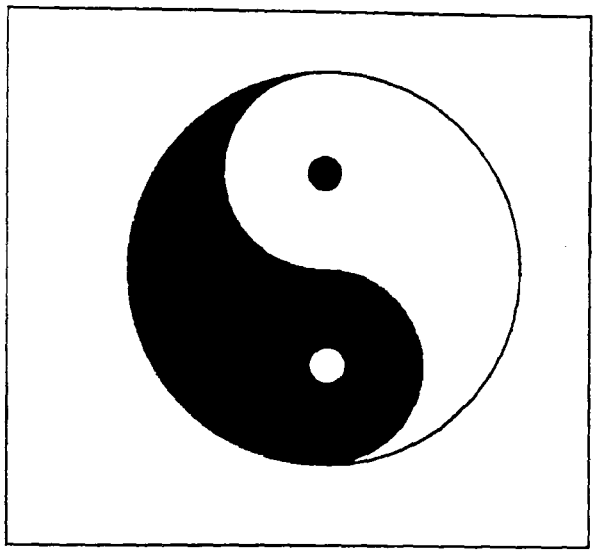


Fig. 1: The dark side is yin and yang represents the bright side.

Yin and yang are relative concepts. They reveal themselves through contrast and expansion. Yin is Earth and yang is Heaven and in the Su Wen: "Heaven is an accumulation of yang and Earth is an accumulation of yin. My body is the same substance as that of heaven and earth. My nature is the same organising principle as it controls heaven and earth" (Zhang Cai, quoted in J. Needham, 1955-1988).

Yi Jing (*"The Book of Changes"*), discussed in Fung(1966), written during the Zhou Dynasty (11th Century - 221 BC), postulated that the human body is a microcosm of the universe and the organs of the body are therefore, equally divided into two interdependent groups of either yin or yang. This explains the Chinese belief that a person is born predominantly with either yin or yang and is directly and indirectly influenced by the movements and changes in nature.

Chinese medicine philosophy and theory

Chinese medicine is the summary of experiences gained by the practitioners in the course of thousands of years of fight against disease. It has a complete theoretical system of its own. It has developed and evolved over the years hand in glove with the philosophy and culture of the Chinese society and the theory of yin and yang has subsequently become its primal theory. CM is based on the concept of maintaining natural balance of the human body both for the purposes of health maintenance and for

treatment of diseases. When harmony and balance exist among all the internal organs, the body and mind, and the external environment, there is good health. In a disease state there is a break-down in the harmonious balance. The treatment is to restore the balance. Chinese medicine is both a holistic system and a single discipline which have several methods of treatment according to the data obtained from the diagnostic procedures. Figure 2 below shows some of the methods of treatment in Chinese medicine.

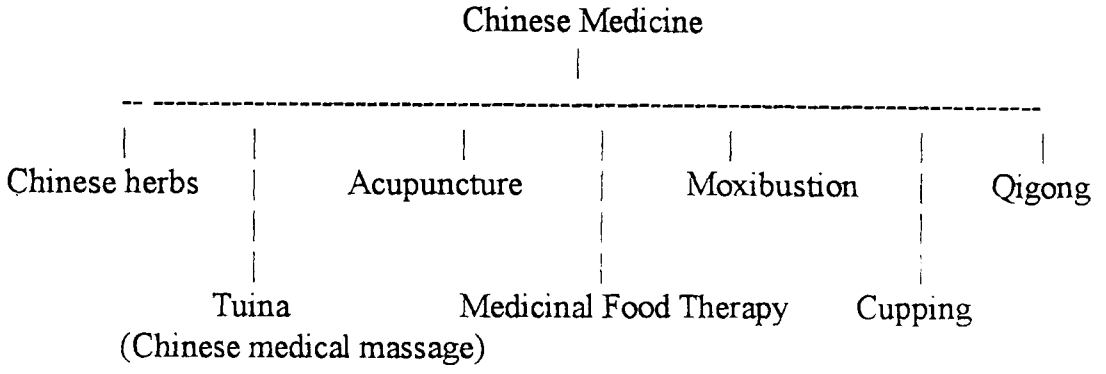


Fig 2: Some of the methods of treatment in CM

"Traditional (Chinese) medicine can be considered an art, and it can claim to be a science", so said Kaptchuk (1983). The inescapable fact is the Chinese medicine's therapeutic use has been constantly tried, tested and modified and according to Said (1965) *Shen'nong Bencaojing* has over succeeding dynasties, been revised and added to 52 volumes with 8160 recipes. Chinese medicine had long developed the principle of using toxic herbs without intoxicating the patients. Today, there is a popular saying in Chinese medicine - "using poison to treat poison". The theory and practice of Chinese medicine are based on the cumulative experiences and knowledge gained thereof. The scientific base of Chinese medicine presently appears unavailable in English. The revision and modification of the prescriptions over the centuries could suggest a type of action research-based approach. The principles are to determine the effectiveness of the treatment and identify alternatives to improve the treatment outcomes. That principle is not far from today's science based orthodox methods.

The "Qi"

"A human being results from the Qi of Heaven and Earth. The union of the Qi of Heaven and Earth is called human being" (Su Wen, Ch. 25). The philosophy, like the universe, explains that the human body is a microcosm of the universe and also has a vital energy or "life force". This vital energy is known as Qi which is the basis of all life. Qi is both a complex and basic substance to sustain life. It is an energy that is in dynamic and constant movement within the body. In human body, Qi flows in channels known as meridians and collaterals. Qi has several functions:

1) Promoting action - activates human growth and development - deficiency will slow down the human development;

2) Warming action - keeps body temperature constant;

3) Defending action - guarding the surface of the skin against pathogens and combatting invading pathogens inside the body;

4) Consolidating and governing action - controls and adjusts blood flow and body fluid secretion and excretion; consolidates and stores life creating materials; maintains body organs in position;

5) Promoting metabolism and transformation - ingesting the food and transform it into other nutrients and Qi itself.

The meridians and collaterals

These are pathways to transport Qi and blood to nourish the body. There are 14 Meridians. They are also the major channels and their collaterals are the branches. They are linked together to the body as a whole, crisscrossing each others in four ways:

a) ascending;

b) descending;

c) exiting; and

d) entering.

The five elements

The Qi is regulated by the waxing and waning of yin and yang in order to maintain the harmonious balance from which good health is achieved. The body is also said to be made up of five basic elements; wood, fire, earth, metal and water, which exist in balance within the body and with the external environment. An imbalance in one of them will cause disease in the body.

Their relationships are about promoting growth and control of each other and also create a balance/equilibrium (fig 3). They are used in CM to explain the physiological and pathological relationship between internal organs and with the environment thereafter, the treatment, the property and the taste of the medicine.

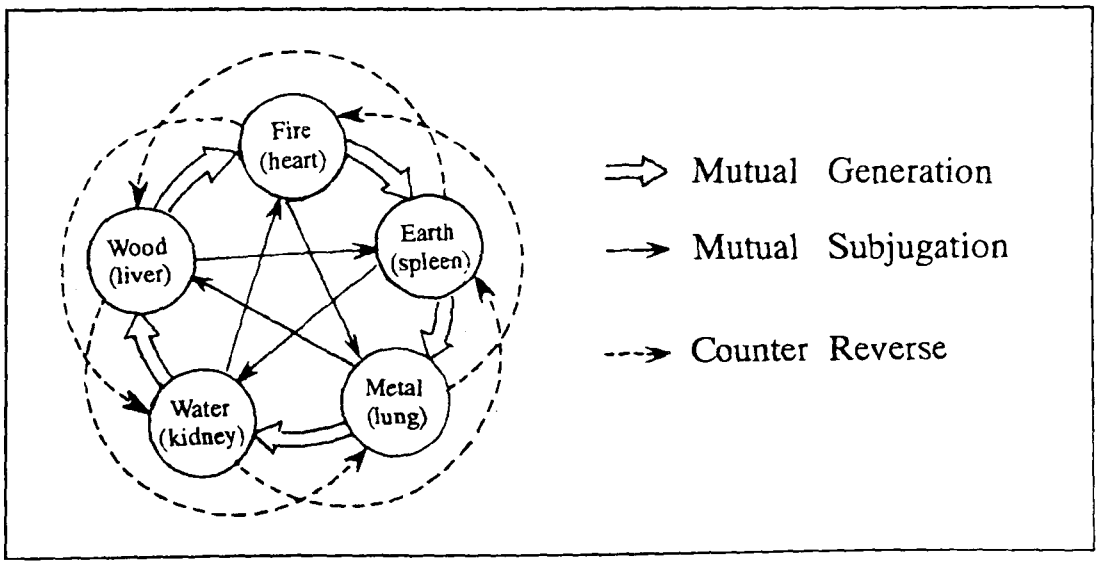


Fig 3: The interrelationship of the five elements

CM in essence is based on the fundamental and basic theory of yin and yang which guide the understanding of:

- the physiology;
- the pathological processes;
- diagnostic processes;
- the treatment prescription;
- the health promotion;

Chinese medicine and Orthodox medicine

Currently, the scientific base of the Chinese medicine is being debated against claims of its efficacy and effectiveness. According to orthodox medicine, it can claim to be scientific only if its principles are science based. The medicine prescribed must have undergone clinical trials and be licensed by the Medicines Control Agency (MCA) as safe for public consumption. The Medicines Control Agency is part of the Minister of Health portfolio which is responsible for policing the quality and safety of medicine on the markets. It consists of policy, chemical analysis and policing arms.

Many explanations have been put forward by Chinese and Orthodox medical practitioners to justify each other's rationale as to why Chinese medicine should or should not be subjected to the western clinical trial methodologies and processes. For example; the most common argument being put forward has been the fact that CM has been practised for so many thousand years. A treatment with CM consists of a mixture of different kinds of herbs and there is no facility or technology to study simultaneously the effects of multiple herbs in the body. The philosophy and the principles of CM are divergent to orthodox medicine (OM) and therefore the principle of the clinical trials which have been good for OM is inappropriate for CM. Or if a medicine is claimed then CM should be subjected to the same clinical trial principles and philosophy and anything less is not acceptable. These are of course extreme views but they also raise the highest decibels in the battle for audience. They are also unfortunately a fair reflection of prevalent general attitudes. Happily, these extreme views are slowly shifting towards an accommodation. For example, OM is beginning to adopt a softer

attitude. It accepts the outcomes of the clinical trials provided a clear description of the methodologies and processes are available to evaluate the outcomes. Orthodox medicine is not demanding that the methodologies must be identical to those applied to the western chemical-based drugs. Rather, it is asking for guidance and evidence on how the researches have been conducted to enable them to make their own evaluation. Naturally, in the absence of any research evidence the issue of legality
for CM will continue to attract much attention and energies which could be better used to identify clear methodologies to conduct the clinical trials.

The question of scientific base of CM was apparently raised in the US District Court for Southern District of Texas (1980). The judgement pronounced was "acupuncture has been practised for 2,000 to 5,000 years. It is no more experimental as a mode of medical treatment than is the Chinese language as a mode of communication. What is experimental is not acupuncture, but Westerners' understanding of it and their ability to utilize it properly . . .Whatever the best explanation is for how acupuncture works, one thing is clear: it does work. All the evidence put before the court indicates that, when administered by a skilled practitioner for certain types of pain and dysfunction, acupuncture is both safe and effective". Despite this legal support, CM still operates on the periphery and not accepted as a medicine in US, UK and Europe.

This negative image has prompted the guardians of CM to review their perspectives. They also realise that the world has changed since the Yandi era. In travel time, it has shrunk into hours but information can now be accessed and delivered instantly across the world. Some steps have been taken to update the Chinese medicine such as dropping the word "traditional" from the traditional Chinese medicine. Recently, the State Drugs Administration has been established to control Chinese medicine in addition to the current State Administration for Chinese Medicine. There are still many challenges for Chinese medicine to face and they include:

- modernising its procedures and processes;
- making information more freely available;

- being more open to colleagues in orthodox medicine, this includes an effort to translate the information at least into the English language which is easily accessible to most people;
- collaborating in research and in the dissemination of Chinese medicine;
- supporting new initiatives both inside and outside China to make Chinese medicine not only available but also of a quality that is recognised and accepted internationally;
- supporting projects to stamp out fast-track training which is equated to a fast buck-making without any concern for the welfare of the public receiving CM;
- it is not up to the government of those practitioners to deal with rogue practitioners. China has a moral duty of care on humanitarian ground towards other fellow citizens and to protect the integrity of Chinese medicine. It is accepted that Pontius Pilate was able to wash his hands!
- accepting that it has a moral duty to lead and to provide support to enable CM to grow with trust outside China;
- safeguarding the biodiversity in the use of Chinese medicine.

Chinese medicine in the European and the UK context

Chinese medicine had been fairly inconspicuous in the United Kingdom until the 1970s. Until then, it had been offered mainly to the Chinese population, in particular to the newly arrived and the first generation. After this long period of stable and incongruous existence, Chinese medicine began to experience rapid growth in the early 1980s, stimulated by increased consumer interest in self-sufficiency, back-to-nature remedies and management of their own health. There was also an increase in consumer dissatisfaction with the side effects of the chemical drugs. This picture can be assumed that it is typical throughout Europe and Chinese medicine is widely used in the overseas Chinese communities.

When I started to investigate the possibility of developing a Chinese medicine undergraduate programme at Middlesex university, there were no "recognised" programmes or educational establishments in Europe and UK for MU to model upon or to learn from. The word "recognised" is used very loosely to mean that the programme is acceptable for study as an academic subject in the higher education section. There were, of course, many small and privately managed "schools" which offered "education and training" in Chinese medicine mostly on a part-time basis. Anecdotal data indicate that unlike UK, the laws in Europe prohibit the practice of Chinese medicine and in some countries only orthodox medical practitioners are allowed to practise acupunctures. Nevertheless, the existence of these laws does not inhibit people from learning and later practising Chinese medicine. Many of the practitioners I have met explained that they spent perhaps up to 10 years in China to learn Chinese medicine. The fact that the laws are not applied rigorously means the practice of Chinese medicine is just as popular in Europe as in UK. In UK, for instance, there is no law to prohibit someone from setting up business and call herself whatever she likes so long the title "doctor" is not used unless the person is orthodox medicine qualified or graduated as Doctor of Philosophy. Prior to MU's joint programme, private colleges existed and still do, to train the individuals to practise Chinese medicine. These colleges were opened by practitioners who saw a need for both the Chinese medicine and the training facilities. The length of their courses varies. These colleges advertise that they issue a licence to those who have successfully completed their course. In fact, the issue of a licence gives the impression that their courses are legally recognised and the general public does not know any better. These colleges also offered insurance services for their course members on qualifying and on payment of an annual fee. Thus, began the associations for the practitioners and further explains why today there are so many associations of practitioners of different size and specialism. Some have merged. British Acupuncture Council is one such merged association and boasts more than one thousand members and associate members. There is also a "love and hate" relationship between these organisations and associations (appendix 1). This is partly attitudinal, perceptual and political. The programme has also placed Middlesex University beyond the bilateral joint programme delivery, into

a political minefield pitting against orthodox medicine. MU has unwittingly raised the status of the Chinese medicine. Will MU do the same for these private colleges when the programme is being submitted to be "approved" by one of the "professional bodies"?

Over the last two decades, there has been a meteoric increase in the demand of complementary medicine/therapies by the public in the United Kingdom outside the National Health Service system. The "Today" programme on BBC Radio 4, reported on 24.2.99 that one in three people now seek health care and treatment from an alternative source other than orthodox medicine. This strong public demand for complementary medicine/therapies and Chinese medicine is one of them also caused concern in orthodox medicine. The British Medical Association conducted a second enquiry within seven years after its first report dismissed complementary medicines and therapies as a "passing fashion" as suggested by BMA (1986). In the second report, BMA (1993) called for improved training and education within complementary medicine and recommended that:

- "priority should be given to research in acupuncture, herbalism, homoeopathy and osteopathy as the therapies most commonly used in this country;

- "the Council of Europe Cooperation in Science and Technology project on non-conventional therapies be approved by the UK Government;

- "accredited postgraduate sessions be set up to inform clinicians on the techniques used by different therapists and the possible benefits for patients...consideration should be given to the inclusion of a familiarisation course on non-conventional therapies within the medical undergraduate curriculum."

The popularity of complementary therapies and medicines continues to rise. Goldbeck-Wood (1996) reported that "one in ten people in Britain consults a practitioner of complementary medicine each year". Thomas et al (1995) found an "estimated 39.5% of GP partnerships in England now provide access to some form of complementary therapy for their NHS patients". HRH Prince Charles (1997) accepted that tremendous advances have been made in scientific and biological research, to the extent that conditions once thought untreatable could be cured. "But clearly, this alone is not fulfilling all our health care needs as large numbers of people are paying to seek help from complementary medical practitioners. We simply cannot ignore what is a very real social phenomenon." He asked that orthodox and alternative medicines collaborate with each other to create what he called "more patient centred health care".

HRH Prince Charles' desire and concern could be viewed as an interpretation of his frustration at the lack of progress in the "establishment" since he first triggered BMA's first enquiry. During his term as President of the BMA, "he urged the Association to look critically at modern medicine. Prince Charles stated that 'today's unorthodoxy is probably going to be tomorrow's convention'. He continued, 'by concentrating on smaller and smaller fragments of the body modern medicine perhaps loses sight of the patient as a whole being, and by reducing health to a mechanical functioning it is no longer able to deal with the phenomenon of healing' (BMA 1986).

There was also overt political support for complementary medicines and therapies to be available but only if orthodox medical practitioners wished to offer them. The Department of Health of the Government of the day gave permission for general practitioners (GPs) to employ a complementary therapist, "it is open to any family doctor to employ a complementary therapist to offer NHS treatment with their patients" (Dorell, 1991). The then Labour Party health spokesperson, Dawn Primarolo (1994) wrote that "in principle, complementary therapies that have value in health care should be available to NHS patients. It is a necessary part of good practice that general practitioners should have access to a wide choice of therapeutic approaches". The supporting evidence indicated that despite these encouraging words, the then government's stance was merely a "benevolent neutrality". The present government's

stand remains identical as confirmed by Tessa Jowell (July, 1998) in a speech to the All Parliamentary Group for Alternative and Complementary Medicine. These are political realities in which the issue of public health become secondary when faced with powerful lobbying groups representing the orthodox medicine and pharmaceutical firms. Nevertheless, the complementary medicines/therapies have grown into a powerful economic base with support from the public. This is not a UK or European phenomenon alone. Eisenberg et al (1993) estimated that one in three American adults had used some form of non-conventional therapy in 1990.

Despite this favourable climate, much was stacked and still is stacking against Chinese medicine. There are several major issues which concern both the practitioners and the Medicines Control Agency (MCA). The quality control is central to these issues. Lack of regulation governing the authentication and quality of herbs in the market has enabled substitute, fake and adulterant herbs being sold to the unsuspected. There is also the issue, as the result of a lack of proper facilities to authenticate and conduct chemical assays, of the level of toxicity which could be naturally occurring from such factors as environmental pollution and soil chemistry and those brought on by the increased use of insecticides and other chemicals during the growing processes. This situation is also compounded by the liberal law in the UK. Any individual can set up a business to import and sell Chinese herbs and other Chinese herbal products, nor does that person require a licence to import these products.

The orthodox medicine in spite of its own governing body's recommendation to include a familiarisation programme on complementary medicine/therapies, maintains its status quo. Until such time when words are translated into actions and minds win over hearts, complementary therapies and medicines will continue to be prejudiced by orthodox medicine both in Europe and UK.

The BSc (Hons) Traditional Chinese Medicine Programme

The idea for a Chinese medicine degree began during the last year of the North London College of Health Studies where I was Academic Registrar and the Associate Principal. I initiated and developed the concept of interprofessional education and training which included complementary medicine/therapies. The latter were becoming popular among the nurses. The education arm (English National Board) of the statutory body for the nursing profession had already approved a post-qualifying professional programme for complementary therapies (Reflexology and Aromatherapy). The then principal of the College was very supportive of such a development. The plan provided the College a strategic opportunity to lead in this area of development. This strategy was also viewed as an opportunity to reduce the College's dependence almost totally on the nurse education consortium contract and to move into interprofessional education as encouraged by the National Health Service Executive (Executive Letter, EL(95)96)

At that particular moment, the College signed an agreement the Middlesex University to become its Faculty of Health Studies in April 1995. On becoming Head of the newly created School, I named it "The School of Multi-Professional Health Care" to reflect the interprofessional Health care academic plan to be developed by the School.

In 1996, a commitment from the University was secured to conduct a feasibility study. Four universities in China were visited, Guanzhou, Nanjing, Shanghai and Beijing and the Beijing University of Traditional Chinese Medicine (BUTCM) was selected to develop the joint undergraduate programme. Two groups were set up to develop and implement the collaborative programme. The Curriculum Committee was the executive committee which supported the Curriculum Development Group (CDG). I chaired both groups. The CDG consisted of qualified TCM practitioners and experts and coopted specialists in other related subject areas to develop specific modules. In the meantime, we received news that the Higher Education Funding Council for England (HEFCE) approved the programme for funding and the then Department for Education and Employment approved it for mandatory grants. In May 1997, the proposed

programme was validated by the University's programme approval committee. The first undergraduate students started the programme in September 1997. To-date there are 52 students studying the programme.

The challenges identified are generated by the degree programme. Thus, immediately, permission was given to develop the degree programme, several curricular issues appeared which the CDG had to grapple with. What should be the length of the programme? According to BUTCM it should be six years and year 6 is a praxis year in which the students will hone their practical skills. This is similar to orthodox medical education and training programme. However, there is the issue of cost since HEFCE only funds up to a maximum of five years. It was therefore, necessary to brief BUTCM about the British Education system which even surprised the Chinese. They were surprised that in a capitalist society, secondary education up to 18 years old is free and education in higher education is also free that is, tuition fees are paid and also there is the means tested grants, when under their socialist regime they have to pay for all their child's education.

This was followed by the curricular contents. Whilst BUTCM wishes to maintain the status quo, it was pointed out that there are certain modules which are not compatible to British culture such as daily qigong exercises, Marxism, as well as very specialised CM subjects. Instead, we were facing several other pressing issues:

- the need to generate confidence in the mind of orthodox medical colleagues that these graduates are competent and professional. They would not take away their livelihood. Rather, it can work side by side to improve the quality of life of those seeking medical assistance. CM is thus introduced as complementing OM.

- What is the scope of practice for the graduates of this degree programme? Should they be taught all conditions including emergencies? This would be a very inappropriate objective for CM to

aim for. This would involve a major nationwide shift in attitudes and cultural values. It took two national referenda to coax the British public to accept EU membership!

To reassure OM, the programme reaffirms the fact that OM is the predominant health care modality in the UK with very advanced and clear specialisation. It also set clear and well-defined parameters and the scope of practice for its emerging practitioners. The programme also offers more than one thousand hours of Western medical anatomy, physiology, pharmacology, pathology, diagnostic processes and procedures. The aim is to provide students with a thorough understanding of Western biomedical approaches to health and illness with the objectives that the graduates will:

- have a biomedical understanding of patients' conditions;
- recognise complex and unusual conditions and know when to seek help;
- accept their limitations and be able to differentiate urgent and serious conditions which should be referred to orthodox medicine;
- understand the effects of TCM and Western drug interactions;
- understand clinical diagnostic techniques and laboratory test results;
- communicate effectively with orthodox medical colleagues

Therefore, the practitioners emerging from this programme will be able to practise in gynaecology, dermatology, paediatry, psychosomatic, neuropathology, chronic conditions, anaesthesia and terminal care. In cases of special and acute medical/surgical, accident and emergency conditions the practitioners will refer them immediately to their GPs or hospitals as appropriate.

What is the programme's underpinning philosophy? Besides BUTCM programme, CDG had no other model to guide it in developing this professional-based programme. Whilst accepting that this programme is about knowledge and practice of CM, we took cognizance that the graduates will most likely practise in UK and Europe. We reviewed both the health care and orthodox medical education philosophies and felt that CM

degree programme should rest on a set of explicit values and beliefs about the client, the nature and context of clinical practice and the possession of a body of knowledge based on the philosophy and theory of Yin-Yang. This body of knowledge is the tool for the professional TCM practitioner. The programme should also aim to provide evidence-based practice and both MU and BUTCM had agreed to the following strategies:

- translation of BUTCM's existing research data for teaching and for replication;
- MU to edit the translation for joint publication in international TCM and orthodox medical journals;
- setting up clinics in NHS Trusts to provide learning research opportunities;
- creating a centre of excellence for TCM to link with other institutions worldwide;
- seeking funding for joint research programmes and eventually with other partners across Europe;
- access to each other's research facilities staff and students to conduct researches;
- supervision of MU's postgraduate TCM research students either at BUTCM or in UK;
- share good practices

How were the challenges tackled?

Harmony between two individuals is never granted
- it has to be conquered indefinitely
Simone de Beauvoir

Reflecting back on my personal experiences, the overemphasis on the possible income stream from the BSc(Hons) Traditional Chinese Medicine has clouded the overall judgement in a number of areas. There was interest and political support. They were not matched by having an appropriate infrastructure to support the development. A good infrastructure is very essential in developing and launching an innovation. I recognize now that the infrastructure was up to me to argue for and to develop at the time. I like to explain how I would do it the second time round with the same subject which will also reflect in part how I went or did not go, about tackling the complex challenges. I realise that my approach is not conventional. I am being pragmatic. I am putting myself in the shoes of busy practitioners. They are also very capable to question and reflect on the evidence before applying it into their workplace. Only they will know and appreciate the complexity of their initiative in relation to their organisational capacity. This approach has the advantage of avoiding compartmentalisation of ideas and actions. Instead my approach encourages holistic approach to analysis and to achieve more effective and reflexive synthesis. Such compartmentalisation has been seen as creating the present gulf that exists between theory and practice. I began with a blank page and what I am describing below is a reflection of my own experiences.

It may also be appropriate to familiarise readers with my role then in order to understand what is being discussed. I was managing 52 staff in a newly created School. Whilst the name was new, the infrastructure and in particular the staff, were transferred from the old College. This meant all the School staff were from a uniprofessional background - nursing. I was deeply involved in managing and facilitating changes in mindsets to embrace the concept of interprofessional learning and working (appendix 2) as well as adapting to higher education culture. I had

introduced a new paradigm - the interprofessional eduction and training to ensure better patient care because practitioners from different professions would work together instead of erecting professional barriers. I was already engaging and "overstretching" the staff capabilities to achieve an ambitious development programme (appendix 3 - see section 3.8 and 3.9 highlighting the size of the School's academic portfolio within two years with half of a DipHE programme at the beginning). This is further confirmed by the proposed increase in its allocated budget (appendix 4)

When embarking onto the explorative discussion with prospective partners it would be most useful to ascertain from them whether they already had an association with organisation/s in UK, the type and purpose of the association, whether they anticipate any difficulties if they have a second partner. This can cause serious misunderstandings. Such a misunderstanding was experienced. If possible ask to meet the teaching staff who are likely to teach in the programme to ensure their language skills are adequate and acceptable. From hindsight, this inexperienced and the naive approach was a leap in the dark and we have yet to fathom this yet. However, this is something very important to bear in mind to avoid future difficulties. The advice is to disengage promptly. Such partners can exact severe "penalties" at a period when they sense that their hosting partners are insecure and vulnerable and the latter are unlikely to remonstrate or seek clarification of the "penalties". In the chess game, the hosting partners are checkmated into position of "give and give".

When the excitement of receiving a positive reply from say a Dragon University to partner in the CM programme development of the BSc(Hons) Traditional Chinese Medicine programme has died down, I would draw up a strategy which will include:

a) formation of a focus group to involve the manager, another senior manager preferably the one who supported the initiative and the university's external marketing manager. This focus group is very essential in order to:

- agree a development plan with milestone chart and review dates;

- agree a budget for the development including replacement cost plus support personnel. The developer must have a say in the appointment of the support personnel. The choice of the personnel is very important. That person must understand the importance of the proposed programme as an academic subject which will be subjected to rigorous quality hurdles and believe in or at least be sympathetic towards CM. It is likely that the supporting personnel may in fact be a member of the negotiating team. The negotiating team must be fully briefed and any sign of less than total interest can be easily detected. They could be personal conduct, postures and other body language. If the partners suspect any less than serious intent during the negotiation they will immediately pull down the shutters and end the discussion. I had to seek permission to take my wife with me as an interpreter to meet and smooth the matter with the leader of the party and to overcome an impasse that had occurred after a long day of negotiation. I noted that the meeting was concluded rather abruptly. On that evening, we spent almost five hours over cold food and a smashed car window to end the day! During the evening meeting, the leader intimated that: there was a lack of respect for them and felt that it was not the right foundation for a cooperation; the day's meeting was like a showcase; a member of negotiating team was impatient and dismissive. It was by coincidence that my wife has the same surname as him and this discovery helped to lighten the rest of the evening's meeting and achieved the necessary changes. Next day, I started another marathon of redrafting the memorandum of cooperation. (Try to put up the guests near you. This will save a lot of travelling time. I would also start the negotiation much earlier as described in (f) below). The personnel should be flexible and be appreciative that not everyone is so desperate as to accept condescending treatment. Leave the party, especially the link role, because the link person will later bear the brunt of the partners' pent-up humiliating experiences and frustrations.

more assistance than the link person for a local collaborative programme. This is a very lonely role and the person is always in a very vulnerable position. Should anything untoward happen, the person has very little opportunity to explain herself. It was once intimated that "the buck has to stop somewhere however unpalatable and unfounded for the link person . . . the university's image is paramount...we don't know the future". Without a genuine commitment, support and trust for the link person, the organisation will be manipulated by the partners once this lack of support is known. If this commitment and trust are not possible, the advice is not to proceed with the collaboration. This also explains why the link person's manager must accompany her in the return trip to the partner's "patch" showing the partner that the link person enjoys her manager's confidence;

- offer a consistent policy and this will reduce the need to point fingers when something goes wrong;
- inspire trust and confidence;
- act as the project's champions.
- organise if deemed useful a proper welcome reception with an allocated budget, to the first intake of students and involve the University's media and marketing services to obtain maximum exposure for the programme.

b) making a return trip to the Dragon University with a member of the focus group, preferably the manager, to discuss and agree with Dragon University the following: meeting and getting to know the Dragon University's link person for the joint programme, the proposed curriculum and any changes therein as required, the concept of curriculum development, the validation processes at MU and within the British higher education system, and the key stakeholders who will be involved in the process of developing a collaborative link and the implications of the partnership. These people are very meticulous in planning visits and in executing them. They are also excellent hosts. These are basic essentials. A project of this nature and complexity needs both

hosts. These are basic essentials. A project of this nature and complexity needs both the manager's personal support and political support. Without the personal support, the political support will be meaningless. Hence, it is essential that the manager is involved and she believes in or at least is not against Chinese medicine,
i.e. her personal prejudice does not cloud the final decision nor should the decision be solely driven by the economic return.

c) setting up the CDG with clear executive role and responsibility. Involve a member of the focus group if possible. This involvement will avoid finger pointing later because any issues relating to the programme would have been agreed and committed. Any agreed on future developments as part and in support of the programme should be recorded for future reference. Organisations have the knack of undergoing change during or immediately after the project. Often the champions disappear, with the changes affecting the previous commitment whether positively or negatively.

d) inviting the Dragon University's link person to spend sometime at MU to familiarise herself with the issues discussed in (b) and participate in the programme development. This will avoid future misunderstandings especially if there is a managerial or political change. Take this opportunity to enrol her into the University's staff development programme.

e) appointing an academic staff to the programme once (a) has been agreed so that a suitably qualified person will be in place to participate in the programme development. The person must have an understanding of the nature of the programme development and the meaning of validation and the concept of adult education and student centred education. Lack of such understanding may cause unnecessary disruptions and misunderstandings during the programme's implementation stage. This may include the students' morale and confidence in the programme. The students are usually very perceptive whether the disruptions are or are not due to the early teething problems of a new programme. They will react accordingly. Any change to the validated learning and assessment strategies or other part of the programme should be evidence-based.

In addition such a change could inadvertently contravene the university's objectives and challenge the authority of the validation panel. Whilst, it is always useful to keep the students informed of any possible teething problems to maintain their confident and trust, they must not be used as leverage for factional interests.

f) identifying a member of the focus group to begin the negotiations on collaboration with an initial draft proposal followed by exchange visits. The negotiations should start early and the signing ceremony should be an occasion of celebration for both sides and should not be burdened with last minute hitches. Any issues as discussed in (a) could be ironed out if the negotiation has started early and in good time. Bearing in mind the partner's meticulous planning, I would plan their stay carefully and include some social visits. Some issues or niggling points are best straightened out over a cup of tea or something in a social situation.

g) planning the signing of the memorandum of cooperation and it is an excellent idea to link this as part of the conference proceedings. But the budget should be identified and agreed by the focus group. The preferred strategy is to give the conference participants an idea of the agreed proposed joint programme even if it is only a skeleton. This is also a good marketing opportunity.

h) weeding out the "extras". Often, these people have very little understanding of the subject matter and they are unlikely to produce any work asked of them. Weeding out these "extras" earlier on in the planning stage will lighten the workload and the politics. They can, in time scale significantly hamper the progress of the programme. This may not be a popular action but much heartache can be avoided later on.

i) locating the experts for the validation purpose well in advance. Being a new professional programme, it is imperative to find an appropriate external specialist assessor. The person must be a professionally qualified practitioner and an academic or at least have an adequate understanding of the British higher education system, the concept of peer validation, the purpose of validation. The general curricular principles

can be covered by a suitably qualified professional in a similar profession. It is also important to ensure the external assessor's language skills are fit for the purpose.

j) discussing the proposal with HEFCE which has an international department and was at the time collaborating with the Ministry of Education in China. The department can be helpful and certainly will be able to use this information (appendix 5) to assure themselves of the quality.

k) liaising with the British Medical Association (BMA) and the relevant "professional" associations. The former can help open doors to organisations and reports which one does not usually think of. Thus, during the programme development I came to know its Chief Scientific Officer and as a result he helped enhance the quality and the authority of the programme by alerting me two important publications on the use of complementary medicine and therapies in the National Health Service: The Scottish Office Department of Health (1996) and The National Association of Health Authorities and Trust (1997). Liaising with the "professional" associations will offer an opportunity not only to sell the programme but to develop a network which will facilitate the programme's ultimate progress. Such a liaison will inform what is happening in the field of Chinese medicine in the UK and any possible implications (appendix 6) or the implications the programme may have on others (appendix 7)

l) clear objectives for the link person who also needs to know the level support and confidence that can be expected from her manager and the wider university's attitude towards the programme and the collaboration. It will be very difficult to receive the manager's support and confidence if the latter does not receive the same from her own manager. In this particular collaborative work, the socio-cultural and politico-economic issues are different and more complex to the focus group and the latter needs greater understanding to develop a plan to facilitate the linking process. When deciding to be a link person, there are several issues which need serious considerations. Who are the partners? What are their expectations? Does the link person share the partners' socio-cultural and political values? Is she willing to champion the subject? If the answer is

negative will this affect the quality of the link? The person must not be placed into a position where a refusal to the role is not taken at face value and is disadvantaged later. Another important point to bear in mind is the link person must tread very carefully because her achievement can cause resentment among colleagues or threaten someone else's opportunity to achieve something. I came across a situation in the commercial sector where a friend was consistently undermined by one of her colleagues when she attempted to develop a joint venture with company A. Despite a successful partnership agreement at the highest level within the organisation, she was quickly "discredited" by the colleague who apparently has already promised company B a similar partnership. Her manager was unaware of this and was therefore unable to support her.

m) making use of an interpreter even if the link person knows the dialect. Always have the minutes of the meetings agreed before leaving the meeting place. It will be very time consuming to get them agreed once out of sight. It is in the link person's interest to keep notes of all meetings and ensure the focus group members are kept informed. The issue here is will they simply acknowledge receipt, file them away and never refer back to them again?

n) future partnership/ cost reviews should be based on recorded agreement, data and certainly not based on the reviewer's personal feelings. What is perceived or felt to be may only represent a small part of the totality and this will have a financial implications which may not be recognised immediately. If a cost is agreed at the executive level, future review should be conducted at the same level. It would be useful to keep separate account for each partnership so that financial health status is easily assessed.

The vision for Chinese medicine outside China

In accepting to develop and deliver the degree programme, MU was fully aware that the latter will challenge its existing mission in professional education. Given the leadership role in promoting CM outside China, MU needs to turn potential competitors into strategic partners. Without such a strategy, the BSc(Hons) TCM will

be challenged by other institutions developing similar programmes through MU's backdoor!. At present the programme is like a ship without a rudder and could easily disintegrate once the sea gets rough. Fortunately, MU has a long history of offering professional education and was therefore well placed to be the best and most successful university to offer the professional programme in Chinese medicine.

The strategic vision for CM in Europe is to have a unified education and training model to be offered by MU as an academic hub. Figure 4 gives a clear picture how and when innovative programmes with creative learning and teaching strategies can be achieved. By superimposing figure 4 over figure 5 it is possible to begin to appreciate the interdependence of various sub-strategies that have been put in place. Some of them like the Middlesex University Chinese Medicine Ethics Committee (MUCMEC) and The Middlesex University Chinese Medicine Learning Fund (MUCMLF) are already developed and are functioning. CMAS, on the other hand has just started life. How these sub-strategic projects will ultimately enable MU to become the "hub" are briefly explained under "the aim of the case study".

The idea of a Chinese medicine academic "Hub" is likened to a bicycle wheel hub which supports the spokes to ensure the wheel is round and rigid. The aim of the "hub" strategy is to develop MU as the hub to provide a range of Chinese medicine programmes to suit the needs of the University's partners as the spokes mainly in Europe. If this is achieved, it will be much easier and simpler to quality assure the programme and the students' experiences.

