

The Next Step in

Primary Care: Integrative Health

Integrative Health for Thai Primary Care



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This translation preserves the Thai edition’s arguments, evidence boundaries, fictional cases and references. Services, referral pathways, emergency numbers and policy context refer to Thailand. “Integrative Health” is the author’s term for the framework described in Chapter 5.

Plearnprai Organic Social Enterprise

Preface • Medicine with Both Eyes Open

If Thailand's health system were a body, primary care would be its heart. Over the past two decades, we have built something that many countries admire: health coverage for the whole population, primary care services close to home, family care teams, and approximately 1.1 million village health volunteers who live in the same communities as their patients. This is a strong foundation, and I am proud to work within this system.

Yet today's challenges differ from those of twenty years ago. The leading causes of death among Thai people are noncommunicable diseases, which develop and progress in everyday life. Of the roughly 7.4 million people receiving treatment for hypertension, nearly half still do not meet their blood pressure targets, despite being in care and taking medication. Patients see a doctor for only a few minutes a year. For the rest of that year, they are at home, at the dinner table, in bed, and within their relationships. What is missing is therefore neither medication nor the commitment of health workers. It is a language that patients can use to understand themselves and take home, a way to connect symptoms with life, and someone to walk alongside them between appointments.

For more than twelve years, I have searched for what is missing, guided by one question: "How can we make it easier for people to care for themselves?" That question took me beyond the consulting room to study Thai traditional medicine, Chinese medicine, and Ayurveda, and to spend my annual leave learning from teachers in many other disciplines. The more I learned, the more I found traditional medical knowledge to be deeper and more powerful than I had previously understood. These traditions did not contradict the medicine I had studied; they looked at people from different perspectives.

Modern medicine looks deeply inside the body, identifies disease, measures, and tests through evidence. Its precision has saved countless lives. Traditional medicine looks more broadly at the life surrounding a person: individual differences in constitution, food, seasons, relationships, and the mind. It therefore offers a language that ordinary people can use to care for themselves before they become ill. One perspective sees disease; the other sees the life in which that disease arises. We can see with one eye, but only with both eyes open can we judge distance accurately and see the whole person.

The integrative health proposed in this book is medicine with both eyes open. It brings the precision of modern science together with traditional knowledge's view of the whole of life, carrying knowledge "from the classical texts" into "the household" in a form that patients, village health volunteers, nurses, Thai traditional medicine practitioners, and physicians can share. I believe this is what Thai primary care needs for its next step, because the resources are already here: traditional knowledge, herbs, food, communities, and health workers closest to patients. This proposal still needs to be tested. The final chapter therefore presents a measurable pilot plan. I have written this book for fellow physicians, primary care teams, and policymakers, inviting us to take that next step together.

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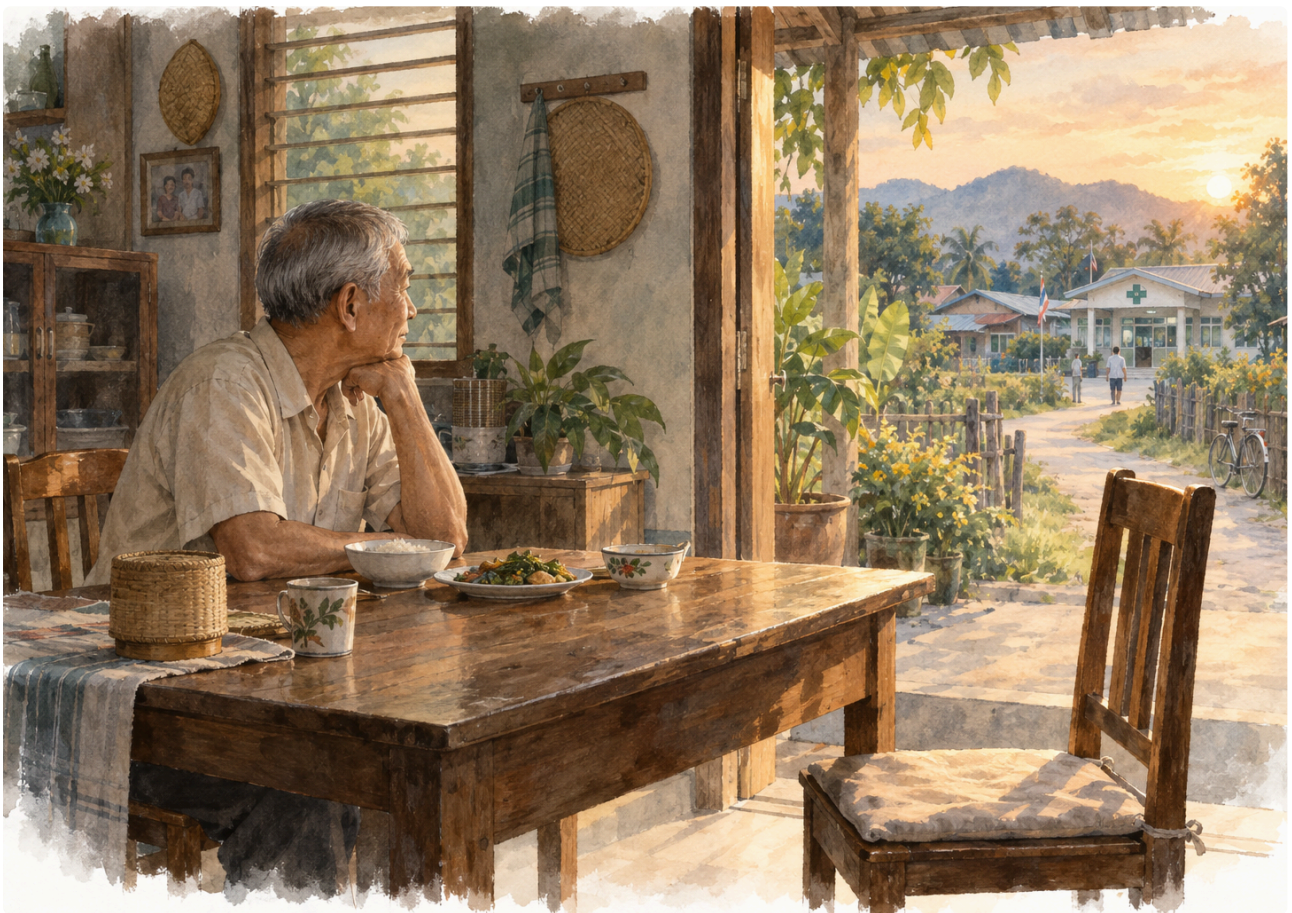
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Companion file: Six-Pole Wheel · English A3 (two sides and complete reading key).

Part 1 • The Gaps, Seen from Within the System

The first four chapters look outward from a conventional physician's consulting room, making the gaps visible before introducing any theory. Chapter 1 describes a day in a primary care unit. Chapter 2 establishes the three-box framework used throughout the book. Chapter 3 examines how well existing tools work. Chapter 4 shows that patients are already integrating different forms of medicine themselves, often without our knowledge.



Chapter 1 • A Day in a Primary Care Unit

All patients in this book are fictional composite cases based on situations commonly encountered in clinical practice. None represents an actual individual patient.

Wednesday Morning

The hospital's primary care unit where I practise opens at eight. Most patients arrive at seven; some come at half past six to secure an early place in the queue and return to work on time. That morning, there were sixty-four names on my list. It was an ordinary day.

I would like to tell you about three of them. None was a difficult case. On the contrary, they were the kinds of patients every primary care physician sees each week. That is precisely why their stories matter.

Patient 1 • Uncle Chai: Taking Every Tablet, but Blood Pressure Still High

Uncle Chai is sixty-eight and has had hypertension for seven years. He attends every three-month appointment without fail and takes all three medications. The tablets remaining in the packets he brought matched the number of days left. His blood pressure that day was 162/94, compared with 158/92 at the previous visit and 165/96 before that.

I knew three familiar options: increase the dose, add a fourth drug, or refer him to an internist. I had already chosen the first option twice that year. Before deciding this time, I asked a question I should have asked at the very beginning: "How have things been at home lately?"

He fell silent for a moment, then briefly told me that his wife had died earlier that year. His children lived in Bangkok. He had been eating alone for eight months. Lately he had been sleeping poorly, waking at three in the morning and unable to get back to sleep. "There's this hollow feeling inside," he said, and then said no more.

At that moment, I felt that a fourth drug would not help. I also knew that, in the four minutes remaining, I had no tool to offer beyond saying, "Try finding something to do, someone to talk to, and cut down a little on salt." He nodded as he always had, and I knew he would return to the same dinner table, alone.

Patient 2 • Ms A: Normal Test Results

Ms A is thirty-four, an office worker who spends nine to ten hours a day at a screen. She came with three months of neck and shoulder tightness, difficulty falling asleep, and waking unrefreshed. She had already visited two hospitals. Her neck X-ray and blood tests were normal. Muscle relaxants and painkillers helped for a few days, then the symptoms returned. As I examined her neck, she mentioned in passing that she had recently taken on a new project and was overwhelmed with work. I nodded and continued the examination.

I repeated the appropriate assessment: no arm numbness, no weakness, no pain radiating down the arm, and no concerning signs. I told her there was nothing to worry about, that the muscles were affected by posture, and that she should adjust her workstation, stand up frequently, and attend physiotherapy.

She asked a question I still remember: “Then why can’t I sleep, doctor? Are the two connected?”

I said they might be: pain makes sleep difficult, and insufficient sleep makes pain more likely. The answer was correct, but it did little to help her because it did not say where to begin. She left with a physiotherapy referral and, I suspect, the feeling that something was wrong which the doctors had not found.

Patient 3 · Aunt La-or: The Herbal Medicine She Had Not Mentioned

Aunt La-or is fifty-five, a homemaker with type 2 diabetes. Her HbA1c had improved from 8.9 to 7.6 over three months. I was pleased and praised her dietary efforts. She smiled and said she had not changed her diet much. Instead, following a neighbour’s advice, she had started drinking a decoction from a local traditional healer and going for massage every week. She had been doing this for two months.

I asked why she had not mentioned it at the previous visit. “I was afraid you would scold me,” she replied frankly. When she had previously asked another doctor about herbs, she had been told not to believe in such things.

I did not know what the decoction contained, whether it interacted with the diabetes medication I prescribed, or what had caused her blood glucose to fall. What I did know was that she would continue regardless of what I said—and that if I scolded her, she would stop telling me. I was more worried about her than I showed that day.

What the Three Patients Had in Common

That evening, I thought about these three patients and realised that their stories were, in essence, the same story.

All three had completed the system’s processes: examination, diagnosis, and medication. No one had missed a step. No one was at fault. Yet all three were still unwell.

Uncle Chai did not need a fourth drug. He needed someone to see that his uncontrolled blood pressure had a starting point at the empty dinner table at home, and he needed a first step he could actually take in a life now lived alone.

Ms A did not need more investigations. She needed an explanation connecting her two symptoms and telling her where to start. She needed a map, not a referral slip.

Aunt La-or did not need me to agree with her traditional healer. She needed a place where she could speak without being judged, so that I would know what she was doing and could help assess its safety.

We already have names for these three needs: self-care, health promotion, and prevention before disease develops. Every family medicine textbook calls them the heart of primary care. They are also the three areas in which my consulting room has the fewest tools.

The Gap Between the Consulting Room and Life

I have not written this chapter to say that the system has failed. The system in which I work does what it was designed to do very well: identify disease, treat it, and prevent avoidable deaths. Thailand's Universal Coverage Scheme enables almost four medical visits per person each year—more than 176 million visits in a single year (NHSO 2024). That number still amazes me whenever I see it.

But a gap remains between my consulting room and my patients' lives. Look closely, and it has a distinct shape.

Time. In my consulting room, I have about five minutes per person, sometimes less. Five minutes is enough to complete the necessary tasks: measure, examine, prescribe, and arrange follow-up. It is not enough to ask whom Uncle Chai eats with. Even if I ask, there is no time to do anything with the answer.

Language. When I tell him to reduce salt and find activities, I am speaking the language of risk factors. He is speaking the language of someone who feels hollow inside. These two languages do not translate into one another. He receives my advice with nowhere to put it, because it is not connected to his sense of who he is.

Someone to walk alongside. During the three months between appointments, no one walks with him. No one helps Ms A explore how her pain and sleep are connected. No one knows what is in Aunt La-or's decoction. We have approximately 1.1 million village health volunteers (VHVs) nationwide (Ministry of Public Health 2024a), yet the tools we give them are blood pressure monitors and record forms. We have not given them a way to understand the person.

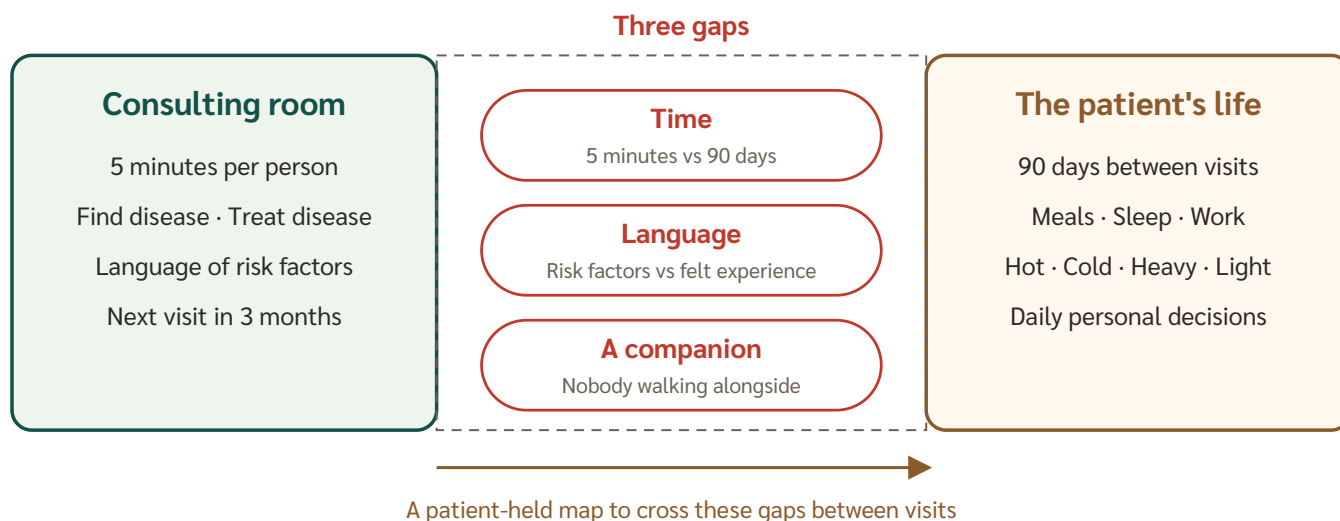


Figure 1.1 Three gaps between the consulting room and the patient's life: time, language and someone to walk alongside.

None of these three gaps can be closed simply by adding more doctors. Thailand has approximately 2,000 family physicians in primary care, against a need for 6,500 (Ministry of Public Health 2024a). Even if we reached that number, five minutes would still be five minutes.

The Question Behind This Book

This book begins with one question: **What would happen if patients held their own map?**

The map I have in mind is another language, one that patients can use to understand what kind of person they are, in which direction they are currently tending, and where they need to return. It is a language VHV's can use in conversation with patients, and which Thai traditional medicine practitioners and physicians like me can read to understand quickly where a patient has reached. This differs from simplifying medical knowledge, because it starts with what patients already feel.

That language has long existed in this country: the language of elements, of hot and cold, heavy and light, dry and moist, which Thai people used to describe their bodies long before the term “blood pressure” existed. Over the past several years, the Plearnprai team and I have organised that language into a system with boundaries, referral points, and ways to measure outcomes, so that people can use it themselves without crossing into diagnosis.

I cannot yet say that this approach works, because it has not been systematically tested. Whenever something remains merely an observation, I will say so at that point. What I can say is that it is safe, has clear boundaries, can be measured, and addresses these three gaps directly. I therefore invite fellow professionals to examine the whole system before judging it.

Something to Try Tomorrow

Before reading the next chapter, I invite you to do just one thing in tomorrow's clinic. Choose one patient whose chronic condition is not controlled and, before prescribing, ask:

“What has changed in your life recently?”

You do not need to do anything with the answer. Just listen, and notice whether it changes what you want to prescribe. The rest of this book explores what we can do with that answer when we have tools and someone to walk alongside. Chapter 2 begins by asking which box of primary care such an answer belongs in.

Chapter 2 • The Three Boxes of Primary Care—and the Gap in Each

A Framework We Already Know

Ask any health professional about the dimensions of primary care and the answer will be much the same: health promotion, disease prevention, treatment, and rehabilitation. We learn this framework in our first year and encounter it in the names of departments, indicators, and plans at every level.

I will use that same framework throughout this book, combining treatment and rehabilitation into one box because, in primary care, they involve the same patients at the same time. That leaves three boxes:

- **Health promotion:** for people who are still well.
- **Disease prevention:** for people beginning to move out of balance but not yet diseased.
- **Treatment and rehabilitation:** for people who already have disease.

I chose this framework because it is familiar. Readers need not learn a new framework; they can look at the old one through a new question: **In each box, what tools can we give patients to take home?**

The Umbrella over the Three Boxes

The three boxes do not stand alone. They sit beneath the same umbrella, which family medicine calls holistic care: considering the patient's body, mind, social circumstances, and environment together. WONCA Europe's 2023 definition of family medicine competencies uses "holistic modelling" and identifies six dimensions: physical, psychological, social, cultural, environmental, and spiritual (WONCA Europe 2023).

At this level, integrative health and family medicine have been speaking about the same thing from the start. The difference lies in the Plearnprai team's attempt to translate that umbrella into a picture patients can see for themselves. In the language of the Care Circles, this picture includes the energies moving within the body, the mind, relationships, and environmental influences. These are terms within Plearnprai's framework, not intended as physiological explanations. I will explore this in Chapter 6.

The Picture We Will Use Throughout

I would like readers to picture the three boxes as overlapping layers rather than three compartments in a row.

The broadest, lowest layer is health promotion. Everyone stands on it throughout life, including those who are ill. The middle layer is prevention: people move onto it when they begin to shift out of balance and can move back down when they regain their balance. The narrowest, uppermost layer is treatment and rehabilitation. People reach it when they develop disease, and its purpose is to help them return to the layers below.

The layers need to overlap because a common misunderstanding in the system is that once a person becomes ill, health promotion disappears from the care plan. Uncle Chai has been in the treatment box for seven years. Throughout those years, no one has asked what kind of person he is or how he might care for himself in accordance with his own nature. Neither have I.

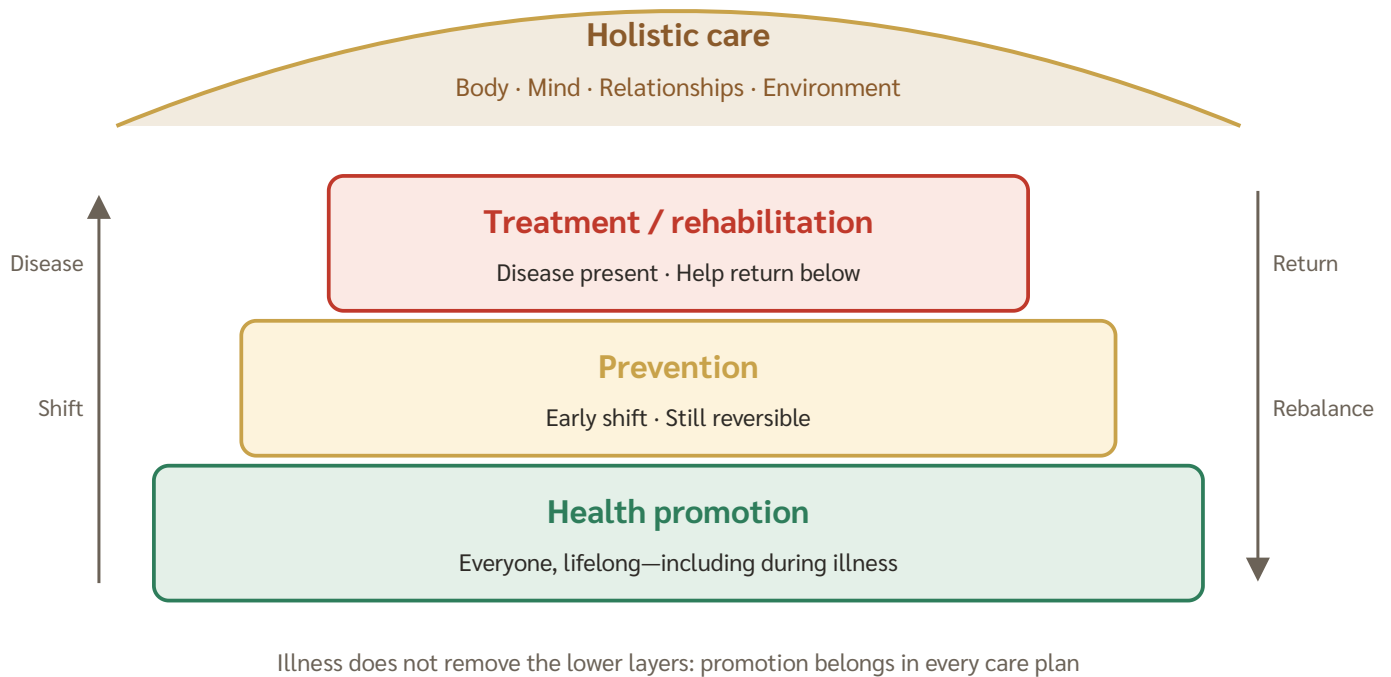


Figure 2.1 Primary care's three boxes are overlapping layers under whole-person care, rather than three separate compartments.

This picture aligns with another that the Plearnprai team and I use in teaching: a lifetime balance timeline, from birth to death. It describes four zones around a person's own balance line: balance, imbalance, symptoms, and illness.

- The balance zone corresponds to health promotion.
- The imbalance and symptom zones correspond to prevention.
- The illness zone corresponds to treatment and rehabilitation.

The width of each zone reflects the person's capacity, which narrows with age. The same fluctuation may therefore carry an older person into the illness zone. This makes health promotion more important, not less, as people grow older.

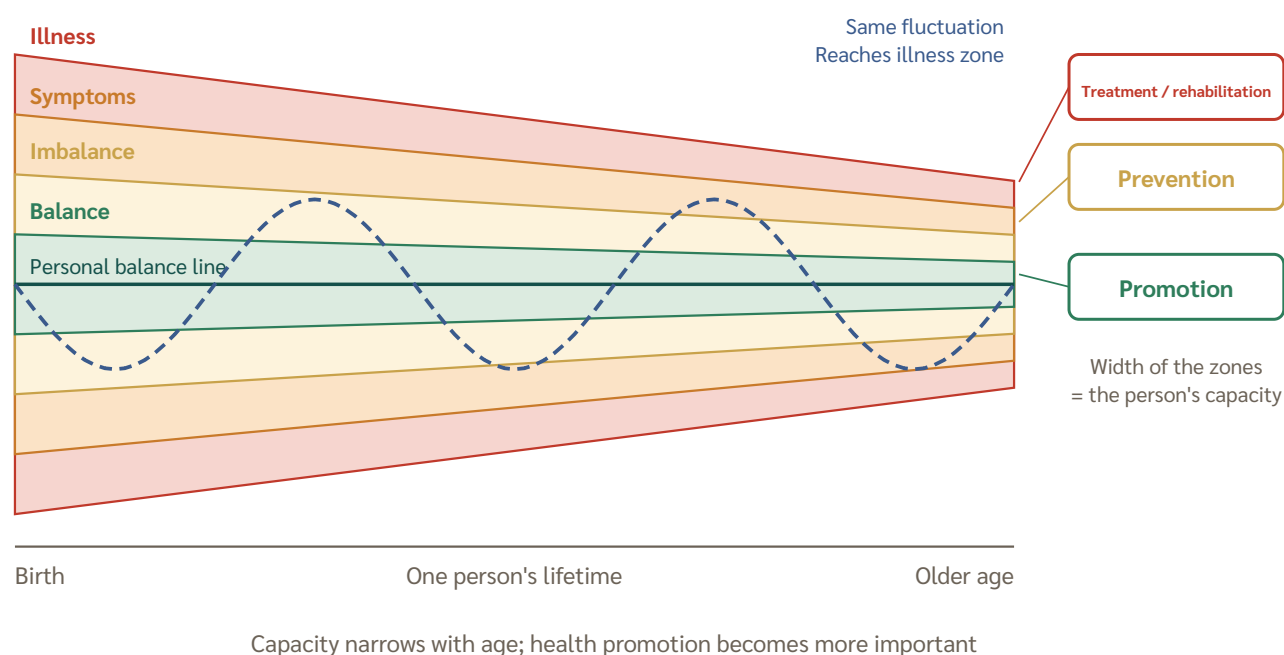


Figure 2.2 A person's line of balance from birth to older age, the four surrounding zones, and their corresponding primary care boxes.

Where the System Places Its Weight

Before discussing the gaps, I want to look at the figures showing where the system places its resources.

Thailand's total health expenditure in 2021 was approximately THB 872 billion, or 5.4% of gross domestic product. The National Health Accounts reported that disease control and health promotion accounted for about 11% of current health expenditure that year. This was probably higher than in a normal year, because COVID-19-related spending reached approximately 14% of current health expenditure in 2021. Historically, disease control and health promotion had accounted for around 8% (IHPP 2023). For fiscal year 2026, the National Health Security Fund was approved approximately THB 265 billion. Of this, about THB 27.76 billion—roughly one tenth—was allocated to health promotion and disease prevention for all Thai citizens across coverage schemes, equivalent to about THB 410 per person. The capitation allocation for Universal Coverage Scheme beneficiaries was THB 4,175.99 per person (Cabinet 2025).

One tenth is not intrinsically too little; many countries spend less. My question is what that allocation buys, and whether what it buys reaches patients in a form they can use.

The other side of the figures is the burden the system carries. Noncommunicable diseases account for around 74% of deaths in Thailand, approximately 400,000 annually, and cost the economy about THB 1.6 trillion a year, mostly through lost productivity rather than treatment costs (WHO and UNDP 2021). These diseases begin in the promotion and prevention boxes but are often detected in the treatment box.

The Health Promotion Gap · No Language for the Individual

Most of our health promotion consists of the same advice for everyone: eat fruit and vegetables, exercise, sleep enough, reduce sugar, fat, and salt, and avoid tobacco and alcohol. All of it is correct. None of it tells an individual patient where to begin.

We have the language of risk factors—age, weight, family history, and blood results—but not a language of a person’s underlying constitution that describes the direction in which they tend to shift before becoming ill. Uncle Chai has always felt cold easily, struggled with sleep, and been prone to bloating. Aunt La-or has felt hot easily, become irritable when hungry, and been prone to acne since youth. We give them the same health promotion advice, although their bodies may need care in different directions.

Thai traditional medicine has long had this language, calling it the dominant constitutional element, or *that chao ruan*. Ayurveda also has it, in the concept of innate constitution. Yet this language has not been placed in primary care’s promotion box in a form patients can check for themselves. This is the first gap, and I think it is the easiest to fill because it does not require a physician.

The Prevention Gap · Detection Once Disease Is Present

Our prevention box is strong in areas we can measure: vaccination, cancer screening, and age-based screening for diabetes and hypertension. These activities must continue. This book does not propose changing them.

Yet our screening detects people once their measurements cross a threshold—when they have already entered the illness zone. Between balance and illness, people may spend months or years feeling “not quite well”: aches, fatigue, insomnia, bloating, or palpitations. This interval has no disease name, no code, and no tool in the system.

The sixth Thai National Health Examination Survey found hypertension in 25.4% and diabetes in 9.5% of people aged fifteen and over. Another 10.7% had blood glucose above normal but below the diabetes threshold (Aekplakorn 2021). This latter group belongs in the prevention box. What we offer is “Be careful” and another blood test next year.

International evidence suggests that change is possible during this period. The US Diabetes Prevention Program showed that structured lifestyle modification reduced diabetes incidence among people with elevated glucose but without diabetes by 58% over three years (Knowler et al. 2002). Chapter 3 examines this study in detail, including the attenuation of benefit over longer follow-up. For now, remember “structured”: someone walking alongside, follow-up, and a goal the patient understands.

The prevention gap is therefore the absence of a tool patients can use to notice changes before their measurements become abnormal, and the absence of someone alongside them between visits. We already know what needs to be done.

