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FEELING THE QI: EMERGENT BODIES AND DISCLOSIVE FIELDS IN AMERICAN APPROPRIATIONS OF ACUPUNCTURE

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE DOCTOR OF PHILOSOPHY

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ABSTRACT

Feeling the Qi: Emergent Bodies and Disclosive Fields in American Appropriations of Acupuncture

by

Mitra C. Emad

The ethnographic core of this dissertation is comprised of the body stories of American acupuncturists and their clients. I posit a notion of embodiment based on “feeling the qi.” A unique bodily sensation during acupuncture treatments, “feeling the qi” also opens up the relationship between embodiment and storytelling. This is a paradigm of embodiment that is enacted in a process of disclosure and requires a revision of the notion of appropriation. The four central chapters are structured in terms of four relational bodies of appropriation: social bodies of translation, technocratic bodies, mediating bodies, and emergent bodies. I open with social bodies as the discursive realm of making sense of bodily being, in that social bodies trace the “translating channels” through which acupuncture is culturally translated into American contexts. Technocratic bodies exert control and act as general gatekeepers in biomedicine’s encounters with acupuncture. Acupuncture practitioners are mediating bodies within the social realm in which practitioners, clients, technocracies, and emergent bodies all encounter one another. Emergent bodies in the stories of individual clients of acupuncture evoke themsatics of gender, care, partnership, and bodily recovery. This dance of translative, technocratic, mediating, and emergent bodies revises conventional abstractions of “the body” as a metaphor. “Feeling the qi,” initiates a movement in this dissertation through these four storied and relational bodies of appropriation, closing with an analysis of issues of positioning and reflexivity.
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# TABLE OF CONTENTS

Chapter One  
Feeling the *Qi*: Beginning Points  

Chapter Two  
Translating Channels Along Social Bodies:  
Towards an American Acupuncture?  

Chapter Three  
Technocratic Bodies: Biomedicine's  
Appropriative Encounter with Acupuncture  

A Patient Public  

Chapter Four  
Mediating Bodies: American Acupuncturists  
and Bodily Transformation  

Chapter Five  
Emergent Bodies: Geographies of Sensation  
and Transformation Among American Acupuncture  
Clients  

Chapter Six  
Twirling the Needle: Reflexivity and  
Demarcating the Field  

Works Cited
CHAPTER ONE
FEELING THE Qi: BEGINNING POINTS

Delicate pins protrude from my elbow, ankle, and knee. My arms and legs are flooded by tiny rivulets of current. It’s not like a hypodermic needle that injects a foreign substance -- what I’m feeling is simply more of myself.

-- Acupuncturist-writer, Harriet Beinfield, *Between Heaven and Earth*

Storytelling, a totally human practice, is an internal dialogue . . . that constitutes our body-image based on the ‘cellular feelings and the sensations of bones, muscles, and organs.’ Every experience therefore entails form-making, *embodiment*, shape.

-- Acupuncturist-writer, Mark Seem, *Acupuncture Imaging*

“Do you have it?” I am in Houston, in Chicago, in a small town in Wisconsin, another in Minnesota. I am in an alternative health care clinic in Portland, Oregon. In all these places, I am seeking acupuncture care, lying on the treatment table with some of the fine, thin acupuncture “needles” in place at various points on my body, the acupuncturist poised, her/his fingers nimbly and gently twirling the needle. Sometimes the question is verbalized, sometimes it is a glance at my face, a listening ear attuned to my grunt or groan of confirmation.

“Do you have it?” What is it that I have when I feel the sensations that most acupuncturists describe as a *qi* response? How to describe those sensations? When the needle is inserted, I feel a prick or a pinch, a surface sensation that quickly dissipates and deepens, often referred to, by practitioners and their introductory pamphlets, as a “dull ache.” A tingling, a heaviness, sometimes a spreading warmth, sometimes a thin stream of electric sensation moving, like the first quickening of a fetus without regard for its mother, from a point on my arm to another point in my belly. Like Harriet Beinfield in the epigraph above, I feel
“more of myself.” As I lie on the table, I wonder about the meridians of qi, of my own vital energy, that untranslatable life force traversing my body. When my acupuncturist returns to the treatment room some minutes later, she/he again twirls the needle and the deep achey sensation points a way through my body. It is the kind of ache of a well-stretched muscle; if meridians of energy could stretch and yawn, this deep, spreading warmth, this not altogether unpleasurable sensation of achiness, might be an embodiment, that of my rising qi.

During acupuncture treatments, “feeling the qi” is a transformative experience, one that can point out a new, yet strangely familiar bodily geography. Seeking an alternative in health care, like acupuncture, often indicates an emergent sense of bodily alienation -- the body has become “other” through illness or a disruption of some kind in what we tacitly understand as “health.” Feminists describe this experience of bodily alienation as the basis for anorexia nervosa and other eating disorders, which primarily affect women (Fallon, Katzman, and Wooley 1994). But to experience the body as “other” is a condition of modernity as much as it is a condition of patriarchy. You lie down on the table to try to “[recover] the body that was once integrally present but now remains unattended or left behind” (Sheets-Johnstone 1992:14). Through unique sensations, “feeling the qi” allows us to be re-introduced to our bodies, to undergo an embodiment that we may not have sought out and that nevertheless we are called to enact. Such transformation, however, is not brought about by some outside source, it must be enacted. Through my own and others’ bodily responses to needling, to acupuncture care, I became interested in a new form
of awareness that was dependent on bodily sensations and the relationship between those sensations and storytelling. How are experiences of bodily recovery and loss narrated? How are storytelling and embodiment linked?

While feeling the qi occurs on the acupuncture table during treatment, I am suggesting here that it also occurs at “the conversation table” during the formulation of body stories. Through engagement with this project, I have come to see a parallel between needling and narrative, that is, storytelling. The experience of acupuncture treatment on the table and the experience of telling one’s body story are comparable modes of bodily attunement. It is this attunement that opens the way for a transformative relationship to bodily being. In writing my own experience of feeling qi above, for example, I find myself, in my own bodily being, sitting up from my classic “computer crouch.” My back stretches up and relaxes, the tension leaves my shoulders. In order to write these words, in order to offer a description of the phenomenon of needling, I must write (speak) from my body. To recall the sensations of acupuncture treatment, I can no longer maintain the disembodied stance concomitant with academic writing. To recall my bodily experience of feeling qi, I re-member my body and my body re-minds me.

Clearly this experience of bodily attunement is a particular kind of embodiment. The rest of this opening chapter will examine feeling the qi as embodied storytelling, by delineating the key terms with which this dissertation engages. I argue that this storied phenomenon of embodiment must be enacted in a process of disclosure and requires a revision of the notion of appropriation.
Moving into the “disclosive” realm of fieldwork and examining my own multiple positions in the field, the chapter then closes with a map of the dissertation that engages four relational bodies of appropriation.

**Storytelling and Embodiment**

In American acupuncture care, the possibility of embodiment is closely linked with storytelling. Partly this is due to the disruption of the doctor-patient hierarchy in alternative modalities like acupuncture. The client-centered approach enacted by most alternative health care modalities emphasizes the actor’s own ‘common sense’ or ‘ordinary knowledge,’... the actor’s own informal (and contextual) knowledge, often organized in narrative form and told as stories... [with emphasis on] ordinary language dialogue and storytelling. (Fischer 1990:366)

Acupuncturist-writer Mark Seem, acutely aware of the dynamic engagement of storytelling with embodiment, has developed an eclectic treatment style that strives to re-introduce clients to their bodies by way of stories:

As I work with clients to guide them toward formulating their own energetic story, I often find it necessary to use metaphors that pertain to getting in touch with one's constitutional core, ... to reorganize the bodymind in such a way that change is possible. (1990:83)

Embodiment, as a form-making, for Seem and his clients, literally gives the body shape through storytelling; embodiment and storytelling make each other possible.

Does this particular storied embodiment hold the possibility of a new body in the making, an emergent body? While I hesitate to generalize a single, unifiable body as emergent in contemporary American acupuncture care, I
suggest in this dissertation that storied bodies are emergent, not only in the research context of their unfolding for the interviewer’s tape recorder, but also in the constant process of individual embodiment.

Embodiment is a much sought-after experience in late 20th century postmodern American culture. The body-as-machine metaphor has achieved narrative hegemony to the point that an internalized sense of our bodies as “other” is as common as the commodification of our everyday lives. An alienation that in another historical and cultural setting may only have emerged on the occasion of illness now characterizes our bodily beings as late 20th century capitalist moderns:

[We have come to believe] that the self can exist independently from the body, which is a collection of parts, or something that each of us must drag around every day, a burden from which we long to be free. . . . (Sault 1994:322).

While this narrative holds hegemonic sway, its antidote remains seeking, New Age and otherwise¹. Seeking health, for all the people speaking through the following pages, meant making a home in our bodies, a new home that did not solipsize our beings from the being of the earth, the environment, a new home that did not cut off the mind from the body or the soul from both. During this process, the previously familiar terrain of the body became strange, uncanny (unheimlich, in German: "un-home-like"). For some of us, turning our attention fully to our bodily selves, we discovered that we were not "at home" in our bodies; for others, a sense of alienation from our bodies turned our attention to our bodily beings. In either case, we experience what many feminist and post-structuralist theorists have termed a "decentering" of the familiar, the real, the true that each of us had
come to believe was our body. The bodies that have not been “given their due” (Sheets-Johnstone 1992) are also storied bodies; these “repudiated” bodies are the somatically felt body -- the body that feels joy, sadness, and anger, the body that feels nostalgia and despair -- and the tactile-kinesthetic body -- that body that feels itself in the act of moving and touching (ibid.)

Seeking alternatives to repudiation lead to a rhetorics of “getting back in touch” with our bodies, reclaiming our bodies, and becoming reanimated after years of disembodiment (Sault 1994:322). Seeking alternatives in health care, such as acupuncture, can be both an impetus for and a consequence of the move towards embodiment. What is this phenomenon of bodily reclamation, of embodiment?

In terms of articulating the movement of embodiment evoked in this dissertation, I agree with Thomas Csordas that we must begin with “an anthropology that is not merely about the body, but from the body” (1994:xii). Throughout this work, I am attempting to listen closely to “body narratives,” the stories of their bodies created by both practitioners and clients of acupuncture in the United States. These body stories raise critical questions about the nature of health, the pursuit of health care modalities alternative to biomedicine, and the nature of bodily being. In paying attention to how people talk about their bodies, I have come also to examine how storytelling itself helps people re-inhabit their bodies. How do Americans integrate their health care practices into their bodily identities? How do we create body stories that make sense and are deeply meaningful? I have been asking these questions tacitly and explicitly in a variety of “domestic” field settings, in formal and informal interviews with acupuncture
practitioners and clients, and in my own experiences of acupuncture care. This listening stance, an anthropology “from [my own] body” has attuned me to storied bodies as plural and multiple. While my project is not dissimilar to Csordas’s influential paradigm of embodiment for anthropology (1990, 1993, 1994), it does resist the move to theorize and abstract pluralized bodily beings into the prevalent anthropological concept, the body.

Csordas’s new paradigm of embodiment revises conventional theories of the body in anthropology: “What we are calling for here is a more radical role for the body than that typical in the ‘anthropology of the body’ that has been with us since the 1970s” (1994:4). Csordas critiques the accepted anthropological notion of the body as an object of culture and argues instead that the body must be regarded as a subject of culture, as the existential ground of culture (1990:5; 1993:135; 1994). The “lived body” becomes Csordas’ methodological starting point rather than the body as an object of study (1993:136). Drawing from the work of Maurice Merleau-Ponty (1962), Csordas emphasizes embodiment as a preobjective experience of the world, the point of origin for perception (1990:9). Careful to emphasize that preobjective does not mean precultural, Csordas’s paradigm entails “that embodied experience is the starting point for analyzing human participation in a cultural world” (1993:135).

Moving from the body as object of analysis to embodiment as a process of perception, Csordas’s new paradigm emphasizes movement, flux, and indeterminacy (1994:4-5). Drawing from the work of Maurice Merleau-Ponty
(1962), Csordas emphasizes embodiment as a preobjective experience of the world, the point of origin for perception (1990:9):

the goal of a phenomenological anthropology of perception is to capture the moment of transcendence in which perception begins, and, in the midst of arbitrariness and indeterminacy, constitutes and is constituted by culture. (ibid.)

This realm of indeterminate preobjectivity gives way, in a wonderful attempt to articulate the connections between storytelling and embodiment, in Csordas’ notion of “somatic modes of attention” (1993). Embodiment for Csordas emerges out of a distinction between the semiotic, textual standpoint of the body as representational and the phenomenological standpoint of the body as “being-in-the-world” (1993:137), aligning “embodiment” with the latter. While Csordas wants to position representationality and “being-in-the-world” “alongside” one another (ibid.), as “dialectical partners” (1994:12), his paradigm does not offer a way to mitigate the oppositionality of this construct. Rather he posits “somatic modes of attention” as a way to account for the indeterminacy of “being-in-the-world:”

Somatic modes of attention are culturally elaborated ways of attending to and with one’s body in surroundings that include the embodied presence of others. (1993:138).

This somatic mode of attention, what I would call “bodily attunement,” clearly entails both attending with and attending to the body. This is precisely the kind of stance that I have tried to develop in my own multiple roles in this project, as researcher, apprentice, client, and writer. Attending with and to their bodies also constitutes the enactments of embodiment emerging in the stories told by clients of acupuncture participating in this work. However Csordas’s
opposition of representation (textuality) from being-in-the-world (relationality) can not adequately account for the phenomenon of enactment which is the focus of my work. Enactment is transformative, it is the experiential ground for bodily emergence, and as such enactment is not an experience that falls into either relationality or textuality. It is precisely the engagements of and between storytelling and embodiment that anchor this work. As such, I examine transformative bodily experiences with and through acupuncture care, as enactments.

I have developed this notion of embodiment as enacted largely from Martin Heidegger’s notion of disclosure which signifies “to lay open’ and ‘the character of having been laid open” (1962:105). While Heidegger never really “theorizes” disclosure, Parvis Emad specifies that the oft-cited characteristic of humans, “being-in-the-world” is not a given or a simple characteristic; it must be enacted and opened (P. Emad 1990). This “opening of the openness” is how P. Emad characterizes disclosure (ibid.). “Being-in-the-world” must be enacted and opened; it is not a theoretical construct that “accounts” for human being. While Csordas contributes a quite necessary rendition of bodily attunement as a somatic mode of attention, “being-in-the-world” remains a theoretical construct out of which he generates a paradigm for research. It is the enactment of bodily being that I hope to evoke in this dissertation, not a theory of embodiment. As such, while disclosure remains an often under-theorized category for thinking in this work, I ask that readers themselves take on a bodily attunement of enactment. Reading and writing are fundamentally disembodied acts, but in
working through embodiment as disclosure, I am also urging that our engagements with the works and lives of others through reading and writing become acts of embodiment.

**Disclosive Fields**

I conducted fieldwork for this project through participant-observation, depth interviews, and fieldnote-making in clinical situations in Chicago, Houston, Portland, Oregon, Minneapolis, Viroqua, Wisconsin, and Winona, Minnesota. Like Davis-Floyd (1992:2), I conducted fieldwork for this project at sites where I happened to be living for extended periods. In all of these sites, delving into the particularities of acupuncture care (what acupuncture “looked like”), especially in urban metropolitan areas as compared to rural and semi-rural settings, compelled and interested me. Portland, Oregon was the only fieldsite that I deliberately chose, and I chose it for its tremendous array of alternative health care options and the mundane status of modalities like acupuncture. Portland is also the location of one of the primary acupuncture training schools in the nation. The Oriental College of Oriental Medicine (OCOM) draws students internationally and focuses on overall education in Traditional Chinese Medicine (TCM), which is widely identified with acupuncture care generally in the United States. However TCM is only one among several treatment styles of Chinese medicine(s) currently taught in the United States. While OCOM never became an explicit field site for me, OCOM students were often present as interns at the clinic where I worked in Portland and clinic practitioners were also OCOM
teachers. Several of the practitioners participating in this project are graduates of OCOM.

I conducted fieldwork in the summers of 1991 (Chicago) and 1992 (Portland), as a backdrop for my graduate studies in Houston from 1991-1994, and intermittently after I moved to the Midwest in 1995 (Minneapolis, Viroqua, Winona). This dissertation raises questions regarding what counts as the field and what counts as fieldwork. The field of acupuncture care has been the subject of at least one other ethnographic analysis. Martha Hare’s 1991 dissertation, *East Asian Medicine Among Non-Asian New Yorkers*, carries out a medical anthropological approach towards alternative health care. In much medical anthropology, alternative modalities of health care are viewed as challenges to biomedicine, and research focuses on uncovering the mechanics of hegemony by examining how biomedicine establishes and maintains its hegemony in the face of a challenge to it (Wolpe 1985). Hare’s overall purpose in studying East Asian Medicine use -- primarily acupuncture -- among non-Asian New Yorkers is to establish a “critical analysis of Western biomedicine by seeking to understand the dynamics of a challenge to that system” (1991:1). Offering rich ethnographic material through participant-observation with and interviewing of 30 acupuncture practitioners and 29 patients in New York City,³ Hare’s study makes an indispensable contribution to understanding how acupuncture has been culturally translated into American contexts. My own work would not be possible without Hare’s groundbreaking ethnographic questions and thick descriptions.
While noting that East Asian medicine consists of many modalities (acupuncture, acupressure, herbology, moxibustion, nutrition and exercise regimens, etc.), Hare chooses an ethnographic focus on acupuncture. Acupuncture, according to Hare, is the best organized of the modalities, and is used in a variety of settings: substance abuse detoxification clinics, biomedical offices, in the back of Chinatown herb shops, and in the apartments of New York practitioners (1991:2).

For me, this raises the question: what motivates my focus on acupuncture? How am I positioned in terms of choosing, delineating, demarcating my field? I have pursued acupuncture care for my own health care for nearly a decade. After preliminary interviews in Chicago, it struck me that my own and others' experiences with acupuncture care indicated that it was an alternative health care modality that seemed extremely conducive to paradigm shift. Shifting paradigms at the level of individual attunements in and through the body fostered bodily transformations, transformations in what counted as my body, in how health, healing, and illness were constituted and understood. I wanted to trace these transformations -- to trace them with my fingers by copying down the words of people's stories, with my eyes by reading and re-reading those stories, with my ears by listening to stories unfold into my tape recorder.

Transformations in paradigms at the level of individual attunement to the body, were of the kind evoked by metaphors like the “body-as-garden” replacing the “body-as-machine” and of the flow of qi replacing or at least resisting a technocratized women's health care. Acupuncture was/is good to think with, good to heal with, for me and for others; I wanted to explore why. As such,
acupuncture, in and of itself, as a uniquely American health care phenomena became my ethnographic focus. This does not entail divorcing acupuncture -- as a child of appropriation -- from either its appropriative originary contexts nor from its eclectic, constantly changing, appropriated contexts. Both sides of the appropriative encounter will be examined through the discussions below of biomedical gatekeeping and cultural translation of acupuncture practice.

