

*Eye of the tiger: Times of transition and  
change in Nurse Education in China*

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Dr Je Kan Adler-Collins  
Associate Professor of Nursing  
Fukuoka Prefectural University  
Japan.

## **Abstract**

*China as a nation often receives a mixed reception from the media depending on the values and orientation of the individuals. With the “opening up” of China new ideas and challenges have come alongside the unprecedented growth of China’s internal changes and growing international influence.*

*Nurse education globally is considered a key area within a nation healthcare system and has seen several recent fundamental changes as western forms of knowing dominate nurse education and new university programmes for western style curriculum start to graduate “Western Nurses” in non-western countries.*

*Western scholarship has included in its core concept the idea that the ability to reflect and evidence the learning achieved by that reflection, is at the heart of continual improvement in practitioner research.*

*This paper offers for discussion that the sudden embracing of western medical/nursing concepts and values could be detrimental to China’s health and result in a non-productive clash of philosophies thus creating unnecessary tensions within the workforce and asks the question as to the suitability of western forms of knowing dominating China’s traditional systems of education in health care through the authors reflections of teaching in Japan and China as a nurse educator*

**Keywords. Paradigm wars, Education in Japan, China, nurse education, colonisation.**

## **Transparency.**

Living action research as a method requires transparency on behalf of the author, and here I declare a bias, namely that of the ontological position I hold as an ordained Buddhist priest. Within this enquiry I am in fact a living contradiction (Whitehead 1989), as my Western logical being and culture with its focus on objectivity, measurement and rationality is held in tension with my embraced Eastern subjective awareness, non-closure and compassionate nature, these coming from my Buddhist faith. I do not see that this tension in any way negates the scholarship of this enquiry even when at times I may appear confused. Such confusion arises from my desire to navigate my consciousness to a conclusion that supports my ontological position. As I reach each new moment of illumination, in the heuristic sense of knowing, such new understandings cause the whole kaleidoscope of myself to reshuffle. Such reshuffling brings about temporary confusion as new insights are integrated into my ontological praxis (Moustakas, 1990). In some cases, however, I have yet to find a satisfactory answer despite my new ontology seeping into all aspects of my life. Personally, I am no longer seeking a conclusion or a fact that can be known as an irrefutable truth. While I acknowledge that some parts of my knowing act as: "*facts in the moment*", as I integrate such knowing into my life some are even represented in this thesis. Even as I understand that such facts are transitory, they allow my already confused sense of being an illusion of time and a fixed point at which to collect my thoughts. I consciously push the boundaries of my ignorance with my Buddhist disciplines of meditation, and in such a manner I embrace a comfortable glow of expectant anticipation that the fluid boundaries of my ignorance are unfolding as surely as each sunrise follows the night. For me, my confusions and my illuminations exist side by

side, acting as a balance as each informs the other. It is this understanding and the joy of the enquiry that I wish to share with my reader.

Historical context of the enquiry.

In 2000 I left England to move to Japan to become a Japanese Buddhist monk. In 2003, I was appointed to Fukuoka Prefectural University as an assistant professor of nursing. In 2007 I was appointed to associate professor of nursing of the health promotion centre. In the same year I graduate Bath University, United Kingdom with my Doctorate in Education. The focus of my thesis was curriculum development of a new curriculum for the healing and enquiring nurse in Japan.(Adler-Collins, 2011) My experiences and research from living in Japan and China gave me a unique understanding of what it is like to live and work as a teacher in a different culture to your own. In 2000 a treaty was signed between my university and a Chinese university which required the exchange of teaching staff. I was selected to represent my university and in 2010 I had my first visit for three months followed by 2 more months in 2011 and I am scheduled for two monthly visits every year for the next three years. I use the experiences I have gained from working as a nurse educator in Japan and China to look closely at the process China has undertaken. There are similarities between what each country is doing but also unique differences.

