Chinese Medicine in Colonial Hong Kong (Part II)

Principles, Usage, and Status vis à vis Western Medicine

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II. When is Chinese Medicine Used?

With such divergent views on disease causation, diagnosis, and treatment, it can be seen that Chinese and Western medicine look upon the human body and its ills from two different, currently irreconcilable perspectives. Yet the people of Hong Kong subscribe to both etiological systems and use both systems of medicine very pragmatically — whichever system can cure their ills or fulfill their prior expectations of what needs to be done will be used. Moreover, there is little concordance between which medical system's treatment will be used and beliefs on disease causation. For example, those who stated the traditional belief that rheumatism is caused by 'wet' energy entering the body were just as likely to see a Western doctor for treatment as those stating a biomedical causation theory [15].

Because of the great variety of activities that can be performed for health reasons — all with the underlying premise that body energy can be manipulated — the delineation of behaviors that are related to Chinese medicine is also not clear cut. In addition to physicians of Chinese medicine, there are other specialists manipulating body energy such as acupuncturists, masseurs, bone setters, qi gong masters, Tai Chi Chuan masters, Buddhist or Taoist meditation experts, etc. There is much cross usage of methods among the specialists. The treatment methods of Chinese medical doctors are not limited to writing a prescription or conducting acupuncture, moxibustion, or massage on a patient. Sometimes a Chinese medical doctor may prescribe Tai Chi exercises or meditation for a patient, and vice versa a qi gong or Tai Chi master may prescribe herbs for their clients.

Many health related behaviors for preventing or treating minor symptoms may also be done by the lay person without seeking the services of professionals. From a previous study on concepts of disease causation, treatment and prevention among 50 Hong Kong families [15], food was the most popular lay method of manipulating body energy levels [9]. Since all foods can be classified according to their energy levels ('hot-cold,' 'wet-dry,' 'tonic,' 'irritating,' or 'poisonous') and one needs to eat every day, an individual can be selective in what he eats in order to balance his specific body energy imperfections on a daily basis. This is more fully described in previous publications [7, 9].

Additionally, the division between medicine and food is not mutually exclusive in Chinese culture because all foods have

energy characteristics. Consequently, any food can be purposely consumed because of its specific energy properties and therefore be used more as a medicine than simply as a food. Of course, there are some ingestants which are more clearly medicinal — e.g. some herbal and mineral compounds — and would not normally be consumed as food. On the other hand, foods with a more energy neutral characteristic — e.g. starches such as rice, flour, and beans — form the bulk of the average diet [7, p. 183]. This is probably not a coincidence since highly allergenic or stimulating foods, by definition, would be intolerable for many people and therefore could not be selected as a dietary staple.

With these caveats on defining Chinese medicine and its usage among the public, we shall now focus on describing what Chinese material medica and proprietary medicines are commonly used in Hong Kong and when Chinese doctors are consulted.

II.A Self medication consumption patterns

Data on self-medication come from an interview study of 200 older Hong Kong Chinese women (mean age of 60.0 years and S.D. 9.6) who were interviewed as 'healthy' neighborhood controls in a 1981-83 case control study of female lung cancer [16, 17]. Utilizing life-history techniques of interviewing, the women were asked to describe their family history, lifestyle, diet, occupation, medical problems, health status, etc. Each tape-recorded interview was conducted in the woman's home and usually lasted for 1.5 to 2 hours. Information from the tape-recorded interview was later transcribed onto data sheets for computer analysis.

Table 1 shows their frequency of consumption of some of the most popular Chinese medicines, most of which were used in self-medication. The women were specifically asked whether they used each of these medicines, and the frequency and duration of use. Many of the women were unable to specify their average monthly use because they said it was seasonal or they would use it only when they felt ill, which was not regular. Hence there is missing data on the monthly frequencies. The medicines are classified by their method of use in this table: topical ointments, inhaled oils, and ingested tonics.

