Fall 2020

Medicinal Roots 相慧 Magazine

Ancient Wisdom - Modern Healthcare

IN this issue

Photo Submissions

We are accepting photography submissions from MRM readers. If you have TCM themed photography you'd like featured, email our editor drkimtcm@gmail.com

MRM 中醫藥慧

EDITOR-IN-CHIEF
Kim Graham

DIRECTOR Kim Graham

PUBLISHER Kim Graham

CHINESE LANGUAGE Weijia Tan

COPY EDITORS Kyla Drever
Shanie Rechner
Katherine Moffat

SOCIAL MEDIA MANAGER Kim Graham

BUSINESS DIRECTOR Kyla Drever

ADVERTISING DIRECTOR Kyla Drever

CREATIVE SERVICES Bizbee Creative

PHOTOGRAPHY Unsplash.com and Pixabay.com

CONTACT

medicinalrootsmagazine.com
medicinalrootsmagazine@gmail.com

Kim Graham, Dr.TCM
Editor-in-Chief, Director, Publisher
drkimtcm@gmail.com
www.drkimtcm.com

Kyla Drever, Dr.TCM
Editor, Business Advisor
drkdtcm@gmail.com
www.kaizenholistics.com

CONTRIBUTE

MRM encourages all article submissions addressing any topic related to the practice of acupuncture and Traditional Chinese Medicine (TCM). Email submissions to medicinalrootsmagazine@gmail.com

Visit our website and click **Submission Guidelines** for more information.

Front Cover Image: Dan Freeman for Unsplash.com

Back Cover Photo: Nathan Anderson for Unsplash.com

by Mallory Harman, LAc, MAcOM, Dipl OM

Failures According to Me and Huang Di

An Introspection Into How We May Be Failing BIPOC

PHOTO: Mallory Harman

As medical providers, questions that we often ask ourselves throughout our careers are essentially rooted in the same fundamental question: how can we better serve our patients? We spend our time and much of our careers in insatiable quests for answers to this, often framing it in two reductionistic questions: 'how do I treat (blank)?' and 'how do I diagnose (blank)?' We search for answers to these questions by attending things like pulse diagnosis trainings, reading research articles, and obtaining case-relevant advice from colleagues. We may revisit classical texts in an attempt to gauge some meaning from the translated interpretations.

While these two questions are important and relevant to us, they are limited in what it means to provide good patient care. Reducing the scope of patient care into nothing more than diagnosis and treatment is a narrow-viewed approach to practice and challenges us to consider, 'are we asking the wrong questions?'

> *What if we took that fundamental question of 'how can we better serve our patients' and instead asked the question, 'how are we failing our patients?'*

To answer this question honestly requires us to reframe our thinking patterns and, with deep humility, to remove our blinders and look into that murky, uncomfortable place that no practitioner particularly wants to go.

We can't begin to talk about failures or best practices without first acknowledging the people who aren't in our practices. The generalization of the statement 'how can we better serve our patients,' in a way,

makes the assumption that all people are our patients. At the very least, it assumes that all people have access to our services. It is a dangerous assumption, as it turns a blind eye to the 93.7%[1] of the population who has not accessed acupuncture services. How many of these people have not come in by choice? How many have not come in due to a lack of education on complementary and alternative medical (CAM) services? Most importantly, how many have not accessed our clinics due to a wide variety of barriers that exist for them?

In a time of global dialogue on racism, health and disparities, it is imperative that we acknowledge the disproportionate rates of Black, Indigenous, and people of color (BIPOC) patients in our clinics, not mention providers in our field.

So, how are we as white acupuncturists making up 68% of the acupuncture profession[2] failing BI-POC communities?

[1] *Yan X, Ni Q, Wei J, Lin L. A systematic review and meta-analysis of type 2 diabetes mellitus treatment based on the "three-typed syndrome differentiation" theory in Chinese medicine. Chin J Integr Med. 2014;20(8):633-640.*

[2] *Bromley A, Tseng L. COVID-19 CRISIS: Working Together Town Hall Meeting — Cultural Competency. National Certification Commission For Acupuncture and Oriental Medicine (NCCAOM). https://www.nccaom.org/nccaom-webinars-posted/townhalls-meetings/. August 19, 2020.*

I would argue that the first and most significant failure of Chinese medical providers is not being accessible. To be accessible is not as simple as having a front desk person and an updated website. To be accessible means to be approachable, affordable and reachable. Everything from clinic location to English-exclusive forms to an all white staff to out-of-pocket pay structures will influence whether or not we are actually accessible to BIPOC. To be accessible also means to step outside of our clinics and show up for communities of color in their churches, on their reservations, and in their community centers. How can we show up for BIPOC patients if they never become our patients? Isn't our first failure that we've robbed them of the opportunity to fail them? Are we then perpetuating a problem that, on some level, is causing or worsening the condition for which they are seeking healthcare?