## Methods

This paper uses a living action research approach (McNiff, 1992; Whitehead, 1989; Whitehead & McNiff, 2006) for the generation of my own understanding and learning as I served as an exchange teacher of nursing in a Chinese University of traditional Chinese Medicine in 2010 and 2011.

I use narrative as I explore my lived context in China and Japan as I struggle to embrace a context and culture very different from my own. This paper is a heuristic action research narrative about an on-going educative and spiritual journey, one where I invite my reader to join me in surfing the dynamic fluid boundaries of my consciousness, hopes, joys and learning. These dynamic boundaries (Rayner, 2003) are the new frontiers of my knowing, where I am permanently on the edge, teasing and challenging the outer envelope of my ontology in a joyous dance of discovery (Eisner 1997). My particular focus centres upon the opportunities and constraints of being both an insider/outsider researcher (Rayner, 2004) at the same time. Some would argue that I cannot do this “fence sitting” and that we cannot see ourselves as we truly are. My own research committee in my university in Japan, reflected their understanding of action research by returning a research ethics application with a note that action research was not science and not research. Such actions were not uncommon and gave clear insights at the limited international understanding of research models outside that of the medical model, thus reflecting that the paradigm wars with their associate forms of colonisation bounded in western forms of rightness are alive and well in Asia. (Said, 1985)

My living educational theory is being practiced within the context of another set of contradictions (Whitehead, 1989). Within educational circles this is known as the paradigm wars, described by Gage (1989, p.43) as: ... *a minefield of conflicting polarities*, and by Schön (1995, p.32) as: ... *an epistemological battle*. The paradigm wars are very real. Donmoyer (1996, p19) wrote of them: ... *the fact [is] that ours is a field characterised by paradigm proliferation and, consequently, the sort of field in which there is little consensus about what research and scholarship are and what*

*research reporting and scholarly discourse should look like.* The paradigm war within the Western academy is at least explicit. Here in Asia another kind of conflict is also occurring that is not so explicit and is much harder to detect. As well as the issues raised in the paradigm clashes and conflicts I have witnessed, there is paradigm colonization under way. I have observed the same issue in all the schools of nursing that I have taught in or visited in Asia. I am now seeing the same signs in China. This, I believe, is a far more serious issue. For example, the importation into Japan/China of Western concepts of nursing, ethics and research, and the subsequent use of these concepts, shows that there has been a change in the way that the ideas are understood by the Eastern academy, as compared with the Western academy, although the ideas originated in the West. Japan is often cited as importing models and paradigms en bloc; a trend that started with Japan's drive to westernise during the Meiji period of the 19<sup>th</sup> Century (Wolferen, 1990). As a result, at the end of the 1930s, according to Wolferen, Japan was: ... *left heirs to a farrago of disjointed, ill-digested bits and pieces of knowledge* (p. 239). I have also observed this in my teaching in China and Japan as I assisted scholars to understand imported foreign concepts of nursing. The problem then, and I would say now, is that the very contextual roots from which the knowledge was grown are not transferable or even fully understood. Hence the situation for Japanese/ Chinese academics was problematic - on the one hand they sought external forms of knowing in their drive to be Western, but on the other hand did not have the resources to reproduce those same paradigms in Japan/Chinese because they were considered to be culturally inappropriate. I refer to this situation as *flower-arranging education*. By this I am using the metaphor of the flowering of different types of knowledge. When Asian scholars see the flower they cut it and bring it back to their own country It is not

difficult to see that the flower is appreciated for being a flower, careers are even based on this, but, however, the flower is but the blooming of a process. Without the roots and stem (cultural context) the flower will die. Even if attempts are made to preserve it, soon the inevitable changes in what was originally attractive will occur.

