Continuity and Innovation Across Cultures

Chinese Health Wisdom and Health Civilization

North American Practice in the International Integration of the Intangible Cultural Heritage of Traditional Chinese Medicine

White Paper Version 0.2

CHUN WANG 王淳

September 2026

Jointly Published by

Vancouver International College of Health and Wellness Inc.

Alpine Holistic Health United Clinics Ltd.

RESERVED DOI: 10.5281/zenodo.22863713

Publication Information

Author CHUN WANG 王淳

Joint Publishers

Vancouver International College of Health and Wellness Inc.

Alpine Holistic Health United Clinics Ltd.

Version 0.2 September 2026

Reserved DOI https://doi.org/10.5281/zenodo.22863713

Disclosure of Institutional Relationship

The author, Chun Wang, is the owner and principal of Vancouver International College of Health and Wellness Inc. and Alpine Holistic Health United Clinics Ltd. Institutional cases discussed in this white paper include programs and practices associated with these organizations. Joint institutional publication should not be interpreted as independent validation of the cases, outcomes, or clinical claims presented.

Publication Note

The Chinese and English editions will be deposited as two separate PDF files in one Zenodo record under the reserved DOI 10.5281/zenodo.22863713.

Foreword Rethinking Health in a Changing World

The vitality of a civilization lies in its capacity to respond continuously to real-world challenges. The significance of the intangible cultural heritage of Traditional Chinese Medicine should be understood in the same way. Safeguarding tradition does not mean placing it beyond change. Heritage continues to create public value only when its knowledge can be understood, examined, governed, and used responsibly in new social settings.

Health needs are changing in the twenty-first century. Population ageing, the burden of chronic disease, mental health needs, health inequities, and pressure on healthcare costs have led countries to place greater emphasis on prevention, rehabilitation, lifestyle support, and person-centred care. The return of traditional medicine to global health discussions does not mean that modern medicine has lost its central role. It reflects the fact that no single professional system can independently address every complex, long-term health issue shaped by daily life and the social environment.

In 2025, the World Health Organization adopted the Global Traditional Medicine Strategy 2025–2034. The strategy identifies evidence, appropriate regulation, the safe and effective integration of services, and the cross-sector value of traditional medicine as priorities for the coming decade.[1][2] It provides a clear policy reference for the international integration of Traditional Chinese Medicine: cultural value should be respected, clinical claims should be tested against evidence, services should comply with local law, and the use of knowledge should protect both patients and holders of traditional knowledge.

Against this background, the white paper proposes three connected concepts. Health Civilization describes the vision, Trust Translation explains the mechanism, and the North America Model summarizes a practical pathway. None is presented as a settled academic conclusion. They are working frameworks intended for discussion, revision, and testing. Drawing on education, clinical practice, mentorship, research, and collaboration in North America, the paper asks one central question: how can Chinese health wisdom make a contribution that is understandable, assessable, and open to cooperation in a new institutional, scientific, and cultural environment?

Executive Summary

The central conclusion of this white paper is that the international integration of the intangible cultural heritage of Traditional Chinese Medicine should not be measured primarily by visibility or the number of institutions involved. Its long-term development depends on a stable foundation of trust that includes professional competence, patient safety, evidence quality, regulatory compliance, cross-cultural interpretation, and public responsibility.

Framework	Level	Central Question	Observable Result
Health Civilization	Vision	How can different forms of health knowledge jointly advance health and well-being?	A person-centred goal for cooperation that respects cultural difference
Trust Translation	Mechanism	How can traditional knowledge become credible across cultures?	Education quality, clinical standards, evidence development, institutional recognition
North America Model	Practice	How can sustainable practice be established in North American settings?	Coordinated education, clinical practice, research, standards, partnerships, and public communication

The white paper advances six principal conclusions:

1. Safeguarding intangible cultural heritage requires both the preservation of knowledge integrity and transmission mechanisms suited to new environments. Neither can replace the other.
2. International integration is first a question of governance. Professional scope, patient safety, informed consent, data protection, and referral mechanisms should be established before expansion in scale.
3. Education is the starting point of Trust Translation. Curricula should integrate classical theory, clinical competence, ethics and regulation, cross-cultural communication, and research literacy.
4. Clinical practice is where value and risk become visible. Statements about outcomes, case records, quality improvement, and adverse-event management should be governed through consistent processes.