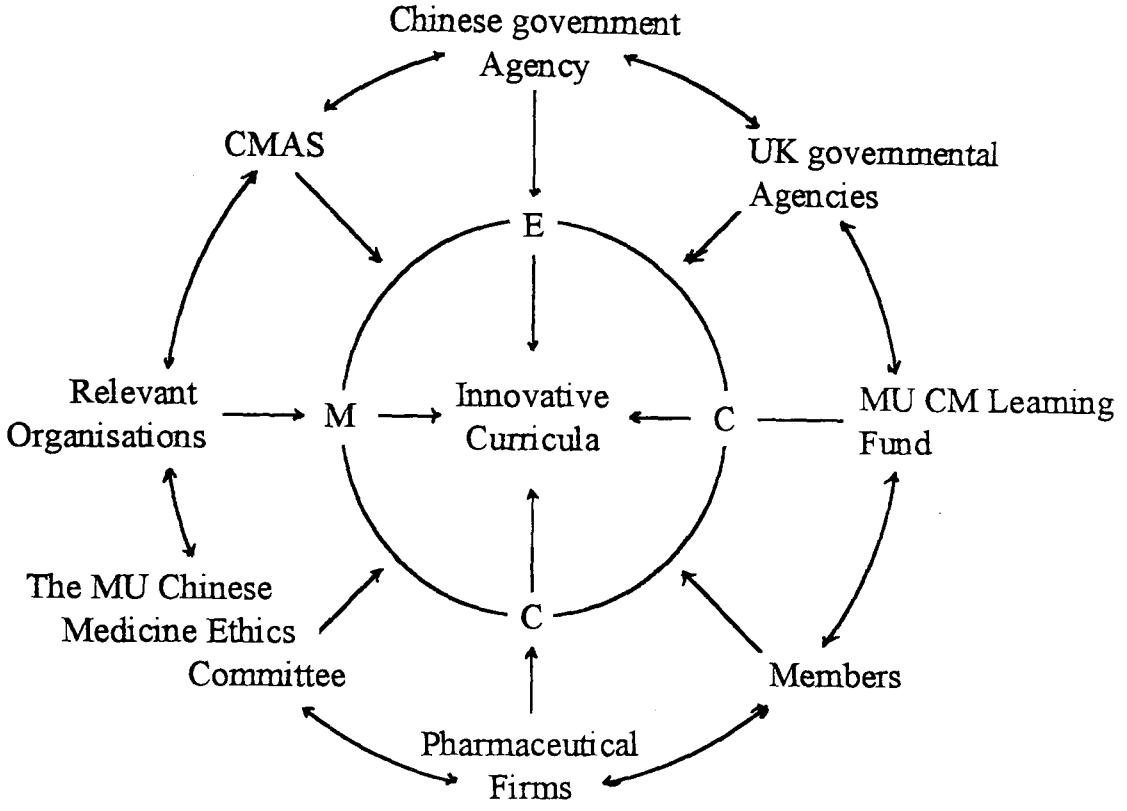


Fig. 4: Developments influencing the realisation of innovative curricula

The degree programme, the generator of the challenges is also the catalyst to the evolution of the "hub". This means that the degree programme must be well grounded through rigorous and critical nurturing and support in order to gain credibility and authority. This degree programme must be as authoritative as the one taught in China except it is taught in English instead of Chinese. Although the programme has been adapted and modernised to meet the academic rigour in the UK, this does not mean westernisation of TCM. Rather changes are introduced so that the programme acts as a bridge between the tradition and the progressive. The overt emphasis on research is to address the perceived lag in Chinese medicine in this area and also to establish Chinese medicine as evidence-based medicine. The programme has immediately become a symbol of a lone star in a very large institution. It became history the moment it was thrust into the centre stage as the world's first programme of its kind. It is becoming insignificant in the world stage despite its glorious birth.

The case study

> *Discover truth through practice, and again through practice Verify and develop truth. Start from perceptual knowledge and actively develop it into rational knowledge; then start from the rational knowledge and actively guide revolutionary practice to change both the subjective and objective world. Practice, knowledge, again practice, and again practice, and again knowledge. This form repeats itself in endless cycles, and with each cycle the content of practice and knowledge rises to a higher level. Such is the whole of the dialectical-materialist theory of knowledge, and such is the dialectical-materialist theory of the unity of knowing and doing.* (Mao Zedong, 1966)

For the purpose of this Doctorate in Professional Studies I am presenting a case study of two of many projects I have initiated, developed, implemented and managed as shown in figure 5 below. They included the Middlesex University Chinese Medicine Ethics Committee, the Middlesex University Chinese Medicine Learning Fund, the European Centre for Chinese Medicine and the Chinese Medicine Association of Suppliers. They offer vital support to the European Chinese Medicine Academic Hub vision. To realise this vision an interlinking parallel development of these sub-strategic projects must happen. A brief explanation of these projects is offered below to place this case study in an appropriate context and also to demonstrate how these projects support and contribute to the hub creation.

MU has set up an ethics committee, the Middlesex University Chinese Medicine Ethics Committee (MUCMEC) to safeguard the safety of the public. It also aims to gain the confidence of the health care professionals and other stakeholders. The role of the Committee is clearly defined in (appendix 8, {p1}). This "policing" role will continue until such time the government has introduced a statutory and regulatory body for Chinese medicine. This Committee has been in place for one year with me as its Secretary. The message from the University is unequivocal. Its graduates will be professionally competent. The membership to the Committee (appendix 8 {appendix 1, p2}) reflects the University's values in promoting and developing professional-based programmes.

In year five of the programme, the students will be required to go to China for a six-month internship in CM hospitals to enhance their technical skills and knowledge prior to their graduation. Whilst, it is the students' own responsibility to finance their internship, the University has set up a learning fund to raise bursaries for those in need. The Middlesex University Chinese Medicine Learning Fund (MUCMLF) was officially launched in November 1998 to offer bursaries and to support students' research project which is the programme requirement. The MUCMLF is totally run by a Committee of students (appendix 9) with support from the University's senior finance officer. Although I am its chairperson, I have just started a scheme to enable the students to develop skills in chairing meetings. They will take turns to chair the meeting. MUCMLF is also viewed as offering learning opportunities to these students to develop skills such as in interpersonal relationship (a very essential part of the students' professional development), managing meetings, finance and networking. The Committee is supported by a group of patrons. There are ten of them presently (appendix 9). The Fund's first attempt at raising money is to sell raffle tickets (appendix 10).

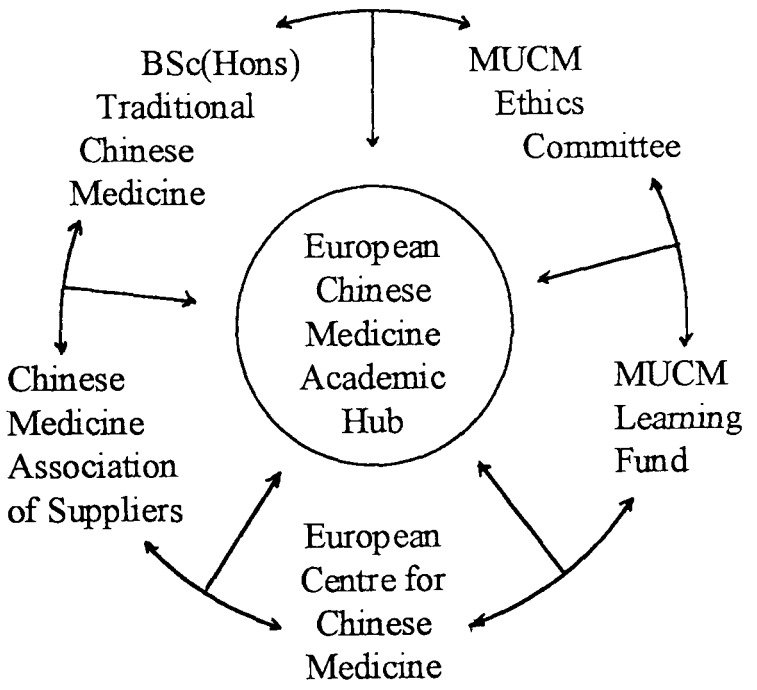


Fig 5: The interlinking sub-strategies to support ECMAH development

This will be followed by other activities which are already planned. The research projects which the students will have to produce whilst in China will contribute towards developing Chinese medicine as an evidence-based medicine which is also the aim of the European Centre for Chinese Medicine.

The European Centre for Chinese Medicine (ECCM) project which has attracted twelve founding members from China, Europe and locally to enable Chinese medicine to be evidence-based clinical practice as well as to initiate clinical research including clinical trials. This will be first steps towards facilitating Chinese herbs and herbal products to be licensed as medicine and be licensed as such by the Medicines Control Agency (MCA), at least within UK. At present, some herbs and herbal products are available as unlicensed herbal products and food supplements. Like many other complementary therapeutic products, Chinese herbal medicinal products have not been clinically tested within the Western clinical trial procedures. They are therefore, sold as unlicensed herbs or herbal teas or food supplements. These unlicensed herbal products cannot make any medical claims on the label such as; "this particular product can treat colitis, angina etc". As food supplements, it is possible to say that "this product will help slimming if taken as part of a slimming plan".

The Chinese Medicine Association of Suppliers (CMAS) project aims to develop an association of importers of Chinese herbs and herbal products. An importer is according to Collins Cobuild English Language Dictionary (1987) "a person, country, or firm which buys goods or services from another country for use in his or its own country". A supplier on the other hand, is defined in the same dictionary as "a person or firm that provides you with something such as goods or equipment". The partners in CMAS project have these dual roles. They both import the goods and then supply to the Chinese herbal shops, Chinese medicine clinic or to individual Chinese medicine practitioners. At the same time there are also owners of Chinese medicine clinics who also import the Chinese herbs and herbal products for their own clinic's use. With the CMAS members' consensus, the latter category of importers and large clinic owners are also allowed and encouraged to join the Association because they can provide the

users' perspectives in the quality assurance debate and its eventual policy development and implementation. The name "supplier" is therefore, used instead of "importer/supplier" since the term denotes well the role of these individuals. For the MCA, these individuals have always been referred to as suppliers from the legal perspective. When a herb is found to be dangerous, MCA will try to trace the source, i.e. who was the supplier. It is hoped that CMAS will initiate several changes, such as improving the quality of herbs supplied to the Chinese medicine (CM) clinics and the public, and introducing sell-by-date policy which is nonexistent presently. It will also promote itself to become a self-regulating body for the suppliers. Such a development will give CMAS the political power base to push for alternative licensing of Chinese herbs and herbal products already recognised in many countries outside the European Union (EU). In USA, the Dietary Supplement Health and Education Act of 1994 defined these dietary supplements as a special category between foods and medicine which are "safe within a broad range of intake, and safety problems within the supplements are relatively rare". These Dietary Supplements include vitamins, minerals and herbal medicine. In Australia, the Therapeutic Goods Act 1989 and the Therapeutic Goods Regulations 1990 specifically exempt bulk herbal liquids from registration. In Canada, the Standing Committee on Health in its 1998 report "Natural Health Products: A New Vision" has recently recommended a new category of products designated as "Natural Health Products" to be treated neither as foods nor pharmaceutical products, but licensed as an intermediary category. As a self-regulating body, CMAS will also certify the Chinese herbs imported into this country as having met its quality criteria.

When both ECCM and CMAS are functioning they will offer MU the unique opportunity to be credible, authoritative and trusted by the European colleagues. As a consequence, MU, if it so aspires, will naturally become the de facto ECMAH and its Chinese medicine academic programmes and activities will be fully accepted for franchising. The current degree programme is recognised as a major achievement. It is further enhanced by the fact that it is backed by the State Administration of Traditional Chinese Medicine vicariously through Beijing University of Traditional

Chinese Medicine. The State Administration of Traditional Chinese Medicine (SATCM) or State Administration of Chinese Medicine (SACM) is a section of the Ministry of Public Health in China. It has the sole responsibility for the education, research and control of Chinese medicine in China. It produces the contents of the Chinese medicine programmes to be delivered in the Colleges and universities in China. People outside China generally perceive the TCM programmes in China as the acceptable benchmark. This does not mean a full acceptance rather that they are the best available. The applicants to the programme continue to question the rationale why the full-time programme is five years long? Will they be licensed to practise? Will they be able to practise in the National Health Service hospitals? Such questions remind us of the challenges facing CM in UK.

Within the context of this case study **Collaboration** means, according to Collins Cobuild English Language Dictionary (1987), that to collaborate means if two or more people collaborate, they work together to produce a piece of work, especially a book or some research. A second definition is that if someone collaborates with an enemy army or government which has taken control of their country by force. Whilst both definitions are not applicable in their totality, there are some comparable elements. Both projects offer the participants something in return. For the ECCM project, the successful development will offer the partners research and clinical trial funds whilst CMAS will offer the partners the opportunity to manage their own destiny working cooperatively, as confirmed by one CMAS respondent "it is good to see competitors working together for the greater good!". It will offer CMAS members the political power base in triangular relationship with MCA and the Chinese Agency. The 13 out of 14 members who returned the questionnaire placed this triangular relationship as a high priority development. This postal questionnaire was devised to seek clarifications and confirmation that the activities undertaken are congruent with their expectations and aspirations. Fourteen questionnaires were given and 13 were returned.

I propose that in this context collaboration begins with consultation with potential participants to become members of a team and contribute to a common aim. These

participants would be selected on the basis that they have something specially to contribute and their sum total will be far greater than a single partner can offer. This "something" can be expertise, know-how technology and sharing the responsibility for outcomes. In the two projects the relationship between individuals is collegiate with an equal share of power. They can be best described as "partners" who agree to collaborate because they share common perceived objectives which will be described for each project later in the case study. As a result, they would be committed to achieve these common goals as I shall demonstrate in their willingness to invest in the projects. One CMAS member in response to the question of the amount of time she can offer for CMAS "if there is a campaign for our survival then 20 hours per week".

The case study aims to demonstrate that mutual collaborative projects are not only effective but also brings the project initiator/manager and the project participants together to identify issues and seek out possible causes and remedial actions:

- to assist the partners to discover and make explicit fundamental issues by first raising their consciousness collectively - the birth of the professionalisation process for the partners;

- to create a cohesive team through empowerment and autonomy based on ongoing cooperative negotiation and interplay of three particular processes - enquiry, action and evaluation.

Whilst the case study for these projects will be presented retrospectively in a narrative combined with reflexive format, it will at the same time explore the processes in gaining these individuals' cooperation to work as partners. It will examine the issues of changing mindset, breaking down the resistance to cooperate, resistance or otherwise to change their work practices to become more closely as team members. This is an age-old challenge which has confronted the managers and the academics such as Lewin (1946) and Lupton (1963). However, there was also the professionalisation issue to be considered since both projects will ultimately impose a

code of conduct on its members, developed by the members themselves. The narrative also highlights that conducting action research could be very frustrating. The projects were not first agreed with the partners and consequently it would be impossible to predict the progression. It will therefore be difficult to follow the spiral steps as advocated in the action research by Lewin (1946). Indeed the beginning and the conclusion of the projects are not predetermined. They may start and be halted as abruptly as they started.

It is possible to argue that this case study lacks rigour in its methodology, biased by my own views which may influence the outcomes as well as my conclusions. In addition, what I have done is difficult to generalise. Although there is ample evidence to counter these arguments and to demonstrate that a case study has many inherent advantages and benefits. For instance, Piaget's and Freud's studies have been notable among others and have enhanced the understanding of child development and human behaviours respectively. However, these charges of bias are valid for this particular case study because the outcomes do rely very heavily on my being able to combine both personal experiences, values, skills and insider knowledge to interpret the context of the observed actions and heard comments. I was in fact studying "things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin et al, 1994). I also used "a holistic perspective which preserves the complexities of human behaviour" (Black, 1994). The social basis of the action research I would argue is involvement, but the projects I conducted are developed to meet my role specification. It also encourages me to reflect on my own mode of thinking and practice in order to achieve the planed objectives. Throughout my exposition of the case study I shall demonstrate that I have exchanged ideas continually; I learned from the partners of the projects as they have learned from me. They validated my ideas and actions just as I validated theirs. These activities were carried out in an environment of general support for the way both the partners and I had progressed the projects. This is borne out in the postal questionnaire survey among the CMAS members to seek out their views about their association (appendix 11). Ten out of 13 CMAS respondents confirmed that their views were heard and acted upon

at meetings and the remaining three felt they were partially met. Here are two contrasting thoughts from "yes" and "partly" - "views are heard. In a discussion process there are agreements and compromises", and "too early to say. We are in a process of formation" respectively. The eclectic model which is described below, did encourage me to be systematic and be critical of my actions and to be prepared to change. Indeed, the nature of the projects left very little room for predictability about the reactions and behaviours of the partners. The case study will demonstrate that I can exert and had exerted rigorous professional code of conduct and research code when analysing the data and presenting this case study.

An eclectic model underpinning the methodology

The two projects are action research-based. They were generated by me as part of my job. The case study is written in a narrative form to convey a sense of the developmental process of the projects and also to illustrate the interactive nature of the various stakeholders' own management processes. It is also presented as a portfolio which reflects the process-led nature of these projects. The portfolio approach indeed fits very well with the philosophy of the Doctorate in Professional Studies. The case study clearly illustrates several pertinent issues as well as facts that: professionals and practitioners at work are not only continually taking stock and seeking to improve their own performance, they are also monitoring their performances in a systematic way and some are making their findings public, (Richard Branson's book 1998 is a good example). The democratisation of research has meant acceptance that workplaces have a vital role to play in initiating innovative ideas and inventions, (Dyson vacuum cleaner and Microsoft are two of a multitude of examples). Many practitioners are also taking the findings of research studies and testing them in their own place of work and in their practices. They may be unaware that they are doing these. They are using what Stenhouse (1979) once stated that "using research means doing research". They are entitled and capable to conduct their own "research" grounded in their work place. The validity of their work is reflected for some in the performance of the share value of their companies as agreed and accepted by the buyers; for others, it could be in the

form of commercialisation of their inventions. All these suggest that these behaviours and activities are underpinned by the "theories of action" (Argyris & Schon, 1974). It also illustrates how genuine empowerment at work can nurture and promote innovative initiatives and encourage collaborative working with colleagues interprofessionally as well as to be culturally and politically sensitive.

My choice of data collection tools for these two projects, was very much influenced by my previous experiences and current role. Over the years I have used elements of problem solving and action research to collect and analyse the information as a health care professional initially and senior education manager later. These projects were not designed in the conventional project or research framework. I assessed and evaluated the appropriateness of the elements of various models in addition to the obvious action research model. I then selected the elements, and grafted them onto the action research framework. The end result was a much expanded and more complex framework. The newly blended framework was named as an "eclectic" model. The model (figure 6) consisted of the most appropriate and useful elements of the action research (Lewin, 1946), the nursing process model/problem solving model and Kolb's learning model (Kolb & Fry,1975) to tackle the complex nature of the projects. From previous experiences, I found that I could secure information which reflected more accurately the individual's thinking by slipping into the ethnographic mode whenever appropriate to utilise my "insider" knowledge to enhance my understanding the partners. I believe that in projects of this nature an insider knowledge will inform the process more positively. Being an insider means having the ability to peel away the facade to access the deep-rooted socio-cultural dimensions of the behaviours and interactions of the observed subjects. Its use must be within an ethical frame to avoid misuse and abuse of trust.

The eclectic model comprised conceptualisations of a dynamic and multidimensional complexity: (a) the conceptual context of the projects; (b) the nature of the projects, (c) the strengths and weaknesses of the projects; (d) the project implications; (e) Formation of abstract concept and generalisation; (f) the project maturation; (g) project

outcomes. This mix is commonly practised in health care professional curricula which aim to produce practitioners whose professional competence is underpinned by evidence-based practice and the capability to reflect at different critical levels and be context bound. So far, I have found this integrated approach both thoughtful and challenging. It also reminded me of the boundaries of the projects which could easily lead to many directions. The model had the reflective theme threaded through.

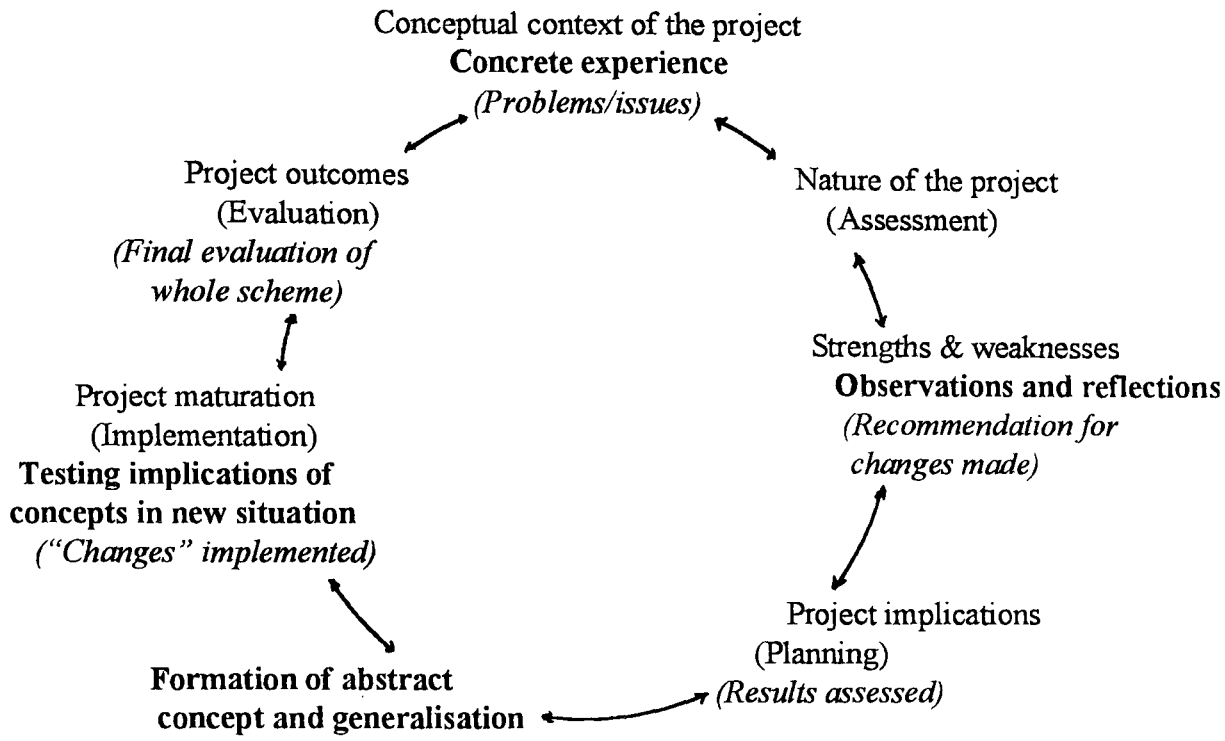
a) *The conceptual context for the project* - very much an exploratory phase to debate over the concepts of the project such as; what is the purpose of the project? Who should be in the projects? Why involve only selected partners? How do these fit into my own organisation's strategic development plan? Where will the project lead my own organisation and also the group to? This exploratory phase will continue throughout the process as a backdrop reminder to the original aims and objectives of the collaborative project.

b) *the nature of the project* - once the concept of the projects and the context is understood and clarified. The University's senior management is the context and the understanding. The concept, or rather the project, is then subjected to rigorous and detailed examinations through meetings with selected prospective partners as a viability test. This was a brainstorming phase to obtain maximum input. Reactions, comments and off-chance remarks or the subtleties are collected for analysis and reflection.

c) *strengths and weaknesses of the project* - the whole project was then reviewed based on the data gathered. They were then reflected upon, assessed and reformulated if necessary. The project was either redrafted or modified after each partner meeting or response. The meeting with prospective partners served two purposes; to "sell" the project and to evaluate the latter's potential strengths. A kind of self-selection operated. This was a two-way process because the identified prospective "partners" may not wish to participate or may not be asked to join. The project could in the first instance select partners who are able to provide a major contribution to the whole of the project. This was not true in the case of CMAS. It was a matter of encouraging

every supplier to join CMAS. The numbers matter and are significant in building a power base.

Fig. 6: An eclectic model



ordinary fonts: Eclectic model (Problem solving cycle)
bold fonts: Kolb's learning cycle
italics: action research cycle

d) *project implications* - this is the final review phase, all available data are inputted, reflected upon and reassessed to draw up the final revised project document. The partners have made a commitment to participate as evidenced by their investments in the projects. Investment by the partners would include nominating representatives and funding travel expenses etc.,

e) *formation of abstract concepts and generalisation-* illustrates the continuous process of recasting and reflecting upon the project until the project is fully implemented and completed. This phase encourages further reflections, debates and reassessment of the implications upon the overall scheme - the ECCM in this instance.

f) *project maturation* - signals the project is now finalised leading to partnership or collaborative agreement signing ceremony. In the CMAS project, the meeting with MCA clearly marked the beginning of a journey which the suppliers had pledged to travel together: (a) financing the administrative support for CMAS to function effectively and (b) organising the launch for CMAS.

g) *project outcomes* - once the partners have signed and the project is operationalised, the inbuilt evaluation and quality control mechanism will be in place with planned review dates. CMAS is now operationalised and is officially recognised by MCA to deal with. These activities should lead MU to gradually evolve into the ECMAH position.

Action research was a very appropriate model to achieve the objectives of the projects. It reflected the dynamic process of the projects which focused more on action and evaluation than research. Throughout the projects' period I enjoyed what Kemmis et al (1982) highlighted as the "conditions under which self-reflection is genuinely possible; conditions under which aims and claims can be tested, under which practice can be regarded strategically and 'experimentally', and under which practitioners can organise as a critical community committed to the improvement of their work and their understanding of it".

Lewin (1946) conceived action research as "a process with spiral steps, each of which is composed of a circle of planning, action, and fact-finding about the result of the action". He reasoned that action research involves the practitioners or the participants and the researcher collaborating with each other to seek solutions or strategies to

resolve the problem. Thus:

> "The next step is composed of a circle of planning, executing and reconnaissance or fact finding for the purpose of evaluating the results of the second step, for preparing the rational basis for planning the third step, and for perhaps modifying again the overall plan. Rational social management, therefore, proceeds in a spiral of steps each of which is composed of a circle of planning, action, and fact finding about the result of the action"

Since then, the concept of action research has been revised and redefined. Rapoport's (1970) definition clearly fits into the projects undertaken within this case study because "action research aims to contribute both to the practical concerns of people in an immediate problematic situation and to the goals of social science by joint collaboration within the mutually acceptable ethical framework". The notion of spiral steps suggests continuous progression. From experience and further supported by these two projects, this notion of continuous progression is less likely to occur and it also allows little room for reflection and adaptation from the outcomes of that reflection. Yet reflection occurs all the time whether in response to a situation or event or one's own reflection on reflection. During these reflexive periods be it on action and in action it was possible to step backwards or forward to the beginning. The notion of spiral steps as suggested in the action research would have excluded this flexibility of dipping in and out as I was able to do whilst conducting the projects.

Foster (1972) suggested that the aims of Rapoport's definition can be identified through the process of changing problem situations itself. ECCM and CMAS, whilst not classified as problems can still be viewed from such perspective to justify that action research is an appropriate methodology to play a major part in the eclectic model for these projects. Action research allows change of tact during the discussion/conversation with the members of ECCM and CMAS. It is also situational because many of the relationships between people, events and things are a function of the situation as defined and dictated by those in the group.

Within the framework of the eclectic model, the project partners were treated as co-initiators of actions rather than as subjects for the research projects. For example,

when I had my dialogues with the potential ECCM partners, we both reflected in action and on action (Schon, 1992). Whether an adoption or adaption was needed, the decision would be based on those reflections. Throughout the projects different ideas were continuously introduced, they were then critically reviewed, developed and tested. The "test" here means receiving approval from other partners for the ideas. One of the down sides of the action research is the outcomes are very difficult to duplicate. To insist otherwise is to ignore the human dimensions which make up the projects. However, the findings can be explored in other similar contexts and the individual must be willing to accept the outcomes and act on the outcomes as guidelines to help the individual to make an informed evaluation. Lewin (1947) argued that "if we cannot judge whether an action has led forward or backwards, if we have no criteria for evaluating the relation between effort and achievement, there is nothing to prevent us from making the wrong conclusion".

According to Lewin (1951), this method facilitates a symbiotic relationship between theory and practice and focuses on practical problems. I was further encouraged by Reason's (1993) proposition that the research process is a "cooperative inquiry" which he described as "a way of doing research in which all those involved contribute both to the creative thinking that goes into the enterprise - deciding on what is to be looked at, the methods of the inquiry, and making sense of what is found out - and contribute to the action which is the subject of the research. Thus, in its fullest form the distinction between researcher and subject disappears and all who participate are both co-researchers and co-subjects. Cooperative enquiry is therefore a form of education, personal development and social action." This "cooperative inquiry" will continue beyond the signing of the final agreement so long the partnership exists. One of the main approaches to action research which I particularly like and whose principle is very relevant to the project is *mutual collaboration approach.* From this approach a new common understanding of the project had been achieved. Given the context in which this project will operate, action research will close the gap between theory, research and practice underpinned by both humanistic and naturalistic scientific methods.

Problem solving model (Nursing process) - was taught to me during my professional development to assess, plan, deliver and evaluate care which would also reflect the cultural needs of the patients. Briefly, the model consists of four components;

Assessment - this involves assessing the patient's needs. This requires building up a data base obtained from observations of the patient, and from interviews of the patient and his or her significant carer. The nurse will then be able to interpret the patient's nursing care needs.

Planning - having decided on the nursing care the patient will need, the nurse together with the patient and his or her significant carer where possible, will formulate a care plan which will include goals to achieve. The plan will be updated at every change of staff or sooner should the need arise.

Implementation - the care plan is now put into action meaning the necessary care is being performed for or together with, the patient.

Evaluation - this is the final and critical phase of the nursing care plan. The care plan is reviewed for its effectiveness and updated or modified noting any weaknesses in the plan or in the provision.

The problem solving model is both effective and efficient in ensuring the patient's problems are looked into holistically. This model can also be used for issues of different complexity and context as I did, as a senior education manager, to achieve innovative initiatives both locally and in Hong Kong. These innovations were achieved through collaboration with colleagues with an element of direction. The element of direction was usually in the early stage of the developments when those innovative ideas had to be clarified and worked through with colleagues until they were empowered and confident to own the ideas and translate them into innovative schemes (appendix 3, section 3.8 & 3.9 offered what could be achieved in this kind of environment). The process usually involved the presentation of the conceptual idea,

brainstorming, reflective period returning to active experimentation, and development leading to implementation and evaluation. This problem solving model is in many respects similar to the action research. East and Robinson (1994) were right to suggest that action research as a research method is increasingly popular among the health care professionals and in health care setting because the model has similar processes with nursing process which health care professionals are familiar with.

Kolb's learning cycle provided the triangulation and offered learning from reflection. Briefly, Kolb model is usually known as experiential learning emphasizing the importance of learning from experience and has four stage cycles such as *concrete experience*, which will enable *observations and reflections* leading to theory formation or *formation of abstract concepts and generalisations*. These generalisations will lead to the final stage *testing implications of concepts in a new situation.* Kolb argued that effective learners need to possess four different kinds of abilities: concrete experience abilities, reflective observation abilities, abstract conceptualisation abilities and active experimentation abilities. They are based on his four stages of learning. Although, Kolb did not discuss in much detail the nature of his stage of observation and reflection, from experience, it is not difficult to apply the model. Experiences and roles are only effective and meaningful if lessons are learned from them. One's life is a lifelong learning process and no two experiences and roles are identical to enable replication. Each situation is a learning situation reinforcing previous learning or improving from what was learned. The concepts of ECCM and CMAS were not new. For example, I had learned the "hub" in a case study for my MBA programme. However, the context and the activities are new. I was able to draw from my past experiences to develop the projects. In my discussion with the partners, the concept of "hub" is unusual for many. Even then, I too was learning as I discussed it with the potential partners. The questions that I could not answer I would examine them and explore them through Schon's (1992) reflection in action and on action. Each meeting was a new learning situation for me and it increases both my understanding of the concept, and the clarity and precision of my exposition of the concept to the subsequent partners reinforcing Newell's (1992) argument to develop a new

epistemology of practice for "reflection-in action" to be viewed as a legitimate form of professional knowledge.

The learning cycle offered the opportunity to reflect and complemented the action research model. Reflection is akin to action research as suggested by Kemmis (1985) with whom I tend to agree. In addition, both projects operate in a 'social' context. Hence, "reflection is a dialectical process: it looks inwards at our thoughts and thought processes and outwards at the situation in which we find ourselves... Reflection is thus 'meta-thinking' (thinking about thinking) in which we consider the relationship between our thoughts and action in a particular context" (Boud et al 1985). Reflection during and after each discussion is both essential and facilitative and it increases the learning potential from experiences; as Boyd and Fales (1983) asserted, it "is the core difference between whether a person repeats the same experience several times becoming highly proficient at one behaviour, or learns from experience in such a way that he or she is cognitively or affectively changed".

In addition, whenever, I held discussions with the potential partners, I also took the position of an ethnographer and insider among the Chinese partners. I tried to understand the partners from a broader and a holistic perspective to include cultures and subcultures of their organisation and their own selves. Having this understanding gave me an added advantage to contextualise my approach and respond to their queries. I discussed in detail in my accredited doctorate claim that I have regularly practised some aspects of ethnography in my job and I nearly came unstuck in Hong Kong had I not been able to understand the Chineseness of the inhabitants who were sandwiched between China, the ever present Dragon, and Britain, the Lion that then ruled them. I always find an ethnographic-based approach adds another dimension to my interpersonal and negotiation skills.

The relevance of an eclectic model

The projects have fulfilled several approaches associated with action research. They included experimental approach as the projects are of unknown quantity involving many nationalities and their incumbent socio-economic, political and cultural values; empowering approach for all involved because they have to work collaboratively among themselves; professionalisation approach demonstrating that both projects demand a rigorous professionalism from the partners in their dealings among themselves and towards the third parties.

The CMAS structure is more in line with Trist's (1977) network of organisations creating a client system in which the members resolve the issues with action research. This client system could be face to face groups, an organisation, the network of organisations or a small community.

I found the inclusion of the ethnographic backdrop combined with critical reflections of my discussion with the potential partners and my observations had enabled me to crystallise my thoughts at various stages of the project development. Schmid (1981) explained that the paradigm found in anthropology and other social sciences that emphasize an understanding of the meaning of human behaviour in social and cultural settings can satisfy the holistic perspective which these projects are seeking.

Litterst's (1985) advocated the use of anthropological fieldwork methods and the concept of culture in occupational therapy research. According to her "occupational therapists as participants in the social process of therapy are in an excellent position to formulate research projects that use fieldwork methods and expand on the dynamic elements in both occupational therapy theory and anthropological concepts of culture". I found her comments were just applicable and relevant to these two projects because of the methods ability to examine the processes involved in developing and managing a collaborative project and to examine the underlying socio-cultural, economic and political dynamics of the project.

Reflecting back, having placed the projects into the eclectic frame, I found the model enabling and facilitative. It encouraged pragmatism which has been the hallmark of these projects. The model has been particularly helpful in the management of the projects as there were no rigid rules or preset criteria. The limitations if any would be self-imposed, i.e. my own capacity to be receptive and perceptive to others' ideas and views and the capacity to meet the needs of the partners without losing the central objective. The model acted as my personal framework. It offered me the opportunity to use my inner perspective in creating and constructing. This framework, I used as a heuristic tool to search for the yet to know truths (partners' understanding of the project and propensity to join and my own organisation's propensity to lead), Polanyi (1962). This personal framework was flexible and allowed modification as I worked between my internal realities and external worlds and was a repository of drives, needs, intentions, intuitions, vision and past learning.

These projects have clearly demonstrated that "reflection is an important human activity in which people recapture their experience, think about it, mull it over and evaluate it. It is this working with experience that is important in learning. The capacity to reflect is developed to different stages in different people and it may be this ability which characterizes those who learn effectively from experience." (Boud et al, 1985).

The insight and learning offered by the eclectic model had been immensely challenging. I was amazed to realise that during a discussion with my supervisor I was intuitively seeking through him to validate my attitudes and habits, strengths and weaknesses to ensure the case study is being critically scrutinised. I also conducted a postal questionnaire among the CMAS members as part of my own strategy to assure myself that the partners and those I led are in a sense right behind me and that they have understood why they joined the party. The postal questionnaires (appendix 10) also give the CMAS partners an opportunity to express their feelings anonymously and to reflect in their quiet moments. The outcomes (13 replies) or rather their thoughts and feelings are interpreted where appropriate in this case study.

The ECCM and CMAS projects

In practising ordinary virtues and in the exercise of care in ordinary conversation, when there is deficiency, the superior man never fails to make further effort, and there is excess, never dares to go to the limit. His words correspond to his actions and his actions correspond to his words. Isn't the superior man earnest and genuine?
(Confucius)

An overview

The two projects in this case study, European Centre for Chinese Medicine (ECCM) and Chinese Medicine Association of Suppliers (CMAS), are pivotal to the future development of Chinese medicine outside China as well as enabling MU to achieve the European leadership in the field of research and academia in Chinese medicine. The central thrust of these two projects was to identify the means to facilitate Chinese medicine (CM) to obtain proper legal status as a medicine in the UK. Their success will naturally support and promote innovative curricula for CM (see fig 4) such as integrated programme for orthodox, Chinese and alternative medicines.

The ECCM and CMAS projects are both radical and innovative. However, behind these acronyms are real people and organisations who will eventually have a stake in these projects. These people come from such countries like China, Spain, Germany, Belgium, Israel and UK to form an international partnership. It is therefore, both relevant and useful to discuss the processes or methods used to gain their participation, views and personnel and financial investment in the projects. It is clear that these stakeholders are independent and are entering into a voluntary partnership. They are also outside my authority as the project initiator and manager. They could have also presented me with serious management challenges. Some questions constantly stayed in the forefront as I progress the projects. How do I convince these stakeholders that I have the authority to negotiate the terms with them? How much can they trust me to deliver what was proposed in the projects? How do I cope with unexpected or unwanted influences from one party against another? Managing the stakeholders in this

sense includes building confidence and trust, and they form an important part of the project management skills.