Table 1. Usage of Chinese medicines specifically asked of female informants in Hong Kong (N=200, mean age=61, interviewed 1981–3)

	Mean values*		
		Among users	
	% used	# times/month	# Years
I. Topical ointments			
White Flower Oil	6% (N=12)	5 (N=1)	14 (N=12)
Kwun Lung Oil	4% (N=7)	n.d. (N=0)	18 (N=7)
Tiger Balm	4% (N=7)	n.d. (N=0)	24 (N=7)
Other traditional ointments	4% (N=7)	13 (N=3)	11 (N=7)
Used any of above	14% (N=28)	11 (N=4)	15 (N=28)
II. Inhalants			
White Flower Oil	11% (N=21)	17 (N=3)	13 (N=21)
Kwun Lung Oil	8% (N=16)	3 (N=1)	17 (N=16)
Tiger Balm	6% (N=11)	n.d. (N=0)	13 (N=11)
Other traditional ointments	4% (N=8)	n.d. (N=0)	21 (N=8)
Used any of above	24% (N=48)	113 (N=4)	13 (N=48)
III. Ingestants			
A. Herbal tonics			
Wai saan	77% (N=154)	23 (N=154)	15 (N=144)
Gei jee 76%	(N=151)	20 (N=151)	15(N=142)
Doeng gwai	43% (N=85)	14 (N=85)	14 (N=84)
Used any of above	84% (N=168)	21 (N=168)	15 (N=162)
B. Propietary drugs			
Bak Foong Pills	9% (N=18)	n.d.	n.d.
Po Chai Pills	25% (N=50)	6 times/yr (N=50)	8 (N=47)
C. Other tonics			
Tonic wines	11% (N=21)	15 (N=21)	19 (N=21)
Vitamins	12% (N=23)	40 (N=23)	5 (N=23)

*Informants who did not answer were excluded from the analysis.
Many informants were unable to numerically specify monthly frequencies.
n.d.=no data.

The most common topical and inhaled ointments were basically the same proprietary compounds, frequently containing menthol as an active ingredient. 'While Flower Oil' (白花油) was the most popular brand. All are easily purchased over the counter in Western and Chinese drug stores, with the most popular ones even available in supermarkets. It can be seen from Table 1 that topical ointments were used by 14% of the women. Usually it is rubbed on the skin for insect bites, muscle aches, or other pains such as on the forehead for headaches. If a woman was a user, the frequency of usage was quite high — 11 times per month for 15 years. By comparison, the usage of the same oils and ointments as inhalants was even more popular, with 24% of the women reporting usage in this manner. This is probably because of the higher frequency of symptoms for which inhalants were used, i.e. usually it is rubbed or placed under the nose to treat nausea, nose blockage, headaches, and dizziness. Among users, their mean frequencies of usage were

similar to the topical users — 13 times per month for 13 years.

For the ingested tonics, wai saan (*Discorea japonica*) (淮山), gei jee (*Lycium chinense*) (枸杞), and doeng gwai (*Angelica sinesis*) (當歸) were among the most common herbs consumed. More than 70% of the women reported consuming wai saan and gei jee, averaging 20–23 times a year for about 15 years. Both of these herbs, the former a root and the latter a dried berry, are frequently added to home cooked soup because they are general tonics that are nourishing for everyone. In the classic Pen Ts'ao pharmacopoeia, wai saan is described as having cooling and tonic properties which can "benefit the spirits, promote flesh, and, when taken habitually, brighten the intellect and prolong life," [18] whereas gei jee has the action of "tonic, cooling, constructive, prolonging life, improving the complexion, and brightening the eye" [18, p. 250].

Doeng gwai is a tonic herb especially taken by women for gynecological disorders, e.g. heavy and/or painful menstrual bleeding, tiredness after menstruation, and for post partum recovery [7, pp.156–162]. In the Pen Ts'ao, the herb doeng gwai is highly used in Chinese medicine, second only to licorice in its popularity in Chinese medicinal prescriptions [18, p. 133]. Its lay usage coincides with its description in Chinese medical texts. Therein, it is said to be good for gynecological complaints [19], has sedative and analgesic properties, can stimulate blood flow, and "is used as a standard tonic for adults, usually immersed in wine as a drink" [11, p. 218–219].