For Hare, the “community” is “the practitioners and users and the places in which they work and meet” (1991:2). My own site(s) certainly include the places where practitioners and clients of acupuncture care meet and work. But more specifically, ethnographic sites, for me, emerged as stories of transformation and embodiment. The people -- both practitioners and clients -- whom I sought to interview were those who expressed a willingness to engage in the creation of body narratives; very specifically, people who had not only experienced generally positive and transformative results from acupuncture care (given or received), but who were willing and able to articulate that. As such, this project remains far from the kind of randomized sampling and site specificity that characterizes most medical anthropological research, including Hare’s.

Including my own experience in this dissertation, as I have already started to do, may make both anthropologists and my other readers slightly uncomfortable. It is one thing to write of a "research project" that entails the anthropological method of "participant observation" and produces particular "conclusions" or "data" that can be examined and interpreted. It is quite another to include myself among the people that most appropriately should be called my
informants*. Where is my objectivity if I have included myself among my informants, my own experiences among my data?

The model of objective scientific research, I believe, limits the possibilities for interpreting human experience. I agree with Ladelle McWhorter that theory, itself, is bound to notions of truth, reality and objectivity (McWhorter 1992). I have found that only careful and sustained thinking -- rather than careful and sustained theoretical structures -- can maintain a clearing of openness in which to encounter other human experiences. The kind of thinking that sustains this clearing has been characterized by Gail Stenstad as "anarchic thinking" (Stenstad 1988); it does not demand a stance of objective distance on the part of a researcher, it does not seek to order findings or "data" hierarchically, and it does not posit a unitary reality (ibid. 87). Stenstad notes that a project of scientific objectivity asks that we settle for unity: one explanation, one voice (89). Anarchic thinking, on the other hand, asks that we keep thinking moving, fluid, always on the way, resisting theoretical resolutions and harboring ambiguities (ibid.). Stenstad argues that if we can harbor or "shelter" the ambiguities that arise when we resist analysis, clarity, and objectivity; we then open up myriad creative possibilities and we sharpen our attunement towards listening to multiple, divergent voices, no matter how different those voices might be from our own (ibid. 94, 89).

If I remained an objective researcher, taking a stance outside the subject of my study, I could potentially produce an empirically grounded social scientific study of alternatives in health care. Meredith McGuire produced such a study in 1988 (focusing on ritual healing rather than alternative health care practices). For
McGuire the stance of an objective researcher entails remaining a "nonbeliever" in the fieldwork setting. She notes that she and her team of six staff members worked hard to remain "unconverted":

We were careful never to profess a belief that we did not truly hold. We were aware, however, that adherents often translated our answers into something more consonant with their own beliefs than we ourselves would have specified; we did not generally confirm or deny their translations....Staff meetings during the participant observation phase also reduced the likelihood of researchers being converted. (McGuire 1988:271).

Each member of the research team worked with numerous groups and practices in order to diminish the "risk" of conversion. By reducing interaction time with one particular group, a member of the team was less likely to become "encapsulated within the group," thereby risking conversion (McGuire 1988:272). This kind of encapsulation is exactly what most cultural anthropologists -- in conventional "exotic" fieldwork settings -- seek in the field. What I am interested in here is the kind of anthropological research that asks the researcher to open herself completely to such an experience of "encapsulation". What happens next is a matter of what Donna Haraway has called "situated knowledges" (Haraway 1991; Chapter 9). Pursuing the particular and specific experiences emerging out of a researcher's encapsulation in a field setting, these kinds of knowledges pay close attention to the researcher's "positioning"; Haraway notes that "positioning implies responsibility for our enabling practices" (ibid. 193). So if the practice that enables my research is total immersion in the culture/worldview/experiences of seekers of health, then I must take responsibility for that enabling practice and ask myself: what are the consequences of my positioning?
I have brought my own experiences and thoughts as a client of acupuncture and an assistant/apprentice, as well as a fieldworker/researcher/writer in the spirit of anarchic thinking and situated knowledges. A blended, blurred, and fluid sense of my own identity within this work along with a focus on alternative cultures called out for attention to forms of representation. I have been greatly influenced by Steve Tyler's notion of *evocation*:

> Evocation is neither presentation nor representation. It presents no objects and represents none, yet it makes available through absence what can be conceived but not presented. It is thus beyond truth and immune to judgment of performance. It overcomes the separation of the sensible and the conceivable, of form and content, of self and other, of language and the world. (1986:123)

To evoke the embodiments of both practitioners and seekers of acupuncture care, people seeking to articulate, to story their bodily beings, I began to think about and experiment with alternative forms of writing. George Marcus and Michael Fischer (1986) have argued that experimental forms of writing are central to the development of a distinctively anthropological cultural critique of American society. While some experimental forms of writing appear on these pages, including “Autoethnographic Reflexions” and pastiches juxtaposing textual and ethnographic sources, the experimental quality of the cultural critiques appearing on these pages emerges more from the polyphonic quality of storied embodiments. Engaging with polyphony allows this work, and the thinking of all who contributed to it, to flourish in the realm of “partial truths” (Clifford 1986).

Storytelling and embodiment are central to understanding “feeling the *qi,*” but this is also a phenomenon that is indebted to cultural translation. Acupuncture
has been appropriated from Chinese and other East Asian cultural contexts; how do we begin to understand and contextualize this phenomenon of *appropriation*?

**The Cultural Appropriation of Acupuncture**

One of the key explanations for acupuncture’s effectiveness cited in the media, by practitioners, and by scholars of Chinese medicine(s) is the age of Chinese traditional medicine; it has been dated as anywhere from 2,000 to 5,000 years old. Exactly how old acupuncture or Chinese traditional medicine(s) are seems to be a matter of some confusion. The figure of 5,000 years (Wolpe 1985:411; Riddle 1974:290) is unsubstantiated. If we take classical Chinese medical texts as a starting point, a figure of 2,000 to 3,000 years seems most accurate (Veith 1949). What we have to take into account here is that acupuncture has -- and continues to -- metamorphose as a result of cross-cultural contact, historical forces, and the influence of other health care modalities (like biomedicine). So if we ask, “how old is acupuncture?” we must also ask, “*which* acupuncture?”

In its current institutional and labeled form China’s “traditional medicine” has only existed since Mao Zedong’s 1955 proclamation that “our motherland’s medicine is a great treasurehouse” (quoted in Farquhar 1995:251). As a result of a preservationist and scientific movement to “legitimize” it, Traditional Chinese Medicine was created as a “discrete ‘system of knowledge’” (ibid.). One of the definitive features of what falls under the label of “traditional medicine” in and out of China is its adaptability. Chinese medicine(s) have
changed and evolved and become something slightly or dramatically different many times within their own history, not just at the critical juncture of reification during the Cultural Revolution. This makes Chinese medicine(s) extremely adaptable to appropriation by foreign cultures, as well as by new political ideologies.

The common philosophical and medical attributes of Chinese traditional medicine as it is practiced in 20th century appropriations include: a core idea that human bodies are healthy when qi flows easily and smoothly along channels or pathways that traverse the body. Acupuncture points exist all along these “meridians” and work as gates opening into this matrix of channels. When we feel sick or in pain, the energy is not flowing smoothly or not flowing at all. Philosophically then, (or poetically, metaphorically, as well, as scientifically and medically), this medical worldview is extremely conducive to being appropriated to contexts of holism, of holistic health. Cassidy (forthcoming) notes that clients of American acupuncture are not necessarily choosing a “foreign” or “exotic” treatment modality, but a familiar one that carries the attributes of holism.

For some Americans the initial encounter with acupuncture is painful. For others, it is an “extend[ing] of my field of awareness” (Beinfield 3). As often happens in a context of appropriation, there are multiple acupuncture to encounter. Acupuncture practice in the U.S. and internationally, varies dramatically. Moreover, every encounter with acupuncture practice is influenced by countless factors, including but not limited to, practitioners’ education, treatment style, class, ethnicity, and gender backgrounds. As such, the very
phenomenon of *appropriation* must be reconsidered and investigated more deeply.

*Appropriation*, as used in cultural studies and critical-interpretive anthropology, signifies a “seizure without negotiation,” a non-critical, unexamined, exploitative act. An almost generic term in cultural studies, *appropriation* has become “a diffuse term used by everybody in a devalued way” (George Marcus, personal communication, 12/92). When a cultural practice is adopted from one cultural setting and employed -- often without a clear sense of its history, its methodologies, or its cultural context -- in an entirely different cultural setting, anthropologists refer -- sometimes condescendingly, almost always dismissively (that is, the story ends there) -- to that adoption as an appropriation. *Appropriation* signals the identification of a powerful, hegemonic force exploiting a subordinated, subaltern people. Examples might include the commodification of Tibetan singing bowls and prayer flags in commercial mail-order catalogues (e.g. *Pacific Spirit Whole Life Products*) or the controversial practice of Native American ceremonies by white, middle-class Americans (Churchill 1990).

As Michael Walzer points out in his critical essay on Antonio Gramsci’s notion of “hegemony,” simply by identifying the forces of hegemony and appropriation in cultural life, intellectuals (anthropologists, cultural workers) set themselves apart from that cultural life and participate in the flow of hegemony themselves (1988:80-100). The call of “appropriation” can no longer remain a straightforward weapon of critique but readily becomes a gatekeeping device
that itself furthers hegemony. The move to dismiss, denounce, even deconstruct appropriation primarily constitutes a way of shutting down an encounter with the things, practices, and people involved in particular instances of appropriation. Considering our own situatedness as contemporary, modern humans, we can not readily dismiss the move to appropriate as politically incorrect or dangerous. Questioning appropriation as a phenomenon (or collection of phenomena) characteristic of modernity remains a relatively unexplored option.

Appropriation can be traced from the Latin, appropriare, “to make one’s own.” This making implies an action upon something, something that through the making process inevitably changes. I argue that the appropriation of a practice — like acupuncture — occurs betwixt and between hegemonies and subalterities, betwixt and between the outright seizure of a cultural form and the loss of culture so often identified with “whiteness” and “middle-classness” in American culture. I am suggesting that negotiation itself is a definitive factor in such cross-cultural interactions. That is, what are the cultural forms that acupuncture takes in American practices? In the global milieu, the fluidity of “appropriation” has become such that borrower/lender, taker/loser, thing-taken/thing-lost can not remain firm, stable categories, and fundamental change results from these highly negotiated interactions. Both the practice and the practitioner, the appropriatee and the appropriator change through the appropriative encounter. These transformative embodiments as narrated by the people represented in these pages and by my own [ethno]graphic hand, constitute the substance of this dissertation.
A Body Story: Kristen

Before proceeding to a map of the dissertation, I include here a complete body narrative of one acupuncture client with whom I worked during this project. While no single story can encompass the thematics of embodiment and disclosure that I am developing in this dissertation, Kristen’s story enacts a voice through which some of those thematics can be grounded. Kristen’s story begins with an evocation of a sense of desperation, not only with regard to a persistent case of excema rapidly taking over most of the surface of her skin, but also a sense of disembodiment in conventional urban life. Her story then follows a classic trope of narrating her “path to acupuncture.”

I’ve realized how far away we’ve gotten from nature! Everything around us, we’ve gotten so far away even from basic necessities, so we forget them. I mean living in the city, it’s always people, people, people, gotta get to class, gotta watch my time, where’s my schedule, gotta do this, gotta do that, ohmygod I gotta get downtown, I gotta get back, it’s gonna take an hour, I gotta get money, gotta go to the cash machine, gotta wait in line, I’m gonna be sick, I gotta get food, ohmygod, fast food, McDonald’s oh that sounds good, oh I feel sick to my stomach now, oh, I gotta relax, I gotta relax, watch TV, oooohhh TV sucks, oh I’ll just go to bed, and you’re all frustrated and you’re lying in bed going, oh, sleep, just fuckin’ sleep! God it’s horrible!

[When I first went to an acupuncturist,] I was in a very desperate state of mind; I was miserable. I had excema all over my face, all over my body, and I knew the doctors couldn’t help me anymore, because I’d been to the doctors for a couple of years. Five or six times. They all gave me hydrocortzone cream and said, well, you just got to wait it out. It just wasn’t doing it. I mean it helped some. The skin rash wasn’t as bad, but the hydrocortzone creme was too painful to put on my skin. And water was too painful to wash my face. It was just horrible. It itches and it hurts and you’re uncomfortable constantly. So I was just really desperate for anything.

So my friend Matilda told me about [acupuncture], and I was just like take me there now because I’m willing to try anything. Matilda told me that we’re so used to Western medicine, that it doesn’t necessarily heal, that there is this other
medicine that people use that is just as good. That you have to try both. Western medicine just kind of treats the symptoms and Eastern medicine is more like finding where it's coming from inside you to heal it. Healing more than just the symptoms of what you've got. [It's not like] okay, it's on your skin, let's put some lotion on it. [It's more like] let's get to the root of it and get rid of it.

I met [the acupuncturist] and she did that muscle testing thing, and she gave me some supplements for the “fire” or something in me. And she said it might get worse before it gets better. It didn't really get worse; it didn't really do much. It didn't start going away until maybe a month after I started seeing her. It took like two months for it to be completely gone from my face [and longer for my arms]. I didn't stop the treatments because she said it would take time. She asked me how long I'd had it. I told her I'd had it a couple years; I'd even had it in my childhood a little bit, but nothing like this. And she said, because you've had it so long, it's going to take a long time to get rid of.

But it was not just like I've got this thing on my skin, let's get rid of it. It was something emotional. It was something beyond going to the doctor and having someone say, it's going to take a long time, blah, blah, blah. There's something about her [the acupuncturist] that's nurturing. I go into that place and I immediately feel better. She gives off this energy that just makes you feel better! I mean I could just go to sleep there and be happy as a lark, you know! And I think that it's just the fact of someone caring about me. Not just looking at me like a technicality, like this is what you got, labeling me, but someone actually seeing me as a human being and caring about me. It's a very comforting thing. Half the time she wasn't even treating me for excema, it was other little things, you know.

It's interesting you know, I was just there last week, and I was having trouble with my stomach. I wasn't hungry, or I mean, I couldn't eat. You know when you're hungry, but you look at the food and you're like, oh, you don't want to put it in your mouth. So I went in there and I didn't say a word, because I'd forgotten. She put needles right here [gesturing to her upper arm, near the elbow; large intestine points], and it was so painful! I said why are you putting needles there? All of a sudden, it just really fuckin' hurts, you know, and she's just like well, you're having trouble with your stomach and your lungs. I'm like, you know, I am kind of! I'm like, that's really funny, Abbie, because I can't eat. She says, "because you're all up here!" and she taps me on my forehead.

After being so stressed out, to go in there, and feel so relaxed. I've got someone here who'll think about me instead of me thinking constantly. I could let go of myself, you know. I'm like, all right, I don't have to think about myself anymore and I don't have to worry about this, because I've got someone else doing it for me. . . . Just to lay down and have someone make your body feel better does something to your spirit as well! It was hard leaving [once the treatments were over].
It's just such a new concept that your body knows what's wrong with it; it's just a matter of how to make your body talk! I think I've become more in tune with my body. I was always in tune with what was going on with me, but it's more so. I'm becoming more aware of my health and that I have to eat and I have to relax and not take things so seriously.

I offer Kristen's story in full to introduce another voice that speaks quite a different language of emergent embodiment. Rather than applying the dissertation's thematics to this story, I urge readers to engage with it as a polyphonic foil against which to think through those thematics.

**A Geography of Embodiment**

In outlining a "Critical-Interpretive Approach in Medical Anthropology," Margaret Lock and Nancy Scheper-Hughes lay out an analytic scheme of three bodies: the individual body, the social body, and the body politic (Lock and Scheper-Hughes 1990). I am interested in developing a "geography of embodiment" that appropriates this model, not as a wholesale seizure, but rather in the spirit of "ownness making." For Lock and Scheper-Hughes, the individual body is the lived experience of the body-self, the social body is the arena in which the body becomes a potent symbol connecting the natural and social worlds, and the body politic is constituted by the political structures which regulate and control our bodies (ibid:50). The links between these three bodies emerges in a polysemy terrain of "the language of trance, ritual, dreams, carnival, and so on" (ibid:71). The separations between these three bodies, however, remain as artificial as separating body from mind, subject from object,
doctor from patient, and clinical diagnostic narratives from experiential body narratives. In beginning with this classic anthropological heuristic structure of the three bodies, my intention is to open up that structure and engage it as “a mode of revealing” (Heidegger 1977:12-16). The realm of acupuncture appropriations, too, is a polysemic terrain, one which relationally engages multiple bodies. I suggest here that Lock and Schepert-Hughes’ three bodies may be opened up to include other bodies, and that the term body when discussing social, political, and individual realms, need not remain a metaphor. While I structure this dissertation in terms of four bodies, my intent is to pluralize each “body” and to focus on the ways in which social, technocratic, mediating, and emergent bodies are all modes of human and relational bodily being. Thus these multiple and pluralized bodies are not static and solipsized, but become moving and fluid.

This dance of technocratic, mediating, and emergent bodies begins and ends with social bodies. In chapter two, I explore social bodies as the discursive realm of making sense of the body. In social bodies, we engage in translation, in walking the paths of metaphors, and creating new channels of translation. This chapter traces some of the “Translating Channels” through which acupuncture is culturally translated into American contexts and raises the question of appropriation as a mode of translation. Translation is always already going on in the clinical and discursive realm of acupuncture care. What metaphors do acupuncturist-writers develop as the primary cultural translators of acupuncture into American contexts? How do practitioners organize their treatments spaces - - sites where social bodies and emergent individual bodies meet in translativ
and transformative clinical encounters? Are emergent “new” acupunctures
developing through storytelling and practice?

Chapter three explores the political economy of biomedical expertise,
what Lock and Schepet-Hughes call “the regulation, surveillance, and control of
bodies” within the body politic (1990:50-51). “Technocratic Bodies” derive their
power from technical and technological knowledge of specialized experts; in
what ways is this culture of expertise embodied in the political economy of
biomedical encounters with acupuncture? In other words, in what ways do
political bodies, or what I call technocratic bodies, exert control, acting as general
gatekeepers, over the appropriative encounter with acupuncture? What are the
structures of appropriation engaged in by Technocratic Bodies through their
regulative forces? Through an examination of both biomedical and
acupuncturists’ rhetorics of integration -- discourses advocating an “integrated
medicine” -- this chapter also moves, in “top down” fashion from hegemonic
institutional forces to the specific practices of individuals within technocracy.

Chapter four situates acupuncture practitioners as “Mediating Bodies”
within the social realm in which practitioners, clients, technocracies, and
emergent bodies all encounter one another. How do acupuncturists choose to
become practitioners of acupuncture, and in what ways do their stories of “why
acupuncture?” embody mediatory thematics that resist, facilitate, and enact
technocracy, translation, and the emergent bodies of their clients? How do
individual acupuncturists come to terms with their role as translators? In what
ways is the conventional doctor-patient relationship revolutionized in acupuncture care?

Alternative models of the relationship between practitioner and client also develop in chapter five, which explores “Emergent Bodies” of acupuncture clients. This chapter returns again to the relational thematic of storytelling and embodiment, and raises the question, “how do we talk our bodies?” Body stories created by clients of acupuncture care form the ethnographic core of the chapter. Women’s voices have a distinct primacy in this chapter; women are the primary seekers of both conventional and alternative health care in the United States, so this chapter also explores the gendered nature of these storied embodiments. Through storytelling, new vocabularies emerge, especially surrounding experiences of pain, sensation, and relaxation. While emergent bodies of individual clients of acupuncture care can not be conceptually unified under a single theme, this chapter evokes thematics of care, partnership, bodily recovery and self-education.