So when BIPOC patients do walk through our doors, how do we fail them then?

Chapter 77 in the Nei Jing[3] titled 'The Five Failures of Physicians' just might give us some answers.

According to Huang Di, the first failing of a physician occurs in diagnosis.

'When a physician overlooks factors such as a patient's social and material status that could

[3] *Ni M. The Yellow Emperor's Classic of Medicine: A New Translation of the Neijing Suwen with Commentary; Shambhala:Shambala Publications, Inc.; 1995.*

PHOTO: Mallory Harman

contribute to the development of disease, that physician ends up making an incorrect assessment.'

As we look at overwhelming ethnic and racial health disparities, we must acknowledge the in-creased rates of comorbidities and disease within BIPOC populations. American Indians and Alaska Natives (AI/AN) have a greater chance of having diabetes than any other US racial group (2x more likely than whites).[4] African Americans are more likely die at earlier ages than whites from diseases such as high blood pressure, diabetes, and stroke.[5]

Some socioeconomic factors that increase risk of disease in BIPOC patients include unemployment, living in poverty and/or lack of resources to adequate healthcare. Barriers for some rural Native communities include limited access to foods that make up a nutritious diet[6] and a greater probability of experiencing financial burden associated with travel.[7] For some Latinx immigrants, barriers to primary healthcare include high cost of services, lack of insurance, and language barriers.[8]

Now more than ever the undeniable effects of racism and its influence on policy and important structural systems that allow these health inequities to persist[9] have been exposed through the current COVID-19 crisis.

[4] *Centers for Disease Control and Prevention. National Diabetes Statistics Report 2020: Estimates of Diabetes and Its Burden in the United States. https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf. Accessed June 9, 2020.*

[5] *Centers for Disease Control and Prevention. African American Health. https://www.cdc.gov/vitalsigns/aahealth/. Accessed September 10, 2020.*

[6] *O'Connell M, Buchwald DS, Duncan GE. Food access and cost in American Indian communities in Washington State. Journal of the American Dietetic Association. 2011;111(9):1375.*

[7] *Espey, D., Jim, M., Cobb, N., Bartholomew, M., Becker, T., Haverkamp, D., & Plescia, M. (2014). Leading causes of death and all-cause mortality in American Indians and Alaska Natives. American Journal of Public Health, 104(S3), 303–311.*

[8] *Luque JS, Soulen G, Davila CB, Cartmell K. Access to health care for uninsured Latina immigrants in South Carolina. BMC health services research. 2018;18(1):310.*

[9] *Gee G, Ford C. Structural Racism and Health Inequities: Old Issues, New Directions. Du Bois Rev. 2011;8(1):115-132.*

Recognizing these social and economic factors is not only important in diagnosis (as Huang Di described) but, in my opinion, in forming appropriate and individualized treatment plans considering all factors and challenges pertaining to the patient's health.

The second failing occurs in treatment.

Huang Di discusses the importance of recognizing a patient's emotional experiences 'which can affect the patient's health greatly.' He describes that adequate recognition of these will influence the proper treatment e.g. tonification or sedation. His ex-ample 'anger damages yin' would therefore lead a provider to tonify yin.

Identifying and treating harmful byproducts of certain emotional experiences is an important and rewarding process, but are we remembering to approach with our holistic lenses to consider the source of these emotional experiences? In other words, are we looking at the macrocosmic roots that might be inducing or perpetuating these emotions?

PHOTO: Mallory Harman

Racism, oppression, and injustice, for ex-ample, are known to affect the mental and emotional wellbeing in many patients, specifically BI-POC patients. Research reviews consistently find that persons who self-report exposures to racism have greater risk for mental and physical ailments.[10],[11] One reason that many undocumented Latino(a)/Latinx immigrants delay or decide not to seek care at all is due to a generalized fear resulting from anti-immigrant rhetoric.[12] Wouldn't the most effective form of treatment for these emotional experiences be to eradicate their roots before they have the opportunity to create disease in the first place? Is it not it our duty, as advocates of preventative medicine, to recognize and eliminate our own racist policies, internal bias and discrimination that exist in our clinics and in ourselves? Can we use our professional influences and privilege to confront these policies and biases that exist in our larger medical systems and institutions? Can we license ourselves to get political?