Japanese/Chinese nursing scholars have entered many foreign universities to take higher research degrees in ever-increasing numbers. On graduation they bring back, quite naturally, the teachings and knowledge they have gained. In the process many become converts to new ways of thinking and many have claimed to have been changed by their experience of studying abroad (Doutrich, 1993, p.141). These new ways of thinking are presented to the nursing academy as new directions, and careers are built by academics following one particular paradigm or another. However, it is often the case that serious consideration is lacking as to the suitability of the imported knowledge for the cultural needs of Asian countries. The same problem is happening in China in the drive to engage western forms of health care, the fact that Western medicine and Chinese Medicine come from very different philosophical paradigms appears to have been over looked. I believe that there is a real danger that the *West is Best* thinking is taking root in many countries that are seeking to upgrade nationally so as to be on a par with the West, such as defence, medicine, dentistry, nursing and other healthcare and para-healthcare disciplines. This danger is even more significant and pressing as I seek clarification of my own embodied values and knowledge in order to design and pedagogise a new curriculum or teach an imported body of knowledge in western nursing or psychology. I need to understand what my own values were right from the beginning of when I started to live the paradigm fusion. This is a process of becoming culturally aware, becoming more discerning with my

reflections as my insights have deepened and I have sought to make sense of what was often incomprehensible.

My analysis of my teaching and methodology progressed over time and I had a sense that the nature of the questions I was changing, reflecting, I would claim, a more inclusional understanding of the context in which I taught and learned. Examples of these questions are: *What is **our** practice and what do our students and patients require from us? How can I/we improve this course for future students?"*

I have grave concerns as I not only watch the paradigm wars unfold not only in Japan and China but I would suggest that many developing countries are suffering from the same issues. Asian cultural thinking and social structures are different from that of the west with its focus on the individual freedoms and a strong concept of a singular concept of "I"

Japanese context

It is still not uncommon these days to have senior faculty in Japanese nursing with no doctoral degrees but who are associate or professorial heads of department or line managers. It is also not unusual for such faculty not to be qualified teachers as no formal teaching certification in higher education exists at this time for Japanese and Chinese faculty members. In Japan there has been an explosion of nursing universities from 11 ten years ago to 132 in 2010. A direct result of this action, which seems to have been missed by the planners, is the critical shortage of suitably qualified nursing faculty. It is not hard to see how individuals in senior posts feel threatened by more qualified staff in junior grades. Is also not hard to see the fragility of nursing



scholarship in terms of critical scholarship, in Japan junior staff members are expected to remain silent in meetings and follow the leadership, however outdated or inappropriate that leadership may be. Nurse educators who have studied abroad for higher degrees feel this disparity most keenly on their return, often opting to remain silent in the hope that they will be reinstated in the communal circle Doutrich (1993, p.155). Once again we are reflected back to the living reality of *thinkable and unthinkable* forms of knowing and control of the primordial gap through the use of academic pedagogy and personal power (Bernstein, 2000).

Such thinking is not well received in Japan, especially when it comes from a foreigner who is searching for Japanese meaning within a Japanese contextual framework and cultural practices. It is my contention that Japanese scholars need to be more critical of the imported knowledge and its impact in terms of its ability to fit into Japanese culture. A Japanese person who has returned to Japan after studying abroad, usually in America, would sometimes be called 'Americagaeri', a derogatory term that has embodied within it negative judgements of that individual as being assertive, outspoken, displaying direct and frank behaviour, and speaking without knowledge of the context. I found it fascinating to read Doutrich's thesis, as much of what she researched and discovered about the experiences of Japanese nurses returning from abroad has also been my experience as a foreign nurse educator. Instead of being called Americagaeri I am called a 'Henna Gaigin', this being a foreigner who has immersed him/herself in Japanese traditions, language and culture and is equally mistrusted. There is no equivalent term in English; perhaps the nearest we have is saying that someone has 'gone native' - tolerated by a few but usually despised for what is seen as abandoning their own culture, nationalism, context and roots. Zinchner (1993, p. 200) sums up the relevance of these distinctions and debates to teachers thus:

*“...There has been a lot of debate in the literature about what is and is not real action research, about the specifics of the action research spiral, about whether action research must be collaborative or not, about whether it can or should involve outsiders as well as insiders, and so on...a lot of this discourse, although highly informative in an academic sense, is essentially irrelevant to many of those who actually engage in action research...”*

In this next section I take a closer look at the system of nurse education in China.