Opening with “Feeling the Qi,” the dissertation moves through four storied and relational bodies of appropriation to “Twirling the Needle.” In the final chapter, I open up the phenomenon of “twirling the needle” as a way of embodying questions of positioning and reflexivity. Raising the question, where are anthropologists’ bodies in the field, this chapter focuses on my own positionings as a body in the field, while allowing the question of how to demarcate “the field” to remain open and fluid.
Qi and the Poetics of Translation

Pastiche Interlude

Technocratic Bodies
The general theory of acupuncture is based on the premise that there are patterns of energy flow (Qi) through the body that are essential for health. (NIH 1997:1).

[Acupuncture] works by suggestion, a mechanism with well-known effects on humans. The concept of Qi is to medical science as astrology is to astronomy. (Fred Levit, M.D., quoted in Marwick [JAMA] 1997:1727).

To a practitioner of traditional Chinese medicine, this energy is palpable. One of the ways a physician determines the state of chi in your body is by feeling a series of six pulses (three superficial and three deep positions, which together cover the twelve meridians) at the radial artery of each wrist. The feel of the pulse -- there are twenty-eight qualities, from floating and sunken to scattered and slippery -- indicates which energy channel needs toning up and which needs sedating. The doctor also looks at your face and tongue, and takes into account your smell, behavior, and emotions for what internal condition they might reflect. . . . Although you can’t get an X ray of chi and the meridians, the way you can of your bones, that doesn’t mean they don’t exist. When you use a portable telephone, you see no wires, no visible source of power, yet you experience that it works, and you don’t doubt it. Consider that the same may be true in energy-based healing” (Knaster 1996:279-80).

Translative Bodies
That which animates life is called Qi (“chee”). The concept of Qi is absolutely at the heart of Chinese medicine. Life is defined by Qi even though it is impossible to grasp, measure, quantify, see, or isolate. Immaterial, yet essential, the material world is formed by it. An invisible force known only by its effects. Qi is recognized indirectly by what it fosters, generates, and protects. . . . In the human being, all functions of the body and mind are manifestations of Qi: sensing, cogitating, feeling, digesting, stirring, and propagating. Qi begets movement and heat. . . . The Qi (Yang) moves the Blood (Yin). (Beinfield & Korngold 1991: 30 & 55).

It is safe to say that without a notion of Yin and Yang and movement of Qi, the medical system in question could not be considered Chinese. (Hare 1991:70).
The idea of Qi is fundamental to Chinese medical thinking, yet no one English word or phrase can adequately capture its meaning. We can say that everything in the universe, organic and inorganic, is composed of and defined by its Qi. But Qi is not some primordial, immutable material, nor is it merely vital energy, although the word is occasionally so translated. . . . Neither the classical nor modern Chinese texts speculate on the nature of Qi, nor do they attempt to conceptualize it. Rather, Qi is perceived functionally -- by what it does. (Kaptchuk 1983:35-36).

The Chinese character for qi is traditionally composed of two radicals; the radical which symbolizes breath or rising vapor is placed above the radical for rice. Qi is linked with the concept of “vapors arising from food.” (Ergil 1996:196).

It is very difficult to translate the word “Qi” and many different ones have been proposed, none of which approximates the essence of Qi exactly [energy, material force, matter, ether, matter-energy, vital force, life force, etc.]. The reason it is so difficult to translate the word “Qi” correctly, lies precisely in its fluid nature whereby Qi can assume different manifestations and be different things in different situations. (Maciocia 1989:35-36).

**Mediating Bodies**

According to Chinese treatment styles, you really go for the qi, and that creates a stronger sensation; it's a stronger treatment style. And the Japanese feel like you don't need to . . . you could just happen to blow on the points in a certain way and you could still get the same effect. In my own experience, I find that some people need that aggressive treatment to feel like they're getting something. Other people are open enough or sensitive enough or not even that, it could just be the state of the day or whatever. But you just need to tap in very little and they're open to the energy moving.

Karen Levine, Licensed Acupuncturist, Portland, OR

The vital force, a term from naturopathy, is the energy or you can look at it as the immune system, you can look at it as the spirit of your body, you can look at it as your life force, or qi. You can't describe it. You know, it's indescribable, but it's what keeps us tickin'!

Edie Vickers, Naturopathic Doctor, Licensed Acupuncturist, Portland, OR

Up to today, this qi, no one explain it very clear. Dictionary only use “the vital energy.” No perfect. You must always explain, make the patient understand a little. . . . Then when we get result, he listen. Some things
difficult to explain. Can’t use the same thing [equivalent word in another language]. You ask me “qi.” English, what is “qi”? Why use “qi”? Because dictionary no good words. So I use “qi.” I told you about how I learn Western medicine through self-study. I love to read books because I want to explain. I want to explain for my patient and for my colleague. Make them both understand. We [my biomedical colleague and I] discuss difficult cases. We have meeting every week. I talk everything, but he don’t understand anything. [chuckles] And then he talk everything and I don’t understand. So we stay there; later we . . . [chuckles]. We must both understand.

Dr. Chengde Wu, Chinese Traditional Medical Doctor, Houston, TX

With new patients I sometimes will have to go to an easy qi obtainable point, put the needle in and then go, “okay, you’re going to feel such and such a reaction,” and then I’ll go and get it for them [manipulate the needle to elicit a qi response], just so they can see what it feels like. What I have realized is that qi sensation is different in different areas of the body. Even though you show them that, they don’t necessarily take that information and apply it to other points. . . . They go, “Oh, that’s painful!” I say, “does it feel like a needle? Does it feel like a burning or a pointing?” And they say, “Oh, no, no, no. It feels like it’s really aching.” Well that’s qi. And I don’t necessarily consider that to be pain.

Terry McCormick, Licensed Acupuncturist, Winona, MN

I’ve been working at a lot of different clinics . . . , and I’ve observed at each . . . before I’ve gone in, because I wanted to see how they approached [their work]. . . . Every practitioner has a different technique. . . . What is my technique? I’ve tried to adapt to the different techniques, so that it’s not a sudden shock to a patient when they go from a size 3 needle to a size 5 needle or a 1 to a 5. The qi gets transmitted in really different ways.

Mary Scott, newly graduated Licensed Acupuncturist and Naturopathic Doctor, Portland, OR

**Emergent Bodies**

Yeah, and qi! I learned the word, qi! I know what qi means now. Energy! That’s the point. Being with [my acupuncturist] and stuff and thinking how is it that when I come now I feel this way, there’s got to be more to this, you know. She keeps talking about this qi and she must give off a certain qi and now I’m beginning to know the qi of other people and how I feel when other people are around me, like some really negative people. You don’t normally think about this, but people who are really superficial or drain you.

Kristen, 22 years old
When [my acupuncturist] wiggles the needles, I like that, it always feels really nice. During my last treatment, I could feel something moving over the surface of my body like a touch or air moving. Of course everything was completely still in the room. But that's how I imagine qi. A movement. Both inside and outside. I really felt that things were moving quickly and could move quickly. I guess I always just understood qi as “energy,” but that seems so abstract. I have a body understanding of it that is much less abstract. With menstrual flow, you can see pain as blockage. I like that language. I never understood my menstrual pain that way before. Something is blocked, there are blockages. This time [my acupuncturist] did a point directly over my uterus [possibly CV 6 “Sea of Qi”] and then things really started to move. It was a very pleasant sensation. You begin to feel everything, the hairs on your arms standing up. Almost a “tingling” sensation.

Patricia, 26 years old

This coursing of this qi, feeling it there, I could work with it, not tense up or reject it. It was a very interactive experience.

Gabriella, 40 years old

I see Terry specifically to try to build up my qi.

Claudia, 50 years old
CHAPTER TWO
TRANSLATING CHANNELS ALONG SOCIAL BODIES: TOWARDS AN AMERICAN ACUPUNCTURE?

Anthropologists are presented as semiotic tour guides, escorting alien “readers” in rough semiotic space.

-- Gisli Pálsson, *Beyond Boundaries: Understanding, Translation & Anthropological Discourse*

I [the practitioner] am like a guide who knows the territory and the characteristics of the bodymind energetic realm’s manifold terrains, and he [the client] is the explorer in search of lost connections, seeking bodymind integrity.

-- Mark Seem, *Acupuncture Imaging*

We have been working with [acupuncture] really for a hundred years in the U.S. It’s gone into many cultures over time, and it has transferred and adapted. We’re adapting it very quickly to Western temperaments and needs. I can’t do a Chinese treatment in my clinic; no one would come back. But I have enough adaptations that I can use it and it works.

-- Susan Cushing, Licensed Acupuncturist, Viroqua, WI

How has acupuncture been culturally translated into American contexts?

While this question may seem clear enough, a response to it must begin with more questions. What exactly is being translated? Styles of acupuncture practice in America are far from uniform. Traditional Chinese Medicine (TCM) practitioners work for the most part with established treatment protocols, modifying them for individual clients’ bodily situations. Five Element practitioners focus on balancing all five organ networks. Japanese-style practitioners use finer needles and shallower insertions, rarely manipulate the needles, and focus on the *hara*, the “energetics” of the abdominal region, for diagnosis. French and British styles, such as those propagated at the turn of the century by George Soulie de Morant and in the 1960s by J.R. Worsley also have influenced American practitioners. Acupuncturists in America are quite likely to mix and
blend these varying treatment styles in the development of their own particular practice. A Minnesota acupuncturist whose clients are primarily new to acupuncture, for instance, follows a clear TCM style, but uses the finer, Japanese needles to produce a milder treatment. These blended treatment styles are very recent developments in acupuncture practice within the context of several millennia of pluralistic practice. So in the issue of what is being translated into what, the notion of translation as a one-to-one correspondence must be seriously questioned. I argue that in the appropriative realm of cultural encounters that constitutes modern acupuncture practice, both the thing translated and the translated thing are altered and newly created by way of translative encounters.

The question of how acupuncture is culturally translated also suggests an interesting parallel between anthropology and acupuncture. Anthropologist Claire Cassidy has noted that acupuncturists “sometimes sound like anthropologists,” citing the focus on language and the “awareness of the created character of reality” demonstrated by acupuncturist-teachers at an American acupuncture school (1996:6). The metaphor of cultural translation has long been an anthropological given, and one that has come under scrutiny for its assumptions regarding the separateness of the cultural world of the Exotic Other from the cultural world of the Mundane Researcher Self, who has a special capacity to fluently understand both worlds (Pálsson 1993; Asad 1986; Tyler 1986; Tyler 1987). While anthropologists may be “translating” in the realm of discourse and textuality for particular readers, acupuncturists’ discursive
translations can not be solipsized from the realm of bodily practice. How do both acupuncturists and their clients *embody* the translative process? I posit that this process is ongoing and often unintentional or without conscious awareness; translation is always already going on and constitutes a fundamental characteristic of the clinical and discursive encounter with acupuncture care.

This chapter delves into cultural translation as a social medium for engaging with Otherness, whether the alienated/alienating Other is one's own emergent body or a medical worldview such as Chinese medicine(s) and acupuncture. The social arenas of encounter between Chinese medicine(s) and Americans are mediated by acupuncture practitioners. Attending to the workings of social bodies as translative mediums can reveal how new practices and concepts are metaphorized, often through narrative paradigm shifts. Shifts in body consciousness, in notions of health and illness will be explored later (see chapter five). Here I will delve into the conditions that make such shifts possible; the translative realm in which acupuncturists learn, practice, and teach. The chapter begins with the question of what exactly is being translated; if acupuncture is a facet of Chinese traditional medicine, how exactly is that medicine constituted? What counts as “tradition” and how can it be translated? An oft-cited story about otherness, translation, and diagnosis follows, opening the way to examination of metaphor. Metaphor occupies a central role in the translative realm of American acupuncture, bridging dualisms like nature and culture, body and medicine, Chinese and American. The central theme of this chapter then is an exploration of some of the key metaphors translating
acupuncture to Americans; through an analysis of three acupuncturist-writers' texts, I will explore the possibilities for newly emergent American acupunctures. Finally, I will look at how three of the acupuncturists participating in this study culturally translate acupuncture through the medium of their treatment spaces.

**Chinese Medical Traditions: What is Being Translated?**

Where does acupuncture come from? Acupuncturist-writers in the field warn against totalizing traditional medicine in China. For Americans, Traditional Chinese Medicine (TCM) has come to stand for the traditional medical base out of which acupuncture emerges. Acupuncturists have argued against this reduction of Chinese medicine into one single practice style that ironically carries the label traditional when it has only a 40 year history (Seem 1990; Flaws, Chace, and Helm 1986; Ellis, Wiseman, and Boss 1991):

Less than three decades ago, in accordance with Mao's famous mandate to uncover and upgrade the treasures of traditional Chinese medicine, the first effort was made to establish a unified system, to be the 'New Medicine' of China. In the texts written or translated for a Western readership, the Oriental medicine aspect of this new medicine was labeled 'Traditional Chinese Medicine' (TCM). The label is inappropriate for two reasons. First it obscures the fact that there has never been one traditional medicine of China. Second, it misleads many students into thinking that this very modern reformulation of Chinese medicine is 'traditional' when it is, in fact, a recent invention. (Seem 1990:5-6)

China's medicine has always been a pluralistic collection of multiple (often oppositional) practices (Unschuld 1985:57-58; Hare 1991:63). Medical historian, Paul Unschuld, argues that even the term, *Chinese medicine*,

...can only refer to a broad range of ideas and practices related to health care and illness prevention that were developed in China or adopted from abroad, over the past three thousand years (1987:1023 & 1024)
Attempts to systematize various “traditions” into a codified and consistent whole were already underway by the time of Chairman Mao's famous mandate to preserve the “treasurehouse” of indigenous medicine (Ergil 1996:193). The new regime’s efforts towards “preservation” of a “tradition” were very much motivated by the rise of modern biomedicine and scientific pedagogy:

After World War II when it [Chinese medicine] was incorporated into a modern mass health-care system, it underwent a thorough revision. Mass health care demanded unified standards of practice and a unified method of teaching in colleges. The traditional medley of different schools of thought and heterogeneous practices, many of which bordered on shamanism, were unified into a more coherent system, and superstitious elements were expunged. Traditional transmission by individual healers to their apprentices, with its emphasis on memorization of the classics and mnemonic verses, was replaced by efficient modern classroom methods of mass education. (Ellis, Wiseman, & Boss 1991:iii-iv)

Within the American context of “alternative or complementary medicine,” it is common to view Chinese traditional medicine as oppositional to Euro-American biomedicine, as somehow more holistic, less interventionist, non-causal, etc. Unschuld (1987) argues strongly against such a polarization, suggesting instead that Chinese medicine(s) and European medicine have some crucial commonalities. Upon beginning fieldwork at the Guangzhou (Canton) College of Traditional Chinese Medicine in 1982, Judith Farquhar found herself making some of these same evaluations of Chinese traditional medicine:

It was tempting when I was first there to see the social relations and institutional arrangements visible at the college as natural to “Chinese medicine.” The particular proportions of time faculty members spent in the classroom, office, and clinic; the lectures I received on the “holism” and “preventive emphasis” of Chinese medicine; the intellectual leadership of senior doctors and the deference younger doctors seemed to accord them; and the elegant order of knowledge laid out in clearly
Later Farquhar came to realize that the cultural features of Chinese medicine, which she had seen as “a refreshing alternative” to Western biomedicine, were actually “quite newly minted, as young as the institutional arrangements that allowed them to flourish” (ibid.). Rather than alternatives to biomedicine, these institutional arrangements, by and large, emerged in direct conversation and negotiation with biomedicine, which had threatened to obliterate traditional medicine during the pre-Liberation years (ibid:13).

Primarily through missionizing, biomedicine had been prevalent in China since the early seventeenth century. After the Medical Missionary Society was established in 1838, Western biomedicine increased rapidly with sizable hospitals established in many Chinese cities (Veith 1949:1). The ensuing clashes over regulation or even elimination of practitioners of Chinese medicine led to a shift in how China’s traditional medicine(s) were labeled: from “medicine” (yì) to “Chinese Medicine” (Zhong Yi). As Ergil points out,

A critical feature of this new Chinese medicine was its rejection of practices that were manifestly “unscientific,” represented in the creation of Zhong Yi. This disciplined form of medicine has emerged today as traditional Chinese medicine. (1996:193)

As such, Traditional Chinese Medicine (TCM) emerged as China's “New Medicine” by the time acupuncture exploded on the scene of American mass media in 1971-72. The key texts that were translated for American and European students of acupuncture date from this era of the new medicine, TCM (Seem 1990:6-7). Clearly, what counts as traditional Chinese medicine, as it has
been (for the most part) practiced and taught in the United States, reflects a very specific and very recent version of Chinese medicine(s).

Throughout this dissertation, I have chosen the term, *acupuncture*, rather than *Chinese medicine* or *Traditional Chinese Medicine*, precisely because of the slipperiness of defining exactly what is being translated. Questions such as which Chinese medicine and which tradition are at issue can not be easily answered. Paul Unschuld, whose medical historiography is cited in every rendition of the history of Chinese medicine(s), warns on the one hand that it would be quite difficult to identify a system of preventive and curative notions and practices, in China, that could be called ‘Chinese medicine’ .. (1987:1024), yet posits on the other hand, the existence of a “durable paradigmatic core” common to the plurality of Chinese medical practices (cited in Hare 1991:64 & 301). TCM can not stand as the sole representative of that paradigmatic core, as it so often does in popular as well as professional contexts in America. Perhaps a more appropriate understanding of TCM might begin by regarding it as a metaphor -- a metaphor for tradition.

**Translation Diagnostics: An Other Story**

As an acupuncturist-writer involved with “translating” Chinese medicine to an American audience, Ted Kaptchuk tells a story that has been told and re-told in many different contexts. The story of Yeshi Dhonden’s (the Dalai Lama's personal physician) visit to the Yale Medical Center offers a rich example of the separate worlds inhabited by biomedicine and Asian medicines. Yeshi Dhonden had been asked to examine a patient chosen at random and to explain his
diagnosis to hospital staff afterwards. Employing Buddhist and shamanic purification and meditation prior to meeting the patient, Dhonden used Chinese pulse-taking as well as other diagnostic techniques from diverse ethnic sources that have for centuries conglomerated into a peculiarly Tibetan medicine (Kaptchuk & Croucher 1987:25). After entering into “a trance-like vigil over the woman,” taking her pulse -- of which the watching Selzer wrote: “I know that I, who have palpated a hundred thousand pulses, have not felt a single one” (quoted in ibid:26) -- and examining a urine sample, Yeshi Dhonden gave his diagnosis in the hospital conference room:

Winds had been coursing through the body of the woman, currents breaking against barriers, eddying. They were in the blood, and were the signs of an imperfect heart. Long before she was born, Yeshi Dhonden explained, ‘a wind had come, had blown open a deep gate that must never be opened. Through it charge the full waters of her river.’ (ibid.: 26).