5. Research requires a layered evidence system. Randomized studies, observational research, real-world data, and qualitative inquiry serve different purposes; no single method can answer every question.
6. Artificial intelligence can support organization, translation, coding, and research design, but it cannot replace professional judgment or bypass data governance and patient consent.

Scope and Method

This white paper draws on three categories of material: public policy and knowledge resources from the World Health Organization, UNESCO, U.S. federal agencies, and related bodies; public information on occupational regulation, occupational classification, and healthcare payment in North America; and organizational materials from the Vancouver International College of Health and Wellness Inc., Alpine Holistic Health United Clinics Ltd., and related mentorship and heritage-promotion initiatives. The cases are used to analyze practical mechanisms and do not constitute independent certification of institutional status, program performance, or clinical effectiveness. Licensing, program approval, treatment indications, and promotional language should always be checked against the latest requirements of the relevant authority in the jurisdiction where the document is published.

This draft does not estimate market size and does not combine revenues from acupuncture, tuina, physical therapy, massage therapy, and chiropractic services. Regulatory definitions, statistical units, and payment structures differ across occupations, and direct aggregation can be misleading. Any future industry study should disclose the data year, currency, sample boundaries, industry classifications, and exchange-rate methodology.

Structure of the White Paper

Part	Central Question	Main Content
Health Civilization	What do we seek to build together?	Global context, conceptual definition, and public communication of Chinese Health Wisdom
Trust Translation	How can traditional knowledge earn justified trust?	Mechanisms of professional, knowledge, institutional, and cultural trust

Part	Central Question	Main Content
North America Model	How do the mechanisms enter practice?	Education, clinical practice, research, standards, cooperation, and communication
Civilizational Integration	How can different knowledge systems cooperate as equals?	Civilizational Translation, working principles, and co-creation
Future Directions	What should be built over the next decade?	Competencies, research, digital transmission, international cooperation, and the initiative

Part I

Health Civilization

Vision and Shared Purpose

This part defines the white paper's normative objective. Health Civilization is neither a new school of medicine nor a substitute for existing healthcare systems. It is a framework for cooperation centred on health, dignity, well-being, and public responsibility.

Chapter 1 The Global Health Transition

Health needs have expanded from the treatment of acute illness to long-term health management. Chronic conditions often interact with age, lifestyle, working conditions, social support, and access to care. Patients need more than a single diagnosis or isolated technique; they also need continuing communication, rehabilitation support, lifestyle guidance, and coordination among professions.

Traditional medicine has attracted renewed attention in this context, but attention is not the same as acceptance. The WHO strategy emphasizes safe, effective, person-centred, and evidence-informed integration.[1][2] Traditional knowledge entering contemporary health systems should neither be exempt from evaluation because of its long history nor excluded in advance because it uses a different knowledge language. Standards of evaluation should be proportionate to the intervention, level of risk, service objective, and stage of evidence development.

The intangible cultural heritage of Traditional Chinese Medicine therefore has a dual character. It encompasses classical theory, diagnostic and therapeutic experience, technical practice, mentorship relationships, and cultural ethics. At the same time, any element used in health services must meet contemporary responsibilities for patient safety, professional

competence, and outcome evaluation. This white paper describes the dual obligation as the joint protection of integrity and verifiability.

Chapter 2 Defining Health Civilization

This white paper defines Health Civilization as a system of knowledge and action through which different medical traditions, scientific research, public institutions, and social practices engage in dialogue as equals to advance health, dignity, and well-being.

Dimension	Meaning	Requirement for This White Paper
Health	Treatment, prevention, rehabilitation, and quality of life	Distinguish cultural value, clinical claims, and health education
Dignity	Informed choice, cultural identity, and individual experience	Avoid idealizing tradition or disparaging other medical systems
Well-being	Individual, family, community, and environmental conditions	Include access, equity, and long-term outcomes in evaluation
Responsibility	Safety, transparency, and accountability as boundaries	Define professional scope, data rules, and risk response

The purpose of Health Civilization is not to enlarge the explanatory reach of Traditional Chinese Medicine, but to discipline the goals of international integration. Every collaborative project should answer four questions: what observable health benefit did participants receive; how were risks identified and managed; were knowledge holders and local communities respected; and can the results be disclosed, reviewed, and improved?

Chapter 3 Public Communication of Chinese Health Wisdom

Traditional Chinese Medicine is an internationally recognized professional term, but it does not encompass the full intangible cultural heritage associated with Chinese medicine. The term Chinese Health Wisdom can describe cultural knowledge related to views of life, prevention, holistic thinking, medical ethics, health cultivation, diagnosis and treatment, and mentorship. It must not be used to blur the boundaries of healthcare services or substitute for evidence about a specific intervention.