The Treatment and Rehabilitation Gap · Treating Disease without Its Starting Point

This is the system’s strongest box, and the one in which the gap lies deepest.

We treat disease, and do it well. Yet most chronic diseases have starting points in everyday life. Uncle Chai’s blood pressure has a starting point at his dinner table. When Ms A came to see me, I did not yet know where her two symptoms began. We will return to explore this together in Chapter 11. When we treat the endpoint without addressing the beginning, patients return and we add medication.

The figures tell this story clearly. Approximately 7.4 million Thai people receive hypertension treatment; around 3.5 million remain uncontrolled despite treatment (Department of Disease Control 2025). Chapter 3 presents the full set of disease-control figures.

I do not think these numbers arise from poor drugs or unskilled doctors. I think our treatment process lacks a step that asks, “Where did the first domino fall?” Even when we ask, no one has time to search for the answer with the patient.

Another, less discussed issue in this box is physical symptoms without an identified cause. A review covering twenty-four countries found that 40–49% of primary care patients had at least one symptom unexplained by disease (Haller et al. 2015). In Thailand, a survey of patients attending subdistrict health-promoting hospitals and community health centres found somatization in 12.5% (Pengpid and Peltzer 2020). These figures use different definitions but tell a similar story: these people occupy the treatment box without a disease to treat. They are among the most exhausting cases for both patients and physicians because investigations seem never to end.

The Shared Gap across All Three Boxes

Placed side by side, the three gaps appear to be one gap in three forms.

The promotion box lacks a language for understanding the individual. The prevention box lacks a tool for noticing changes before disease. The treatment box lacks a process for finding the starting point in life. All three lack **something patients can hold and use themselves** between visits.

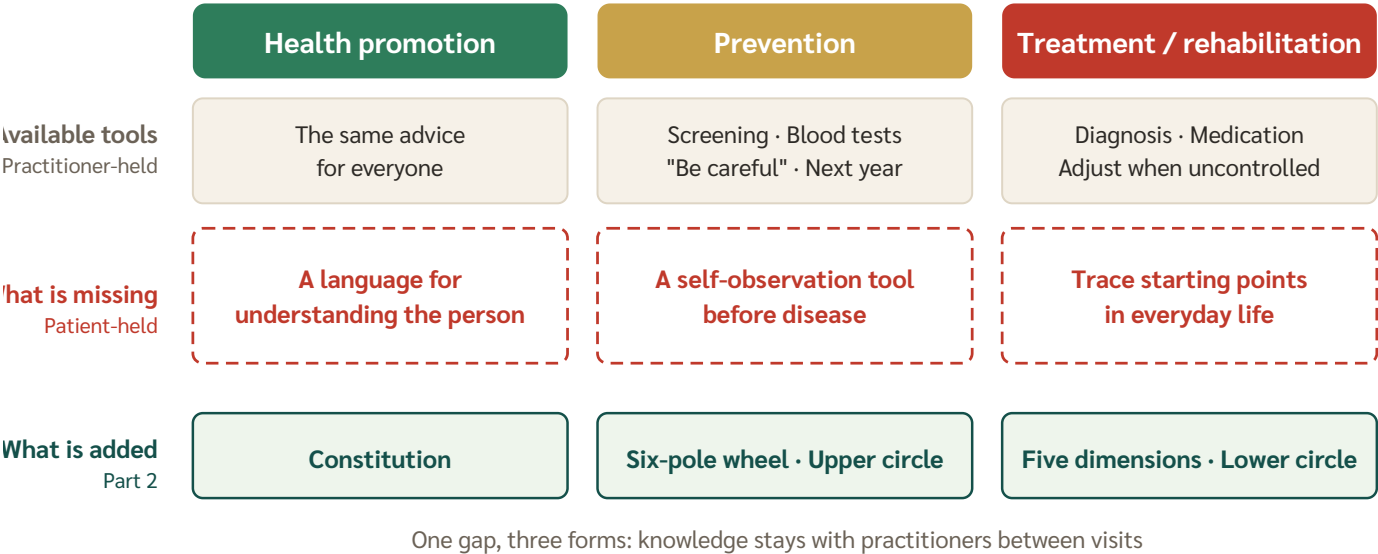


Figure 2.3 The shared gap in all three boxes, and what integrative health adds to each.

Our system locates knowledge with the practitioner. Patients provide information and receive a plan. This design makes sense in treatment, where diagnosis must remain with trained professionals. In promotion and prevention, however, it means those activities must also queue for the consulting room when they need not do so.

Evidence on chronic care points in the same direction, but requires careful interpretation. A review of seventy-seven studies of the Chronic Care Model found that self-management support was its most commonly used component, but could not establish which component produced the benefits (Davy et al. 2015). A review of patient activation found better outcomes among patients with higher activation (Hibbard and Greene 2013). A separate observational study found costs approximately 8–21% higher among those with the lowest activation (Hibbard, Greene and Overton 2013).

On the other hand, a review of patient-held tools such as health records found no clear benefit, and the available evidence was of low quality (Ko et al. 2010). It did not test whether connecting such tools to something else would make them effective. What follows is therefore my own interpretation: simply giving patients something to hold may not be enough unless it is connected to an explanation and action undertaken with a supporter. This is the condition I set for the tools in this book.

This Book's Proposal in One Paragraph

The integrative health described in Part 2 adds something patients can use themselves to each box. Promotion gains a language for understanding the individual: constitutional elements. Prevention gains a way to notice a shift before disease: the six-pole wheel and the upper circle that patients navigate themselves. Treatment and rehabilitation gain a process for tracing starting points in life: the five dimensions and the lower circle, navigated with a trained guide. Chapter 12 explains who can take that role. All of these fit on the same map, which a physician can read quickly. No step replaces our diagnosis or treatment.

Something to Try Tomorrow

Take tomorrow's patient list and mark the box for each person: H for health promotion, P for prevention, and T for treatment and rehabilitation. This can be done briefly before the clinic begins.

I expect T will predominate, with some P and almost no H. There are many healthy people, but they never come to see us—and we still have little to offer them if they do.

That is the starting point for Chapter 3, where I take an honest look at why our existing tools remain insufficient for people marked P and H.

Chapter 3 • Why Existing Tools Are Not Enough

The Chapter I Did Not Want to Write

This was the hardest chapter in Part 1 to write. It meant sitting down to count how well my everyday work actually works, and the answer is uncomfortable. This chapter blames no one. Everyone in the system works harder than the figures convey, including patients. I want to examine our tools one by one and ask honestly what each was designed to do, and which we are using for the wrong task.

I will move from lifestyle advice to chronic disease treatment, unexplained symptoms, and the workforce.

Advice That Is Entirely Correct—and Changes Little

In the final minutes of almost every consultation, I repeat the same phrases: reduce salt, reduce sugar, walk for half an hour a day, get enough sleep, stop smoking. Every word is correct, and I mean it sincerely each time.

For a long time, I avoided asking myself whether these sentences worked.

Two studies address this particularly directly. The first was a systematic review of twenty-five randomised trials of physical activity promotion in primary care. At six months, the effect size between those receiving advice and those not receiving it was 0.04 (95% confidence interval –0.06 to 0.14), almost zero. Because the interval crossed zero, it was not statistically significant. At twelve months, the effect size was 0.20 (95% confidence interval 0.04 to 0.36). The interval no longer crossed zero, indicating statistical significance, but 0.2 remains a small effect. The authors concluded that primary care physical activity counselling has limited effects and may be insufficient on its own to change behaviour (van der Wardt et al. 2021).

The second, larger review covered forty-six randomised trials with 16,198 participants. It found that primary care physical activity promotion increased moderate-to-vigorous activity by approximately fourteen minutes a week (Kettle et al. 2022). A real effect, but a small one.

Reading these together was both encouraging and humbling. Advice in the consulting room works, but its effects are small. I do not think we should stop giving it. I have stopped expecting words spoken in five minutes to change a life by themselves.

Conversely, the evidence clearly shows that lifestyle change works when delivered intensively. The US Diabetes Prevention Program found that intensive lifestyle modification reduced diabetes incidence in people with elevated glucose by 58% over three years, compared with 31% for metformin (Knowler et al. 2002). After twenty-one years, the reduction had diminished to 24%, with disease onset effectively delayed by about three and a half years (DPP Research Group 2025). The programme used individual coaches, sixteen sessions in the first six months, and continuing follow-up over years—a long way from my five-minute advice.

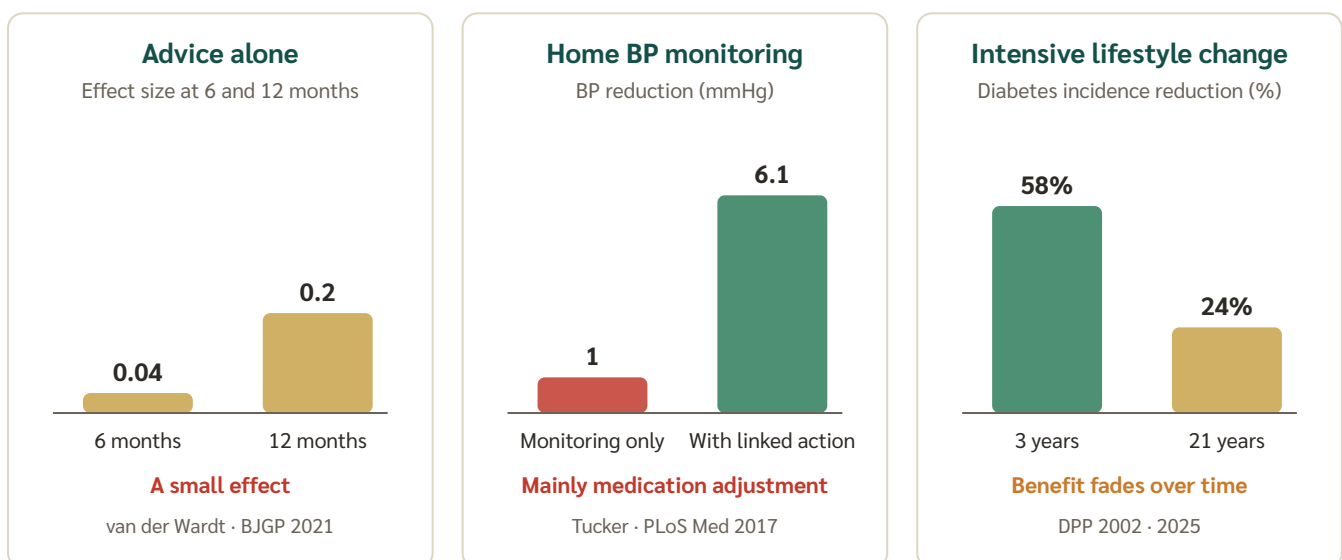
Together, these studies offer lessons I will carry into Part 2:

- Lifestyle change really works and initially can have a greater effect than medication.

- What makes it work surrounds the advice: a companion, the frequency of contact, and a plan connected to that person's real life.
- Even an intensive programme such as DPP loses effect over time. Something people can return to repeatedly is needed, rather than a programme that simply ends.

Another lesson comes from home blood pressure monitoring. An individual patient data meta-analysis of twenty-five trials found that monitoring alone reduced blood pressure by 1.0 mmHg, not significantly different from zero. When monitoring was combined with intensive support, the reduction was 6.1 mmHg (Tucker et al. 2017). Support in these studies largely involved systematic medication adjustment by doctors, pharmacists, or patients themselves. TASMINH4 pointed in the same direction: doctors used patients' home measurements to adjust medication (McManus et al. 2018).

These studies support a principle I follow throughout this book: recording alone is insufficient; action must connect to the information. However, that action consisted mainly of medication adjustment. The non-drug action proposed by the Care Circles has not been tested. I therefore include an action step in the patient's map in Part 2 and propose measuring it in the Chapter 14 pilot.



Advice has small effects; linked action and support help; benefits fade without return

Figure 3.1 Three findings that shape these tools: advice alone has a small effect; measurement works when linked to action; and even intensive programmes lose some effect over time.

The Chronic Diseases We Know Best—and Still Struggle to Control

Hypertension and diabetes receive some of the greatest investment in Thai primary care: dedicated clinics, indicators, registers, and national screening. We have understood their mechanisms and had effective, affordable medicines for decades.

Department of Disease Control figures indicate that approximately 7.4 million Thai people receive hypertension treatment, of whom about 3.5 million do not reach their blood pressure targets (Department of Disease Control 2025). That is almost half of those already within the system, aware

of their condition, and taking medication. For diabetes, approximately one third achieve control targets (Diabetes Association of Thailand 2023). The ministry's own targets are 40% for diabetes and 60% for hypertension, and some regions still fall short (Ministry of Public Health 2025b).

The 40% diabetes target stopped me when I first saw it. It suggested that the system itself recognises how difficult it is for existing tools to bring most patients to target. This is not because anyone is failing to try.

Uncle Chai is among those 3.5 million people. What I can do for him is increase medication, which I have already done twice this year. What he needs is someone to help him see how his blood pressure connects to his dinner table and sleep, and to change both within his actual life. A fourth drug cannot do that work for him.

Patients Who Fill the Consulting Room but Have No Place in the System

The third group consists of people I see every day for whom the system has no name: people with real symptoms and real suffering, but no disease found on investigation.

A review of research in twenty-four countries, covering more than 70,000 patients, found that 40–49% of primary care patients had at least one physical symptom unexplained by disease, while approximately 26–35% met criteria for a somatoform disorder (Haller et al. 2015). In Thailand, a survey of people attending subdistrict health-promoting hospitals and community health centres found somatization in 12.5%, depression in 15.8%, and anxiety in 3.5% (Pengpid and Peltzer 2020). The Thai figures are lower because the definitions differ, but both datasets show that this group is substantial.

The system typically sends these patients for tests. Normal results lead to further tests or reassurance that nothing is wrong, which patients hear as “The doctor does not believe I am ill.” I think Ms A left my room feeling that way, and the thought still troubles me.

One of the most encouraging studies here is England's randomised Multiple Symptoms Study 3. Specially trained family physicians saw these patients up to four times, following a sequence: acknowledge that the symptoms are real, develop an explanation together until the patient can picture the mechanism, then take action. At fifty-two weeks, physical symptom scores on the PHQ-15 were 1.82 points lower than with usual care (Burton et al. 2024). A report from the UK National Institute for Health and Care Research assessed the intervention as cost-effective against UK health-system thresholds (Burton et al. 2025). The researchers' account of the mechanism is worth underlining: an explanation the patient can accept acts as a bridge from uncertainty to action.

Did I have such a bridge for Ms A? Not then. I had “muscular pain from posture” and “possibly related to sleep”: two unconnected pieces of explanation she could not take home and use.

The Largest Workforce—and the Smallest Toolkit

Finally, consider people. Thailand has approximately 2,043 family physicians working in primary care units, against a policy target of 6,500 teams, each requiring one physician (Ministry of Public Health 2024a). This is an increase from 628 in 2017, an achievement worth recognising. But if asked when

the target will be reached, the honest answer is probably not within this decade. Even then, one team per 10,000 people would still leave each physician only a few minutes per patient per year.

At the same time, Thailand has approximately 1.1 million VHVs, receiving THB 2,000 a month in allowances, with annual expenditure of roughly THB 25 billion (Ministry of Public Health 2024a). This is the country's largest health workforce. They live in patients' villages, know their homes and families, and know what people eat, when they sleep, and whom they have quarrelled with.

We give VHVs blood pressure monitors, glucose meters, record books, and reporting apps. All measure or record. None helps them "read the person" or sit down with a patient and understand where to begin. VHVs consequently become endpoints for data flowing upwards to us, rather than starting points for care beginning in the home.

Here, the missing companion from Chapter 1 appears in numerical form. We already have a million people who could walk alongside patients. We have not given them a map.

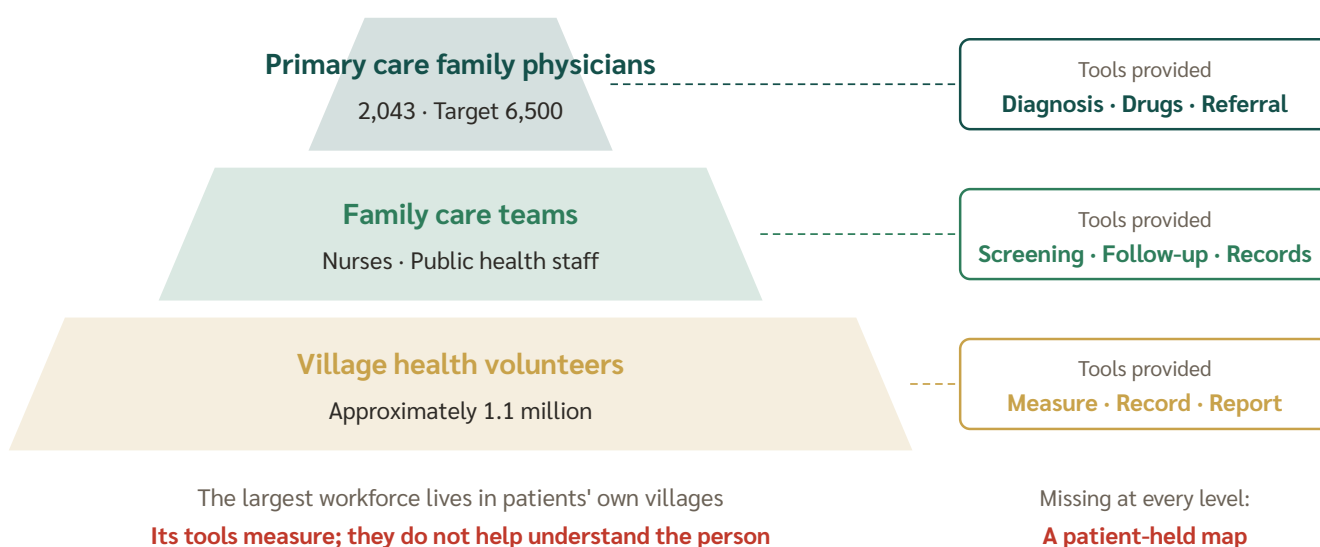


Figure 3.2 Three workforce levels in primary care, and the tools available to each.

What Existing Tools Do Well

Before closing, I want to acknowledge the other side. Conventional medicine's tools perform their intended tasks extremely well. They identify hidden disease, distinguish dangerous from non-dangerous symptoms within minutes, and provide medicines that genuinely reduce blood pressure, glucose, and mortality. They rest on a level of evidence unmatched by other disciplines and a referral system capable of taking a patient from a village to a regional hospital within a day. Nothing in this book replaces those achievements. Chapter 8 reiterates that every tool I propose must first pass through the safeguards of existing clinical tools.

Those tools were not designed for the three other tasks described here: changing behaviour through a single conversation, helping people with chronic disease see where their illness begins in their own lives, and offering usable explanations to patients whose tests are normal. These are different tasks

requiring different tools and different companions. Part 2 presents my proposal for what that toolkit might look like.

Something to Try Tomorrow

At the next appointment with someone whose chronic condition has long been uncontrolled, change one question. Instead of asking whether they take all their medicines, ask, “Before your blood pressure became difficult to control, what changed in your life?” Then listen for two minutes without interrupting.

Imagine Uncle Chai at his next visit. With this question, the brief story from Chapter 1 gains detail. His wife died early in the year. Since then, he has eaten alone, bought ready-made food at the market, had dinner in front of the television at irregular times, and slept poorly. His blood pressure became uncontrolled afterwards. It had a starting date, and that date was not in his medical record.

Two minutes like this does not treat anything. But it may change the physician’s question from “Which drug should I add?” to “Who can help him with dinner?” More people than a physician alone can answer the second question.

Chapter 4 turns to another subject patients often do not mention unless we ask: what they eat, drink, and seek outside the consulting room, as Aunt La-or did in Chapter 1.

Chapter 4 • Thai People Already Use Traditional and Alternative Care

Asking the Wrong Question

Whenever I discuss connecting Thai traditional medicine with primary care, the first question from fellow physicians is “Should we?” This is followed by entirely reasonable concerns: insufficient evidence, herb–drug interactions, patients stopping essential medication, and whether we can carry the responsibility.

For years, I asked the same question. Then I thought of patients such as Aunt La-or in Chapter 1, sitting before me and explaining that, for two months, she had been drinking a local healer’s decoction and having weekly massage on a neighbour’s advice. She had never told me because she was “afraid the doctor would scold me.”

Thinking of her, I realised that “Should we integrate?” is the wrong question. It assumes we have a choice not to. Patients are already combining approaches every day, without supervision, and they bear the cost of our not knowing. The better question is “How can we connect them safely?” That is the question this book attempts to answer.

What Happens in the Consulting Room

I do not have a national figure I can confidently cite for the proportion of Thai people who use traditional medicine or herbs in a year. The National Statistical Office’s Health and Welfare Survey collects this information, but the published tables have not presented it in a form I can cite with confidence. I have also been unable to find figures for the number of Thai traditional medicine practitioners in the public system or the proportion of primary care units actually providing these services. I will not guess. Instead, I will describe what I see and invite readers to compare it with their own clinics.

In my experience, among ten patients with chronic disease, several take something in addition to my prescriptions: herbal capsules, decoctions, fermented preparations, supplements, or traditional pills of unknown origin. Most do not mention it because they think it irrelevant or were criticised when they previously did. Few deliberately conceal it. Most patients with aches and pains have tried massage before seeing me. Sometimes it helps, sometimes it makes things worse, and sometimes a red flag that should have reached us in the first week arrives in the third month.

The costs of failing to connect are tangible and take several forms:

- **Interactions:** a patient taking warfarin and certain herbs without our knowledge; a patient with diabetes combining glucose-lowering herbs with medication and developing hypoglycaemia; a patient with kidney disease taking a potassium-rich decoction.
- **Missed red flags:** symptoms requiring diagnosis are managed by other means until the appropriate time has passed.
- **Lost trust:** the quietest but most costly form. Once patients learn that some subjects cannot be discussed with their doctor, they say less and less. What they withhold extends beyond herbs.

I worry most about the last because I cannot see it from inside the consulting room.

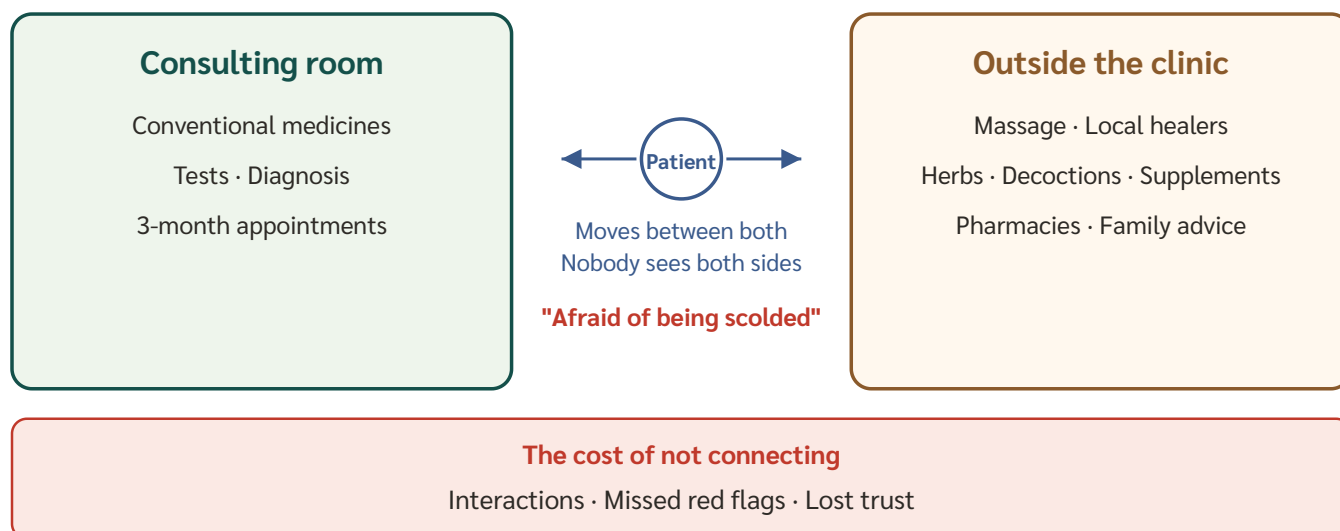


Figure 4.1 Two worlds that patients cross between on their own, with no one seeing both sides, and the three costs of failing to connect them.

Policy Has Moved Further Than We Realise

Only recently did I understand that the system in which I work had already made this decision at policy level, largely without conventional physicians—including me—knowing much about it. Taken together, the developments form a clearer picture than I expected.

- **Legislation:** the Thai Traditional Medical Professions Act has been in place since 2013, establishing Thai traditional medicine as a profession with its own council and licensing.
- **Indicators:** the Ministry of Public Health previously set a target for Thai traditional and alternative medicine to account for 19.5% of all outpatient services in fiscal year 2020. In fiscal year 2026, a new indicator requires at least 50% of primary care service encounters to involve Thai traditional or alternative treatment. This counts encounters, not individuals, and includes every encounter in which herbal medication is dispensed (Ministry of Public Health 2026).
- **Funding:** the National Health Security Fund increased the Thai traditional medicine allocation from THB 31.90 per person in 2025 to THB 63.24 in 2026 (NHSO 2025).
- **Medicines:** the National List of Essential Herbal Medicines contained ninety-four items in 2021, with the ministry announcing an increase to approximately 106 in late 2024 (Royal Gazette 2021; Ministry of Public Health 2024b). From 1 March 2025, NHSO adjusted reimbursement to support herbal alternatives to thirty-two conventional medicines in ten symptom groups. This is voluntary, not compulsory.
- **Facilities:** the Department of Thai Traditional and Alternative Medicine launched ten Thai Traditional and Integrative Medicine Hospitals in December 2023 (Department of Thai Traditional and Alternative Medicine 2023).

In fiscal year 2025, the Universal Coverage Scheme recorded 4.05 million Thai traditional medicine service encounters and 13.2 million encounters involving herbal medicines on the National List of Essential Medicines (NHSO 2025). The latter figure was much larger than I had imagined.

Internationally, the World Health Assembly adopted WHO's new Global Traditional Medicine Strategy 2025–2034 in May 2025. It sets four objectives, including appropriate integration of traditional medicine into health systems, alongside evidence generation, safety regulation, and assessment of value (WHO 2025).

I describe this not to claim that every policy is right, but to show that the system has already answered “Should we?” The unanswered question is “How?”

Unmet Targets—and What They Tell Us

The ministry's 2025 government action-plan evaluation reported that the herbal prescribing indicator “did not meet the criterion” (Bureau of Policy and Strategy 2025). Its indicator system showed Thai traditional medicine in primary care at approximately 45% of encounters, below the 50% target, with only one of twelve health regions reaching it (Ministry of Public Health 2026). I think this reveals something beyond the numbers.

Existing integration connects **services**: add a traditional medicine room, more herbal medicines to the formulary, and more per-capita funding, then count service encounters. This connects the treatment and rehabilitation box—necessary work that I support—but does not yet reach promotion and prevention. It remains a service patients must come to receive. They still have no language to take home.

Dispensing herbal medicines 13.2 million times a year is still a long way from patients understanding themselves. A hospital's traditional medicine room is a service point; a VHV cannot carry that room into a patient's home. Policy has opened the door. What is missing is a path from that door to the kitchen and bedroom.

This Book's Position

Before Part 2, I want to state this book's position so readers know what they will—and will not—find.

This book proposes connecting through language and a shared map, rather than through medicines.

Formulas, procedures, and diagnosis based on classical texts are the work of licensed Thai traditional medicine practitioners and should remain in their hands. What I borrow from Thai and other traditional systems is their centuries-old **way of seeing people**: individual constitutions differ; symptoms can be seen as shifts from balance that may be addressed before disease; and the beginnings of much discomfort lie in life rather than solely in organs.

This way of seeing requires no professional licence. It involves no drugs, procedures, or assignment of disease names. It is a language patients, VHVs, nurses, Thai traditional medicine practitioners, and I can use to tell the same story. When everyone can tell the same story, I hope Aunt La-or will no longer need to keep her decoction to herself.

Connecting through language works across all three boxes. Healthy people use it to know themselves; those beginning to shift use it to notice changes before disease; people already ill use it to seek starting points in life. When medication is needed, whether mine or a traditional practitioner's, the prescriber remains a professional with the same legal responsibility as before.