Among menstruating or perimenopausal Hong Kong women, doeng gwai and the proprietary drug Pak Foong Pills (白鳳丸) (which contains doeng gwai as well as other tonics such as ginseng and deer antler (鹿茸)) is commonly consumed after every menstrual period because of the belief that a tonic is needed to replenish the body energy stores that have been depleted due to the loss of menstrual blood, a material manifestation of life energy. Usually the root doeng gwai is prepared by steaming it with red dates or boiling with chicken, and the soup is drunk after the menses. The practice of eating it after each menstruation may also explain its mean consumption frequency of 14 times per year. Another proprietary drug commonly consumed in Hong Kong is Po Chai Pills (保濟丸), which 25% of the women said they used on average about 6 times a year. These pills, according to the package insert, contain some 15 different medicinal substances, and are said to be “good for fever, cold, diarrhea, vomiting, motion sickness, stomach disorder, overeating, intoxication, and gastrointestinal diseases.” Since most of these symptoms are self-limiting, whether a patient takes Western or Chinese medicines for symptomatic relief would probably make little difference to a patient's prognosis.

Tonic wines were also consumed by 11% of the Hong Kong women. This is usually a tincture where one or more tonic herbs and animal parts like doeng gwai, he shou wu (*Polygonum multiflorum*) (何首烏), ginseng, deer antler, tiger bones, etc., are soaked in wine. Many women reported that they particularly liked to drink tonic wines during the winter months to stimulate blood flow and keep warm. Among the drinkers, their mean consumption frequencies were 15 times per month, 1.3 taels per serving, for an average duration of 19 years.

The practice of drinking tonic wines seems to be more popular among older women, as another study conducted from 1993–94 by telephone interviews of 500 women with a mean age of 42 (SD=18) indicated that only 4 women (0.8%) consumed tonic wines. Further analyses indicated that the 4 tonic wine drinkers were all aged between 60 and 65 years of age (mean age 64), again confirming the propensity of older women to drink tonic wines. In fact, the alcohol drinking patterns among the two age cohorts were very different. Among the 200 older women, tonic wine was the most common type of alcoholic drink consumed, whereas among the younger cohort of 500 women, beer was most popular and drunk by 37 of the women (7.4%). Moreover, older women were more than twice as likely to be regular consumers of alcohol, i.e. drinking more than 1 drink a week (23%) than younger women (10%). What is also culturally interesting is that conceptually, the older women saw their drinking of tonic wines as a health promoting activity rather than as a ‘recreational drug.’

Table 1 also includes the frequency of consumption of vitamins among the women. Although vitamins are a Western drug, they are conceptually perceived as a Western-made tonic [9]. Therefore, their usage arises from the traditional concept of increasing body energy, and it is interesting to note that 12% of the women

Table 2. Other ingested Chinese medicines independently stated by female informants in Hong Kong (N=200, mean age=61, interviewed 1981–3)

	Mean Values % used
A. Other tonics	
Pakkei	5%
Chingpoleung herbs	4%
Fongdong, dongsum	3%
Meat, poultry	3%
Wild animals	2%
Ginseng	2%
Chungtso	1%
Animals living in water	1%
Others	9%
Any of the above (Among users, 36 times/yr & 8 yrs duration).	22%
B. Cooling herbs/foods	
Ngfacha, huisupcha, mukminfa	30%
Chrysathemum	12%
Hafootso	11%
Kamngaifa	2%
Yeemik	2%
Chitsoyung	2%
Yasaimei, wonglogug, maleiyu	1%
Tofukling, fotanmo	1%
Shuetyee, songyip	1%
Lukdao, hoidai, hoitso	1%
Chukche, wanling, pakshuet	1%
Eno salt	1%
Others	9%
Any of the above (Among users, mean values of 22 times/yr & 20 yrs duration).	51%

were regular consumers of vitamins. Their shorter duration of consumption, i.e. for only 5 years, shows that this is a more recently adopted practice. Unlike the age differences in drinking tonic wines, our data from the younger cohort of 500 women indicated that 10% of the women were regular vitamin consumers, which is similar to its consumption frequency of 12 among the older women.

In our interview study of the 200 older women, we also had an open-ended question asking them what other tonics they frequently consumed. These are listed in Table 2. It is apparent that 22% of the women specified other common tonics, and these ranged from specific herbal substances to animal products. Although the percentages are small, they give a relative ranking of common tonics that women were able to recall at the time of interview. Their relatively high frequency of consumption — i.e. about 3 times per month — also shows its importance since women need to spend a considerable amount of time to purchase, cook, and consume these special foods. The lower percentages in Table 2 relative to Table 1 also show how different methods of eliciting information may produce different results. If the list of tonics in Table 2 had been specifically asked of all informants, the percentages reporting consumption would have been much higher.