The projects were part investigative and part experimental. They were also incremental in design to enable the partners to fully participate in developing their final version of the project. Consequently, there was much exchange of ideas and issues between the partners and myself. Except for CMAS, the exchanges were between the suppliers and I was refereeing and facilitating. The rationale behind this semi-structured approach partly reflected my previous experiences of successfully developing and managing new ideas, and collaborations. It also reflected the dynamic nature of the projects. There was no initial consensus among the partners that the project should go ahead as one expects in a classical project. The partners in these projects were not involved in conceiving the idea. Rather, they were led into it. They were given the opportunity and time to understand, appreciate and evaluate the implications of the projects. Over the project lifespan, I expected the roles and relationships to change so that the partners become the insiders and the owners of the projects to allow me to change my role and to move on to other projects as required by my role with the University.

Both projects have considerable change implications upon current practices in the areas of medical clinical trial, the medicine licensing regulation. They will also influence the professional practices and socio-cultural values and expectations. They may eventually affect the Sino-British academic and research relationship in the field of Chinese medicine. The projects did not set out to initiate change, rather to facilitate the partners to think creatively in the ECCM project to turn Chinese medicine into evidence-based medicine, whilst the CMAS project aims to empower the suppliers to develop their own political power base and to influence current medicine licencing regulations, to think for themselves and to be accountable for their own future destiny rather than being frightened into joining an inappropriate association which does not serve their needs.

Both ECCM and CMAS projects had been carefully planned. They started as concepts. I then drew up draft proposals for discussion which started with face to face meetings. Like the CMAS project, this ECCM project is an insider-generated project based within the eclectic framework. The ECCM project illustrates the processes in bringing together senior and very experienced individuals of different nationalities into partnership to work as teams. They are many thousand miles away from each other and their only bond to each other is they have an interest in Chinese medicine, as educators, researchers, and business entrepreneurs. Several major issues immediately spring to one's mind: Why develop the projects? Why develop an association of the suppliers of Chinese herbs and herbal products? How do you go about bringing together two groups of people who in one project are in the same market as competitors and whose values and expectations are as broad as their socio-cultural, politico-economic spectrum?

I have already alluded earlier on that MU will have possible competitors in CM education. It has already been approached by other institutions in Spain and Israel to franchise this degree programme. It was considered too early to franchise the degree programme. Besides, it is not yet properly grounded, I for one certainly, have yet to clearly appreciate and understand the meaning and the implications of this programme within MU and UK.

As head of the Chinese medicine developments, I began to develop strategies which on one hand meet MU's (1998) mission/vision to provide a strong international outlook and on the other hand reassure the programme's potential external competitors and to help them to think collaboratively with MU. These strategies are also preemptive measures which MU can use to buy extra time to enable the programme to mature in a fairly stable environment. Thereafter, the programme can then be franchised across to Europe. Without such a strategy and a commitment to it, the BSc(Hons) TCM will be like a boat with no sails.

Unlike other projects the participants of both ECCM and CMAS different. They are required to participate in formulating and solving issues. They are also the change agents within their own organisations as a result of participating in the projects. This was one of the reasons why I chose the term "partners" (footnote) and acknowledged them as equals. This term is in fact more appropriate and complemented action research model whose "principal focus of collaboration involves interaction between a practitioner or a group of practitioners and a researcher or a research team *and eventually the participants become the expert and invaluable collaborators/partners contributing to the success of the projects (my italics)*" (Lewin, 1947). The approach, on reflection, encouraged both me and the partners as in Reason's perspective (1988) of a form of cooperative exploration in which we all contributed to "the creative thinking".

The European Centre for Chinese Medicine

ECCM's Mission Statement

To promote high quality, evidence-based Chinese medicine and through scholarly activities to foster a complementary relationship with the Orthodox medicine to enhance the quality of life of those who suffer from ill-health.

The aims and objectives of ECCM

In pursuing its mission the ECCM has several aims:

- to encourage selective Chinese herbal and patented products to be brought out of China initially for medical conditions identified by the British Government in its Health of the Nation (1991). They included: coronary heart disease, cancer, senile dementia and HIV/AIDS.

Footnote: **Partner** - This term is used instead of collaborators. "Partners" offer a much warmer and friendlier notion which conjures up the image of people with equal power and authority in a non hierarchical environment working together to achieve a common goal.

- to subject them to large clinical trials across Europe. If the outcomes meet the MCA's approval, these products will then be submitted for licencing with MCA to become medicines.

- establish itself as a centre of excellence to attract both quality researchers and academics.

- to foster collaborative links with partners from America, Australia and other South East Asian countries.

In developing the ECCM it also hopes that its partners will be stimulated to think creatively and laterally to turn Chinese medicine into evidence-based medicine, a precursor to gaining medicine status. Since the idea of the ECCM was first conceived, the list of objectives has grown against the backdrop of the general principles of its primary objective to be the ECMAH to provide innovative and creative programmes in Chinese medicine across Europe. The final agreed objectives are to:

- establish and promote strong links with China to advance Chinese medicine
- be Europe's resource centre for Chinese medicine
- promote evidence-based practice offering clinical trial facilities across Europe in collaboration with China
- promote, nurture and conduct different levels of and interdisciplinary and transcultural research projects including clinical and commercial-related research programmes
- offer and support opportunities for postgraduate and postdoctoral research among its members
- collaborate with pharmaceutical industries to conduct evaluative studies of existing research data and new clinical studies
- support present and future Chinese medicine programmes both at the undergraduate and postgraduate levels

- safeguard the biodiversity in the use of Chinese medicine
- promote public education on Chinese medicine so that informed choice can be made
- collaborate with government and private institutions to develop effective and added value mechanisms to control the quality of all Chinese medicine products.
- benchmark clinical practices

The ECCM project is also in many ways an external strategic collaborative development. It recognises that going alone MU cannot hope to achieve its vision. This collaborative development offers many advantages like:

- operating economies of scale because the strengths of the partners will be pooled together. No one organisation can singularly operate effectively and efficiently in a tight financial environment;
- a multi-partnership bid for research funds is more likely to succeed than as a single organisation;
- faster growth with capacity to achieve the multi-partnership functional and effective network which MU cannot achieve by itself because of its internal competing demands on its limited resources;
- such a Centre will be recognised quicker by other institutions and gain respect and recognition quicker;
- easier to gain entry to clinical areas for research purpose;
- increase areas of synergies will reduce the capital outlays through sharing technology, capabilities and expertise including development and product costs without affecting the partners' ability to achieve their own altruistic agenda whilst working as collaborators;
- such partnership will enhance the quality of long term plans by sharing with others' vision and aspirations, being flexible and innovative;
- a genuine international curriculum that will offer same level of standards and quality assurance;

- a major influence in the future development of Chinese medicine internationally;
- potentially an international regulatory body for the governance of professional practice instead of the present piece meal approach at national levels;
- a faster pace for Chinese medicine to achieve evidence-based medicine.

The ECCM project was scheduled to be completed within one and half year with a formal launch meeting within the next subsequent six months at which partners will sign a memorandum of collaboration. It began in November 1997 with a prolonged exploratory phase which was spent on testing and bouncing ideas. This project is now completed and is awaiting a managerial response.

Establishing contacts and building relationships with ECCM partners

Like CMAS, ECCM is a strategic collaborative project and is also as a collaborative joint venture. This concept is very common in the business world in which business partnerships are developed to achieve synergies as well as greater effective use of expertise and resources in areas like research and development. The concept also meets the criteria set by Harrigan (1988) that joint ventures are business agreements whereby two or more owners create a separate identity. The project partners included those

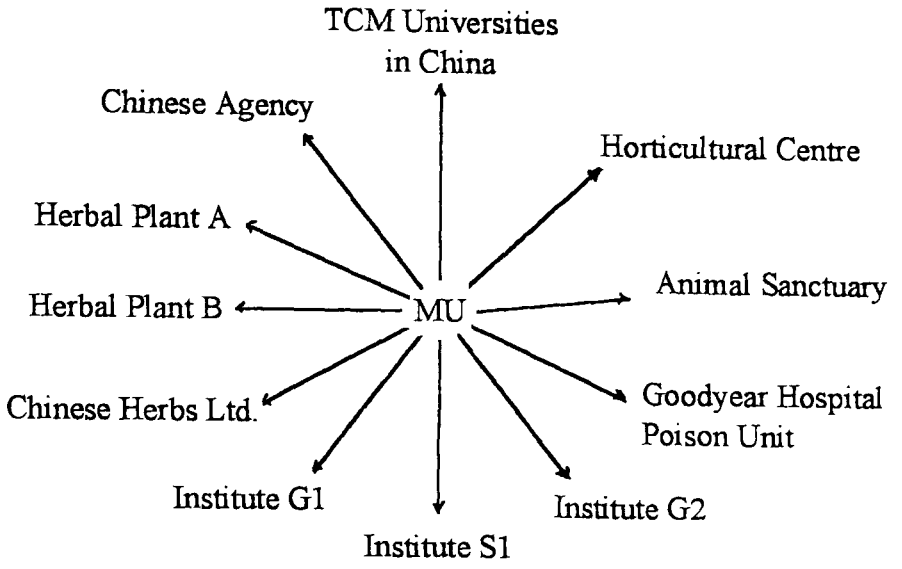


Fig. 7: ECCM partners

Goldenberg (1988) ascribed to as companies, state-controlled or mixed economies, private enterprise and government. During the developmental stage I approached the project as a series of joint venture agreements MU will have with each of its identified partners and they are then knitted together like a "spider web" (Gullander, 1975). I anticipated that by the time the project becomes live at the point of calling for the foundation and inaugural meeting, all the partners will know each other at least on paper. At this inaugural meeting, before the joint venture collaborations are signed, I would propose a minor change in MU's relationships in figure 7 to those in figure 8.

The project would create a macro inter-member relationships of equal status shown in fig 8. However, MU will act as the ECCM facilitator and administrator. There are many advantages to this proposal. Having equal status will remove suspicion immediately and increase collaboration at the same time. Transparent relationship will enhance understanding, confidence and trust. Instead of hierarchical power related structure will be the presence of an intellectual relationship towards emergent shared goals.

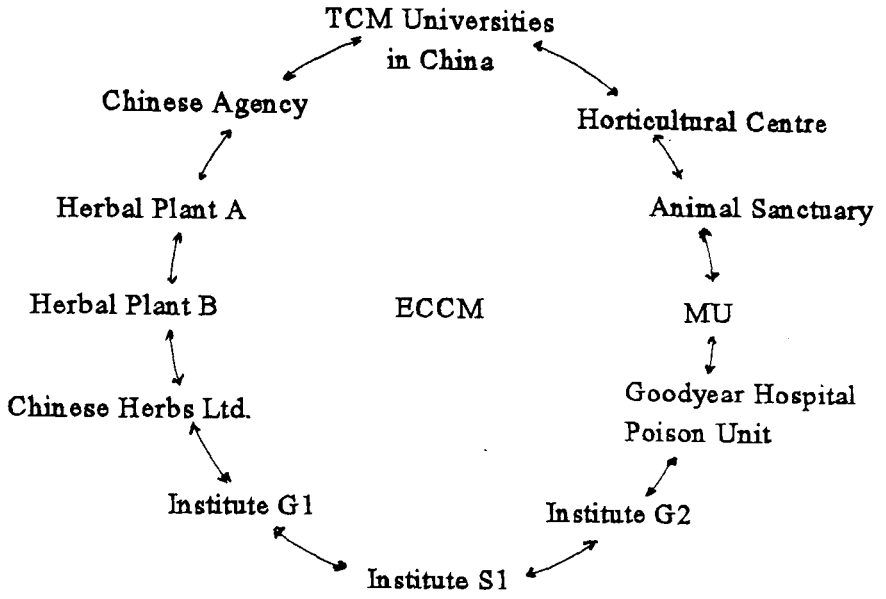


Fig. 8: Final shape of the ECCM partnership

The manner ECCM started was by default rather than by design. The European partners were at that time in the UK and contacted me after learning about the degree programme. The President of the University J of TCM was also visiting UK when we met. I had two face to face meetings with the Chinese Agency to discuss the project. The local partners were visited individually to introduce the proposal to them. As explained, the face to face meetings started as an opportunistic coincidence. The benefits of this approach were real and long lasting. They laid down the foundation of trust and prepared the mindsets.

During these exploratory phases every partner in the projects was learning, a fact I emphasized to every partner I met. I was seeking to validate my hunches for the proposals and their viability, I believe that the partners were seeking to understand the context of the projects, their implications and this would include the basic questions like "What is in it for me? Why I am selected?" The advantages of face to face encounters, on reflection, were the opportunity to study the partners' reactions and the body language to the proposals. It also allowed changes to be understood and implemented or agreed either during or after the discussions. Those encounters also helped to lay down the ground rules to protect each others interest and they took place "within a mutually acceptable ethical framework", Foster (1972). ECCM's structure

is more ephemeral and ad hoc in nature until such time as the project is implemented. So far, I acted as the intermediary for the partners and also their link to others. There is no reason except economic, why a face to face meeting cannot be arranged for everyone to meet as a group. Even this can be resolved once MU has taken the decision to implement the project and agreed to pump prime the project to finance the group meeting and to sign the memorandum of collaboration at the same time.

Following the face to face discussions with both the European and Chinese Agency partners the proposal was overhauled, taking into account suggestions from the partners. The proposal was more detailed when the other Chinese Universities of TCM were sent a copy pointing out the support of the Chinese Agency. This approach worked well. Three of them replied and agreed to join.

The postal dissemination method was followed up with personal telephone calls. These tended to be among the European partners. The Chinese partners would either e-mail or fax their reply. The telephone calls were comprehensive and detailed covering issues like business confidentiality, costs and funding for the clinical trials. These telephone conversations also helped to reinforce the partnership bond and to increase stake ownership.

The Institute S1 from Spain had two face to face meetings. The second one was in Spain, where I was invited to present the project to its Executive Committee. They funded the trip, board and lodging. The second meeting was as important to them as it was to me. Unpicking from their discussions and questions, they wanted to confirm their own understanding of the project, to assure themselves that the project is logically located to form part of MU's core business - education and research - for organic growth. MU is not using this as a pretext to compete in their business area. Personally, it was a morale booster to confirm that the proposal is both strategic and makes business and academic sense, and that the partners are willing to invest in the project.

As the ear and mouth of the partners I had a professional duty to report what others

felt about the project and the issues they had raised. At the same time, I was also discussing the project with them from my own perspective. I had to be extremely careful and accurate in my reporting. Most importantly, I was very aware of the danger of using the information to play against each other to gain a personal advantage. For example, pressing them to join on the pretext that others have agreed to join etc. I could be easily found out once the project was in operation and would damage my own credibility to lead them

How will ECCM work?

The Centre will initially operate with the founding partners to ensure a firm and strong scientific base before welcoming other members. This is expected to occur between the Centre's second and third birth dates. Because of the nature and commercial value of the research outcomes all members must abide by a code of conduct (appendix 12). Existing clinical research data will remain the property of the originator and will be brought to the Centre on the need to know basis to the appropriate partners. For example, if a colleague in China has discovered a formula to reduce the risks of cerebro-vascular disease or wishes to bring to the Centre, an existing formula for either replication or evaluative study or clinical trial, say for a senile dementia condition, Middlesex University will bring together the relevant members. The parties will then agree the best way forward to conduct the evaluation or the clinical trials with MU as the intermediary to monitor the agreement and manage the research outcomes.

Middlesex University and the Chinese Agency be the "twin engines" that drive the Centre's initial scientific and academic developments. The Chinese Agency, in collaboration with the universities it supports in China, will vet and offer research-based clinical data to the Centre. Middlesex University which manages and services the Centre, will provide the administrative support and expertise to seek funds to evaluate or conduct clinical trial programmes. A collaboration of this scale will enable the Centre to gain international recognition very quickly.

Partners approached for ECCM

As a collaborative project, ECCM aims to recruit 12 founding members from China, Europe and locally. ECCM is a virtual centre. It will be administered as already stated, by MU in order to bring Chinese medicine out of China and be recognised as medicines following successful clinical trials. The funding for the clinical trials will be raised from the international pharmaceutical firms. A brief description of the partners' potentials is given below. Each of these partners identified have its particular strengths whose sum total will create a strong Centre.

The Middlesex University

Middlesex University is presently well positioned in the world of Chinese medicine education since its successful validation of the world's first five-year full-time BSc (Hons) TCM programme jointly developed with Beijing University of Traditional Chinese Medicine. MU is now regarded as the true standard bearer for Chinese Medicine outside China. Evidence comes from media interest, European interest, and of course the willing partners for the project.

It has also a very thriving undergraduate programme in Western herbs which has been running for the last four years. The Phytochemistry Natural Product Research Group has grown in stature internationally. It has very diverse interests and has capacities to authenticate herbs, development of assays, sourcing material and also analysis of herbal products, in particular detection of adulterants or toxicological studies (appendix 13).

MU enjoys the understanding of the Medicines Control Agency and has strong links with private industries including international pharmaceutical firms. MU offers each partner organisation the opportunity to contribute towards achieving a critical mass to influence and shape the attitudes of the orthodox medical practitioners and the public towards Chinese medicine. This Centre will also satisfy each partner organisation's altruistic raison-d'etre and will support enterprising spirits.

MU will act as a sanctuary which will receive all scientific data, collate and publish them from the Centre. It will also be a broker for clinical trials to take place within the Centre's agreed specifications. It has much experience of bidding successfully to European and other funding organisations for collaborative research and these skills and expertise will be available to the Centre's activities.

The Chinese Agency

This Agency is part of the Ministry of Public Health. It oversees the Chinese medicine education and research. It sets the TCM curricular contents and delegates them to TCM universities to deliver.

The Agency has many strengths in addition to being a Government body. It manages the science- technology and education of the Chinese medicine. It regulates both the academic and professional standards. It also facilitates and supports research studies to modernise and enhance the quality of Chinese medicine.

The Centre will benefit much from the Agency's invaluable input. I had two meetings with the Director General and deputy director (January and May 1998). Through these face to face discussions, the director expressed his full support for the project both directly and indirectly. Indirectly, he commented that the Agency cannot dictate what other universities should do and it is their internal business. However, he did fax me the list of the universities as requested. There are many ways to interpret this action. Many colleagues agreed with my assumption that the Agency is genuinely interested and it is likely that the director would discuss the proposal with the presidents of the universities. The rationale for such an assumption is experientially based. In general, government organisations are not known to be expedient in translating words into actions. There was no other reason why such a list needed to be given. After all they have indicated that the universities are responsible for their own internal management. In the May 1998 meeting, I also met the deputy director for Science, Research and Education. He was nominated as the Agency's representative to the ECCM.

The universities of TCM

The Chinese Agency supports several universities of TCM. They all conduct clinical research and clinical trials. Each has its own special strengths to offer. My understanding is that each of these universities specialises in one aspect of Chinese medicine such as internal medicine, external medicine, acupuncture etc. This Centre will bring these universities close to each other and also closer to the "scientific world" outside China. MU is interested in collaborating with all the universities for their strengths and also to maintain and support its joint programme's strong position. Such a position will attract quality researchers because the collaboration will be able to offer the best opportunities and facilities for research. Being supported by the Chinese Agency, these universities are also known internationally. For example, one of them is recognised by World Health Organisation(WHO) for its work in acupuncture. The universities will therefore add value to the Centre as well as gaining much from the Centre. They were approached by correspondence and in return they indicated their wish to collaborate with ECCM. The president of the university J, was on a visit in England, November, 1997. The proposal was therefore, discussed with him face to face. His initial verbal enthusiasm for the collaboration was reinforced in a letter.

The Horticultural Centre

The Horticultural Centre is very a famous and popular centre which hopes to develop an Authentication Centre for Chinese herbs. As I am writing this case study, such centre is now established to offer authentication and quality control services. When it is fully developed, it will provide a range of authentication tests and reference materials for checking the identity and quality of those plants commonly used in traditional Chinese medicine in the West. When the proposal was first discussed in 1997 with the head of this Centre, the proposal was still in its infancy. The reaction was positive. When the proposal, which has since then been drafted several times, was subsequently submitted, it was met with a slightly different response from that expected. This clearly illustrated the need to ensure that the right person in the organisation is approached.

By the time the right person is identified that person may feel overlooked and reject the proposal off hand. At a subsequent meeting with the head, the director and another member of staff the misunderstanding was clarified. Their anxieties were overcome and they did not envisage any difficulty with their "trustees to endorse the Centre to collaborate with ECCM". The Centre's role will be both supportive in ensuring the herbs used for the clinical trials are clearly identified, investigated and certificated. The investigative nature will arise if the prepared products in the form of pills, tablets or liquid were presented to identify and confirm the ingredients as stated.

Herbal Lab A/ Herbal Lab B/ Chinese Herbs Ltd

Herbal Lab A was established one hundred and fifty years ago to carry out herbal extraction and therefore, this experience will be invaluable to the ECCM. It was a face to face meeting initially and that progressed to correspondence and telephone conversation to either amplify points or simply answer queries. These methodologies were used in the same order with the pharmaceutical companies.

Herbal Lab B is a new and small pharmaceutical company specialising in developing prescription medicines formulated from traditional plant-based treatments, often with a long history of use. Its approach differs from that of other pharmaceutical companies in that clinical evaluation in human takes place after initial pre-clinical safety and efficacy tests but usually before the precise chemical composition of the whole plant extract is known. It has extensive laboratory facilities for clinical researches and tests.

Chinese Herbs Ltd is a manufacturer, distributor, wholesaler and retailer of herbal based dietary supplements and nutritional products with emphasis on Chinese medicine. It has also worked as advisor to government agencies including National Poison Unit, the Environment Department and the Metropolitan Police in matters relating to herbs and herbal products. The R & D arm has developed the Bioprinting technique which will be able to trace the effect of multiple herbs singularly in the cellular activities. This will eventually be a major boost to the Chinese medicine in the

field of clinical trials. So far this type of facility is not available and its absence has contributed to reinforce the polarisation of views about Chinese medicine. It is also presently conducting in conjunction with Imperial Cancer Fund clinical trials for the treatment of the side effects of chemotherapy.

The discussions with international pharmaceutical companies had been very fruitful. However, their identity will remain confidential because of the present climate towards Chinese medicine by the orthodox medicine. They are concerned that the attributions to them of their interests to support clinical trials in Chinese medicine before it becomes a reality would affect their business. They are very interested to support clinical trials. Their rationale is very simple. The Chinese market is huge and ECCM offers the foothold they needed. Similarly, the return from the R & D for the orthodox medicine is becoming smaller and smaller and more infrequent.

The Goodyear Hospital Poison Unit

One of the foremost poison units which is also the national poison centre. It offers 24 hours advice on poisons and their possible antidotes. It has the experience and facilities to conduct toxicological tests on Chinese herbs. The person, Jenny Nightshade, responsible for the Chinese medicine, now works part-time with Horticultural Centre. The role of the poison unit is to conduct the pre and post clinical trials tests for toxicological effects. I had two meetings with Jenny Nightshade.

The European Partners

Institute G1 is a hospital for TCM and *Institute G2* is developing a TCM hospital in Bonn. Both will therefore, offer research opportunities, including clinical trials, to the Centre. Institute G2 has also seconded a student to the programme. It has agreed over the phone to join but it is awaiting ministerial permission to occupy the vacated embassy building in Bonn. It has also agreed a collaborative working relationship with Institute G1 as well as securing the partnership for the ECCM. Institute G1 was

established about five years ago by a business person who has converted to use Chinese medicine after a serious illness. The hospital offer dual diagnosis and the patients will be the most appropriate form of treatment, that is either Chinese or orthodox medicine or a combination of both.

The Institute S1 approached MU initially to franchise its undergraduate programme. They have been offered opportunities to get to know each other whilst waiting for the programme maturation before the franchise, like seconding a student to the programme. The possibility of joint research was discussed and they were enthusiastic. In September 1998, I was invited to meet their Executive Board members to discuss ECCM project in details. The Board has given its approval.

Animal Sanctuary

Animal Sanctuary is a very large charitable organisation which cares for the welfare of the animals in crisis. The policy of the Sanctuary has major impact upon Chinese medicine. Its aim is to find substitute herbs to replace the animals. It has been approached to fund a project to identify herbs to substitute for animals used in Chinese medicine. Upon approval, this will be ECCM's first major project.

A reflection on the ECCM project

The project progressed rather quickly and smoothly with very minimal contentious or difficult issues. I believe the opportunistic face to face meetings had been a major contributing factor. Those opportunistic meetings were nevertheless framed within the project management principles such as contact, entry, relationship establishment and final agreement. The initial phase began with a notion. The idea was then discussed with potential partners, reviewed and reshaped with support from the Deputy Vice-Chancellor. This was an exploratory phase. Eventually, the title had to change. The proposed Centre started as the European Research Centre for Chinese Medicine. This was changed after much debate as to whether a Centre comes first or after

accomplished researches have been achieved. The go ahead was given at the senior level highlighting that the proposal has strategic implications and requires urgent decisions from the School Management Team (appendix 14).

Following the face to face discussion, I sent copies of the first working draft of the project to prospective partners in China and Europe for their comments. That period was considered an extension of the exploratory phase except it was more advanced because the concept was clearer and more focused. This advanced exploratory phase had been very helpful in enabling me to get a sense of the magnitude of the project I was undertaking and to examine possible problems and "what if" scenarios. Thus, if the Chinese Agency does not participate I have to review the project so that the Chinese element is still very strong. That period offered the opportunity not to reflect but also to consolidate to ensure the direction and the nature of the strategy were still appropriate and within the achievable parameters. My experience concurred with the advice of Cohen and Manion (1984) that preliminary discussions and negotiations among the interested parties are vital to the success of a research project:

> "This is often the crucial stage (*having a draft of the project*) for the venture as it is at this point that the seeds of success or failure are planted, for unless the objectives, purposes and assumptions are made perfectly clear, and unless the role of key concepts is stressed (*such as feedback*), the enterprise can easily miscarry."

In the end, all the identified partners except three Chinese universities had face to face discussions about the project. The follow-ups were conducted either by phone or correspondence. Whilst I did not encounter any difficulty in engaging the partners as co-participants in the project, I was prepared to cope with any emerging difficulties or issues. This explained why I added a problem-solving model into my armoury of methodologies. Eden et al (1983) argued that a "process of assisting the defining and formulation of a problem is a crucial and often neglected precursor to any attempts to solve it." This point was further reinforced by Cunningham (1993) that the successful identification of problems is at the heart of the action research effort. I was presenting the partners a picture that is not yet actualised. Somehow, it was my role and duty to

be clear and precise about the projects and be confident to enable the partners to see both the picture and the backdrop. It also illustrated that when the process appeared under control and transparent, it helped to generate participation and involvement to be co-project partners instead of being interested partners. This empathy was clearly demonstrated in my meeting with the Institute S1 partner. Over the dinner, the partner stated that "it will take your organisation another year at least to get this running. This is too long. This is an innovative idea and in business you will lose it to your competitors. Here, if we sense something, worthwhile doing we will set it up next day... You see you have too many layers and you debate and consult too much. Really, what for, I can smell a good thing and I am prepared to pay the membership fee to get it moving . . . ". Another frequently heard remark is "universities in general are either discovering or playing with politics!"

In my ethnographer's role I was able to increase understanding of the discussion and decision making processes in different cultures. During the exploratory phase, I soon realised that I was facing an array of cultural values, social mores and expectations, socio-economic and political influences. The Chinese Agency initially took a very official and hierarchical stance. Unless one understands how the system works a person can spend much of his time in meetings starting from the bottom rung of the ladder of authority. In this matter, I am grateful to a friend from Beijing. With lessons learned from previous experiences, I believed that I had fared well with the Chinese Agency and met the appropriate person for the purpose. Having an understanding of the cultural and political context of what was asked and stated I was also able to decline offers of "coming to UK to discuss the project" without causing offence. It was a genuine reason when I explained that I have no authority to authorise such meetings at this early stage but that some have been planned at a later stage following an initial agreement. The fact was also I had zero budget. I have also learned to accept graciously a promise of being sent various scientific papers. I used to get very disappointed when the papers never arrived. Today, I would acknowledge, wait and see. During the early stages, I used to receive unsolicited offers of scientific papers on various illnesses treated by Chinese medicine for the Centre. They all wanted to meet

international pharmaceutical companies to discuss their "discoveries and inventions" and asked if I could arrange with the companies to invite them over to UK.

My background was a positive asset to the projects on this occasion because I was by then well known to the Chinese Agency. Nonetheless, I was and still am a paradox and an enigma to the Chinese. Initially, they were very cautious as how close they should come to me and how true is it that I do not speak Mandarin dialect. I do not believe that there was a genuine trust. This belief is applicable to many other cultures I have encountered. Again, I am making an experiential and reflexive statement. Having said this I am still an unknown quantity to the Chinese. Therefore, this continues to generate a certain degree of curiosity to know who is this "Henry Lee" who facilitated the Chinese medicine education outside China to be taught in a government-funded university. They nevertheless accepted that I was genuinely interested in promoting Chinese medicine. One CMAS member W offered me the following unsolicited advice: "let me give you a bit of advice. I come from China. Except, I have lived in UK for more than 10 years and have worked in the NHS as a consultant in ophthalmology. I have a better understanding of the culture here than many of my fellow countrymen here. For example, I know one of the professors who is teaching TCM in one of the British Universities. He came to me for weekend work. I tried him one Sunday and have not employed him since. He may be very good at repeating information in the classroom but he did not meet my stringent standards. Listening to his complaints demonstrate that he does not understand the British culture nor is he willing to learn. He seems to have an agenda in coming here. You know, the Chinese, be it the government or individual, will not trust you enough to accept your assistance. Of course they are glad you have raised the TCM profile with the undergraduate programme. Rather, there is much jealousy in the system. For example, I have never met you and I have only recently heard of you. I seem to know a lot about you. You should not worry what they say. I only want to illustrate what I mean by jealousy in the system. I fully support your work and I know it is a good work you are doing for CM and for us . . . I can write the cheque in your name for the membership fee but not to CMAS. I do not yet wish my name in the CMAS members list. I want to conduct my

business behind the scene." Whilst appreciating the person's advice which had clarified certain points of concern regarding the behaviours of University A, I see these as challenges for the uninitiated into the Chinese culture. They may be misconstrued. I believe that attitudes and behaviour we have come across are in the past and there is a definite change in the "Chinese wall" type mindset. The Times (5.4.99) reported how for the first time, China has allowed a small British company "to produce (in a CD-Rom) a comprehensive list of foreign joint venture projects operating in this country (China) . . . It is the first time that the information, which was previous treated as highly classified by the Chinese Government, has been made available to the international financial community." This conversation also reveals the complex challenges in general facing innovators highlighting the importance of having some knowledge of the cultural values and expectations they will need to deal with.

I was courteously treated at all times. This virtue is very much noted and remembered by the Westerners long after they have left China. That is, the unforgettable banquet style meals with so many different dishes. This ability to leave their guests both impressed and be warm towards them, is a "must do" cultural value. Unfortunately, it is also a well-known fact that it takes an exceptionally long time to receive an official reply if it were to give one. It is also true that, the reply tends to be noncommittal and non specific. My experience with the Chinese Agency and the universities except University A, must be taken as a sign of a cultural shift in response to the changing international environment. As already mentioned other universities have responded positively even in the absence of a face to face meeting. If this were the case, it does confirm that the culture of communication is changing in China, and the behaviour of University A must be viewed as an exception.

My experiences with University A brought back vivid memories of those I had encountered when I was seconded to the Health Department in Hong Kong in the early 1980s. The Chinese hosts had little regard for, and trust of, their overseas counterparts. When in mixed groups the Chinese hosts always spoke to the non-Chinese and all the eye contact was focused onto the latter. Yet, away from the group, they would make

an effort to speak to the overseas Chinese. This was not to say sorry or to absolve their guilt but it was a deliberate attempt to verify what they have just been told by their non-Chinese guests!

During my meetings with University A, the latter agreed and supported the ECCM project but I felt as if I was being "interrogated". I later learned that the person I met most regularly was a party secretary and not an academic or administrator. I was informed that in China every major organisation in particular governmental organisations, has a party secretary to ensure the party line is adhered too. I did not feel uncomfortable but I was very conscious of the line of questioning. They were very interested in me and questioned my background more than a social chat interest. On reflection, I believe they were introducing their own agenda in a piece meal fashion. In effect, I was engaged in a game of solving a jigsaw puzzle with the host holding the pieces and with no notion of the final picture. (Except, in this case the jigsaw puzzle was an organisation and the pieces are individuals). I was met in my own hotel room, in public arenas outside their offices in addition to the official scheduled meetings. Their interest in the projects was unusually detailed and their questions were also very focused. They did not appear interested in what I was saying. Perhaps, I told myself at the time that they had already read my proposal which I sent over prior to the meetings. Instead, they wanted to know how funds are obtained and the names of the funding bodies. Can any other organisations obtain these funds? They interjected with promises of scientific papers. At one of those meetings, they wanted to know the degree of empathy MU has with Miss Wong in London. Miss Wong claims to be an expert in acupuncture and owns several Chinese medicine clinics. I was advised that I should work closer with Miss Wong as I am from the same ethnic group as her and would also be to my own advantage. I was also reminded that MU has just started an undergraduate programme whereas Miss Wong's organisation is offering postgraduate programmes in CM. I have brought this out to illustrate that in some circumstances Chineseness may be a disadvantage. The nature of this conversation could not happen had I been a non-Chinese. It also demonstrates their ambivalence between not trusting and yet wanting to influence the overseas Chinese by exploiting their Chineseness.

University A certainly was not representative of my dealings in China. But the experience had a lasting impression in my memory. I have also made many friends who are willing to analyse the situations for my understanding, for example, someone during one of the meetings made an off the cuff remark that I am a "banana". There was a sudden and transient silence and noted the speaker's face reddened. This "banana" means that I may look Chinese (the yellow skin) but deep down I behave like a white (beneath the banana skin) hence the speaker's red face I observed. This clearly illustrates that although the insider knowledge can be tactically useful, it can also be hurtful. The hurt arises from the way and the context "you are a banana!"

Many colleagues in UK did not hold out much hope in my achieving anything in China. The degree was a lucky strike they explained because it will attract income and foreign currency for them. Some even advised me to reconsider my proposal because China's culture of secrecy means that the level of cooperation and openness expected in the ECCM would not be allowed. My request to meet the Director General was granted without much fuss. The meeting was very well conducted with a very good translator on both occasions although the Director General himself spoke very good English. He had been trained in orthodox medicine and his interest and that of the Chinese Agency was the same, that is to enhance the image and quality of CM and to attract funds. The same cannot be said for University A which changed its mind and withdrew its support for the ECCM membership. Does it have another agenda? Did my lack of response to its "advices" and "requirements" influence the decision?

My exploratory discussions with other partners had been both fruitful and encouraging. There was an instant recognition of the strategic value this Centre will have for themselves and for Chinese medicine. It was accepted that these partners have their own agenda for joining the Centre which is viewed as a commercial enterprise offering financial opportunities through research contracts. I found the UK partners are more willing to praise the project whilst asking for more time to consult with their colleagues or partners. They are reticent to act spontaneously. On the other hand, the Europeans

are more willing to make decisions there and then, bearing in mind that all the European partners are private entrepreneurs.

Throughout this project I maintained the role of a strategic entrepreneur to conceive, initiate, develop, implement and manage this process. I offered expert knowledge and to help partners with different cultural and national values understand the rationales of the project. The project also benefitted from:

- personal commitment;
- an in-depth knowledge of and skills in initiating, nurturing and managing unpredictable and complex interdisciplinary and interprofessional projects which involved bridging cultural, national, political, economic and developmental differences;
- a proven record of skills and experience in dealing successfully with complex issues in extreme cultural expectations and values within a professional and ethical framework;
- the benefits of solid experience in recasting the information and ideas into the melting pot and developing new paradigms to fit into the new situations;
- experience and expertise which were and still are nurtured by working with critical communities and through continuous self-appraisal and reflection;
- capabilities to work autonomously in close collaboration with relevant and appropriate personnel and professional organisations.

The project involved complex and parallel activities, including enquiry, negotiation, action, reflection and evaluation at every stage of its developmental process. Whilst every partner has a stake in the success of the ECCM, there are degrees of stake ownership. The small but private business partners in Europe are very committed and they were able to respond positively either at the time of discussion or soon afterwards. In others, the willingness to participate is underlined by personal agenda "so long I am

here (working for the organisation) I am participating." These are two extremes to demonstrate the range of stake ownership in the ECCM.

The Chinese Medicine Association of Suppliers project

Why an association is needed for CM suppliers?

Over the last two decades, there has been a meteoric increase in the demand for complementary medicine/therapies by the public in the United Kingdom outside the National Health Service system. The "Today" programme on BBC Radio 4, reported on 24.2.99 that there is now one in three people who seek health care and treatment from an alternative source other than the orthodox medicine. The burgeoning number of Chinese medicine clinics being opened in the high streets around the UK and near the proximity of most of London's underground stations is a testament that Chinese medicine is also enjoying a similar popularity. However, there are several major issues which concern both the practitioners and the Medicines Control Agency (MCA). Central to these is quality control. Lack of regulation over the authentication and the quality of herbs in the marketplace has enabled substitute, fake and adulterant herbs being sold to the unsuspected. At present, there are no proper facilities to authenticate and conduct chemical assays, on the level of toxicity which could be naturally occurring from such factors as environmental pollution and soil chemistry and those brought on by the increased use of insecticides and other chemicals during the growing processes. This situation is also compounded by the liberal law in the UK. An individual can set up a business to import and sell Chinese herbs and other Chinese herbal products. The person also does not require a licence to import these products.

Chinese medicine, particularly patented formula, is neither recognized nor licensed by MCA as medicine despite the fact that CM has been around for more than two thousand years. Instead, these Chinese medicinal herbs and patented products are being sold as Chinese herbal teas and food supplements which do not require a licence. At

present much energy is spent in avoidance strategy to satisfy MCA's definition. It is my belief that these energies can be better channelled to develop a strategy by the suppliers to facilitate the process of enabling Chinese herbal and patented products to be licensed as medicine. Such a strategy will include developing acceptable methodologies to conduct clinical trials and other clinical research to demonstrate whether or not these products have the medicinal efficacy to treat particular medical conditions. Whether a product is licensed as a medicine will depend upon the outcomes of those clinical trials. Figure 8 (page 65) demonstrates the essential processes, procedures and the organisations/ agencies involved to achieve this objective.