## **BACKGROUND**

**Acknowledgement. This section draws on conversations and material made available by the Dean and school of nursing Beijing University of traditional Medicine, Professor Hoe from 2010 to date. (Hao et al. 2010). Without the scholastic help given and translations of Chinese texts this section would not have been possible.**

Traditional Chinese Nursing.(TCN)

In ancient times, TCN did not exist dependently, though there was abundant knowledge of nursing theory and practice in the field of Traditional Chinese Medicine (TCM). Like TCM, TCN has always been closely integrated with disease prevention, health care, life cultivation and rehabilitation (Hao, 2010). The work of the Chinese physician provided cures, herbal medicines and caring. The family were responsible for all daily tasks of caring that we associate with western modern concepts. Nursing is a foreign term in China; it appeared only with the Opium Wars (June 28, 1840~August 29, 1842), when missionaries from every nation came to China and helped to build hospitals and schools (Chen, 1996). There is a common belief among Chinese people, characterized in an old Chinese saying that *“thirty percent of healing Depends on curative means and seventy percent on nursing care”*.(Wang, 1987, p. 14).

At the same time, nursing education in China is strongly influenced by Western nursing and the curriculum mainly focuses on modern nursing (Y. Xu et al., 2002). Wong(2000).argues that China has a strong emphasis on the caring process as consistent theme found in nursing publications in China over the past century, citing *Nursing the Sick*, one of the early Chinese nursing textbooks written by Yao Changxu (1939) listing the ethical requirements for nurses. Traditional Chinese ethics in nursing include concepts and values of on serving humanity out of compassion alone, almost no importance was attached to self-benefit and self-actualization. (Unschuld, 1979; Wong & Pang, 2000) Wong & Pang (2000) state that in a traditional Chinese society, family members accept a moral duty to take care of their sick relatives, grounded in the Confucian ethical system of role relationships. *Although people may ask their servants to undertake the caring tasks, they would commit moral failure if they did not assume their caring responsibilities. This insight helped me understand the deep feelings of low status that Chinese nursing students told me about.*(p.15.). All the students I talked with expressed the same feelings along with many of the staff. It appears that self-image is an area that needs to be closely looked at and researched as a matter of urgency .Chinese nursing needs to find its own self-identity within a society that is in a state of flux as old ideas and values sit in tension with new policy and social directives. Altum (2002) notes that Chinese society has undergone a change in values during last 20-30 years, suggesting that the old Confucius values of Moral attributes such as humility, altruism and devotion are not so pronounced as before. Freedom, equality and self-realization are emphasized in current society, especially more important to the young. Altum is concerned that the pursuing freedom and self-concern too much may lead far away from accepting responsibility.

In the early 1960's, training in TCN was held in Nanjing for the first time (Hao, 2010; Liu, 1996). TCN was not considered an independent subject until advanced education in TCN appeared in 1984 in the universities of Chinese medicine.

Along with the development of higher education in TCN, the theory and the techniques of TCN are becoming more systematic and concrete. The teaching system of TCN along with teaching plans and curriculums, differ from nursing programs in general medical universities. In a school of TCN, 20%~25% of total nursing course hours focus on the theory and techniques of TCN, (L; Hao Han, Y, 2002) compared with only 5.5% (Y. Xu, et al., 2002) in general schools of nursing. In all hospitals and wards of TCM in general hospitals, there are professional nurses engaging in TCN. In June 1984, the Chinese Nursing Academy convened a forum about TCN and the combination of TCN and modern western nursing. A Committee on Combination of TCN and Modern Nursing was set up (Hao, 2010), and since then there has been an increase in TCN publication as TCN is gradually evolves into an independent, complete and systematic scientific system (Hao, 2010).