The third failing occurs when the physician lacks deductive reasoning.

Much information is gathered about the patient's condition including not just patient symptoms but 'lifestyle, occupation, social and family circumstances, emotional stress, and immediate environment.'

This concept overlaps with the previous two, but speaks largely to the idea of holism: recognizing that our patients do not live inseparably from the influences around them. East Asian medicine is built on the concept of interconnectedness, as is the more recent concept of intersectionality.

As providers, are we picking and choosing which patients and issues that we advocate for? Are we speaking loudly about one issue and remaining quiet about another? Are we raising concerns and awareness on our personal feeds but remaining quiet on our professional ones? Do we then have a

[10] *Brondolo E, Brady Ver Halen N, Pencille M, Beatty D, Contrada RJ. Coping with racism: a selective review of the literature and a theoretical and methodological critique. J Behav Med. 2009 Feb; 32(1):64-88.*

[11] *Williams DR, Mohammed SA. Discrimination and racial disparities in health: evidence and needed research. J Behav Med. 2009 Feb; 32(1):20-47.*

[12] *Doshi M, Lopez WD, Mesa H, et al. Barriers & facilitators to healthcare and social services among undocumented Latino(a)/Latinx immigrant clients: Perspectives from frontline service providers in Southeast Michigan. PloS one. 2020;15(6):e0233839.*

PHOTO: Mallory Harmon

responsibility to merge our professional and personal roles because above all, we owe transparency to our patients? As holistic providers, these are important questions to be asking ourselves.

The fourth failing occurs in counseling.

'When a physician lacks compassion and sincerity, then a physician is hasty in counseling and does not make the effort to guide the patient's mind and moods in a positive way, that physician has robbed the opportunity to achieve a cure.'

Compassion and sincerity are, in my opinion, requisites for the job as a medical provider of any kind. I include active listening as a part of these traits Huang Di is describing, which I believe it is more important than 'guiding the patient's moods in a positive way.' However, even these two admirable traits are arguably only as useful as the feeling of trust the patient has in and is being understood by their medical professional. We must also apply Huang Di's message to the reality of todays white-dominated profession and uplift the importance of having practitioners who resemble the communities they aim to support. In a survey including 83% of patients identifying as POC, 73.3% of participants reported a preference for a provider who shares/relates to their culture.[13] Although cultural competence trainings are on the rise and have been proven to show some benefit to patients, there is still little evidence that this knowledge improves their ability to relate to and/or treat the population they serve.[14] So, how can we create access for BIPOC providers to enter this field?

PHOTO: Mallory Harmon

[13] *Coleman R. Barriers to Traditional and Complementary Medicine in the African American Community of Aurora/Denver, CO. Capstone presentation presented at AOMA Graduate School of Integrative Medicine. February, 2020; Austin, TX.*

[14] *Govere L, Govere EM. How Effective is Cultural Competence Training of Healthcare Provid-ers on Improving Patient Satisfaction of Minority Groups? A Systematic Review of Literature. Worldviews Evid Based Nurs. 2016 Dec;13(6):402-410.*