The formal diagnosis of the hospital staff was then given:


Kaptchuk calls the Tibetan's diagnosis “monk-like, furtive, poetic” (ibid.: 26). He does not analyze it further, and indeed there is a certain intractability to the story, to the alienating Otherness of each medical perspective in relation to the other.

The compelling nature of Dhonden's explication versus the objective, clinical rationalism of the biomedical diagnosis appear to stand worlds apart; how can cultural translation between these two worlds occur? One possibility, that of assuming the two worlds are inherently transparent to each other, is offered in by
Mirka Knaster in a popular book on alternative therapies in America. Knaster’s rendition acknowledges a differentiation between diagnostic practices but asserts an easy equivalency between the diagnoses themselves:

He [Dhonden] employed the Chinese method of pulse diagnosis -- reading the energy, or chi. The Western doctors used all manner of technology to investigate the same patient’s anatomy and physiology. Yet both came up with the same conclusion. . . . Different language, same condition. (1996:104)

This easy dismissal of “different language” as “same conclusion” or “same condition” is only possible within a tacit presumption that cultural translation can operate, like a dictionary, with a one-to-one correspondence between terms. Such an assumption not only neglects the intractable within translation, it jumps over intractability and otherness, reifying the translation process and totalizes the two “terms” as inherently the same. So how can translation occur, somehow leaving intractibility intact? American acupuncture practice is an arena where this kind of cultural translation -- one in which paradigm shifts are constitutive -- can begin to happen. An American client of acupuncture is likely to have encountered the classical Chinese concept of wind that is so central to Dhonden’s description of the patient’s condition. Treatment for a cold or flu may lead to questions regarding sweating on a cold or windy day: “Did you leave the door open so that a wind could enter?” While this example does not remove the intractability of Dhonden’s perspective, it gives a glimpse of a translative realm within which it might be engaged. Asking the question, how has acupuncture been culturally translated into American contexts, this intractability must remain our constant companion. At the same time, we can dive deep into each of the
worlds exemplified by the two diagnoses above with a questioning and open attitude. We may find then that "let[ting] that which shows itself be seen from itself" (Heidegger 1962[1931]:58) mitigates the alienating effect of the intractable -- what Kaptchuk refers to as "monk-like, furtive, poetic".

**Cultural Translation: Acupuncturists as Anthropologists?**

The facility to remain "with the phenomenon" is important because the EM [sic] of acupuncture claims that energy moves and people change, so it is incumbent upon practitioners to stay with what is happening now, and not become mired in the conclusion represented by a disease label. Of course, this [practitioners'] goal is not dissimilar to the ethnographic goal of relativity, and calling oneself back into awareness is not unlike reflexivity. (Cassidy 1996:5)

Cultural translation is a messy and mobile process that yields multiple and mutable results. Unlike translation between languages, there is no dictionary to which to refer. As noted in the Yeshe Dhonden story above, clear one-to-one correspondences between an objectified entity and its linguistic equivalent (such as "dog" and the German, "Hund," ) rarely appear in cultural translation. Cultural translation entails questioning into the nature of culture as well as into the nature of translation. On one level, we may be talking simply about how a cultural practice such as Ndembu boys' circumcision (Turner 1967) can be "translated" into English and into a cultural matrix that makes sense to Euro-Americans. For Victor Turner, that matrix or metaphor is the notion of rites of passage. The Ndembu themselves do not speak of rites of passage, they do not operate with the linguistic or theoretical equivalent of this structural metaphor. Turner uses it to render present [represent] a cultural practice of boys' circumcision that may
appear quite strange and alienating to a Euro-American readership. In the process he renders the strange familiar and the alienating sensible. But "to render" also carries the connotation "to rend." And in the process of making the strange familiar, making the bizarre sensible through the translatable medium of rites of passage theory in an essential and peculiar way leaves the Ndembu behind. When we speak and think of Ndembu experiences as "rites of passage" we have moved from the experience-near quality of ethnographic fieldwork to the experience-distant quality of most ethnographic theory.

This process can work in the opposite direction as well. Robbie Davis-Floyd (1992) uses the same translatable medium of rites of passage theory to render the familiar strange. "Standard procedures" for American hospital births suddenly seem bizarre and irrational when viewed through the anthropological lens of ritual and rites of passage.

These are examples of cultural translation as it is undertaken by anthropologists. Acupuncturists in the United States take on a similar challenge by undertaking a practice that has its own historical contexts primarily in cultural settings coded as "Eastern" and "Oriental" and therefore as Other. 9 Acupuncturist-writers are often quite explicit about taking on this challenge:

The ancient Chinese had their own myths, language, circumstances, preoccupations, and we have ours. This book represents a nexus, a point of convergence, a meeting of worlds. . . . Between Heaven and Earth is a cross-cultural transmission and transplantation. . . . We have dug into and mined the rich ore of Chinese medicine for the purpose of creating a new metal, a refined alloy. Through cultural blending, we are transmuting wisdom from early China into what has relevance for us today. Welcome to an ongoing process. (Beinfield & Komgold 1991:xiv)
In the process of this kind of cultural translation, how has otherwise been transmuted -- to use a potent aspect of the mining and alchemy metaphor presented by Beinfield and Komgold? How does the Other -- “traditional” or “classical” Chinese medicine -- become the newly transmuted, culturally blended Self -- American acupuncture?

**Metaphors of Social Bodies**

Lock and Scheper-Hughes indicate that the social body is a site of negotiation between nature, culture, and society (1990:50). The natural and social worlds are connected through symbols and metaphors of the social body that often operate as a powerful mode of translation (translation from nature to culture or from culture to nature). The mechanistic view of the body prevalent in modern Euro-American civilization, for instance uses the metaphor of the “body-as-machine” to translate from the cultural realm of production and mechanization to the natural realm of the body (Davis-Floyd 1992:48-51, Martin1987:chapters 4 & 5, Lock & Scheper-Hughes 1990:64). Within this worldview, human bodily being is separated from the realm of spirit, mind, or soul, and is reduced to the workings or malfunctions of its constituent parts. The results have been monumental. In pregnancy, labor, and birth the uterus is viewed as a more or less efficient machine, the woman as a factory laborer, and the doctor as the mechanic or factory boss, with the baby as a low or high quality product (Martin 1987:139-55). An elderly man’s heart failure is viewed by his doctor as “an old Cadillac that has broken down and needs to be repaired” (Davis-Floyd 1992:48).
A woman's uterus is removed, not for any pathological reason, but because she is menopausal and will no longer be "using" it (personal communication with a college student regarding her mother's hysterectomy). As Lock and Scheper-Hughes point out, within this machine-to-body equation

Lives are saved, or at least deaths are postponed, but it is possible that our humanity is being compromised in the process. (1990:65).

As developed in the next chapter, a technocratic culture of expertise has developed in which the power to understand and fix the body-machine lies in the hands of technical experts. Ordinary people could not possibly master the technical knowledge required to administer their own health:

This shift in the organization of medicine taught people to feel that science knew more about them than they could ever know or understand about themselves. People as patients began giving away the responsibility to care for their own health. The phrase health-care delivery system suggests the doctor is like a mail carrier who can deliver health at the doorstep. (Beinfield & Korngold 1991:24).

Health delivery to a passive patient by an expert doctor comes under sharp scrutiny by people who suffer from chronic conditions or conditions for which biomedicine really has no successful protocol:

I was mad at the medical establishment in general. That I had gone to doctors for so many years and sort of fell into two categories. One was that they completely dismissed me and told me that it was in my head. And the other was that they wanted me to do this laparoscopy and to sign a release so that they could make a determination at the time of surgery what they're going to take out and what they're going to leave behind. And I wanted them touching none of my organs. (Patricia, 26 years old)

For people like Patricia, the tacit agreement between doctor and patient in which "the client agrees not to challenge the professional's judgment or to demand explanations" (Fischer 1990:358) is no longer viable. Seeking and developing
other ways of working with and understanding her body leads Patricia to formulate a critique of biomedical hegemonies of expertise. When acupuncture becomes the venue for such an exploration, acupuncturists are uniquely positioned as cultural translators of an alternative medical worldview.

Metaphors as translative mediums for Chinese traditional medicine's multiple, fluid, and continually re-negotiated emergence in American contexts can reveal as much or more about the metaphor-makers as about the metaphorized subject matter. With the aim of effecting a cultural translation of an alternative medical worldview, many acupuncturists find themselves challenged to translate-create alternative metaphors for an alternative-hungry clientele or readership. How do practitioners meet clients' needs for alternative narratives and metaphors? How do they represent acupuncture in popular and educational texts? I will look here at acupuncturist-writers like Harriet Beinfield and Efrem Korngold, authors of *Between Heaven and Earth* (1991), one of the most popular books on Chinese medicine ever published, and Ted Kaptchuk, author of *The Web that has No Weaver* (1983), which, until publication of *Between Heaven and Earth*, held pride of place as the book recommended by most acupuncturists when their clients requested a book on Chinese medicine. It is now used primarily as a student textbook, and remains generally more popular among acupuncture students and practitioners than clients. Other acupuncturist-authors writing primarily for practitioners, eschewing the popular readership of Beinfield & Korngold or Kaptchuk, are working towards formulating “classic” styles of acupuncture treatment on the one hand (Ellis, Wiseman, and Boss 1990) and
distinctively “American” styles of acupuncture on the other (Seem & Kaplan 1987; Seem 1990).

**Metaphor I: a Mine or a Garden?**

As noted earlier, mining and alchemy are metaphors carried throughout *Between Heaven & Earth*. Clearly acknowledging that Chinese medicine cannot be appropriated wholesale, intact, and statically from one cultural context to another, Beinfield and Korngold compare the messy and constantly ongoing encounters between American acupuncturists like themselves and Chinese medicine to the creation of a new metal, “a refined alloy.” This alchemical process of appropriation (translation) is a process first of “mining” then of “refining,” “blending,” “transmuting.” Mining still carries much of the resonance of appropriation as a seizure without negotiation. To dig into the earth in order to extract an extant object has particular implications. Even if as an alchemist, you plan to “transmute” that object, the implication here is that you have the power to gain access to a highly valued object as well as to transmute a potentially less valuable object (coal, for instance) into something more valuable (diamonds) through alchemy.

Beinfield and Korngold further develop the metaphor of alchemy in the later portions of their book which follows a five element structure. While five element theory may be seen to have an origin (like yin and yang, qi, and the meridians) in classical Chinese medical texts and practices, Beinfield and Korngold render the five elements into five archetypes, one of which is the Alchemist. A postmodern blending of Jungian psychology, classical Chinese
medicine, and the self-quiz so popular in many health and beauty magazines,

Beinfield and Korngold’s archetypes are an explicit attempt to render Five

Element (or Five Phase) theory relevant to contemporary Americans:

Just as native flora transplanted to another region adapts to the new
environment in order to survive, so theories conform to cultural settings
and historical ages in order to remain relevant. Translating age-old
concepts from one culture to another in itself alters them. But in these
next chapters we have gone a step further by exercising our imaginations
and daring ourselves to cut a new trail through the old territory of Five-
Phase thinking.

We are reinventing as well as recapitulating classical concepts in order to
address the concerns of the people who walk through our clinic doors.
(1991:131)

Beinfield and Korngold structure much of their book in terms of a shift
from “body-as-machine” to “body-as-garden.” Like the archetypes and
metaphors of mining and alchemy, this metaphor (garden) is not inherent in
Chinese medicine (though it is a central part of Taoism). It is a translative move
between nature (the body) and culture/nature (the garden -- a cultivated natural
space). The acupuncturist as gardener is engaged “in an attempt to orchestrate
a fortuitous convergence of natural forces” (1991:242). Natural metaphors
prevail throughout the book as a means of asserting that humans and their
environment are not separate. In their chapter on acupuncture, for example, the
natural world appears when the function of the meridians is compared to a river
system:

The Qi courses through the body in perpetual motion similar to water in a
riverbed. Like the matrix of waterways that cover the surface of the earth,
these channels empty into one another, intersect, and have underground
as well as surface streams, connecting the interior with the exterior of the
body. (ibid:236)
In delineating the "motive force" of qi, the natural world again appears:

Like air, Qi has its own movement and also activates the movement of things other than itself. Just as the wind moves through the trees, grasses, and water, so Qi moves the chest, causing inhalation and exhalation. People do not inhale Qi. Rather Qi is the motive force that establishes respiration. In this way, Qi is the cause and also the effect. (ibid:31)

Beinfield and Korngold's references to nature, to the environment -- the trees, grasses, and water -- to exemplify qi works in tacit conversation with the worldview that most of their clients inhabit: the objectification of bodies, the alienation of self from body, the view of the body as other. This worldview, they argue explicitly, is part and parcel of the alienation and exploitation of the environment. Throughout their discussion of qi and of the doctor as gardener metaphor for understanding Chinese medicine, Beinfield and Korngold refer to ecology and use ecological metaphors. They reference the ecological practice of Feng Shui ("Wind Water") to show the activity of qi -- the movement of wind and water -- as either advantageous or disadvantageous:

By closely observing the formation of mountains, growth of trees, flow of water, movement of wind, and patterns of light and shadow, the practitioner of Feng Shui places us in a favorable relationship to these forces, to derive maximum benefit from the environment. The object [of Feng Shui practice] is to align human dwellings, objects, and activities with the current of Qi . . . . The doctor as gardener practices Feng Shui in that he seeks to place human beings in a beneficial relationship to Qi. (ibid:31-32)

Cultural translation for Beinfield and Korngold entails multiple metaphors that convey the complexity of Chinese medicine(s). In facilitating a particular American translation of acupuncture, these metaphors also collide with each other in their creative movement towards "transmutation" of a traditional, exotic
Other into a postmodern, holistic Self: Can an ecological emphasis co-exist with a mining operation? The book’s popularity suggests that as a cultural translation it works; it makes sense and helps acupuncture make sense to its readers. Perhaps, then, this translative combination of appropriation as seizure with a close attention to humans in their environment emerges out of and in conversation with a uniquely American social body.

**Metaphor II: Webs without Weavers**

Ted Kaptchuk’s *The Web that Has No Weaver* also develops an ecological metaphor for Chinese medicine(s) in which nature and landscape exist in deep relationship with the body. Rather than gardening, Kaptchuk’s ecological metaphor arises through art. The doctor is not compared to a gardener in this rendition, but to a painter. Humans and their environment, bodies and landscapes emerge as deeply relational in an analysis of traditional Taoist landscape paintings:

> In each person, as in every landscape, there are signs that when balanced define health or beauty. If the signs are out of balance, the person is ill or the painting is ugly. So the Chinese physician looks at a patient the way a painter looks at a landscape -- . . [the] body’s signs . . . express the essence of the bodily landscape. (1983:18).

The patterns of human bodies and the natural world, suggests Kaptchuk, share “an identity of poetic equivalence” (ibid:118).

In this translation of acupuncture and Chinese medicine(s) to Americans, the ecological relationality of humans and the natural world does not move forward to the creation of “a new alloy, a new medicine, as it does for Beinfield and Korngold. Kaptchuk’s ecological metaphor moves in some sense
"backwards" to a cultural critique of the assumptions underlying Euro-American ("Western") philosophy and medicine. In his opening chapter, Kaptchuk compares medicines of "East and West" through another example of "translation diagnostics" very similar to the Yeshe Dhonden story he tells later in Kaptchuk and Croucher 1987. Citing a clinical study carried out in several Chinese hospitals, Kaptchuk describes six patients who have all been diagnosed with peptic ulcer disease. The patients are then sent to a Chinese (traditional) physician who diagnoses the six different patients with six different conditions, from "Damp Heat Affecting the Spleen" to "Exhausted Fire of the Middle Burner" (1983:4-7).

Where Yeshe Dhonden's diagnosis is left intractable, Kaptchuk here uses the Chinese physician's descriptions of the six conditions not only to explicate the Chinese medical notion of "patterns of disharmony," but also to develop a critique of the Euro-American notion of causality. Rather than six separate diagnoses, or disease labels, the Chinese physician's descriptions of each patient's condition are descriptions of "patterns of disharmony." Kaptchuk distinguishes such patterns from a mono-causal diagnosis. A pattern of disharmony is discernible from asking "What is the relationship between X and Y?" rather than "What X is causing Y?" (ibid:4).

Oriental diagnostic technique does not turn up a specific disease entity or a precise cause, but renders an almost poetic, yet workable, description of a whole person. (ibid.) Describing the whole person rather than working from an assumption of causality as the basis of this form of diagnosis also forms the basis of Kaptchuk's critique.
The “web that has no weaver” is also the “cause [that] is not a cause” (the subtitle for chapter five of Kaptchuk’s book).

In evoking this relational worldview, Kaptchuk gives his readers necessary tools for making a leap in thinking about how a person gets sick. Such a paradigm shift from causality to relationality requires more than an abstract philosophical understanding of critiques of causality. Kaptchuk notes that in thinking about why people get sick, a person, in Chinese medical thinking, must be regarded in terms of “environment, emotional outlook, and way of life” (116, 118). Again, a human being is a microcosm of the natural environment (117). In a pattern of disharmony such as “Dampness,” for example, bodies and environment are congruent:

To the [Chinese traditional] physician, the view of Dampness, for example, as a cause of disease is less important than . . . Dampness [as] a pattern of qualities and events that relates a person to the natural environment. . . . Dampness in the environment is wet, heavy, sodden, and lingering; Dampness in the body makes a person heavy, bloated, and slow. (116-117).

Now used primarily to orient students of acupuncture to an alternative medical worldview, The Web that has no Weaver translates the culture of Chinese traditional medicine through an ecological metaphor. By aligning bodies and landscapes, nature and humans, Kaptchuk facilitates a cultural critique: readers are urged to question tacit notions of disease causation and make a paradigm shift into a relational etiology of illness.

Metaphor III: Images of Energy

Offering an alternative to the biomedical model of body-knowledge as accessible only to trained physician experts, acupuncturist-writer Mark Seem’s
work also translates acupuncture into a realm of paradigm shift. While some
acupuncturists and writers about acupuncture argue against reducing how
acupuncture works to the amorphous category of “energy,” Mark Seem’s practice
of and writing about what he explicitly describes as a distinctively American
acupuncture style relies heavily on the development of a notion of “energetics”
(cf. Seem and Kaplan 1987). A fascinating blend of academic and health care
training, Seem’s brief biography reads as follows:

Mark D. Seem received his doctorate in French Studies from the State
University of New York, where he studied with Michel Foucault and wrote
a dissertation on the Nietzschean concepts of power and force in modern
French philosophy. While co-translating Deleuze and Guattari’s Anti-
Oedipus, he trained at the innovative La Borde clinic in France.
Subsequent to finishing his dissertation, he worked with the mentally ill
and retarded, taught psychology, and trained mental hygiene therapy
aides in a state institution, while beginning his formal study of
acupuncture. He trained at the Quebec Institute of Acupuncture in
Montreal and at affiliated centers in New York City. Dr. Seem is founder
and director of the Tri-State Institute of Traditional Chinese Acupuncture
... [as well as] a past president of the National Council of Acupuncture
Schools and Colleges and a former commissioner on the National
Commission for the Certification of Acupuncturists. (MacPherson &
Kaptchuk 1997:365)

Seem describes his style of acupuncture practice as “stemming from French,
TCM, and Japanese influences, and informed by a Western psychosomatic and
behavioral perspective” (1990:7-8).