With the development of science and technology, TCM and TCN have been modernized in recent decades, and there is now a strict division of work between doctor and nurse. The doctor of TCM focuses mainly on diagnosis and medication for disease and the application of invasive treatments such as acupuncture. The nurse of TCN focuses mainly on health education and application of techniques of TCN which include non-invasive approaches (Hao, 2010). TCM is generally regarded by the west as a kind of alternative and complementary therapy (Eisenberg DM, 1998; Kemp, 2004; Michalsen et al., 2009; Sancier, 1999). Both TCM and TCN share the same theoretical base and have similar techniques, but they have different foci. The theoretical system of TCN is different from that of modern nursing. Nurses of TCN are required to grasp not only the theory and techniques of TCN, but also modern nursing (L Hao Han, Y, 2005).

Nursing students who graduate from schools of nursing in universities of Chinese medicine can work in the modern hospital or the hospital of TCM or the primary nursing system. They can provide both modern nursing and TCN. In the general hospital, the difference between a nurse of TCN and a general nurse lies mainly in the content of their nursing education. The nurses of TCN have more advantages in the hospital of TCM and in primary nursing. They have more opportunities to apply the theory and techniques of TCN (Hao, 2010). TCN focuses on mobilizing the human capacity for self-adjustment and self-rehabilitation, which have effects not only in curing disease, but also in preventing disease and in rehabilitation and preservation of health (Yang, 2006). Johannessen concluded that nurses who work with alternative and complementary therapy are “more nurses”. That is, they are more likely to nurse patients holistically and they place more emphasizes on patients’ self-healing ability (Johannessen, 2004).

### **Basic characteristics of TCN**

The theoretical system of TCN, has two cardinal characteristics: the concept of holism and nursing based on syndrome differentiation which is studied by TCN students

#### *Holism*

The concept of holism in TCN holds that the unity of the human body is achieved by combining the zang-viscera (heart, liver, spleen, lungs, kidneys) with the fu-viscera (gallbladder, stomach, large intestine, small intestine, bladder) to link the tissues and organs of the body through the meridian system. The human body is an organic whole in which constituent parts are structurally inseparable, functionally coordinated and interactive, and mutually influencing. The human body is also closely

related to the natural and social environment (Hao, 2010) In TCN, illness is regarded as a state of disharmony between the individual, the natural, and the social environment. Accordingly, the aim of TCN is to help people regain a state of harmony. The curative and caring approaches focus on not only treating illness but also counteracting the imbalances, which are the source of the illness. An old Chinese saying is that “thirty percent of healing counts on curative methods and seventy percent on nursing care” (Hao, 2010).

The holism found in TCN and Western nursing is similar. The American Holistic Nurses Association (AHNA) has defined this: “Holism involves identifying the interrelationships of the bio-psycho-social-spiritual dimensions of the person, recognizing that the whole is greater than the sum of its parts; and that holism involves understanding the individual as a unitary whole in mutual process with the environment” (Shin, Eschiti, Shin, & Eschiti, 2005). This perspective is consistent with the holism of TCN.

#### *Syndrome differentiation diagnosis skills*

Syndrome differentiation involves analysing the patients’ history, signs and symptoms collected by looking, hearing and smelling, asking, examining pulses and palpating, to differentiate and recognize the syndrome of a disease. Nursing determination involves considering and formulating the corresponding nursing principles and methods based on the result of syndrome differentiation. Syndromes, as a basic concept of TCM, are summaries of a given stage of a disease, which include the cause of the disease, the nature of the disease, the situation of the disease, and the relationship between the pathogenic and the vital energies. Syndromes differ from signs and symptoms. They mark the essence of pathological change at the present

(Hao, 2010). Nurse practitioners focus mainly on nursing determination based on understanding the result of syndrome differentiation, which Chinese doctors focus on Discussion.