Something to Try Tomorrow

Add one question to every history, in the same tone used to ask about regular medication: “Besides the medicines I prescribe, is there anything you take, drink, apply, or go for—herbs, supplements, massage, anything at all? It’s all right; I just want the complete picture.”

The second half matters more than the first, because it tells patients they will not be judged. Asked this way, many answer sooner than we expect.

Before showing what this language looks like, I need to define what this kind of connection means and how it differs from familiar terms such as “alternative” and “integrative medicine.” That is the subject of Chapter 5.

Part 2 • What Integrative Health Is—and Is Not

These four chapters define the terms, introduce the tools, connect them into a circle, and establish safety boundaries. Chapter 5 separates three frequently confused terms. Chapter 6 provides a shared language patients can hold themselves. Chapter 7 explains the Care Circles in clinical language. If time is short, Chapter 8 is the one to read first.



Chapter 5 • Connecting at the Core, Not Collecting Tools

Why Definitions Come First

Imagine a hospital with a massage room, a herbal dispensary, a yoga room, and a meditation corner in one building. The sign outside says “integrated,” but patients carry nothing from room to room, and each practitioner has no idea what the next room has done for the same patient. The building is the only thing connecting them.

Many fellow physicians have seen this and been disappointed. “Connected,” “integrative,” “alternative,” and “holistic” become so mixed together that some stop listening at the first word. I understand. Before explaining what I mean by integrative health, I want to clarify how it differs from more familiar terms and why I chose it.

Three Terms Often Confused

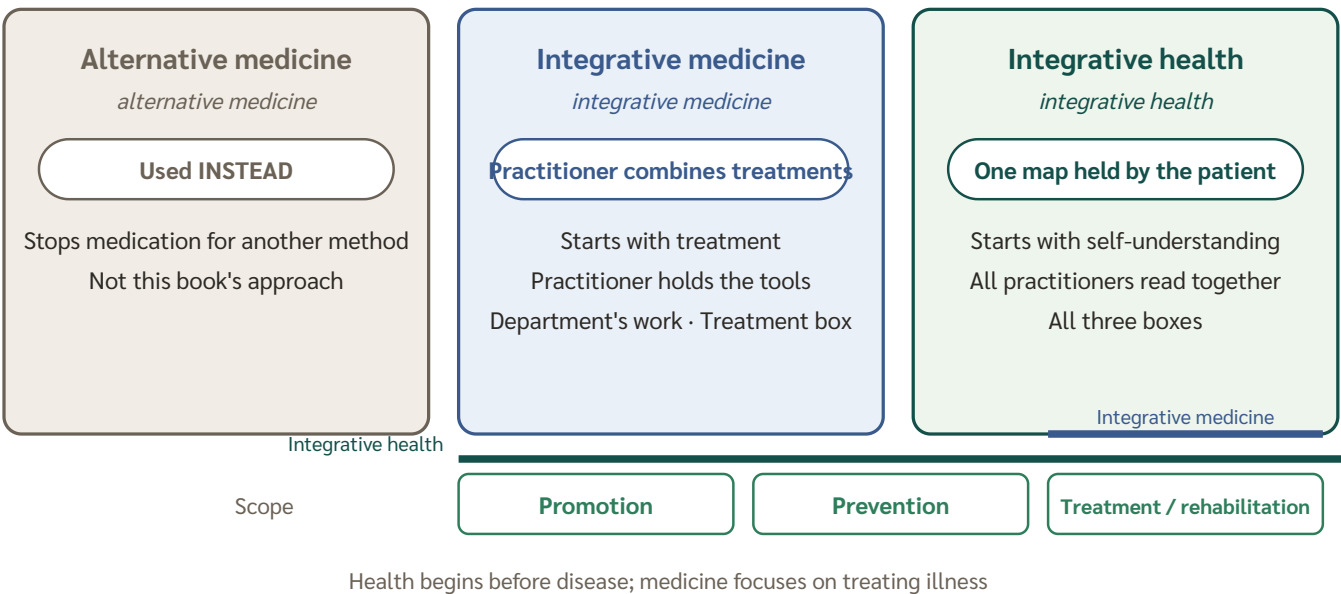


Figure 5.1 Three different terms and the primary care boxes each encompasses.

Alternative medicine means using another approach instead of conventional medicine. The key word is “instead.” A patient who stops diabetes medication and uses herbs alone is practising alternative medicine. This book does not advocate that direction. Stopping necessary medication is one of the red lines revisited in Chapter 8.

Integrative medicine, as commonly used and as used in this book, means that a practitioner combines approaches from several disciplines in treating an individual patient. The emphasis is on **the practitioner combining treatments**. A doctor referring someone with chronic back pain for Thai massage alongside physiotherapy, or a hospital providing acupuncture for stroke patients, is

practising integrative medicine. In Thailand, this work belongs to the Department of Thai Traditional and Alternative Medicine—hereafter “the Department”—and the ten Thai Traditional and Integrative Medicine Hospitals. It is real, valuable work, primarily within treatment and rehabilitation.

Integrative health is the closest English expression for *kan phaet chueam sat*, the term the Plearnprai team and I use for a broader approach. It places the **core principles** of several disciplines on one map that patients hold and practitioners from every discipline can read together. It spans all three boxes, from people who are well to those already ill. “Health” points towards people’s health before disease exists, whereas “medicine” directs attention towards treatment once disease is present.

The latter two terms differ in two respects. First, **who holds the map?** In integrative medicine, it is the practitioner. Integrative health first places it in the patient’s hands, then invites practitioners to read the same sheet. Second, **where does it begin?** Integrative medicine begins with treatment. Integrative health begins with self-understanding, in the promotion box.

I chose the Thai expression meaning “connecting disciplines” rather than “blending approaches” for related reasons. I wanted to distinguish it from the Department’s established work rather than imply that this book simply proposes the same thing. The words also matter: “blending” suggests pouring things together until they become indistinguishable; “connecting” allows each to remain itself, with bridges between them. That better expresses my proposal.

A Lesson from an Agency’s Change of Name

In 2014, the US National Institutes of Health renamed its National Center for Complementary and Alternative Medicine the National Center for Complementary and Integrative Health, or NCCIH.

The reason was straightforward. Surveys showed that very few Americans actually used these methods **instead of** conventional medicine. Most used them **alongside** it, primarily for health maintenance, pain management, and well-being rather than disease treatment. “Alternative” did not reflect what people did, and “medicine” was too narrow (NIH 2015).

NCCIH’s definition clearly separates three terms: complementary approaches are used alongside conventional medicine; alternative approaches are used instead of it; and integrative health coordinates conventional and complementary approaches systematically, emphasising whole-person care, prevention, and health promotion (NCCIH 2021). WHO uses “traditional, complementary and integrative medicine,” defining integration as an interdisciplinary, evidence-based approach combining biomedicine and traditional medicine (WHO 2025).

I mention this to show that Plearnprai did not invent “integrative health.” One of the world’s largest public health research institutions adopted it because its former terminology did not match what people actually did. What Americans were doing resembles Aunt La-or’s behaviour in Chapter 1: drinking a local healer’s decoction alongside her diabetes medication, not instead of it.

Heartwood, Sapwood, and Bark

How can disciplines that arose thousands of kilometres and centuries apart connect? The answer my team and I return to is: connect at the core.

Imagine a tree with three layers. The bark is what we first see. In medical traditions, it includes names, rituals, specialised vocabulary, dress, and products for sale. Beneath it lies sapwood: genuine wood, but still specific to that tree. In medicine, this is the technical system: Chinese pulse diagnosis, Thai medicine's forty-two elemental components, Ayurveda's twenty qualities, or modern laboratory investigation. Each is deep, complex, and takes years to master.

The heartwood lies at the centre. In this analogy, it is what trees share. In medicine, the core consists of the questions every approach must answer when someone arrives unwell.

Connecting at the bark means putting things from several disciplines together and calling them integrated, like the building at the start of this chapter. Nothing has actually connected. Directly connecting technical systems is also not possible: Chinese pulse patterns cannot simply be translated into Thai elements, nor can either be translated into laboratory values. What remains is connection at the core, where the disciplines ask the same questions.

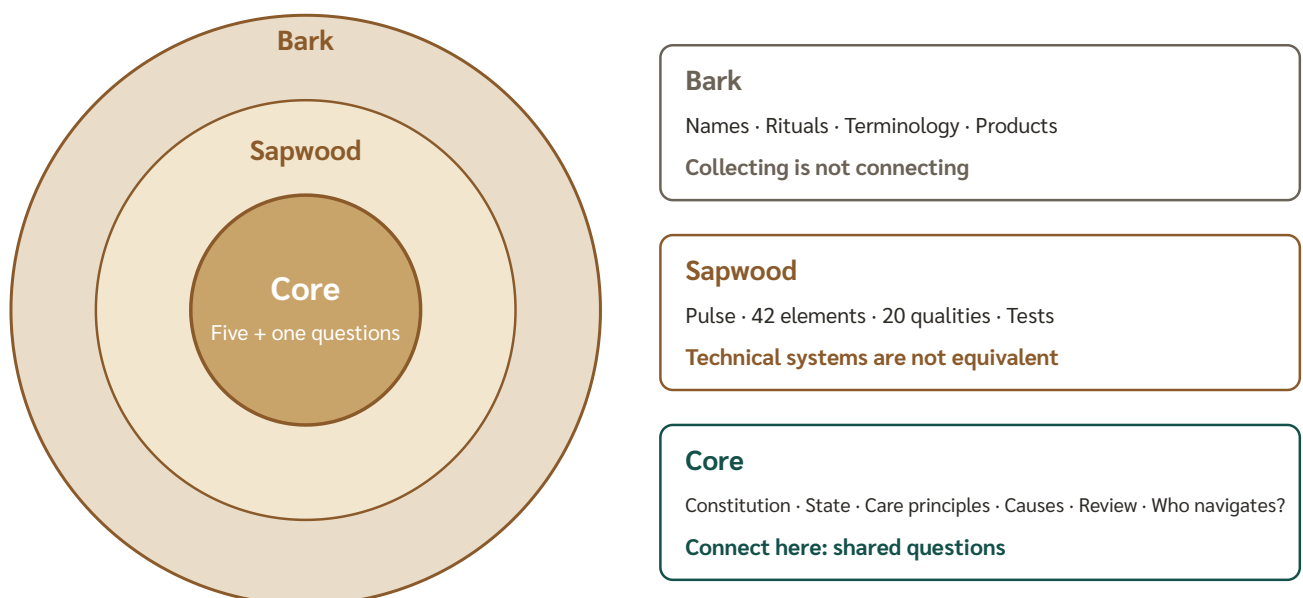


Figure 5.2 Core, sapwood and bark. Disciplines connect at the core, where they ask shared questions.

When my team and I compared four medical systems, I saw five questions each must answer, though their language and sequence differ:

1. **The person's baseline:** What has this person been like from the beginning? Thai medicine speaks of the dominant constitutional element; Ayurveda of innate constitution; Chinese medicine describes nine constitutional types. In modern medicine, records contain the language of risk factors. Understanding what a person is like often stays in the memory of the physician who has known them for years.
2. **Reading the current state:** How is balance disturbed, and how much? Thai medicine considers excess, deficiency, and derangement; Chinese medicine uses the Eight Principles; conventional medicine uses presenting symptoms, urgency, and disease names.
3. **Principles of care:** How should we respond? Thai medicine and Ayurveda use opposing qualities; Chinese medicine treats according to pattern; conventional medicine follows disease mechanisms

and evidence.

4. **Finding causes:** Why did this happen, and where did it begin? Thai medicine describes eight causal factors. Ayurveda identifies three pathways of causation and places removal of the cause first in treatment. Modern medicine uses disease mechanisms, the biopsychosocial model, and social determinants of health.
5. **Follow-up:** Did it work, and what next? Every discipline reassesses. When the answer feeds back into question 2, care becomes a circle rather than a one-off encounter.

My team and I add a sixth question, where Plearnprai's Care Circles differ most: **Who navigates the circle?** In all four disciplines, the practitioner does almost all the navigating, while patients provide information and receive plans. The Care Circles are designed so patients and families can navigate the upper circle themselves from the outset, with guides, Thai traditional medicine practitioners, and physicians joining where needed. A guide is a community member or health-team member trained to help another person navigate the circle. Chapter 12 discusses these people.

At the core, modern medicine answers questions 2, 3, and 5 best, with precision and evidence difficult for other disciplines to match. For question 1, knowledge of the individual often resides in the family physician's head, not the patient's hands. For question 4, we explain disease mechanisms deeply. At the level of life, we know we should ask, but often lack time and a tool patients can continue using themselves. Traditional systems offer more detail for questions 1 and 4, but less precision for question 2. Connection is useful here: each has different strengths, and none excels at all six questions.

Four Red Lines

Connecting at the core requires caution. In borrowing ways of seeing from traditional systems, we may also import things we should not borrow. My team and I therefore set four red lines that every Plearnprai document must respect.

1. **No promise of cure.** No tool in this book promises that a disease will disappear. We can speak of greater self-understanding and actions patients can take themselves. Outcomes must be measured.
2. **No fear-based messaging.** Some traditional approaches use fear: eat this and you will get cancer; fail to do that and your elements will collapse. Every Care Circles message should leave readers feeling that a practical way forward exists.
3. **No rejection of necessary medication.** No tool in this book is a basis for independently stopping, reducing, or adjusting prescribed medication. If medication may be contributing to symptoms, take it to the prescribing physician or pharmacist and ask. This statement appears throughout Plearnprai's materials.
4. **Elements are not astrology.** Constitutional elements are explored through longstanding physical characteristics and habits dating back to childhood, not birth dates. They do not predict destiny. They must not explain away new or severe symptoms instead of red-flag screening. An element describes a tendency towards imbalance; it is not the cause of a symptom.

I hope these boundaries help fellow physicians trust the toolkit. Chapter 8 explains how each is built into the actual tools.

What This Book Does Not Replace

Before closing, I want to return to the Department's integrative medicine work. Some readers work within that system, and I do not want this chapter to place them on the other side of a divide.

The Department brings evidence-supported traditional and alternative services into the health system, with standards, oversight, and benefits coverage. This connects treatment and rehabilitation through professional practice, and this book relies on it. When someone navigating the Care Circles needs herbal medicines or procedures, the Department's Thai traditional medicine practitioners take over.

What this book adds is something patients can hold themselves across all three boxes. In promotion and prevention, that means a language healthy people can use to understand themselves and a tool for noticing shifts before disease. Such work needs neither a licence nor a service room, and need not wait for patients to attend. I do not think these boxes remain underfilled because anyone neglected them, but because patient-held tools for them are still scarce. In treatment and rehabilitation, the addition is a process through which patients and guides explore starting points in life before reaching a physician or Thai traditional medicine practitioner when examination, medication, or procedures are required.

Something to Try Tomorrow

As the next patient enters, ask yourself the six core questions. Notice which you can answer immediately, which require more time, and which you have no tool to answer. Invite a colleague to do the same and compare at lunch; the picture may become clearer.

For me, questions 2, 3, and 5 fit into five minutes. Question 4 needs fifteen. For longstanding patients, I have some answer to question 1, but it stays in my head; patients have never taken it home. I have scarcely asked myself question 6.

The next chapter supplies tools for questions 1, 2, and 4. Chapter 7 connects them into circles and answers question 6.

Chapter 6 • A Shared Language Patients Can Hold

Four Tools for Understanding the Person, and One Screening Tool

Asked to describe himself in three sentences, Uncle Chai might say, “I’ve felt cold easily since childhood. I find it hard to sleep. I get bloated easily.” None appears in his seven-year hypertension record, although they tell me something I have always wanted to know: what kind of advice would fit this person?

The five tools in this chapter address core questions 1, 2, and 4: What is this person like? In which direction are they currently shifting? Which bodily function is affected? Where in life might the cause lie? I hope fellow physicians will recognise things we already do mentally each day, now written in a form patients can take home.

All follow the same rules: none diagnoses disease; red flags always come first; none authorises stopping, reducing, or adjusting prescribed medication.

Tool 1 • Constitutional Elements

Thai traditional medicine describes the body through four elements: Earth, Water, Wind, and Fire. This tool builds on that principle, viewing Earth as the containing bodily form, while grouping what moves and changes within it into three main elements. This three-element organisation is Plearnprai’s adaptation for everyday use; the classical texts distinguish forty-two elemental components.

- **Wind:** movement, dryness, lightness. Wind-dominant people often have smaller builds and dry skin, feel cold easily, think and change quickly, struggle with sleep, and bloat easily.
- **Fire:** heat, metabolism, sharpness. Fire-dominant people often feel warm, become irritable when hungry, digest quickly, develop acne easily, are quick-tempered, and make firm decisions.
- **Water:** heaviness, coolness, moisture. Water-dominant people often have larger builds and moist skin, are patient, sleep readily, start slowly but persist, and gain weight easily.

Some people have one dominant element, others two, and a smaller group have all three in balance. This produces seven types: Wind, Fire, Water, Wind–Fire, Wind–Water, Fire–Water, and Balanced.

Constitutional elements are explored through characteristics present since childhood in three areas: body build and skin; bodily functions such as digestion, sleep, and tolerance of heat and cold; and mind and personality. The sequence is:

1. Complete the twenty-one-item constitutional-element questionnaire yourself.
2. Review your answers.
3. Read the resulting description and ask, “Does this sound like me?”
4. Ask someone at home who has known you for a long time.
5. If uncertain, consult a guide or Thai traditional medicine practitioner.

My team and I do not use birth dates, although the Thai texts contain that method. We want something patients can check against experience rather than something they must believe. Uncle Chai's questionnaire points to Wind, matching his three-sentence self-description.

Compared with familiar clinical concepts. A constitutional element describes a response pattern patients can observe in themselves. Someone who has always felt cold, slept poorly, and bloated easily may tend towards dryness and cold under stress or sleep deprivation. Someone who feels hot and becomes irritable when hungry may tend towards heat under pressure.

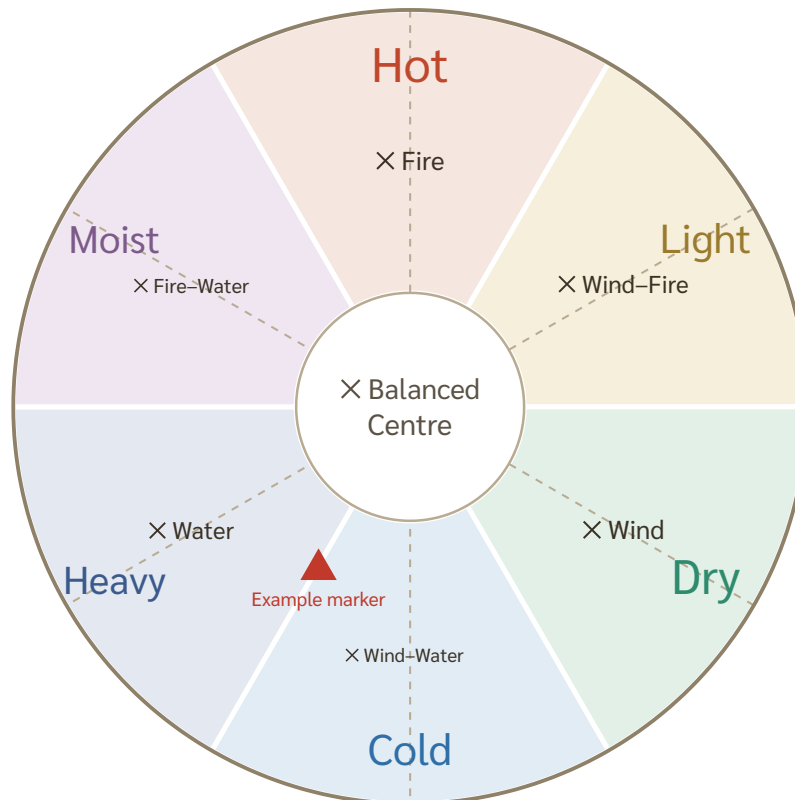
Physicians often ask whether there is a biological basis for this classification. An Indian research field called Ayurgenomics addresses precisely that question. Ayurveda describes three principal constitutions resembling Wind, Fire, and Water, with seven combinations similar to those used here. Researchers at Indian government research institutions selected healthy individuals whom Ayurvedic physicians judged to have clearly predominant constitutions. They found differences in blood gene expression and certain blood measures, including lipids, liver function, and haemoglobin (Prasher et al. 2008). Later work found variation between groups in EGLN1, a gene involved in oxygen sensing, associated with high-altitude adaptation and susceptibility to high-altitude pulmonary oedema (Aggarwal et al. 2010). Another team examined genome-wide variation in 262 men selected from 3,416 assessed individuals, identifying fifty-two genetic markers differing across the three groups and using them to classify people back into their original groups (Govindaraj et al. 2015). Unsupervised computer grouping based on bodily characteristics and habits also produced three clusters corresponding to the constitutional types (Tiwari et al. 2017). This work has expanded into a research network across Indian populations (Prasher et al. 2017).

These studies make me wonder whether centuries of observation may be closer to biology than we assumed. They also demand caution. Most come from a small number of research networks, select people with strongly expressed constitutions, have small samples, concern Indian populations, and show associations rather than causation. Crucially, none has studied Thai constitutional elements or Plearnprai's questionnaire. I therefore do not claim that constitutional elements constitute a biological phenotype or correspond to particular genes. What we can say is that this question is being investigated scientifically and the early findings warrant further study. This is one reason the Chapter 14 pilot includes questionnaire validation.

Constitutional information cannot identify disease. It can help consider how health promotion advice for someone who feels cold might differ from advice for someone who feels hot. Clinical guideline targets remain the same across constitutions. Constitution only helps select the steps towards them.

This tool belongs to health promotion and provides the foundation beneath everything else. Knowing their constitution gives patients gentle daily adjustments and an understanding of things that may disagree with them, without imposing lifelong prohibitions.

Tool 2 • The Six-Pole Wheel



× Constitution: fixed • ▲ Current direction: changes with symptoms • Opposites guide adjustment:
Adjust towards the opposite of ▲

Figure 6.1 The six-pole wheel: fixed × positions for the seven constitutions and a changing ▲ marker read from symptoms.

The six-pole wheel is the Care Circles’ single-sheet map. Three opposing pairs—Hot/Cold, Dry/Moist, and Heavy/Light—are arranged clockwise from the top as Hot, Light, Dry, Cold, Heavy, and Moist. It answers three questions on one sheet: Who is this person? Where are they tending now? In which direction should they adjust?

Each constitution has a fixed position, marked ×: Wind at Dry, Fire at Hot, Water at Heavy, Wind–Fire at Light, Wind–Water at Cold, Fire–Water at Moist, and Balanced at the centre. The current direction, read from symptoms, is marked ▲ and called the **marker**. It may change with the day, season, and life circumstances, while × remains a lifelong reference. × is not ▲; they may point in different directions.

The adjustment principle is called “the opposite is the remedy.” A Hot marker suggests a cooling direction; a Heavy marker suggests a lightening direction. Do not push past the centre towards the constitutional pole, and match intensity to the person’s capacity. “Remedy” names a principle; what patients do themselves is called an **adjustment**.

Uncle Chai illustrates the distinction. His × is at Dry because he is Wind-dominant, but his current symptoms place ▲ between Cold and Heavy. Care based only on × would not match his current state. During imbalance, the marker takes priority.

Compared with familiar clinical concepts. Patients already use these six words: feeling hot, cold hands and feet, a heavy body, a light or hollow feeling, dry mouth, and thick phlegm. The wheel organises their words into a quickly readable map. If a VHV tells me Uncle Chai’s marker is Cold and Heavy, I still do not know his diagnosis—the marker gives direction, not disease—but I have a starting point for history-taking. I can ask about movement, eating, and daytime sleep. He may then tell me he buys ready-made meals, sits watching television all day, and naps. Those facts come from him; the marker merely indicates where to ask.

The wheel primarily serves prevention, in the hope that patients can notice shifts before disease. That hope still needs to be measured.

Tool 3 • The Five Dimensions

When symptoms persist or recur, the question shifts from “In which direction?” to “Which bodily function is affected?” The five dimensions group bodily and mental functions into five categories, each with questions about how that function may be disturbed.

Dimension	Function	Possible disturbance
Structure	Bearing weight and moving	Too much or too little use, inadequate rest, or prolonged unsuitable posture: for example, neck and shoulder tension after bracing at a screen all day.
Vitality	Taking in food, digesting, absorbing, producing energy, repairing, eliminating waste, and providing warmth	Intake exceeds digestion and elimination, leaving things unprocessed, or expenditure exceeds recovery: for example, bloating after late meals or persistent exhaustion after overwork.
Circulation	Moving, delivering, and connecting between cells and organs, including breathing	Weak propulsion, obstruction, or excessive acceleration: for example, cold hands and feet, swollen legs, or palpitations.
Brain	Receiving and processing signals, maintaining the body clock, and connecting body with mind	Information overload, disrupted rhythms, or inadequate rest: for example, racing thoughts or mistimed sleep.
Mind	What we take in, give out, carry, or let go	Imbalance between receiving and giving, or carrying burdens without release: for example, caring for others to exhaustion or grieving alone.

Dimensions describe function. Symptoms in the same organ may therefore belong to different dimensions. Bloating after prolonged sitting that improves with movement may be placed under Circulation; bloating following unsuitable food that improves with dietary change may be placed

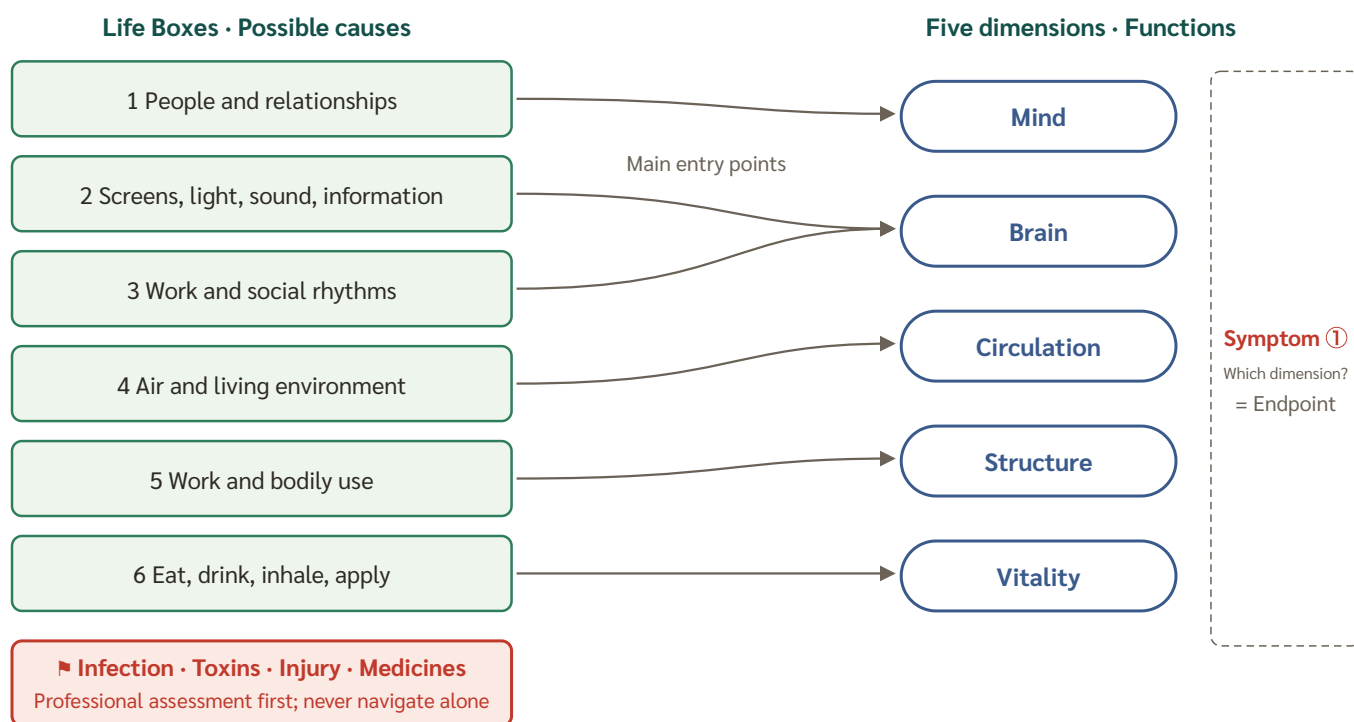
under Vitality. Palpitations belong to Circulation even when stress triggers them, because the dimensional question is “Which function is affected?” “Where did the cause arise?” comes later, in the Life Boxes. Palpitations in an older person are also a level-2 red flag.