The current clinical trial methodologies and processes used for orthodox medicine are ill-equipped to assess the treatment effectiveness of the Chinese herbs. As already explained, A blend of different Chinese herbs are prescribed per single dose/treatment and this has so far confounded Western scientists to bring Chinese medicine within the parameters of existing clinical trial regimes. This method has also proved unsatisfactory because these herbs invariably comprise more than a single chemical component and their overall effect cannot be simply assumed by reference to the perceived active constituents as in synthetic-based drugs. The existing licensing protocols are therefore less than adequate to assess and license the complex formulary which is needed in CM treatment. In addition, the holism of CM states that "same disease different treatment. Different diseases same treatment". This means, two person with same condition may not need same treatment unless the causes are identical and yet two different conditions with identical causes will be prescribed same treatment. There is also an intense debate around the methods and processes of clinical trials for complementary medicine/ and therapies. Unfortunately, this debate is also increasingly partisan and entrenched between the complementary therapies and medicines and orthodox medicine camps.

In an unregulated environment the cry of rogue practitioners and importers and sellers is inevitable. But some of these cries can be assigned to the "cry wolf" category for those in the Chinese herbal business. Many small importers complain that they are simply making a living. They also accuse the motives of their "big brothers" as no more

than to make a quick buck as long as the demand for Chinese medicine is rising. These accusations will continue so long there is no properly and professionally organised group to speak with one voice. For example, the British Medical Association speaks with authority on behalf of the orthodox medical practitioners.

My involvement in the supply side of Chinese medicine was planned to support the effectiveness of the ECCM through the use of quality herbs. Whilst this volatile and unregulated market continues to operate, Chinese medicine will exist in the shadow of doubt and be easily blackened by any dubious supplier supplying rogue herbs and other herbal products. The public is also beginning to trust the genuine effectiveness and efficacy of Chinese medicine. However, each publication of malpractice will chip away this hard earned trust. At present, the government is loath to introduce (appendix 15) and the government's preference to encourage self-regulation (Tessa Jowell - July 1998) whilst continuing with the current "benevolent neutrality" approach explained by Baroness Cumberlege (appendix 16), CMAS's strategy to develop a self-regulated quality management system in the supply of these products will therefore, fill the void. Such a development will also encourage the suppliers to put their own house in order.

The aim of the project is to create an association of suppliers to organise and empower the latter to develop the association into a self-regulatory body and to assure the public the safety and quality of CM in the UK. The project illustrates the processes in bringing together fifteen suppliers (seventeen including one from Spain and Poland) to form an association. Their only rapport to each other is they are suppliers of Chinese herbs and herbal products to the Chinese medicine clinics and practitioners. One serious concern I had from the very beginning had been "Can I do better than others who have already tried and given up?"

CMAS's Mission Statement

The members will be guided by the Association's code of practice to uphold both quality and safety in the supply of Chinese herbs.

The aims and objectives of CMAS

The Chinese Medicine Association of Suppliers is a self-regulated professional organisation for the suppliers of Chinese medicine. The aims and objectives of CMAS are to:

- campaign for formation of a third category within the law for the use of herbal medicine
- oversee the supply of good quality CM to practitioners and retailers
- ensure public safety through good practice
- liaise with appropriate government agencies to protect the public
- preserve the pharmacopoeia and promote the benefits of Chinese medicine outside China
- protect the legitimate rights and interest of its members
- enforce the code of practice
- make its annual reports accessible to the public
- develop a good practice kite mark
- promote good working relationships with other associations

Since the undergraduate programme for Chinese medicine was validated, I have been approached by several importers to consider regulating the quality of the Chinese herbs and the herbal products imported into the UK market. Their interest was for their own needs, i.e. "It is better we do it than the government does it for us. At least we know what we are talking about whereas the government may simply have a blanket approach which will ban all herbs for the sake of simplicity".

This earnest desire to have some form of regulation also stemmed from the fact that Chinese medicine is not allowed to be sold as a medicine but instead as a herbal tea or as food supplement or unlicensed herbal products in the UK. This is restricting the sales as well as incurring prosecution if this code is breached. This picture is further complicated by very varying practices among the European Community States. The

herbal medicine market in Europe is worth at least US$7000M. The market share has continued to increase as corroborated by the rising public demand. As a growing sector of the economy, every government is well aware that it is also a politically sensitive issue.

In the meantime, everyone including the MCA believes that some kind of self-regulation is necessary to protect both the public and the Chinese medicine per se. MCA found it difficult to communicate with the wholesalers because "they do not have an organisation with whom we can liaise". One officer used to tell to me this whenever we met. I started the idea of developing an association by obtaining from MCA a list of the major suppliers of Chinese herbs. Each one of them was then invited to attend an exploratory meeting in the Middlesex University's premises in September 1998. I decided to go ahead with this development as planned but modified my strategic approach. I believe I have many strengths which are acceptable to the suppliers:

- I am a neutral person from an academic background
- I have spearheaded the development of a degree in Chinese medicine with Beijng University of Traditional Chinese Medicine
- I am not a competitor to them
- I can offer them links to Medicine Control Agency
- I can offer them links to Chinese Agency
- I empathize with them and understand the challenges facing them as demonstrated in fig 9 below in addition of the pressure of the publicity surrounding the use of animals.

At the September exploratory meeting, eight members attended (by the way "eight" is a lucky number for Chinese because it sounded like "prosper"). The day was very hot for the September month. The pre-ordered sandwich and drinks did not arrive on time. The room was hot and the participants were hot and bothered. There was an air of hesitancy and the participants were "ill at ease". The early arrivals occupied the four corners of the tables which were arranged in the middle for the food. They hardly said

anything to each other. I too was affected by the awkwardness and this may attribute to my babbling away in an attempt to get them to communicate with each other. At last, the food and drink arrived! Everyone was indecisive and in fact some did not eat until towards the end of the meeting when they were more relaxed. The anxiety level had markedly declined as the meeting progressed, but I sensed that there were still feelings to be expressed. However, the hesitation and tension were more overpowering

The meeting started with a general introduction of each other. I then gave a brief introduction to the purpose of the meeting and why an association of this kind would be an advantage to themselves. I was constantly reassuring them that it was an exploratory meeting to gauge their interest in forming an association for themselves. However, if they felt that there was no need for such an association then we could forget the idea. Some members were bemoaning that not everyone was present and it will be very difficult to speak on their behalf. They were reassured that the fact they took the trouble to attend which was what mattered most. This indicated that they were interested and at the end their decision will become the majority decision. If they decided to go ahead then again, those who joined later will have to accept their agreed terms and conditions. I assisted them to think in terms of:

- public safety in the absence of a statutory regulatory body;
- the Medicines Control Agency who wishes to liaise with a body instead of individual suppliers;
- eventual progression to become a self-regulatory body for the suppliers;
- the opportunity of links with MCA and the Chinese Agency - an eventual triangular relationship to develop a quality assurance system from growth, production of herbs to public consumption;
- being proactive and making representation to appropriate government bodies;
- working with other associations to increase its political standing both locally and Europe wide;
- eventual quality procedures which will include pre-entry to UK

sampling testing at the port's warehouses and certification from approved laboratory analysis such as Middlesex University's Phytochemistry Natural Product Research and the Authentication Centre at the Horticultural Centre;

- being a resource centre for research and for the public;
- an association kite mark to maintain quality.

As the meeting progressed, the suppliers began to be noticeably more at ease and the discussion became more lively. Indeed, we had moved to discuss an appropriate name for the association, the association's mission, aims and objectives and the code of practice as if an association was already in existence. Encouraged by the lively exchanges among the members I asked whether I was right to think that they wished to form an association. I was indeed very relieved with their positive reply and being told "you must chair the meetings for us!" Effectively, I was decreed the Chair of the Association. I accepted the offer because I had anticipated this scenario might happen partly because of their own previous negative experiences at being asked to form an association and my neutral position as I have previously indicated.

At the same time this initiative was started, Association B was again also trying to recruit the suppliers. This was their nth attempts without success. This subject came into the open spontaneously among members who wanted to know where did they stand vis a vis Association B. The members were very candid and explained they have no desire to join Association B. Their reasons were already discussed earlier in this chapter. Figure 9 below shows the challenges facing the suppliers.

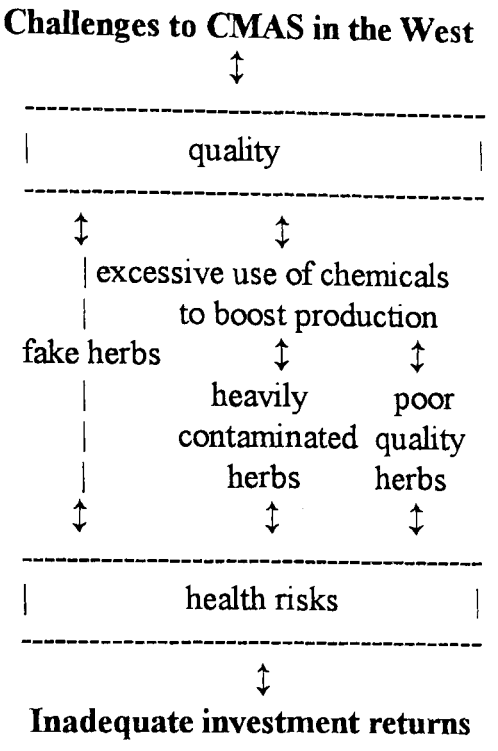


Fig 9: Challenges to the Chinese Medicine Suppliers

Later, I had a separate meeting with member C, an American, who informed me that he also had attempted to organize the suppliers. He briefed me of his experiences and possible reasons why his attempt failed. It appeared that he had asked one of his employees, a well-known Chinese pharmacist. It did not succeed because:

- " there was not enough trust among the suppliers particularly the Chinese;
- they perceived each other as business competitors instead of collaborators;
- there was also an element of suspicion as to why should supplier C wish to organize them;
- there was also an element of strong personality".

Towards the end of the exploratory meeting which lasted three hours, the suppliers agreed several important steps to be taken to ensure the association would be realised:

- to think over the proposed name for the association - Chinese Medicine

Association of Suppliers with a fairly catchy acronym - CMAS;

- date of next meeting;
- to accept interim association officers' roles;
- to contact the suppliers they know personally to persuade them to join forces;
- to review the draft mission statement, aims and objectives and code of conduct.

The next two meetings were attended by fewer suppliers than the first meeting and also by some new suppliers. I indicated my willingness to offer my services free to them as long as they continued to attend the meetings. The CMAS name was formally adopted at the second meeting and several members offered to design letterheads and logos to be assessed and approved by the Committee. There were many occasions when I feared that CMAS may not make it because some of the big names in the supply side have not yet joined. There was also doubt whether CMAS can command the respect of the MCA. CMAS's fortune took a dramatic turn for better. MCA produced a circular MLX 249 which can potentially affect the Chinese herbs (appendix 17). The members were advised of the circular and the need to discuss it in detail in order to give a response from CMAS. An emergency meeting was convened in December and to everybody's surprise thirteen suppliers turned up. The December meeting marked the turning point. The meeting was very lively and emotive because of the possible threat to their livelihood. A proposed draft reply was suggested at the meeting. We also received unexpected support from the Professional Association E in the form of a copy of their response to the circular MLX249. Some members also reported the latter's open verbal support for CMAS. The members were asked to study the draft again and let me have their comments by an agreed deadline. Everyone responded and MCA had received an official response from CMAS!

Official recognition for CMAS

In the meantime I negotiated a meeting between CMAS and MCA in the following month, January 1999. CMAS had a pre-MCA meeting to discuss and agree the issues to be raised with MCA. At the pre-meeting a representative from the Belgian suppliers joined in and also at the meeting with MCA next day. Unfortunately, the Spanish

member fell ill and did not join as intended. Every member contributed and agreed an agenda for next day's meeting with MCA.

Four members of the MCA - two from the policy section and two from the policing section - attended the meeting. I introduced the CMAS team and the issues to an amazed team of MCA officials. All CMAS members but one who was out of the country at the time were present. The MCA officers' amazed expression was noticeable as one of them whom I have known for a long time later explained that "we were really very delighted that you have been able to organise the suppliers. We were of course amazed because I have not known such a show of unity."

The meeting lasted nearly three hours and the discussions were focused and conducted in a very warm and cordial atmosphere. There was an understanding that:

- CMAS is officially recognised;
- MCA will communicate with CMAS on issues that affect Chinese herbs and herbal products;
- CMAS will be supplied with appropriate publications to enable it to build up a reference resource;
- MCA will cooperate with matters concerning Chinese herbs and herbal products recognising CMAS's knowledge and expertise;
- MCA will from behind the scene assist with the concept of alternative registration for Chinese herbs and herbal products;
- existing allowance on what can be or cannot be sold will continue.

After the meeting, the positive expressions on the faces of both parties said it all. The members were visibly invigorated and expressed their satisfaction with the meeting. For some it was the first time they had come face to face with MCA officials. For the Chinese in particular, they were quite overwhelmed to experience the warm and friendly encounter with MCA officials. Usually, Chinese people tend to hold the official with awe because they would have heard about the raids the MCA policing officers conducted on their colleagues' premises. This meeting had dispelled any doubts they may have about joining the Association. After this meeting the Finance officer for CMAS had received all the members' subscription fees!

The MCA meeting has injected the incentive booster and the members have since been attending regularly the meetings and many had found it a valuable experience of meeting regularly with other colleagues as partners to share common concerns. The MCA has also kept its word and begin to correspond with CMAS direct. They learned that they were not alone in their concerns. The earlier members were also encouraged by the fact that by December - three months after the inaugural meeting, all major suppliers have joined. They began to think ahead and strategically such as what CMAS should do and how to take full advantage of their personal connection in China to strengthen CMAS's position as a voice of authority in a tripartite partnership with the Chinese Agency and MCA.

For the next phase of the project, the members have agreed to formally launch CMAS to the public. As it turned out, member N has invited a delegation from the Chinese Agency to visit UK in April 1999 and everything is now geared to launching CMAS during the Chinese Agency's visit. A Launch Committee is now set up with clear targets to achieve the launch. At least six members volunteered in the Launch project. To illustrate their commitment and enthusiasm, the members who live in Manchester, Oxford and Bath agreed to conduct teleconferencing to achieve these objectives.

By January 1999, four months later, CMAS recruited its first European member from Spain. Indeed CMAS has established a firm shared commitment to provide quality Chinese herbs and herbal products. In the meantime other members are busy reviewing CMAS's Mission statement, aims and objectives and the code of practice (appendix 18).

Who are the suppliers?

It may be appropriate to briefly describe the suppliers who joined CMAS which now boast fifteen local members plus one from Spain and one from Poland. The number represents all major suppliers in the UK but there are still small suppliers not known to CMAS. They all had paid the initial administrative fee which will be adjusted once the membership structure and the fees are settled. The administrative fee is requested to meet the cost of administering the embryonic CMAS. Seven members are non-Chinese (American, English, Scottish, and German), three Chinese from Hong Kong and the rest are from China. The rationale in highlighting their ethnic background is to illustrate the complex maze of interpersonal relationships this group could generate and their effects on the development of the Association. Unless one has such understanding as already illustrated above, CMAS could have suffered the fate of still birth. I learned later that many previous attempts had suffered this fate. The suppliers never wanted to join Association B which was established more than ten years ago for the manufacturers of western herbal products and was not intended for the Chinese herbal products suppliers. It did not foresee that Chinese medicine would be so popular. Consequently, all its protocols were developed on behalf of the western herbal manufacturers. In the past few years it started to court the Chinese herbal product suppliers under pressure from Association R but without much success. I learned that Association B did not attempt to understand the Chinese herbs because it believed that there is no difference in the principles of the Western herbs and the Chinese herbs. Association B members extract and create tinctures from the herbs, whilst Chinese herbs are used as whole and are concocted by patients themselves. This view does not give the Chinese herbal products suppliers confidence that their interests will be

adequately and effectively looked after by Association B. This lack of confidence in Association B coupled with their desire to manage their own "affairs" cemented the foundation for CMAS. Their dislike for Association B was clearly demonstrated at one of the CMAS meetings. It was during a good natured debate on the Launch of CMAS when member "H" who works as a consultant to a supplier and attends on the firm's behalf, suggested that the Launch should include Associations B and R as partners. The statement provoked an instant silence and questioning looks from and across the members. Member H I learned later was the ex-president of Association R which has very strong ties with Association B. It stirred Member G to question "what is the original aim of CMAS?" which really summed up the mood of the other members at the time. As the Chair and also as a participant observer, I quickly made a tactical intervention and suggested that the members should think about the *guests* (I emphasized the word "guests") to be invited to the launch as it would be a good opportunity to inform them of CMAS and its aims and objectives. The incident clearly demonstrated that a "loose cannon" in the midst can either cause a splinter group formation or reinforce the group cohesion. In this case, member H had achieved the latter. Member H is in fact in a very weak position as he is attending on behalf of the supplier he is a consultant to. He will not be able to decide on behalf of his "employer" without consulting the latter.

The non-Chinese members are more relaxed and are able to express themselves more fluently. They are just inscrutable and mask their dislike and agree more readily with the majority's will in the open. However, they would be quite critical behind the scene, for example, a few would phone me about their views on other associations and conclude "We should never be part of Association B!" The Chinese members are similarly manipulative. They too would telephone to offer their views. Some are very frank. Member C volunteered that he and member O are not on talking term but did not offer any reasons.

Those from Hong Kong had been brought up in a benign autocratic and bureaucratic society run by the British Government until June 1997. They tend to blend

Confucianism into the "democratic" values they learned in Hong Kong. Hong Kong had therefore been sandwiched between two cultural and social meanings and values. Hong Kong people enjoyed freedom of speech without democracy. They were free from overt corruptions and fear of being locked away or "disappeared" as it was and still is in China. Deep down, the cultural and social values were Confucian. Outwardly, they appeared westernised. They are pragmatic entrepreneurs and have retained their ancestral work and business ethics which are to work hard and to deal with business colleagues with deference. To them to develop a business plan is tantamount to accepting that they lack business acumen and stamina in themselves. They would prefer to pick a stick fallen off the chim, (a wooden cup) full of prayer sticks at Wong Taising Temple in Hong Kong than to submit to the demand of their bank manager for a business plan. Their Chineseness remains true to their ancestral traditions despite the colonial rule. Money is not a big issue if they think it is fair. To them, money is easy come easy go and their motto is "work hard and live well". For example, after the meeting with MCA members, member M offered to fund the lunch (20 people!) in a restaurant.

China has a different political system which is authoritarian. The recent demise of the commune system has opened the floodgate to business opportunities making her the most envied market to be exploited commercially. It is also true that many "escaped" to the West in search of wealth. One must understand that these people's desires for material wealth had been suppressed for more than five decades under Mao Zedong's regime. Today, since the relaxation of the state economy, they have a compulsion to satisfy themselves. The acquisition of material wealth is a national mantra. Chinese medicine is one of the means to accumulate wealth so it appears. This is a very unfortunate perception of the people of China. But these stories are abound and well known among those who had dealings with officials in China. Many have been unfortunately tarnished by some of their compatriots whose behaviours many Chinese compatriots would readily deplore. This behaviour is no more nor less in other cultures. Perhaps, this is more a reflection of the basic human instincts to be selfish towards, and jealous of, others. The type of political system may either intensify or

reduce these basic instincts. For example, the 80s and 90s are often said to have created a culture of greed and self-centeredness in the British society. It is therefore, safe to suggest that preoccupation with seeking extra income is a universal phenomenon.

It would be very unfair to pin this oversimplified label onto these suppliers because I do not know them intimately. My experiences suggest that they are very friendly and in fact some of them are very keen supporter of CMAS and did much to speed up the latter's development by contacting and convincing their colleagues to join. From my observations they are quieter and prefer to express their needs indirectly. For example, member F queried "Do you think CMAS should be only for the suppliers and only they should have a voting right". What it really meant was CMAS should be only for the suppliers and "I would like to be involved in the committees and should be automatic instead of offering myself for the membership". Every member must take part in the activities.

A reflection on the CMAS project

The above account raises a number of issues of general relevance to this kind of collaborative project. The immediate aim was to develop an association of suppliers. I anticipated that should such an association be formed, the members' interaction and cooperation will influence each other's mindset and will internalise their feeling of ownership and empowerment. Within a supportive environment, the members, particularly the Chinese members, came to realise that CMAS is a reflection of themselves of their own thoughts and feelings and that they were indeed in a position to influence the direction of CMAS. The members began to focus on issues of immediate concern to them at the time of writing this case study. They have started to use "we" more frequently. This is confirmed by eleven of thirteen replies to the questionnaire, that CMAS has met their expectations. Seven and six were respectively either "fully satisfied" or "satisfied" with CMAS's performance so far.

As chair, I assessed the group interactions and their potential effects upon the group and partnership dynamics. I then had to weigh carefully whether, when and how to intervene and to what degree in order to reduce the risks of collaborative "glueing" (Carnall, 1990) process being broken down. With insider knowledge not only could I be a more effective chair I could also take a more critical analysis on how these members think and act. This approach might be criticized as flawed because the distinction between the researcher and the participants has become blurred. The same can be argued with a project that should meet the strict conventions of research. Such a project will still be challenged for its reliability, credibility and validity particularly in its methodology. This project does not claim to adhere to the research convention, rather it was a very pragmatic approach as it occurs in a praxis environment as part of my job. As a facilitator I was also in a position to support and encourage the members throughout the developmental stage. I believe that I am also entitled to conduct my own research into my own work and develop an alternative model based on my own experiences which were grounded in praxis to improve my own practice. It is being validated by consultation with others. This validation I am claiming is based on these partners agreeing that my proposals' supporting evidence is contextually appropriate. Hence their desire to become partners.

On my part, I deliberately chaired the meetings in such a way that everyone has an opportunity to express his or her views and feelings. For example, member K both imports and manages a group of Chinese medicine clinics. He initially believed that he should be treated as an associate member of CMAS (without the voting rights and at a fixed membership fee), because his imports are mostly used in his clinics. He has been discussing quality issues affecting the purchasers such as "'moulded herbs', goods not stamped with a 'sold by date' leading to out of date goods being supplied at times. Occasionally, 'fake herbs' were supplied." Lately, realising that the full membership means access to MCA and the Chinese Agency, (both are initiators, producers and enforcers of policies, member K shifted his attitudes and has decided that he is a supplier instead of a clinician. Another member G (Chinese from China) who lives in Manchester and has always used the travelling distance as an excuse for not joining or attending the meetings. Gradually, when he realised that CMAS genuinely needed him

he offered to attend if the meetings could be held on Monday afternoons. The members agreed and he has since regularly attended the last four meetings! He too has modified his attitudes. He has become one of the most active members. He initially offered to assist in arranging the Launch. Lately, he has assumed the chairmanship of the Launch project with full approval of the other members. He has also offered to design a logo for CMAS (appendix 19), and to develop a data base for the herbs as a resource for CMAS. He had availed himself of the opportunity to select task activities that make sense to him and performed them to the best of his ability. This feeling of choice is the feeling of being free to choose or to use his own judgement over the task. The members were supportive and enabled him to feel that he was doing good and quality work which was worth his time. As he explained, "I am glad I can be of some help and that my contributions matter in the objectives of CMAS".

The initial meeting with MCA in January has a profound effect upon the members. I believed the meeting was the make or break of the CMAS. As it turned out the meeting has reinforced their resolve to organise CMAS appropriately. They also began to understand why they were always reminded that CMAS is their association and it is their political power base. They have now accepted that they are responsible for nurturing and managing CMAS appropriately to ensure that CMAS does not squander its official recognition from MCA; that the latter will in future liaise with CMAS alone and will welcome CMAS's input in its broad policies on Chinese herbs and herbal products. The silent reaction to the suggestion by member H that the launch should include Associations B and R as reported early illustrates clearly how far these members have travelled together and have understood each other. The proposal was silenced out. During a telephone conversation, member K clarified that the silence was not against the idea rather against a hidden agenda. "The proposer was an ex-president of the association and we could understand that he wishes to promote the association, but he is now working for a supplier and should therefore let go his baggage and promote CMAS instead!"

There is now a noticeable qualitative change in the group interactions since the

"hesitant" explorative meeting last September. This shift was subtle and gradual. I knew that the Chinese members who came late had investigated my background (this was reported to me in confidence by colleagues to whom the members had approached). They accepted that I was genuinely interested in enhancing the image of the Chinese medicine and that I was not collaborating with any particular suppliers. Many Chinese suppliers initially suspected that I was collaborating with member F's company because in my first letter to them I acknowledged the latter had sponsored the buffet lunch. Member A who was at the initial meeting remarked in a separate conversation that "you should not have put in your invitation letter that F's company is paying for the buffet, we all will contribute if you ask us!" or another frequent remark was "I thought you were collaborating with F. It was noteworthy to highlight that once the Chinese members realise that CMAS is really their voice, they have become more assertive and confident. One of the respondents to the questionnaire suggested that "*we have to* agree on the level of quality and impose it. We all have our own quality. We need one the public will see".

Robottom et al (1993), suggested that there may come a time when participants seek to take control of the research and direct it towards their own agenda. This was certainly true for CMAS. From the onset, the members were reminded that my chairmanship is temporary and I shall relinquish it as soon as they feel confident to run CMAS by themselves. By December, the room was buzzing with excitement, vitality and enthusiasm, accepting that the task they had in hand was very close to them, the MLX 249 circular. Nevertheless, it was possible to experience the waves of confidence and passion as they put across one by one their points of view and offered their proposed response to MLX 249 circular. One could sense they were doing their best and learning very quickly at the same time. Similarly, the prospect of meeting the MCA officials created an atmosphere of anticipations.

I have maintained a very neutral but facilitative role to create the building blocks of empowerment within a supportive environment for the members. I was also conscious that creating an association of suppliers is part of my strategic plan. Therefore, my

neutral role did not mean to create a separate and independent views nor to reinforce their "distrustful" mindset but to challenge their assumptions, encourage collaborative thinking and provide the opportunities for them the right to make decisions, to trust members' judgement, to support honest and genuine but opposing views, to decide their own association's aims and objectives and to share with their colleagues their own information to make informed decisions. I have already explained earlier that CMAS members had confirmed that their views were either met (10) or partly met (3). One member explained that ". . . is both generous and impartial"

Members are now bringing in news and publications to share with each other. What is also remarkable, the length of meeting times has always been between three and four hours and every member is happy to sit through the meeting. In fact, I have to remind them of the time whereas before members began fidgeting after two hours. On one occasion member R came ten minutes early and because not everyone had arrived he decided to leave! He has since changed. Another member P was regularly interrupted via his mobile phone but in last three meetings, there was only one interruption. That occasion brought out a chorus of "hurrah" because everyone was so used to his mobile phone interruptions that they seem to miss them now.

In retrospect, the successful outcome of this project proved to be a key driver in developing the self-confidence as well as group confidence. Individuals are beginning to offer assistance and act as models. Recently a member started to give positive feed back on what has been achieved and how others have helped in the tasks, his colleagues were more willing to give him credits for his work. The members were continuously stretched to take on different roles which they are happy to do without any inference of incompetence if they do wish to take on the roles. This is further confirmed in response to the questionnaire, on average, the members are willing to give 2-3 hours per week of their time for CMAS work. This amount of time per week is indeed a good reflection of the members' commitment to CMAS and willingness to invest to achieve their shared goal. One felt "hard to quantify at this stage. It is a new organisation and I believe everyone involved needs to make extra efforts".

Fortunately, my role allows me to establish a relationship with the suppliers and be involved in their search for a meaningful objective, and from my perspective, it improves my action research skills because I was able to use the knowledge which I would not otherwise know to help the members to gel. I was offering the members a non-cynical climate to encourage members with idealism and caring to express themselves, to develop a shared value system for the team that is important to CMAS, to develop an exciting vision of the future that CMAS wishes to create and add value to itself, and to set up task groups or subcommittee which contribute to the realisation of that vision. In return, there is now a commitment to the project and a willingness to collaborate with each other. Twelve "fully agreed" and one "partially agreed" with CMAS's proposed mission, aims and objectives and code of practice. The latter explained that "I agree partially as CMAS is investigating its role within the area of Chinese herbal supplies".

At the September meeting I did make it clear that the aim was to create an association. Having gained their confidence in me, I was able to work with the members individually to understand the person and how best to meet her needs. I was therefore, fully collaborating with the members to offer the support and coordination to work and to aim for the objective together. I assisted them to map out the milestones of the project such as meeting with MCA, with pharmacognosist and botanist, the launch, the business plan etc. I gave them every encouragement for their achievements pointing to the next milestone. This approach had paid dividends as demonstrated in their attendance record to the meetings but further confirmed in their responses to the questionnaire. Ten members agreed that "their views were heard and acted upon at the meetings". The remaining three felt that they were "partially heard and acted upon".

One of the most important lessons I have learnt from this project was the importance of maintaining neutrality to the letter and also paying attention to the way roles are distributed or shared. This means much more research into the suppliers background in terms of social standing in the community they serve, any personal/ or political influence. In this case, member M's boss had some very lofty views of the rest yet the

others have a certain "respect" for his firm which is a world wide established name in Chinese medicine dating back more than two hundred years. The effect of this neglect, i.e. not persuading the person to join earlier on, had slowed the progress. Without the insider knowledge, not only could I have committed a grave error of judgement by bringing two sworn enemies to work in a team. My strategy to know the members individually, had prevented this from happening. It appeared that members O and C were initially business partners until one day one of them decided to move out of the partnership. The matter ended up in court and they had since become sworn enemies! It is still a bumpy road along which CMAS is travelling. The journey is at least clearly mapped out. The CMAS was officially launched on 28.4.99 and has received support from many associations and government agencies including MCA and the Chinese Agency (appendix 20). It also made national and international news on the BBC One's Breakfast programme on 29.4.99.

What were learned?

If you lead the people with political force and restrict them with law and punishment, they can just avoid law violation, but will have not sense of honour and shame. If you lead them with morality and guide them with li (social values), they will develop a sense of honour and shame, and will do good of their own accord. **(Confucius)**

Managing the processes of the projects - a personal perspective

There is no denying that the two projects in this case study when measured against their aims and objectives, have been very successful and they will impact onto the status of Chinese medicine both internationally and nationally. Whilst this success is undeniable, the case study was conducted for the award of Doctorate in Professional Studies and the expectation is beyond the obvious success of the projects. I was conscious of a number of critical questions throughout the projects' developmental processes. Have I conducted them with the depth and breadth expected of an initiator, developer, implementor and manager of healthcare education? Were the projects adequately complex and were thus, rigorously conducted to increase or add a new dimension to existing understanding and knowledge in the management of the stakeholders and in the processes of managing people-based projects? Was there evidence that I was managing the projects with depth of knowledge of an interdisciplinary nature? Did the projects breach the conventional boundaries of a project and did they demonstrate versatility appropriate to the context? Were reflexive inquiry and practice present with active transfer of skills?

In the Accreditation of Prior and Work-based Learning (APWBL) module of this DProf programme, I established that I have for nearly twenty years been involved in initiating, developing, implementing and managing innovative health care education programmes in a variety of educational organisations as well in a variety of cultural settings. The innovations spiralled upwardly in complexity and magnitude thereby challenging and enhancing my professional capabilities.

It was also evident that a central theme in the case study is my intentional reflexive activity. For instance, in the CMAS project, the existence of social conflict has always been in the forefront. Conflict occurs even in the most cohesive social group. It is pervasive, inevitable and ubiquitous. The fact is the CMAS members are from different socio-cultural, politico-economic backgrounds and ethnic groups. Bringing them together created a microcosm of the larger organisational dynamics of their nationalities. They are independent and business entrepreneurs. I have already hinted how insider knowledge has helped me to avoid a potential personality clash between member C and O in addition to the potential group conflicts.

I was fortunate that no significant social or personal conflicts occurred during the embryonic stage and growing stage of the CMAS. The nearest possible one occurred during the exploratory September, 1998 meeting. I have already described the intense hesitation and caution that hovered in the room and how it gradually lifted towards the end. The members are now on first name term. Their eye contacts were more frequent and the discussion became increasingly animated and multi-channelled. I remembered that I did a lot of talking (perhaps nonsensical rubbish!). I was nervous. I was also encouraging the individuals by name to respond. It was a very strenuous meeting. The underlying concern was of course the unknown factor or rather I was anxious lest it should fail.

I also remembered that after each CMAS meeting I felt mentally tired because I was forever having to be vigilant. In a sense my antennae were out to detect any nuances which may possibly lead to conflicts. I was trying to make full use of the psychological and the intellectual resources of the members. I allowed discussions and arguments to take their natural course. If there were any risk of conflict or if the discussions appeared circular I would interject. Similarly, when the discussion became one to one I would intervene by pulling other members into it. This required me to make sequential use of various abilities and judgements such as sensing to establish facts, intuition to develop possible solutions, weighing out different options and their possible outcomes, and thinking about who will accept the solutions and why.

When the discussion became detailed and with individual agenda buried into the general discussion, I would honestly advise the person concerned that the discussion is too detailed and would be more appropriate as a subcommittee agenda. To illustrate the point, during the MCA MXL 249 circular discussion, member D was trumpeting about the Vietnamese herbs and herbal products and suggesting that MCA should recognise them. Member D was advised firmly to raise this issue as an agenda item in the future meetings. Another example, member C was discussing how members will be made to adhere to the CMAS code of conduct and what sanctions should be available. He was advised that the subject was very important but the details of which should be discussed when the code of conduct is discussed. In both cases, I also took the signals and cues from the others - their eye contacts, smiles etc., and intervened. I believe my chairmanship has been supportive and met the members' expectation as confirmed in their replies to the questionnaire. Here are a sample of their views: "the meetings are very open and constructive . . . I enjoyed . . . firm and impartial chairmanship. So far the best meeting among competitors . . . is both generous and impartial. Good chairman". This is about one of the two projects. Once the ECCM is operative, I would conduct a similar postal questionnaire to learn lessons from the two projects.

ECCM and CMAS are two teams

Although personality clashes can be a major source of conflict, I do not believe that it will be as intense as a conflict arising out of a diametrically opposed policy disagreement. The latter could cause permanent rift if it is not resolved in a "give and take" or "win win" for both parties. Nevertheless, personality clashes are always problematic. I highlighted in my accredited APWBL that my experiences in my first post as a senior tutor/manager of a school. Potentially, personality conflicts however small and infrequent can be disruptive and detrimental to the overall performance of the project. CMAS project was not about selecting members to achieve instant interpersonal compatibility, CMAS aimed to facilitate CM suppliers to form an association. This means the members need to confront the issues as and when they

come up. They also have to work harder at developing a cohesive team. Unlike ECCM, MU can select the partners it wishes to work with.

Unlike a project team, both ECCM and CMAS teams will be permanent so will be their members. As the chair to CMAS, it is incumbent upon me to guide the team to move through various stages of development: forming, storming, norming and performing to support them to become a cohesive and friendly team to function effectively and spontaneously. Already, there is evidence that this is happening.

The case study demonstrated that the projects were conducted in an informal environment. There were no power groups or individuals to undermine the collaborative relationship that was developed. There was however, ever present, the organisational political powers. For example, Chinese Agency was clearly cautious in their response to the ECCM proposal. They were weary of the power relationship this partnership may generate i.e. will MU dictate the terms and how to convey their caution? Is MU attempting to claim sole ownership? These questions were couched in their responses; "Of course, the Chinese Agency will consider the proposal and a reply will be forwarded to you from the Director . . . the Chinese Agency wishes to cooperate and we are already conducting much research in the areas you mentioned and we shall be happy to supply you with the information".

Although, these projects were initiated by the author, the final aims and objectives of the projects were agreed by everyone concerned. They illustrated very clearly that it is not possible to predict or impose the conditions or factors which will encourage the members' full participation. Rather, the participation process had to be allowed to develop itself in response to the members' feelings at the time. There were nevertheless clear steps that were taken and prepared such as creating the environment to promote participation, directing the activities and the discussions. This was noted by one CMAS member who wrote 'thank you for your leadership and help to organise this for us. This further confirmed a belief and practice I always adhere to, that is a project manager does not only need to be very clearly focused with the basic tenets of the

projects but having an understanding of the context, in particular cultural, socio-political issues are very important.

When the project group processes were analysed and reflected upon, it revealed that the partners were able to work as a cohesive team, collaboratively and individually in parallel. In either situation, a great deal depended on the project initiator's ability to create energetic and resourceful teams and to encourage them to work together for their common objective. It also illustrated that having the overall responsibility for the projects was a very important prerequisite to enable the projects to develop successfully from inception to completion. This usually enhances the group commitment, ownership and clarity, and avoids confusion and group factions. My principle to maintain an open communication channel and be neutral in my treatment of the partners paid dividends. I was able to minimise any possibility of factions forming within the project teams. Team concept and team work is prevalent in all areas of human activity as Ryan argued (1989). He described the teamwork in the stock exchange as "sophisticated management process". In both project teams, especially the CMAS team I created and developed in Simon and Farrell's (1979) words: " a group in which the individuals have a common aim and in which the jobs and skills of each member fit in with those of others, as . . . to take a very mechanical and static analogy - jigsaw puzzle pieces fit together without distortion and together produce some overall pattern." So far, the ECCM partners has yet to meet as a group. Despite, the absence of this opportunity, these partners were able to mentally picture the activities and how each partner may or may not play a part because I was able to describe the overall scene.

In the final analysis, the partners in both projects were self-selecting and their selection was also dependent on external factors like what the partners' organisations can contribute to the project which was seeking synergies between its members. There was clear evidence throughout the case study that I was able to transfer skills and knowledge to enable team development and collaborative partnership. The partners with encouragement and facilitation did:

- develop and agree common aims and clear objectives. One member explained that "it is essential that TCM suppliers have a professional organisation to represent them and that the quality of the product is of highest standard" Twelve of the CMAS members "fully agreed" with their association's stated aims and objectives. Ten were clear that their priority is to aim for self-regulation followed by authentication (9) and registration of products as medicine (7).
- conduct themselves with professionalism as well as develop a code of conduct for themselves;
- think about long term strategy. One member suggested that "CMAS should focus on implementing the codes of ethics and practice, attract new members and work closely with MCA and other organisations to achieve a new regulatory status for herbs";
- work as an egalitarian team. This member explained that " . . . *in meetings* views are heard. In a discussion process there are agreements and compromises." Another felt that "the meetings are very open and constructive";
- understand their roles and responsibilities and work together including teleconferencing among CMAS members. One member felt that "it (CMAS) is a new organisation and I believe everyone involved needs to make extra effort *to help run CMAS*". Another indicated that "if there is a campaign for our survival then 20 hours per week *if necessary*";
- share same values and conduct themselves with frankness and autonomy and had special skills, knowledge and experiences to offer to the team and to each other. This CMAS member commented that "we at . . . thank . . . for all the work and organising he has done so far. It is not easy setting up such a disparate group of people. I feel this time we may succeed in our aims and objectives." Another member commented that "I do not think we are ready and have the strength to move CMAS to a permanent base."