The first baccalaureate nursing program in China was developed at Peking Union Medical College in 1920. The higher nursing education program was closed in 1951, keeping only the secondary training program. Nursing education was totally stopped during the Cultural Revolution (1966-1975). Higher nursing education was re-established in 1984.(Li, 2001). The profession of nursing began to take its shape in the early 20<sup>th</sup> century, nurses were regarded as an assistant helping physicians implement their treatment regimen.(Pang, Arthur, & Wong, 2000) Nursing education and practical system of care were strongly influenced by biomedical model. Chinese nursing curriculum is still “*physiologically based and disease-oriented with the minimal presence of the humanities and social sciences*”. (Y. Xu, Xu, & Zhang, 2002). Until now, public image including doctors and nurses following old western based nursing education still identify nurses as medical assistants.(Li,2001).

During my teaching in China, I asked all my classes if they would help me understand the issues that they were facing. The prime response was that most nursing students wanted to be Doctors and had been allocated to nursing because of their grades.

Nursing was not their first choice and many looked forward with trepidation that this was to be their future. I realised that different and conflicting forces were in play. The different system in Chinese nursing concerning curriculums of TCN training and the mix of TCN and western training compounded by nurses whom trained totally in the western model only compounds the uncertainty of the nurses entering the profession Students voiced their concerns about the status of the nurse and felt that the work was

like being a servant. Such comments show that the very basics of nursing are conflicted in China. Students felt that the different levels of hospital, class 1 , class 2 and class three, with the different resources and pay scales were a problem This was compounded by the fact that there were different pay scales for nurses working in a surgical ward to a medical ward. All complained bitterly that they could not live on the salary of a nurse and had to rely on their families support. All the above indicate that there are major challenges facing Chinese nursing.

### **IMPLICATIONS FOR NURSING**

In the previous sections, it can be seen that there are challenges that face China that will present formidable obstacles that will need to be surmounted for Chinese nursing to continue its evolution. In Japan, with its colonisation as a result of losing the Second World War, original Japanese thinking in terms of finding systems of health care that support the full needs of the nation in terms of mental, spiritual and social health are hard to find. The domination of American systems of health care that require no thinking just placid acceptance and compliance result in a lack of motivation in the students of nursing that I have been teaching. Many do not want to be nurses and will not nurse as professional after graduation. While the reasons are different than in China, the outcome in terms of nurses joining the profession and staying there is the same. The system in Japan has nurses working in many private hospitals under the Doctors control as a profession linked to serving the will of the medical profession. This results in the non-transferability of nursing skills and practices. . In China hospitals usually employ nurses that have trained in their district and it is hard for graduates to secure a position if, for example they came from the provinces and trained in the City. It is hard for them to find a job in the city and it is



equally as hard for them to find a job back in the province or district of their birth. Nursing scholarship remains fragile in Japan as existing systems do not allow rigorous challenges to their personal power of position or academic ability. Japanese nursing scholars are hindered in terms of scholarship by their inability to speak English which means that the bulk of academic material published in English is not available to them. China however, has a very different approach and even with the array of challenges facing them there is a determination to succeed. When I asked about this drive and energy I see in the Chinese students I was informed that all students are driven by one thing only and that is to find a way to survive in the very competitive society that China has become. The level of spoken English in the universities I taught in was remarkable, as is their ability to engage critically with ideas and concepts.

In answering the issues raised, my work in Japan has been to introduce the value of community education as a resource and to enable middle aged housewife/scholars to return to higher education and find new ways to learn and new ways to serve their communities in health care. In China the colonisation is not yet, set in stone and a middle way needs to be found where the best of east and the best of west can move forward together, their differences held in tension but forming new understandings. The rich and long history of TCM needs to be cherished and protected as honouring the past in the present empowers the future.

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