Compared with familiar clinical concepts. The five dimensions resemble a review of systems, condensed from more than ten systems into five memorable functions. They differ in two respects: they put mind and body on the same map, and ask about impaired function rather than the affected organ. I particularly value the first, because psychological concerns often come last in consultations—if time remains.

The five dimensions serve treatment and rehabilitation as the first step in tracing a starting point in life. We ask which dimension contains the most troublesome symptom. This is the **endpoint**, from which we trace backwards. The dimensions are not separate rooms: disturbance in one can affect another. We will return to this after introducing the Life Boxes, because both tools are needed to see the whole picture.

Tool 4 • The 6+1 Life Boxes

I believe much chronic discomfort begins in the life surrounding the patient. The Life Boxes organise that life into six areas people can change themselves and one that always requires professional assessment.



The starting point must be in a Life Box; if still at a dimension, ask why again

Figure 6.2 The six Life Boxes plus the ► box, and their main entry points into the five dimensions.

Each box has a **main entry point**, a dimension it commonly influences first:

1. People and relationships → Mind.

2. Screens, light, sound, and information → Brain.
3. Work and social rhythms → Brain.
4. Air and living environment → Circulation.
5. Work and use of the body → Structure.
6. What we eat, drink, inhale, and apply → Vitality.

Box 7, marked ■, contains infection, toxins, injury, regular medication, and adverse drug effects. Patients do not navigate this box alone. A Thai traditional medicine practitioner or physician assesses it every time, and it must be screened before anyone searches the other boxes for a cause.

The central rule is that the starting point must lie in a Life Box. If tracing backwards stops at “I cannot sleep because my brain does not rest,” ask why again until reaching a box: “Because I watch a screen in bed until midnight,” for example, belongs to Screens. Sometimes the identified cause cannot change, such as night shifts under Work and Social Rhythms. Then find something changeable within the same box, such as sleep timing after the shift or the timing of the main meal.

Compared with familiar clinical concepts. The Life Boxes resemble the biopsychosocial model and social determinants of health in a form patients can point to themselves. Our models help practitioners think; these boxes help patients indicate. What patients choose may be something they are more ready to change than what we choose for them.

The Five Dimensions as a Domino Chain

So far, each symptom may seem to have its own dimension and each dimension its own box. But the body is not divided into rooms. The dimensions are continuously connected: disturbance in one can affect another, like falling dominoes. This is central to the lower circle, because the symptom patients report is often one of the last dominoes, not the first.

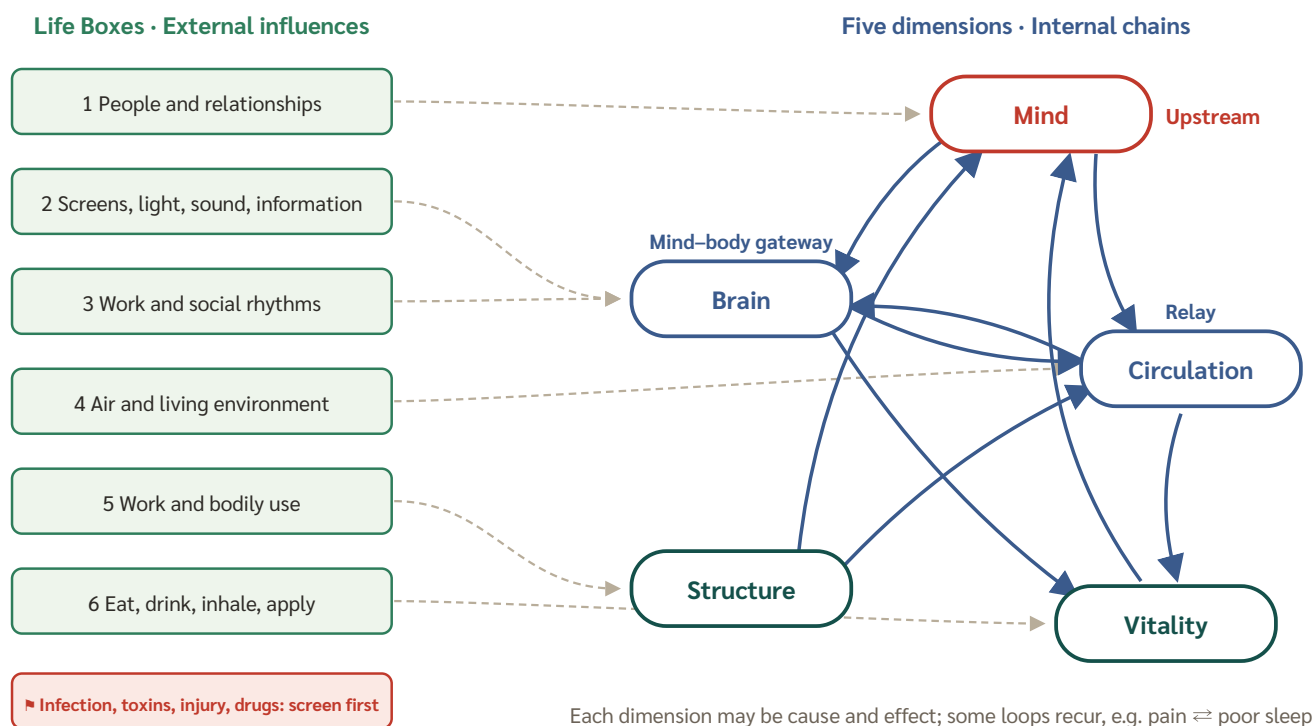


Figure 6.3 The five dimensions interact. Forces enter from Life Boxes through main entry points (dashed lines) and cascade across dimensions (solid lines). Mind is upstream, Circulation transmits, and Brain connects mind and body.

Influences come from two directions. External influences enter from the Life Boxes through their main entry points, as in Figure 6.2. Internally, one dimension influences another. Examples familiar from the consulting room include:

- A heavily burdened mind prevents mental rest and sleep, then circulation accelerates into palpitations (Mind → Brain → Circulation).
- Prolonged muscular bracing tightens the neck and shoulders, followed by poorer circulation towards the head and light-headedness (Structure → Circulation).
- Longstanding back pain leads to discouragement and loss of motivation (Structure → Mind).
- Constipation and intestinal discomfort are followed by irritability (Vitality → Mind).
- Persistently shallow breathing and cold extremities are followed by difficulty sleeping (Circulation → Brain).
- Late nights disrupt the body clock, followed by changes in bowel habits and skin (Brain → Vitality).

Three dimensions have particular roles. When we draw these connections on one sheet, recurring patterns appear. Mind is often upstream, sending more influence out than it receives. Circulation acts as a relay, receiving from almost every dimension and passing the influence onward. Palpitations, light-headedness, dizziness, and cold extremities are therefore often endpoints of a chain beginning elsewhere. Brain is the gateway between mind and body: most links cross through sleep, rest, and the body clock.

Three chain patterns commonly appear:

- **Mind downward:** beginning in Mind and moving into the body, as with Grandma Boonmee in Chapter 10. After her grandchild moves away for work, she eats dinner alone. The influence enters through Mind, passes through Brain, and appears as altered sleep.
- **Body upward:** beginning in the body and affecting the mind, as with chronic pain or older people losing former abilities. Low mood reduces movement, which further weakens the body.
- **Branching from an entry point:** one entry gives rise to several branches. In Chapter 11, Ms A's work without a clear finishing boundary enters through Brain, leaving her unable to rest, while another branch produces neck and shoulder tension and light-headedness. Similarly, D's late-night phone use disrupts his body clock and then affects bowel habits and skin.

Some connections loop back. The last domino may push the first again: pain disrupts sleep, poor sleep worsens pain; low mood reduces movement, reduced movement weakens the body, and mood falls further. Such loops can sustain themselves after the initial trigger has gone. Each dimension in the chain can be both cause and consequence, depending on where we look.

Rules for tracing connections. We use five rules to prevent endless speculation:

1. Always screen the ► box and conditions that mimic imbalance first. A convincing story may conceal disease needing diagnosis.
2. Start at the endpoint and trace backwards no more than three links. If no Life Box is reached, the starting route is often wrong.
3. The starting point must be in a Life Box. If you stop at a dimension, ask why again.
4. Constitution does not select the chain; it influences how the effects travel and how the endpoint appears. The same emotional burden may present as insomnia, palpitations, and bloating in a Wind-dominant person, or mouth ulcers, irritability, and stomach burning in a Fire-dominant person.
5. A traced connection is a hypothesis. Its truth is explored by removing the proposed trigger for fourteen days and observing whether the chain eases.

Why one step may be enough. Because the dimensions affect one another, interrupting the first domino may ease several dimensions at once. Ms A changes only her work-ending boundary, followed by improvements in sleep, shoulders, and light-headedness. The map identifies three possible intervention points: the endpoint, for immediate relief, such as a warm shoulder compress; the pathway, to reduce onward effects and interrupt loops, such as mental rest before bed; and the starting point, to prevent recurrence through a trigger-removal step. Endpoint relief remains necessary, but without addressing the beginning, the same dominoes may fall again.

Compared with familiar clinical concepts. Physicians already recognise stress leading to insomnia and raised blood pressure, pain and sleep worsening one another, and chronic illness accompanied by depression. The addition is a map patients and guides can draw in a shared language, counting the links back to the proposed starting point. I must be clear that these connections are a model developed by Plearnprai from experience and traditional texts. We have not measured how often each occurs or how consistently two guides draw the same chain. The Chapter 14 pilot will collect those data.

The Screening Tool · Three Capacity Questions

The four tools identify directions and locations, but not intensity. These three questions assess bodily capacity over the past two weeks:

1. **Capacity for daily activities:** Can you still walk, climb stairs, or do housework as usual without stopping midway to rest?
2. **Recovery after exertion:** After exertion or demanding work, does one night's rest restore you?
3. **Recovery from illness:** Do you seldom become ill, and recover about as quickly as others when you do?

Three yes answers indicate high capacity; two, moderate; zero or one, low. If uncertain, answer no. Recent illness, convalescence, or several nights of sleep deprivation should initially be treated as low capacity. The result serves one purpose: to reduce the intensity of self-care. Low capacity calls for gentle, short, frequent measures—replenish before reducing. No fasting, prolonged heat exposure, or strenuous exercise.

Compared with familiar clinical concepts. This is a light-touch screen, far from a clinical functional assessment, and it does not determine medicines, doses, or procedures. The team should remember one point: a clear unexplained loss of capacity accompanied by unintentional weight loss, breathlessness when lying flat, or swelling is a level-2 red flag requiring a physician. It is no longer simply a matter of capacity.

All the Tools in One Table

Tool	Question	Box	Closest clinical comparison	Difference
Constitutional element X	What has this person always been like?	Promotion	No exact equivalent; closest is a family physician's knowledge of the person	Systematic and confirmed by the patient
Six-pole wheel ▲	Where is the current shift, and where should adjustment go?	Prevention	Presenting symptoms and the patient's descriptions	Organises the patient's words into a quickly readable map
Five dimensions	Which function is affected?	Treatment and rehabilitation	Review of systems	Five functions, mind and body together; function rather than organ
6+1 Life Boxes	Where in life might the cause lie?	Treatment and rehabilitation	Biopsychosocial model; social determinants	Patients point for themselves; ► always requires professional assessment

Tool	Question	Box	Closest clinical comparison	Difference
Three capacity questions	How gentle should the adjustment be?	All boxes	A rough functional screen	Only reduces intensity; never determines medication

Why Every Tool Needs an Action Step

Two findings from Part 1 shape these tools. First, a review of patient-held health records found no clear benefit, with low-quality evidence (Ko et al. 2010). Second, home blood pressure monitoring had little effect alone but clearer benefit when linked to intensive support, mainly systematic medication adjustment by doctors, pharmacists, or patients themselves (Tucker et al. 2017).

These support the principle that recording alone is insufficient: action must connect to the data. The further ideas—that a tool needs an explanation and that the Care Circles’ non-drug actions will work—are my own conclusions and remain untested. I treat them as design principles, not evidence that the Care Circles are effective. The four tools are therefore linked into circles containing action, follow-up, and a companion.

Something to Try Tomorrow

Look at the day’s first two patients through the lens of constitution. No questionnaire is needed: simply notice a small build, dry skin, and rapid speech; or warmth, a loud voice, and impatience; or a larger build, moist skin, and slower speech. Ask whether the advice “Eat vegetables, exercise, and sleep enough” should be identical for both.

If not, that is the gap constitutional elements seek to fill. The next chapter connects all five tools into circles patients can navigate themselves.

Chapter 7 • Two Care Circles around One Axis: A Clinical Explanation

The Whole Process on One Page

Follow Uncle Chai from learning his constitution to the evening he cooks rice and sits down at the table, and we see seven small steps. He takes some alone and others with company. At three points, a door to a physician is always available. I want to describe this route in language that helps fellow physicians see where they stand.

The Care Circles comprise one axis and two circles around it. The axis is constitution. The upper circle identifies imbalance and adjusts towards balance; patients and families navigate it themselves. The lower circle identifies and addresses causes, with a guide or Thai traditional medicine practitioner. Both meet in one personalised health plan.

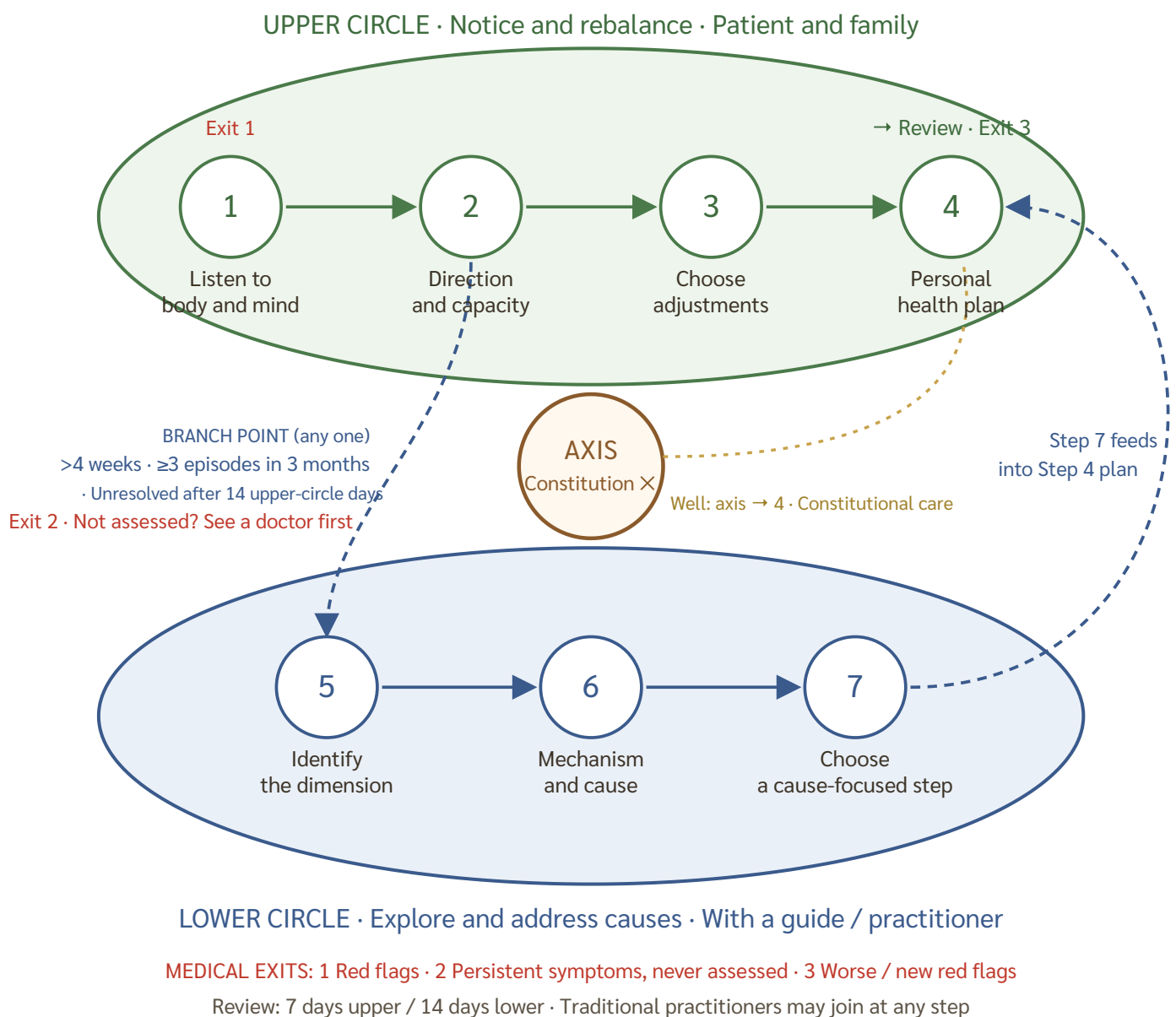


Figure 7.1 Plearnprai Care Circles: one axis, two circles, one plan and three medical exits.

In the three-box framework, the axis belongs to promotion, the upper circle to prevention, and the lower circle to treatment and rehabilitation.

The Axis • Know Yourself before Illness

Everyone begins by understanding their constitution: locating X on the wheel, identifying gentle daily constitutional adjustments, and recognising things that may disagree with them without imposing absolute bans. People who remain well can stay at the axis throughout life and return to it whenever symptoms resolve.

For physicians, the axis supplies a line I wish our records had always contained: what this person was like before any disease appeared.

The Upper Circle • Steps 1–4

Step 1: Listen to body and mind. Patients write one to three troublesome symptoms in their own words, starting with the worst. The first becomes **symptom ①**, scored from 0 to 10 and used as the single outcome measure throughout. They record how long it has been present and what preceded its onset, then screen for two levels of red flags. Level 1 means call 1669; level 2 means see a physician before self-care. This is medical exit 1. All medicines, herbs, and supplements go on a separate sheet: “Medication List to Take to the Physician or Pharmacist.”

Step 2: Identify direction and capacity. Patients mark symptoms across all wheel zones, then use each zone’s distinguishing criterion to determine direction, rather than counting marks. Uncle Chai meets both Cold’s criterion—improvement with warmth—and Heavy’s—difficulty starting but improvement once moving. He places ▲ between them, then answers the three capacity questions. The marker indicates direction; capacity indicates intensity.

Figure 7.2 shows the symptom side of Plearnprai’s double-sided element-wheel card. Its six poles form three opposing pairs: Hot/Cold, Dry/Moist, and Heavy/Light. Within each pole, symptoms run from centre to edge through eating, sleep, elimination, mind, body, and distinguishing symptoms. Patients underline matching symptoms in every zone and place ▲ in the best-fitting zone. If several zones seem similar, the outer band helps distinguish them. One symptom may appear in several zones, so assess the overall pattern rather than one symptom alone.

Physicians read the patient's marker in the same language and connect it with examination findings. Context arrives quickly without starting the history from zero. If the marker conflicts with findings, ordinary clinical assessment continues. If the marker is unclear, a Thai traditional medicine practitioner takes a further history and examines the patient.

Step 3: Find a balancing adjustment. Using “the opposite is the remedy,” choose one or two adjustments from the side opposite the marker in four self-care areas: food, physical activity, sensory experience and environment, and care of the mind. Match intensity to capacity. Try them for seven days, then ask whether symptom ① is better, unchanged, or worse. These adjustments contain no medicines, herbal medicines, or procedures. Herbal prescribing belongs to Thai traditional medicine practitioners; conventional prescribing belongs to physicians.

Step 4: Write a personalised health plan. Everything comes together on one sheet written by the patient. It has two parts: one step to stop a trigger, and no more than two helpful additions—**“Stop one, add two.”** In the upper circle, include a trigger-removal step if the cause is clear. Otherwise use only the additions. Family members or guides may write down the patient's own words if writing is difficult.

The “Practitioner's additions” area allows a Thai traditional medicine practitioner to add a formula or procedure and a physician to add non-prescribing advice. The plan has no medication field or medication-adjustment function. Changes to medication are recorded in the physician's medical record. A daily tracking strip is completed honestly, and every sheet states that it is not a diagnosis or prescription.

The Branch Point • When to Enter the Lower Circle

I want this decision point to feel flexible. Everyone first tries simple upper-circle measures for seven days; nobody stays there longer than fourteen. Everyone begins with red-flag screening. If a cause is already clear, the upper-circle plan may include a trigger-removal step. At day 7, the answer to one question, together with symptom duration, determines the next route.

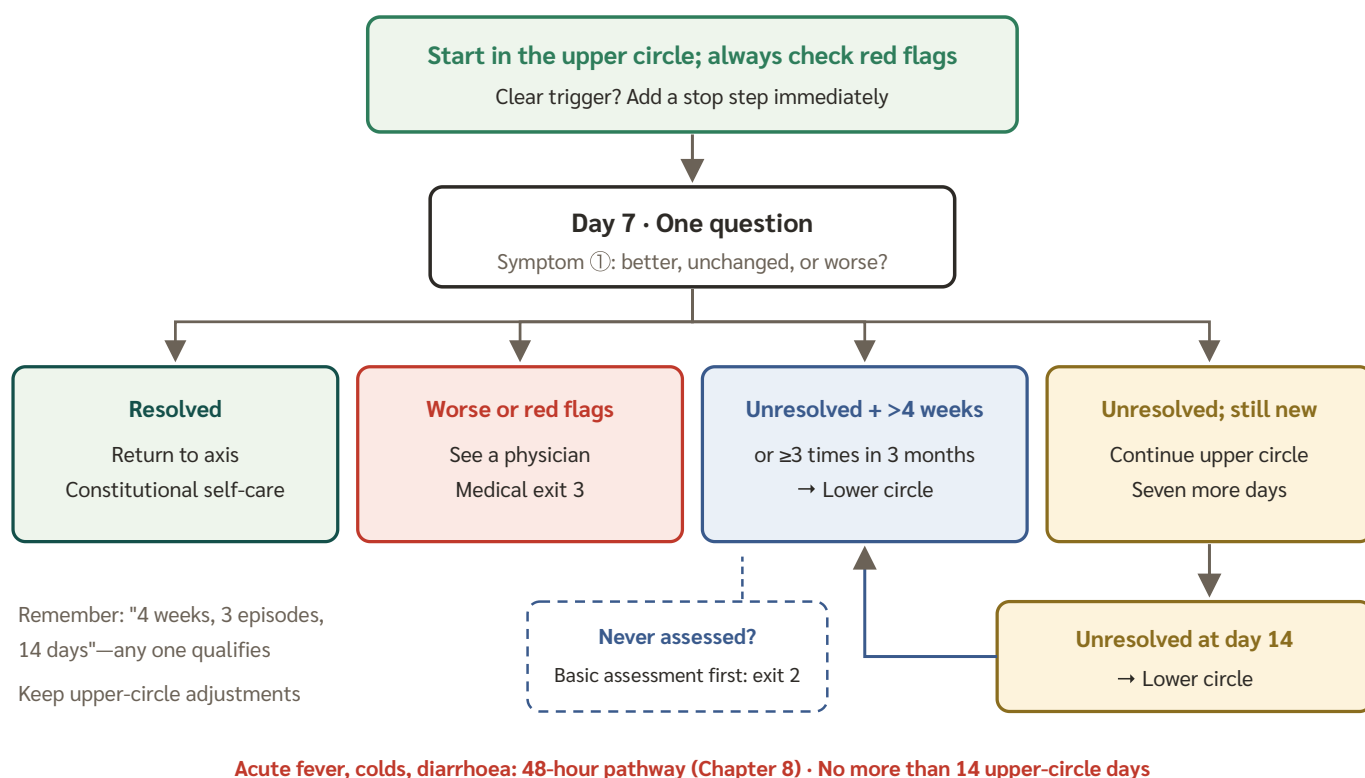


Figure 7.3 The branch-point pathway. Everyone first tries the upper circle for seven days; no one remains there beyond fourteen days.

At day 7	Next step
Resolved	Return to the axis and constitutional self-care.
Worse, or red flags present	See a physician: medical exit 3.
Not resolved, and present for over four weeks or recurrent at least three times in three months	Enter the lower circle. If never assessed, obtain a basic medical assessment first: medical exit 2.
Not resolved, but still a new symptom	Continue the upper circle for another seven days.
Still not resolved at day 14	Enter the lower circle, using medical exit 2 first if never assessed.

“Not resolved” includes improvement without resolution and no change. We ask patients to remember **“four weeks, three episodes, fourteen days.”** Any one criterion is enough. Entering the lower circle does not mean abandoning the upper one: Step 3 adjustments continue alongside it. Uncle Chai follows this route. At day 7, symptom ① remains, and it has been present for more than four weeks, so he can enter the lower circle then.

These are pragmatic, memorable thresholds, not research-validated ones; the pilot must evaluate them. I am more confident in the underlying principle: self-care needs time limits patients can count themselves. Acute symptoms such as fever, a cold, or diarrhoea use forty-eight hours under the Chapter 8 referral pathway.

The Lower Circle • Steps 5–7

Step 5: Identify the endpoint. Always screen the **■** box first, including conditions mimicking imbalance and regular medication. Ask which of the five functions symptom ① affects: that dimension is the endpoint. Briefly scan all five before focusing. If two dimensions fit equally, a Thai traditional medicine practitioner or physician decides.

Step 6: Explore mechanism and cause. Trace backwards from the endpoint through the links between dimensions, asking which dimension is influencing this one. Follow no more than three links until reaching a Life Box that explains the pattern. Then identify the **first domino**: one thing in that box whose change might ease the chain. Use narrative questions: “What changed in life before this began?” “What makes it worse?” “What makes it better?”

For physicians, Step 6 is the history we would like to take but rarely have time for. Uncle Chai’s wife’s death early in the year is a Step 6 answer that had never entered his seven-year hypertension record. With a guide, he locates the starting point in Food and Daily Rhythms: salty ready-made dishes, late dinners in front of the television, and days without regular timing. The chain passes through Vitality to Brain.

Step 7: Address the cause. Change one thing at the first domino by stopping, avoiding, or altering it. Write an **if–then** plan tied to an existing time or event in the day. Try it for fourteen days. One step only, and it must not be a medicine.

Uncle Chai chooses dinner time: “If it is half past five, then I will cook rice and eat at the table, not in front of the television.” His helpful addition is attending the temple’s older people’s club once a week. I like this step because it specifies a time, a place, something his hands will do, and a choice he made himself.

If–then plans correspond to **implementation intentions**: deciding in advance when and how to act. A meta-analysis of ninety-four studies found a medium-to-large effect on goal attainment ($d = 0.65$) (Gollwitzer and Sheeran 2006). Those studies did not test the Care Circles; they support the form of the action we ask patients to write.

The step does not move directly to follow-up. It returns to the same plan as the Step 3 adjustments. The lower circle adds the “stop a trigger” component to the existing plan.

A New Balance • One Question

At seven days in the upper circle or fourteen in the lower, first check whether the plan was followed on at least half the days. If not, its effect cannot yet be judged: make the step smaller and restart the count. If it was, ask whether symptom ① is better, unchanged, or worse than on day 1. The upper circle follows the branch-point pathway; the lower follows this table.

Lower-circle response	Next step
Resolved, and both criteria met	Return to the axis and constitutional self-care.
Unchanged	Adjust the helpful additions or explore a secondary chain; do not increase additions to three or four.

Lower-circle response	Next step
Worse, or a new red flag	See a physician: medical exit 3.

The paired criteria are improvement in symptom ① **and** improvement along the chain: symptoms in an intermediate dimension ease, or the proposed trigger in its Life Box diminishes. Improvement in symptom ① alone, with the starting point unchanged, does not qualify. A secondary chain is one whose links elicited only “sometimes” during backward exploration. Every review has four tasks: screen red flags, score the symptom, reassess capacity, and return to Step 1 for any new symptom rather than appending it to the old plan.

On day 14, Uncle Chai says he sleeps better. His blood pressure awaits the next appointment. I am pleased for him but cannot yet say it will also fall.

Who Does What?