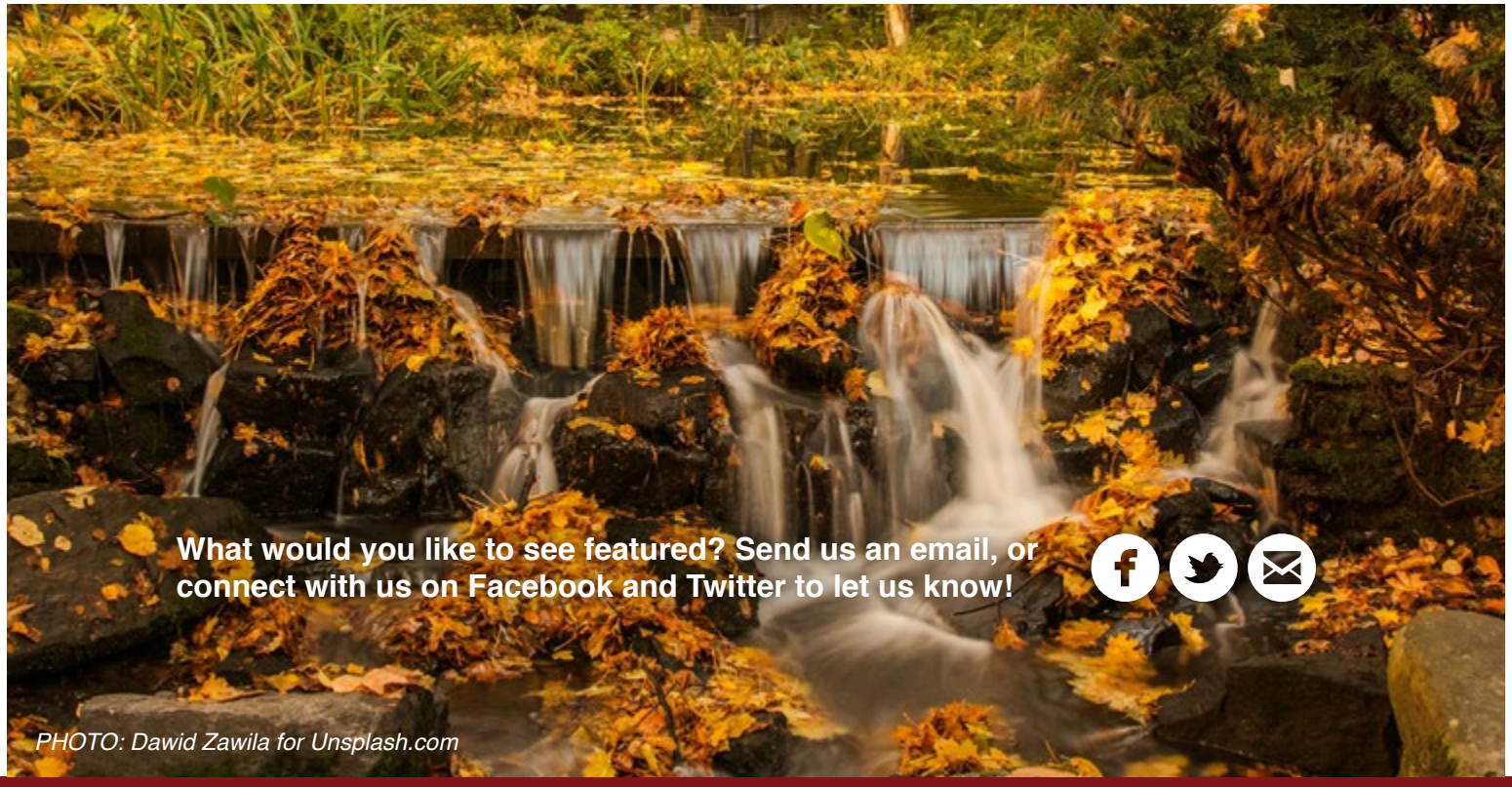

PHOTO: Dawid Zawila for Unsplash.com

The fifth failing occurs when a physician 'is simply inept and careless.' Do I even elaborate on this one?.

These five failures according to Huang Di may give us some answers as to where we might be failing, or at least they offer some thought provoking questions we can ask ourselves in efforts to do better by our BIPOC communities. But we may also need to challenge the Nei Jing, a book that was written before a time of colonization and multicultural societies. A book that was written under that same dangerous assumption that the patients referenced throughout apply to all people. What I didn't find in the Nei Jing were discussions on accessibility, on barriers, on racism or other such influences, that while they may not have applied to health and disease then, are alive - and very unwell - today.

So, is it up to us to continue the conversation, to write the next script for future providers to reference and rely on? Where do we even begin? I'm certainly no expert, but I do believe a good place to start is to ask ourselves these questions. Only through the yin space of introspection can we pull out fruitful action of yang.

PHOTO: Mallory Harmon

PHOTO: Evgeni Evgeniev for Unsplash.com

One thing I know for sure is that we cannot do this alone. The hope for me exists in the people and organizations who are already doing the work:

- Doctoral graduates like Dr. Rhonda Coleman who is researching topics like Barriers to CAM in the African American Community13 and Dr. Tamsin Lee (@ theinfluentialpoint), writing petitions and speaking loudly about important issues within our field;
- Projects that have been formed with the mission of supporting and empowering communities of color across borders, such as Crossroads Acupuncture, Acupuncture Relief Project, GUAMAP, and PanAfrican Acupuncture Project;
- Acupuncturists such as Jewel Thais-Williams in the US setting up clinics in underserved neighborhoods;
- Institutions such as POCA tech, whose mission is to make acupuncture education accessible and affordable, while also operating under the framework of Liberation Acupuncture: a praxis that begins with the needs and the perspectives of the oppressed, the exploited, and the excluded;[15]
- Models such as the National Acupuncture Detoxification Association (NADA), putting acudetox into the hands frontline workers, Indigenous tribal members, and everyday people;
- People outside of the field, for example film directors such as Mia Donovan and Jenna Dini Bliss who are uncovering the important and under-discussed historical roots of acudetox made accessible by Black and Puerto Rican activist groups.