International communication should distinguish three levels. The first consists of cultural and historical statements, such as the lineage and cultural meaning of a practice. The second consists of health education and lifestyle guidance, for which the intended population and general limitations should be stated. The third consists of clinical diagnosis

and treatment claims, which must satisfy local law, professional standards, and evidence requirements. Clear separation among these levels reduces misunderstanding and protects heritage narratives from being depleted through excessive commercial promotion.

In 2010, acupuncture and moxibustion of Traditional Chinese Medicine were inscribed on UNESCO's Representative List of the Intangible Cultural Heritage of Humanity.[3] Inscription recognizes cultural practice and transmission value; it is not scientific certification of every clinical claim. Communicating this distinction clearly is an essential foundation for credible international engagement.

Part II

Trust Translation

Building Credible Cross-Cultural Trust

This part explains how trust can be built progressively when traditional health knowledge enters a new social setting. Trust Translation is not a rhetorical technique. It is a process produced jointly by education, clinical practice, research, standards, and institutions.

Chapter 4 Why Trust Is the Central Variable

Barriers to cross-cultural communication are often attributed to language, but the deeper issue is that stakeholders use different grounds for judgment. Patients focus on safety and experience; regulators on professional scope and public risk; researchers on reproducibility and bias; educators on competency standards; and cultural practitioners on the integrity of knowledge. If terms are translated without addressing these different grounds for judgment, wider dissemination may create more controversy rather than more understanding.

Trust should not mean unconditional belief. Reasonable trust in health settings rests on verifiable information, clear responsibility, continuing quality management, and the capacity to correct error. A system that permits external questions, records uncertainty, and reports improvements publicly is more likely to earn durable recognition than one that repeatedly invokes historical longevity.

Chapter 5 The Trust Translation Chain

Trust Translation can be described as an interdependent chain. Education establishes core competence; clinical practice turns competence into service; research turns service

into assessable evidence; standards turn dispersed experience into consistent requirements; institutions turn those requirements into public responsibility; and social recognition emerges from sustained, observable professional performance.

Link	Primary Task	Minimum Evidence	Trust Outcome
Education	Curriculum, competence, ethics, and clinical training	Syllabi, assessment records, faculty qualifications	Professional trust
Clinical practice	Safe services, records, referrals, and follow-up	Standard records, quality indicators, risk records	Patient trust
Research	Ask testable questions and report results	Protocols, data dictionaries, analyses, and limitations	Knowledge trust
Standards	Align processes, terminology, and quality requirements	Operating standards, audits, and revision records	Organizational trust
Institutions	Licensing, compliance, oversight, and accountability	Regulatory compliance, complaints, and corrective mechanisms	Public trust
Communication	Explain value, risk, and uncertainty accurately	Source disclosure, evidence grading, and interest disclosure	Social trust

No link in this chain can fully replace another. Strong clinical experience does not replace compliance, and compliance does not by itself prove effectiveness. Published research does not replace daily quality management, and cultural recognition does not cancel informed consent. The significance of North American practice lies in addressing these requirements within a single system.

Chapter 6 Four Forms of Trust and Common Failures

Professional trust arises from training, competence, and ethics; knowledge trust from evidence and transparency; institutional trust from the enforcement of rules and accountability; and cultural trust from respect, explanation, and equitable cooperation. These forms of trust reinforce one another, but they can also create tensions. Excessive standardization may weaken the contextual character of a practice, while reliance on individual experience alone may reduce reproducibility.

Common failures include replacing specific evidence with expansive narratives; treating cultural heritage status as proof of clinical effectiveness; insufficiently explaining

treatment boundaries, risks, and referral conditions; reporting only successful cases; omitting data ownership and intellectual-property arrangements from institutional partnerships; and using AI-generated content without professional review. Trust Translation turns these weaknesses into concrete governance tasks.

Part III

North America Model

Practice and Institutional Adaptation

The North America Model is an analytical framework for practice. It examines how traditional knowledge adapts to varied professional regulation, education quality systems, research standards, and multicultural environments, and how coordinated mechanisms can support continuing improvement.