The projects have empowered both the individuals and their organisations. For over a decade, for example, different groups and individuals had attempted to create an association of the Chinese medicine suppliers with little success. It would appear that previous attempts were seen by most of them as either "big brothers" wanting to control them or they were questioning the motives of the individual(s) who called for the formation of the association since they themselves were suppliers in the final analysis. I believe I have met their "acceptable" criteria because the Chinese partners in particular did search about my credentials and vet me: I have no business in CM, but I am known to most of them for the development of the CM degree programme with China. As the director from firm M whom I met for the first time explained, "Of course I know of you. I have seen and heard of you in news broadcast. I have read about you in the newspapers. I am pleased to have made your acquaintance at long last. . . I would like to support your project but I needed to be sure that it will benefit my organisation and that there is opportunity for us to influence change among the importers and suppliers". Like this director, many others doubted that I do not speak Mandarin, that I was genuinely interested in my search for quality Chinese medicine, that I am not in the pocket of some suppliers. It was most unfortunate that the first invitation included an acknowledgement of F's generosity and sparked a diplomatic fiasco and a wave of suspicion in terms of team building exercise. Again, this highlighted the importance of cultural dimensions in team building and in any partnership development. Many Chinese partners did not attend the first meeting as a result. The personal telephone calls paid dividends because not only the conversations were impersonal (faceless), this method allowed individuals to be frank and to ask questions which may be embarrassing in a group situation, e.g. "I am sure F is big enough for your association!" Telephone should therefore, be used as another "face saving" device for both parties and allow a "win win" opportunity to enable them to join the group as happened for some CMAS members.

It was evident that the partners recognised the purpose of the collaboration. One CMAS member remarked " it is good to see competitors working together for the greater good!" My meeting with member M had been unusual. At the very beginning,

the conversation was restrained but friendly. I noted a total change in behaviours and attitudes on my return from the washroom and the rest of the meeting remained very warm and frank. Apparently, whilst I retired to the washroom, the director sought confirmation from my wife who accompanied me to that meeting, that I really do not speak Mandarin but she was helping me with interpretation. Thereafter, the conversation and discussion were genuinely warm and revealing and helped me to understand his reluctance in attending the meetings.

There were significant personal and environmental factors which can be identified as positively supporting the team building in both projects such as; the individual's readiness, understanding, willingness to acknowledge other's strengths, openness and acceptance in a supportive and nurturing environment. The analysis also reveals that, collaboration is a complex and sophisticated process involving total commitment from all those involved in the project to nurture the collaborative spirit. The initiator/project manager needs to be clear how his or her own personal values will influence the team and having a knowledge and understanding of the cultural sensitivity about the "face saving", "network or 'quanxi' in Chinese" are just as important. One notable point to conclude is CMAS is building itself a problem-solving team.

When will an eclectic model be appropriate?

Much has already been said about the eclectic model. The discussion will therefore, focus on the quality of the outcomes. These projects were experimental. They were very novel and did not have established rules and procedures. Instead, with the partners, I experimented. We did not have a control group in the way positivists would approach the experiment because these projects cannot be broken into dependent and independent variables. I have made it clear to the prospective partners what are the issues or the problems and offered them a picture that was yet to be actualised. I imagined a possible end goal, iterated, evaluated and adapted the issues. I took on the partners' suggestions to reflect upon and made further modification or validation.

These issues also had an organisational implication as both ECCM and CMAS will eventually become very complex organisations which will require a philosophical direction, mission, aims and objectives and appropriate organisational procedures to underpin their activities. Another element of the project is professionalism. When the projects are fully operationalised the final activities will involve people in the clinical researches, clinical trials or with the public and stakeholders. The conduct of the partner will be under intense public scrutiny. An element of appropriate professional conduct will be called upon to ensure trust and confidence.

The construction of the eclectic model was like a single lens reflex camera with zoom lens facilities. Effectively, the model offered a three-dimensional image of the process under observation. It is capable of providing the macro-snap shots which are then studied and essential information is then selectively analysed. During the projects, the model was able to sift and search important qualitative data in the complex processes of the projects. It helped to enhance the overall capacity to examine the processes of interfacing different cultures, beliefs, values and practices that existed among partners from diverse and international backgrounds. In addition, they brought with them different and complex organisational dimensions. By integrating effectively various models it increases their capacity to capture various perspectives of the "owners", managers and other stakeholders, and to enable the partners to develop an appropriate strategy to manage the social conflicts which will inevitably arise, the barriers and drivers of effective team performance. This approach improved the chances that my statements and supporting evidence are appropriate to the context. I was continually taking stock and seeking to improve my own reflexive and consultative performance to achieve collaboration. I was also demonstrating that practitioners are capable of conducting systematic "researches" grounded in their workplace.

The major benefit of the eclectic model was the opportunity of working with partners in a way that is non-hierarchical and non-exploitative. The model offered an organised, systematic and deliberate approach to ensure the focus was on the projects which were about people explaining themselves why they act, behave or do, and enabling them to

share their knowledge with each other. It provided the checks and balances for monitoring the progress of the projects. Continuous adaptations were possible as issues appeared and they were then evaluated against the expected objectives. Reflecting on the comments and the expectations generated, the action research-based projects also revealed more than the micro-politics of vested interest, self-interest and ideological interest described by Ball (1987). These were obvious and expected but they did not hamper the developmental progress of the projects because they were acknowledged and dealt with sensitively. The model was formative as well as democratic and supportive and unobtrusively involved the partners as "researchers" to find solutions together to the issues.

Seeing the process from the viewpoint of an action research-based model, I was able to maintain an iterative approach as the project progressed. The partners generated their own "action research" first to accept me as a neutral person and finally to participate in the projects. Having cleared the way, the partners in both projects participated together to resolve differences and issues as I have described earlier, and the Horticultural Centre was a good example of this shared responsibility to achieve understanding. The case study clearly underlines the need for senior managers to be committed to the espoused strategy and accept and offer the necessary support.

I followed Buber's (1947) guidance of being humble and approached the projects with a sense of tension because I could not know and needed to evaluate and to find out. I developed my confidence as the projects advanced along.

I have conducted both projects based on the action research model and supplemented it with the distinctive and facilitative features of other models as described above in fig 6 to enhance the success rate in gaining the partnership agreements. In this way, I was able to use the information gained during the discussions or from observations, to reflect, adapt and improve the proposals thereafter. I added the ethnographic role to enhance the data gathering process whenever there were opportunities such as during pre-, peri- and post- discussion periods. Discussions and correspondence during the

different phases of the projects and also during casual conversations, were always viewed as a new learning situation for me. Each meeting increased my understanding of, and belief in, the projects as I gained a clearer view of the total picture of the whole projects.

On a personal note, the model afforded me the opportunity to experientially manage the projects in complex, uncertain, fluid and unique ways than anything I had come across. However, the processes in these indeterminate contexts and cultures could not be conducted by recourse to specialist knowledge and skills of a project manager alone or even those of a good negotiator. I believe that in developing and managing these projects and the manner I reflect-in-action throughout the projects I have become what Schon described "a researcher in practice context. He is not dependent on the categories of established theory and technique, but constructs a new theory of the unique case. His inquiry is not limited to a deliberation about means which depend on a prior agreement about ends. He does not keep means and ends separate, but defines them interactively as he frames a problematic situation. He does not separate thinking from doing, rationing his way to a decision which he must later convert to action. Because his experiments are a kind of action, implementation is built into his inquiry. Thus reflection-in-action can proceed, even in situations of uncertainty or uniqueness, because it is not bound by the dichotomies of Technical Rationality" (Schon 1983).
Is insider knowledge a help or a hindrance? I discussed at length in the accredited APWBL project, my experiences of working as a Chinese expatriate in Hong Kong. I had definitely and personally benefitted from this. I was of course very hurt to learn that I was not accepted by my own kind instead I was considered an outcast into the society in which I was born. Yet these same people had no compunction to parade me in front of their "colonial masters". When I was among them, I was an outsider. It would be wrong to suggest that they practised exclusivity, even though their actions may appear to be so to someone who is not culturally tuned in. I believe the Hong Kong experience was an exception and special because of the political context, they were in. It could be said that they were subjugated and their abilities had not been rewarded and recognised. Instead, until some years before Hong Kong was to be

handed over to China, all middle and senior ranking posts were filled by the British expatriates, their colonial masters, whose abilities they questioned in silence. In the accredited APWBL project, the Hong Kong nursing teachers I was working with also had a political agenda. They were unwilling to acknowledge that the clinical practitioners were capable and in many ways, more competent in managing and delivering care to patients. To acknowledge my proposal to introduce continuous assessment for the students' practical skills in the clinical areas would have meant accepting the practitioners as having a complementary and equally important role in the education and training of future nurses. Such information would have been inaccessible to a non-Chinese. The fact that the friends I have developed, also knew that my wife is also Chinese from Hong Kong, gave them the confidence to discuss the underlying reasons for their senior colleagues' apparent obstinate refusal to accept continuous assessment strategy for the student nurses.

I explained how, peeling away the top cultural layer of the Hong Kong society, the "truth" stared straight into my eyes. Whyte (1955) also emphasized the need to understand the cultures and subcultures of the people being researched by submerging into their circle. I also discussed the cultural dichotomies being a foreigner in one's own culture simply because I have lived abroad and returned to work with them as an "expatriate".

Almost more than fifteen years after my Hong Kong experience, I had prepared myself to expect a "rough" cultural encounter in China. I would liken my experience with the Chinese in the projects to a coin standing and turning on its rim. There was still the automatic assumption that "I looked down on them and not being sincere". This explained why they were not receptive at first to my suggestions when they had to do with Chinese medicine. Then, there was the constant need to "save face" which is very important in any encounter. The guest is always observed even during the social hours! These make up the rim of the coin. The experience with the Chinese Agency and other universities except University A had been very positive and I was able to concentrate for most of the time in the projects. They represent the head of the coin. The meetings

with University A represent the tail of the same coin and they will add to my repository of learned experiences. It was a revolving experience. The insider knowledge had therefore enabled me to:

- appreciate the partners' behaviours and expectations
- acknowledge any possible difficulties or issues which concerned them
- decide when to impose a time table
- have a better appreciation of the political realities in the partners' organisations
- enhance my "knowledge-in-action and reflection- in- action" (Schon 1983)

I am quite positive that insider knowledge helped me to know what to look and how to interpret objectively and contextually what I found.

Of course, there are disadvantages. They are more difficult to disentangle since they are very much webbed into the cultural and political dimension. It is however, noteworthy to reflect on the advice offered by CMAS member W (p76, 115) and also the Hong Kong experience highlighting the cultural conflicts between the local and ex-patriate Chinese. It was and still is assumed that if you are not "native" you automatically look down on them. It would appear that in a crosscultural collaboration it is easier and more acceptable to point finger to own race if there were one (and if the person is also a member of the minority groups and this happens in other races when it is convenient) in the partner's camp to avoid remonstration. Experiences confirmed that when the collaborators have a third party which can satisfy their personal needs or when the link person, for whatever reasons, could not comply, the former were more "trigger happy" with unsubstantiated and variable charges or complaints against the link person. They seem well informed of the link person's organisation's impotence to query the allegations for the sake of the "collaboration".

Both projects will impact upon the ethics of everyday practice in Chinese medicine.

Considerations have been given to this issue and will be developed side by side with the projects. The work of the ECCM can potentially trigger a serious ethical dilemma because of the clinical trials it will approve and conduct. The outcomes of the clinical trials could have commercial implications. It is therefore important to consider setting up an ethical clinical research and clinical trial committee. The members should be broad and embracing to ensure authority and general acceptance across the spectrum of medicine. I have reassured the Chinese partners that formulary will not be required at the initial stage and it will only be released after MU has obtained an agreement from the funding organisations that the patent rights rest with the original owner(s) of the treatment. Any commercial exploitation from the work should be negotiated and agreed with proper and adequate legal representation from both sides with MU as the middleman. Intellectual property is another issue which should be ironed out before the partners sign any partnership agreement. In normal practice, if the work is conducted collaboratively by ECCM partners, the work will be owned by the partners. Extra contribution by a specific partner that extra part is owned by the specific partner concerned.

Before CMAS's existence, most of the suppliers have been practising "ethically". With CMAS in place, all the suppliers are in a sense put on notice that ethical considerations will focus more on their practices, advertisements and support systems to the purchasers. There is also another level of moral duty not only in maintaining biodiversity which is included in CMAS's aims and objectives, also respecting the wishes of the majority in the West which does not favour the use of animals in medicine. Whether, it is the duty/ role of CMAS to change the practices in China particularly in the sustenance of various herbs, the use of chemicals and possibly genetically modified herbs as China faces with growing demand for CM world wide. This is a dilemma CMAS members need to debate very extensively and rationally.

As an initiator and promoter of the projects, I had to be specially sensitive to the diverse socio-political issues in attempting to bring in partners. There were also professional issues which on reflection, I could have easily breached particularly during

my meetings with the Chinese partners. I was aware of my own feelings towards the Chinese and I was careful to ensure my behaviour and conduct were within the bound of the professional etiquette. The fact that the eclectic model had encouraged regular and more frequent reflections had also helped me to recognise my own weaknesses. Participating as the Chair for CMAS and an advocate in another project, I was assuming several roles; a participant observer but had to maintain a high degree of neutrality simultaneously and a facilitator role.

I have demonstrated within the case study that I have constantly reminded myself of the possible ethical implications. There were opportunities to possible abuse of the information I have gained from the partners hence I emphasized the need to conduct oneself professionally. Similarly, the opposite is also possible. CMAS member W during a pre-meeting "chat" at the former's request explained that "It is not that we do not want to join your association. We also know that what you are doing is good. We want you to be in the front . . . because if anything happens, the focus will be on you. You know that if anything is going to happen to the Chinese herbs such as being banned, many Chinese suppliers will blame you . . . you started this association and you have stirred it up!" "How about the forthcoming regulations and EU laws which will really hit the Chinese herbs and besides, CMAS will provide a base to ensure these regulations and laws are fair?" I asked . . . " who will advise them? That conversation had shaken my confidence and I do believe that what was said was a real possibility. Despite, the "full" membership, I am afraid that many of these Chinese members still rely on the views of those who are seen as being "better with their English" among themselves.

The projects are still progressing but it is envisioned that CMAS will eventually develop into a self-regulating body to manage and police the quality of the Chinese herbs and the herbal products. It will wield adequate political muscle to influence policy making at the ministerial level if it can continue to develop and strengthen its ties with the Chinese Agency and MCA. Middlesex University will be able to benefit most in the areas of Chinese medicine education and research. Its enhanced reputation will

help to promote the concept of being the European Hub for the Chinese medicine academic programmes or ECMAH. Middlesex University will also gain expertise in the field of pharmacognosy as its Phytochemistry Natural Product Research Unit will be engaged to conduct analysis of herbal products for CMAS.

The case study clearly establishes that the processes to help to promote collaboration are only effective when the aims and objectives are clear and relate to the participants' particular needs or concern. It also demonstrates that it is possible to shift entrenched attitudes through cooperation in a supportive climate.

The case study clearly demonstrated what could be achieved without any additional funds or support to develop the projects. However, there are down sides to this approach such as relying solely on the projects being done out of good will. This tends to reduce ownership of the project. These projects were obviously subject to political influences both at local, national and international levels.. If the partners lack clear and firm commitment, particularly, the Chinese, to the projects, this would be a serious blow to empowerment and ownership. These problems have yet to materialise. This can be triggered by the present campaign by the Chinese Government to reduce by 50%, the civil service workforce. They anticipate that at least half of the country's doctors will be employed when the Ministry of Health begins to introduce insurance type care later this year. This means that many of its citizens who do not have an insurance policy will receive very limited or no medical treatment.

The projects benefitted from the excellent relationship nurtured among the stake holders. For example, the partners in CMAS were able to own their 'Association' and felt empowered. There was willingness to work in their spare time. The case study reveals that over the life time of the projects, roles and relationships have changed. In the CMAS project, as the members gained confidence and were able to trust each other, they became more involved and became insiders so to speak. They played more responsible roles. As the lead person, my duties have become lighter as others offered to assist. A good example was the proposals to set up various subcommittees to

examine the issues on alternative licensing, quality, membership, public relations and code of conduct. I am becoming more of an outsider as the members took on the initiatives. I am able to report that there is a sense of excitement, vitality and enthusiasm among the partners who appeared to be nourished and sustained by the tasks they played. These were confirmed by the partners themselves in their response to the postal questionnaire survey (appendix 21) which contains the raw outcome data and comments from the postal questionnaire. I have decided not to present them in the main text as it is a very small sample (13 out of 14). They nevertheless reveal their inner feelings. I shall however, use these data as a comparative study with the ECCM members later as I intend to conduct a similar postal questionnaire survey.

Another important lesson learned was that the process of defining the issue and framing the questions or solutions needed to be collective or at least the members being facilitated to work collaboratively. The case study also illustrated that the experiences as discussed and analysed can be generalised only in so far as they are contextually applied. Other important issues to take into consideration are the social and political values of the societies to which the application is being made. Because the experience is personal and specific to the situation and to the group and types of people involved, it will be difficult to replicate the outcomes. Nevertheless, the underlying principles and processes can be generalised to a certain degree.

What is the next step or the future?

In my introduction I discussed the major and complex challenge facing Chinese medicine outside China. It was and still is my believe that CM continues to require careful nurturing to achieve both the status of medicine and to be evidence-based medicine. It must also subject itself to appropriate clinical trial procedures and protocols. The case study confirmed the general view that 1997 was the watershed for Chinese medicine both inside and outside China when the world's first BSc(Hons) TCM was developed at the MU. I have shown that the initiation and germination of the vision to be a "hub" for CM education, research and training are almost completed. This vision is based on a series of sub-strategic projects as described under "the case

study" (p38) I have given a rich account of managing the developmental processes of ECCM and CMAS from socio-political, cultural and economic perspectives. Who would have foreseen such a dramatic surge in just over a decade, for natural therapies by a society which is best known for its conservatism? In a time of major environmental and social changes even the degree programm is not safe. I have throughout the case study used the analogy of a boat without a sail to the degree programme to emphasize that the development was an important beginning, but, how far, steady or fast and safe can it be as an ocean going vessel? The study also identified and conceptualised the forces of innovation and creativity and clearly demonstrated that innovative education must be based on a managed transnational and cultural dimension instead of the conventional approach to curriculum development processes. This means identifying the core educational principles which acknowledge that the expertise is dispersed, interdependent, specialised and culture specific and that these need to be developed jointly and shared transnationally. Transnational education means learning from programmes free from national and cultural barriers but enhancing the national values and expectations and empowerment of those accessing the programmes.

I would like to conclude this case study by sowing a seed for a new beginning or the next evolution in the CM development outside China. We had the BSc(Hons) TCM programme. What can we build from it? Let us sail the boat to the other side of the horizon. Figure 10 below, is the seed and is called "Beyond the vision" in the shape of a complex cogged-wheel orbit. It encapsulates what I believe will be the first step to achieve HRH Prince Charles's (1997) future - OM, alternative medicines [AM]) and CM collaborating together to create a "more patient centred health care".

Although it was evident from the case study that all but one of the sub-strategic projects are now developed and are in operation. However, their effects are still intangible. It would appear that the ECCM's first funding will come from Animal Sanctuary for the research project on finding herb substitutes to replace the use of animals in CM. This will immediate trigger a multi-and interdependent activities.

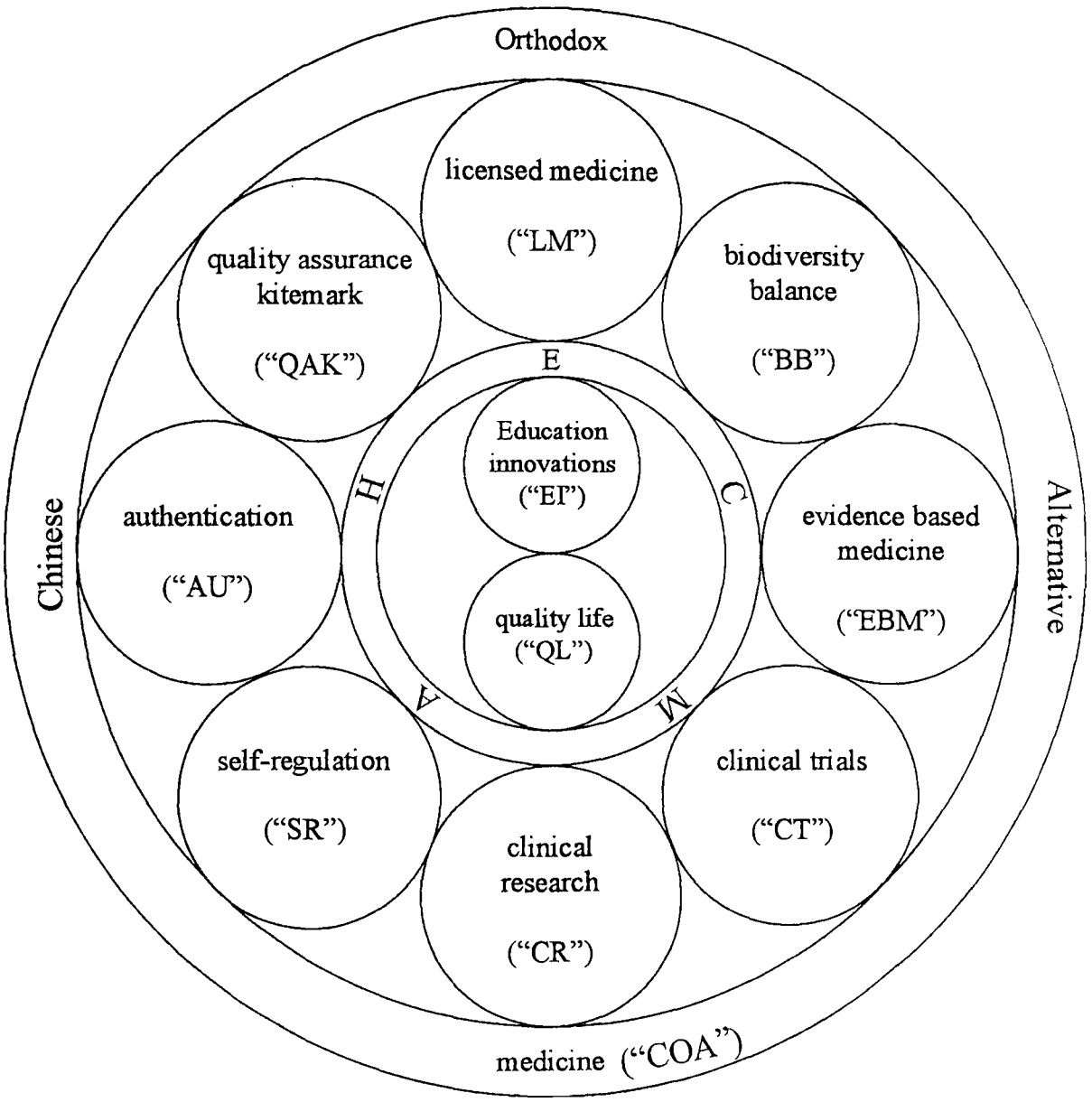


Fig. 10: Beyond the vision

The orbit consists of 12 cogged-wheels of activities as shown in figure 10 and conventionally and ultimately, their movements ought to be interconnected and they will eventually. However, this orbit will in a sense be assembled wheel by wheel within a predetermined frame. Initially, they will revolve independently by raising themselves separately and occasionally several wheels will simultaneously raise on their own axis. Ultimately, they will be interconnected for a synchronised movements/ activities. They are also capable of self regulating. The outer and largest wheel is the CM, OM and AM ("COA") wheel. This wheel will remain dormant for sometime until such time CM, OM and AM are accepted as complementing each other. Between the ECMAH and the "COA" wheels lie eight smaller wheels. At the centre of this complex cogged-orbit lies two smallest and core wheels, Educational innovations ("EI") and Quality of life ("QL") which will eventually drive ECMAH wheel and the rest. In the short term, this is not possible because of the existing socio-cultural, politico-economic and professional attitudes, OM dominates and dictates our health needs and the quality of our life and the public is led to believe that this is done in their best interest. In the education, it is still very much institutionally driven although there is evidence of limited innovations. Thus, in the short term, ECMAH wheel will instead stimulate "EI" and "QL" wheels to revolve.

The case study established that all but one of the sub-strategies are implemented. Nevertheless, the functional MUCMEC, MUCMLF and CMAS are at their very early stage to bring in any noticeable effect. However, the impacts will ultimately be like a chain reaction or the domino effect causing the wheel to be more in full synchronised motion. When the Animal Sanctuary agrees to fund the research project to find herb substitutes, this will push the "clinical research" activities ("CR") wheel upwards and begin to move on itself until such time "self-regulation" ("SR") is achieved by CMAS sending the "SR" wheel upwards to link up with the rotating "CR" wheel. To achieve "self-regulation" status, it will have to demonstrate it has several core activities in place such as the authentication process and procedure, the quality assurance system including CMAS's approved kite-mark. This means both "AU" and "QAK" wheels (activities) will follow suit and rise on their own axis and move. They will be linked

to "SR" which is already to "CR". By such time, the Sanctuary funded research outcomes will be known and "clinical trials" will be conducted on human beings to evaluate the effects of these identified herb substitutes, thus, raising the "CT" wheel to connect to "CR" wheel. By now, five wheels are moving interconnectedly, that is "CR", "SR", "AU", "QAK" and "CT". When, the clinical trials outcomes are positively evaluated, approval will be sought from MC to license them as medicine thus raising the licensed medicine ("LM") wheel and connect to "QAK". With CM confirmed as medicine, based on the outcomes of the clinical trials and the clinical research, CM will move to the evidence-based medicine ("EBM") phase. The "EBM" will be boosted further by the graduates from the BSC(Hons) TCM programme which promotes "EBM". "EBM" wheel is therefore raised up and connected to "CT" wheel. When these developments have been achieved the final attention will focus on the concept of "Biodiversity balance". Although, China and other herb producing countries have already signed to this international accord to protect and promote better safeguard for endangered species (animals and plants), this is yet to be effectively managed. With CM in the international arena as a medicine, "Biodiversity balance" will become a priority thus raising the "Biodiversity balance" ("BB") wheel and connect to both "LM" and "EBM" wheel forming a ring of eight interconnected wheels in synchronised movements.

Coming back to the "ECMAH" concept, if MU decides to accept the challenge of the vision, it will be a "de facto" academic "hub" in Europe and causing much activities within and confirming that "ECMAH" is moving and will connect to the above eight interconnected and moving wheels. The effects of EBM and other activities will not only trigger but force innovations into CM education causing "Education innovations" ("EI") to respond to the increasing demands. The quality assured CM can now offer evidence to show that CM can improve the quality of life especially for patients with chronic conditions thus activating the "Quality life" ("QL") cog at the same time.

The vision is for the whole wheel to be in active motion. As I have explained earlier, there exist certain strong negative attitudes towards CM and Alternative medicines. I

believe that when the chronically-ill persons begin to enjoy an improved quality of life as a result of using CM and other available Alternative medicines the public attitudes, economic factors and innovative and creative education developments in CM will begin to raise the "CAO" cog to connect with rest of moving wheels. The "EI" and "QL" wheels will now become the primary force to drive the rest of the wheels.

This seed I am sowing will germinate with strong roots and become a very sturdy and powerful tree of knowledge if it is nourished with ideas, support and patience. The seed itself will germinate in the absence of ideas and support however, its eventual development is likely to be weak and the strongest part is likely to "snatched" and grafted onto something else, thus creating different and disjointed developments. The "Hub" concept requires the same degree of unwavering commitment and trust to develop itself lest the organisation "assigns" this role to a third party. Educational innovations will include transnational education and research exchange schemes, post-graduate and post-doctoral fellowship schemes, continuing professional development programmes, integrated programmes to educate both OM, AM and CM students to learn and work together with interchangeable skills to meet the increasing public demand for better quality of life.

As we approach 21st century, across the world, nationals are now migrating and intermingling more regularly to become new constituents. We are faced with the greatest dual challenges; to build a sustainable future and to improve international collaboration. Educators have a duty to build the international platform on which both will develop complementing each other. This platform is to be truly holistic and portable transnational curricula inclusive of the rich cultural, socio-economic and political experiences these different nationals bring with them. The aims will include facilitating these new constituents to achieve a smooth transnational transition and to preserve their identity.

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Appendix 1

A love-hate relationship among the associations

Your Ref:
Our Ref: KLH/AM/95032.007

05 June 1996

For the Attention of the Registrar

:ture and
ıe

Dear Sirs

Practitioners Association, which provides training courses which lead to the qualification and graduation in Traditional Chinese Medicines (including acupuncture). Our Client is extremely proud of its growing reputation and goodwill in this field.

It has come to our Client's attention that the Prospectus issued by your College contains inaccurate and potentially misleading information and, as a result, our Client considers it will suffer considerable financial loss and damage (which is, as yet, unquantifiable). Our Client is surprised at the comments made on page 19 of the Prospectus in relation to the British Acupuncture Council ("the BAcC") and the British Acupuncture Accreditation Board ("the BAAB"). The following statements are of particular concern:

1. The British Acupuncture Council is a unified body (formerly the Council For Acupuncture (CFA) made up of five previously separate acupuncture registers. The Council is concerned with the regulation of the acupuncturé profession and with educational standards in acupuncture training. The BAcC has been instrumental in establishing the British Acupuncture Accreditation Board.

2. The British Acupuncture Accreditation Board (BAAB) is an independent review body set up by the profession to set and monitor standards in acupuncture training. The Board comprises members of the British Acupuncture Council, representatives from schools of acupuncture, representatives from higher education including medical education and representation of the public interest.

moderate and strong force to study the superficial, medium and deep pulse. These pulses appear in complex and varying configurations. To master these complexities requires several years intensive training followed by practical experience. Professionally trained TCM practitioners relate pulse readings to their scientific anatomical knowledge, analysing the condition and activity of the four chambers of the heart, the muscles, the valves, the blood vessels, the nerves, the elasticity of arteries etc.

Other detailed methods of examination are inspection of the tongue, facial and skin coloration, inspection of facial expression, behaviour, body surface, excreta and secretions. Examination is also carried out using interrogation, olfaction, auscultation and palpation, considering internal and external factors affecting the patient, including physical and mental states. All information gathered from different examinations needs to be assimilated to arrive at diagnosis.

TCM diagnosis and treatment methods have developed simultaneously over thousands of years of practice. Diagnosis reveals imbalance in the body, which is then corrected by a specific formula of acupuncture points and herbal medicine. It is important to realise that treatment is not determined by symptoms. This means that the same symptoms presenting in a number of patients will have different causes and will therefore require different formulae for treatment. Using a set formula to treat particular symptoms will often be incorrect, even harmful and without adequate diagnostic skills damage caused may not be detected.

Therefore, from our professional judgement and deep knowledge of the subject area, claims of the majority of commercials schools in the UK to have lecturers qualified and graduated from China are misleading and against professional, educational ethics. Furthermore they threaten to spoil the students' professional training career.

THE BRITISH ACUPUNCTURE COUNCIL AND THE BRITISH ACUPUNCTURE ACCREDITATION BOARD

The British Acupuncture Council (in affiliation with the British Acupuncture Accreditation Board) issued press releases informing the public that they govern the acupuncture profession. Our frequent correspondence with the Department of Health confirms the following:

The enclosed letter from Mrs Angela Walker, Branch HEF2, Department of Health, dated 17th April 1996 to the solicitors of The Institute For Complementary Medicine (ICM) states:

I would like to make it clear that the Department did not appoint the British Acupuncture Council, nor does the Council have any statutory powers to support its claim to govern the acupuncture profession. We give this organisation no special recognition - it is not, in any case, our policy to show preferment to any one organisation working in a particular field of complementary medicine over and above organisations in the same field.

Appendix 2

Article about changing mindset

Appendix 3

Final Annual Report for

School of Multi-Professional Health Care

MIDDLESEX UNIVERSITY

The School of Multi-Professional Healthcare

The final report

(1996-1997)

Henry Lee
September 1997

CONTENTS

The School of Multi-Professional Healthcare

The final report

1 Introduction

1.1 Changes in Higher Education continue to occur at bewildering speed. We are all faced with new situations and new demands upon us that challenge our traditional assumptions. Today many HE institutions find themselves competing fiercely for limited and decreasing resources. Yet at the same time we are under increasing pressure from stakeholders to provide quality and fit for purpose programmes.

1.2 New challenges necessitate new thinking. And, in the education sector at large, there is clearly a move towards a new model for academic success. This model is based upon broader, "sell by date" strategic programmes and a more inclusive view of the purpose for which HE establishments exist. For the School of Multi-Professional Healthcare this exciting idea is not new at all. In last year's report, we described the "revolutionary developmental strategy" being undertaken to establish the School. Unfortunately, another wave of change has just swept us removing faculties and schools in its wake.

1.3 With the passing of the School this is also the School's last report. Nonetheless, I am pleased to present this final report (1996/1997) for the School of Multi-Professional Healthcare. The School had another challenging but very successful year. The School staff have achieved planned objectives and firmly established the School's position as a leader for interprofessional healthcare learning and working. Their effort has been further recognised because the School has secured a 98% increase in funding for its programmes. This is a major achievement for a School that was just over two years old. This is a huge tribute to the commitment of its staff and their ability to spot the needs of the day and the future, rebalancing our activities in response to current and anticipated demands in the healthcare sector and in the complementary medicine/therapy sector. As expected, the demands for traditional studies and healthcare programmes have begun to fall, instead the growth is in the new generations of programmes that are work based and interprofessional. I would like to take this opportunity to thank many colleagues and particularly the deputy head, Madeline Brett-Richards, for their belief in, and support for, the School's vision and planned development.

1.4 In this final report as Head of School, I have many people to thank for their contribution to transferring the School since its creation just over 2 years ago. I particularly want to express my indebtedness to Carole Lamb. She has very skilfully combined the roles of PA and School secretary to run a very efficient and demanding School. Carole has very ably integrated the School Resource Room as the hub of the School activities. The School Resource Room was developed almost simultaneously with the School. The Room houses all the information the School received and is catalogued for easy access and reference. Its development represented the University's open and equitable policy. It is well used by most School staff who share similar values. Carole was instrumental in ensuring the information was updated and easily accessible. Sadly, Carole is leaving us and she will be sorely missed. The School's targets could not have been achieved "smoothly" without the support of the Dean of the Faculty, Stephen Li.

2 School's Vision, Mission and Objectives

2.1 Vision

To be an international leader in interprofessional healthcare education and training, including orthodox and complementary medicine/therapies.

2.2 Mission

To provide the highest quality practice based education programmes possible to enable practitioners from all fields of healthcare to achieve their levels of academic and professional studies through open access and flexible programmes.

2.3 Objectives

- To develop and nurture an interprofessional culture in health and welfare services whilst providing the highest quality interprofessional education and training programmes. These should recognise, respect and enhance professional differences but also encourage the lowering of professional barriers to improve the delivery of healthcare. The culture focuses on working across the professions.

- To deliver intellectually challenging programmes and research based study programmes to develop the professional practitioners confidence and competence to face the challenges of a rapidly changing world.

- To collaborate in joint programmes and research projects with health professionals locally, nationally and internationally.

2.4 The School's Statement of Values

The statement of values is the School's working framework to facilitate its development and growth. It reflects the University's own set of values and covers the importance of the students, staff and the School.

2.5 The School will:-

- promote lifelong learning among its students;
- use resources responsibly without blunting risk taking and creativity;
- strive for flexible accessibility to its education programmes;
- strive to extend the scientific frontier;
- promote a climate conducive to the students, colleagues and clients sharing and discussing their values openly;
- respect and value the contribution of different health professionals and non-professionals;
- collaborate with other schools and faculties in order to maximise strengths and expertise and to complement these as appropriate;
- operate in a cost-effective manner.

2.6 The students will:-

- respect the dignity of peers and school staff;
- be responsible for their own learning;
- have the choice and be encouraged to propose learning opportunities appropriate to their needs
- learn in a supportive adult environment;
- respect and welcome diversity among peers and school staff;

- respect the professional standards to which they and their colleagues owe allegiance.

2.7 The staff will:-

- take personal responsibility and accountability for their actions;
- recognise and value individual colleagues' strengths;
- respect and value the dignity and cultural differences of students, clients and peers;
- be aware of the consequences for others of their actions;
- ensure that their own skills, knowledge and experience are continually developed.

2.8 The School's INTER-PROFESSIONAL HEALTHCARE Model

The Inter-Professional Healthcare Model aims to coordinate the specialist skills and practices of different professional colleagues in order to provide effective and sensitive client care. At the same time it accepts that access to a range of professional professional skills and approaches enhances the client's experience of the services received. The model views the client as the catalyst which initiates the inter actions within the multi-professional team and he or she is central to all interventions that take place. The model;

- believes providing care is at the minimum a two person transaction.
- believes the recipient/client requires an input from more than one profession.
- believes that all caring professionals share similar humanistic attributes such as compassion, support, concern, and empathy.
- will preserve the unique relationship between client and professional.
- will enhance the client's understanding of professional services available to them.
- will focus on the real needs of the client, and their carers.
- believes all professionals share the ethos that effective and efficient services are the cornerstone to health gain.
- believes that appropriate interventions will produce identifiable benefits for the clients' well being.