Failure is inevitable but unwillingness to see where we are failing is complacency. Let us learn from each other, let us learn from the voices of our BIPOC communities, let us use our needles to pop open the closed circuit bubbles that our clinics and our minds exist in. Let's write the next classic.

- Mallory Harman

---

[15] *Liberation Acupuncture. What is Liberation Acupuncture? https://liberationacupuncture.org/. Accessed 9/11/2020.*

ABOUT THE AUTHOR

Mallory Harman, LAc, MAcOM, Dipl OM

Mallory Harman graduated with a B.A. in Psychology from the University of Montana in 2012 on the path to becoming a counselor. Shortly after, she pursued a yoga teacher training in South America which changed her professional trajectory and kicked off years of work and travel in countries such as USA, Perú, India, and Guatemala.

In 2018, she graduated from the Oregon College of Oriental Medicine with a Masters Degree in Acupuncture and Oriental Medicine. She spent the next four months working as an acupuncturist and primary care provider with the Acupuncture Relief Project in rural Nepal. After, she flew to Juárez, MX to observe and work with the project Promotores Descalzos. In June of this year, she went back to Juárez for a second visit.

She is currently living and working as a licensed acupuncturist in Portland, OR. She divides her work life between private practice, assistant teaching at OCOM, and running community acupuncture groups at the Native American Rehabilitation Association (NARA). She sees more travel in her future, and maybe one day a project of her own.

ACUFAST

THE EARTH FRIENDLY NEEDLE

A REVOLUTIONARY NEW
EARTH FRIENDLY ACUPUNCTURE NEEDLE!

because you care about your patients and the planet

BIODEGRADABLE PACKAGE

The world's smallest and only biodegradable bulk-pack

RECYCLABLE POUCH PACKS

Easy-tear technology for fast pouch opening

NEW INNOVATIVE ACCESSORIES

Convenient magnetic needle clip for complete control during treatment

PINCHABLE & FLEXIBLE TUBES

Tubes are optional and sold separately

Available in Canada: eastern currents | In USA: LHASA OMS® EVERYTHING ACUPUNCTURE™ Golden Flower Chinese Herbs

Buy Acufast – Grow a Forest | **Learn more at www.acufastneedles.com**

The Development of TCM in Canada

Katherine Moffat, R.Ac.

PHOTO: Lyndon Li for Unsplash.com

For the purposes of this article and considering the current spotlight surrounding the reform of the Health Professions Act (HPA) in British Columbia (BC), whilst discussing the development of the regulation of Traditional Chinese Medicine (TCM) and acupuncture, it would be remiss not to discuss the current changes being proposed in BC as they will have a direct impact on the future of TCM in BC and likely, the rest of the country.

Historically, neither acupuncture nor TCM were regulated in Canada until the 1980s. Prior to that the profession was largely association-led. Associations such as the Chinese Medicine and Acupuncture Association of Canada (CMAAC), established

in 1983, lobbied for the 'regulation of TCM and acupuncture for the best interests of the public and to protect the high repute of the TCM community.'[1]

Alberta was the first to register acupuncture and has done so since 1988[2] under the Health Disciplines Act. Quebec regulated the profession ten years later in 1995,[3] with BC following suit in 1996[4] and Ontario in 2006.[5] In 2011, the Albertan government established a regulatory college and association to regulate the acupuncture profession.[6] Finally in 2012, Newfoundland and Labrador became the fifth province to regulate acupuncture.[7]

In BC, despite acupuncture being regulated in 1996, the wider scope of the practice of TCM was not regulated until 1999. Following applications submitted by associations, the College of Acupuncturists of British Columbia (CABC) was expanded by the Government of BC to amalgamate TCM and acupuncture as a whole in a unified college, marking the birth of The College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC (CTCMA).

The CTCMA became effective in April 2003 and from that point onwards, a valid registration issued by the College has been, and still is, required to practice TCM and acupuncture in BC.

In the beginning, Doctors of TCM who were already practising in BC prior to the implementation of the regulations were offered a 'grand-parenting' option, consisting of a series of assessments to determine whether they met the new qualifications. The CTCMA issued a licence to practise to approximately 231 Doctors of TCM, the occasion of which was marked by a large ceremony at the University of British Columbia.