In Acupuncture Imaging (1990), a text that is clearly written in
conversation with other practitioners, Seem notes that the phenomenon of
“imaging” (a sort of visualization), as he describes it occurs whenever
acupuncturists meet their clients,

especially in the initial interview, because they are taking the details from
the client’s report and reconceptualizing it -- whether they share this
reconceptualization with their clients or not -- as an energetic phenomenon requiring an energetic treatment. . . . (57-58, emphasis in original)

Through “energetics,” Seem develops a metaphor that helps him translate the practice of acupuncture into terms that his clients can not only understand, intellectually, but also engage with bodily. For the practitioner, while this imaging may be a largely unconscious process, a process of translation, Seem advocates for it to become not only conscious and mindful, but also a basis for facilitating clients' healing:

When we acupuncture therapists perform an acupuncture imaging, I do not see how we can maximize the effects of acupuncture unless we are clear with ourselves and our clients [about the process of reformulation] . . . Imaging empowers a person to perceive his problem in a new light and from a different vantage point, serving as a catalyst to change. (ibid:58)

The key to the effectiveness of energetic imaging is the particular embodied way that Seem shares the imaging with the client, inviting clients to formulate “their own energetic story” (ibid:83):

I take this imaging a step further by educating the person about what I perceive in the acupuncture-energetic terms that I use. Rather than making an acupuncture or Oriental medical diagnosis, I offer a phenomenological description of the person’s energetics as I see it, while palpating the points and zones to elicit confirming responses (a bodily felt sense) from the client. . . . Palpating the affected zone while providing an energetic description of the zone leads the client into a bodymind energetic image. Pacing my comments and my palpation so that intellectual understanding and bodily awareness coincide with bodily felt reactions . . . in a way that empowers the client and maintains control in his hands . . . . (ibid:58-60).

Literally “pointing out the body” for clients, Seem guides clients to their own “imaged” bodies with his words and his hands. Embodying his words through
touch, Seem invites individuals to “give the body its due” (Sheets-Johnstone 1992) and develop their own body narratives.

As a result of becoming aware of “imaging” in his own work, Seem has a radically different view of the effectiveness of needling. Rather than seeing acupuncture needles as a particular kind of technical intervention, over time Seem came to view the imaging of complaints in energetic terms as the precondition for the effectiveness of the needles once they were inserted. I began to trace the pathways carefully on the client, to help him feel the areas of conflict and to visualize how they would flow when restored to normal functioning. (ibid.: 10)

Needles, too, “point the way to the body” allowing clients to become active agents in the healing process, to enact their own bodily transformations towards healing.

Seem’s metaphor of energy imaging, of visualizing meridians and the flow of qi along them opens the way to another crucial paradigm shift. The physician-patient relationship as constituted in biomedical models of health care precludes patients from the kind of knowledge physicians have about patients' bodies. Seem’s newly American practice of acupuncture emerges in explicit response to that model, inviting clients, not only to learn through the guidance of their practitioners (practitioners here as teachers rather than experts), but also to supersede practitioners’ knowledge and develop their own body-knowledges, creating their own body narratives.
Space as Translative Medium

The requirements for practicing acupuncture are quite minimal: a warm room, a place for the recipient to lay during treatment, and a collection of needles are the essentials. Any accouterments beyond these clearly represent cultural rather than physical necessities. A close look at the choices made by practitioners in settings in the United States reveals much about the cultural translative moves made by acupuncturists as they bring this healing modality to a Euro-American clientele.

Once deciding to pursue acupuncture care, a client's first encounter with acupuncture is generally the acupuncturist's office or clinical setting. What messages are conveyed through the spatial arrangement of key objects, some familiar and some quite strange to the new client? What are the translative moves ostensibly made to attract American clients? How do practitioners structure their clinical environments to accomplish reassurance, familiarity, and ease in the face of a treatment modality that most Americans encounter with some measure of nervousness?

A natural health care clinic in Portland, where I worked as an acupuncturist's assistant as well as an ethnographic researcher, occupies a building that used to be a dentist's office. The structure of its spaces creates the reassurance of allopathic familiarity. Offering naturopathic care, acupuncture, shiatsu massage therapy, chiropractic, and counseling, the clinic contributed to the oft-quoted New England Journal of Medicine statistic: 33% of Americans were involved in some form of alternative health care in 1990 (Eisenberg et al.
1993). Upon entering, there is a reception room with staff behind a walled desk and requisite chairs and magazines for waiting. Off to one side is the hallway with treatment rooms, numbered one through eleven, each with its own sliding door. The staff in the reception area can communicate with practitioners in any of the rooms via intercom if necessary. A stereo system pipes soothing New Age music into each room.

In the allopathic model of health care, the patient is the one “acted upon.” Alternative health care practitioners often complain about this designation, indicating that the politics involved in using the term, *patient*, structurally position the practitioner as active and the client as passive. At the Portland clinic, the designation, *patient* was retained and used frequently. This may be due in part to the fact that almost all the staff, especially the primary receptionist, had worked in conventional health care before working for alternative practitioners. It was also very clear, however, that this usage lent an air of professional authority to a clinic wishing to dispel misperceptions about a lack of “seriousness” in alternative health care. The acupuncturist I assisted, who is also the clinic’s co-founder and manager, responded as follows when I asked whether there was a dress code for staff members:

People already think we’re a little kooky. We don’t need to give them anything to support that. (Edie Vickers)

Phrases like “the doctor is in with a patient now” allow new patients to feel they have entered a familiar setting when they come to the clinic for the first time. Already nervous about needling, these patients often require reassurance if they are to feel at home with alternative health care. The institutional shape of
the clinic, with its tacit replication of allopathic clinics and its explicit
*doctor/patient* designations, broadcasts a clear message that alternatives in
health care are safe, familiar, and noncontroversial. People often try an
alternative or unconventional therapy precisely when the boundaries between
allopathic and alternative treatments are blurred. Clinics such as this one in
Portland provide reassurance and familiarity in the organization of their spaces
and in the signifiers broadcasting social roles and statuses of practitioners.

In contrast to the setting of a multi-practitioner clinic (that may come to
represent “alternative health care” in general), acupuncturists in private practice
may organize their spaces quite differently. Clients encountering acupuncture
with Sarah Wilson, a Minneapolis acupuncturist who practices in her home, enter
into the living room of a comfortable, neat and clean house. They may sit on a
couch with magazines and books nearby that seem to be in the process of being
read by the house’s inhabitants. The only clue that a business is run out of the
house is the large desk and telephone at the foot of the stairs near the front
door. Here clients make new appointments and Sarah organizes her schedule.
Generally greeting clients at the door, there is not much need for a waiting area
in Sarah’s purposefully small practice. Following her up the narrow stairs to her
home’s second floor, clients may note the location of the bathroom and of
Sarah’s study/office. All other doors are closed until the client reaches the
treatment room at the end of the hallway. A sparse and small room, the only
furniture is a treatment table covered with a fresh sheet, a tall stool (level with the
treatment table), and a low table on which acupuncture needles and moxa have
been placed. A generic “Oriental” looking painting hangs from one wall. There is barely room for a practitioner in this room. Sarah shows me how the treatment table only barely allows her small body to fit between it and the wall so she can move around the client in a complete circle. There is no stereo and no music. Sarah explains to me that for the twenty short minutes of a treatment, a client would do well to experience a little silence.

What messages of cultural translation are conveyed through Sarah’s sparse and homey practice space? It is clear, as Sarah also states in her interview with me, that she is not seeking new clients, she is not attempting to “attract” and “reassure” a clientele of people who have never before encountered acupuncture. Her practice is geared towards a body of people who intermittently, sometimes for a period of several weeks (for a particular problem), seek a good portion of their health care from her. When they come to her house, they feel they are visiting a friend. The atmosphere of hominess was exemplified during one of my visits to Sarah’s practice when a client appeared after riding her bike through a steady rain. Sarah immediately offered to throw her wet clothes into the dryer in the basement. The client remarked to me: “that’s just how she is, she makes you feel at home.” If clients do need to wait because a treatment is running long, Sarah offers her kitchen and an array of herbal teas.

Rather than the reassuring familiarity of a doctor’s office, Sarah’s practice space conveys the reassurance and nurturance of home. In direct contrast to a clinical space, there is no receptionist (walled off from clients), no separated
waiting area, and no markers that indicate the space is being used for health care. Some clients find this disconcerting, as did one woman who traveled to Sarah's neighborhood -- an ethnically diverse section of Minneapolis that is not at all free of gang violence or racial tension -- from an upper class suburb. Of this woman, Sarah observed:

She had a lot of stereotypes of what my neighborhood was like and then coming into the house and walking up the stairs and the stairs weren't quite fixed up and sitting on the thing [?] and then . . . said "I can't take this" and left. I said, "okay."

Class issues are critical here and Sarah describes her clientele as primarily lower-middle class and working class. Clearly her messages of "hominess" do not fit with a class sensibility that aligns itself readily with biomedical health care structures and biomedical practitioners who often share the same class backgrounds as the suburban woman.

Straddling the clinic spatial structure and the "alternative" structure of a practitioner like Sarah, both Abbie Dring and Terry McCormick offer some of the familiarity of a conventionally structured health care space: a waiting area, alternative health care magazines and a reception area where clients make appointments, pick up herbs, and pay for treatments. Nestled in an old building in the Lincoln Park area of Chicago, Abbie's office had many decades of doctors' practicing in it. Describing the first time she ever saw the office space, Abbie remarked, "the healthy energies of the previous tenants would be as healing for people as the treatments I give." Her treatment room, comfortable and eclectic, subtly lets clients know, however, that they are not in the realm of conventional allopathic medicine anymore. Fragrant incense greets clients as they walk into
the reception area, accompanied by a small notice on the wall informing clients that the smell is “traditional Chinese incense.” Abbie’s treatment room carries few markers of conventional health care: A remarkable collection of colored glass ornaments in the windows to detailed posters of acupuncture points and meridians, as well as charts delineating the five elements (or five phases) of earth, fire, metal, water, and wood. Shelves are stocked with Chinese patent medicines and books on acupuncture, acupressure, chiropractic, anatomy and physiology, and kinesiology. Books and notebooks for Abbie’s chiropractic studies are strewn together with the fresh fruits and vegetables comprising her lunch. Underneath the treatment table itself, clients soon become familiar with Abbie’s beloved dog, Daisy. Like Sarah’s home-based practice, Abbie’s office has the feel of a college student’s apartment. Clients often readily become friends, and the tops of her bookshelves hold small crystal and glass gifts given to her over the years by her clients.

Terry McCormick’s practice is much newer than Abbie’s or Sarah’s; he is a recent graduate from OCOM who is just beginning to practice on his own and in a community where potential clients know very little about acupuncture and may be quite wary of trying it. Terry’s first office, rented within a counseling clinic, had no waiting area, although clients could wait in the large waiting area that served the entire building. Clients walked into a room that included the practitioner’s desk and phone with herbs lining the shelves along the walls and one shelf of books. A chair next to the practitioner’s desk invited clients to sit down and talk with the acupuncturist. An adjacent room functioned as the
treatment room, with hooks to hang coats and clothes. A massage table in the center of the room, covered with a clean sheet, focused clients’ attention. A wheeled chair for the practitioner, another chair for clients, a heat lamp and a low table with needles and cotton balls constituted the furniture in the treatment room. On the walls hung one or two artworks depicting the acupuncture points and meridians as they would relate to male bodies.

Terry recently moved into a new building with much more space. While retaining a decidedly “Oriental” decor, the new office, as a whole, carries many more markers of allopathic medicine. He now has a private reception area (not shared with other practitioners), a private office which houses his desk, books, and a burgeoning herbal pharmacy. With two treatment rooms, he can now treat two patients simultaneously. Overall, this office would feel quite familiar and reassuring to new clients whose only health care experiences have been in physicians' offices. Terry was “the talk of the town” when he first arrived in Winona, and at least one new client of acupuncture described him as “an excellent physician.” While I don’t think the speaker mistook the acupuncturist for an actual physician, the allopathic markers in Terry’s treatment space allowed this client to freely compare Terry’s services to that of an allopathic physician.

The arrangement of treatment spaces conveys a great deal about the social space within which acupuncture is encountered by clients and practiced by acupuncturists. Different types of clients are attracted to each of the spaces described above, and each acupuncturist expresses different facets of her or his treatment style through their spaces. While Abbie’s and Sarah’s treatment
spaces challenge clients to make a shift in their paradigm of health care. Terry's and the Portland clinic's spaces reassure clients that their treatment choice has not led them to a terribly foreign country.

**Autoethnographic Reflexion**

Late last summer I became quite sick with stomach and intestinal symptoms that claimed my body tenaciously for over a week. The pain was intense, and I was obligated to fast as any food was immediately expelled in either of the two ways human bodies commonly deal with lethal toxins. It seemed clear to me that this was no ordinary stomach flu. I feared food poisoning, some intense new virus, or a parasite comfortably lodged in my stomach lining. Terry, my acupuncturist took one look at me, especially upon tongue diagnosis, and nodded knowingly. “You've got Summer Damp Heat.”

After seven years of field and library research on acupuncture, I blinked back tears. “So is it a virus or food poisoning or what?” I demanded.

“Now you know, Mitra,” my inimitable practitioner reminded me earnestly, “that is a whole other system of medicine.”

With the warmth of the heat lamp relaxing my stomach, along with an incredible spreading *qi* response to a needle in my upper abdomen (CV 12, “Center of Power”), I breathed deeply and decided to enjoy feeling well rather than obsessing over why I was sick. While Terry’s ministrations helped my body tremendously -- I had no more fever after my acupuncture treatment, and the herbal remedy soothed my stomach cramping considerably -- my mind was in a furor. What had happened to me? What caused my horrible experience?

Later that evening, I decided to ask that question of Ted Kaptchuk’s *the Web that has No Weaver.* Kaptchuk reminded me of what my practitioner’s perspective was as he made his “diagnosis”: his concern was not to figure out what “the invading force” (virus, bacteria, etc.) actually is, but to take the signs of that force and add them “into the patient’s total configuration of signs -- including color of face, pulse, tongue, emotional outlook, and so forth” (1983:117). When the practitioners does this, Kaptchuk notes, the environmental, emotional, and physical factors contributing to the illness are never separate from the illness.

Chinese traditional medicine is not a causal system -- this I knew. It is a relational one -- this I knew, too, but had yet to embody. To embody this
relationality, you are required to make a paradigm shift. You can’t keep one foot in the paradigm of causality. Kaptchuk sums it up, coincidentally using just the condition I had been diagnosed with: “The condition is not caused by Dampness; the condition is Dampness. The cause is the effect; the line is a circle” (1983:117).

So if I really take myself -- with both feet -- out of the paradigm of causality and into a relational interpretive story, then I simply see myself as I am. I am a person who is juggling the beginning of a new semester, with a three-course teaching load, writing and finishing her doctorate, practicing calm-patience with her three year old, relaxing with the bright engaged mind and heart of said three year old, homesteading, loving and supporting her partner, loving and supporting her friends, loving and supporting herself. Not least of these characteristics, then, is living as an integral part of her physical environment, which has been hot and inordinately damp and moldy. The point being that all of this just is in all its peculiar specificity. The nagging question of “why did I get sick?” in some measure actually simply falls away.

Conclusions

Cultural translation always already occurs in the encounter between Americans and acupuncture. Whether as clients or practitioners, Americans who engage with acupuncture contribute to and help create precisely what it is that they are engaging with. This encounter is primarily a social one; it is in the social body that political and individual forces interact and appropriation takes its different forms. “Translating channels” entails a movement of appropriation that can range from an unnegotiated seizure to a highly negotiated “ownness making.” The following chapters will explore this range more specifically, beginning with the political realm of biomedine’s appropriative relationship to acupuncture.
CHAPTER THREE
TECHNOCRATIC BODIES:
BIOMEDICINE'S APPROPRIATIVE ENCOUNTER WITH ACUPUNCTURE

It is commonplace today to say that we live in the age of expertise. Expert knowledge is indeed one of the most distinctive features of modern society; it is tightly woven into the very fabric of our existence. . . . Our reliance on experts is now nothing less than a central component of a deep-seated transformation.

-- Frank Fischer, Technocracy and the Politics of Expertise

As a seizure without negotiation, appropriation at the political level engages forces of regulation, surveillance, and control (Lock & Scheper-Hughes 1990:50-51). Beginning this analysis of acupuncture appropriation with Technocratic Appropriation allows me to examine the political economy of appropriations of acupuncture. Following Davis-Floyd's (1992) and Fischer's (1990) analyses of technocracy, as well as Foucault's analysis of the mutuality of power and knowledge (1980), I define technocratic bodies as those politico-economic entities that derive their power from the technical and technological knowledge of highly trained and specialized experts. In individuals' encounters with acupuncture, can we identify the technocratic bodies that exert control over individual bodies? What structures of appropriation do technocratic bodies engage in through regulative, gatekeeping forces? How do individual bodies ("the Public," below) as well as the mediative bodies of practitioners respond to technocratic regulation and rhetorics of paternalism? How are the hegemonic structures that keep technocratic bodies alive sustained?

In studying health care practices "alternative" to biomedicine, medical anthropology generally emphasizes biomedicine and examines how it is
constructed and maintained as a cultural authority. Alternatives are viewed as challenges to biomedicine, and research focuses on uncovering the mechanics of hegemony by examining how biomedicine establishes and maintains its hegemony in the face of a challenge to it. As previously noted, Martha Hare's overall purpose in studying acupuncture use among non-Asian New Yorkers is to establish a “critical analysis of Western biomedicine by seeking to understand the dynamics of a challenge to that system” (1991:1). Paul Wolpe's analysis of the political economy of acupuncture also problematizes acupuncture as a threat to the professional authority of American physicians (1985). Within this medical anthropological research model, biomedicine occupies an intellectual and discursive primacy. My aim in this dissertation generally is to keep acupuncture at the forefront of analysis. When examining biomedical hegemony, I am interested not so much in how that hegemony is maintained but rather in how the appropriative encounter changes both appropriator (biomedicine) and appropriatee (acupuncture). The analysis of rhetorics of integration later in this chapter allows acupuncture to return as the central focus.

In the meantime, acupuncture, for the most part, does not retain a discursive primacy in the pages of this chapter. My effort here has been towards enacting the medical anthropological research model as a mode of disclosure. What reveals itself through implementing this model of research and in what ways can it open up the technocratic crossroads of power and knowledge? As such, Wolpe's technocratic "history" of the emergence of acupuncture in the United States is the only such history that specifically contends with that
emergence as a challenge to biomedicine’s cultural authority. I find it useful, then to follow Wolpe as a preliminary guide for unpacking the specific manifestations of power/knowledge as biomedicine’s gatekeeping forces are mobilized through technocratic bodies like the American Medical Association (AMA), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH). These institutional bodies have conducted a series of tacit conversations with a public that in 1993 spent an estimated half billion dollars (almost entirely out-of-pocket) on acupuncture care (Eisenberg et al. 1993). I am interested in the archaeology of those conversations, the modes by which powerful societal institutions maintain cultural authority and narrative hegemony. And finally, what effect does an increasingly engaged-with-health-care public have on that hegemony? The conclusion of this chapter will analyze why Wolpe’s and others’ (ex. McQueen 1985) pessimistic prognosis for the future of acupuncture -- as a completely marginalized, co-opted, and silenced modality -- have not in fact come true.