Chapter 7 Why Examine North America

North America is neither the endpoint of the international development of Traditional Chinese Medicine nor a single unified system. Professional licensing in the United States is determined primarily at the state level, while health-profession regulation in Canada is largely provincial. Education approval, insurance coverage, and scope of practice also vary. This institutional diversity, active professional competition, and cultural plurality make North America a useful setting in which to examine the adaptability of Traditional Chinese Medicine.

North America also provides three types of institutional signal. The U.S. occupational statistics system recognizes acupuncturists as an occupational category; Medicare covers acupuncture for chronic low back pain under specified conditions; and Canadian education directories and provincial regulatory systems classify institutions and professional identities.[6][7][8] These signals should not be interpreted as comprehensive recognition of the entire system of Traditional Chinese Medicine. They do show that some services have entered occupational, payment, or public-administration frameworks.

Research on the North America Model should therefore focus not on reproducing a particular institution, but on identifying mechanisms that can travel across jurisdictions:

alignment between curricula and competency standards; clinical documentation and referral processes; responsible collection of real-world data; interprofessional agreements; and risk communication suited to local languages and cultures.

Chapter 8 Six Coordinated Systems

System	Core Function	Recommended Output
Education	Develop dual literacy and professional competence	Competency framework, curriculum map, clinical assessment
Clinical practice	Provide safe and traceable services	Record template, referral rules, quality indicators
Research	Evaluate effectiveness, safety, and implementation conditions	Registry, research protocol, data report
Standards	Reduce variation among institutions and practitioners	Terminology standard, technical procedures, audit mechanism
Partnerships	Connect schools, clinics, researchers, and communities	Partnership agreement, shared governance, interest disclosure
Communication	Help the public understand evidence and boundaries	Bilingual materials, evidence grading, public reporting

The six systems should operate together around the needs of the person receiving services. When education is disconnected from practice, students struggle to develop judgment in real situations. When practice is disconnected from research, experience cannot be evaluated systematically. When research is disconnected from communication, the public may see conclusions without their limitations. When partnerships are disconnected from governance, growth magnifies variations in quality.

Chapter 9 North American Practice Cases

The cases below are drawn from presentation materials, publicly available institutional information, and Canadian education directories. They illustrate mechanisms and do not constitute independent performance evaluations. Before publication, the participating organizations should verify program names, approval status, scope of services, data definitions, and dates.

Case	Practice	Relevant Mechanism	Next Evidence Needed
Vancouver International College of Health and Wellness Inc.	Courses and research activities related to TCM, acupuncture, and health education	Education connects classical training, clinical competence, and local requirements	Publish curriculum maps, learning outcomes, faculty information, and clinical assessment methods
Alpine Holistic Health United Clinics Ltd.	Holistic services connecting prevention, rehabilitation, and interprofessional collaboration	A clinical network supports standard processes, referral, and quality improvement	Develop consistent records, quality indicators, and an annual service report
TCM Heritage Mentorship	Institutions, mentors, and learners define the learning relationship and responsibilities	Traditional apprenticeship is translated into modern contracts, ethics, and competency assessment	Establish mentor eligibility, learning logs, complaints, and withdrawal procedures
Heritage Practice Promotion Centre	Project-based transmission, training, and cross-cultural explanation of inherited practices	Connects heritage safeguarding, professional training, and public communication	Establish provenance and authorization, technical boundaries, training standards, and outcome evaluation

The transferable value of a case lies in its governance structure, not in an institutional brand. Before replication, partners should verify teaching authority, scope of service, documentation and referral procedures, data governance, and dispute-resolution mechanisms.

Part IV

Civilizational Integration

Dialogue Across Knowledge Systems

Civilizational Integration calls for cooperation among different knowledge systems while preserving meaningful differences. It rejects both simple replication and the reduction of differences to a vague slogan of holistic medicine.

Chapter 10 Civilizational Translation

Civilizational Translation begins by translating questions, not merely answers. Concepts in the Chinese medical classics have their own historical settings and theoretical relationships. Searching immediately for one-to-one equivalents in modern biomedicine can lead to oversimplification. A more responsible approach explains the function of a concept within its original system and then clarifies whether its relationship to a modern research question is analogous, complementary, or not yet established.

High-quality translation should preserve three kinds of information: the boundaries of the original concept, the established meaning of terms in the receiving context, and the uncertainty between them. Clinical terminology should also be accompanied by explanations of risk, alternatives, and referral conditions that service users can understand. Such bilingual expression protects the integrity of knowledge and reduces false inferences caused by superficial similarity between terms.