Another class of herbs that is commonly consumed, probably encouraged by the hot sub-tropical climate of Hong Kong, takes the form of 'cooling' teas. Fifty one percent of the women were able to specify some type of herb that they frequently drank for 'cooling' purposes. According to the energy perspective of health, this means that they have too much 'hot' energy in their bodies and need to neutralize this excess. Although the specific percentage of each individual item is low, the richness of the responses in terms of listing specific herbs or combinations is remarkable. Moreover, the frequency and duration of consumption was relatively high among consumers — an average of drinking these teas 22 times per year for 20 years.

II.B Choice of Chinese or Western doctors

In contrast to the high usage Chinese medicines and foods for self-medication, various surveys in Hong Kong have all shown that Western doctors are usually preferred when professional care is sought [e.g. 15, 20–22]. The survey with the largest sample size of respondents was conducted by the Hong Kong government in 1992 as part of the General Household Survey organized by the Census and Statistics Department. Table 3 shows the results of the survey, where 23 183 persons were interviewed in 6612 homes. Each person was asked about their consultation of Western or Chinese doctors (excluding dentists) in the 14 days prior to interview. Western doctors in private practice made up some 68% of the total consultations, usage of government out-patient clinics made up another 20%, and consultations with Chinese doctors only made up 8.6% of the consultations [23]. In this survey, the government defined Chinese doctors as herbalists, acupuncturists, and bone-setters. We must clarify, however, the misconception inherent in calling Chinese

Table 3. Type of doctor consulted for out-patient care in Hong Kong

	% of consultations*
Western medicine:	
Private practice	68.0%
Government clinics & depts.	20.3%
Chinese medicine:	
Herbalists, acupuncturists,bone setters	8.6%
Others:	
Chiropractors, homeopaths, etc.	3.1%

*Based on total # of consultations (maximum=3/interviewee) in the 14 days prior to interview.
Source: General Household Survey conducted by the Census & Statistics Dept. of 23,183 persons in 6.612 households from Aug-Sept 1992.

doctors 'herbalists' because the Chinese pharmacopoeia includes flora, fauna, and mineral products, and all are utilized in Chinese medicinal prescriptions [19].

The government survey also provided a breakdown by demographic characteristics of the kinds of persons consulting Chinese or Western doctors. This is shown in Table 4. It is apparent from these statistics that consultation patterns for Chinese or Western doctors differ according to the age, income, and occupation of the patient.

From the rate of consultation among each age group, the frequency rates for Western doctors form a 'U' curve, whereas for Chinese doctors it directly increases with age. This means that for Western medicine, the very young and the very old are the highest consumers, while for Chinese medicine, the elderly are the highest users. However, the absolute rate of consultation of Western vs. Chinese medicine shows that within each age group, Western doctors were consulted 10 to 84 times more than Chinese doctors. The difference in absolute values was highest among the very young, i.e. 84 times higher among the 0–4 age group, and 50 times higher among the 5–14 age group.

These age-specific consultation rates support the findings of our previous interview study of 50 households in 1981, where informants were asked how they would treat 60 different health problems [9, 15]. For diseases of childhood, e.g. measles, polio, diarrhea, fever, etc. Western doctors were preferred when professional help was sought. There was general recognition by the public that Western medicine was effective in treating and preventing infectious diseases by the use of antibiotics and immunizations. For mechanical problems, surgery was also widely accepted as an effective Western medical treatment.

On the other hand, the chronic degenerative symptoms of older adults were believed to be less effectively cured by Western medicine. Frequently, both systems of medicine would be used for these latter symptoms like arthritis, diabetes, and hypertension. Usually this would mean that Western maintenance drugs would be taken, e.g. non-steroidal anti-inflammatory drugs and anti-hypertensives for arthritis and hypertension respectively, but Chinese medicines and foods would also be consumed concurrently to cope with the side effects of the drugs or to supplement the body so that it was better able to cope with the disease. For example, many of the diurectic hypertensive drugs act on the kidneys. In Chinese medical theory, these drugs may overwork or weaken the kidneys, and therefore kidney tonics may be consumed to compensate for this energy depletion. It is also noteworthy than in Chinese etiology, sexual performance is associated with kidney energy [11, p. 60] and the frequent complaint of impotence among hypertensives taking diuretics is an interesting side effect supporting Chinese medical observations.