**Acupuncture’s Arrival Story**

Acupuncture has been practiced in the United States since the 1800s, but this practice had been largely limited to Chinese and other East Asian immigrant communities. Americans remained largely unaware of acupuncture as a treatment modality available to them until its “arrival” just prior to President Nixon’s historic opening of diplomatic relations with China. The story of acupuncture’s arrival in the U.S. is often rendered as a dramatic “explosion” (NIH
1997:1) or “flurry of activity” (Culliton 1997), an event that even has a specific birthdate. On the front page of the New York Times on July 26, 1971, foreign correspondent, James Reston, titled his report, “Now, About My Operation in Peking.” Told and retold in the popular media ever since, this story and its retellings reveal a great deal about the tensions between a biomedical hegemony and marginalized health care alternatives. Covering the gradual warming of U.S.--China relations during Secretary of State Henry Kissinger’s groundbreaking visit, Reston suddenly found himself undergoing an emergency appendectomy at the Peking Anti-Imperialist Hospital (which he calls “the quietest hospital in the world”).

Treated with acupuncture for post-operative pain, Reston described his second night in the hospital:

Li Chang-yuan, doctor of acupuncture at the hospital, with my approval, inserted three long thin needles in the outer part of my right elbow and below my knees and manipulated them in order to stimulate the intestine and relieve the pressure and distention of the stomach. That sent ripples of pain racing through my limbs and, at least, had the effect of diverting my attention from the distress in my stomach. Meanwhile, Doctor Li lit two pieces of an herb called ai, which looked like the burning stumps of a broken cheap cigar, and held them close to my abdomen while occasionally twirling the needles into action. All this took about 20 minutes, during which I remember thinking that it was a rather complicated way to get rid of gas in the stomach, but there was noticeable relaxation of the pressure and distention within an hour and no recurrence of the problem thereafter. (Reston 1971:1 and 6).

As the first account of patient satisfaction with acupuncture, Reston’s story stimulated tremendous popular and medical attention. His choice of descriptive phrases also positions the writer and reader in particular ways in relation to the viability of acupuncture as a health care option. Clearly acupuncture treatment
itself is painful for Reston -- needling sends "ripples of pain racing through my limbs" -- but he describes this pain as a "diversion" from the overall condition of his body. This cultural trope of abandoning the body in pain, escaping from it, is one I take up in chapter 5 and one that was culturally familiar to many of Reston's American readers.

The burning herb Reston mentions is a reference to moxibustion, a common complement to acupuncture treatment in Chinese as well as American practices. Comparing the moxa stick to "the burning stumps of a broken cheap cigar" also positions writer and reader in specific ways in relation to acupuncture care. At this point, neither Reston nor the American media generally is suggesting that acupuncture is a viable health care option for Americans. Clearly his description is intended to evoke an exotic, though also "cheap" and less sophisticated "folk" remedy than modern biomedical health care. While Reston's overall description is extremely respectful and grateful of the care he received in the Peking Anti-Imperialist Hospital, his "insider" perspective maintains the journalist's exotifying and othering gaze.

But Reston's report was not to remain a "sensation of the week" story that quickly faded out of popular consciousness. Martha Hare describes the social context of American medicine in the 1970s as one of explicit critique, in which the professional hegemony of biomedical health care was on the decline due to "racism, sexism, and general inability to deliver the goods." (1991:51):

The timing of this announcement [Reston's report] could not have been better. Here was a low-cost, low-tech medical intervention which also received media attention with seemingly fantastic images of individuals sipping tea while undergoing major surgery. Thus, there was a
confluence of the American need for something simple, and the mystique of the Orient. (ibid:61).

On the heels of Reston's July 1971 report, a flurry of media coverage followed including claims that Chinese medicine could cure blindness and deafness and that surgeries could be and had been conducted with only acupuncture anesthesia. In September 1971, a few months after Reston's surgery, four distinguished physicians spent a month as guests of the Chinese Medical Association. These delegates, along with the personal medical and osteopathic physicians who accompanied President Nixon during his historic visit several months later, all wrote with astonishment about witnessing acupuncture anesthesia (ex. Dimond 1971). As Paul Wolpe points out, what counted as "acupuncture" was immediately refined by the biomedical delegates:

American physicians concentrated their glowing reports on acupuncture anesthesia and usually ignored therapeutic or 'traditional' acupuncture, which had been developed over 5,000 years based on Chinese theories of etiology, diagnosis and treatment. (1985:411).

In a footnote, Wolpe finds it "interesting" that this focus on acupuncture anesthesia emerges in the context of James Reston's operation which "was performed under conventional anesthesia [while] what he reported in the New York Times was his experience with traditional acupuncture" (1985:411n. 5).

Even more interestingly, in retellings, Reston's story has on occasion been rendered as a story about acupuncture anesthesia rather than traditional acupuncture.17

The shift in focus from what Wolpe calls "traditional acupuncture" to acupuncture anesthesia after the medical delegates returned to the United
States is significant. Western biomedicine was clearly a primary form of medical care in China at the time of Nixon’s visit. To attend to acupuncture anesthesia and ignore “traditional acupuncture” entailed attending to a very recent biomedical co-option of traditional acupuncture practices, while marginalizing the health care modality that most of China’s population used and that emerged out of several thousand years of consistent use. The U.S. delegates, while seeking the familiar in the strange, were also interested in what could be readily appropriated into American biomedical practice. Appropriating a new form of anesthesiology was not only familiar territory, but also more appealing than studying an entire medical cosmology for its appropriability.

Seeking the appropriable is a key activity of hegemonic institutions. Wolpe notes that the status of legitimacy for an institution like biomedicine “depends on ongoing public acceptance of a profession’s claim of exclusive expertise over a realm of specialized knowledge” (1985:409). Thus, this initial biomedical encounter with acupuncture must be seen in terms of the power structures that protect, reify, and control particular knowledges.

**Barbarian at the Gates: the AMA Protects Patients**

Historically the American Medical Association has situated itself as the arbiter of safety and efficacy in American health care. In 1847, at its founding, the AMA described its mission as “enlightening and directing public opinion in regard to the duties, responsibilities, and requirements of medical men” (quoted in AMA 1992:vii). In 1998, the AMA identifies as part of its “core purpose” the
pursuit of “being the world’s leader in obtaining, synthesizing, integrating, and disseminating information on health and medical practice” (www.ama-assn.org). The 1998 Mission Statement emphasizes “advocating for the highest principle of all—the integrity of the physician/patient relationship” (ibid.). Acupuncture’s appearance on the scene of mainstream American health care poses a challenge to the overall mission of the AMA. As Wolpe points out, acupuncture fell under physicians’ cultural jurisdiction, so the public turned to the medical profession for interpretation. Hundreds of letters flooded the AMA, many of them still archived in its Historical Health Fraud and Alternative Medicine Collection (AMA Archives, Chicago, IL). Responses to these requests for information were met with a dismissive form letter:

The American Medical Association does not engage in the approval or disapproval of forms of practice, except where the method follows the ideas of an individual and can be classified as cult practice. This would apply to chiropractic, naturopathy and others. It does not appear that acupuncture falls in the category of cult practice. (AMA Historical Health Fraud & Alternative Medicine Collection, Box #18).

While it may not have been dismissable on the basis of “cult practice,” acupuncture in the early 1970s was also not dismissable, because

Acupuncture was an alien treatment with an alien philosophical basis . . . ; it was not an indigenous alternative modality that reacted to (and thus was informed by) the biomedical model. (Wolpe 1985:413).

The challenge for biomedicine as a hegemonic institution was to render acupuncture familiar, to “de-alienate” it, to domesticate it. From that standpoint, it could be taken over -- seized and redefined -- appropriated by physicians.
By 1974, public interest and media coverage had reached such a degree of infatuated curiosity that the AMA took an official position that attempted to situate acupuncture into an appropriable position. In December 1974, the AMA’s House of Delegates declared acupuncture “an experimental medical procedure which should be performed in a research setting by licensed physicians or under their direct supervision and responsibility” and adopted a House Resolution urging “constituent state and territorial associations to seek appropriate legislation and regulations confining performance of acupuncture to such research settings” (AMA Digest of Official Actions, 1969-1978:350). Without specific legislation stating otherwise, medical doctors could legally practice acupuncture without any training in acupuncture techniques or knowledge of Chinese traditional medicine while professionally trained acupuncturists would be practicing illegally. Like New York’s statute, adopted in 1974 (and unrevised until 1991), most states found themselves “backed into a corner” by pressure from the AMA to relegate acupuncture as an “experimental” practice, only to be conducted under physician supervision (Hare 1991:287).

**TV Doctors: Protecting Patients from Themselves**

Using the physician as the standard of an alternative therapy implies that with his or her medical training, a medical doctor would be capable of practicing other health care modalities, even those that have thousand year histories in other cultural settings and extensive training requirements. The AMA has long taken the paternal role of protecting a nation of patients. This paternalistic role
was satirized and reinforced in an NBC teleplay that aired in 1972 in which doctors at a highly respected pain clinic worry that if acupuncture is not properly regulated and relegated into the hands of physicians, where it will be “safe,” the nation of patients is in danger of becoming a “nation of pincushions.” Everyone would have the opportunity to buy their own acupuncture kit and try out different points on themselves:

It’s too late to ignore it; it’s getting attention from the media and if we don’t study it, someone else will, with the end view of commerce. Arthritis bracelets and ozone boxes will be nothing compared to do-it-yourself acupuncture kits. Five dollars for charts and needles. We’ll have a nation of human pincushions on our hands! (Collins & Schlitt 1972).

Directed at a public who may well pursue acupuncture regardless of AMA warnings of its “experimental” status, the teleplay acts as a scare tactic to warn consumers that if they take matters into their own hands, they’ll end up “the sickest goddamn nation in the world.” Directed also to America’s physicians, the program’s protagonist, a renegade physician-researcher, rails against the medical profession’s resistance to research acupuncture. His proclamation to appropriate acupuncture through research and experimentation is not made in the interest of offering a potent new analgesic to the patients at the pain clinic, but in a vision of the future intended to horrify both audiences -- the potentially renegade “public” and the recalcitrant “medical profession”:

You know what you’re doing, don’t you? With your smug, self-satisfied stupidity? You’re going to take acupuncture out of the medical academy and you’re going to put it in the hands of quacks. You’re going to have neat little offices all with charts on the walls and incense in the ashtrays, and they’re going to be treating coronaries and cancer, and people are going to die because you intransigent reactionaries won’t even listen. Okay, you hang onto your diplomas and your initials after your name, because in 20 years you’re going to have the sickest goddamn nation in
the world, because you're compounding your ignorance and complacency with ignorance and rigidity. (ibid.)

Paternalistic control is the central force in this popular cultural rendition of a pro-appropriative (through the benign medium of "research") AMA stance. Protecting its children from hurting themselves, potentially even from death at the hands of "quacks" is the ultimate motivating force.

**Eisenberg: the Politics of "Advising" Patients**

In June of 1997, technocratic forces of regulation, surveillance, and control emerged again on the scene of American health care through nation-wide media coverage of the publication of the latest professional paper by a physician who has positioned himself as an expert on Chinese medicine(s) and alternative therapies, generally. A founding member and director of Beth Israel Deaconess Medical Center's Center for Alternative Medicine Research, David Eisenberg has been an interesting political player on the field of acupuncture appropriation. As the first U.S. medical exchange student to China, post-Nixon, he has been positioned (and has positioned himself) as a pre-eminent cultural translator of Chinese traditional medicine to the West. In *Encounters with Qi*, Eisenberg relates his experiences, concluding that

\[
\ldots \text{well-designed clinical studies [are needed]} \ldots \text{to confirm acupuncture's clinical efficacy, reliability, and safety [or] there will be no referrals between conventional Western doctors and acupuncturists.} \\
\text{There will be no mutual understanding and no integration. (1985:120-21).}
\]

This rhetoric of integration has become a significant facet of biomedicine's current relationship with acupuncture, which I will take up below in the section on
the NIH. When Bill Moyers featured Eisenberg as his guide through Chinese
traditional medicine on a segment of his popular "Healing and the Mind" series in
1992, Moyers asked Eisenberg if after studying Chinese medicine between 1977
and 1985, he had ever become proficient in acupuncture as a technique. “No,”
responded Eisenberg, “I never felt the Qi” (Moyers 1993a and 1993b:265).
Moyers’ choice of Eisenberg as his expert guide conveys a particular stance
towards Chinese medicine(s); like fellow journalist, Reston, Moyers remains
engaged, respectful, and distant throughout his report on “the Mystery of Chi.”
Eisenberg -- a physician who has contacts among traditional medical doctors in
China, but has never “converted” to Chinese medicine(s) (has never “felt the qi”)
-- is a perfect choice for reinforcing the “othering” journalistic stance of
“objectivity.”

In a published interview, Moyers also asked Eisenberg how he initially
became interested in studying acupuncture and Chinese medicine(s).
Interestingly, Eisenberg cites Reston’s 1971 report as an impetus, making a
critical mistake in delineating that influence:

Twenty years ago I read James Reston’s column in the New York Times
about how he had an emergency appendectomy in China, and his pain
was controlled by needles. It was the first time I had ever read about
acupuncture anesthesia. (Moyers 1993b:313).

As we know, Reston experienced an acupuncture treatment from a Traditional
Chinese Medical doctor for post-operative pain and not acupuncture anesthesia.
Eisenberg’s conflation of Reston’s experience with acupuncture anesthesia
(whether intentional or not) again takes an alternative practice that did not react
to and was not informed by biomedicine, thus a completely alien treatment
modality (Wolpe 1985:413), and converts it into a familiar arena -- biomedical anesthesiology -- thus also placing it solidly under the purvey of biomedical control.

Also in 1993, during the time Eisenberg appeared on millions of television screens as Moyers' expert on medicine in China, the publication of a research article co-authored by Eisenberg caused a media sensation. Cited in professional, academic, and mass media contexts repeatedly ever since, Eisenberg and his colleagues reported on data demonstrating that 33% of Americans used alternative therapies (a much larger number than expected) without telling their doctors (Eisenberg et al. 1993) -- a punchline that really only had any resonance from the perspective of maintaining biomedical hegemony.¹⁹ Data suggesting that annual visits to alternative practitioners exceeded annual visits to U.S. primary care physicians (ibid.:247) profoundly challenges the maintenance of cultural authority.

Labeling the alternative medicine seeking public an "invisible mainstream," Eisenberg began to pursue a very particular vision of an integrated medicine, one in which the reins of power could remain in the hands of physicians (Eisenberg 1996). Again physicians are thought of as being knowledgeable on all fronts, even those about which they know little. Sparked by managed care organizations beginning to offer alternatives like acupuncture, chiropractic, and naturopathy as "expanded benefits," Eisenberg's latest article (1997),²⁰ which has received less long-term media coverage than the 1993 NEJM study, sets out to provide physicians with a "step-by-step strategy" for helping patients "use or
avoid" alternative therapies, a process that includes identifying "a suitable licensed provider." Aimed at accomplishing patients' "disclosure" of their potential and actual use of alternative therapies, Eisenberg outlines a strategy by which physicians can extract information from patients and control their use of alternative therapies. The physician's role in the doctor-patient relationship is one of surveillance and regulation, and the relationship itself is characterized by a covert metaphor of warfare:

No patient should feel that their medical journey is to be taken alone or according to some stealth trajectory, invisible to their conventional providers. The delivery of medical care, like the experience of illness, is best viewed as a journey shared.

This emphasis on avoiding a "stealth trajectory" and pursuing a course of action that is "invisible" to their physicians, belies Eisenberg's rhetoric of sharing and metaphor of companionable journeying. If the patient is to be persuaded not to sneak out the window of the doctor's office in the middle of the night, so to speak, the relationship between doctor and patient is parallel to that of a parent and a child. The covert backdrop of this relationship -- a "stealth trajectory" -- is warfare: the patient actually has the power to sneak attack, to ambush and must be persuaded not to use that power (or convinced that it doesn't exist). Clearly what is at stake -- physicians' control, their cultural authority, their expert status -- must be protected at all costs.

Eisenberg's challenge is to protect physicians' professional authority and maintain the hegemony of biomedical narratives, without appearing to do so. Accomplishing this when physicians are faced with managed care organizations beginning to pay for alternative therapies for which there is only "inconclusive
evidence about the safety and efficacy," Eisenberg begins by raising the
question of professional liability. In preliminary remarks preceding the outline of
his strategy, the focus on medical malpractice confirms his tacit constitution of
the doctor-patient relationship as one of warfare:

Will I be sued if I knowingly co-manage a patient who sees an alternative
therapy practitioner and experiences a bad outcome from that therapy? . .
. no cases have involved conventionally trained physicians who have
advised patients about alternative medical therapies.

The juridical focus of biomedical health professionals, especially physicians, is a
manifestation of a much larger issue: the hegemonic structures that protect
cultural authority are predicated on a juridical foundation. In the face of liability
issues, the theme of documentation recurs throughout the article. He urges that
every step in the protocol be documented, ending with step #9:

Provide documentation. Conventional providers are encouraged to build
a record of the clinical encounters, conversations, and advice that lead to
all treatment decisions.

In dealing with patients who already use alternative therapies, the emphasis is
on recording that use in the medical records. If the patient or the patient’s
alternative therapy provider at any point in time refuse “to discuss these
alternative practices” or to follow the 9-step protocol, all of this, too, must be
clearly documented in the patient’s record.

After addressing liability, Eisenberg attempts to persuade physicians to
make extra time for this discussion of alternative therapy use by their patients:

Undoubtedly, talking with patients about alternative therapies requires
additional skills and time. Yet, is this responsibility significantly different
from exploring patients’ use of alcohol or drugs, exposure to abuse, or
preferences for cardiopulmonary resuscitation?
This comparison of the use of alternative therapies with the use of drugs and alcohol or exposure to abuse is an interesting juxtaposition. The subtext might read: get a complete list of patients' weaknesses, including possible use of alternative therapies. Moving on to “Asking the Unasked Question,” Eisenberg sets the scene for his 9-step protocol for dealing with alternative medicine-seeking patients. Giving physicians exact words with which to formulate this apparently quite difficult question, Eisenberg urges physicians to maintain a tone of “neutrality” and to refrain from referring to “other therapies” as “alternative” or “complementary” or “unorthodox”: “Such labels may be perceived as judgmental, thereby inhibiting disclosure and discussion.” When the patient is disclosing substance abuse experience, sexual abuse experience, and alternative therapy use in an uninhibited way, cultural authority and narrative hegemony have been protected.