Chapter 11 Working Principles for Civilizational Integration

1. Equity. Partners jointly determine the question, methods, data use, and attribution of results.
2. Evidence. Clinical claims are matched to the level of evidence, with uncertainty and negative results reported.

3. Safety. Local law, patient rights, and professional scope take precedence over promotion or expansion.
4. Culture. Lineage, community rights, and knowledge sources are respected, and decontextualized appropriation is avoided.
5. Sustainability. Long-term demands on people, funding, environmental resources, and organizational governance are considered.

These principles align with the UNESCO Convention for the Safeguarding of the Intangible Cultural Heritage, which emphasizes community participation, intergenerational transmission, and continuing practice.[4] International cooperation involving the intangible heritage of Traditional Chinese Medicine should not focus only on technical transfer. It should also define knowledge provenance, authorization, benefit sharing, and continuing renewal.

Chapter 12 Co-Creation

Co-creation means including the perspectives of patients, tradition bearers, clinicians, researchers, educational institutions, and regulators from the stage at which a collaborative project defines its problem. It does not require every participant to accept the same theory. It requires explicit agreement on shared goals, evaluation measures, and boundaries of responsibility.

Appropriate topics for co-creation include chronic pain management, rehabilitation support, health education, care for older adults, and culturally adapted services. Each should begin with a limited pilot that specifies safety indicators, participant experience, clinical outcomes, implementation cost, and equity measures before any decision to expand.

Part V

Future Directions

A Ten-Year Agenda

The priority for the coming decade is not to enlarge the concepts, but to strengthen the capacity for verification. Education, research, digital development, and international cooperation should advance within a shared governance framework.

Chapter 13 An Educational Competency Framework

Future curricula should develop five areas of competence: understanding classical texts and lines of transmission; applying safe clinical skills; knowing the relevant local law and ethics; demonstrating research and data literacy; and communicating across cultures. These areas should be connected through curriculum mapping and assessed through observable performance rather than instructional hours alone.

A contemporary mentorship system can retain the strengths of clinical observation, demonstration, and contextual judgment while adding requirements for mentor eligibility, learning objectives, patient consent, privacy protection, conflicts of interest, process records, complaints, and withdrawal. Mentors' experience should be respected while remaining subject to the same requirements for patient safety and professional ethics.

Chapter 14 A Layered Research System

The research question determines the method. Randomized studies or pragmatic trials can evaluate the effects of a defined intervention. Cohorts, registries, and real-world studies can examine long-term safety and service models. Qualitative research can explore patient experience and cultural adaptation. Quality-improvement and implementation research can be used to improve processes.

North American initiatives could begin with a minimum viable dataset covering basic demographic information, primary health concerns, intervention category, course of care, patient-reported outcomes, safety events, referrals, and follow-up. Collection must undergo appropriate ethics and privacy review and identify the data controller, purpose of use, retention period, and withdrawal process. Real-world data can complement trials, but it does not automatically eliminate selection bias, contextual effects, or incomplete documentation.

Chapter 15 Artificial Intelligence and Digital Transmission

Artificial intelligence can support the organization of classical literature, terminology alignment, first-draft bilingual translation, case coding, literature screening, and teaching assistance. Its primary value lies in reducing repetitive work and improving knowledge retrieval. When an output relates to diagnosis, treatment recommendations, risk stratification, or communication with patients, it must be reviewed by an appropriately qualified professional.

Digital transmission requires records of source, version, and responsibility. Every digital description of a practice should identify the knowledge source, compiler, intended use, revision history, and evidence status. Patient data must not be mixed into public heritage resources. When data are used for model training or research, there must be a lawful basis, appropriate consent, de-identification measures, and access controls.

Chapter 16 Mechanisms for International Cooperation

International cooperation can be organized in four categories: education recognition and faculty exchange; clinical quality and referral collaboration; research-method and data collaboration; and intangible-heritage safeguarding and public cultural exchange. Each category requires different responsible authorities, agreements, and evaluation measures. A broad memorandum of understanding should not substitute for specific governance.

An annual collaboration register should disclose the purpose of each partnership, participating organizations, responsible persons, funding sources, data arrangements, interim results, and next steps. A public register can reduce fragmentation and help identify duplicated investment and conflicts of interest.

Chapter 17 The Health Civilization Initiative

This white paper proposes a Health Civilization Initiative as an open platform for cooperation rather than the branded project of a single organization. It could begin with four foundational tasks: establish bilingual terminology and evidence-communication standards; create education and clinical quality indicators; conduct a multicentre real-world research pilot; and publish an annual transparency report.