Once registered with the CTCMA, the grand-fathered cohort was enlisted by the CTCMA to create the exams for future aspiring registrants, establishing a measurement of the basic skills necessary to qualify as an Acupuncturist or TCM Practitioner. In addition to creating exams, certain prerequisites and minimum education requirements were established for registrants with the aim of ensuring that acupuncture and TCM were of equal standing as other professions under the HPA.

Currently in BC, there are over 2500 practitioners registered with the CTCMA under the four different

[1] *CMAAC*

[2] *The College & Association of Acupuncturists of Alberta (CAAA)*

[3] *Association des Acupuncteurs du Québec*

[4] *CTCMA*

[5] *The College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario*

[6] *The College & Association of Acupuncturists of Alberta (CAAA)*

[7] *The Newfoundland and Labrador Council of Health Professionals (NLCHP)*

PHOTO: Annie Spratt for Unsplash.com

THE DEVELOPMENT OF TCM IN CANADA - A TIMELINE:

1983

The Chinese Medicine and Acupuncture Association of Canada (CMAAC) was established.

1988

Acupuncture regulated in Alberta under the Health Disciplines Act.

1992

Traditional Chinese Medicine Association of BC (TCMABC) submits an application for the designation of TCM as a self-regulating health profession under HPA.

1993

The Government of BC Health Professions Council determined that the designation of acupuncture under the Health Professions Act is in the public interest and recommends that a College of Acupuncturists be established to regulate acupuncture and that the title of 'Acupuncturist' be reserved for registrants of the College of Acupuncture.

1995

Acupuncture regulated in Quebec by the Ordre des Acupuncteurs du Québec (OAQ).

OAQ

1996

CABC ATCMA

Acupuncture regulated in BC. The College of Acupuncturists of BC (CABC) was established.

In BC, applications are made by the Canadian SinoBiology Practitioners Association (CSPA) and the Pacific Region TCM Practitioner and Acupuncturist Society (PRTCMPAS) to HPC for designation of TCM as a self-regulating health profession under HPA.

ATCMA established in BC.

1999

CTCMA

CABC expanded by the Government of BC to amalgamate TCM and Acupuncture as a while in a unified college that then became known as the College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC (CTCMA).

2003

CTCMA started to create bylaws and became effective in April 2003. First registrants grandfathered in.

2006

In Ontario, the Traditional Chinese Medicine Act 2006 was passed and established the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario.

2008

Canadian Alliance of Regulatory Bodies of Traditional Chinese Medicine Practitioners and Acupuncturists (CARB-TCMPA) established.

BC became the first Canadian province to offer acupuncture treatments as a supplementary benefit for its Medical Services Plan premium assistance recipients.

2011

CAAA

The College and Association of Acupuncturists of Alberta (CAAA) designated by Albertan government to regulate the acupuncture profession.

2012

Acupuncture regulated in Newfoundland & Labrador.

2013

Pan-Canadian registration examinations for acupuncturists, herbalists and TCM practitioners established.

2018

Cayton Report - an inquiry into the performance of the College of Dental Surgeons of BC and the Health Professions Act. Part Two made recommendations for the wider reform of the statutory framework for health professional regulation in BC.

2019

ICBC began covering preauthorized acupuncture treatments.

2020

The Steering Committee on Modernization of Health Professional Regulation published a summary of feedback from the public and stakeholders about the recommendations for wider reform in BC.

titles of R.Ac, R.Herbalist, R.TCMP and Dr. TCM.[8] As with other colleges under the HPA, the CTCMA was built to protect the public.

In 2008, with various provinces having been regulated and still no national organization to govern and monitor the practice of TCM Practitioners, Acupuncturists and/or Herbalists, the Canadian Alliance of Regulatory Bodies of Traditional Chinese Medicine Practitioners and Acupuncturists (CARB-TCMPA) was established.

Today, acupuncture and TCM are still not fully regulated nationwide.

CARB-TCMPA presently has five members: Alberta, BC, Ontario, Quebec and Newfoundland and Labrador. Of those five members, TCM is only regulated in BC and Ontario, whereas acupuncture is regulated in all five. At the time of writing, the regulation of TCM as a whole in Newfoundland and Labrador is in discussion but has currently been put on hold due to the ongoing pandemic. In Canada's unregulated provinces, the onus is currently on the public to determine whether or not the practitioner they are being treated by is qualified to treat them. In regulated jurisdictions, the onus is shifted to the regulatory body, such as, the CTCMA.