Stage	Patient and family	VHV and guide	Thai traditional practitioner	Physician
Axis	Explore constitution; ask family	Review “Does this sound like me?”	Assist when uncertain	Read a one-line summary
Step 1	Write and score symptoms; screen red flags; list medicines	Repeat red-flag check	—	Receive exit 1; review medicines
Steps 2–3	Place marker; assess capacity; choose adjustments	Help interpret distinguishing criteria	Assess unclear markers	Relate the shared marker to clinical findings
Branch point	Count time; answer the single question	Level 2: ask and follow symptoms	—	Basic assessment at exit 2
Steps 5–6	Tell the story; identify a box	Level 3: trace together, with supervision	Screen ㉞; resolve equally fitting dimensions	Screen ㉞, mimics, and medication effects
Step 7 and plan	Write the step and plan	Help select a step; transcribe patient’s words	Formulas and procedures in practitioner’s area	Non-prescribing advice; medication changes in medical record
New balance	Complete tracking; answer the question	Perform four review tasks	Reassess unchanged symptoms	Receive exit 3

The second role column follows Chapter 12’s four-level training ladder. Level-2 VHVs can ask the follow-up question and monitor people outside their own households as follow-up supporters. Level-3 VHVs may guide the lower circle with a level-3 Thai traditional medicine practitioner, nurse, or public

health professional as adviser. Medicines belong to the professional columns because prescribing is not the circle's task. Physicians have a role at every stage, but their time is brief. The time-intensive work rests with patients, families, VHV's, and guides.

What Is Familiar—and What Differs

Care Circles stage	Familiar clinical concept	Difference
Step 1	Red-flag screening	Patients begin themselves and repeat it every cycle.
Step 2	Chief complaint	A map with shared language.
Step 3	Lifestyle advice	Chosen by direction; only one or two adjustments.
Step 4	Shared care plan	Patient-written; practitioner's area; medicines on a separate list.
Branch point	Referral criteria	Time limits patients count themselves.
Step 5	Review of systems	Five functions including mind; function rather than organ.
Step 6	History-taking; biopsychosocial approach	Changes preceding symptoms and the first domino.
Step 7	Behaviour change; implementation intention	One non-medication if-then step for fourteen days.
New balance	Follow-up	Patient symptom score; criteria specified in advance.

Two features are central: patients begin by navigating themselves, and the lower-circle threshold is a time they can count. These may allow the Care Circles to enter prevention without waiting for a physician to have time.

Something to Try Tomorrow

Open one record of an uncontrolled chronic condition and read it through the Care Circles' structure. No tool is necessary. Ask seven questions: What troubles this person most? In which direction are they shifting? What is their capacity? Which function is affected? What changed in life before the symptom? What single change might ease it? What first step could they realistically take for fourteen days, written as an if-then plan?

I suspect questions 5 and 6 will be hardest. Before trying them with a patient, we need to know where we must not proceed. That is Chapter 8.

Chapter 8 • Safety and Boundaries

The Chapter to Read First

For physician readers, I suspect the first question raised by this book's title is not "Does it work?" but "Might it cause my patients to miss something important?" I asked the same question before allowing this system near my own patients. It deserves a full answer before anyone is invited to try it.

One principle governs the entire system: **If uncertain, refer.** Every point where a patient or guide might make a wrong decision has a clearly marked route to a physician. When uncertain, this system never recommends trying self-care first.

I will follow the usual clinical concerns: missed red flags, mimicking conditions, medicines, the four red lines from Chapter 5, the law, and what remains unproven.

Two Levels of Red Flags

All tools use the same central Plearnprai red-flag list, dated October 2026. No document independently copies and modifies it. The two urgency levels answer the only decision patients and guides must make: "Go now" or "Go before starting self-care."

Level 1 • Emergency: call 1669 immediately. Do not continue self-care.

- Difficulty breathing, breathlessness, or blue discolouration.
- Altered consciousness, confusion, marked drowsiness, or inability to wake.
- Sudden severe pain described as the worst in one's life.
- Major injury or bleeding that does not stop.
- Fever above 39°C, or above 38°C in an infant.
- Stroke-like symptoms: facial droop, weakness or numbness on one side, slurred speech, sudden blurred vision, abrupt severe headache, or dizziness so severe that walking is impossible.
- Possible myocardial ischaemia: chest pressure or pain radiating to the arm, jaw, or back; sweating; palpitations with near-fainting.
- Loss of consciousness, seizure, or unexplained fainting.
- Vomiting blood, bloody or black stools, or coughing blood.
- Thoughts of self-harm or wanting to die: call 1323 and do not leave the person alone.

Level 2 • See a physician promptly, before beginning self-care.

- Possible cancer warning signs: unintentional weight loss, a lump, a non-healing wound, abnormal bleeding, persistent cough or hoarseness, difficulty swallowing, or sustained change in bowel habits.
- Severe depression lasting more than two weeks and preventing everyday functioning, or an abnormally elevated mood.
- Palpitations, dizziness, or near-fainting in an older person.
- Fever lasting several days.

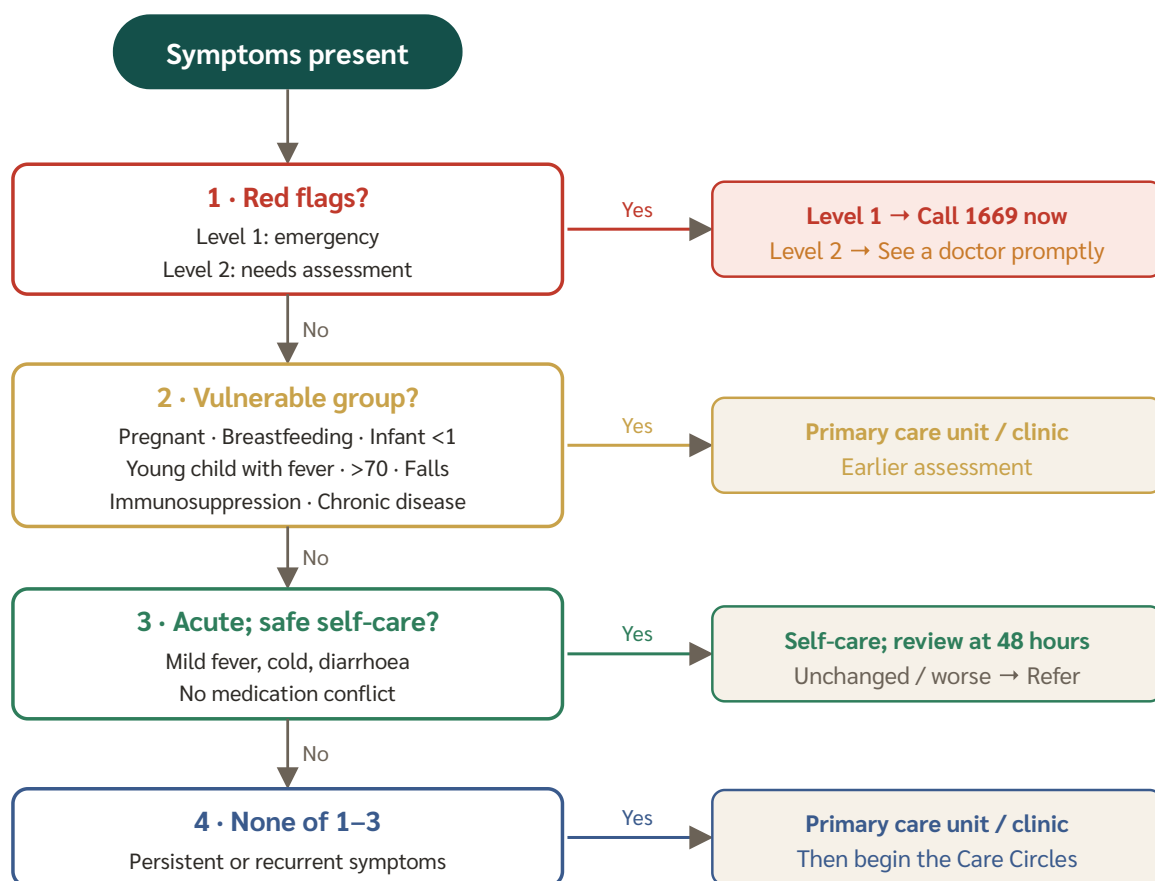
- Swelling of one leg, or swelling with breathlessness that prevents lying flat.

Physicians will find nothing new in this list, which is precisely what I hope. It is everyday red-flag screening written for public use and placed at the start of the Care Circles. Patients check before placing a marker every time; guides must complete the red-flag module before helping anyone else.

Four Referral Questions—and People Who Need Earlier Assessment

When symptoms occur, follow this sequence:

1. Any level-1 red flag means immediate hospital care. A level-2 flag means prompt medical assessment before self-care.
2. People in vulnerable groups should attend a primary care unit or clinic earlier than usual: pregnant or breastfeeding women, infants under one, young children with fever, adults over seventy, older people who have fallen, and people with immunosuppression or chronic disease.
3. Acute symptoms suitable for safe self-care, without conflict with regular medication, may be monitored for forty-eight hours. Refer if they fail to improve or worsen.
4. If none of 1–3 applies, attend a primary care unit or clinic.



Acute symptoms and elemental shifts use different pathways · One central red-flag list

Figure 8.1 Two red-flag levels and four referral questions: the first step before opening any other Care Circles tool.

Acute symptoms in item 3 and constitutional shifts are different matters; their time limits are not interchangeable. Fever, colds, and diarrhoea use forty-eight hours. Chapter 7's seven-to-fourteen-day Care Circles address gradual shifts. Fever or marked weakness must always pass through this four-question pathway first.

Three Medical Exits within the Care Circles

Beyond initial triage, the patient-held map contains three exits to a physician.

Exit 1: at Step 1, when screening identifies a red flag.

Exit 2: at entry to the lower circle, when symptoms have lasted over four weeks without prior assessment, or remain unresolved after fourteen days in the upper circle without prior assessment. A basic medical assessment must precede any search for causes in life. This is not itself a red flag; it prevents the system from sheltering diseases needing diagnosis. For primary care physicians, this is the clearest interface between our work and the patient's circle.

Exit 3: during follow-up, when the person worsens or a new red flag appears.

I intend these exits to close every route by which someone might continue indefinitely without seeing a physician.

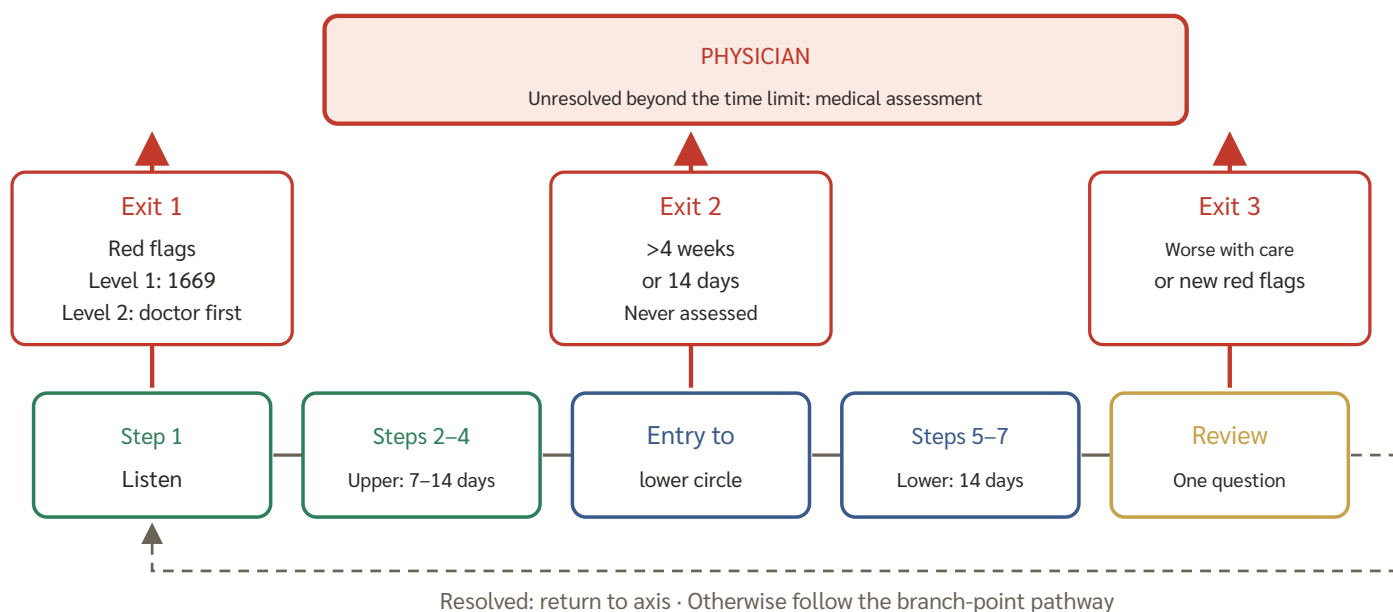


Figure 8.2 Three medical exits along the patient's pathway. Unresolved symptoms beyond the specified time require medical assessment.

Conditions That Mimic Imbalance

This concerns me most because elemental language can describe almost anything—and that flexibility can be dangerous. Fatigue, sensitivity to cold, dry skin, and weight gain may look like a Heavy marker. They may also be hypothyroidism.

We therefore require **screening before trusting the chain**. Before attributing symptoms to life circumstances, consider at least:

- Anaemia.
- Thyroid disease.
- Sleep apnoea.
- Depression.
- Adverse drug effects.
- Localised symptoms—focal pain, a lump, a wound, or unilateral swelling—which lie outside the wheel’s directional framework.

The physician performs this assessment, not the guide. Guides need to know these possibilities and refer when symptoms fit. Exit 2 ensures assessment occurs before anyone starts tracing life connections.

Plearnprai’s causal-pathway library, which guides use to generate hypotheses, separates three **must-not-miss** routes: medication; infection, toxins, and injury; and underlying bodily conditions. All belong to ➤. Any route entering that box requires medical referral, without exception.

Medicines Patients Already Take

The rule for prescribed conventional medication is absolute: **The Care Circles do not interfere with prescriptions.** They do not recommend, adjust, or stop medicines at any stage.

Every medicine, herb, and supplement is recorded at Step 1 on the separate “Medication List to Take to the Physician or Pharmacist.” The personalised plan contains no medication field or adjustment function. Changes belong in the physician’s medical record. If a drug may be causing symptoms, the guide can only encourage the patient to take all their medicines to the prescriber or pharmacist.

Conversely, patients may use things without telling us. Aunt La-or drank her local healer’s decoction for two months because she feared being scolded. A non-judgmental list with room for everything creates an opportunity to disclose it. Whether a product conflicts with prescribed medication is for the pharmacist or prescriber to assess, together with a Thai traditional medicine practitioner for herbal issues. That is not the guide’s role.

For primary care physicians, this may be the quickest visible benefit: learning what patients actually take. Aunt La-or may no longer have to keep her decoction secret for two months.

The Four Red Lines in Practice

Chapter 5 introduced four boundaries. Here is how the tools enforce them.

No promise of cure. The circles promise no outcome in advance. At day 7 or 14, patients report whether symptom ① is better, unchanged, or worse, with a prewritten next step for each answer. All I can promise is that patients will have something they can do themselves.

No fear-based messaging. Constitutional cards describe things to use in moderation, not threats of serious disease if instructions are ignored. I want people to leave with one thing they can do rather than one thing to fear. Fear may change behaviour on day 1, but I do not believe it sustains the journey.

No rejection of necessary medication. Several layers protect this boundary. There is no medication field on the plan, regular medication belongs in ■, and all documents repeat the instruction not to stop, reduce, or adjust prescriptions independently.

Elements are not astrology. Constitution is explored through lifelong bodily characteristics and habits, not birthdays or prediction. It never explains away a new or severe symptom. New chest tightness requires red-flag screening regardless of constitution. In Step 6, “because I am Wind-dominant” is not a starting point: that must lie in a Life Box.

Legal Boundaries

Here I turn to the wording of the law.

Section 3 of the Thai Traditional Medical Professions Act B.E. 2556 (2013) defines practice broadly as professional acts performed or intended upon humans concerning advice, examination, diagnosis, therapy, treatment, prevention, health promotion, and rehabilitation, using knowledge of Thai medicine, Thai pharmacy, Thai midwifery, Thai massage, and Thai indigenous medicine. Section 31 prohibits unlicensed practice, with important exceptions including acts upon oneself; assistance to patients in accordance with duty, law, humanitarian principles, or moral obligations without remuneration; and indigenous healers recognised under ministerial regulations. Section 53 provides penalties of imprisonment for up to three years, a fine of up to THB 60,000, or both.

This definition is broad: it includes advice and promotion, not merely treatment. Any system sharing knowledge for household use must therefore draw very clear boundaries around what non-professionals may do.

Plearnprai’s boundary is that trained community guides and knowledge-sharing volunteers may only **explain tools, invite questions and reflection, and help record information**. They must not examine, diagnose, name diseases, recommend or adjust medicines, or perform procedures in place of a practitioner. Self-care falls under the exemption for acts upon oneself; unpaid family assistance under the assistance exemption. Examination, diagnosis, and treatment through Thai traditional medicine remain professional work.

I must be candid: this boundary still needs testing. Legal language and the language of self-directed learning do not align perfectly. No one can yet say precisely how far “inviting reflection” differs legally from “giving advice.” Plearnprai chooses the clearest ground: patients decide at every step; guides do not tell them what to do, but help them see options and choose, referring immediately whenever examination is required.

Another unresolved question is whether the government allowance paid to VHV for their duties counts as “remuneration” under this provision. I have found no ruling. I therefore place all VHV activity within the same boundary as guides: education and help with recording, outside examination, diagnosis, and treatment from the outset.

What Guides May—and May Not—Do

May do	Must not do
Explain the wheel, five dimensions, and Life Boxes	Tell a patient which disease they have
Invite red-flag checking and refer when found	Decide that symptoms are “probably nothing”
Ask what preceded symptoms or what improves them	Perform any physical examination
Record the patient’s words, for example for an older person who struggles to write	Devise the step and write a plan on the patient’s behalf
Help patients see possible trigger-removal steps and choose themselves	Instruct them to stop, change, or start any medicine, including herbs
Encourage taking the medication list to a physician or pharmacist	Judge a medicine as good or bad
Accompany patients through steps not requiring examination	Perform procedures, massage, compresses, or heat treatments on patients

The difference between transcription and writing a plan for someone is who chooses. If patients choose the step and supply the words, guides may record them. If guides invent and write the step, they are taking over the plan.

What Has Not Yet Been Demonstrated

I place this list in the safety chapter because knowing what remains unproven is itself a safeguard.

The tools build on Thai traditional concepts of elements, disease origins, causal factors, medicinal tastes, and things that disagree with a person. Their organisation into the wheel, five dimensions, Life Boxes, and Care Circles is Plearnprai’s own.

The following are practice observations, not research-established findings:

- The first-domino rule: chronic symptoms often begin in a Life Box one to three links from the symptom.
- The seven-day, fourteen-day, and four-week thresholds, chosen for practical simplicity.
- The twenty-one-item constitutional questionnaire, whose validity has not been studied.
- “Action labels” assigning methods from thirty-two healing disciplines to dimensions; these are Plearnprai’s classification.

International evidence supports related principles but has not directly tested this system:

- Trained physicians providing explanations that connect symptoms and life can reduce unexplained physical symptoms: PHQ-15 scores were 1.82 points lower at fifty-two weeks (Burton et al. 2024).
- Home blood pressure monitoring works when connected to action, but that action largely consisted of systematic medication adjustment by doctors, pharmacists, or patients. The circles’ non-drug actions remain untested (Tucker et al. 2017).

The final chapter returns to this list with a proposal for testing it.

A Checklist before Implementation

Before a primary care unit adopts the system, I suggest answering seven questions:

1. Can everyone involved, including VHV's, recall the full level-1 red-flag list and the numbers 1669 and 1323?
2. Is a physician responsible for all three exits, with a defined clinician and timeframe for each referral?
3. Can a pharmacist or prescriber address herb–drug questions, working with a Thai traditional practitioner on herbs?
4. Has every guide completed red-flag and referral training, with a level-3 Thai traditional practitioner, nurse, or public health professional available as adviser?
5. Is the medication list separate from the plan, with no medication field on the plan and a statement that it is not a diagnosis or prescription?
6. Is there a way to record missed red flags, with a target of zero?
7. Has a legally knowledgeable reviewer examined the wording defining the guide's scope?

Something to Try Tomorrow

Compare this two-level red-flag list with your unit's screening guidance. Identify items present in one but missing from the other. If you find any, I would like to know: this list can grow, and should grow from real clinical practice.

Now that the stopping points are clear, Chapter 9 takes the Care Circles into practice, beginning with community health promotion.

Part 3 • Putting It into Primary Care Practice

These four chapters form a practical guide, moving through the boxes one at a time. Chapter 9 covers promotion that could begin next week. Chapter 10 addresses prevention in chronic disease clinics and consultations. Chapter 11 considers treatment and rehabilitation for patients who keep returning. Chapter 12 answers the question: where will the people to do this work come from?



Chapter 9 • Health Promotion: Constitutional Elements in Community Work

A Question in the Temple Hall

At the older people's club's monthly meeting in the temple hall, a woman asked the primary care team, "Why can my husband eat spicy food at every meal and feel fine, while a little leaves me bloated all night?"

I like this question because our usual one-size-fits-all food talk cannot answer it. Reducing sugar, fat, and salt is sound advice, but does not explain why two bodies respond differently to the same dish. I believe usable health promotion begins with "What is this person like?" The simplest tool I know for that question is constitution.

Part 3 begins here because promotion tools do not prescribe or diagnose and can fit into existing primary care work. I will call the questioner Aunt Somjai and return at the chapter's end to how far her question took her.

A Half-Day "Know Your Constitution" Station

The smallest unit is a half-day activity called the **Know Your Constitution Station**, lasting about three hours. It can take place at a subdistrict health-promoting hospital, temple hall, school, or community office. Participants leave with one card describing their constitution, a direction for everyday care, and things to use in moderation. It corresponds to level 1 of the community learning ladder and always begins with red-flag teaching, as described under boundaries below.

The facilitator first introduces Wind, Fire, and Water through recognisable people: small-built, dry-skinned, quick-thinking, poor sleepers; warm-bodied people who become irritable when hungry and develop acne easily; and larger-built, moist-skinned, patient people who sleep readily. Once the three are clear, participants explore their own combination:

1. Complete the twenty-one-item questionnaire covering three areas of lifelong characteristics.
2. Review their answers.
3. Ask, "Does this sound like me?"
4. Ask someone from home or a companion.
5. If still uncertain, arrange a conversation with a guide or Thai traditional medicine practitioner.

Those answering no or unsure need not force a conclusion: their constitution remains undetermined. This questionnaire has not undergone research validation. I regard it as a revisable starting tool, not a test giving a fixed result. Self-confirmation and family feedback are integral, not optional extras.

The card has two sides. The front shows constitution, X on the wheel, and one or two gentle everyday adjustments. The reverse lists things to use in moderation and a daily checklist we call the **Seven Foundations of Life**: sleep, rest, breathing, mind, intake, water, and movement. Most derive from the eight causal factors in Thai traditional texts; Plearnprai adds breathing and rest and organises them into daily practices people can tick off.

The Body's Calendar

The card also shows that the body is never static. Three influences overlay constitution: time of day, season, and age. They do not change constitution but may push the person towards the element associated with that period.

We use approximate seasonal months: the hot season, March–May, corresponds to Fire; the rainy season, June–October, to Wind; and the cool season, November–February, to Water. Fire-dominant people in hot weather, Wind-dominant people in the rains, and Water-dominant people in cool weather are encouraged to prepare, because the influence aligns with their constitution. Classical texts place the period after age thirty-two in the Wind stage. As age advances, this influence strengthens. Older people gradually add warmth, moisture, softness, and regularity even if their constitution is not Wind, without pushing past the centre towards the other extreme.

We add a principle drawn from modern life: attend to actual exposure rather than the season's name. Someone in air conditioning all day during summer, entering a cold room after rain, or travelling to a cold country in April experiences something different from the seasonal label. Frequent or intense switching becomes more than background context: it may be a cause in the Air and Living Environment box.

I can use this with patients saying “I’ve had frequent colds since moving to office work” or “My joints hurt more in the rainy season,” without mentioning elements. I simply ask, “When this started, how long each day were you somewhere hot, cold, damp, or windy, and how often did you switch?”

A Family on One Sheet

Constitution belongs to an individual, but health happens at home. The next tool is a family constitutional map, placing everyone's X on one wheel.

It helps explain small conflicts: a mother feels cold while her child sets the air conditioner to 23°C; a father tolerates spicy food while grandmother develops stomach pain. People in the same house are not simply stubborn; they need different directions of adjustment. A Fire-dominant child can prepare warming food for a Wind-dominant mother, understanding that she needs something different from them.

A related tool, **Meals Matched to Constitution**, starts with one shared pot and varies seasonings or side dishes for each person. I like that it asks what to add rather than telling everyone to stop eating something.

The book groups family roles into four life stages: young children, school-age children, working-age adults, and older people. Young children's care focuses on avoiding phlegm accumulation, reducing very sweet or very cold foods, and using ordinary food, sleep, and movement—not self-directed herbs or massage. Working-age adults often care for the whole household and need their own cards, because carers may be the first to lose balance. For older people, steps become smaller, and multiple regular medicines must be checked first.

Connecting with Existing Work

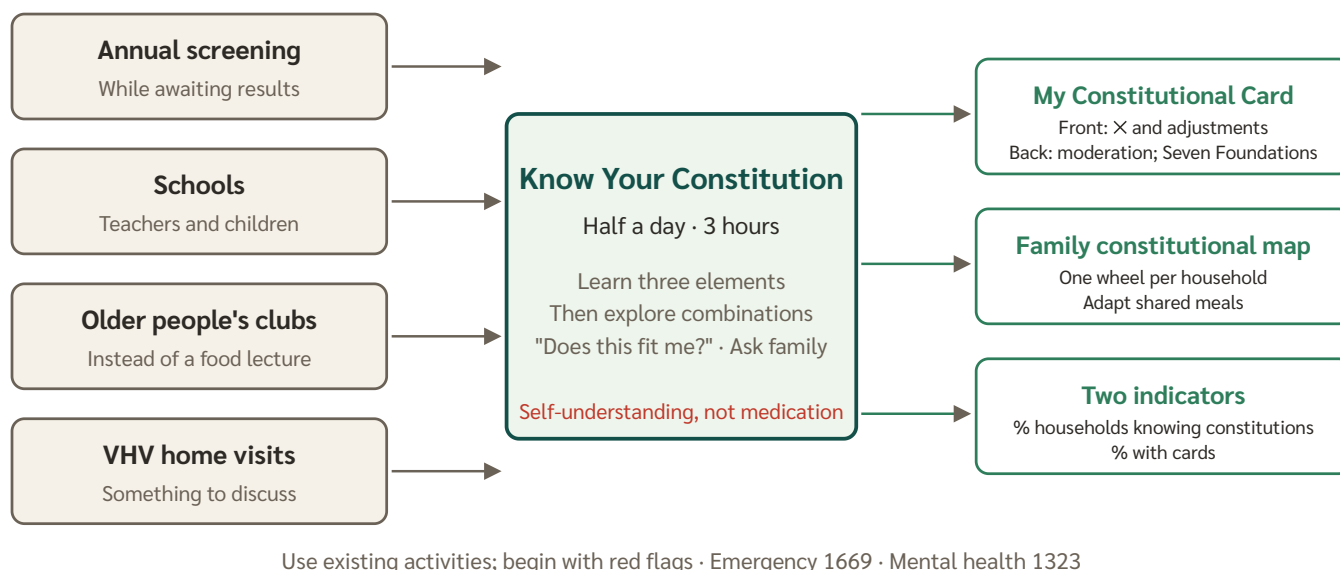


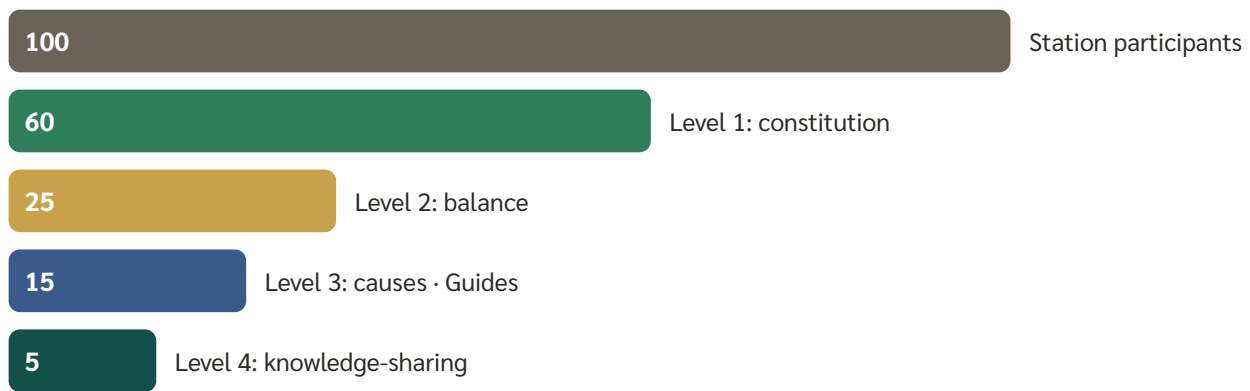
Figure 9.1 A constitution-awareness station within four existing primary care activities, and what participants take home.