In terms of personal monthly income, there was no clear trend of monthly income and usage of Western medicine from the rates per 1000 population in each income bracket in Table 4. However, the column percentage data showing the proportional distribution among the total number of consultations, indicate that those with lower incomes formed most of the Western doctors' patients. By contrast, for Chinese medicine, persons with higher personal incomes (especially more than HK$20 000 per month in 1992) were more likely to consult a Chinese doctor.

Although no data on education were

published from this survey, the information on occupation can be taken as an indirect indicator of education. From Table 4 it can be noted that semi- and less skilled laborers and retirees were more likely to consult Western doctors. By comparison, skilled workers, the unemployed, clerks, professionals, service workers, and managers/administrators were the least likely to do so. When these results are combined with the findings on income and Western doctor consultation practices, a pattern emerged that the lower incomed, less skilled, and lower educated persons were more likely to consult Western doctors than those who were wealthier, higher skilled, and more educated.

A number of possible explanations for these results are: the poorer are sicker and therefore need to see Western doctors more often, the kinds of diseases that the poor have are more amenable to treatment by Western medicine, the less skilled are in jobs where they need a sick leave certificate for minor ailments like colds and flus (which form some 42–62% of the patients seen in Western medicine clinics [24]), and/or the less educated have more faith in Western medicine. The real reasons are probably a combination of these factors for each individual case.

The preference for using Chinese medicine by occupation of the subject indicated that homemakers (mostly housewives) were the most likely to consult Chinese doctors, followed by the unemployed, retirees, and professionals. Service workers and students were the least likely to see Chinese doctors. Since Chinese medicine is seen to be especially beneficial for gynecological disorders, this may explain the high consultation rate among housewives. Chinese medicine's treatment methods for chronic degenerative diseases among the elderly, as discussed above, may also explain the high usage among older retired persons and lack of usage among the students and service workers who are generally younger.

What is perhaps more remarkable is the relatively high Chinese doctor consultation rate among professionals, also reinforced by the income data where the highest income groups had the highest consultation rates. It is possible that professionals are consulting Chinese doctors to alleviate their symptoms of high stress from their jobs (migraine headaches, fatigue, backaches, etc.). They may be disillusioned with the limited treatment methods of Western medicine, or may have suffered serious side effects from Western medicine. Since they are among the most highly educated among the occupational groups, and since most of this education was in Western science and methods, this indicates that their selective use of Chinese doctors is not due to relative ignorance of Western science.

From these various surveys, it becomes apparent that preference for Chinese or Western doctors is dependent on the type of illness experienced and what people believe each system of medicine can do for them. Personal factors such as age, education, and occupation are only indirect indicators of personal beliefs about etiology and possibilities of treatment/cure

Table 4. Demographic characteristics of patients who consult Western vs. Chinese doctors in Hong Kong, 1992

	Western Doctor		Chinese Doctor	
	Rate/1000 pop.	Column %	Rate/1000 pop.	Column %
Age				
0–4	200.8	11.4%	2.4	2.0%
5–14	105.1	15.4%	2.1	4.6%
15–24	58.5	9.1%	4.6	10.6%
25–44	75.8	29.0%	7.6	43.0%
45–64	107.7	20.9%	8.5	24.5%
65+	142.5	14.2%	10.3	15.2%
All	96.6	100.0%	6.5	100.0%
Personal monthly income				
4,000 HK$	84.2	13.0%	5.6	11.9%
4,000–5,999	65.0	22.0%	5.1	23.7%
6,000–7,999	66.0	24.9%	4.6	23.7%
8,000–9,999	72.2	13.5%	5.9	15.3%
10,000–14,999	90.6	14.7%	5.3	11.9%
15,000–19,999	71.3	4.3%	2.0	1.7%
20,000 and over	90.4	7.5%	10.4	11.9%
All	73.3	100.0%	5.3	100.0%
Occupation				
Managers & administrators	80.0	3.4%	5.2	3.3%
Professionals	73.6	5.4%	8.5	9.3%
Clerks	73.3	6.5%	6.1	7.9%
Service & shop sales	75.6	5.5%	1.2	1.4%
Skilled workers	63.4	8.2%	5.5	10.6%
Semi & less skilled workers	159.5	7.3%	5.2	6.6%
Unemployed	67.4	0.6%	10.4	1.4%
Students	101.3	23.7%	2.9	9.8%
Home-makers	113.5	16.8%	13.9	30.6%
Retired, others	151.7	22.6%	8.7	19.1%
All	544.1	100.0%	36.6	100.0%