As formal TCM education in Canada is relatively new compared to other healthcare professions, CARB-TCMPA is striving to develop CEU education, practical elements and national standards of practice, to promote national cooperation, build relationships with key stakeholders in the community and increase engagement throughout Canada with educators, special interest groups and practitioners; all of which is no small task. The hope is that through collaboration, CARB-TCMPA can help shift perceptions of TCM and acupuncture from being the last alternative, which it quite frequently is, to an effective and valid health service.

[8] *CTCMA, September 2020.*

To legally practice as a protected title in one of the five provinces (eg R.Ac) an individual must successfully complete the Pan-Canadian Written and Clinical Case-Study exams that are issued across all five provinces by CARB-TCMPA. Depending on the province, additional safety and/or jurisprudence exams may be required.

In contrast to the provincial regulatory bodies, associations such as the BC Association of Traditional Chinese Medicine and Acupuncture Practitioners (ATCMA) represent practitioners and the TCM profession to different levels of government, employers and other organizations. They help to support research and promote the profession.

Whilst membership to the College is mandatory to practice acupuncture or TCM, membership with an association is voluntary. Associations focus on professional activities, promotion of the profession and advocating on behalf of the profession.[9] For example, the most recent petition in BC, in light of the amalgamation of the Colleges under the HPA, was initiated by the ATCMA to secure and protect the title of practitioners and the scope of practice of acupuncture and TCM. At the time of writing, the ATCMA had 410 members.[10]

True to the nature of Chinese Medicine, the whole is greater than the sum of its parts. This is particularly true when it comes to advocating on behalf of the TCM profession and creating a unified voice. With numerous associations scattered around the province, we are very much in a 'sum of its parts' state, which presents its own challenges when advocating for the profession.

To help increase consistency amongst regulated provinces, CARB-TCMPA has launched an important education and accreditation project with the aim of

[9] *CTCMA, September 2020.*

[10] *ATCMA, September 2020.*

PHOTO: Sandis Helvigs for Unsplash.com

completion by mid-2021. It involves several rounds of consultation with different groups and educators across Canada. The focus is on educators but to roll it out requires working with practitioners. Unfortunately, at this time, CARB-TCMPA does not work with practitioners in non-regulated provinces.

Dan Garcia, the Executive Director of CARB-TCMPA offers some excellent insight on the challenges of such a nuanced profession:

'the practice is evolving and brings with it challenges, such as interpretations of older texts, that cannot be handled by any single group or organization and would benefit from a group effort. The recent and ongoing pandemic has highlighted how many opportunities there are to work together to bring educators, regulators and professionals together to develop consistency and teamwork and benefit from the creation of these relationships. Certainly, the amalgamation of the colleges under the HPA brings with it an added benefit of increased communication between professions.'

PHOTO: Aaron Burden for Unsplash.com

Considering that the practice of acupuncture was not regulated anywhere in Canada until 1985, the country has come a long way in regulating the profession integrating TCM and acupuncture into the Canadian health care system. In April 2008, BC included acupuncture amongst the health care services available on the Medical Services Plan and last year the Insurance Corporation of BC began covering preauthorized treatments.

> *However, until relatively recently, there has not been any real vehicle or organization that has been able to set uniform professional standards across Canada.*

Typically, such standards have been siloed into provincial bodies. Certain groups have formed alliances but currently there is no consistency across Canada, something CARB-TCMPA is seeking to change, despite only having five provinces as members.

With regards to the proposed changes to the HPA in BC, in 2018 An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act (the 'Cayton Report') was published with recommendations to overhaul and improve health professional regulation in the province. In August 2020, following a consultation phase in which feedback was invited from the public and stakeholders, the Steering Committee on Modernization of Health Professional Regulation published a summary of the feedback.

Recommended changes include improved governance, a reduction in the number of regulatory colleges, the creation of a new oversight body, improving complaints and adjudication procedures and information sharing to improve patient safety and public trust.[11]

At this stage it is difficult to speculate exactly what effect this will have on the TCM profession. However, based on the recommendations made one could hypothesize that TCM professionals would become a member of one of two new umbrella colleges being proposed, likely the 'Regulatory College of

---

[11] An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act, December 2018.

PHOTO: Veliko Karachiviev for Unsplash.com

Complementary and Alternative Health and Care Professionals', which would regulate chiropractors, massage therapists, naturopathic physicians, and traditional Chinese medicine practitioners and acupuncturists.[12]

As TCM practitioners and acupuncturists would be part of a multi-disciplinary regulatory college, profession-specific councils have been recommended to address matters requiring profession-specific expertise.