This box can begin quickly because no new programme is needed. Almost every primary care unit already has suitable activities:

- **Annual health screening:** people waiting after blood pressure, glucose, and waist measurements can complete the questionnaire. Those with “normal results,” who previously left empty-handed, can now take home a personal card.
- **Schools:** teachers can recognise natural differences—feeling hot or cold, getting hungry often—and adapt classroom care. Constitution must not explain behaviour, attention, or learning problems; concerns require ordinary developmental assessment. A child who understands grandmother’s constitution may be an excellent messenger to the household.
- **Older people’s clubs:** I expect early benefits here because older adults know their bodies well, and some may continue up the ladder to become community guides.
- **VHV home visits:** carrying the household’s constitutional map may shift visits from measurement and recording towards conversation, because there is something meaningful to discuss.

Illustrative Numbers for the Ladder

We use an illustrative planning scenario: of 100 station participants, perhaps sixty identify their constitution and take home a card; twenty-five progress to level 2, navigating upper-circle self-care; fifteen reach level 3, exploring causes and beginning to guide others; and five reach level 4, sharing knowledge in the community.



Hypothetical per 100 starters; not observed data; revise after the first cohort

Figure 9.2 Illustrative figures for a constitution-aware community ladder per 100 station visitors. These are not observed data.

These are hypothetical figures, unsupported by real data. They help teams estimate staffing and time and are meant to be revised after the first cohort. From day 1, I would collect just two actual figures: the proportion of households in the catchment area that know their members' constitutions, and the proportion of residents holding a card. Both are simple, need no physician time, and indicate whether promotion tools have begun reaching people's hands.

A Case from the Older People's Club

This year, the primary care team held a station at Aunt Somjai's club instead of its annual food lecture. About forty older adults attended. Many recognised their constitution within the first hour, surprising the team with how well they knew their bodies.

Aunt Somjai is Wind–Water: she feels cold easily, bloats, and sleeps poorly. She did more than care for herself. She placed her husband and daughter on the household wheel, then returned the following month with the question at this chapter's beginning. The team saw it as a sign of readiness to progress.

She completed level 2 and practised the upper circle herself for three months. Whenever bloating returned, she placed a marker—usually Cold—chose an adjustment, and reviewed on day 7, until she became fluent in reading her own body. She then entered level 3, beginning with the two red-flag levels and medical exits. She now helps club members navigate the lower circle, with the unit's nurse as adviser.

What pleases me is that she did not rush. A common mistake is to skip level 2 and start helping others as soon as enthusiasm appears. She became familiar with her own upper circle first. I hope station teams preserve this pace.

Boundaries of This Box

Promotion applies to everyone, but two cautions matter.

First, constitution must not explain new or severe symptoms. A participant reporting recent unintentional weight loss has a level-2 red flag requiring medical assessment. Every station therefore begins with the complete two-level list in Chapter 8 and Appendix A, without shortening or changing it. Before the first word about elements, everyone records 1669 for emergencies and 1323 for thoughts of self-harm or suicide.

Second, food and routine advice for people with diabetes, kidney disease, or heart disease must not conflict with medical advice. The Wind life-stage suggestion to add richer, warming foods cannot be applied automatically to someone prescribed fat restriction. People on fluid restriction must not increase water from the checklist. The card therefore says to consult a physician before major dietary changes when a chronic condition is present.

Something to Try Tomorrow

Look at next month's activity calendar, identify an annual screening event or older people's club meeting, and reserve three hours for a station. Decide who will teach: preferably the unit's Thai traditional medicine practitioner or someone trained as a facilitator, because questionnaire interpretation requires learning and the red-flag list must be taught completely. If nobody is ready, invite a traditional practitioner to mentor the first session. No new budget line is needed.

Prepare Plearnprai's questionnaire and constitutional cards (Appendix C), plus one large wheel on which to place everyone's constitution that day. This becomes the first community constitutional map.

Some people who take home a card will begin to shift out of balance the following month. Chapter 10 is where they will use the upper circle.

Chapter 10 • Prevention: The Upper Circle in NCD Clinics and for Patients with Normal Tests

Ninety Days We Do Not See

A patient with hypertension leaves with three months of medication and advice to reduce salt and exercise. We will meet again in ninety days. What happens in between? I often ask myself, and the most honest answer is usually: I do not know.

Chapter 3 showed that consultation-based lifestyle advice has small effects that fade over time. The upper circle connects that advice to a patient's identity and everyday life during those unseen ninety days. I will begin with what it leaves untouched.

What Remains Unchanged

Disease screening, vaccination, diagnostic criteria, treatment targets, and guideline-based medication remain entirely within the existing system. Hypertension treatment continues according to guidelines; people with diabetes still receive metformin and scheduled retinal and foot assessments. The upper circle neither reduces nor stops medication. Every plan states that prescribed medication lies outside it.

What it adds is a practical response to the “behaviour modification” section of clinical guidelines—the section often left to each unit to work out for itself. I see the upper circle as one possible answer.

Two Entry Points

The first is the chronic disease clinic: people with hypertension, diabetes, or dyslipidaemia whose reasons for poor control remain in everyday life. They belong to the treatment box, but their underlying promotion and prevention layers have long been underfilled. The upper circle adds those layers without altering treatment. Uncle Chai enters here.

The second is persistent symptoms with normal investigations: aches, insomnia, fatigue, bloating, or dizziness. As Chapter 3 noted, roughly 40–49% of primary care patients have at least one symptom unexplained by disease. Instead of leaving with “Nothing is wrong,” I want them to take this tool home. Ms A enters here. She places her marker at Dry and uses the upper circle for seven days before her story continues in Chapter 11.

Both entrances always begin with two-level red-flag screening. Acute fever, colds, and diarrhoea follow Chapter 8's forty-eight-hour referral pathway, not a seven-day upper-circle trial. At day 7, unresolved symptoms present for over four weeks move to the lower circle; if never assessed, the patient first needs our basic assessment at exit 2. Most patients entering through the second route have already had this.

The Physician's Five Minutes

If the upper circle needs more physician time than we have, it will not happen. This is therefore the heart of the chapter.

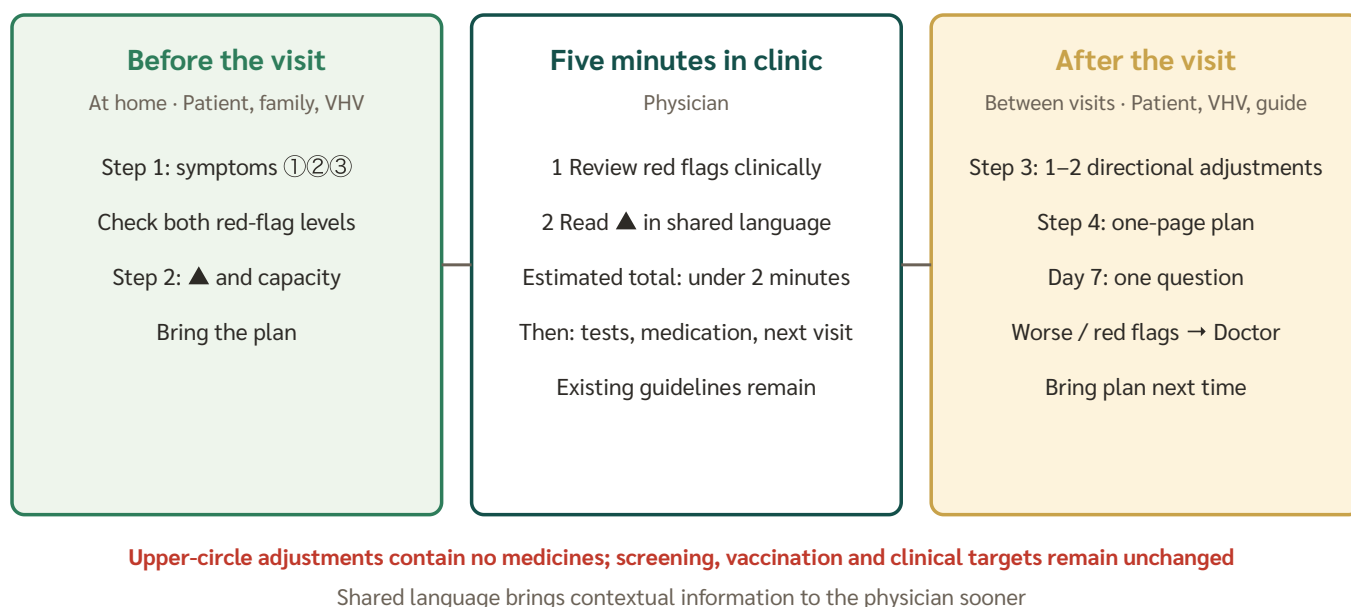


Figure 10.1 Five minutes of physician time. The upper circle asks the physician to do two things; the rest happens before and after the consultation.

It asks physicians to do two things they already do. First, review red flags. Patients have already completed Step 1 at home using the same list. The physician reviews it clinically in under a minute.

Second, read the ▲ patients have placed in Step 2. They arrive with a marked wheel. The physician reads it in their shared language and relates it to examination findings. A Cold/Heavy marker immediately prompts questions about movement, daytime sleep, and swelling rather than starting from a blank sheet. A few sentences may provide context that ordinarily takes longer, and I hope patients feel their observations have a place in the consultation.

If the marker conflicts with findings—for example, Cold/Heavy despite warmth, tachycardia, and weight loss—I investigate normally. The marker does not replace examination. Unclear markers receive further assessment from a Thai traditional medicine practitioner.

I estimate these two tasks together should take no more than two minutes, although the pilot must measure that. The remaining time goes to blood results, medication adjustment, and the next appointment. Step 3 adjustments, Step 4 planning, and day-7 review take place outside the room with patients and families.

“The Opposite Is the Remedy” and the Six Pillars

Lifestyle medicine’s six pillars—food, movement, sleep, stress management, relationships, and avoidance of addictive substances—are sound. The difficulty is that patients receive the same set without knowing where they should begin.

The four adjustment areas cover similar ground: food, physical activity, sensory experience and environment, and care of the mind. Two differences matter. First, choices follow direction. A Heavy marker points towards Light: a smaller evening meal, more movement, gentle pungency, less

sweetness. Dry points towards Moist: more water, warmth, and rest, and less dry, crisp food. People prescribed fluid restriction must not increase water independently. Two people with hypertension may therefore receive different practical advice.

The reverse of the Figure 7.2 card is called “The Opposite Is the Remedy.” When flipped, the marked zone stays in the corresponding position and contains adjustments towards its opposite—Hot towards Cold, Heavy towards Light—across all four areas. The outer band gives pole-specific precautions. Patients can choose without memorising the opposite pairs.

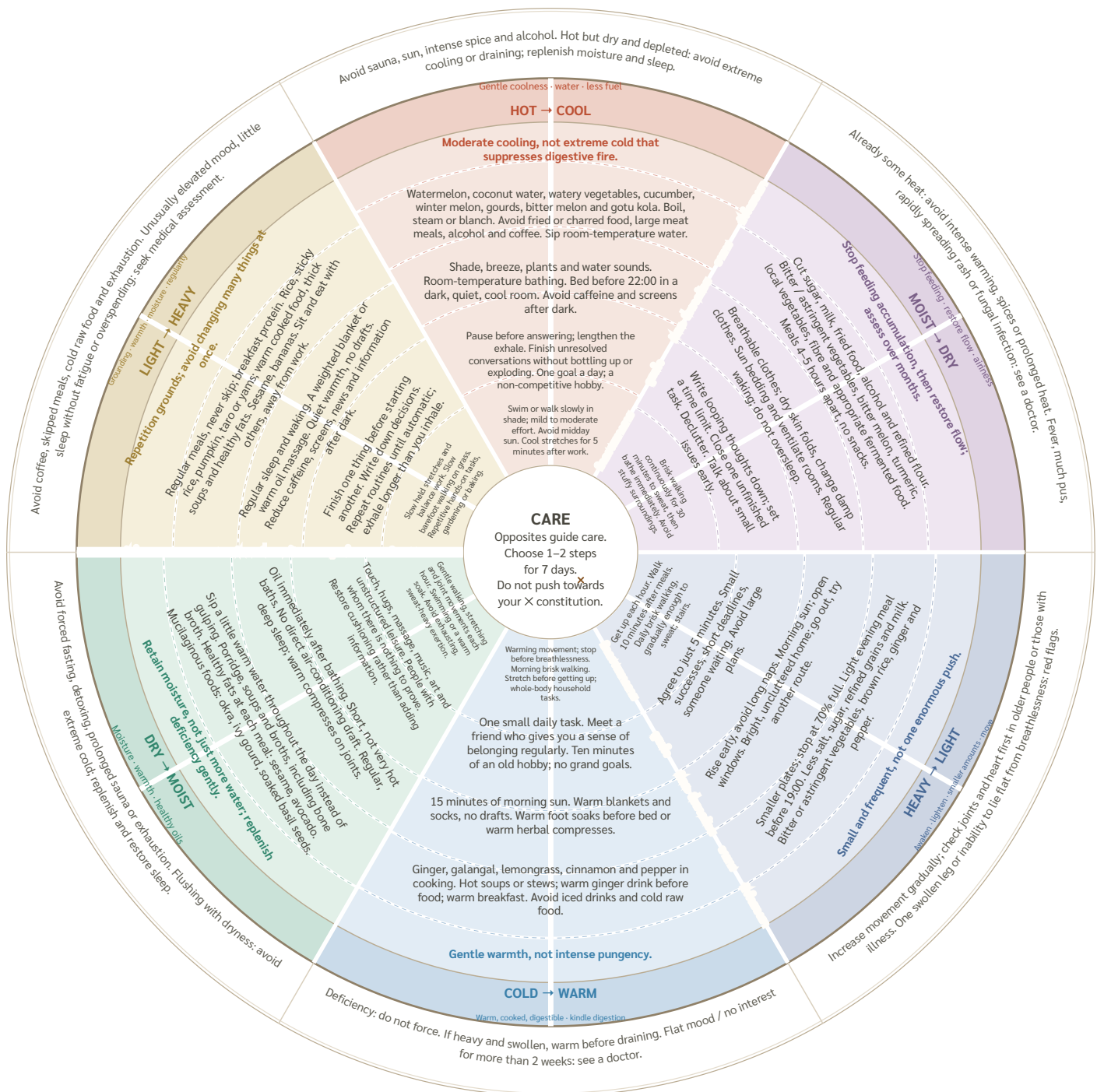


Figure 10.2 The care side of the same wheel. The corresponding zone on the reverse provides adjustment towards the opposite pole—for example, Hot → cooling. Rings show physical activity, mind care, sensory input and environment, food, and a guiding principle. The outer band gives cautions. The reverse is mirrored for long-edge duplex printing.

Second, patients choose only one or two measures from the same zone, try them for seven days, then ask the single question. Intensity follows capacity. Low capacity means gentle, brief, frequent measures, with no fasting or strenuous exercise.

For physicians, choosing by direction explains why “reduce salt” should become different practical advice for different patients. Limiting choices to two helps make action feasible.

One Plan and a Tracking Strip

The one-page personalised health plan is patient-written and includes symptoms ①②③ with scores, capacity, one or two chosen adjustments, a “Practitioner’s additions” area, and a statement that it is not a diagnosis or prescription. It has no medication or medication-adjustment field. The practitioner’s area accommodates a traditional practitioner’s formula or procedure and a physician’s non-prescribing advice. Patients bring the sheet to the next appointment.

The medication list is separate, recording every medicine, herb, and supplement for the physician or pharmacist. My medication changes remain in the ordinary medical record. The plan belongs to the patient; prescribing remains with the prescriber.

The fourteen-day tracking strip is completed honestly each day, including days the plan was not followed. Those days are information too.

The single day-7 question: Is symptom ① better, unchanged, or worse? Patients ask themselves and record the answer. Family may help. Level-2 VHV’s may ask as follow-up supporters. The answer determines the next step under Chapter 7’s branch-point pathway:

- Resolved: return to the axis and constitutional self-care.
- Worse or a new red flag: see a physician without waiting for the three-month appointment—exit 3.
- Unresolved and present over four weeks, or recurring at least three times in three months: enter the lower circle.
- Unresolved but still new: continue another seven days; if unresolved at day 14, enter the lower circle.

Everyone has seven days to try simple measures. Nobody remains in the upper circle beyond fourteen.

Why the Whole Circle Matters

The closest research concerns home blood pressure monitoring. Monitoring alone reduced blood pressure by 1.0 mmHg, not significantly different from zero; with intensive support, by 6.1 mmHg. Support was mostly systematic medication adjustment by doctors, pharmacists, or patients (Tucker et al. 2017). England’s TASMING4 used the same principle: doctors adjusted medication using home readings, achieving reductions 3.5–4.7 mmHg greater than usual care at one year (McManus et al. 2018).

I read these as support for one principle: recording needs connected action. But the action was mainly medication adjustment. The Care Circles’ non-drug action has not been tested.

If people merely place a marker and nothing follows, the result may resemble monitoring alone. The upper circle therefore needs Steps 3 and 4, review and adjustment, and a point where physicians use the information: the next visit, when the patient brings the plan.

Another finding concerns time. DPP's 58% reduction in diabetes incidence at three years became 24% at twenty-one years (DPP Research Group 2025). Lifestyle effects fade without a way to return. The upper circle is therefore repeatable whenever imbalance begins, with a return to the axis whenever symptoms resolve.

A Case • Grandma Boonmee

Grandma Boonmee is seventy-eight, Wind-dominant, and receiving hypertension treatment. She presents with three weeks of palpitations and dizziness on standing.

Her age and symptoms constitute a level-2 red flag: there is no need to wait four weeks. Concerned, I examine her heart, measure lying and standing blood pressure, obtain an ECG, and review medicines. Two antihypertensives are contributing to postural hypotension, so I adjust them. This is medical work that no part of the circles replaces.

After adjustment, the palpitations and dizziness improve but do not resolve. She enters the upper circle. Step 1's "What preceded it?" brings out: "Since my grandchild went to work in town, I've eaten dinner alone." She eats less, goes to bed early, and wakes before dawn. Her marker is Dry/Cold, near her Wind X, and capacity is low.

The upper circle ordinarily starts with balancing adjustments, but her cause is apparent at Step 1, so the plan can include a trigger-removal step. She chooses to eat dinner with a neighbour and adds one helpful adjustment: a warm evening meal containing liquid.

Seven days later, her VHV asks the single question. She says she is better: palpitations have gone, with occasional dizziness on standing quickly. The symptoms are still new, so she continues for seven more days. At day 14 she reports further improvement. At the next appointment, she brings her plan, and I am glad we have more to discuss than a blood pressure reading.

The case has two components: medical screening, examination, and medication adjustment; and the upper circle's exploration of life changes and patient-selected action. They complement one another. I hope the second helps sustain the first, but because improvement also followed medication adjustment, this case cannot separate their effects. The pilot must measure that.

Something to Try Tomorrow

Choose one chronic disease clinic session and add two things. Before discussing medication, ask, "Lately, do you feel hot or cold, heavy or light?" Listen to the patient's own words. Before they leave, invite them to choose one action for the next seven days and ask themselves the single question on day 7. A level-2 VHV may follow up if available.

These are the physician's two minutes the upper circle asks for. If feasible for one day, the rest can be built around them. For those still symptomatic after the review question, Chapter 11 is the next path.

Chapter 11 • Treatment and Rehabilitation: The Lower Circle for Persistent Symptoms

Ms A's Seventh Day

On day 7, Ms A answers, “It hasn’t gone away. Even in bed, my head is still working.” Her symptoms have lasted three months. Under Chapter 7’s pathway, this is the day she enters the lower circle.

The lower circle explores starting points in life when symptoms persist, recur, or fail to resolve with the upper circle. In my experience, such patients often have what we call a first domino in a Life Box. One well-targeted change may help prescribed treatment work more fully—a hypothesis Chapter 14 proposes to test. Physicians know this work matters but rarely have time. The lower circle assigns the non-medical portion to trained people.

Two Gates before Entry

First is exit 2: symptoms lasting over four weeks without prior assessment require a basic medical assessment. This prevents the lower circle from concealing undiagnosed disease.

Second is ■. Before exploring life causes, screen three must-not-miss routes: bodily conditions mimicking imbalance, such as anaemia, thyroid disease, sleep apnoea, and depression; regular medicines and their adverse effects; and infection, toxins, or injury. These require assessment or referral, not a search for a lifestyle domino. This is the physician’s clearest lower-circle role.

The Three Steps in Ms A’s Case

Ms A is the thirty-four-year-old office worker from Chapter 1, with a Wind constitution. Symptom ① is difficulty sleeping, work thoughts continuing in bed, and waking unrefreshed, scored 8/10. Symptom ② is neck and shoulder tightness with light-headedness. Normal X-rays and blood tests mean she has passed exit 2. She enters on day 7 rather than waiting fourteen. Before starting, I review ■ again, asking about depression, snoring and sleep apnoea, and previous medication. Nothing calls for further investigation.

Step 5: Identify the endpoint. The guide asks which function symptom ① affects. A mind still occupied with work at bedtime suggests an overloaded, unrested Brain dimension. Brain is the endpoint; symptom ② is recorded as a clue.

Step 6: Explore mechanism and cause. The guide asks three narrative questions. “What changed before the sleep problem?” After a pause, she says, “It started with the new project. There’s so much work I don’t even get up for lunch. At home I keep working until ten.” “What makes it worse?” “Late-working nights.” “What helps?” “Days off when I don’t turn on the computer.”

The first chain follows Ms A’s own suspicion. Tracing what influences Brain leads directly to Work Rhythms: overload with no stopping time leaves no rest before bed. The same starting point branches elsewhere: she stays braced at her screen all day, producing Structure-related neck and shoulder tension, then, in the five-dimensional model, Circulation-related light-headedness.

We call this **branching from one entry point**. Both branches reach a Life Box within three links. The guide explains it simply: “Work without a finishing boundary means your head never rests and your body never gets up.”

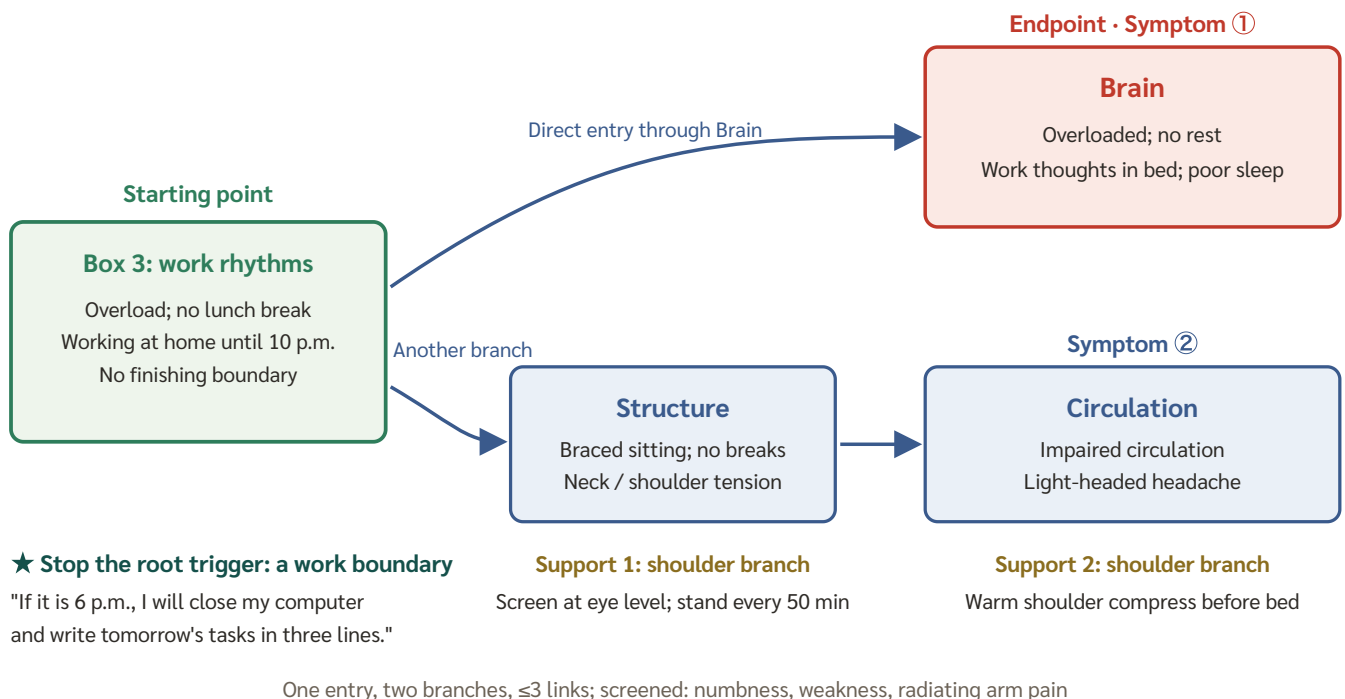


Figure 11.1 Ms A's chain of connections: one starting point in work rhythms, two branches leading to two symptoms, and three places to act.

Plearnprai maintains thirteen causal pathways as a source of hypotheses only. Comparing a story with this library to generate hypotheses is reasoning stage 5, a Thai traditional medicine practitioner's task. Guides use the patient's own suspected connection, as here. Every pathway has a paired danger route to check first. For the neck and shoulder branch, this includes numbness, weakness, and radiating arm pain, which I assessed at the first visit in Chapter 1.

The guide then asks, “What one change in this box might ease both branches?” Ms A chooses a work-ending boundary, because an unfinished working day follows her into bed.

Step 7: Address the cause. Her fourteen-day if-then step is: “If it is six in the evening, then I will close the computer and write tomorrow's unfinished work in three lines.” Her reason is her own: “If I write it down, my head can stop holding it.”

The step returns to the same Step 4 plan used in the upper circle, which continues. Her plan now has one root-level trigger-removal step and two supportive additions for the shoulder branch: raise the screen's upper edge to eye level and stand every fifty minutes; and use a warm shoulder compress before bed.

A new balance. At day 14, the guide confirms that she followed the plan on more than half the days, then asks the question. She falls asleep more easily, and symptom ① has fallen from 8 to 3. Her shoulders and light-headedness have also improved, meeting the paired criterion of symptom and chain improvement. She returns to the axis, maintains Wind-appropriate care, and keeps the work-ending boundary as a habit. I am very pleased for her.

I contributed twice: screening danger routes and ■ at the start, and reading her plan at follow-up. The remaining work did not require me.

Recall Chapter 1: I advised workstation changes and frequent breaks. That advice was sound and remains in her plan, but addressed only one branch. The circles reached the shared root: work rhythms without a finish. She chose the step, tied it to a real time in an if-then plan, and had someone review it at fourteen days. If colleagues ask what this adds to ordinary advice, my answer lies in that process more than in the advice itself.

The Reasoning and the Journey

The **eight reasoning stages** guide the person facilitating the process; patients need not see them. Guides use the abbreviated version—stages 1, 2, 3, 4, 7, and 8—following the patient’s own suspected connection. Full stages 5 and 6 belong to a Thai traditional medicine practitioner or physician.