3 The School review and major events

3.1 The School's academic portfolio and its activities reflected the increasing confidence of the School staff in the HE culture and environment. They showed the capability to meet the new challenges positively and successfully, displaying their understanding of the School's vision and willingness to feliver it despite increasing demand and reducing resources. This confidence was given a timely boost last October when the School submitted itself for a mock review similar to HEFCE's process. The review was led by the head of the University's Academic Development and Quality Assurance, Professor Alderman. The School came through with very respectable grades (see *appendix A* - a report of the review).

3.2 In view of the continuing demand on staff time, we reviewed the School's workload between November and December 1996. The outcome raised many interesting and challenging issues. However, early retirement of 4 colleagues added further complications to this complex subject. We also learned a valuable lesson - that is the School needs time and space to plan teaching load. Starting March this year the School has identified 2 administrative weeks annually to plan the teaching load.

3.3 To prepare the School for the coming HEFCE review, the School Management Team set up a peer review group led by Dina Coutsaftiki. The purpose is to familiarise colleagues with the HEFCE review process. We have designed a special

assessment form which was implemented in April 1997.

3.4 Last year we reported that NVQ contracts were being reviewed. We are pleased to report that the School has successfully implemented a customerised contract for all NVQ courses. This has since improved the delivery and the candidates' completion rate. A similar contracting model is now used for other non- North London Education Consortium contracts.

3.5 In the previous report we highlighted the planned development of the School's first postgraduate programme - MSc Interprofessional Healthcare. We are pleased to confirm that after several hiccups, the programme leader Kay Caldwell's determination overcame the hurdles with support from colleagues. The programme was validated in December. With less than two months recruitment drive, it had a healthy and respectable eight students when it started in February, 1997.

3.6 The School's international aspirations began to bring successes:

3.6.1 Last November, the School with Ming Ai organised the first Traditional Chinese Medicine conference. The conference was a momentous occasion for both Middlesex University and Beijing University of Traditional Chinese Medicine(BUTCM). During this well attended conference Professor Ken Goulding and President Long of BUTCM formally signed a memorandum of cooperation to jointly develop the BSc (Hons) Traditional Chinese Medicine programme and joint clinical research. The ceremony was filmed by the Chinese Television Channel and broadcast in the UK and throughout South East Asia. It was also reported in the Sing Tao and Wen Po Chinese Language Newspapers both in the UK and SE Asia and China.

3.6.2 A memorandum of cooperation was also signed with Caritas Medical Centre in Hong Kong which has a School of Nursing and Midwifery. This signature has led to the development and validation of a Diploma in Higher Education in the Care of Elderly. This diploma is now being delivered there by Boon Choo Soon, whose remit also includes developing local nurse teachers to take over the responsibility eventually. This development is the first of many and is a major boost to the healthcare professionals in Hong Kong. They no longer need to travel half the world to access quality healthcare programmes. The first intake of students started February 1997 and it is due to complete later this year. Reports from the students, service managers and external examiners suggest that the programme is well received and the students are doing well. This diploma is also Middlesex University's first overseas collaboration with healthcare providers to jointly deliver quality post-qualifying specialist healthcare programmes.

3.7 Last September, a realignment of subjects took place between the Faculty of Social Sciences and that of Health Studies. This School took on the undergraduate health studies programme which was delivered in the School of Social Work and Health Sciences. Several member of staff of the programme also joined the School. They were Janet Higgins, Neville Hall, Sue Winsor, Rhion Jenkins and Peter Fenwick. They quickly settled into the School and actively contributed to the School's academic portfolio. On transfer, Gina Taylor took over the programme leadership and carried out a brief audit with some changes being implemented in line with the Bedfordshire Declaration.

3.8 Lifelong learning is an important part of the School's mission to support its students

to develop a love for lifelong learning and continuous self-development. It also believed that learning takes many forms according to individual learning styles. It has set the foundation. It established itself as a centre for:
a) the Training and Development Lead Body for its "D" series 32,33,34 & 36. These series facilitate individuals in their workplace the opportunity to pass on their knowledge and skills to their colleagues. The "D" series equips them to do so with appropriate professional skills and judgement.

b) NVQ in care. It has overhauled the previous collaborative centre status for NVQ in care. It reapplied for a stand alone centre for NVQ in care. It wished to thank its previous partners for their support.

c) for City & Guild 7306 for teaching in further education with NVQ 3, 4 and 5.

d) Administration with NVQ 3 & 4;

e) Institute of Management NVQ level 3,4 and 5

The offer of a "Student Self Audit Learning Logbook" to all students accessing its programmes from this coming academic year is the School's other contribution to the lifelong learning process. This learning portfolio becomes a professional portfolio in which the students will continue to record their personal and professional life events, achievements and continuing education development. This portfolio concept appears to meet one of the Dearing's recommendations.

3.9 The academic portfolio the staff have developed consisted of:

a) Advanced Diploma in Complementary Therapies - a conjoint validation with the English National Board. The programmes has also gained accredition from the Guild of the Complemetary Practitioner;
b) MSc Interprofessional Health Studies - a truly interprofessional healthcare programme. The programme is part of a longitudinal study by the Scottish Council for Research in Education (SCRE). It has proven very popular;
c) BSc (Hons) Sports and Performance Therapy - the first degree of its kind in the UK;
d) BSc (Hons) Human Biology - a very focused degree in the area of human biology to meet the needs of healthcare professionals and those interested in health;
e) BSc (Hons) Traditional Chinese Medicine (Chinese Herbal Medicine)/(Acupuncture and Moxibustion) Mirroring BUTCM's own degree programme. This is the only programme in the World run in collaboration with Beijing University of Traditional Chinese Medicine; it is approved and accredited by the State Administration of Traditional Chinese Medicine in China. This programme sets the benchmark for all future developments concerning TCM
f) BSc Hons) Occupational Health & Safety Management - a conjointly validated programme with ENB. It is a very innovative programme which aims at all personnel working in the Health and Safety field. The first intake will be mainly for those wishing to work in Occupational Health Nursing;
g) Advanced Diploma in Health Research - a conjoint validation with the ENB;
h) Module in Moving and Handling - modularised study days;
i) HND Health, Fitness and Complementary Therapies in collaboration with Harlow College;
j) BSc Osteopathy - the School supported the College of Osteopathy Trust to a

successful validation, including the signing of a memorandum of cooperation;
k) Advance Diploma In Health Care Ethics - due to complete validation;
l) Ford Motor Company programme in Health and Safety;
m) A cluster of single modules and study days;
n) Madeline Brett-Richards is leading a joint interprofessional care project with Redford Lodge Hospital, a private hospital for people with mental health problems.
o) British Association of Dietetics are asked to accredit several modules and Karen Hyland is leading this development

3.10 Research and teaching resources

3.10.1 In 1996 we reported that a School Research Coordinator had been appointed to facilitate and encourage research activities. Our research portfolio continues to be a priority issue. Although some headway has been made, much remains to be done (*appendix B* - report from the School research coordinator). The research programme did extremely well in encouraging students to progress beyond the ENB 870 programme. As a result there are 5 BPhil and 1 MPhil students. The latter is the recipient of the School's first research studentship.

3.10.2 Our teaching strategies continue to diversify in response to the needs of the students. The chief laboratory technician with other colleagues carried out a review of the laboratory activities with a view to providing facilities outside the normal 9-5 day. This is important as more and more programmes are developed to meet demand, such as part-time programmes involving weekend delivery. A strategy paper was produced for discussion.

3.10.3 Computer Based Learning to which the School wholeheartedly support has made little headway. The School coordinator is nevertheless well prepared and is aware of the University's strategy to implement this aspect of resource-based learning.

3.10.4 The School's part-time programmes are delivered outside the normal 9-5 time-table in order to fit in with the students' professional working hours. Some parts of the programmes may be offered in the early morning or late afternoons for night shift workers.

3.11 Staff movements.
New appointments: Lily Lim, Jidong Wu and Chris Hadaway.
Leavers: The following colleagues have taken early retirement and we all wish them well; Helena Gyory, Henry Giddings, Ina Kirkland and Teresa Kelledy.

4 The School sets

In the School's first report we reported the reduction of the given 10 sets to 2 following advice from the Administrative Officer of the Quality Assurance Unit. This change has enabled a larger pool of expertise to meet the School's developmental programme. In most areas there was cohesive support and collaboration for each other's academic programme development. The School was relieved of the interminable round of set assessment board meetings and other related administrative duties. The set leaders - Madeline Bree-Richards for "Education for Health Care" set and Mary Tilki for "Interprofessional Health Care" have very ably supported and encouraged colleagues to review and develop their respective set portfolio as demonstrated in their reports (*appendices C and D* respectively).

5 Staff development and empowerment

5.1 Staff development is very important at any time but more so at a time of unabating pressure for change. The School's continuing success and ability to cope with the planned revolutionary development have been very largely due to the extraordinary enthusiasm, commitment and adaptability of the School staff. The approach of the School to staff development is non-prescriptive. Instead it encourages colleagues to focus on their professional development, to plan their future career pathways in close collaboration with their manager through the appraisal system and to analyse their needs against the School's needs.

5.2 Last year, we reported several adjustments which were thought helpful to both the School's and staff's needs. One of them was to ask the deputy head to refine the School's approach to staff development. The School does not prescribe a particular development method/s but the latter once identified and agreed with the manager is taken seriously and supported. This approach seems to be very effective and encourages the identification of imaginative methods of self-development. The development of the School function coordination role has been one of many. This scheme too was reviewed as part of the School's planned development. Assignment of these roles (*appendix E*) to colleagues was carefully coordinated with their appraisal. For example; Karen Hyland who is interested in the educational contractual issues, offered to coordinate the School's extra regional contract work. As a result we were able to monitor more accurately our work load and income stream (*Appendix F*); Paul Lowe offered to assist with Schoolwide monitoring of the effectiveness of the School's programme delivery process because he is interested in the School's broad operation. Other activities, be they organised by the School or by the individual, play just as an important role in the total picture of staff development, such as school away days, study days organised by the University Staff Development Unit and many others. Below is a sample of details received from colleagues:

5.3 Research, publication, Workshop, Programme of Study and Conferences

Madeline Brett -Richards	* Institute of Management Annual Conference, Coventry, November 1996 * Research supervision workshop, May 1997 * Dearing and beyond, MA Association Annual Conference, April 1995
Caldwell K	* London Health Emergency - Conference of Association of Local Government, presented the paper on "The impact of the NHS Reforms on Hip Replacement - A survey of Orthopaedic Consultants, 1997 * Ideological influences on curriculum development in nurse education, Nurse Education Today, Vol 17, Pp 140 -144
Clow G	* Moving & Handling People Conference, London 1997 * Completed PGCE programme * Successfully Achieved D32/33 and * City & Guild 9282
Cooper N	* Attended study day - "Menopause"- London 1996
Sheila Cunningham	* Royal College of Nursing Research Nursing Conference, April 1997
Evans D	* Conference on Human Right, Canada, 1997

Ghazi F	* Presented paper at the Rutgers University, USA, September,96
Hyland K	* Institute of Management Annual Conference, Coventry, 1997 * Presented a paper "Competence for PAMS" at the North Thames Training and Development Forum * Competence based development makes business sense-Regional Conference,Apr 97
Kerr C	* Research Supervision workshop, November 1996 * with Lowe P, "Reflective learning- does it work? Learning Action Bulletin, Middlesex University Press, Issue No 6,1997
Lee H	* Senior Managers Conference May 1997 * "Changing the Mindset - preparing staff" - CAIPE Bulletin, No 13; Summer, 1997
Lim Lily	* Attended RCN Occupational Health Nursing Annual Conference, and a poster presentation, Nottingham, November 1996
Madley C	* CPR Conference at Brighton, April 1997 * Attending PGCE programme
Novicky A	* Attending PGCE programme
Pettit P	* Research Supervision Workshop * Writing for publication workshop * with Hunt,WB, George, SJ & Barnes, AJ - "Is impaired red cell filtration in diabetes due to a small abnormal sub-population of cells", Clinical Haemorheology. 16 No. 4 Pp 479-485 1996
Rawnsley A	* National Osteoporosis Conference, April 1997
Saib M	* Italian Science Seminar - Recent advances in pharmacology, October 1996 * Presented a paper - Is mental illness a factor in challenging behaviour?" - at ENB Learning Disabilities Conference, July 1997
Taylor G	* Social Policy in theory & practice, LSE, November 1996 * The right to health care, Oxford University, 1996 * et al(in press) Current Issues in Transcultural Care:a guide for healthcare professionals, Quay Books
Taylor M	* National Association of Theatre Nurses Annual Congress, Harrogate, October 1996 * Presented a paper - "Students - an investment in the operating team of the future" at the European Operating Room Nurses Congress, Brussel, Apr 97 * NVQ Conference - key skills in administration, Nottingham, April 1997 * "A new model for Project 2000 students in theatre" - British Journal of Nursing 5:3 1996 * " Are you research minded? Viewpoint - the discussion forum for Ethicon Customers Issue 6, 1997 * "Making the most of Congress" British Journal of Theatre Nursing, August 1997

Tilki M	* Presented "Issues for the Irish in Britain" at the Health Education Authority: Sharing good practice in mental health promotion with Black and minority ethnic communities, Birmingham, November 1996 * "Health promotion in the Irish Community" at the Kings Fund/Federation of Irish Societies National Conference: The health of the Irish in Britain,London,November96 * "Midlife crisis; the situation of Irish people in Britain" at The Emigrant Network - The cycle of emigration: policy and practice, Dublin, March 1997 * " Cultural sensitivity in care" at the Commission for Racial Equality: The Irish in Britain - Health and Community Care Panel, London, June 1997 * "From Reminiscence to History" at the Fifth European Congress of Psychology, Symposium: Psychology, literature and Narrative, Dublin, July, 1997 * "Older Irish People in London Federation of Irish Societies and Middlesex University, submission to Kings Fund, London Commission 1997, The health and care of older people in London(1997) * "Mental Health Issues for Irish People.", Health Education Authority Factsheet, Health Education Authority World Mental Health Day Campaign, 1997 * et al: Current Issues in Transcultural Care: a guide for healthcare professionals, Quay Books(in press)
Angie Ungoed -Thomas	* 12th Annual Research Conference - Sigma Theta Tau Alpha Tau Chapter - Rutgers College of Nursing. New Jersey, New York - presented The teaching of ethics and its impact on practice", 1996

5.4 Attending/attended Courses

Louise Bradley	* MSc Social Anthropology, module leader for managing self and fundamentals of client care. This course is selected in order to meet the deficits in knowledge and skills of trans-cultural issues in health care
Kay Caldwell	* PhD Quality of Services in NHS - Successfully completed
Felicity Clark	* Certificate in Aromatherapy(Successfully completed). Module leader for Appreciation of Complimentary Therapies. This aspect of knowledge and skills contributes the alternative therapies in care in P2K programme.
Dina Coutsaftiki	* MSc Health Promotion (successfully completed). Module leader for family health. She contributes in all pre- and post-registration programmes, health education and health promotion with special reference to people with learning disabilities.
Sheila Cunningham	* MSc Nursing - year 2, module leader for A & P structures and functions of the body. She also inputs into P2K programmes with reference to Theories and Models of Nursing Theme.
Helena Gyory	* MSc Practice of Education-year 3; the Common Foundation Programme (P2K) leader. As an academic leader, participates with specific reference to Education for Health and Management of Care - incomplete and retired

Lynne Henshaw * MPhil -coordinator for Women's Health Elective for P2K

Andrea Hughes * PhD Nursing Practice yr2, teaches Theories, models and perspectives in nursing and coordinates Ethics for CFP

Donna Lewis * MSc Physiology - year 2, module leader for Adult practice and teaches biological sciences at pre- and post registration programmes

Paul Lowe * PhD Biology - year 3, module leader for Body and the Environment and teaches biological sciences at pre- and post registration programmes

Jay Luckraz * MA Psychology (successfully completed) - Module leader for psychological perspective of healthcare and people in groups for the P2K programme

Madley C * PGC in HE started 1996 - teaches CPR, Moving and Lifting
Register for part-time undergraduate programme

Abdool Rajbally * MA Neuro-science (successfully completed), coordinator for manual handling for CFP with biological sciences input in pre- and post registration programmes

Mohamed Saib * MSc Behavioural Biology final year. Module leader for Challenging Behaviours in people with learning disabilities and clients with learning disabilities with mental health problems. Contribute to the biological sciences subjects in pre- and post registration programmes. Successfully completed. Registered for PhD studies.

Boon Choo Soon * BSc Health Studies (successfully completed). Module leader for promotion of continence and better management of incontinence, mental health practice.

Mary Tilki PhD Health needs of the older Irish, year 2. Set leader and input in the politics of care in pre- & post registration programmes, care of the elderly

Angie Ungoed -Thomas * PG Diploma in Law- successfully completed year 1

Anora Withe * Has registered for PhD with OU

HL/annualreport97/DiscReports

Appendix 4

School's allocated budget for 1997/1998

Redistribution of School Staffing Budgets 1997 - 99

all at 1996 prices

Faculty/school	weights	96-97 load	load 99 total	load 99 load	load % change	baseline budget 96	baseline budget 97	baseline budget 98	baseline budget 99	% change to 99	moderated over period 97	moderated over period 98	moderated over period 99	year on year change 96 - 97	year on year change 97 - 98	year on year change 98 - 99
Art & Design & Performing Arts		*normalised*		*normalised*		4,743,000	4,132,032	4,054,278	3,989,674	-16%	4,523,848	4,250,047	3,989,674	-5%	-6%	-6%
Drama & Theatre Arts	1.6	618	559	751	21%	659,000	856,075	897,095	898,587	36%	724,035	810,565	898,587	10%	12%	11%
Fine Art	1.4	288	235	277	-4%	503,000	342,635	333,907	331,304	-34%	446,340	388,822	331,304	-11%	-13%	-15%
Dance	1.6	357	287	386	8%	352,000	456,666	471,692	461,470	31%	388,125	424,797	461,470	10%	9%	9%
History & Theory of Visual Culture	1.0	400	477	401	0%	456,000	500,957	487,877	479,675	5%	479,675	479,675	479,675	5%		
Music & Electronic Arts	1.6	477	409	550	15%	617,000	660,657	653,854	658,212	7%	658,212	653,854	658,212	7%	-1%	1%
Product & Architectural Design	1.4	451	312	367	-19%	865,000	535,677	476,624	439,285	-49%	724,514	581,900	439,285	-16%	-20%	-25%
Textile, Fashion & the Decorative Arts	1.4	237	235	276	17%	501,000	330,002	327,224	330,443	-34%	444,716	385,970	330,443	-11%	-13%	-14%
Visual Communication Design	1.4	301	278	327	9%	790,000	449,363	406,006	390,699	-51%	658,231	524,465	390,699	-17%	-20%	-26%
Business School						3,674,000	4,892,295	4,895,461	4,883,496	37%	4,017,065	4,415,096	4,883,496	12%	10%	11%
Accounting & Finance	1.0	844	1,375	1,155	37%	740,000	1,206,061	1,311,986	1,382,355	87%	951,977	1,131,982	1,382,355	29%	19%	22%
Economics	1.0	696	741	623	-10%	729,000	822,771	765,045	745,315	2%	745,315	745,315	745,315	2%		
Law	1.0	665	849	713	7%	683,000	877,345	880,757	853,585	25%	739,293	796,439	853,585	8%	8%	7%
Management	1.0	1,697	1,892	1,590	-6%	1,422,000	1,986,118	1,937,672	1,902,240	34%	1,580,479	1,741,360	1,902,240	11%	10%	9%
Health Studies						3,812,000	3,611,923	4,028,335	4,184,003	10%	3,934,761	3,958,482	4,184,003	3%	1%	6%
Nursing	1.4	542	928	1,091	101%	1,584,000	941,670	1,146,778	1,305,326	-18%	1,492,037	1,319,408	1,305,326	-6%	-12%	-1%
Midwifery & Family Health	1.4	253	315	370	46%	998,000	362,884	399,951	443,203	-56%	814,917	607,434	443,203	-18%	-25%	-27%
Multi-Professional Health Care	1.4	1,566	1,731	2,035	30%	1,230,000	2,307,368	2,481,606	2,435,474	98%	1,627,807	2,031,640	2,435,474	32%	25%	20%
Humanities						3,003,000	3,004,950	2,854,737	2,772,612	-8%	2,817,303	2,794,957	2,772,612	-6%	-1%	-1%
nglish, Cultural & Communication Studies	1.1	915	846	782	-15%	1,027,000	1,050,636	976,097	935,894	-9%	935,894	935,894	935,894	-9%		
History & Politics	1.0	617	662	556	-10%	691,000	727,861	684,520	665,311	-4%	665,311	665,311	665,311	-4%		
Modern Languages	1.2	701	619	624	-11%	793,000	776,463	763,797	746,110	-6%	746,110	746,110	746,110	-6%		
Philosophy & Religious Studies	1.0	349	423	355	2%	492,000	449,990	430,323	425,297	-14%	469,988	447,642	425,297	-4%	-5%	-5%
Social Science & Education						4,943,000	4,344,417	4,332,918	4,406,454	-11%	4,708,616	4,515,727	4,406,454	-5%	-4%	-2%
Education	1.2	938	856	863	-8%	1,118,000	1,136,774	1,022,362	1,032,442	-8%	1,032,442	1,022,362	1,032,442	-8%	-1%	1%
eography & Environmental Management	1.2	454	426	429	-6%	971,000	515,038	512,350	513,526	-47%	820,033	666,192	513,526	-16%	-19%	-23%
Psychology	1.2	817	984	992	21%	988,000	1,100,380	1,161,514	1,187,063	20%	1,053,691	1,107,602	1,187,063	7%	5%	7%
Social Work & Health Sciences	1.2	288	316	318	11%	872,000	347,523	344,773	380,861	-56%	709,924	527,348	380,861	-19%	-28%	-28%
Sociology & Social Policy	1.0	942	1,286	1,080	15%	994,000	1,244,702	1,291,920	1,292,562	30%	1,092,525	1,192,223	1,292,562	10%	9%	8%
Technology						4,698,000	4,787,382	4,607,272	4,536,762	-3%	4,637,411	4,584,167	4,536,762	-1%	-1%	-1%
Computing Science	1.2	1,573	1,800	1,814	15%	987,000	2,241,053	2,197,239	2,170,855	120%	1,377,672	1,774,263	2,170,855	40%	29%	22%
Electronic Engineering	1.4	619	540	635	3%	1,085,000	726,298	754,198	760,037	-30%	977,762	865,980	760,037	-10%	-11%	-12%
Environmental Science & Engineering	1.4	429	290	341	-20%	1,053,000	549,206	445,287	408,287	-61%	840,245	624,266	408,287	-20%	-26%	-35%
Mathematics & Statistics	1.0	509	643	540	6%	657,000	664,304	650,475	645,984	-2%	645,984	645,984	645,984	-2%		
Mechanical & Manufacturing Engineering	1.4	508	392	461	-9%	916,000	606,520	560,072	551,599	-40%	795,748	673,673	551,599	-13%	-15%	-18%
Total		19,048	20,704	20,704	9%	24,773,000	24,773,000	24,773,000	24,773,000	-0%	24,639,004	24,518,476	24,773,000			

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Heung Lee

Resources to the Year 2000

Table 3

Rebalancing Academic Staff Provision

Faculty/School	Budget 96	Budget 99	Redistribution %
Art & Design & Performing Arts	**4,743,000**	**3,989,674**	**-16%**
Drama & Theatre Arts	659,000	898,587	36%
Fine Art	503,000	331,304	-34%
Dance	352,000	461,470	31%
History & Theory of Visual Culture	456,000	479,675	5%
Music & Electronic Arts	617,000	658,212	7%
Product & Architectural Design	865,000	439,285	-49%
Textile, Fashion & the Decorative Arts	501,000	330,443	-34%
Visual Communication Design	790,000	390,699	-51%
Business School	**3,574,000**	**4,883,496**	**37%**
Accounting & Finance	740,000	1,382,355	87%
Economics	729,000	745,315	2%
Law	683,000	853,585	25%
Management	1,422,000	1,902,240	34%
Health Studies	**3,812,000**	**4,184,003**	**10%**
Nursing	1,584,000	1,305,326	-18%
Midwifery & Family Health	998,000	443,203	-56%
Multi-Professional Health Care	1,230,000	2,435,474	98%
Humanities	**3,003,000**	**2,772,612**	**-8%**
English, Cultural & Communication Studie	1,027,000	935,894	-9%
History & Politics	691,000	665,311	-4%
Modern Languages	793,000	746,110	-6%
Philosophy & Religious Studies	492,000	425,297	-14%
Social Science & Education	**4,943,000**	**4,406,454**	**-11%**
Education	1,118,000	1,032,442	-8%
Geography & Environmental Management	971,000	513,526	-47%
Psychology	988,000	1,187,063	20%
Social Work & Health Sciences	872,000	380,861	-56%
Sociology & Social Policy	994,000	1,292,562	30%
Technology	**4,698,000**	**4,536,762**	**-3%**
Computing Science	987,000	2,170,855	120%
Electronic Engineering	1,085,000	760,037	-30%
Environmental Science & Engineering	1,053,000	408,287	-61%
Mathematics & Statistics	657,000	645,984	-2%
Mechanical & Manufacturing Engineering	916,000	551,599	-40%
Total	24,773,000	24,773,000	-0%

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Appendix 5

Letter to HEFCE

Head of International Development
HEFCE
28/F
Centre Point
103 New Oxford St
London WC1A 1DD

29.1.98

Dear

Kung Hei Fat Choy! May the year of the Tiger bring you good health and prosperity.

I am writing to thank you for the opportunity to meet you on 15.1.98.

As I explained, I met David Bradbury by chance and he mentioned about your collaborative work with the Ministry of Education in China. I wanted to know more about the work you are doing in China hoping that I could learn something from your experience since I am working closely with Beijing University of Traditional Chinese Medicine and also with the State Administration of Traditional Chinese Medicine in Beijing.

I found the meeting both informative and very interesting. I am also grateful for your advice regarding the quality of the joint BSc (Hons) TCM programme Middlesex University is delivering with BUTCM.

If you come across any useful information regarding TCM, I hope you will be able to advise me.

Once again, thank you for your time and advice.

Your sincerely,

Henry Lee.
Head of TCM Developments

HL/cl/jcheung/a:mphd2

Appendix 6

Correspondence suggesting
the lively exchange of views

北京中醫藥大學
Beijing University of Chinese Medicine and Pharmacology
No. 11 Bei San Huan Dong Lu. 100029, Beijing China
Tel: (8610)64286458 64218624 Fax: (8610)64220867

C.C fo/ K.G SL.
13.4.97

Mr. Henry Lee
Head of School
Faculty of Health Studies
Middlesex University

30th March, 1997

Dear Mr. Henry Lee,

Re: British Acupuncture ~~Association~~ Council

Further to our discussion regarding submitting our collaborative degree programme to the above association for approval, I have reflected on this matter. I have also discussed this matter with the State Administration for TCM.
We are pleased you have consulted us. We take a very strong view in this matter: This collaborative degree is a matter between BUCMP and MU. The students on completion of this course, will be competent to practise. If the students wish to join any association, is a matter for the students to decide after graduation.
If UK. has a TCM regulatory body, we would wish to be informed so that we can collaborate with the body concerned. I am taking this opportunity to thank you for the fruitful meeting we had on January 1997.
If I can be of further help, please do not hesitate to contact me.

Yours sincerely,

Prof. J

---END---

北京中醫藥大學
Beijing University of Chinese Medicine and Pharmacology
No.11 Bei San Huan Dong Lu. 100029,Beijing China
Tel:(8610)64286458 64218624 Fax:(8610)64220867

To: Mr. Henry LEE
Faculty of Health Studies
Middlesex Universitv
From:

02. SEPT 97

harmacology

Aug. 29, 1997 Beijing

Dear Mr. LEE,

Thank you for your fax dated on June 15, 1997 regarding to the proposed accreditation of the acupuncture part to our joint programme by BAAB.

Our position is hereby stated that Beijing University of Chinese Medicine & Pharmacology is one of the key institutions of higher learning at the national level in China. Its full-time teaching programme has been approved by state departments concerned. As our cooperative partner, Middlesex University is also a state university in UK.The joint programme between our two parties, not only from the content but also to the form, have already obtain the approvals from state departments concerned of both countries. In view of that, it is not necessary that our joint programme should be approved by any other unofficial academic organizations.

Please keep me informed of this development, and hope everything will be all right.

MIDDLESEX
UNIVERSITY

Trent Park
Bramley Road
London
N14 4YZ

Tel 0181 362 5000
Direct 0181 362 5656
Fax 0181 449 0798
Email:
K.Goulding@mdx.ac.uk

22 December 1997

_____hair
British Acupuncture Accreditation Board
Suite D
Park House
206-208 Latimer Road
LONDON W10 6RE

ACADEMIC COURSES IN COMPLEMENTARY MEDICINE

Thank you for your letter dated 5th December which was received in the Vice-Chancellor's Office on 15th December and forwarded to me for response.

We have corresponded previously on the topics raised in your letter and are in contact with officers of the Board. We continue to consider our position, not least because the Board remain committeed to acupuncture not to the full range (and interactions) of Traditional Chinese Medicine.

We agree that there is a need for regulation but it remains our view that acupuncture should not be separated from other aspects of Traditional Chinese Medicine.

The University will continue to seek to work with the Board but, for the time being, reserves its position related to accreditation for acupuncture only.

Appendix 7

Letter showing the possible implications

RBAL
DNERS ASSOCIATION

C.Ac

5th March 1997

STRICTLY PRIVATE & CONFIDENTIAL

Stephen Li
Dean of Health Studies
Middlesex University
10 Highgate Hill
LONDON
N19 5ND

c.c.: Baroness Platt of Writtle, Chancellor
Professor Michael Driscoll, Vice-Chancellor

Dear Stephen Li,

DEGREE IN TRADITIONAL CHINESE MEDICINE

In an article in the Kilburn Times on 22nd August 1996 we read that Middlesex University was proposing to implement a BSc (Hons) degree course in Traditional Chinese Medicine (TCM), including acupuncture. When two people telephoned your institution at that time they were informed that no literature was available for distribution. A recent article in the Evening Standard dated 8th January states that the degree course will commence in September 1997.

Although we can only comment on the detail as reported in that article, we would like you to be aware of certain matters.

The Evening Standard states that *the major selling point* of the five year BSc (Hons) course is the promise of six months in China, studying at the feet of the aged herbalists of the Beijing University of Chinese Medicine and Pharmacology.

This would seem to imply that Middlesex University students, after four and a half years study there, would spend their last six months alongside Chinese students at the same stage of training at the Beijing University of Chinese Medicine and Pharmacology. If Middlesex University students have been trained to the same quality, standards and comprehensive knowledge in

genuine Traditional Chinese Medicine as these Chinese students, then we would agree with the article. *It would be a priceless experience for them.* These students could then sit together and learn together at the feet of aged herbalists. This quality of training would also indicate that Middlesex University was achieving their academic aim of bringing quality control to a notoriously unregulated industry. (It appears that at least one university in this country is aware that a large number of UK Acupuncture Schools offer very different training to that given in China).

With this in mind, we are concerned that you intend offering part-time posts to two Traditional Chinese Medicine *practitioners.* In our view, it is unlikely that *practitioners* will be equipped to offer the same standard of teaching as full-time lecturers in Traditional Chinese Medicine universities in China. It is vitally important to ensure that lecturers are really trained in ***genuine*** Traditional Chinese Medicine with considerable practical experience. As far as we can confirm, most practitioners and lecturers in the UK gained their main paper qualifications from UK schools that do not conform to standards and practice of TCM as taught and practised in China and in our opinion their skills are very remote from real TCM, including acupuncture. We have also found that those claiming to have graduated in China have attended only short courses, as outlined above. As our enclosed letter from Professor Zhang Jia Wei from one of the top TCM universities in China points out, these courses are merely foundation sessions for foreign students and it is unacceptable to then call themselves graduates of Chinese acupuncture or Chinese medicine. "Genuine acupuncture or Traditional Chinese Medicine is a five year bachelor course, and is only taught in Chinese".

Without having achieved the same standards in ***genuine*** Traditional Chinese Medicine, the four and a half years training at Middlesex University would be meaningless and they would not be able to sit and learn alongside the Chinese students. If the latter is the case, the Beijing University of Chinese Medicine and Pharmacology may simply be offering a course specifically designed for foreign students, in line with common practice at TCM universities in China. These courses are purely for commercial purposes. We have considerable evidence, through personal origins and professional training in China as well as communication with one of the top traditional Chinese universities there (see enclosed), to indicate that these short courses provide only the most elementary introductory type training and are geared towards foreign students to provide a mere insight into TCM. As our attached Information Sheet shows, entry qualifications for comprehensive TCM study require fluency in Chinese language as all teaching is in Mandarin. It should be of concern to you that students could bring a charge of misrepresentation against your university if this aspect of the course is the major selling point.

If Middlesex University is not attempting to achieve the same standards as ***genuine*** Traditional Chinese Medicine then their training is at odds with the concept of Traditional Chinese Medicine education. Sooner or later students will confirm that they cannot obtain work (as per the enclosed cutting from the Sunday Times). Then it may be necessary for you to drop these degree courses and the institution's reputation will suffer. Postgraduates who have attended degree courses recognised at the new universities may end up with mere paper qualifications. They may

possibly obtain work but will be unable to maintain it for any length of time because of their inability to practise properly. Employers may not be willing to keep them in the clinic. Setting up their own clinic would result in disappointed patients and a lot of stress, leading to unhappiness for the rest of their life.

You will be aware of the growing trend for students to take legal action against their university, claiming that teaching or courses were unsatisfactory and damaging to their career prospects. As the enclosed Times article points out: "students are customers who sign a contract requiring universities to provide a professional standard of education". Taking the necessary precautions at this stage will enable you to guard against such a challenge.

We also note that students will touch nothing but plant matter. Neither do we use powdered rhino horn, tortoise shell and bear bile in this country. However, Herbal Medicine is based on Traditional Chinese Diagnosis. We trust that your lecturers will be sufficiently experienced in this field as incorrect diagnosis and/or prescription could be significantly more dangerous than political in correctness.

Our association is concerned about poor standards taught and practised in the UK and we have been campaigning for some time to highlight certain matters. That concern has recently been heightened by the knowledge that certain new universities are offering degree status for courses of extremely low quality that are highly unprofessional. The attached Information Sheet highlights the issue of degrees being devalued by some universities. We are sure that Middlesex University would not want this accusation levied against it. You must ensure that unless you can guarantee teaching and standards of the same quality as ***genuine*** TCM that the degree is cancelled without delay, as it may ruin real Traditional Chinese Medicine and jeopardise the citizens' health.

To help you evaluate academic content and pre-requisite teaching skills for a course of degree level we would like you to be aware of certain factors relating to current activities in the UK TCM and acupuncture profession including schools, councils, associations, societies and practitioners.

We would request that you take time to read our attached Information Sheet and trust that when you have done so you will appreciate why some courses in TCM should not qualify for degree status. To do so would only reinforce the view held by some that the value of degrees is being eroded by questionable courses offered by various former Polytechnics. We are in communication with the Higher Education Funding Council and the Higher Education Quality Council regarding a degree course currently available at one of the 'new' universities. The enclosed Sunday Times cutting, 23.2.97, outlines the issues surrounding falling degree standards (with a specific reference to Middlesex University). From it you will notice that the HEQC is proposing to set minimum standards. We are certain that you will want to ensure that your degree courses meet those standards from the onset.

Should you require any further information or our advice on any matter please do not hesitate to contact us. We would also like to know your opinion on this extremely serious matter, as we have already received some complaints about the situation from our association members and queries from prospective students. We hope, on the question of Chinese Medicine including acupuncture, that your university ensures training consistent with genuine Traditional Chinese curricula. Then we need not enter into any further debate.

Yours sincerely,

Appendix 8

The Middlesex University
Chinese Medicine Ethics Committee
Annual report

MIDDLESEX
UNIVERSITY

Middlesex University Chinese Medicine Ethics Committe

Annual Report

(1997/1998)

THE QUEEN'S
ANNIVERSARY PRIZES

Middlesex University Chinese Medicine Ethics Committee

This is the first annual report to the Vice-Chancellor. It is a very brief report to reflect the fact that the Middlesex University Chinese Medicine Ethics Committee (MUCMEC) is settling down and has been concerned with developing procedures to ensure MUCMEC will function effectively and efficiently.

When the BSc(Hons) TCM collaborative programme with Beijing University of TCM was validated in May 1997, one of the recommendations was to set up the above MUCMEC to "police" the professional practice of MU's own graduates in the absence of a statutory regulatory for the Chinese medicine. The Validation Panel recommended that the role of the MUCMEC will primarily:

1) protect the public from malpractice;
2) maintain a register of MU's CM graduates;
3) produce a code of practice
4) monitor MU's CM graduates' eligibility to have their names placed on the register
5) monitor the continuing careers of MU's registered CM graduates.
6) recommend the removal of any MU graduate CM practitioner from the CM register in the event of proven professional misconduct, thus deterring them from practising.

The inaugural meeting for this MUCMEC was held on 26.6.98 to agree its terms of reference and membership. The membership is drawn from a very wide spectrum of interest in the community as shown in appendix 1

At this inaugural meeting, a sub-committee was set up to develop a Complaints Procedure and Code of Practice (Appendix 2 & 3). These are now completed and have been approved by the members of MUCMEC. A copy will be sent to all the students in their third year when they will start their clinical practice. A draft paper on one of the papers on "good practice" is now developed for members to study and discuss. Others will follow in due course.

The MUCMEC met on 2 occasions as agreed per year. The minutes of these meeting are enclosed as appendix 4 & 5

The MUCMEC noted the high interest shown in the programme and also the multi-national students on the course. We believe that the "regulatory measures" and "the Code of Practice" which MUCMEC will be putting in place with the University will enhance the credibility and reputation of Middlesex University's graduates in Chinese medicine.

The members of the MUCMEC wish both the programme and the students well and also the staff responsible for the programme.