It is clear that at a national level, the TCM community voice would be stronger if more jurisdictions were regulated, and therefore members of CARB-TCMPA. This would help to increase the public confidence in TCM across the country. At a provincial level, an amalgamation of associations or educating students of acupuncture and TCM about the importance of being a member of an association to advocate on their behalf, could also help to create a more unified voice.

> *With the current reform of the HPA and the amalgamation of colleges in BC at the moment, all eyes are on the province.*

Regulated professions across Canada are under scrutiny now more than ever and BC could be seen to set a precedent. It is certainly an interesting time to be a member of the Canadian TCM and healthcare community.

I would like to personally thank Dan Garcia (CARB-TCMPA), Alice Kennedy (NLCHP), Dr Weijia Tan and Dr. Berte Marr for their time, extensive knowledge, insight and dedication to the profession, without whom this article would not have been possible.

- Katherine Moffat

[12] Recommendations to modernize the provincial health profession regulatory framework, Steering Committee on Modernization of Health Professional Regulation, August 2020.

ABOUT THE AUTHOR

Katherine Moffat, R.Ac.

Katherine is a Registered Acupuncturist with CTCMA in BC. Having first been introduced to Chinese medicine during her childhood spent in Hong Kong, whilst also making her fairly proficient in the use of chopsticks, gave her a strong appreciation of the value of both Eastern and Western medicine and that the pair of them, used together, is one powerful medicine. To the TCM community she brings with her ten years of sports industry experience teaching skiing and yoga and is passionate about spreading awareness of the true scope of Chinese medicine

PHOTO: Aaron Burden for Unsplash.com

School is Back in Session

TCM Education Accreditation

Dan Garcia
Executive Director, CARB-TCMPA

PHOTO: Aaron Burden for Unsplash.com

With my children now reaching school-age, education has been on my mind for several weeks. I have been reflecting on all the groups that contribute to the successful development, maintenance, and delivery of high-quality education programs. This, of course, goes beyond my kids' elementary school; this applies to TCM education in Canada as well.

As CARB-TCMPA embarks on the journey of developing education accreditation standards, it is important to recognize all the interested groups that will be invited to participate in this project. We have started with the recruitment of an advisory committee that will provide guidance on the content of the accreditation standards and requirements. Although participation on this committee is limited, there will be more opportunities for educators, practitioners, and others to support the development of these standards.

For example, we will be inviting detailed feedback from practitioners, educators, associations, and others on the draft standards through a national survey.

This will be an important opportunity for stakeholders to carefully review, consider, and provide feedback on the standards with ample time to do so. We will carefully consider all the responses we receive through this consultation. This is the most effective, fair, and transparent method to include the diverse range of perspectives of the TCM community.

We are also exploring additional opportunities for stakeholders to participate. This may be in the form of smaller consultation groups, piloting of the draft standards, or other methods. More information on these opportunities will be published as the project progresses.

> *We recognize and appreciate the experience and expertise that different members of the TCM community bring and intend to involve as many perspectives as possible.*

Ultimately, we want to develop a fair and transparent process that recognizes an organization's commitment to high-quality TCM education. I believe that CARB and other stakeholders share the common goal of ensuring high-quality TCM education that embeds quality, safety, and ethical practices while reducing patient risk. These standards will benefit everyone in the TCM community and the public it serves.

As my kids start their education journey, I recognize that others have recently completed their formal education. To those of you preparing to write the Pan-Canadian Examinations in October, we wish you the best of success on your exams and future practise!

For the most up-to-date information on CARB's activities, follow us on LinkedIn: **https://www.linkedin.com/company/carb-tcmpa**

- Dan Garcia, Executive Director of CARB-TCMPA

ABOUT CARB-TCMPA

The Canadian Alliance of Regulatory Bodies of Traditional Chinese Medicine Practitioners and Acupuncturists (CARB-TCMPA) is the national forum and voice of provincial regulatory authorities that are established by their respective provincial legislation. Through collaborative activities, CARB-TCMPA promotes quality practice and labour mobility across Canada. For more information about CARB-TCMPA, visit: **carb-tcmpa.org**

PHOTO: Stephen Ellis for Unsplash.com

PHOTO: Ricardo Gomez Angel for Unsplash.com


MEDICINAL
ROOTS
MAGAZINE
Ancient Wisdom - Modern Healthcare
medicinalrootsmagazine.com