Reasoning stage	Care Circles step
1: Screen before reasoning; 2: Listen before concluding	Step 1
3: Locate the endpoint and scan broadly	Step 5
4: Timeline; 5: Generate hypotheses; 6: Weigh them; 7: Find the first domino	Step 6
8: Check your reasoning and explain it to the patient	Step 7 and the plan

Physicians will recognise clinical reasoning. Stage 6’s five criteria are familiar: the cause precedes the symptom; a plausible mechanism exists; greater exposure worsens symptoms; secondary symptoms fit; and removing the exposure improves them. These adapt epidemiological causation criteria to one person. A rule I particularly value is to exclude a less likely but more dangerous pathway first—the “rule out the dangerous first” principle taught since medical school.

Stop One, Add Two—and the Practitioner’s Space

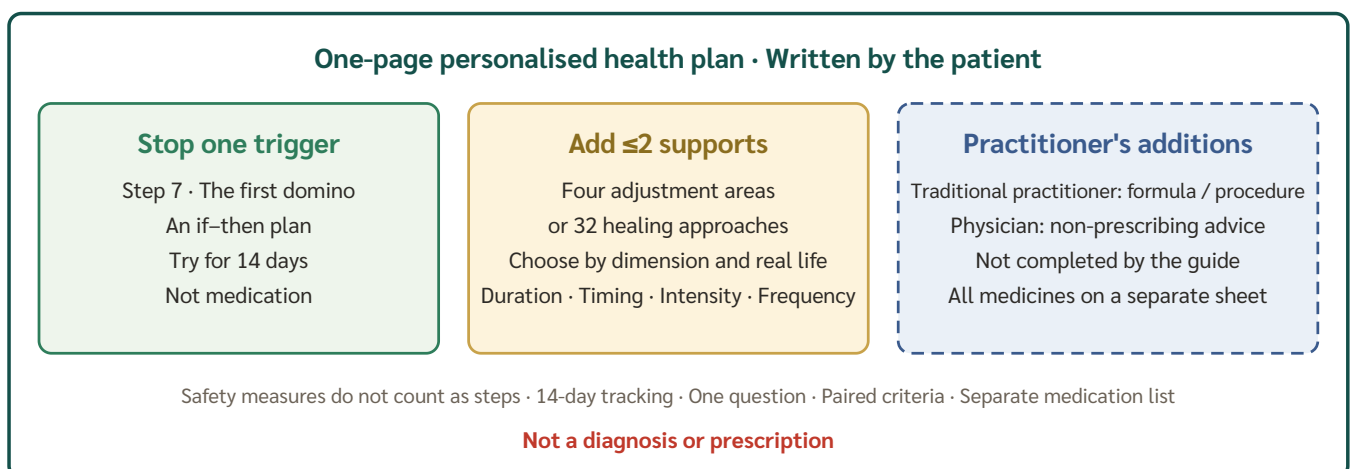


Figure 11.2 The personal health plan: stop one, add two, and the section completed by the physician.

The plan's rule is deliberately simple: stop one trigger, add no more than two supports. Safety instructions do not count towards the limit.

“One” reflects behaviour change: most people change a little at a time, and a five-item plan often becomes a plan nobody follows. “Two” preserves interpretability: if three or four additions help, we cannot tell which mattered; if they fail, we do not know what to change.

Supports come from what we call the **thirty-two healing disciplines**. Here “discipline” includes twelve major systems with their own principles and texts, such as Thai massage and yoga, and twenty individual practices usable at home, such as compresses and foot soaking. Selection follows the endpoint or intermediate dimension, filtered by the person's life and contraindications, then adapted to constitution using four controls: duration, timing, intensity, and frequency. Herbal heat exposure suitable for a Water-dominant person may need to be much shorter for someone Fire-dominant. Direction thus depends on how a method is used. Before heat treatment, hot compresses, or vigorous massage, vulnerable people and those on regular medication need physician or Thai traditional practitioner review under Chapter 8.

Only a licensed practitioner writes in “Practitioner's additions”: traditional formulas or procedures, and a physician's non-prescribing advice. Guides do not. The plan has no medication-adjustment field. All medicines, herbs, and supplements appear on the separate medication list, and prescribing changes remain in the physician's record.

Working with the Unit's Thai Traditional Medicine Practitioner

Many units already have Thai traditional or applied Thai traditional medicine practitioners. The lower circle lets the professions work on one sheet. The traditional practitioner:

- Assesses an unclear axis or marker.
- Resolves symptoms fitting two dimensions equally.
- Generates and weighs hypotheses from the pathway library: full reasoning stages 5 and 6.
- Adds formulas and procedures in the practitioner's space.

Traditional practitioners also teach levels 3 and 4. Level-3 VHV's may guide the lower circle with a level-3 traditional practitioner, nurse, or public health professional as adviser, as Chapter 12 explains. Physicians screen ►, receive the three exits, and retain responsibility for all conventional medicines. Questions about a medicine causing symptoms go to the prescriber or pharmacist.

Aunt La-or is a useful example. At her next visit she brings the decoction and records it on the medication list. This time she need not fear scolding. The pharmacist reviews concurrent medicines, the traditional practitioner reviews the formula, and the team watches for hypoglycaemia. I still cannot identify the cause of her glucose improvement, but everyone now knows what she takes.

Professional roles remain divided by licensure. Thai traditional examination, diagnosis, and treatment belong to practitioners licensed under the 2013 Act. Conventional diagnosis and treatment belong to us. Between them, exploring life circumstances and choosing one change belong to the patient and require no professional licence.

The Closest Evidence—and What Remains Untested

The closest evidence is Multiple Symptoms Study 3, described in Chapter 3. Specially trained family physicians met patients with multiple unexplained physical symptoms up to four times to acknowledge, explain, and act. PHQ-15 scores were 1.82 points lower than usual care at fifty-two weeks (Burton et al. 2024). The principle resembles the lower circle, but MSS3 used specially trained doctors throughout. Having guides perform non-medical parts remains untested.

The first-domino idea—that one change can often ease an entire chain—is a Plearnprai practice observation, not a research finding. The frequency of pathways and the fourteen-day interval are likewise unvalidated. Ms A’s story is one illustrative case and proves nothing. Chapter 14 returns to these questions.

A Second Case • D

D is a twenty-year-old student living in a dormitory, Fire-dominant, with two months of constipation (symptom ①) and worsening acne (symptom ②). A basic assessment at exit 2 and danger-route questions reveal no concern. After seven upper-circle days with a Moist marker, symptoms remain; because they have lasted over four weeks, D enters the lower circle.

The endpoint is Vitality: constipation accompanies late eating and incomplete digestion. Symptoms began after moving into the dormitory and using a phone in bed until midnight each night. The proposed chain begins in Screens, disrupts Brain’s body clock, and reaches Vitality, another branching pattern. D chooses the phone charger as the first domino: “If it is 11:30 p.m., then I will charge my phone outside the room.” Fourteen days later, constipation improves while acne changes little. Moist-side symptoms such as acne can be monitored beyond fourteen days, so D remains in follow-up.

I include this case because the lower circle also applies to young people with symptoms we have little time to explore and no medicine to offer, not only older adults with chronic disease.

A Small but Meaningful Part of This Box

Palliative and end-of-life care is small in numbers but large in meaning. I do not give it a separate box: it belongs to care from birth to death, not something beginning only after treatment ends.

At the end of life, symptom management belongs wholly to the medical team. The circles have no role in medication or medical decisions. They may still provide families with a language for comfort and emotional care: warmth and gentle touch for a cold-sensitive Wind person; a comfortably cool room and sips of water as advised by the care team for a Fire person feeling internal heat. Plearnprai’s aim here is “to leave peacefully, with the heart still full.” Home carers also need their own constitutional cards and plans, because those caring for others may be most vulnerable to imbalance.

Something to Try Tomorrow

From tomorrow’s list, choose one patient who has returned with the same symptom more than three times. Before prescribing, ask Step 6’s three questions: “What changed before this began?” “What makes it worse?” “What makes it better?”

If the answer identifies something changeable, invite the patient to choose one if-then step and arrange a fourteen-day review. A level-2 VHV or available traditional practitioner may ask the follow-up question.

These questions take about three minutes. For a repeatedly returning patient, I think that time is worthwhile alongside necessary examination. Chapter 12 considers who in your unit can guide the lower circle.

Chapter 12 • People and Systems: Who Navigates the Circles in Primary Care?

The Administrator's First Question

When I describe the Care Circles to administrators, their first question is usually not “Does it work?” but “Where will we find people to do it?” It is the right question, and one I share. Chapter 3 showed that family physicians number less than one third of what is needed, with little prospect of catching up this decade.

Perhaps we need not create a new workforce at all. More than a million people already reach patients' homes. What is missing is a ladder defining what each person can do, and a clear line marking when to refer.

A Four-Level Ladder

Plearnprai organises learning into four levels, called **Community Constitutional Literacy**. I use “level” for this ladder to distinguish it from the circles' seven steps.

- **Level 1: Know Your Constitution.** Understand “Who am I?” and “What suits me?” About three hours—the half-day station in Chapter 9.
- **Level 2: Understand Balance.** Recognise current direction and basic self-care; navigate the upper circle yourself. About nine hours over three sessions.
- **Level 3: Understand Starting Causes.** Explore why a shift occurs, locate the first domino, and begin guiding others through the lower circle. About eighteen hours over six sessions. This is the **guide** level.
- **Level 4: Community Knowledge-Sharer.** Guide independently and teach levels 1–2. About eighteen further hours.

The total is roughly forty-eight hours over eleven months. These are starting estimates to revise after the first cohort. More important than hours is the principle: level 2 is for oneself; level 3 and above is for guiding others. Nobody jumps from level 1 to guiding without first using the upper circle personally.

Level 3 begins with both red-flag levels and all three medical exits, before dimensions or connecting pathways. Anyone guiding another person must first know when to refer.

Boundaries Guides Must Not Cross

Before assigning levels to staff, the boundary needs to be clear enough to support legal compliance and clinical trust.

Guides may do four things: explain tools, invite questions, encourage reflection, and help record information.

They must not:

- Examine.
- Diagnose.
- Name diseases.
- Recommend or adjust medicines.
- Perform procedures in place of practitioners.

These are boundaries derived from two laws: the Thai Traditional Medical Professions Act 2013, reserving traditional examination, diagnosis, and treatment for licensed practitioners; and the Medical Profession Act B.E. 2525 (1982), reserving professional medical examination, diagnosis, treatment, and prevention for licensed physicians. Guides provide education and help people record their own experiences, outside those professional activities so long as they do not cross these five boundaries.

The shared rule every guide learns is: **If uncertain, refer.**

Placing the Ladder on the Existing Workforce

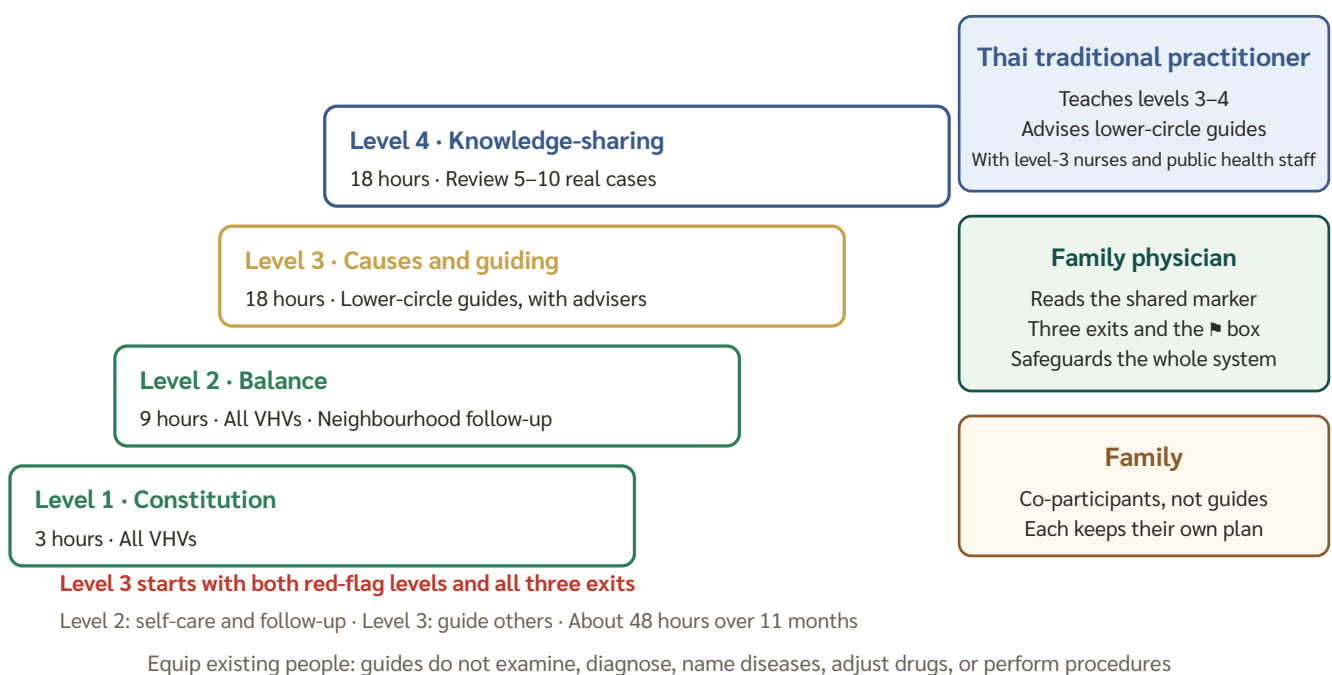


Figure 12.1 A four-level training ladder built around people already present in primary care.

This ladder can fit existing primary care personnel without creating new posts.

All VHV's: levels 1–2. Thailand's 1.1 million VHV's are our largest resource. Levels 1–2 take approximately twelve hours. Once volunteers understand their own constitution and upper-circle care, I expect home visits to change because they have language beyond blood pressure readings. Level-2 VHV's can ask the day-7 question and follow symptoms outside their household as follow-up supporters, completing Chapter 10's upper circle. Lower-circle guidance requires level 3.

Ready VHV: level 3. Not every volunteer needs this level, nor do I think all should reach it. Plearnprai's hypothetical planning figure is fifteen per hundred starters. Level-3 VHVs become village guides for eligible patients, supported by a level-3 traditional practitioner, nurse, or public health professional. Chapter 11 can then happen with physician time concentrated at the three exits. VHVs do not replace the medical team's chronic care. Select them by actual upper-circle experience and red-flag competence rather than seniority.

Thai traditional medicine practitioners: teachers and lower-circle support. Traditional or applied traditional practitioners have two roles: teaching levels 3–4, and supporting the lower circle. They perform full reasoning stages 5–6, assess unclear markers, add formulas and procedures in the practitioner's space, and review real cases submitted for level-4 certification. I welcome this role because it extends their work beyond massage and dispensing herbs. Primary care indicators for traditional medicine should count it too.

Family physicians: interpreting markers and safeguarding the system. Physicians read patients' markers in shared language and relate them to findings, gaining context more quickly within five minutes. Conflicting findings prompt ordinary clinical assessment. They also receive the three exits, manage ► issues, review every missed red flag and delayed referral, and decide whether the unit's system is safe enough to continue.

Nurses and public health professionals may participate at any level according to interest. Many could be excellent level-3 guides because of their knowledge and relationships with patients; after level 3, they can advise VHV guides. I do not make this compulsory: family care teams already have full workloads.

Certification—and Unresolved Questions

Level 4 requires five to ten real cases reviewed by a Thai traditional medicine practitioner. Every patient must consent, and cases must be anonymised. Level-4 participants do not independently certify learners or replace traditional practitioners in teaching levels 3–4. For level 3, we propose passing red-flag training, then guiding five practice cases, drawing the connections, and referring correctly in every case. That number remains a proposal.

Questions remain: how many practice cases are enough for level 3? Should each level's pass criteria be consolidated into one curriculum standard? Should the course seek recognition from the Thai Traditional Medical Council or another body to establish a clear role for guides? These questions belong as much to administrators as to me. Chapter 14 returns to the guide's status.

Family as Co-Participants

When I see children and grandchildren caring attentively for their parents, I want them to have a place in the circles. They do—but helping at home does not make someone a guide unless they have completed level 3. Every plan therefore separates two signatures: **“Family co-participant”** and **“Guide/practitioner.”**

Families can:

- Give reminders and help complete the tracking strip.

- Change household triggers together, such as dinner timing, late-night television noise, or bedroom screens.
- Care for themselves as carers, because caring for others can also lead to imbalance.

They do not guide a relative's lower circle without training. Our teaching phrase is: **"Act together; each person keeps their own plan."**

Structural Conditions the Model Must Fit

Three facts shape the model:

1. There are 5,123 registered primary care units against a target of 5,396, or 94.9%, under the Primary Health System Act (Ministry of Public Health 2025a). Infrastructure already exists across most of the country.
2. Of 9,878 subdistrict health-promoting hospitals, 5,176 have transferred to Provincial Administrative Organisations (The Coverage 2026). The model must work under both ministry and provincial administration and not depend on a single command structure. The ladder is therefore designed for community ownership rather than ownership by one agency.
3. The 1.1 million VHVs receive THB 2,000 monthly, approximately THB 25 billion annually (Ministry of Public Health 2024a). The funding exists. Chapter 14 asks what more it might achieve if volunteers had tools for understanding people alongside tools for measuring them.

Something to Try Tomorrow

Count the VHVs in your catchment and prepare one question for the next monthly meeting: "Would you be interested in a half-day session on understanding your own body, which you could also use in conversations during home visits?"

Those raising their hands become the first level-1 cohort. Someone asking, "What if I want to learn more?" may become the unit's first guide—after completing personal upper-circle practice. Once people in the village can navigate the circles, the picture widens to the whole subdistrict. That is Chapter 13.

Part 4 • Systems and Evidence

The final two chapters move from individuals to communities and cities. They close by distinguishing what has been demonstrated from what remains unproven, and offering proposals administrators can put into practice within twelve months.



Chapter 13 • From Households to Cities

If the Starting Point Is in a Life Box

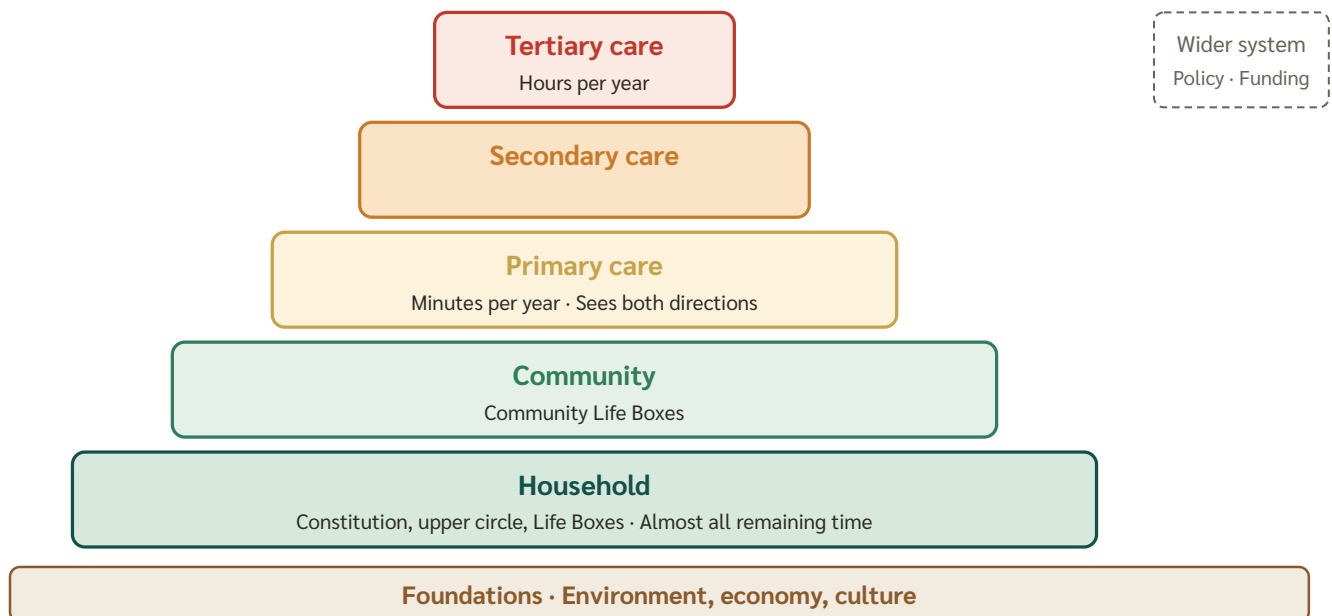
Uncle Chai's dinner table has been empty since his wife died early in the year. He ate alone for eight months, and his first step in Chapter 7 began at that table. Grandma Boonmee in Chapter 10 also ate dinner alone. Whenever I think of them, I wonder how many such tables exist in one subdistrict.

Part 3 considered individuals. Here I invite a wider view. If much discomfort begins in the Life Boxes—people, screens, rhythms, air, work, and intake—then shaping those boxes across a community is directly public health work. It is our work, not merely another ministry's work for which we request cooperation.

This is not a new idea. Social determinants appear in every public health textbook. What this book adds is a single language that can connect one patient's plan to a subdistrict development plan. The six boxes an individual points to are also boxes a community can identify.

Seven Layers, with the Weight at the Base

Plearnprai views the health system in seven layers: household, community, primary care, secondary care, tertiary care, the wider system, and the foundations—the environment, economy, and culture on which all layers stand.



Health's weight is at the base; primary care connects households and communities with clinical resources

Figure 13.1 Seven layers of the health system, with the greatest weight at the base, and primary care's position within them.

Unlike the familiar health-system pyramid, this picture places the weight of health at the base. A person spends a few hours a year in hospital, a few tens of minutes in primary care, and almost all remaining time in households and communities. That is where constitution, the upper circle, and Life Boxes operate. Primary care connects the two largest lower layers with the medically resourced layers above. Primary care physicians can see in both directions.

A Community's Life Boxes

Every individual box has a community counterpart. Primary care teams see many of them daily without a place to record them.

People and relationships: older people whose children have moved to cities, grandparents raising grandchildren, and people eating alone. A shared community dinner table may therefore be public health work that the system has never counted.

Screens and information: schoolchildren across a village staying up with phones, and older people receiving inaccurate health information through LINE groups. Primary care can reach this box through schools and those same groups.

Work and social rhythms: factory shifts, agricultural seasons, and religious festivals determine when a subdistrict sleeps throughout the year. The individual “disrupted rhythm” hypothesis may have a community version.

Air and living environment: fine particles during burning seasons, urban heat without shade, poorly ventilated homes, and planning that discourages walking. This directly connects public health with local public works and environmental management.

Work and bodily use: local occupations—rubber tappers rising at two, rice farmers bending throughout planting season, factory workers standing for eight hours. Our clinical term is occupational health.

What people eat, drink, inhale, and apply: local food, market offerings, agricultural chemicals, and drinking water. Chapter 9's constitution-sensitive meals can extend to school and market menus.

The community **box** concerns safety: outbreaks, poisoning, and accidents, areas where existing disease-control systems already work well.

My one request to primary care units is to aggregate lower-circle starting-point boxes annually, anonymised and only with patients' consent. Which box is identified most often in your catchment? It may become next year's subdistrict health-plan priority. This uses patient plans to inform community design without another survey.

Community Constitutional Literacy and Four Pillars of Community Assets

With community development partners, we have developed a model using the ladder's name, **Community Constitutional Literacy**. The network views community assets through four pillars: natural resources, local knowledge, four life-stage groups, and an economy that builds the asset base. My positioning principle is that health is not a fifth pillar: it is the person standing among the four. When people become ill, all four weaken together.

Elemental language can enter each pillar. In Nature, forests and gardens offer sensory adjustments, and seasonal living draws on local resources. In Knowledge, elements help explore why ancestral practices may work and for whom, with recognised local indigenous healers—not Plearnprai—as teachers of their own traditions. In Life Stages, Thai texts already connect age and elements, and schools quickly carry knowledge home. In Economy, locally made products adapted to constitution carry a story, while workers able to care for themselves are another form of capital.

I do not expect primary care to replace community development work. I hope a shared language enables conversation with development, schools, agriculture, and tourism in the same subdistrict—something public health indicators alone cannot do.

Connecting with Existing Mechanisms

Several local mechanisms could support this work.

Local or area health security funds: under National Health Security Board announcements, these may support community organisations’ or groups’ promotion and prevention activities, including training. Stations and levels 1–2 may therefore be proposed as community-group projects, subject to each fund’s formats and criteria.

Community-led subdistrict health management: this structure lets communities analyse problems and create their own plans. Aggregated Life Box information can be used directly.

Social prescribing: primary care referrals to community activities alongside medical treatment. England recorded approximately 1.3 million such referrals in 2023 (Bu et al. 2025). Thailand already has older people’s clubs, exercise groups, and temples, although we have not routinely counted them as treatment. The circles give them a place on the plan. Uncle Chai’s weekly temple club and Grandma Boonmee’s dinner with a neighbour become social participation written into their own care.

England also offers a caution. Despite rapid expansion, outcome evidence remains thin, trials have not shown consistent effects, and clear cost-effectiveness evidence is lacking (Kiely et al. 2022). An appealing idea can spread before anyone measures it, leaving little to examine when proof is requested. I do not want the Care Circles to repeat that pattern. The next chapter therefore proposes measurement from the first patient.

Evidence on Strong Primary Care

Since training, I have often returned to Barbara Starfield’s work. Countries with stronger primary care had lower premature mortality and expenditure; US data associated one additional primary care physician per 10,000 people with approximately 5–6% lower mortality (Starfield et al. 2005). This is correlational, not causal evidence, but its direction is clear enough to guide me.

Starfield identified four attributes: first contact, continuity, comprehensiveness, and coordination. The circles might contribute to two. Her **continuity** means a long-term relationship with the same provider; the circles cannot replace that relationship, but may help care continue between visits. For **comprehensiveness**, they add patient-held tools across all three boxes. First contact and coordination remain with the existing system, which already performs them well.

Something to Try Tomorrow

Ask one VHV for last month's home-visit records and read them together. Count which Life Boxes appear in the stories. An afternoon may be enough to see the same village differently.

Once a unit has about ten lower-circle patients, place their starting-point boxes on one sheet. Perhaps People and Relationships appears more than any other. If so, the subdistrict may need a place to eat together more than another hypertension clinic day.

That "perhaps" needs measurement. The final chapter distinguishes what we know from what we do not.

Chapter 14 • What Is Established, What Is Not, and a Pilot Plan

Closing with Honesty

From Chapter 1, I promised to identify what remains unproven. This chapter gathers those statements so colleagues and administrators can see the whole picture before deciding.

The system's value today does not lie in proven effectiveness. It lies in being safe, clearly bounded, measurable, and ready to test—four qualities not all health innovations brought to us possess.

What We Know—and What We Still Need to Learn

The tools build on Thai traditional medicine; their organisation into Care Circles is Plearnprai's. I separate the account into two sets.

Supported by existing evidence:

- Intensive lifestyle change works, and effects diminish over time (DPP).
- Consultation-based physical activity advice works, but effects are small (van der Wardt et al., BJGP 2021; Kettle et al., BMJ 2022).
- Home blood pressure monitoring alone does not significantly reduce blood pressure; intensive support, mainly systematic medication adjustment, produced a 6.1 mmHg reduction (Tucker et al., PLoS Medicine 2017). TASMINH4 likewise used home readings to adjust medication. Recording needs connected action.
- Patient-held records have no clear established benefit, with low-quality evidence (Ko et al. 2010).
- Shared, acceptable explanations delivered by specially trained physicians can reduce unexplained physical symptoms (MSS3, Lancet 2024).
- Self-management support is the most commonly used component of chronic care programmes, but the effective component cannot be isolated (Davy et al. 2015).
- Stronger primary care is associated with lower mortality and expenditure; this is correlational evidence (Starfield).

What we are learning and will measure in the pilot:

- Patient-data-linked non-drug action of the kind proposed here remains untested.
- My inference that patient-held tools may work when linked to explanation and action was not tested by Ko et al.
- Validity of the constitutional questionnaire.
- Placement of seven constitutions on six poles.
- The first-domino rule.
- Thresholds of seven days, fourteen days, four weeks, and three episodes.
- Dimensional action labels for thirty-two healing disciplines.
- Frequencies of the thirteen causal pathways.

- The hypothetical 100/60/25/15/5 learning funnel and forty-eight training hours.

The first set is the evidence on which this system stands, not evidence this system has produced. The second is Plearnprai's construction and needs testing. Its design aligns with the first set: time boundaries and return cycles, action beyond recording, and shared explanation inspired by MSS3. Alignment, however, is not proof.