HL/a:\anreport/tcmethics2

THE MU TCM ETHICAL COMMITTEE
FOR
THE PRACTICE OF TRADITIONAL CHINESE MEDICINE

TERMS OF REFERENCE

1 PREAMBLE

1.1 On 30.5.97, the University's BSc (Hons) Traditional Chinese Medicine (TCM) jointly developed with Beijing University of Traditional Chinese Medicine, was successfully validated to begin 22.9.97. In the absence of a Statutory Regulatory Body and unified Professional Association for the practice of TCM in the UK, the Validation Panel felt the University has a duty of care towards the safety of the public and its graduates and thus recommended that a TCM Ethical Committee be set up (hereafter known as the "Committee"). The Validation Panel recommended that the Committee's primary role is to:

a) protect the public from malpractice;
b) maintain a register of MU's TCM graduates;
c) produce a code of practice
d) monitor MU's TCM graduates' eligibility to have their names placed on the register
e) monitor the continuing careers of MU's registered TCM graduates.
f) recommend the removal of any MU graduate TCM practitioner from the TCM register in the gvent of proven professional misconduct, thus deterring them from practising.

2 Passing judgements

2.1 The Committee members dealing with allegations of misconduct have two principal tasks to undertake prior to making any judgements about a practitioner's status vis a vis his/her remaining on the University's TCM register.

a) decide whether the alleged facts against the practitioner are proven. The judgement will be the equivalent of the criminal burden of proof, which is "beyond reasonable doubt" or "satisfied so that you are sure".
b) determine whether the facts proved constitute misconduct.

2.2 When dealing with practitioner's fitness to practise, members will consider whether, based on medical evidence and their own judgement, a practitioner's fitness to practise is so impaired that s/he is likely to be a danger to the vulnerable public.

2.3 It must be emphasised that the purpose of these proceedings is not:

a) to punish the practitioner appearing before the Committee (though the person whose name is removed may interpret a decision of removal from the register to constitute punishment.
b) to provide an employer with grounds to dismiss the practitioner or
c) to provide an employer with an additional avenue of complaint to use when an appeal against dismissal has been upheld.

2.4 However, the above would not exclude us from passing the information to employers who may wish to take steps appropriate to them.

3 MEMBERSHIP

3.1 The Committee will have a maximum of 15 members.

3.2 Membership of the Committee will be deemed to have lapsed upon the failure of any member to attend 2 consecutive scheduled meetings of the Committee from the date of the first absence and without having tendered reasons for such failure to attend which, in the

opinion of the Committee are acceptable.

3.3 Members (except the Secretary and the Principal Lecturer) should serve for 3 years. Term of appointment may be renewed for a maximum of two consecutive terms, but reappointment is not automatic. The Head of TCM developments will serve as the Secretary to the Committee.

3.4 At the end of first term, the membership will be reviewed and a rotation system will be introduced to ensure the Committee's continuity.

3.5 Present membership

Ms Adele Biss (Chair) member of MU Board of Governors - lay member
Dr BC Chan of Traditional Chinese Medicine
Mr Shaw Edwards - Chief Executive, North Middlesex Hospital - Lay member
Ms Stephanie Ellis - Patients Association - lay member
Mr Stanley Lau, Lay member
Mr Henry Lee - Committee Secretary
Mr KH Liu - Lay member
Mrs Joyce Struthers- Vice-chair of Association of Community Health Councils -lay member
Mr David Tan, London Chinese Community Liaison Officer - lay member
Ms Angie Ungoed-Thomas - Principal Lecturer in Healthcare Ethics
Dr D Cox - Representative from Royal College of General Practitioners Council
Ms Catherine Hamblin - Confederation of NHS

4 Working arrangement

4.1 Meetings of the Middlesex University's TCM Ethical Committee will take place at agreed intervals but annually for the first 5 years of the programme as there will be no graduates until then and thereafter not more than twice per year. The Chairperson may call additional meetings to those previously scheduled in emergency cases or for such other reason as the Chairperson may deem appropriate. A quorum can also call a meeting.

4.2 A quorum should be at least one third of the membership of the Committee and should always include more lay persons. Where a pre-arranged meeting is inquorate and provided Chairperson or Vice-Chairperson is present, it shall be for the Chairperson or the Vice- Chairperson and those present to decide whether or not to proceed with the business for which that meeting has been called. If it is decided to proceed then any decisions taken at that meeting shall be deemed to be Chairperson's Action to be ratified at the next full (quorate) meeting of the Committee.

4.3 Where the Chairperson and Vice-Chairperson are absent from a meeting which is otherwise quorate, those members present may, if they so agree, elect from their number a member who will act as Chairperson for the duration of that meeting to transact only the business for which that meeting was called. In such circumstances, any decisions taken at that time shall be deemed to be the Chairperson's Action to be ratified at the next full (quorate) meeting of the Committee.

5 Production of an Annual Report

5.1 Each year the MUTCMEC will submit a report to the University's Vice-Chancellor

NB: This was produced in October 1998, please contact the University's Academic Registry to check for any amendment.

Amended October 1998 - This will be reviewed at the next AGM, September 1999
HL/termsref/disc TCMethis2

Middlesex University Traditional Chinese Medicine Ethical Committee(MUTCMEC)

COMPLAINTS PROCEDURE

Principles of this procedure

1) The Middlesex University Traditional Chinese Medicine Ethics Committee was created to promote and provide a set of standards of behaviour to be expected of the University's graduate TCM practitioners. These standards are laid down in its Code of Practice. In addition it will also, from time to time issue Good Practice Guidance Notes to provide further advice on issues.

2) If anyone believes a practitioner to have behaved inappropriately, contrary to the Code of Practice or to the Good Practice Guidance Notes s/he may write to the Academic Registrar as set out in Clause 5 who will arrange for the complaint to be reviewed using the procedures outlined below.

3) To this end the Committee has set up a Complaints Review Panel (the details of this committee are set out at paragraph 9) which it has asked to look at all cases sympathetically but to ensure that the standards are upheld and that patients are protected.

Standards of conduct expected of practitioners

4) *(a)* The Committee recognises that when assessing a practitioner's actions the standards used should be appropriate. *(b)* The standard which the Committee takes as its yardstick is *the standard* which can reasonably be expected of an average practitioner as set out in Bolam's case. (c) A practitioner is a person who graduated from Middlesex University or from a programme approved by Middlesex University in conjunction with the State Administration of Traditional Chinese Medicine in China.

How complaints should be made

5) If someone wishes to make a complaint about the conduct of a TCM practitioner graduated from Middlesex University s/he should do so by writing to The Academic Registrar, Academic Registry, Middlesex University, White Hart Lane, London N17 8HR.

6) The letter should set out the essential details of the complaint, and provide as much information as is available to assist identification of the practitioner on the MU's TCM Register. When the practitioner has been identified, the letter of complaint, or a summary of it, will be sent to the practitioner for comment. The practitioner will have 21 days in which to respond.

7) The Secretary to the Committee will in the meantime examine the complaint and ascertain whether the complaint relates to gross misconduct on the basis of;
a) the notes within this procedure;
i) the Code of Practice
ii) any Good Practice Guidance Notes the Committee have published
iii) any additional guidance provided by the Complaints Review Panel,

8) The complaint will then be passed over to the Chair of the Committee's Complaint's Review Panel.

8a) The complainant has the right to appeal against the decision by writing to the Chair of the Committee who may refer the case to the Complaints Review Panel.

Complaints Review Panel

9) The Complaints Review Panel, a sub-set of the Committee, will be appointed annually to review complaints received, and provide advice and guidance to the Committee on issues relating to complaints, and to the conduct of practitioners. The membership drawn from the Committee, will not be less than 3. The Secretary will not be part of this committee. The Chair will be chosen from the group. At least one member of the panel must be a layperson, and one of the programme's external examiners (a properly qualified TCM practitioner)

10) In addition to hearing complaints made by private individuals and professional colleagues the Committee's Complaints Review Panel will also consider cases that arise because of the conviction of a practitioner in Criminal Courts, as well as reports received from public bodies such as Health Authorities/Boards, NHS Trusts.

Complaints that may be Made

11) Complaints must normally relate to the Code of Practice, the Complaints Procedure or the Good Practice Guidance notes that may be issued by the Committee. If a complaint is made that does not clearly relate to these, the panel will first be asked to decide whether the complaint can appropriately be heard by them and may have the complaint referred to another appropriate body/authority.

12) The procedure for hearing complaints has been designed to be as simple and straightforward as possible whilst ensuring that it is sufficient to provide both complainant and practitioner with sufficient opportunity to outline their case, and for the committee to hear all the necessary evidence. However, whilst all complaints are seen by the Committee as being important it also recognises that some complaints relate to gross misconduct (as defined in paragraph 14), resulting *in* the practitioner being struck off the Register *in which case* the hearing should be heard in a more formal manner.

Definition of Gross Misconduct

13) It is impossible to provide a definitive description of gross misconduct. It will be up to the Complaints Review Panel to decide whether individual cases relate to gross misconduct. However the Committee has already determined that the following offences, although not a definitive list are examples of gross misconduct, and as such might lead to the Panel recommending that the practitioner be struck off the Register if he or she is found guilty.

14) Examples of Gross Misconduct:

a) reckless and negligent practice;
b) concealing untoward incidents;
c) failure to keep essential records;
d) falsifying records;

e) failure to protect or promote the interest of clients;
f) failure to act knowing that a colleague or subordinate is improperly treating or abusing clients;
g) physical or verbal abuse of clients;
h) theft from clients or employers;
i) drug related offence;
j) abusing therapeutic Nature for sexual or financial purpose
k) breach of confidentiality
l) failure to have up to date, adequate and valid insurance cover.

15) Once the 21 days have passed since the first letter was sent out to the practitioner, and whether or not the practitioner has responded (but subject to the discretion of the Chair of the Complaints Review Panel), a letter will then be sent out to both practitioner and complainant announcing the date of the hearing which will be no more than 42 days after the date of the letter.

Representation

16) Both the complainant and the practitioner may invite someone to assist and represent them. This representative may be a friend, colleague or trade union representative. Legal representation would not be appropriate unless the hearing was about an allegation of gross misconduct. It is the responsibility of the complainant and representative to pay for their representation. There is no provision within the remit of the Complaints Review Panel to award costs. If either party wishes to sue the other party for damagess then they would have to do so through a Court of Law.

Legal Advice to Panel

17) It is not expected that the Panel would normally require legal advice, and therefore no provision would be made for it. The Panel may, however, adjourn a hearing where they feel that legal advice is necessary for them to make appropriate judgement. In instances where it is evident that the case of alleged gross misconduct is to be heard and it is evident that one or more of the parties intend to use legal arguments the Panel may decide in advance to request the presence of a legal advisor.

The Hearing

18) When the hearing relates to an allegation of gross misconduct the hearing will necessarily follow the standard procedures of a court of law. In cases which do not relate to accusations of gross misconduct (as defined in paragraph 14) the Chair of the Complaints Review Panel should endeavour to relax the rules to make the hearing more accessible to those taking part.

19) If the hearing has to follow standard court of law rules then witnesses, when called, will be required to testify under oath, and hearsay will not be acceptable as evidence. This is the first version of the complaints procedure. Before anyone graduates from this course, a more detailed Guidance Note will be issued giving fuller details on how a hearing should be held.

20) In all cases the original letter of complaint, as well as any response made by the practitioner will be sent to the panel members at least *7* days in advance of the

hearing.

21) At the start of the hearing the complainant's party will be invited to present their case first, presenting witnesses when necessary. The practitioner's party may question the witnesses.Once the complainant has completed his/her presentation the Complainant's party can then respond, calling witnesses as necessary. Once this is completed the complainant may then make a second presentation. At the end of each of these presentations Panel members may ask questions to clarify what has been said.

22) The panel will also have before it a written note about the previous history of the practitioner. This will enable the Panel to be aware of whether the incident is an isolated one. The Committee recognises that it would not be appropriate to regard a practitioner who has made a single slip up, and who has been anxious to correct it, in the same light as one who has been consistently negligent in their conduct.

23) In addition to this the Panel will wish to take into consideration how the practitioner has behaved in dealing with the complaint. The Committee has, for example, no wish to punish a practitioner who during a period of intense pressure made one mistake, but who has otherwise *an* exemplary record, and who has co-operated fully in the hearings - including being open and honest about the mistakes that have been made.

24) Once the presentations are over, and panel members have asked all the questions they need to ask, the panel will retire to discuss the case, and make a decision. They will not ordinarily make an announcement of their decision on the day but will write to the parties announcing their decision within 7 days with reasons where appropriate.

25) In arriving at their decision the Panel will take note of the need to have heard only evidence that is admissible. The evidence must be sufficient to ensure there can be no doubt in anyone's mind. Where the hearing relates to complaints which do not relate to allegations of gross misconduct the panel may, subject to the agreement of both parties, take a more relaxed view, and take into consideration the balance of probabilities. A Guidance Note will be issued before anyone graduates from the course giving a fuller description of this.

<u>The Judgements the Panel May Make</u>

26) The written judgement of the panel will be sent out within 7 working days of the hearing. A copy of the judgement will be sent to the following

a) The Royal Colleges
b) Confederation of Health Authorities
c) Association of the Community Health Councils for England and Wales
d) The Patients Association
e) The Consumers Association
f) The Practitioners Insurers where appropriate
g) Appropriate Trading Standards Officers

27) A press release detailing the judgement will be sent to the Press Association for relay to relevant local newspapers.

28) The Complaints Review Panel may issue any one of the following findings:

a) the practitioner is not guilty of the matters alleged or, where although the facts were proved, they did not amount to malpractice, the case is closed.

b) the misconduct did occur but the Panel feels that it would not be appropriate to do anything beyond, the case is closed.

c) that misconduct did occur and that the Panel is sufficiently concerned about this misconduct that it will issue a formal caution about future conduct. This note will remain on the record for five years and may be quoted on request for information about the practitioner, and would be quoted in the written history of the practitioner given to future hearings of the Complaints Review Panel should the practitioner be the subject of another complaint again within the 5 year period. The case would then be closed.

d) that the misconduct did occur but judgement *is* postponed for a set time, that the Panel determines. This will usually, but not necessarily, be because the Panel wishes to obtain further information or because it is sufficiently concerned about aspects of the misconduct that it issues a formal request for the practitioner to provide evidence (within the set period of time stipulated by the panel), demonstrating that corrective action has been taken to ensure that the misconduct does not occur again. A copy of such a letter would be attached to the record for five years. The case would not close until the date set. If by the set date the practitioner has failed to provide the acceptable evidence requested then the panel will convene a hearing to decide on the finding: it is not expected to be any other finding than *that* the practitioner be struck off the Register.

e) that the misconduct did occur and that the misconduct is of sufficient severity that the practitioner's name should be removed from the Register. The Panel can determine whether the practitioner should be struck off for a set period, or for life. If the Panel removes the practitioner for a set period they may also lay down specific conditions that the practitioner must meet before being reinstated.

f) refer the practitioner for a health review, and may *suspend* final judgement until after the results of that review.

g) impose an interim suspension of the practitioner's registration. The Panel would reach this finding if it is felt that the hearing needed to be adjourned and that suspension was in the best interest of either the practitioner or the public.

Appeals

29) An appeal may be made by either party. This must be in writing and must reach the Secretary of the Committee within 21 working days of the date of the letter announcing the judgement.

30) The appeal must be on one of the following grounds:

a) the procedure was not followed

b) the hearing did not hear important evidence - an explanation of why the evidence

was not heard at the original hearing must also be provided

c) the punishment was inappropriate for the offence

31) If a valid appeal is made then a new panel will be convened. A new panel of the Ethics Committee will be convened by the Chair/Vice Chair of the committee. The Chair will chair the panel. The Complaints Review Panel membership rules will apply.

32) The complainant and practitioner will, within 21 working days of receipt of the appeal, be invited to attend the hearing, which will be no later than 42 working days from the date of the letter inviting them to attend the appeal hearing.

33) Both the complainant and the practitioner may invite someone to assist and represent them. This representative may be a friend, colleague or trade union representative. Legal representation is not appropriate.

34) Both parties will be invited to send in written submissions, but they will also be allowed to present their case orally. The appellant will be invited to present their case first. The other party may if they wish respond. The appellant may then make a second presentation. Panel members may ask questions at the end of each presentation.

35) Once the presentations are over, and panel members have asked all the questions they need to ask, the panel will retire to discuss the case, and make a decision. They will not ordinarily make an announcement of their decision on the day but will write to the parties announcing their decision within 7 days giving reasons where appropriate.

36) This will be the final hearing within the auspices of the Middlesex University Traditional Chinese Medicine Ethical Committee. If either party still feels aggrieved they will need *to* pursue their complaint through other avenues (e.g. civil court).

NB: This was produced in October 1998, please contact the University's Academic Registry to check for any amendment.

Amended October 1998
HL/A:\TCMCOMP.TCM ETHICS

MIDDLESEX UNIVERSITY
TRADITIONAL CHINESE MEDICINE PRACTITIONERS
CODE OF PRACTICE

A qualified TCM practitioner is personally accountable for his/her own practice and must:

1) practice in appropriate professional surroundings and maintain high standards of behaviour and personal appearance when dealing with patients. Where a clinic is part of a shop premises it should be kept distinct from all commercial activities;

2) be registered with the appropriate Local Authority and ensure that the premises are clean and where appropriate sterility of instruments meet the required standards under the Local Government Act 1982 and other relevant legislation;

3) always act in such a manner as to promote and safeguard the patients' interests and well being;

4) act promptly to ensure that actions carried out by the practitioner or colleagues are not detrimental to patient's safety, interest or condition;

5) regularly update his/her professional knowledge and competence;

6) acknowledge own limitations and refer patients to other healthcare colleagues immediately as appropriate;

7) work from an interprofessional healthcare perspective to benefit patients and support colleagues effectively;

8) empower patients and their carers to achieve effective treatment outcomes;

9) practise within the spirit of Equal Opportunities framework and treat each patient as a unique person with his/her own rights;

10) not abuse the position of trust and privilege the TCM profession has conferred upon the practitioner; when dealing with any intimate examination of patient of opposite gender ensure either a relative of the patient or an assistant is present;

11) protect the confidentiality of any information about patients obtained in the course of duty and only disclose with patients' consent, or where required by the order of a court or where disclosure can be justified in the wider public interest;

12) consider very carefully the implications of *(i)* recommending a course of treatment contrary to the advice of the patient's GP or *(ii)* of non-referral to NHS in case of serious illness; be aware of own vulnerability in law on this issue and ensure that in such cases all available information is given to the patient and that the patient makes the final decision without coercion;

13) always ask a parent or supervising adult to be present when treating or examining a child under the age of 16. Where a patient has a mental health problem or a learning disability the practitioner must follow the guidance that will be set out in a Good Practice Guidance Note. (Until such time as this Good Practice Guidance Note is published practitioners must not treat clients with these conditions).

14) be fully familiar and comply with the terms of the Medicines Act 1968 and

subsequent statutory instruments, notably The Medicine Order 1977; and herbal remedies must not contain animal products from endangered species or heavy metals;

15) never claim verbally or in print to be able to cure any life threatening or serious illness unless it can be substantiated by research findings: neither should professional judgement be influenced by commercial considerations.

16) maintain contemporaneous record of consultations and treatment

17) always provide the patient with a written note of the treatment plan, including details of fees and charge, before the commencement of treatment. The treatment plan should be regularly reviewed and if it there are any changes the client should be provided with a new version

18) not practise without a valid indemnity insurance cover certificate, which must be on display in the reception area of the clinic.

19) hang in all treatment rooms and reception area a notice as in table 1 below:

MIDDLESEX UNIVERSITY
TRADITIONAL CHINESE MEDICINE ETHICAL COMMITTEE

Graduates of the Middlesex University Traditional Chinese Medicine Course are required to conduct themselves according to the Code of Practice issued by the above Committee.

A copy of this Code of Practice is available for inspection from this clinic, or you may obtain a copy by writing to The Academic Registrar, Academic Registry, Middlesex University, White Hart Lane, London N17 8HR. Tel: 0181-362-5956.

If you have a complaint about a practitioner who has not followed the Code of Practice you should write to the Academic Registrar at the above address setting out the details of your complaint, and as much information as you can to assist in the identification of the practitioner you wish to complain about.

Table 1

Each year this Committee will publish an annual report. In the annual report besides reporting on its work during the year, the Committee will also publish the names of any practitioners who have been called before the Committee's Review Panel, and the judgement of that hearing.

PRACTITIONERS ARE REMINDED THAT THIS CODE OF PRACTICE REPRESENTS MINIMALLY ACCEPTED STANDARDS OF LEGAL AND ETHICAL CONDUCT IN THE UK FOR MIDDLESEX UNIVERSITY GRADUATES. FAILURE TO OBSERVE THE CODE RENDERS PRACTITIONERS LIABLE TO DISCIPLINARY PROCEDURES. MOREOVER, IN MANY CASESPRACTITIONERS *MAY* BE OPEN TO CRIMINAL PROSECUTION AND/OR CLAIMS FOR DAMAGES IN THE CIVIL COURTS AND IT IS POSSIBLE THAT PROFESSIONAL INDEMNITY INSURANCE COVER WOULD BE THREATENED. YOUR NAME MAY BE REMOVED FROM THE UNIVERSITY'S TCM REGISTER.

NB: This was produced in October 1998, please contact the University's Academic Registry to check for any amendment. HL/tcmcode/disctcmethics2/July97

DRAFT

Middlesex University

TCM Ethical Committee

Meeting to be held on Thursday 26th June 1997
10.00 a.m. Discussion Room 2
Faculty of Health Studies, Royal Free Centre

AGENDA (Standard)

1. Present

2. Apologies

3. Minutes of last meeting

4. Ratification of draft papers on:
   a) Terms of Reference(A)
   b) Code of Practice(B)
   c) Statement of Competence(C)

5. Any other business

6. Date of next meeting - future meetings will be held on Fridays

HL/cl/comm.agn/a:ethcomm

MIDDLESEX UNIVERSITY

AMENDED MINUTES

TCM ETHICAL COMMITTEE

MINUTES OF THE INAUGURAL MEETING OF THE TCM ETHICAL COMMITTEE HELD ON FRIDAY 26TH JUNE 1997

Present: Ms.A Biss(Chair), Mr D Tan, Mr H Lee, Ms.S Ellis, Mr S.Lau, Mrs J. Struthers, Mrs A Ungoed-Thomas

Secretary: Mrs C. Lamb

1. FORMAL BUSINESS

1.1 Henry Lee welcomed all members to the inaugural meeting of the TCM Ethical Committee and thanked them all for the interest they have shown. Adele Biss reiterated this adding it was an exciting venture for all.

1.2 Apologies for absence

Apologies for absence were received from Dr. Cox, Ms. C. Gunn, Mr K. Liu, Dr. C. Worth, Mr S. Edwards, Dr. S. Hiew, Dr. P.C.Chan

1.3 Introduction of members

All present introduced themselves stating the association they were representing and giving a brief description of their role.

2. Minutes of last meeting

There were no minutes available as this was the inaugural meeting of the Committee.

3. Background to the committee

Papers giving a brief guide to the programme were handed out to those present, Henry gave background information into the initial concept of the programme 2 years ago. The programme was finally validated in May 1997. One of the conditions of the validation was that an Ethical Committee was set up, hence the meeting being held today.

Members then looked at the programme structure and content with Henry giving a brief description. Adele Biss asked for explanation of credits and skills level which Henry provided.

4. RATIFICATION OF DRAFT PAPERS

4.1 Terms of Reference

The purpose of the committee was established. David Tan asked where committee members stood regarding any legal issues arising and Henry confirmed Middlesex University has access to the appropriate legal advice as the need arises. It was confirmed that in drafting the Terms of Reference the General Medical Council's Code of Practice and other professional bodies had been referred to, this had been contexualised to Middlesex University.

Stephanie Ellis felt the need for further procedure stating a mechanism is required if a student has a grievance, the Committee has a duty to set up a duty of care to patients and a proper grievance procedure should be in place. It was agreed that a sub-committee was formed to look into this in readiness for the next meeting when a summary of legal obligations/protection guidelines/complaints procedure should be provided. Stephanie Ellis agreed to be a member.

All members agreed on the primary role of the Committee in the Terms of Reference, with an additional sentence being added to the effect that it was ethical to pass on information regarding any malpractice. Suggested wording to read "however the above would not exclude us from passing on information to an employer to take steps which are appropriate to them". This was agreed by the committee and suggested the next meeting would discuss the right balance of confidentiality.

4.2 Membership

Adele Biss sought views on the membership of 14 members, and they were agreed as sufficient. But a fifteenth member will be sought to allow the quorate of 1/3 be achieved.

It was agreed that members would serve initially for 3 years and re-appointment will not be automatic. It was proposed that membership be reviewed at the end of the initial period and appointments on a rotation period be introduced to be reviewed 2 years from now. It was agreed that a rotation of 1/3rd of membership be considered. Each member to serve no more than 2 consecutive terms. It was also agreed the Chair is to be a member.

4.3 Working arrangement

It was agreed that a quorum (1/3rd) requires the secretary to call a meeting.

4.4 Production of an Annual Report

Agreed that a draft report is submitted to the Ethical Committee prior to the

report being submitted to the University Academic Board.

Terms of Reference (Paper A) was therefore ratified.

4.5 Code of Practice

The code of practice was agreed in principle - it was felt however a need to redraft this paper to include the disciplinary procedure.

Clause 13 - to be reworded by the sub-committee.

Clause 16 - Members also agreed that the likely length of treatment and treatment plan discussed should be included.

Code of Practice Paper (B) ratified subject to amendments.

4.6 Statement of Competence

This statement would be needed prior to the degree being awarded.

5. ANY OTHER BUSINESS

5.1 TCM Association

It was questioned as to whether there will be an association for TCM students. Henry confirmed that students in the UK will link with Beijing TCM students to form an association.

5.2 Vice - Chair

Agreed election of Vice-Chair at the next meeting.

6. DATE OF NEXT MEETING

The next meeting will be held on Friday 30th January 1998 at North Middlesex Centre commencing at 10.15 a.m.

A further meeting will be held in June 1998 to agree the annual report.

Prior to the close of the meeting Henry was offered congratulations in obtaining validation of the TCM programme.

All members were unanimous in wishing the course every success.

MIDDLESEX UNIVERSITY

TCM ETHICS COMMITTEE

SECOND MEETING OF THE TCM ETHICS COMMITTEE CALLED FOR 10.15AM ON FRIDAY 30TH JANUARY 1998 IN ROOM 16A, NORTH MIDDLESEX CENTRE

AGENDA

1. FORMAL BUSINESS

1.1 Apologies for absence

1.2 Adoption of minutes

To ADOPT the minutes of the meeting held on 26th June 1997

2 REPORT

2.1 Brief report from Henry Lee re TCM programme

3. PAPERS

3.1 To RATIFY papers on:

3.1.1 Terms of Reference
3.1.2 Code of Practice
3.1.3 Complaints Procedure

3.2 To CONSIDER paper on Good practices in TCM

4. ANY OTHER BUSINESS

5. DATE AND VENUE OF NEXT MEETING

hl/cl/300198/a:ethcomm

MIDDLESEX UNIVERSITY

TCM ETHICAL COMMITTEE

MINUTES OF THE SECOND MEETING OF THE TCM ETHICAL COMMITTEE HELD ON FRIDAY 30TH JANUARY 1998

Present: Ms. A. Biss (Chair), Mr H. Lee, Mrs J. Struthers, Mr S. Lau, Mr K.H. Liu, Dr. S. Hiew, Mr D. Tan, Ms. S. Ellis, Dr. P.C. Chan

Minutes Secretary: Mrs C. Lamb

Prior to formal business commencing members introduced themselves, suggestion made that members have their name displayed at future meetings to ease identification, this was agreed.

1. FORMAL BUSINESS

1.1 Apologies for absence

Apologies for absence were received from Mrs Y. Mouncer, Dr. D. Cox. Mrs A. Ungoed-Thomas.

1.1.1 The committee wished to express their condolences to Mrs A. Ungoed-Thomas in her recent bereavement.

1.2 Adoption of minutes

Minutes of the meeting held on 26th June 1997 were adopted with the following amendments: *(i) Mr K. Kiu to read Mr K. Liu. (ii) Dr. Chan apologies for absence were not recorded.*

2. REPORT (Henry Lee's)

2.1 Members read through the report previously submitted. *Amendment to Paragraph 2 to add Sing Tao Agency* also attended TCM launch on 2nd October 1997.

2.1.1 In response to a query from Mrs Struthers, Henry explained why at this stage it would be inappropriate to submit MU/BUTCM programme to BAAC's approval. TCM is characterised by a plethora of organisations claiming to represent the interest of TCM practitioners. For instance at least over 5 organisations represent acupuncturists, including British Acupuncture Council and British Medical Acupuncture Society; three represent herbalists and more than 2 represent TCM practitioners. They do not communicate. The members

supported MU's position and the idea of encouraging another association which can accommodate BAC, BMAS, ATCM and others.

2.1.2 Stephanie queried if Henry had approached the Dept. of Health to have the MU/BUTCM programme approved. Henry confirmed that initial contact was made. However, DoH does not approve the programme, nor does it approve or recognise organisations like BAC, BMAS or ATCM. He also explained as a result of this contact, he was able to contact the Medicine Control Agency which is concerned with the lack of quality control for the Chinese herbs.

2.1.3 Henry also explained that Adele has helped in identifying a Nursing Officer who has responsibility for complementary medicine/therapies at DoH. He is now pursuing this avenue to inform the officials of MU/BUTCM programme and the concept of TCM.

2.1.4 With reference to TCM in Europe, Henry explained that contact has been made with the EMP Clive Needle at Norwich. Clive Needle is very keen to know more about TCM and complementary therapies as they are of special interest to him.

2.1.5 Adele also informed members that she has already written to Hugh Bayley MP, offering to meet and discuss TCM. She also suggested that after the initial meeting, it may be useful to set up a get to know session with interested MPs and the Committee members be invited. This was welcomed.

2.1.6 Stephanie will continue to write to other TCM clinics.

3. PAPERS

3.1 Terms of Reference

3.1.1 Chair requested election of Vice-Chair. Henry nominated Stephanie and was seconded by Joyce Struthers. No other nominations were put forward, It was therefore unanimously agreed and carried that Stephanie to be Vice-Chair to the TCM Ethics Committee.

3.1.1a The primary role of the Committee was discussed as clauses 1 - 6 . All present approved these clauses .

3.1.1b Clarification was sought on "beyond reasonable doubt" or "satisfied so that you are sure" Stephanie and Henry will discuss these further to find ways to be more precise.

3.1.1c The sub-committee had met and discussed legal obligations/protection guidelines and the complaints procedure and Henry conveyed his thanks to Stephanie and Angie Ungoed-Thomas for their assistance in this.

3.1.1d Henry confirmed he had met with the Academic Registrar regarding

submission of the Annual Report. Following discussion, it was agreed members are to receive a draft copy no later than one month before the next meeting.

3.1.1e Terms of Reference were ratified with the recommended amendments in italics in the text.

3.1.2 **Code of Practice**

3.1.2a The code had been scrutinised by the sub-committee with comments and amendments received by members. However, the committee still had to receive and endorse the "Good Practice Guidance Notes" which is due to be received. Upon receipt, Henry will ensure all members receive a copy prior to the next meeting.

3.1.2b The Code of Practice were ratified subject to the amendments in italics in the text.

3.1.3 Complaints Procedure

3.1 The Complaints Procedure was ratified with the recommended amendments made in italics in the text.

3.2 Good Practices in TCM

3.2.1 This paper had not been received, Stephanie Ellis will investigate, forward to Henry who will forward to Committee members.

4. Any Other Business

No further business to discuss.

5. Date and venue of next meeting

Mr David Tan kindly offered to host the next meeting which will be held on 2nd October 1998 at 11.00 a.m. - 1.00 p.m. To be held at 103 Berwick Street (1st Floor). Further details will be sent with the agenda.

HL/cl/3001.mins/a:ethcomm

Appendix 9

The Middlesex University
Chinese Medicine Learning Fund
Committee members

THE MIDDLESEX UNIVERSITY
CHINESE MEDICINE LEARNING FUND

Patrons

Sir Christopher Lever, Bt
Mike Brown
Bernie Grant MP
Dr Luo Ding Hui
David Tan
Mrs Katy Tse Blair
Sir Sydney Chapman MP
Billy Ko JP
Donald Lyen
Mayor Sheila Peacock

Fund Committee Members

Arthur Hing - Vice Chair
Klemens Felder- Public Relations
Jane Hanks - Coordinator
Jason Unwin - Public Relations
Nhuong Ho -Public Relations
Minnel Maru -Commuinty liaison
Alison Davidson- Secretary
Liana Su- Treasurer
Britta Engert- advisor
Ken Williams (MU's Senior Finance Officer) - advisor
Hassan Patel -Public Relations
Patrick Adams - advisor
Ian Chan - Coordinator
Doreen Corbin - advisor
Lynn Morra -Public Relations
Michi Naomoto - advisor
Pam D'Alberto - Public Relations
Sing Sing Yu
Henry Lee - Chair

Appendix 10

A sample of the raffle draw ticket

Middlesex University Chinese Medicine Learning Fund
funding traditional treatments for today...and tomorrow

No:

Promoter: Henry Lee,

Your chance to see Beijing or Hong Kong, the choice is yours and show you support

TICKET TO HEALTH

☆ *FIRST PRIZE: Return flight to either Beijing or Hong Kong, generously donated by Key Travel*

☆ *Plus many other prizes*

The fund will support students during their crucial six month internship in hospitals in China. Thank you for your generous support.

DRAW WILL TAKE PLACE ON 13TH MAY 1999 WINNERS WILL BE NOTIFIED BY POST TICKETS 50 PENCE EACH

Licensed under the Lotteries and Amusements Act 1976 with London Borough Of Enfield

Tickets printed and kindly donated by Pineland MU Ltd, Bounds Green, N11 2NQ

Appendix 11

Questionnaire for CMAS Members

Questionnaire for CMAS members

Please either tick ( ) or write your answers as appropriate.

1) Has CMAS met your expectations?

yes.....☐
partially.....☐
no.....☐

please explain including why you join MAS.....
.....
.....
.....

2) How much do you agree with CMAS's proposed mission, aims and objectives, and code of practice ?

fully agreed.....☐
partially agreed.....☐
totally disagreed.....☐

Please explain your answer with suggestions.....
.....
.....

3) What should be CMAS's priority?

authentication.....☐
register products as medicine..☐
self-regulation.....☐
simply influencing voice.....☐
other.....☐

Please explain your answer:.....
.....
.....

4) Are your views heard and acted upon at the meetings

yes.....☐
no.....☐
partly.....☐

please explain with suggestions.....
.....
.....

5) So far, how satisfied are you with CMAS's performance

very satisfied.....☐
satisfied.....☐
dissatisfied.....☐
very dissatisfied.....☐

Please explain your answer.....
.....
.....

6) Please give your views on the proposed launch

7) In your view how should CMAS move forward?

8) Please indicate in order of preference the organisations CMAS should have liaison with.
(1= very much)

MCA.....☐
ATCM .....☐
BAeC.....☐
BHMA.....☐
EPHA.....☐
RCHM.....☐
other .....☐

please name the "other"

please explain your answer with suggestions.....
.....
.....

9) How much time are you will to give to the running of your CMAS? please indicate hours per week

10) How frequent are you willing to to attend meetings

monthly.....☐
two monthly.....☐
three monthly.....☐
six monthly.....☐

11) Which is your best time and weekday to attend meeting?

12) Please indicate your annual turn-over

under £1m.....☐
£1m - £1.5m.....☐
£1.5m - £2m.....☐
£2m +.....☐

13) Is it time to move CMAS to a permanent base?

yes.....☐
no.....☐

Any suggestion?

14) Please add any comments you may have, using extra paper if necessary.

Thank you very much for your kind assistance. Please return within one week of receiving this questionnaire in the addressed envelope.

Appendix 12

Code of Conduct for ECCM

EUROPEAN CENTRE FOR CHINESE MEDICINE (Draft)

Code of practice

This code is developed as a draft for the partners to study and make suggestions to either improve it or suggest an alternative

Trust and confidence are the foundation to long lasting partnership among the partners. More important is the patients who will be involved in the clinical trials and research. The code of practice is therefore developed as broad guidelines. We as professionals have a duty to maintain good standard of practice and care and show respect for human life.

Each partner shall act, at all times, in such a manner as to:

Partners

- ♦ respect partners are equal irrespective of creed, belief, sex and sexual orientation;
- ♦ respect and protect confidential information given as part of the project. Research etc;
- ♦ work collaboratively at all time in the ways that best serve patients' interests;
- ♦ work within the Centre's agreed protocols;
- ♦ adhere at all time to the Centre' protocols such as representation of themselves to the public; authorship etc;

Patients as research subjects

- ♦ make the care of his/her patient his/her first concern;
- ♦ respect and protect confidential information;
- ♦ treat every patient politely and considerably irrespective of their creed, belief, sex and sexual orientation;
- ♦ respect patient's dignity and privacy;
- ♦ listen to patients and respect their views;
- ♦ provide patients in a way they can understand;
- ♦ respect the rights of patients to be fully involved in decisions about their care;
- ♦ be honest and trustworthy;
- ♦ ensure that own personal beliefs do not prejudice your patients' care.

It is also a partner's responsibility to safeguard the biodiversity in the use of Chinese medicine

A detailed paper on the Code of Practice will be available to all partners in due course

November 1998 - first draft.

Appendix 13

Phytochemistry Natural Product Research

School of Health, Biological and Environmental Sciences

MIDDLESEX
UNIVERSITY

Queensway
Enfield
Middlesex
EN3 4SF

Phytochemistry Natural Product Research

We carry out the following functions:-

* **International contract research** and development work in natural products, phytochemistry, organic chemistry, pharmacognosy.
* **new product development** in herbal cosmetics, herbal medicines, natural insecticides and repellents, aromatherpy.
* **development of assays** and efficacy testing of natural products using: - alternatives to animal experiments, tissue cultures, in vitro assays; human studies: clinical trials of herbal products
* **development of product licenses** for herbal medicines.
* measurement of anti oxidant, anti viral and anti bacterial effects in plant extracts, food phytochemicals, functional foods, cosmo and nutraceuticals
* **literature searches**, product reports, preparation of monographs.
* **development of new extracts**; optimisation of active extractives.
* **standardization of plant extracts** for specific product requirements; special extract preparations. Scale up from grams to tonnage quantities can be arranged using pilot plant facilities.
* **sourcing of plant material** for screening purposes, via dried, or fresh material (delivered in liquid nitrogen), or extracted, especially those plants used in ethnobotanic and traditional medicine programmes.
* **cultivation of medicinal plants** and phytochemical optimisation yields to improve efficacy or economic value of herbal crops.
* **analysis of herbal products** / essential oils; detection of audulterants.
* **market trends / sales** figures for natural products worldwide.
* **large collection of quality colour slides** of medicinal plants.