Once the patient has undergone a complete medical evaluation, has been advised of his or her conventional therapy options, and has tried or exhausted those options and all of this has been carefully documented -- including patient rejection of conventional therapy options, then and only then, can “detailed discussion about alternative therapy” occur. In a section on safety and efficacy, Eisenberg briefly covers literature on toxicity of herbal preparations, dietary regimes and supplements, noting that “the absence of documented toxicity for herbs, supplements, or chemical preparations does not equal safety.” Beth Israel Deaconess Medical Center's press release on the publication of Eisenberg's article noted that “Americans are using alternative therapies known
to be dangerous" and that this motivated Eisenberg's work (www.acupuncture.com 7/97). In a CNN television interview about his article on June 30, 1997, Eisenberg noted "Patients need to be advised that 'natural' does not necessarily mean safe. Snake venom is natural. It is also deadly." In his article, Eisenberg concludes this section on safety and efficacy with the assessment that "Reviewing the current medical literature fails to provide unequivocal documentation of the safety or efficacy of the overwhelming majority of alternative therapies."

Before letting the patient loose into the clearly potentially dangerous world of alternative health options, the physician is encouraged to “Provide key questions for the alternative therapy provider during initial consultation.” Supporting the physician’s paternalistic role, the subtext here is that patients are not capable of negotiating the world of alternative health care on their own. Also, the physician’s role is to maintain influence and control even in the heretofore private arena of health care practitioner and new client. Among the key questions, patients are to ask whether the provider’s “belief in the effectiveness of the therapy” is based on previous clinical experience. Clearly as long as clinical efficacy has not been documented, all that the cultural authorities on health care can say is the provider must somehow have come to “believe” in the effectiveness -- not efficacy -- of his/her particular therapy.22

Several follow-ups by the physician with the patient are then recommended with the paternalistic conclusion that
patients who pursue an alternative therapy while being monitored by their physicians tend to feel ‘listened to’ and enjoy a degree of perceived safety that they might otherwise be denied.

Interestingly, here physicians are the purveyors of “perceptions” of safety as well as of safety itself. Encouraging in the patient a “feeling [of being] listened to” (while perhaps secretly not listening at all) falls among the responsibilities to be pursued by a good physician.

The article ends with the most dangerous or “worst case” scenario possible in this world of physician-mediated encounters with alternative health care: the patient who rejects conventional diagnosis or conventional therapy. Eisenberg encourages physicians to “convince such patients that an ‘integrated’ approach is in their best interest.” Throughout the article, and explicitly in this final section, Eisenberg offers physicians a very particular definition of an “integrated medicine”. While stating in his article that “disagreement is extremely valuable” and that “physicians and patients should dare to disagree,” he stated on CNN that “the patient's wishes should not override a physician's professional judgment and advice” (www.acupuncture.com 7/97).

While integration implies equality, Eisenberg’s effort throughout the delineation of a strategy for “advising patients” has been a veneer of integration painted over a covert subtext of war. Physicians and patients have a parent-child relationship that can only be maintained if the child never becomes aware of the “invisible” weaponry at her disposal to overthrow the authority of the parent -- the realization that she has access to some of the same resources out of which the parents’ authority is constructed; that she may in fact not be a child at all, but
an adult. A rhetoric of integration placates the child and turns her attention away from her own empowerment.

**Consensus Production and “Integrated Medicine”**

The National Institutes of Health held a Consensus Development Conference on Acupuncture on November 3-5, 1997. The purpose of the conference was to gather together national experts on acupuncture and review all available information regarding acupuncture efficacy. On the final day of the conference, a Consensus Statement was produced and a press conference held to release the Consensus Panel’s findings to the public. As delineated by the NIH,

NIH Consensus Statements are prepared by a nonadvocate, non-Federal panel of experts, based on (1) presentations by investigators working in areas relevant to the consensus questions during a 2-day public session; (2) questions and statements from conference attendees during open discussion periods that are part of the public session; and (3) closed deliberations by the panel during the remainder of the second day and morning of the third. (1997:1).

The experts designated to hear reports on the clinical effectiveness of acupuncture were primarily physicians or medical academics (professors of epidemiology, pharmacology, etc.). Of the twelve members, six were physicians, one an osteopathic physician, four medical academics and one a medical anthropologist. The 25 speakers presenting research results to the panel and the public audience were also primarily physicians (12), with one representative from the NIH and one from the FDA. Of the 25 speakers, a minority (6) were acupuncturists. This small number of participating acupuncturists may be
partially due to a general resistance among acupuncturists to clinical trials and
double-blind studies (Hare 1991:309).

While I was unable to attend the conference, one attendee described for
me the vocal involvement of acupuncturists in the public audience (up until doors
were closed during preparation of the Consensus Statement). She noted that
remarks about acupuncture as an alternative distinct from biomedicine received
applause and that catcalls, thumping of feet, applause, and other vocalizations
were used to express an overall dissatisfaction with the conference's emphasis
on efficacy via clinical trials (Claire Cassidy, personal communication).

The panelists worked through five key questions in formulating their
Consensus Statements. The consensus statement responding to the first two
questions, dealing with acupuncture efficacy, emphasizes that the research
designs of "the vast majority of papers studying acupuncture in the biomedical
literature" remain inadequate to assess efficacy (1997:4). The panel defined the
assessment of treatment efficacy as

the differential effect of a treatment when compared with placebo or
another treatment modality using a double-blind controlled trial and a
rigidly defined protocol. . . . Optimal trials should also use standardized
outcomes and appropriate statistical analyses. (ibid:5).

Given this criteria, the panel found that there was "clear evidence" that
acupuncture is efficacious for nausea and vomiting resulting from chemotherapy
or surgery, for post-operative dental pain, and "probably" for the nausea of
pregnancy (ibid:6). A major portion of the reviewed research was on pain -- just
as pain is the primary presenting complaint for acupuncture care (Culliton
1997:41); the panel deemed the research on menstrual cramps, tennis elbow,
and fibromyalgia to be "reasonable," although "there are also studies that do not find efficacy for acupuncture in pain" (NIH 1997:6). While the data on acupuncture for smoking cessation "does not demonstrate efficacy" (ibid.), postoperative, myofascial, and low back pain are cited as examples where acupuncture "may be a reasonable option" (ibid:8). The research is viewed as "less convincing" even though there are "some positive clinical reports" for addiction, stroke rehabilitation, carpal tunnel syndrome, osteoarthritis, and headache (ibid.).

The authors of the Consensus Statement note that "the data in support of acupuncture are as strong as those for many accepted Western medical therapies" (ibid:7), especially for painful conditions -- conditions for which biomedicine has no real adequate protocol -- for which steroid injections or anti-inflammatory medications are the widely used and acceptable treatments: "The evidence supporting these therapies is no better than for acupuncture" (ibid:7-8).

These very conservative assessments of "reasonableness" indicate a tight adherence to the scientific method as it is evinced in controlled, clinical trials. Efficacy and not effectiveness is the focus of these statements that have come, since November, to be taken as a general approval score for acupuncture. "Does it work?" is the most common question among consumers, and the NIH's very conservative listing of conditions for which acupuncture might be efficacious (to say nothing of effectiveness) has been taken through the media and into the public consciousness as a resounding "yes!" (interview with Susan Cushing, L.Ac.).
Regarding effectiveness of acupuncture care, the Consensus Statement mentions only that "non-specific' effects account for a substantial proportion of its effectiveness, and thus should not be casually discounted" (NIH 1997:10). Among these "non-specific effects," the Statement includes the practitioner-patient relationship, especially in terms of "the degree of trust, the expectations of the patient, [and] the compatibility of the backgrounds and belief systems" (ibid.). While these factors remain secondary to establishing clinical efficacy, they are some of the key elements constituting patient satisfaction as expressed by clients of acupuncture themselves (Cassidy forthcoming).

One of the main purposes for this particular Consensus Conference is delineated in the last two questions addressed by the Consensus Panel. In dealing with how acupuncture can be "appropriately incorporated into today's health care system" as well as "directions for future research," a model for an Integrated Medicine emerges through the discourse of the Consensus Statement. Among the characteristics required for "the integration of acupuncture into today's health care system," the statement includes: fully informing patients of any "adverse events" resulting from acupuncture care, using acupuncture needles as per FDA regulations, and strengthening communication between acupuncturists and physicians who are providing care for the same patients (ibid:12). The statement urges patients to inform both practitioners when seeking acupuncture and biomedicine complementarily (ibid.), which echoes the emphasis of the 1993 NEJM report that the users of alternative health care modalities are not telling their doctors about such use.
The Consensus Statement asserts that “Care should be taken so that important medical problems are not overlooked” (NIH 1997:12); this is an especially revealing statement in the context of rhetorics of integration. The question raised by a Conference observer who read this part of the statement was:

Well, which condition should we be careful not to overlook? “Damp Heat” or “Irritable Bowel Syndrome”? I mean which medical system is likely to accuse the other of having overlooked something? (personal communication)

The point underscores that “integration” here actually means “appropriation,” in the sense that the biomedical system of scientific medicine, as carried out by the NIH, may engage in a rhetoric of integration while enacting a politics of domination.

Another key concept in the NIH’s rhetoric of integration is that of rigor, research designs are repeatedly challenged to “withstand rigorous scrutiny” (1997:13 and throughout). The measure of rigor, the standard by which other medical systems, new treatments, or alternative health care modalities are to be evaluated and judged as to their suitability for “incorporation” are clearly dictated by the hegemony of scientific medicine:

The demands of evidence-based medicine, outcomes research, managed care systems of health care delivery, and an existing plethora of therapeutic choices make the acceptance of new treatments an arduous process. The difficulties are accentuated when the treatment is based on theories unfamiliar to Western medicine and its practitioners. (ibid.).

Clearly “Western medicine and its practitioners” are the acceptors or rejectors of new treatments. The rhetorical subtext states that in order for acupuncture to be
“accepted,” “incorporated,” or “integrated,” it must withstand the rigorous scrutiny of Western medicine and its practitioners.

The last paragraph of the Consensus Statement, quoted in full below, provides a solid rendition of this particular Integrated Medicine:

The introduction of acupuncture into the choice of treatment modalities that are readily available to the public is in its early stages. Issues of training, licensure, and reimbursement remain to be clarified. There is sufficient evidence, however, of its potential value to conventional medicine to encourage further studies. [A previous draft published online on the Internet stated: “There is sufficient evidence of acupuncture’s value to expand its use into conventional medicine and to encourage further studies of its physiology and clinical value.”] (ibid.:16).

After 25 years of “the public’s” increasing pursuit of acupuncture care, the notion that it is “in its early stages” in terms of its acceptability as a treatment choice borders on the ridiculous. Clearly assessing “the public” and their relationship with acupuncture is not an aim of this Consensus Panel. What does fall into their purview is delimiting the expansion of Otherness (alternative treatment modalities) into the Self (conventional medicine), once the “value” of such an expansion has been clearly identified through the methods of scientific medicine. An “Integrated Medicine” here is a version of biomedicine that conforms and adapts to the hegemonic structures of clinical efficacy and clinical value long established by scientific medicine.

Before turning to another enactment of “integrated medicine,” one from the margins, here is the same acupuncturist’s rendition of public and media responses to the NIH Consensus Statement:

Cushing: It’s affected everything. It’s really shifted the public and legal orientation about this profession in a very dramatic way. It went from being questioned to now being accepted.
Emad: Overnight?

Cushing: Pretty much. As limited as the NIH research and presentations were, it’s just like looking outside and giving a weather report for the nation! They really haven’t got a clue what’s going on. But it changed the attitude of basically the whole country. And you add that along with the FDA licensing and restructuring last year, which most people never even heard about, and it adds up to a very powerful political professional bop on the head. So most of the people in the field, the doctors and therapists and people like that, are just going to wait and see what happens. It doesn’t mean they’re going to do anything differently.

Emad: But you feel that the public you’re dealing with was dramatically affected by [the NIH Consensus Statement]?

Cushing: They’re really picking up on what’s in the media. The TV shows and the Newsweek and Time or whatever. . . . Those things, people read them. And they react, as you probably know, to very particular, very certain things in an image or a story that’s given to them, and that’s what they hold on to. They don’t very often see the whole story or understand the whole picture. But if it says definitively anywhere something, they’ve got it. There’s been a broad acceptance of it, in a very casual sort of way by the average person in town. It’s like, oh, yeah, yeah. . . . Like I just decided to go to this grocery store instead of that grocery store. There’s a certain amount of that. Their friends told them they should come, so they’re coming, but there’s no question about it being safe or okay to do or weird. Things that a few years ago might have come up for people. They’re not particularly bothered about the needles. I think there’s been enough public [exposure]; you know, just all the photographs and images of faces and hands, [smiling with needles]. . . .

**Acupuncturist on Hospital Staff: Another View of “Integrated Medicine”**

Susan Cushing is a professional acupuncturist who has been practicing since 1995 in Viroqua, WI (population 4,000). Last September she was hired as staff acupuncturist at a nearby rural hospital:

I am acupuncturist in the hospital. I am medical staff, which doesn’t particularly make the doctors happy, most of them, but they’re lumping it right now. It’s the only place in Wisconsin, it may be the only place in the Midwest that made the alternative wellness clinic a department of the hospital. So what the administration did was they built this into the
system. So if the administrator goes or the CEO goes, nobody can make me disappear either. They're trying to integrate it and they've been hiring new doctors and they're hiring ones that are actively interested in working with this. The new doctor they hired in December, the first week he was there, he invited me out to lunch, which was a very political move. I mean he knows which side of the bread the butter is on at administration and he wasn't going to waste any time cultivating those connections. So for whatever reasons -- some are good, some may be self-serving, I just don't know, you know, there could be layers there -- they are really making an effort to explore this.

I have a very good relationship in the hospital with the pharmacist, a developing relationship with physical therapy. They're a little bit unsure, but interested and willing. And I'm working with cardiac rehab. and pulmonary rehab. At this point we're just doing educational programs and developing things, so talking to the doctors and the pharmacist mostly about surgical and trauma recovery, which is an area that can be very useful.

So we're going to just try to start different things which seem likely to work there while I maintain a general clinical patient practice, and see what happens.

Clearly her hospital work and the structuring of the new Wellness Center offer a model of Integrated Medicine very different from the rhetorics of integration offered by the NIH Consensus Statement. Cushing's work in Viroqua constitutes an even more thoroughly enacted integration of multiple practitioners working in cooperation; here is her story regarding her participation in a local multi-disciplinary chronic pain team:

The chronic pain team got started a year and a half ago. Several doctors.... I think it was two or three doctors and the pharmacist were working on these people that nothing is working on. [The type of patient that] everybody hates to see come through the door. [The doctors and the pharmacist thought,] well, what if we decide to work together on this? A meeting was called and it started out fairly small. But very quickly it grew to a lot of people. We met in the back room here [of the cafe], and we had two or three dozen people in a meeting. And we just made a big circle.
We started out pretty quickly with paper cases. So everyone would hear what was going on and then everyone had a say in what they might do; what they might notice about [a case] or questions they might ask. Sometimes then whoever was taking care of that person would have some ideas they could go back and do, and referrals they could make possibly to other people: well, it seems like this other therapy would help you.

Then very quickly, we started bringing people in who were okay with [coming to our meetings], and they would come in and tell their story. Then the presiding doctor (almost always) would tell their story: this is what I'm doing, this is what I see is going on. Sometimes the partner or family member would come in too. And it was really pretty intimidating for a lot of people to do that, because here's a bunch of people that they don't know and they're in pain and they don't feel good. It's a really different kind of thing. And we tried to be as nice about it as we could, but we decided after a number of months of doing that that it was too hard on people to expect them to go through that, especially on a repeated basis and that smaller groups worked better.

So we started with a few patients and several people would go back to hear this patient and they're telling their story. Whoever felt that they had something they could offer would describe what they did, and the patient would get to see the person and ask them questions and hear about what they do. Then they could go home and think about it. We would give them something in writing so they could go home and they wouldn't have to remember all that stuff. Then often they would try some of these different things and sometimes they would have to be sort of sent by their doctor, because they basically just wouldn't get there on their own. Payment was a big issue, because they didn't have any money. All these people didn't find it easy to do these things without getting reimbursed, more than a little bit. And I think that first year I donated several thousand dollars worth of treatments to people that I never got any payment for at all.

We decided let's not just have these big meetings where we're not doing anything anymore. Let's break down into something where we can really work on what our mandate is: How do we work together, how do we develop more effective therapies. How do we do that? We can't do that when there's twenty people sitting together in a room. So there were a couple of smaller meetings this fall.

So what the chronic pain team was trying to do in relation to payment issues was set up something that could have doctor-referral; so that people on disability would start to see some insurance coverage. It would be seen as a program people were in; they had contracts about their
medications; they had people they were supposed to check in with. It still wasn't enough, because their lives were difficult. They just were not consistent, they didn't have much control over their lives and so the treatments were sketchy. They'd show up for a while and then they wouldn't show up. So it got to be that we were not getting... we got some really good results considering the difficulties we were working with, we had some people that really made improvements. And it was very gratifying to see that. But for the amount of work we were putting into it, it wasn't enough. We couldn't sustain that kind of thing. So we all kind of backed off. A lot of people [participating practitioners] who weren't getting referrals, people who were making their living doing what they were doing, just quit coming if they weren't getting referrals. They expected to get some business off it. People like me, I can donate a certain amount of my time, but there's a limit to it. And these people take up a huge amount of time. It's not that they take up a regular appointment, they take up three appointments when they come in.

In one small meeting, I had the idea that we stop working on these chronic pain, Vietnam vets on 6,000 mg of morphine kind of people, and we pick people who have a chronic problem. But yet they have a number of things working for them. Because many of the people we worked with couldn't... their home lives were really difficult, they were on lots of medications, their pain was out of control. There was nothing really working for them and we had to build everything. And it was too hard to keep all that supported and working. So the idea was pick someone who's got some kind of pain, maybe. Some kind of problem that's really affecting their life. But maybe they've got a job or maybe they actually do show up for appointments or they do what they say they're going to do when they're home; there's something we can work with here. And if we put our heads together on these problems and learn how to work with them, then we can move to something more difficult and know what techniques will work. How do we know what's working and failing because we've got a situation that's impossible to start with. Everyone thought that made sense.

I began working [in a small group] with a reflexologist, the homeopathic M.D., a healing touch person, and me. There's four of us. I had a patient who also went to other people, and we picked her. And she's been going back and forth to us all for several years in sort of a haphazard way. And she's tried other things, but these are the practitioners that she's come back to. She's a rheumatoid arthritis patient, she works full time, takes care of herself. She's eighty percent responsible for taking what she's supposed to take, showing up for appointments and things. She's someone we all know a little personally. So we brought her in and we all sat down with her and we said, let's develop a way that we can put these things together and find out what's working best for you and how we can
enhance this. So we started that in November. And we were going to check in January. So we're going to have a meeting next week with her and all the practitioners to see what progress we've made. Then we're having a whole larger group meeting too.

What we have learned from working with her in this way is that we need to communicate better than we had. So the idea that we came up with is that she has a notebook, like you have there, and every time she goes to an appointment, the person doing the treatment writes down anything that they would normally write down. What they did, why they did it, what's going on with her, what their assessment is, and then she can write down things. Either at the appointment or afterwards and during the week about what's changing for her, how she felt.

Everything goes in this one notebook. I mean I would still write in my charts and keep my own chart. But she would have this notebook, so when she would come to me, I could look back and see oh, Dr. so and so did this and the other person did that and the other person did this, and this is how she's felt during the week, and we can all start to see the whole, what's going on. And that has been really helpful. Interestingly enough, she lost the notebook last week, so I hope she finds it! Talk about people's attachments to things! It's interesting. She can hang on to it for months. So I don't know. But working on that level...