Phase	Period	Priority Tasks	Phase Outputs
Foundation	2026–2027	Governance, terminology standards, and a minimum dataset	Methods handbook and register of participating organizations
Pilot	2027–2028	Education evaluation, clinical quality, and research pilots	Pilot evaluation and public data summary
Expansion	2029–2031	Multi-region cooperation, standards alignment, and workforce development	Cross-institutional curriculum and service-quality reports
Evaluation	2032–2035	Independent evaluation, framework revision, and international exchange	Ten-year evaluation and strategy for the next cycle

The initiative should be evaluated by public value, including safety, access to services, patient-reported outcomes, education quality, evidence transparency, fairness in partnerships, and the quality of heritage transmission. Institutional numbers, media exposure, and revenue may be reported as operational information, but they should not replace health and social outcomes.

Chapter 18 Conclusion

The international integration of the intangible cultural heritage of Traditional Chinese Medicine is a long-term undertaking in knowledge, institutions, and culture. North American practice suggests that the hardest task is not translating terminology into another language, but translating experience into competence, competence into service, service into evidence, and evidence into institutional arrangements capable of carrying public responsibility.

Health Civilization provides a shared goal, Trust Translation explains the mechanism, and the North America Model locates that mechanism in education, clinical practice, research, standards, cooperation, and communication. All three require continuing revision

through practice. Their value lies not in creating a closed system, but in establishing clearer conditions for cooperation among different medical traditions and modern science.

The lasting contribution of Chinese Health Wisdom will depend on whether it can retain its cultural roots while accepting rigorous evaluation; respect inherited experience while protecting patient rights; and participate in international dialogue while disclosing its boundaries and uncertainties. Under these conditions, the intangible cultural heritage of Traditional Chinese Medicine may move from recognition to understanding, from individual practice to reliable cooperation, and become part of the shared construction of a global Health Civilization.

Prepublication Verification Checklist

Item	Verification Question	Suggested Responsibility
Concepts	Have Health Civilization, Trust Translation, and the North America Model been sufficiently compared with existing scholarship?	Academic committee
Cases	Are institutional status, program status, participant numbers, dates, and results supported by original records?	Case organizations and legal counsel
Clinical practice	Do scope, outcome statements, risk information, and referral rules comply with local requirements?	Clinical governance lead
Research	Are data definitions, ethics, privacy, statistical methods, and limitations disclosed?	Research lead
Heritage	Are lineage, authorization, community participation, and knowledge sources accurate?	Tradition bearers and cultural advisers
Bilingual edition	Does the English terminology fit the local professional and regulatory context?	Bilingual medical editor

References

[1] World Health Organization. Global Traditional Medicine Strategy 2025–2034. https://www.who.int/teams/who-global-traditional-medicine-centre/traditional-medicine-strategy-2025-2034

[2] World Health Organization. Traditional complementary and integrative medicine global strategies. https://www.who.int/teams/integrated-health-services/traditional-complementary-and-integrative-medicine/global-strategies

[3] UNESCO. Acupuncture and moxibustion of traditional Chinese medicine. https://ich.unesco.org/en/RL/acupuncture-and-moxibustion-of-traditional-chinese-medicine-00425

[4] UNESCO. Convention for the Safeguarding of the Intangible Cultural Heritage. https://ich.unesco.org/en/convention

[5] National Center for Complementary and Integrative Health. Traditional Chinese Medicine What You Need To Know. https://www.nccih.nih.gov/health/traditional-chinese-medicine-what-you-need-to-know

[6] Medicare.gov. Acupuncture coverage. https://www.medicare.gov/coverage/acupuncture

[7] U.S. Bureau of Labor Statistics. Occupational Employment and Wages Acupuncturists. https://www.bls.gov/oes/2023/may/oes291291.htm

[8] Canadian Information Centre for International Credentials. Vancouver International College of Health and Wellness Inc. https://www.cicdi.ca/872/search_result_in_the_directory_of_educational_institutions_in_canada.canada?id=8504

[9] Vancouver International College of Health and Wellness Inc. Public website and contact information. https://wellnesscollege.ca/contact

[10] Wang Chun. Chinese Health Wisdom and Health Civilization: North American Practice in the International Integration of the Intangible Cultural Heritage of Traditional Chinese Medicine. Presentation materials. September 2026.