Knowledge Gaps to Close

After two rounds of review, the team identified five priorities:

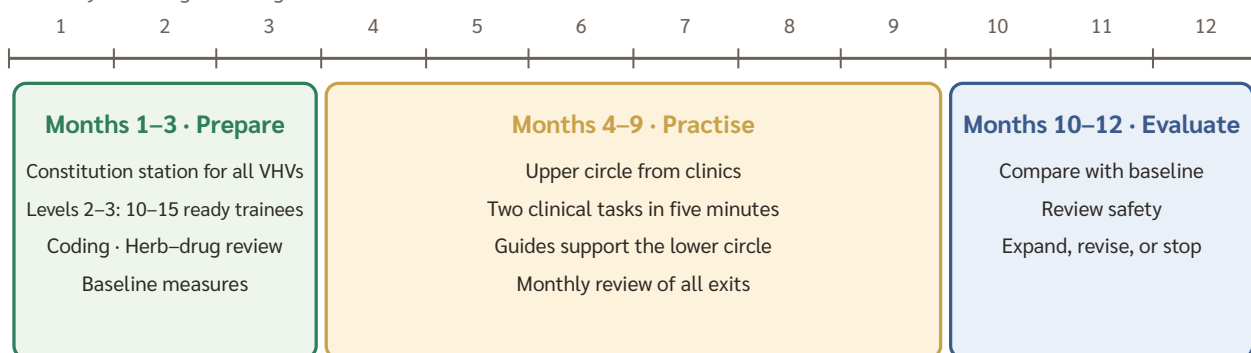
1. **Questionnaire validity:** how closely self-recognition agrees with a traditional practitioner's assessment, and whether repeat results are stable.
2. **Inter-rater agreement:** whether two guides working with the same person identify the same endpoint and first domino.
3. **Terminology mapping to ICD-10 and ICD-10-TM:** enabling plan data to enter existing reporting without a parallel system.
4. **Condition-specific pathways:** mapping each upper-circle step to ministry guidance for hypertension, diabetes, and dyslipidaemia.
5. **Herb–drug safety:** systematically reviewed by pharmacists, building on Plearnprai's central list maintained separately from the textbook.

These need not all be completed before piloting, but should be incorporated into it.

A Twelve-Month Pilot in One Primary Care Unit

One unit · ~10,000 residents · Uncontrolled NCD and unexplained symptoms: 50–100 each

Voluntary · Red-flag screening and basic assessment first



Primary: BP · HbA1c · Symptom ① · Repeat visits · Appropriate referrals · Missed red flags = 0

Secondary: constitutional literacy · Level-3 guides · ≥half of days followed · Guide agreement

Not an RCT: tests feasibility, safety, uptake and trends · Existing promotion and traditional medicine funds

Figure 14.1 A twelve-month pilot in one primary care unit.

I propose something small enough for one unit and measurable enough to answer initial questions.

Where: one primary care unit with a family physician, a Thai traditional medicine practitioner, and willing VHVs, serving approximately 10,000 people.

Who: people whose chronic conditions have remained above target for over a year, and people with persistent symptoms despite normal investigations—fifty to one hundred in each group, participating voluntarily after red-flag screening and basic assessment.

Months 1–3: prepare. Hold stations for all local VHVs; train willing volunteers to level 2 and ten to fifteen ready volunteers and staff to level 3, taught by a traditional practitioner. Develop coding correspondence and review herb–drug issues in parallel. Obtain research ethics approval, prepare consent materials, and collect baseline measures.

Months 4–9: use the circles. Recruit through chronic care clinics and consultations. Physicians perform the two tasks within the five-minute visit. Level-2 VHVs ask the day-7 question and follow symptoms as supporters. Level-3 volunteers and staff guide eligible patients through the lower circle, with a level-3 traditional practitioner, nurse, or public health professional as adviser. The physician reviews every case using a medical exit each month.

Months 10–12: measure and decide. Compare outcomes with baseline and with non-participating patients in the same unit. Review all safety events, then decide whether to expand, revise, or stop.

Primary measures:

- Blood pressure and HbA1c in the chronic disease groups.
- Patient-scored symptom ①, recorded in every plan.
- Visits for the same symptom.
- Proportion of appropriate referrals.
- Safety: missed red flags, with a target of zero, and herb–drug adverse events.

Secondary measures:

- Households knowing their members' constitutions.
- Number of level-3 guides.
- Patients following the plan on at least half the days.
- Agreement between guides.
- Date of symptom ① improvement, starting Life Box, and first domino for every case, to examine timing rules and domino hypotheses.

What this design cannot claim: it is not a randomised trial and cannot establish that the circles themselves outperform usual care. It can assess feasibility in a real unit, safety, uptake, and the direction of outcomes. Those questions should be answered before a larger trial is justified.

Proposals to Health Regions and NHSO

My proposals use existing funding:

1. **Promotion and prevention funding:** approximately THB 410 per Thai citizen in fiscal year 2026 could potentially support stations and levels 1–2, which are promotion and prevention activities,

or support them through local health security funds.

2. **Traditional medicine funding:** the fiscal-year 2026 allocation of THB 63.24 per person could support traditional practitioners' teaching and assessment roles in the lower circle. I also propose counting this work in the primary care traditional and alternative treatment indicator, beyond massage and herbal dispensing. Current performance remains below target; counting only services may never reach promotion and prevention.
3. **VHV roles:** formally include level-2 follow-up support and supervised level-3 lower-circle guidance in the unit's chronic care work. Add tools rather than allowances, and assess patient outcomes alongside numbers of measurements and records.

Items 1 and 3 may be decided regionally; changing indicator definitions under item 2 requires ministry-level action. I therefore address both regional clinicians and administrators and national policymakers.

Questions Still Open

Some questions remain for readers.

What should a guide's formal status be: a VHV role, a professionally recognised curriculum, or informal community learning? Each has trade-offs. The pilot should inform the answer.

How will circles data fit the unit's information system? A parallel system disconnected from reporting may not survive, like many earlier innovations.

Who owns this knowledge? Plearnprai organises it but intends community ownership, and indigenous healers were there before Plearnprai. How does knowledge in a textbook become a community's own? I do not yet know.

Something to Try Tomorrow

Send this book to another family physician, one traditional practitioner, and one VHV. Ask which chapter makes each want to try something. If you are an administrator, place the pilot page on the next network meeting's agenda to select a pilot unit.

If the three answers align, that may be a beginning. If not, the difference is information I need for the next edition. Before closing, I leave these final words.

Closing Words

Elements, disease origins, causal factors, medicinal tastes, things that disagree with a person, and assessing capacity before prescribing are old knowledge, present in classical texts for centuries and in everyday Thai speech: hot-hearted, cool-hearted, heavy-hearted, light-hearted.

I do not know how effective the Care Circles will be. I know that in Chapter 1 Uncle Chai, Ms A, and Aunt La-or left my room with nothing that was truly theirs. That is what I want to change.

Across the book, each acquires something small of their own. Uncle Chai has dinner at the table. Ms A chooses a finishing boundary for work. Aunt La-or brings her decoction to the pharmacist and traditional practitioner. I still do not know whether Uncle Chai's blood pressure will fall, but I am glad

all three now hold something in their hands.

This book does one new thing: it places old knowledge within one circle and hands it to patients, while their clinicians remain beside them at every step.

Appendix A · Two Red-Flag Levels, Four Referral Questions, and Three Medical Exits

This appendix uses Plearnprai's central red-flag list (October 2026), shared and updated across all textbooks and worksheets. Implementing units should always use the latest version and must not copy this page into independently modified lists.

Level 1 · Emergency: call 1669 immediately. Do not continue self-care.

- Difficulty breathing, breathlessness, or blue discolouration.
- Altered consciousness, confusion, marked drowsiness, or inability to wake.
- Sudden severe pain described as the worst in one's life.
- Major injury or bleeding that does not stop.
- Fever above 39°C, or above 38°C in an infant.
- Stroke-like symptoms: facial droop, weakness or numbness on one side, slurred speech, sudden blurred vision, abrupt severe headache, or dizziness so severe that walking is impossible.
- Possible myocardial ischaemia: chest pressure or pain radiating to the arm, jaw, or back; sweating; palpitations with near-fainting.
- Loss of consciousness, seizure, or unexplained fainting.
- Vomiting blood, bloody or black stools, or coughing blood.
- Thoughts of self-harm or wanting to die: call 1323 and do not leave the person alone.

Level 2 · See a physician promptly, before beginning self-care.

- Possible cancer warning signs: unintentional weight loss, a lump, a non-healing wound, abnormal bleeding, persistent cough or hoarseness, difficulty swallowing, or sustained change in bowel habits.
- Severe depression lasting more than two weeks and preventing everyday functioning, or an abnormally elevated mood.
- Palpitations, dizziness, or near-fainting in an older person.
- Fever lasting several days.
- Swelling of one leg, or swelling with breathlessness that prevents lying flat.
- A clear unexplained loss of strength accompanied by weight loss, breathlessness when lying flat, or swelling.

Groups requiring medical assessment first when symptomatic: pregnant or breastfeeding women; infants under one; young children with fever; adults over seventy; older people who have fallen; and people with immunosuppression or chronic disease.

Four referral questions:

- 1: A level-1 flag means immediate hospital care; a level-2 flag means prompt medical assessment.
- 2: Vulnerable groups should attend a primary care unit or clinic earlier than usual.

- 3: Acute symptoms suitable for safe self-care and not conflicting with regular medication may be monitored for forty-eight hours. Refer if unchanged or worse.
- 4: If none of 1–3 applies, attend a primary care unit or clinic.

Three medical exits:

- Exit 1: the first step, when a red flag is found.
- Exit 2: entry to the lower circle, for symptoms lasting over four weeks without prior assessment.
- Exit 3: review of the new balance, when symptoms worsen or new red flags appear.

If uncertain, refer.

Not a diagnosis or prescription.

Appendix B • Terminology across Thai Medicine, Plearnprai, and Conventional Medicine

This starting table helps primary care teams share a language. It is not a complete equivalence map; the last row identifies unfinished work.

Thai traditional medicine	Plearnprai	Closest conventional concept
Dominant constitutional element	Constitution X: three main elements, seven types	No direct equivalent; a family physician's knowledge of the person
Excess, deficiency, derangement	Current direction ▲ on the six-pole wheel	Chief complaint
Disease origins: age, season, time	Context around the axis: age and season	Age-related risk; disease seasonality
Opposing medicinal tastes	"The opposite is the remedy"; four adjustment areas	Lifestyle advice
Eight causal factors	Seven Foundations of Life; 6+1 Life Boxes	Biopsychosocial model; social determinants
Forty-two elemental components	Five dimensions	Review of systems
Traditional history-taking and examination	Eight reasoning stages	Clinical reasoning
Formulas and manual procedures	Practitioner's additions to the plan, entered by a traditional practitioner	Prescription; procedure. Conventional medicines remain in the medical record, not the plan.
Things that disagree with a person	Moderation guidance on constitutional cards; safety instructions	Contraindication; precaution
ICD-10-TM disease codes	Not yet mapped	ICD-10

Mapping plans to ICD-10 and ICD-10-TM for routine reporting is a gap to address before piloting, with a physician, traditional practitioner, and the unit's information-system staff working together.

Appendix C • Forms for Primary Care Units

Personalised health plan

Name ____ Start date ____ Recurrences ____

Axis Constitution X ____ Daily adjustment ____

Step 1 Symptom ① ____ Score _/10 ② ____ ③ ____

Safety: Level 1 ☐ Level 2 ☐ Vulnerable group ☐ None ☐

Step 2 Marker ▲ ____ Capacity: ① ☐ ② ☐ ③ ☐ = high / moderate / low

Step 3 Adjustment 1 ____ 2 ____ (opposite ▲; seven days)

Thresholds >4 weeks ☐ ≥3 episodes/3 months ☐ Upper circle 14 days ☐ Assessed ☐

Step 5 Endpoint (dimension of symptom ①) ____

Step 6 Starting Life Box ____ ★ First domino ____

Step 7 One trigger-removal step: If ____ then ____ (14 days)

Plan Add ≤2 supports: 1 ____ 2 ____ Safety measures ____

Practitioner Formula, procedure, non-prescribing advice ____

Separate list All medicines, herbs, supplements → Medication list for doctor/pharmacist

14-day tracking: record honestly, including missed days

1

2

3

4

5

6

7

8

9

10

11

12

13

14

Day 7: ① _/10 Better ☐ Same ☐ Worse ☐ Day 14: _/10 Better ☐ Same ☐ Worse ☐

Paired criteria: symptom ① improves ☐ AND starting/intermediate point improves ☐

Family co-participant _____ Guide/practitioner _____

Not a diagnosis or prescription • Never change prescribed medicines yourself • Emergency: 1669

Figure C.1 Outline of the one-page personal health plan. The working form belongs to Plearnprai's worksheet set.

One-page personalised health plan. Fields follow this sequence: axis (constitution X) → upper circle (symptoms ①②③ and scores; safety check; ▲; three capacity questions; one or two adjustments) → thresholds (onset date; recurrence count) → lower circle (endpoint; starting Life Box; first domino) →

plan (one if–then trigger-removal step; no more than two supports; safety instructions) → practitioner’s additions (traditional formulas and procedures; non-prescribing medical advice) → follow-up (fourteen-day strip; single review question) → signatures for family co-participant and guide/practitioner. There is no medication-adjustment field. Every sheet states “Not a diagnosis or prescription.” The patient writes it.

Medication List to Take to the Physician or Pharmacist. A separate sheet records all conventional medicines, herbs, and supplements and accompanies every physician, pharmacist, or traditional practitioner visit. The prescriber or pharmacist checks interactions. Do not stop, reduce, or adjust prescribed medication independently. Medication changes belong in the physician’s record, not the plan. The sheet states “Not a diagnosis or prescription.”

My Constitutional Card. Front: constitution, X on the wheel, and one or two everyday adjustments. Reverse: things to use in moderation; the Seven Foundations daily checklist; 1669 and 1323; and “If you have a chronic condition, consult your physician before major dietary changes.”

Fourteen-day tracking strip. One box per day, completed honestly including missed days. Days 7 and 14 include symptom ① scores and the response: better, unchanged, or worse.

Appendix D • Relevant Laws and Policies

Instrument	Relevance to this book	Source
Primary Health System Act B.E. 2562 (2019)	Section 3 defines primary care units, networks, family physicians, and primary care teams; population registration; section 43 requires complete provision of units within ten years.	Royal Gazette, vol. 136, part 56 A, 30 April 2019
Thai Traditional Medical Professions Act B.E. 2556 (2013)	Section 3 includes advice, prevention, and promotion in the definition of practice. Section 31 prohibits unlicensed practice, with exceptions including self-care, unpaid assistance, and recognised indigenous healers. Section 53: up to three years' imprisonment, THB 60,000 fine, or both.	Royal Gazette, vol. 130, part 10 A, 1 February 2013
Medical Profession Act B.E. 2525 (1982)	Section 4 defines medical practice including examination, diagnosis, treatment, and prevention. Section 26 prohibits unlicensed practice, with exceptions such as self-care and unpaid moral assistance, excluding surgery, injections, needling/acupuncture, and dangerous medicines.	Royal Gazette, vol. 99, special part 111, 11 August 1982
Ministry regulations on recognition of indigenous healers, B.E. 2562 (2019), as amended	Minimum age thirty-five; local residence and inherited knowledge for at least ten years; community recognition; certification valid five years. Amendments extend to the fourth version, B.E. 2568 (2025).	Royal Gazette, vol. 136, special part 146 D, 10 June 2019; Department of Thai Traditional and Alternative Medicine
National Health Security Board announcements on local/area health security funds	Support promotion and prevention by local organisations, public groups, or other bodies, including training.	Announcements of B.E. 2561 (2018), B.E. 2567 (2024), and amendments
Primary care traditional medicine indicators	Fiscal 2020 target: 19.5% of outpatient encounters. Fiscal 2026 target: at least 50% of primary care encounters involving traditional/alternative treatment. Herbal prescribing failed the fiscal 2025 criterion.	healthkpi.moph.go.th; Ministry action-plan evaluation 2025

Instrument	Relevance to this book	Source
National Health Security Fund, fiscal 2026	Capitation THB 4,175.99 per Universal Coverage beneficiary; promotion/prevention THB 27,761.92 million across all Thai coverage groups, about THB 410 per person; traditional medicine THB 63.24 per person.	Cabinet resolution, 4 February 2025; NHSO
WHO Global Traditional Medicine Strategy 2025–2034	Adopted at the 78th World Health Assembly, May 2025. Four objectives: evidence; safety and regulation; health-system integration; cross-sectoral value.	WHO 2025

This table provides an overview, not a legal opinion. Implementing units should read the full Royal Gazette texts and consult their own or their provincial health office’s legal adviser.

Appendix E • References

In-text citations identify authors or organisations and publication year. Bold labels below match those citations. Thai-language documents are listed first in the original edition's order, followed by English-language documents. In this English edition, Buddhist Era publication years are converted to Common Era years; Thai legal titles retain both dating systems. English renderings of Thai document titles below are descriptive translations.

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- **Ministry of Public Health 2024b** · Ministry of Public Health. Support for expanding the National List of Essential Herbal Medicines to 106 items. Press release, 6 November 2024. Nonthaburi: the Ministry; 2024.
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- **Ministry of Public Health 2026** · Ministry of Public Health. Indicators under the ministry's government action plan, fiscal year 2026 [Internet]. Available from: <https://healthkpi.moph.go.th>
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Figure Reading Key · The Six-Pole Wheel

The English text from Figures 7.2 and 10.2 is repeated here at reading size. Pole labels describe the author's framework; they do not replace the safety screening in Chapter 8.

Hot · Symptoms and Care

Symptom pattern: Outward · fast

Eating, sleeping and elimination. Dark urine; hard stool. Cannot fall asleep: the mind keeps working on tasks and goals.

Mind. Impatient; irritated by delays or unmet wishes. Disproportionate anger, then regret. Must win or be right; hurries others. Each achievement needs another goal.

Body. Heat intolerance; flushing, red face or eyes. Craves cold drinks and air conditioning. Mouth ulcers, bitter taste, heartburn. Hot red itchy rash, worse with warmth or sun; hives; inflamed acne. Still energetic despite heat. Worse late afternoon; afternoon headaches.

Distinguishing feature. Hot but still energetic; feels better with cooling.

Care direction: Gentle coolness · water · less fuel

Physical activity. Swim or walk slowly in shade; mild to moderate effort. Avoid midday sun. Cool stretches for 5 minutes after work.

Mind care. Pause before answering; lengthen the exhale. Finish unresolved conversations without bottling up or exploding. One goal a day; a non-competitive hobby.

Sensory input and environment. Shade, breeze, plants and water sounds. Room-temperature bathing. Bed before 22:00 in a dark, quiet, cool room. Avoid caffeine and screens after dark.

Food. Watermelon, coconut water, watery vegetables, cucumber, winter melon, gourds, bitter melon and gotu kola. Boil, steam or blanch. Avoid fried or charred food, large meat meals, alcohol and coffee. Sip room-temperature water.

Guiding principle. Moderate cooling, not extreme cold that suppresses digestive fire.

Caution. Avoid sauna, sun, intense spice and alcohol. Hot but dry and depleted: avoid extreme cooling or draining; replenish moisture and sleep.

Light · Symptoms and Care

Symptom pattern: Mobile · drifting

Eating, sleeping and elimination. Irregular eating and sleeping. Wakes at night with thoughts jumping between topics.

Mind. Scattered thoughts; surges of anxiety. Many starts, few finishes. Changes mind after the last conversation. Alternates between wanting and not wanting.

Body. Floating, ungrounded, little sense of feet. Restless, easily startled. Intermittent palpitations, unsatisfying breaths, frequent sighs. Migrating pain; shooting pain, tingling or numbness. Spinning vertigo. Thin, losing muscle; movement increases fatigue and the wish to stop.

Distinguishing feature. Easy to start; more activity brings more scattering and fatigue.

Care direction: Grounding · warmth · moisture · regularity

Physical activity. Slow held stretches and balance work. Slow barefoot walking on grass. Repetitive hands-on tasks, gardening or baking.

Mind care. Finish one thing before starting another. Write down decisions. Repeat routines until automatic; exhale longer than you inhale.

Sensory input and environment. Regular sleep and waking. A weighted blanket or warm oil massage. Quiet warmth, no drafts. Reduce caffeine, screens, news and information after dark.

Food. Regular meals, never skip; breakfast protein. Rice, sticky rice, pumpkin, taro or yams; warm cooked food, thick soups and healthy fats. Sesame, bananas. Sit and eat with others, away from work.

Guiding principle. Repetition grounds; avoid changing many things at once.

Caution. Avoid coffee, skipped meals, cold raw food and exhaustion. Unusually elevated mood, little sleep without fatigue or overspending: seek medical assessment.

Dry · Symptoms and Care

Symptom pattern: Less cushioning · reduced neutrality

Eating, sleeping and elimination. Hard pellet-like stool, difficult to pass. Shallow sleep.

Mind. Tiny things irritate: chewing, typing, slow walking. Sarcastic, cold; others feel burdensome. Dislikes touch or questions. Rigid control and perfectionism. Wants to cry but cannot. Small pleasures lose their appeal.

Body. Dry mouth, throat and stinging eyes; dry tickly cough without phlegm. Flaky itchy skin; cracked heels or lips; dry hair, hair loss. Stiff, clicking joints improve with oil massage. Water does not relieve dryness. Air conditioning, wind or dry air trigger it. Thinner, tense and fatigued.

Distinguishing feature. No cushion: every contact lands directly and hurts.

Care direction: Moisture · warmth · healthy oils

Physical activity. Gentle walking, stretching and joint movements each hour. Swimming or a warm soak. Avoid exhausting, sweat-heavy exertion.

Mind care. Touch, hugs, massage, music, art and unstructured leisure. People with whom there is nothing to prove. Restore cushioning rather than adding information.

Sensory input and environment. Oil immediately after bathing. Short, not very hot baths. No direct air-conditioning draft. Regular, deep sleep; warm compresses on joints.

Food. Sip a little warm water throughout the day instead of gulping. Porridge, soups and broths, including bone broth. Healthy fats at each meal: sesame, avocado. Mucilaginous foods: okra, ivy gourd, soaked basil seeds.

Guiding principle. Retain moisture, not just more water; replenish deficiency gently.

Caution. Avoid forced fasting, detoxing, prolonged sauna or exhaustion. Flushing with dryness: avoid extreme cold; replenish and restore sleep.

Cold · Symptoms and Care

Symptom pattern: Inward · slow · deficient

Eating, sleeping and elimination. Little hunger; bloating, fullness and sleepiness after food. Cold food triggers bloating or loose stool with undigested food.

Mind. Wakes with nothing to look forward to. No anger or self-protection even when warranted. Agrees because resisting takes energy. Former desires lose meaning; withdraws from work and people. Flat rather than sad.

Body. Feels cold; cold hands and feet; pale face and lips; quiet voice. Wants warm food and drinks, little thirst. Clear nasal discharge, sneezing or congestion in cold air or mornings, relieved by warmth. Dull aches improve with warmth. Slow from lack of fire, without swelling; hard to wake.

Distinguishing feature. Better with warmth. “Would you get up if it mattered?” — “I don’t know.”

Care direction: Warm, cooked, digestible · kindle digestion

Physical activity. Warming movement; stop before breathlessness. Morning brisk walking. Stretch before getting up; whole-body household tasks.

Mind care. One small daily task. Meet a friend who gives you a sense of belonging regularly. Ten minutes of an old hobby; no grand goals.

Sensory input and environment. 15 minutes of morning sun. Warm blankets and socks, no drafts. Warm foot soaks before bed or warm herbal compresses.

Food. Ginger, galangal, lemongrass, cinnamon and pepper in cooking. Hot soups or stews; warm ginger drink before food; warm breakfast. Avoid iced drinks and cold raw food.

Guiding principle. Gentle warmth, not intense pungency.

Caution. Deficiency: do not force. If heavy and swollen, warm before draining. Flat mood / no interest for more than 2 weeks: see a doctor.

Heavy · Symptoms and Care

Symptom pattern: Less movement · accumulation

Eating, sleeping and elimination. Heavy meals bring sleepiness and heaviness. Sleep never feels enough; snoring, unrefreshed waking, hard to get up.

Mind. Knows what to do but cannot begin. Emotionless procrastination—not fear or regret, but no starting energy. Holds to old methods despite poor results. Identical days lead nowhere.

Body. Heavy body and legs; hard to rise. Heavy, dull head, as if bandaged. Morning facial puffiness, tight rings; pitting swelling, tight shoes by evening. Much white or clear morning phlegm. Heavy eyelids, daytime sleepiness; avoids movement and going out. Worse on cool damp rainy days; better after moving.

Distinguishing feature. Hard to start, but once moving, feels better.

Care direction: Awaken · lighten · smaller amounts · move

Physical activity. Get up each hour. Walk 10 minutes after meals. Daily brisk walking, gradually enough to sweat; stairs.

Mind care. Agree to just 5 minutes. Small successes, short deadlines, someone waiting. Avoid large plans.

Sensory input and environment. Rise early, avoid long naps. Morning sun; open windows. Bright, uncluttered home; go out, try another route.

Food. Smaller plates; stop at 70% full. Light evening meal before 19:00. Less salt, sugar, refined grains and milk. Bitter or astringent vegetables, brown rice, ginger and pepper.

Guiding principle. Small and frequent, not one enormous push.

Caution. Increase movement gradually; check joints and heart first in older people or those with illness. One swollen leg or inability to lie flat from breathlessness: red flags.

Moist · Symptoms and Care

Symptom pattern: Water, oil, heat · accumulation

Eating, sleeping and elimination. Yellow or green sticky, smelly phlegm or nasal discharge; yellow itchy, smelly vaginal discharge. Sticky, strong-smelling stool, incomplete emptying. Worse after sugar, fat or milk.

Mind. Loops around people and feelings: longing, worry, regret, guilt. Takes on the household's emotions. Compassion prevents decisions; cannot let go. Tears bring no relief. Much sleep, yet wakes tired.

Body. Oily skin and face, blocked pores and pustules. Sticky sweat, strong body odour; still feels unclean after bathing. Weeping rashes in folds or groin; recurrent fungal infection. Thick sticky tongue coating. Worse in hot stuffy weather; better in dry airy conditions.

Distinguishing feature. Oily, sticky, coloured, smelly: takes things in but cannot let them out.

Care direction: Stop feeding · restore flow · airiness

Physical activity. Brisk walking continuously for 30 minutes to sweat, then bathe immediately. Avoid stuffy surroundings.

Mind care. Write looping thoughts down; set a time limit. Close one unfinished task. Declutter. Talk about small issues early.

Sensory input and environment. Breathable clothes; dry skin folds, change damp clothes. Sun bedding and ventilate rooms. Regular waking; do not oversleep.

Food. Cut sugar, milk, fried food, alcohol and refined flour. Bitter / astringent vegetables, bitter melon, turmeric, local vegetables, fibre and appropriate fermented food. Meals 4–5 hours apart, no snacks.

Guiding principle. Stop feeding accumulation, then restore flow; assess over months.

Caution. Already some heat: avoid intense warming, spices or prolonged heat. Fever, much pus, rapidly spreading rash or fungal infection: see a doctor.

Similar Symptoms · Distinguishing the Poles

INSOMNIA — Hot: cannot fall asleep, task-driven mind. Light: wakes, thoughts jump. Dry: shallow sleep. Moist: much sleep, still tired.

IRRITABILITY — Hot: delays / unmet wishes. Dry: friction, no cushion. THOUGHTS — Moist: same people / feelings. Light: jumps. Hot: achievement.

NOT STARTING — Cold: no desire. Heavy: wants to, cannot rise. Moist: cannot close an old story.

SLEEPY — Cold: after food, bloated. Heavy: all day, heavy lids. STOOL — Dry: pellets. Cold: loose / undigested. Moist: sticky, smelly.

PHLEGM — Cold: clear, better warm. Heavy: white / clear mornings. Moist: yellow-green, sticky, smelly. Dry: cough, no phlegm.

RASH — Hot: red, hot, worse warm. Dry: flaky / cracked. Moist: weeping folds. WITHDRAWAL — Dry: contact wears. Cold: feels meaningless.