If we cannot help you we have a network of over 600 medicinal plant experts worldwide that we can call upon. Contact:-

Dr John A. Wilkinson BSc PhD DIC MRSC C CHEM
Senior Lecturer in Phytochemistry and Pharmacognosy
Tel: 0181 362 6425 International: 44 181 362 6425 Mobile 0370 981 145
Fax:0181 805 0702 International: 44 181 805 0702 (non confidential)
E mail : J.Wilkinson@mdx.ac.uk

THE QUEEN'S
ANNIVERSARY PRIZES
FOR HIGHER AND FURTHER EDUCATION
1996

Appendix 14

Senior manager giving the "go ahead" for the ECCM Project

Date: Tue, 27 Jan 1998 08:37:11 +0000 (GMT)
From: mdx.ac.uk>
Subject: TH:Lee" <HENRY4@NM1.mdx.ac.uk>
Cc: NW.MDX.AC.UK>
Reply-to:
Organization: Middlesex University
Priority: normal

Henry

Thank you for your memo dated 20 January.

I have discussed the idea etc with Ron Hamilton and we agree there are several key strategic decisions we need to take, some of which are pressing.

In the first instance, it is appropriate for you to discuss the issues raised in your memo with Ron and the School's Management Team. I understand Ron is meeting you soon anyway.

Ron will then advise me of the School's view and after which I will discuss it with you and him together if necessary.

Ron and I are anxious that these key issues are debated openly with key colleagues in the School so that, whatever decision we take, it is owned by all the staff as far as is possible.

Appendix 15

Department of Health

Letter dated 17.4.96

Skipton House 80 London Road London SE1 6LW Telephone 0171 972 2000
Direct line 0171 972 5091

LS25 6BH

Your ref: JCC/JB

17 April 1996

Dear Sir/Madam

Thank you for your letter of 1 April about the British Acupuncture Council. I have been asked to reply.

I would like to make it clear that the Department did not appoint the British Acupuncture Council, nor does the Council have any statutory powers to support its claim to govern the acupuncture profession. We give this organisation no special recognition - it is not, in any case, our policy to show preferment to any one organisation working in a particular field of complementary medicine over and above other organisations in the same field.

To give you some background about the Department's general approach to statutory regulation of the complementary medicines professions, our view is that the issue of whether to attempt to achieve this statutory status is a matter for the professions themselves to consider. Should a particular profession wish to try for statutory regulation, as has recently happened with osteopaths and chiropractors, it must first satisfy us that it is able to meet certain strenuous conditions - including achieving a clear consensus between the different groups within the profession on the way forward - and also that it has the support of the medical profession. This has not yet happened in the case of acupuncturists and, although we would welcome the establishment of soundly-based voluntary systems based on a systematic body of knowledge, a well-developed education and training base, workable registration scheme and enforceable code of practice, we do not ourselves take any lead in establishing them

I hope this answers your query sufficiently. If you have any further questions relating to the Department's standpoint, please contact me again and I will be glad to answer them.

Yours faithfully

Branch HEF2

g:miscelto

IMPROVING THE HEALTH OF THE NATION

Appendix 16

Letter confirming the
government's "benevolent neutrality"
Dated 19.1.95

RG.4514140.01

Richmond House 79 Whitehall London SW1A 2NS Telephone 071 210 3000
From the Parliamentary Under Secretary of State

POH(6)4514/140

19-1-95

Dear Anthony.

Thank you for your letter of 5 January enclosing one from your constituent Mr M C Tozer of The Old Vicarage, Plymouth Road, Kingsbridge expressing concern about new EC regulations which restrict an individual's freedom to obtain complementary medicine treatment such as spiritual healing.

Within the UK, the majority of complementary medicine is provided by practitioners and therapists working almost exclusively in the private sector. Except in a few, very specific circumstances, such as, for example, purporting to cure cancer or AIDS, these practitioners have the right under common law to offer their services privately to members of the public. In the same way, members of the public are free to consult whomsoever they wish about their health. These are important principles on which the UK Government sets a great deal of store. The UK Government's stance towards complementary medicine, described as 'benevolent neutrality', is therefore one of not wishing to restrict the practice of complementary therapists, or the choice of the public in using their services.

We would resist, on grounds of subsidiarity, any proposals the European Commission may make instructing Member States to regulate, which would restrict the publics' access to complementary therapists.

Yours [illegible]

IMPROVING THE HEALTH OF THE NATION

Appendix 17

MLX249 Circular

Department of Health

MEDICINES CONTROL AGENCY

Market Towers 1 Nine Elms Lane London SW8 5NQ

Telephone: 0171 273 0131

Facsimile: 0171 273 0676

To: interested organisations

6 November 1998

Dear Sir or Madam

CONSULTATION LETTER: MLX 249

Proposed amendments to The MEDICINES FOR HUMAN USE (MARKETING AUTHORISATIONS ETC.) REGULATIONS 1994

INTRODUCTION

1. I am writing to consult you about proposals to amend the Medicines for Human Use (Marketing Authorisations Etc.) Regulations 1994.

BACKGROUND

2. Regulation 3 (1) of the Medicines for Human Use (Marketing Authorisations Etc.) Regulations 1994 provide that no relevant medicinal product, (i.e. medicines for human use which are subject to EC medicines legislation), unless exempt, shall be placed on the UK market or distributed by way of wholesale dealing unless a marketing authorisation has been granted for it by the licensing authority or the European Commission. Schedule 3 to the Regulations contains offences relating to the marketing of relevant medicinal products without marketing authorisations.

3. The European Court of Justice has ruled that it is for national authorities to determine, subject to review by the Courts, whether or not a product should be controlled as a medicine. Under EC and domestic law it is the MCA, on behalf of the UK medicines licensing authority, which has the initial responsibility of deciding what is or is not a medicinal product so as to protect the public against the dangers to public health which can result from the marketing of unlicensed medicinal products. Details of how the Agency classifies such products are found in its guidance leaflet MAL 8 "A Guide to What is a Medicinal Product", attached as Annex 1.

PROPOSALS

4. For greater legal certainty and transparency of decision-making it is proposed to put the classification process and the decisions which emerge from it onto a statutory basis. The aim is to open up the process and enhance confidence that classification decisions will

be taken and implemented fairly and consistently. The proposed classification procedure is summarised in the flow-chart at Annex 2. The principal features are

(i) an MCA notice, issued on behalf of the licensing authority, that it is minded to determine that a product is a relevant medicinal product;

(ii) the right of a recipient of the notice to make written representations, or to make oral representations on the issues;

(iii) that, in any legal proceedings, a final decision at the end of the process that a product was a medicinal product would be sufficient evidence that it *was* a medicinal product, unless it is shown that the licensing authority's decision was made unreasonably;

(iv) specific time limits for each stage of the process.

Draft legislative amendments are attached as Annex 3.

THE REVIEW

5. It is proposed that, where a company decides to make representations, a review will be carried out by a Committee comprised of a Chairman supported by a maximum of two members appointed by the licensing authority. The Chairman would be permanent and a senior member of the Agency's staff, supported by two members drawn from a pool of experts chosen for their expertise in the area most applicable to the product under consideration. Members of the Committee would have no previous involvement in the provisional decisions under review. The Committee would review all papers and in the case of an oral review hear argument. Its recommendations would be considered by the licensing authority when making a final determination.

COSTS

6. Costs to the MCA would arise when a company decided to invoke appeal procedures. It is anticipated that transferring the present non-statutory decision-making process onto a statutory basis would not impose additional costs on industry. However, if you consider the legislation would impose either recurrent or non-recurrent costs on your business, please provide details in your response (see par. 7 below).

COMMENTS

7. You are invited to comment on these proposals and a form is attached for your reply.

8. Comments should be addressed to Paul Brittain in room 619 at the above address, to arrive **by 31 December 1998**.

9. Subject to the agreement of Ministers, we plan to implement the changes from 1 April 1999 by laying a Statutory Instrument in Parliament.

POM-MLX

MAKING COPIES OF REPLIES AVAILABLE TO THE PUBLIC

10. To help informed debate on the issues raised by this consultation exercise, and within the terms of the Code of Practice on Access to Government Information ("Open Government"), the Agency intends to make copies of comments received publicly available. Copies will be available shortly after the public consultation has ended.

11. The Agency's Information Centre at Market Towers will supply copies upon request. Copies may be further reproduced. An administrative charge, to cover the cost of photocopying and postage, may be applied. Alternatively, personal callers can inspect the replies at the Information Centre by prior appointment. To make an appointment, telephone 0171-273 0351.

12. It will be assumed that your comments can be made publicly available in this way unless you indicate that you wish all or part of them to be treated as confidential and excluded from this arrangement. Under the Code of Practice on Access to Government Information, the Agency will not release confidential replies or replies containing personal confidential information.

Yours faithfully,

John Kneale
Manager, Policy & Borderline Unit

POM-MLX

A GUIDE TO WHAT IS A MEDICINAL PRODUCT

Introduction

1. The Medicines Control Agency (MCA) regulates medicinal products for human use in the UK in accordance with the Medicines for Human Use (Marketing Authorisations, Etc.) Regulations 1994, [SI 1994/3144], ("the Regulations") and the Medicines Act 1968 (" the Act").

2. It is the responsibility of the person or company marketing a product to do so in accordance with the relevant legislation, and in particular only to market a medicinal product in accordance with the Regulations. These provide that, unless otherwise exempt, a medicinal product may not be placed on the UK market without a marketing authorisation or product licence. This is granted by the Licensing Authority when it is satisfied that the product meets the prescribed standards for safety, quality and efficacy.

3. The status of many products occupying the "borderline" area between medicines and, for example, nutritional or cosmetic substances can be difficult to determine. These guidelines have been drawn up to explain the MCA's policy and practice on borderline products like these, and the principles on which they are based. The guidelines should not be applied to products on the borderline between medicinal products and medicinal devices.

4. The Cosmetics Directive 76/768/EEC, as amended, defines cosmetic products and sets limits for certain ingredients. Where medicinal claims are made for cosmetic products, the determination of an individual product's status should be informed by reference to both the Cosmetic and Pharmaceutical Directives.

5. Products which are clearly foods, or which are foods for particular nutritional uses as defined by Directive 89/398/EEC, come under food safety and food labelling legislation.

6. These notes are for guidance only, and may be subject to change and development over time where experience shows this to be necessary. They should not be taken as a complete or definitive statement of the law.

What is a "medicinal product"?

7. The Regulations set out the current legal regime in the UK for the grant, variation, renewal, suspension and revocation of a marketing authorisation for a **"relevant medicinal product"**. This is defined as a **"medicinal product for human use to which Chapters II to V of Directive 65/65 EEC apply"**.

Article 1 of Directive 65/65 EEC defines a "medicinal product" as:

(a) **"Any substance or combination of substances presented for treating or preventing disease in human beings or animals".**

(b) **"Any substance or combination of substances which may be administered to human beings or animals with a view to making a diagnosis or to restoring, correcting or modifying physiological functions in human beings or animals is likewise considered a medicinal product".**

The paragraph identifications (a) and (b) are not part of the definition and are added here solely for ease of reference later on.

MCA policy and practice

8. In the past when deciding a product's status under the Medicines Act 1968, the MCA placed particular emphasis on the claims made for the product and less on the ingredient(s) and other factors. However, changing circumstances, European Court of Justice (ECJ) judgements, the evolution of professional opinion and changes in marketing practices have required corresponding changes to the way the Agency assesses products whose status is in doubt. In particular, it takes full account of the ECJ view that competent authorities of Member States should consider all the characteristics of the individual products, and are obliged to consider what impression of the product "an averagely well informed consumer" would be likely to gain.

9. In practice, the MCA considers each individual product on its merits and any information which may have a bearing on the product's status. For example:

- The claims made for the product, implicit as well as explicit, (including any made on linked "help-lines" or publications, or in the product's actual name).
- The pharmacological properties of the ingredient(s) and any significant effect(s) they have on human beings.
- The labelling, and the packaging/package inserts, including any graphics.
- The promotional literature (including testimonials and any literature issued by a third party on behalf of the manufacturer or producer)

and advertisements (including those appearing in so-called "advertorials"

- The product form, (tablet, capsule etc.) and the way in which it is used.
- To whom the product or information about the product is directed, perhaps sections of the population with, or vulnerable to, a specific adverse condition).
- Whether there are similar licensed medicinal products on the market.

10. No single factor is necessarily conclusive or more important than any other.

Paragraph (a) of the definition

11. Paragraph (a) of the definition considers, in particular, the presentation of the product. The MCA looks at claims in the context of the product and its presentation as a whole - not in isolation. Nevertheless, the claims made for a product are normally a very strong factor in deciding whether it is medicinal by presentation. For example, the MCA may regard a product as licensable if "medicinal" claims (see paras. 14 to 17) are made for it, even though it is otherwise presented as a nutritional substance or cosmetic.

12. It is impossible to produce a definitive list of the kind of claims that the MCA regard as acceptable or unacceptable for an unlicensed product. However, the guidance in paras. 16 to 21 may be helpful.

Paragraph (b) of the definition

13. Paragraph (b) of the definition considers if the product may be administered with a view to correcting, modifying, or restoring a function of the body. If it contains any ingredient(s) with a significant pharmacological effect, this will indicate that the product may be medicinal by function.

14. Many herbs have well-established pharmacological properties: for example, as bronchodilators (Ephedra), as respiratory stimulants (Lobelia); or as sedatives (Valerian). The presence in a product, in significant quantities, of medicinal herbs like these (and there are many more) will be considered as evidence that the product is intended for a medicinal purpose.

15. A product presented as a nutritional substance or cosmetic may still be a medicinal product if it contains ingredients which have a significant pharmacological effect.

Medicinal claims

16. Claims to treat or prevent disease, or to interfere with the normal operation of a physiological function of the human body are regarded as medicinal. Claims of relief from symptoms, or to cure, remedy or heal a specific disease or adverse condition are similarly regarded as medicinal. In some contexts, "protect" or "avoid" may have the same meaning as prevent. Stress, anxiety and nervous tension are all adverse conditions, and claims to cope with or manage them are regarded as medicinal.

17. "Maintenance" claims are likely to be regarded as medicinal when made for a product targeted at a vulnerable section of the population if there is an implication that it will restore, or help to restore, a specific bodily function or organ to a normal healthy state.

18. On a case by case basis and considering each product on its merits, particular words which the MCA may regard as indicating or implying a medicinal claim include the following examples:

> restores; repairs; eliminates; controls; counteracts; combats; alleviates; clears; stops; removes; heals; cures; remedies; treats; avoids; protects; prevents.

19. Particularly if they are used in connection with, or in the context of, a disease, illness or specific adverse condition, words and phrases which are generally regarded as indicating or implying a medicinal claim include the following examples:

> help with/may help with/is said to help with; traditionally used for; is said to benefit those who suffer from; can lower cholesterol; strengthens or boosts the immune system; fights gum disease; stops craving for; burns fat; increases metabolic rate; helps body adjust after crossing time zones (jet lag is an adverse condition); strips off sun damaged pre-cancerous cells; at the first sign of a spot, use.....; calms; calming; detoxifies; helps maintain normal water balance; stimulates the nervous system.

Non-medicinal claims

20. Generalised claims to "maintain" or "help to maintain" health or a healthy lifestyle are unlikely, taken alone, to be considered medicinal, (but see para 17)

21. Provided that they are not used in connection with, or in the context of, a disease, illness or specific adverse condition, the following words are not generally regarded as indicating or implying a medicinal claim:

> beneficial; revitalising; relaxing (except for products containing sedatives); refreshing, invigorating; uplifting; soothing.

Marketing authorisations/ product licences

22. Guidance on marketing authorisations/product licences is provided in MAL 81 (to be revised and published as MCA Guidance Note no 22 in the near future) and should be read alongside volumes 2A and 2B of the *Rules Governing Medicinal Products in the EU*.

2A ISBN 92 828 2060 2
2B ISBN 92 828 2061 0

The "Rules" are available from:

The Stationery Office Books
Publications Centre
PO Box 276
London SW8 5DT

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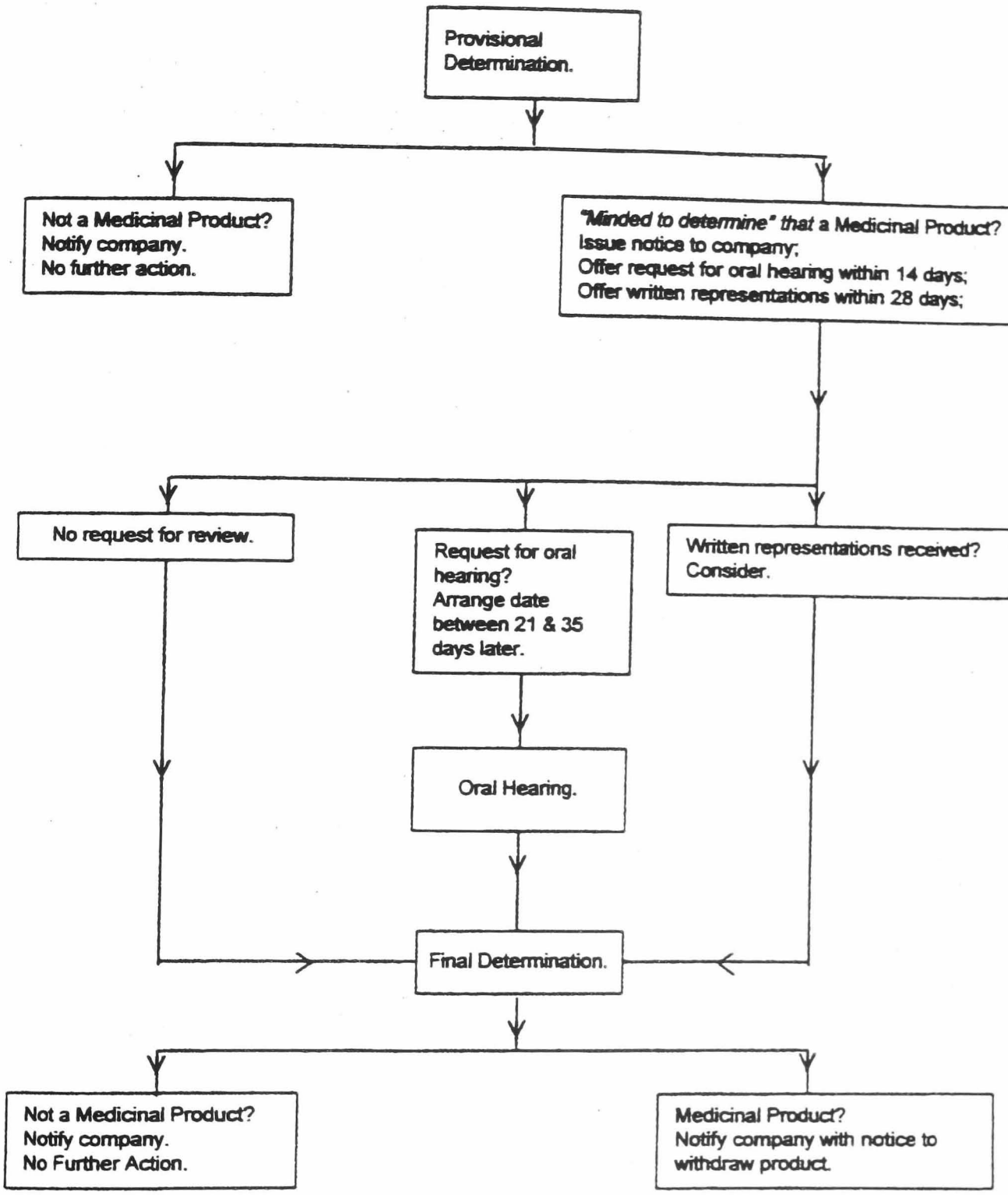
"Borderline" Product Classification

Annex 2



STATUTORY INSTRUMENTS

1998 No.

MEDICINES

The Medicines for Human Use (Marketing Authorisations Etc.) Amendment Regulations 1998

Made - - - - -	*1998*
Laid before Parliament	*1998*
Coming into force - -	*[1st April 1999]*

The Secretary of State, being a Minister designated for the purposes of section 2(2) of the European Communities Act 1972(a) in relation to medicinal products(b), in exercise of the powers conferred upon him by the said section (2) and of all other powers enabling him in that behalf, hereby makes the following Regulations:-

Citation, commencement and interpretation

1. (1) These Regulations may be cited as the Medicines for Human Use (Marketing Authorisations Etc.) Amendment Regulations 1998 and shall come into force on [1st April 1999].

(2) In these Regulations, "the principal Regulations" means the Medicines for Human Use (Marketing Authorisations Etc.) Regulations 1994(c).

Insertion of regulation 2A into the principal Regulations

2. After regulation 2 of the principal Regulations (responsibility for Member States'

(a) 1972 c.68.

(b) S.I. 1972/1811.

(c) S.I. 1994/3144; amended by S.I.

functions under the Regulations and Directives) there shall be inserted the following regulation-

"Borderline products"

2A. (1) Where the licensing authority is of the opinion that a product without a marketing authorization is a relevant medicinal product, they may, by a notice in writing served on any person who has placed or who in the opinion of the licensing authority may place the product on the market-

(a) inform him that they are minded to determine that the product is a relevant medicinal product (in this regulation referred to as "the provisional determination"); and

(b) advise him that if he disagrees with the provisional determination, he may request that the licensing authority review their provisional determination, provided that within 2 weeks of the date on which he was informed of the provisional determination (in this regulation referred to as "the date of the provisional determination") he makes that request, and

(i) within 4 weeks of the date of the provisional determination, he furnishes the licensing authority with written representations explaining why he considers that the product is not a relevant medicinal product, or

(ii) within 2 weeks of the date of the provisional determination, he informs the licensing authority in writing that he wishes to make oral representations to the licensing authority explaining why he considers that the product is not a relevant medicinal product.

(2) Where the licensing authority has been informed, pursuant to paragraph (1)(b)(ii), that a person wishes to make oral representations to them, they shall, after consultation with that person ("the applicant"), fix a date for the oral hearing, and-

(a) the licensing authority shall offer the applicant a date for the oral hearing and that date shall be no less than 3 weeks and no more than 6 weeks after the date on which they were informed by the applicant that he wished to make representations to them, and if the applicant agrees to that date, that date shall be the date fixed for the oral hearing; or

(b) if the applicant does not accept the date offered pursuant to sub-paragraph (a), the oral hearing shall be as soon as practicable after the date offered, provided that licensing authority shall, if they are unable to agree to a date with the applicant, set a date for the oral hearing and that date shall be no more than 9 weeks after the date on which they were informed by the applicant that he wished to make representations to them, and that date shall be the date fixed for the oral hearing,

except that, in circumstances where a date has been fixed in accordance with sub-paragraphs (a) and (b), where the licensing authority considers that the nature and complexity of the issues warrant additional time for the preparation for the hearing, they may alter the date of the hearing to a different date, that different date shall be the date fixed for the oral hearing.

(3) Where a person on whom a notice has been served under paragraph (1)-

(a) has not requested that the licensing authority reviews their provisional determination within 2 weeks of the date of the provisional determination; or

(b) has made such a request but-

(i) has withdrawn the request,

(ii) has not informed the licensing authority in writing within 2 weeks of the date of the provisional determination that he wishes to make oral representations to the licensing authority explaining why he considers that the product is not a relevant medicinal product and has not, within 4 weeks of the date of the provisional determination, furnished the licensing authority with written representations explaining why he considers that the product is not a relevant medicinal product, or

(iii) has not made any oral representations at an oral hearing held on a date fixed in accordance with paragraph (2),

the licensing authority shall, after further consideration of the matter, determine whether or not the product is a relevant medicinal product and shall inform that person in writing of their determination.

(4) If a person on whom a notice was served under paragraph (1)-

(a) has made written representations to the licensing authority pursuant to paragraph (1)(b)(i); or

(b) has made oral representations to the licensing authority at an oral hearing arranged in accordance with paragraph (2),

the licensing authority shall, after further consideration of the matter and in particular after having considered any such representations, determine whether or not the product is a medicinal product and shall inform that person in writing of their determination.

(5) In respect of any product which the licensing authority determines, in accordance with paragraph (3) or (4), is a relevant medicinal product the licensing authority may by a notice in writing served on any person who has placed or who in the opinion of the licensing authority may place the product on the market, require that he shall-

(a) stop marketing the product from a date specified in the notice; or

(b) not place the product on the market,

unless or until a marketing authorization is granted in respect of that product.

(6) In any legal proceedings, whether civil or criminal-

(a) a determination by the licensing authority in accordance with paragraph (3) or (4) that a product is a relevant medicinal product shall, unless it is shown to have been made unreasonably, be sufficient evidence that the product is a relevant medicinal product, unless the licensing authority have announced that they have annulled the determination; and

(b) a statement by the licensing authority to the effect that a determination by them that a product is a relevant medicinal product was made in accordance with this regulation shall, until the contrary is proved, be sufficient evidence that the determination was made in accordance with this regulation.

(7) For the avoidance of doubt-

(a) nothing in this regulation requires the licensing authority to determine in accordance with this regulation whether or not a product is a relevant medicinal product before commencing legal proceedings in the course of which the issue of whether or not the product is a relevant medicinal product may arise;

(b) the existence of legal proceedings in the course of which the issue of whether or not a product is a relevant medicinal product may arise does not, of itself, preclude the licensing authority from making a determination of that issue in accordance with this regulation;

(c) nothing in this regulation precludes a determination by the licensing authority that a product is a relevant medicinal product otherwise than in accordance with this regulation in appropriate circumstances, in particular where-

(i) they have already determined (whether in accordance with this regulation or otherwise) that a product which contains the same active ingredient or combination of active ingredients, or which (being an instrument, apparatus, appliance, material or other article) achieves its principal intended action by the same means, is a relevant medicinal product because of the effect which it causes, or

(ii) in order to ensure the fulfilment of a Community obligation, contribute towards the fulfilment of a Community objective or to safeguard the public from a risk to their health the licensing authority considers it is necessary for them to take measures to ensure that the supply of the product is prohibited and the product is withdrawn from the market without delay,

but without prejudice to their power to make a determination in accordance with this regulation in respect of any product without a marketing authorization which, in their opinion, is a relevant medicinal product, where they consider it appropriate to do so; and

(d) where the issue of whether or not a product is a relevant medicinal product arises in legal proceedings and the licensing authority has determined that the product is a relevant medicinal product otherwise than in accordance with this regulation, paragraph (6)(a) shall have no effect with regard to-

(i) the standard of proof required to determine the issue, or

(ii) where the burden of proving whether or not the product is (or is not) a relevant medicinal product may lie.".

Amendment of Schedule 3 to the principal Regulations

3. After paragraph 1 of Schedule 3 to the principal Regulations (offences, penalties etc.) there shall be inserted the following paragraph-

"**1A.** Where the licensing authority in respect of any product serves a notice on any person under regulation 2A(5) requiring him-

(a) to stop marketing the product from a date specified in the notice unless or until a marketing authorization is granted in respect of that product, if after the date specified-

(i) he places that product on the market, or

(ii) in the course of a business carried on by him, he sells, supplies to a member of the public or procures for sale or for supply to a member of the public that product,

without a marketing authorization having been granted in respect of that product, he shall be guilty of an offence; or

(b) not to place the product on the market unless or until a marketing authorization is granted in respect of that product, if he thereafter places the product on the market without a marketing authorization having been granted in respect of that product, he shall be guilty of an offence,

unless the licensing authority have announced that they have annulled the determination or it has been overridden by a court.".

Department of Health
[date]

One of Her Majesty's Principal Secretaries of State

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations make amendments to the Medicines for Human Use (Marketing Authorisations Etc.) Regulations 1994 ("the principal Regulations"), which implemented for the United Kingdom a range of Community measures relating to the marketing of medicinal products for human use.

Regulation 2 of these Regulations inserts a new regulation 2A into the principal Regulations which is a new statutory procedure for determinations by the licensing

authority (as defined in the Medicines Act 1968(a)) of whether or not a product is a relevant medicinal product for the purposes of the principal Regulations and so is regulated under those Regulations. The procedure allows for representations to be made against a provisional determination, but once a final determination is made, it will be sufficient evidence for the purposes of legal proceedings that a product is a relevant medicinal product, unless it is shown to have been made unreasonably or has been annulled.

If the licensing authority makes a determination that a product is a relevant medicinal product, they may, by a notice in writing, require that a person either does not place the product on the market or that he stops marketing the product from a date specified, unless or until a marketing authorization is granted in respect of that product. Regulation 3 inserts new offences into Schedule 3 of the principal Regulations relating to breaches of such notices.

(a) 1968 c.67; *see* section 6 of that Act.

Appendix 18

Code of Practice for CMAS

The Chinese Medicine Association of Suppliers (CMAS)

Code of practice

Each member shall act, at all times, in such a manner as to:

- ♦ supply authenticated individual herbs and genuine non-toxic herbal products
- ♦ safeguard the biodiversity in the use of Chinese medicine
- ♦ act with due regard to laws, customs and practices of the land
- ♦ promote good working relationships with other members, manufacturers, practitioners and consumers
- ♦ maintain and improve his or her professional knowledge and competence
- ♦ use appropriate designatory letters on letterheads and in advertisements and publicity providing that the placement and content of such advertising material always conforms to the high standards of professional practice, without hint or reference to any form of impropriety
- ♦ conform to GMP and GCP set down by the Association

A detailed paper on the Code of Practice will be available to all members in due course

Discipline

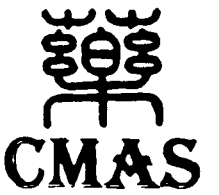
All members are subject to CMAS's Code of Practice

CMAS reserves the right to investigate any reported incident of misconduct or breach of its Code of Practice and to take whatever action it deems to be appropriate in the interest of CMAS, the public at large and Chinese medicine.

March 1999

Appendix 19

CMAS Logo



CHINESE

MEDICINE

Association of

Suppliers

Contact:

Henry Lee
Middlesex University
Queensway
Enfield
Middlesex
EN3 4SF
Tel/Fax
0181-362-6186

"Quality & safety

in the supply of

Chinese medicine"

Appendix 20

Message of support from Chinese Agency

Ladies & Gentlemen,

We regret that we are unable to be with you on 28.4.99 to take part in the Launch as originally planned.

At the l, we are very interested to learn the development of self regulating CMAS and we fully support its aims and objectives to maintain and enhance the quality of Chinese medicine and to promote Chinese medicine in the UK. In the matter of public health, quality and safety is also a priority for us in China.

We are aware that you are supported and recognised by the Medicines Control Agency of Department of Health with whom we are also collaborating very closely. We have also noted the work CMAS has done since its inception in September 1998.

We take this opportunity to wish CMAS a very successful future and achieve its mission and look forward to working with CMAS in the very near future.

We hope this organisation will work closely with relevant government organisations and achieve effective self-regulation.

99.4.25

Professor Li Zhenji
Deputy General Director

People Republic of China

Appendix 21

Raw data from postal questionnaire to CMAS members

Questionnaire for CMAS members

Please either tick (✓) or write your answers as appropriate.

1) Has CMAS met your expectations?

yes.....11
partially..... ... 1
no..... 1

please explain including why you join CMAS.....
.....
.....
.....

2) How much do you agree with CMAS's proposed mission, aims and objectives, and code of practice ?

fully agreed.....12
partially agreed..... 1
totally disagreed.....0

Please explain your answer with suggestions.....
.....
.....

3) What should be CMAS's priority?

authentication.....9
register products as medicine.....7
self-regulation.....10
simply influencing voice..... 5
other.....1

Please explain your answer:.....
.....
.....

4) Are your views heard and acted upon at the meetings

yes.....10
no.....0
partly.....3

please explain with suggestions.....
.....
.....

5) So far, how satisfied are you with CMAS's performance

very satisfied.....7
satisfied.....6
dissatisfied.....0
very dissatisfied..... .0

Please explain your answer.....
.....
.....

6) Please give your views on the proposed launch

7) In your view how should CMAS move forward?

8) Please indicate in order of preference the organisations CMAS should have liaison with.
(1= very much.....)

MCA.....13
ATCM 3
BAeC.....1
BHMA..... 2
EPHA.....3
RCHM.....2
other 0

please name the "other"

lease explain your answer with suggestions.....
.....
.....

9) How much time are you will to give to the running of your CMAS? please indicate hours per week

10) How frequent are you willing to to attend meetings

monthly.....11
two monthly..... 1
three monthly..... 1
six monthly..... 0

11) Which is your best time and weekday to attend meeting?

12) Please indicate your annual turn-over

under £1m.....9
£1m - £1.5m.....4
£1.5m - £2m.....0
£2m +.....0

13) Is it time to move CMAS to a permanent base?

yes..... 2
no.....10
Not sure..... 1

Any suggestion?

14) Please add any comments you may have, using extra paper if necessary.

Thank you very much for your kind assistance. Please return within one week of receiving this questionnaire in the addressed envelope.

Q1 (1) to achieve better quality for CHM. Reduce malpractices
(3) Because it seems a good idea to form a lobby for Chinese Medicine
(4) It is essential that TCM suppliers have a professional organisation to represent them and that the quality of product is of the highest standard
(5) Survival and better quality
(6) An excellent way to lobby for change and make Chinese medicine available to public with quality
(7) to have a unified voice
(9) a good deal of development in a short time. Success where to date there had been failure
(10) create a good political environment for Chinese Herbal Medicine
(11) To have a voice for suppliers
(12) It is essential that we have increased political representation in all areas of Chinese medicine especially supplies
(13) to urge suppliers to put proper quality control procedures in place

Q2 (1) We discussed them and we decide them ourselves
(4) I believe that quality of product and public safety is the number one priority, our aim is to introduce authentication
(5) I have to see this in operation very quickly
(9) some reservations about ties with Chinese Government
(10) so far so good, don't add unnecessary items
(12) I agree partially as CMAS is investigating its role within the area of Chinese herbal supplies
(13) Essential steps for suppliers of Chinese herbal products

Q3 (1) I like to see CH products registered as medicine
(2) Focusing in helping to create a new regulatory category for herbal medicines
(3) work towards a soft licensing procedure. raise the standard of quality, raise the public confidence in TCM products
(5) It is important we can show that we are able to run our own house properly first
(6) public must be confident in TCM
(8) Only strong self-regulation can prevent strict government control
(9) registering products with MCA/EU as other pharmaceutical medicines
(12) Authentication is a process that Kew is involved with. Let's support them. Self-regulation is essential - and authorities want it.
(13) To self-regulate to maintain high quality standard

Q4 (3) Views are heard. In a discussion process there are agreements and compromises
(4) the meetings are very open and constructive
(5) I enjoyed Henry's firm and impartial chairmanship. So far the best meetings among the competitors
(6) Henry is both generous and impartial. Good Chairman
(10) We are all going in same direction at the moment
(12) Too early to say. We are in a process of formation

Q5 (4) The MCA will I believe want to start seeing action not words. The sooner we are launched we can get on to the actual work the better
(8) Not all the suppliers here yet
(10) you are a good man, Henry!!
(12) Satisfied that we are in a process of formation that seems to progress down a logical line

Q6 (1) We need to do this as early as possible
(2) The launch should be carefully managed so as to have the maximum positive impact on the MCA and the public
(3) It is a good thing and well prepared opportunity to create a good public

impression
(4) It will be good to have a high profile launch but we must then be seen to actively tackling our published aims and objectives
(5) excellent idea
(6) good opportunity to tell the public we care
(7) open to discussion
(8) Launch should go ahead as planned
(9) An independent venue is best
(10) Last meeting was good, ideas for the launch
(11) I fully support this

Q7 (1) We have moved very far and it is good
(2) CMAS should focus on implementing the code of ethics and practice, attract new members and work closely with MCA and other organisations to achieve a new regulatory status for herbs
(3) It should be clarified which quality standards. can be reached for the various category of herbal products (i.e.) pills, raw herbs, granules, work out the public image of TCM, actively influence national & European legislation, make positive suggestions
(4) We should try and embrace all branches of TCM. Publicise our desires to improve quality to the practitioners & the general public
(5) Steadily and resolutely
(6) agree on level of Quality and impose it. We all have our own quality. We need one public will see
(7) discussion needed
(9) Lobby for a soft licensing
(10) Keep going slowly
(11) We have moved very quickly. Need to organise ourselves next few months
(12) At these early stages- if CMAS manages to continue to survive - that is great progress! Bear in mind we have had 2 other failed herbal suppliers groups

Q8 (4) Good relations with MCA are essential if we wish to be a self regulating body
(10) Start with MCA and develop rest later
(12) all countries that manufacture and export traditional medicine should be alerted that their potential huge export is under threat and they should offer support (financially)

Q9 (2) Hard to quantify at this stage. It is a new organisation and I believe everyone involved needs to make extra efforts
(4) will vary according to commitments and importance of CMAS agenda
(12) If there is a campaign for our survival then 20 hours per week

Q13 (1) Too early. Need to think carefully about the site
(2) not sure

Q14 (1) Thank you for your leadership and help to organise this for us.
(3) It is good to see competitors working together for the greater good
(5) I like to take this opportunity to thank Henry for an excellent job he has for Chinese medicine. He gives us something to aim for and be first to achieve it for others to follow
(6) Thank you, Henry, to bring us competitors together and to encourage us to work together
(7) I do not think we are ready and have the strength to CMAS to a permanent base
(11) Excellent work. You have achieved a lot in such a short time
(12) We at Mayway - thank Henry for all the work and organising he has done so far. It is not easy setting up such a disparate group of people. I feel this time we may succeed in our aims and objectives