Source: General Household Survey conducted by the Census & Statistics Dept. of 23,183 persons in 6,612 households from Aug–Sept 1992.

by each medical system. Overall, however, Western doctors and Western medicines were generally preferred by the majority of the Hong Kong population. A study by Tam [14] which asked 120 informants about the comparative reliability of Chinese or Western doctors found that 40% said that Western doctors were more dependable vs. 4% for Chinese doctors. However, 37% said that their choice of doctor would depend on the health problem. In our 1981–1983 study of 200 older women [17], when they were asked about what types of medicine they usually preferred, 51% said Western medicine, 16% said Chinese, 17% said both, and 17% said none.

The data from the Hong Kong trade statistics also seem to support this relative preference for Western over Chinese medicine. For the period January to September 1994, about HK$1.57 billion worth of herbal and animal products for Chinese medical use were imported vs. HK$5.86 billion worth of Western pharmaceutical products. Re-export values were HK$1.36 billion and HK$4.31 billion respectively. Thus the financial value of Western medicines imported and re-exported were 3.7 and 3.2 times higher than Chinese medicine. Another method of estimating relative consumption is to compare the difference between import and export values. For unprocessed Chinese medicines this amounted to approximately HK$207 million, whereas for Western pharmaceuticals this amounted to HK$1.56 billion — a difference of 7.5 times.

Comparative consultation frequencies of Western vs. Chinese medical doctors can also be understood by comparing out-patient attendance rates offered by non-government organizations which offer the services of both Chinese and Western doctors. The Tung Wah Group of Hospitals is the largest non-government welfare organization and offered free medical services at five hospitals and clinics at an estimated cost of HK$27 million in 1994. From their 1993 statistics on out-patient attendance, these numbered 655 461 for Western medicine and 239 097 for Chinese medicine, i.e. 27% of the out-patient visits were for Chinese medicine.

The Hong Kong Federation of Trade Unions is another non-government organization offering both Chinese and Western medicine in their Workers' Medical Clinics so that patients are free to choose either system. They have some six clinics offering Western medical out-patient treatment and seven clinics offering Chinese medical treatment. Their clinic attendance statistics indicate that choice of Chinese or Western medicine is about equal [personal communication]. Furthermore, the director of the Workers' clinics said that employers were usually willing to accept the sick leave certificates signed by the Chinese doctors in their clinics. This latter factor is important for patients, and may explain the higher usage of Chinese medicine among these workers. By contrast, sick leave certificates signed by Chinese doctors would not be generally acceptable in the civil service, schools, and the larger Westernized companies.

These data indicate that if patients have a fair playing field where the services of Chinese doctors were reliable, convenient, at a similar low cost, and equally valid in justifying sick leave, more people would choose to use Chinese doctors for their less serious ailments that can be treated on an out-patient basis. Moreover, Chinese medicine usage is commonly believed to have fewer side effects than Western medicine, and this lay belief is supported by survey research in Hong Kong [22]. Since Chinese medicine is not available on an in-patient basis in any Hong Kong hospital, one can only speculate on reactions to such a choice if it were made available, as it is in China.

Although at the current time, Western doctors are consulted more frequently than Chinese doctors in Hong Kong, it is possible that usage of Chinese doctors will increase in the future because the demographic groups that currently have high usage will increase in the future, i.e. those with higher incomes, the professionals, and the elderly. Additionally, as Hong Kong's political status shifted from being a British colony to a Special Administrative Region (SAR) of China in 1997, adherence to certain Chinese practices such as Chinese medicine will probably also increase in the future.

(Note: Part III, which deals with the changing legal and political status of Chinese medicine in Hong Kong, will be published in Vol. 2 No. 2.)