So I think we're going to hopefully start this with a couple of other patients and hopefully other practitioners will start to do this too. Out of the whole group, which there were forty-some practitioners involved at one point, there are only about six of us actually carrying something out. So if we can get some other people to make some little groups, and then the little groups will come back to each other and say, well, we're learning this or we're learning that or we'd like to send someone over to you for a while; we'll start developing out of that.

**Conclusions**

Writing in 1985, Paul Wolpe believed he was witnessing the end of acupuncture. Through regulation by state medical boards and an insistence that acupuncture be interpretable through the biomedical paradigm, biomedicine maintained its cultural authority.
... within five years of its introduction, acupuncture research reached the end of its growth curve in the United States, almost no physicians included acupuncture in their treatment regimen, and practically no medical schools had instituted acupuncture as a normal part of their curriculum. Why did acupuncture fail to become firmly established in American medicine? (1985:413).

Wolpe devotes much of his paper to developing responses to this question, clearly assuming that acupuncture has been thoroughly subverted by the hegemonic force of biomedical technocratic bodies. It is interesting that Wolpe mis-read many of the signals, and perhaps was ill-positioned historically to see the outcome of acupuncture’s encounter with biomedicine. Citing the story of the first acupuncture clinic to open in the United States, Wolpe notes that

The first acupuncture clinic in New York City opened in July 1972; one week later, when it was shut down by the State Health Department for practicing medicine without a license, 500 patients had been served, and the clinic was booked solid for months in advance. (1985:412).

While clearly spurred by “fascination with this exotic new therapy” (ibid.), public interest in acupuncture has never really waned. The more pertinent question seems to be: what are people consistently finding in acupuncture care that keeps a steady public interest sustained for over 25 years?24

Most states require non-physician practitioners (i.e., professional acupuncturists) to complete licensure programs and pass state and board exams. Since state statutes regulating acupuncture practice began to be adopted in 1973, approximately 10 states per decade have adopted statutes, with several more states passing statutes in the late 1990s. Currently 34 states allow professional acupuncture practice. The American Academy of Medical Acupuncture (the simple existence of which runs counter to Wolpe’s
assessment) estimates that in 1996, there were approximately 3,000 physicians practicing acupuncture in the United States. Currently 34 medical schools include courses in acupuncture and other alternative medical practices in their curriculum (Diehl, et al. 1997:120).

If Wolpe’s delineation of the hegemonic power of biomedicine to maintain its cultural authority does not pan out historically, how do hegemonies establish and maintain themselves; how does biomedicine contend with challenges? Hare clearly delineates the process of construction of hegemony through the 1910 Flexner Report, commissioned by a newly re-organized AMA to make recommendations for the medical education of America’s increasingly numerous physicians. Flexner’s “prescription for professionalization” entailed identifying and advocating for a laboratory science paradigm of medical education, which could be divided into two clear parts: first “university-based, post-collegiate courses of study with strong laboratory facilities” (Hare 1991:44), and then, anticipating the long-term specialization residencies of today, work in the hospital, which Flexner notes “is itself in the full sense a laboratory” (quoted in ibid. 37).

This emphasis on empirical evidence elicited through experimental laboratory conditions elicited the “clinico-pathological-correlation” through which “disease” as an entity was moved out of the experiential realm of patients and into the objectified field of pathology (Sullivan, quoted in Hare 1991:35). A patient’s pain is no longer a means of achieving clinical knowledge, but becomes a knowable object among other objects (Sullivan, quoted in Hare 1991:38):
Symptoms were now data to be used in the search for the identity of the disease rather than constituting that identity themselves (ibid.).

The relationship between physician and patient has become objectified and distant in large part because

the patient was seen as an object of scientific experiment within the clinical setting which was now an extension of the laboratory . . . (Hare 1991:39).

Flexner notes: “The student is to collect and evaluate facts. The facts are locked up in the patient. To the patient, therefore, he must go” (quoted in Hare 1991:40; emphasis added). While Flexner emphasizes the excitement of clinical teaching which brings student into close and active relation with the patient (ibid.), the result has been an emotional distancing borne of the power relationship between the laboratory researcher who must “unlock” the secrets of disease from an implicitly resistant subject. In contemporary medical training, individual patients have been rendered invisible by the focus on their pathologies. This distance between students/physicians and patients is identified by Foucault throughout Birth of the Clinic as an increase in objectification due to the deeper gaze into the sick body. The physician’s ability to intrude into the physical space of the patient increased the emotional distance between physician and patient (cited in Hare 1991:38-40).

Physicians themselves have remarked on and developed critiques of this alienating aspect of biomedical cultural practice:

When your beeper wakes you after two hours sleep (having not let you rest for thirty hours before that) and you roll out of your cot and rush to the bedside, you will be faced with decisions no person should have to make. . . . The fatigue and stress make you care a little less; they enable you to make the decisions. You do it in a daze. After doing this hundreds and
then even thousands of times, they are no longer deliberate or even confused, but reflexive. You have learned to bypass existential moralizing. . . . Eventually, you do this even when you are well rested and not under any stress. And when that happens you have become a doctor. (Konner 1987:373)

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet. (Remen 1996:52)

In some ways, a medical training is like a disease. It would be years before I would fully recover from mine" (62).

I problematize the issue of physicians' professionalization and consequent maintenance of cultural authority at some length in order to illustrate Wolpe's tacit complicity with that authority. Wolpe's assumption that this process of professionalization will successfully sustain a hegemonic medical technocracy ignores the very "public" that is never specified or developed in his analysis. Who are the people with half a billion dollars to spend, mostly out of their own pockets, on acupuncture care? Who is the public that since 1972 has needled their doctors with curiosity about acupuncture as an alternative to biomedicine? Who is the 33% of "the American public" who used alternative therapies in 1993 without telling their doctors they were doing so?

It is precisely this "patient public," this "public of patients" that has made choices out of a dissatisfaction with the conventional physician-patient relationship. In the social realm of agency and choice, technocracies like biomedicine may not always hold hegemonic sway. In what contexts do alternatives become acceptable choices? How are those alternatives -- like acupuncture -- simultaneously created by their practitioners and their clients, not only as alternative treatment modalities, but also as revolutions in the
technocratic structure of the relationship between “healers” and “seekers?” The next two chapters will ethnographically explore the constitution of acupuncture as a particularly American alternative to technocratic medicine. By delving into the role of acupuncture practitioners as “mediating bodies” between technocratic and emergent individual bodies in the social realm, chapter four explores the possibility of transformation in practitioner-client, healer-seeker relationships. Chapter five, then deepens questions of “who is the public,” what stories emerge from the “body narratives” of individuals experiencing acupuncture as an emergent transformation?
A Patient Public
What does it mean to be a patient?25
A Lingual Interlude

Oxford English Dictionary: Entry for “PATIENT”

Adjective
1. a) bearing or enduring (pain, affliction, trouble, or evil of any kind) with composure, without discontent or complaint; having the quality or capacity of so bearing; exercising or possessing patience.

1.b) longsuffering, forbearing; lenient towards, bearing with (others, their infirmities, etc.)

1.c) calmly expectant; not hasty or impetuous; quietly awaiting the course or issue of events

1. d) continuing or able to continue a course of action without being daunted by difficulties or hindrances; persistent, constant, diligent, unwearied

2. a) enduring or able to endure

3. undergoing the action of another; passive

Noun
1.a) a sufferer; one who suffers patiently

1. b) especially one who suffers from bodily disease; a sick person

2. One who is under medical treatment for the cure of some disease or wound; one of the sick persons whom a medical man attends; an inmate of an infirmary or hospital

3. A person subjected to the supervision, care, treatment, or correction of some one

4. A person or thing that undergoes some action, or to whom or which something is done; “that which receives impressions from external agents” as correlative to agent, and distinguished from instrument; a recipient
CHAPTER FOUR
MEDIATING BODIES:
AMERICAN ACUPUNCTURISTS AND BODILY TRANSFORMATION

As cultural translators of acupuncture practice to American clients, acupuncturists in America mediate between and among the technocratic and social bodies that influence, define, and constrain acupuncture treatments. Through addressing the central question of why individuals chose to become acupuncturists, I will identify several themes running through the following stories and explore the mediatory character of those themes. In other words, if these acupuncturists are living and working in the social world between technocratic hegemonies and the emergent bodies of their clients, how do they effect, facilitate, or contribute to crucial transformations in their own life worlds as well as in the bodily beings of their clients?

Of the eight practitioners participating in this study, all but two are trained in the TCM style of acupuncture practice (four received their educations at the Oregon College of Oriental Medicine [OCOM]). Of the remaining two practitioners, one received training in and practices Japanese-style acupuncture and the other received her education before accredited, nationally known acupuncture schools were established in the United States and pursued a certification program; she now practices an eclectic mix of styles. Mixing and blending of styles, however, is common to all the practitioners whose stories appear below. All eight have developed unique treatment styles, taking or leaving specific attributes of their TCM training, while incorporating elements of other styles, and constantly changing and moving in new directions. This raises
the issue of emergent American acupunctures: Are there common characteristics among these healers? What do the defining elements of American acupuncture look like?

Chapter 2 explored some of these characteristics for acupuncturist-writers engaged in cultural translation within the social body of American health care. Ted Kaptchuk (1983) and Harriet Beinfield and Efrem Korngold (1991) emphasize an ecological perspective in which humans and the natural world are inherently relational. Beinfield and Korngold also develop a psychological interpretive frame of archetypes to engage late 20th century American readers/clients, while Kaptchuk emphasizes a strong philosophical critique of causality. Mark Seem’s (1987, 1990, 1993) energy medicine, or “bodymind energetics” allows clients to embody a new perspective that facilitates their engagement with their own healing.

What are some of the key elements of American acupuncture for the practitioners in this study? Through their stories of why they became acupuncturists, several significant themes appear. Like shamans in many tribal cultures (Halifax 1979), several of the acupuncture practitioners below became healers after experiencing illness, sometimes severe illness, themselves. Many practitioners, while mixing and blending within acupuncture styles, also integrate other health care modalities into their practice, most commonly naturopathy and chiropractic. Other themes include the role of the doctor/practitioner/healer as a teaching role, one that emphasizes facilitating change in clients. Transformation of clients’ immediate complaints -- of unhealthy behavior patterns, such as
addictions, and of emotional, personal growth -- are at the forefront of American acupuncture care. This emphasis on change/transformation positions the American acupuncturist in a mediatory role between the hegemonies of technocratic bodies in American health care and the empowerment of emergent bodies in individual health care seeking.

**Practitioners’ Stories: Why Acupuncture?**

The following stories are drawn from interviews I conducted with seven American practitioners, as well as an eighth interview conducted by Jennifer Hamilton, an anthropologist and seeker of acupuncture care, with a Chinese Traditional Medical doctor practicing in Houston. My commentary within and following these stories is also based on participant-observation of practitioners’ clinical practice. My apprenticeship at the An Hao Natural Health Care Center in Portland, Oregon, in the summer of 1992 provides a particular field context for these stories. During formal interviews, I asked each practitioner to talk about how she or he became an acupuncturist. I have edited and summarized the basic lifestory narratives elicited by that and other questions. The core thematics emerging from these stories will be explored in the section following this one.

**Abbie Dring, Certified Nurse, Licensed Acupuncturist, Chiropractor Chicago, IL**

Abbie was a Chicago hospital nurse in 1972 when acupuncture first emerged on the scene of American health care. She began to volunteer at a free clinic in 1970, run by Rising Up Angry, a local grass roots organization that
based its activism on "the premise that health care was a human right and not a privilege." Her experiences there deeply affected her relationship to the politics of biomedical health care. "It helped me see that there are a lot of other things to medicine besides just regular hospital nursing." While doctors only volunteered two hours or so at a time, Abbie and other non-physician volunteers "all stayed around. We cleaned it up, and we ran the specimens over, and we did the outreach and all the followup." While doing followups with patients, Abbie often felt bombarded by unanswerable questions: "What do I do about this?" "How did I get this problem?" "What should I change in my diet?" She began to feel frustrated with the constraints of her profession:

I might know in terms of drugs, say, "Well, you need some antibiotics" or "You need some of this or that, but I can't give it to you because I can't write prescriptions." We had a pharmacy there where sometimes I could go in if it was an emergency, you know, I could go in and get it. It was really somewhat looser than it is today. Today, it's a lot more strict about all that stuff . . . I didn't like being under doctors. As a nurse, I was seeing all the problems the doctors would create. And it was very scary. The more I was in a hospital, the less I wanted to be a nurse.

The group of 16 health care providers who ran the free clinic organized a street fair in 1974 that included a booth on acupuncture. Aside from casual reading during the media blitz of 1972 and 1973, this was Abbie's first exposure to acupuncture. After talking to the practitioner at the booth, she got a book:

a real simple book; I believe it was *Principles of Acupuncture and Moxibustion*, and I carried it everywhere. I remember going through it and saying, "oh, you have a headache; press these points. Oh, you have cramps, press these" and it worked! And I did it more and more, and I could see how it helped people. I realized that I needed to learn this.

Since its emergence in the mid 1970s in Illinois, acupuncture was and still is legally practiced only by physicians, osteopaths, and chiropractors. There
were no schools in the Midwest to train interested health care providers or lay persons in the study of Chinese medicine or acupuncture. Weekend courses and day-long seminars proliferated around the U.S., but Abbie wanted to take up serious study of acupuncture care. In the tradition of many Asian training programs in Oriental medicine, she and a friend began an apprenticeship with a Korean practitioner who had treated her friend after a car accident, restoring mobility to her neck.

So we went there three nights for two years, and it turned out that it was four blocks away from our house. So it was meant to be. It was one of those things that when the student is ready, the teacher appears.

As she began to practice this new health care modality, Abbie found herself becoming one of the first cultural translators of acupuncturists to Americans. She felt that people who came to her for treatments enjoyed understanding their bodies and their health care through this newly Americanized lens of Chinese medicine.

Acupuncture explained things in a way that I could understand, in a way that people could understand. People will say, for example, that they have headaches and when they describe the type it is, I'll say, "Oh, well, that's this problem" or "That's damp congestion" or "That's your energy rising" or "You're stuck in the middle of something" and they'll say, "Yeah! Yeah." People related to it; people understood it. People have said time and time again [that it makes sense]. It made a lot of sense to me. It made me feel good. Plus, I could do something about it. And I liked that, too.

Abbie finished a certification course in 1978, eventually taking national board exams when they became available in 1985 (?CHECK). She began a practice out of her home part-time while still working in the hospital as a part-time nurse.28
As my practice grew, at first I treated friends, later on I started to treat more and more people who'd get referred to me, and I did less and less nursing. By the end of 1979, I was working about two days a week doing nursing and the rest of the time doing acupuncture.

Several years later, Abbie traveled to Ireland, with the intention of leaving her life in Chicago, "I thought, well, maybe I'm done being a healer." Before leaving a Chinese fortune-teller told her, "Yes, you can go over to Ireland, but your work needs to be here in Chicago." As she prepared to return, she decided to visit a friend of her brother's in England.

He was just going into [the field of acupuncture care], was mid-way through acupuncture school there, and it was so much fun to talk to him. You know, "Oh wow, ooh, oh yeah!" So I really regained my enthusiasm for healing. And then I came back here and began my business.

By now, Abbie had studied and practiced acupuncture for over a decade and realized that she wanted to incorporate more than just the system of needling and the rudiments of Chinese medicine she had learned thus far into her health care practice. She began a life-long Qi Gong practice which taught her to embody many aspects of Chinese medical philosophy:

The focus of Qi Gong is the mind and the spirit . . . And if you have a good teacher, one who knows their Qi Gong, they will direct your mind and say, "OK, now focus here."

She also began to attend workshops on Chinese herbology and to incorporate Chinese patent medicines into her practice. All along, Abbie felt the need "to do more bodywork." When I met Abbie in 1986, she had recently begun to study chiropractic. She often worked head and neck adjustments into treatments while clients were resting on their backs with acupuncture needles in.
In 1992, after the death of her mother, Abbie left Chicago, and began practicing as a chiropractor and acupuncturist in Colorado Springs.

Karen Levine, Licensed Acupuncturist and Herbalist
Portland, OR

Growing up in a family that meditated together from the time she was twelve years old, Karen credits her childhood with the openness towards alternatives and the interest in emotional, spiritual, and physical health that ultimately drew her to study acupuncture and Chinese medicine. Her mother followed many of the dietary suggestions of Adele Davis, and Karen grew up regarding organic foods, health foods, and a vegetarian diet as natural and given. As a teenager, Karen attended yoga camps and developed a life-long yoga practice. She was rarely sick and through her yoga practice developed an interest in natural healing. While in college in Boulder, Karen began to study with members of an intentional community that incorporated Taoist philosophy, Chinese medicine and Chinese medical practice.

[I learned how] just tracing meridians could change my mind set and my state of being. So from there I learned a lot of hands-on work. I learned that by holding [certain] acupressure points, I would be able to really experience a lot of change and could help people to change. So I did that for a long time, and did massage work. . . .

Karen soon decided that she wanted to make a profession out of this work and that she wanted "to be really legitimate," so she moved to Portland and began to study at Oregon College of Oriental Medicine (OCOM), one of only a handful of schools in the U.S. that offered a long-standing, accredited program in both Chinese medicine and herbology. After graduating, she pursued further
advanced training at a Beijing hospital, where she completed a more intensive herbal program. She found her Chinese teachers to be an inspiration:

You really saw how people lived the medicine. That's what I loved about the community I was in, and that's what I love about this medicine. That you live the medicine, you live the elements, and you get in touch with the elements within yourself. So that you're able to identify when you're deficient earth or when you're lacking fire or you need to support the water. So it makes it a very alive medicine. And that's how they respond in China, you know, it's incorporated throughout their lifestyle.

Karen also expressed an interest in making her work in health care more of a “hobby” while pursuing a career in art, dance, or movement therapy. The reason she gave was that as a result of her strong practice, she has found herself conserving her touch for her work and rarely feels the energy to massage or friend or family member or give them acupuncture. She misses this relational quality of providing health care to those she loves and wants somehow to return to it, to have it on a daily basis as during her the days of her education.

Karen is one of two acupuncturists at the An Hao Natural Health Care Clinic in Portland, and her husband, Doug, is the Clinic's chiropractor. When I met and worked with Karen in 1992, she and Doug often referred clients to each other and spent a lot of time in and out of the clinic, working out how best to encourage and facilitate change in their mutual clients.

**Edie Vickers, Licensed Acupuncturist and Herbalist, Naturopathic Doctor Portland, OR**

"I think I've always been interested in health care because my dad's an M.D., and I always knew I wanted to be a doctor, but I didn't want to be an M.D."
says Edie Vickers in her characteristic straight-to-the-point manner upon hearing my first interview question. After studying Western herbalism with her first boyfriend's mother and studying general sciences at Toronto University, Edie decided to move to the U.S. to study naturopathy. She looked for a school that emphasized hands-on training and empirical knowledge and decided National College of Naturopathic Medicine (NCNM) in Portland was "more me," because empirical knowledge was emphasized over scholastic knowledge. While still in naturopathy school, she attended a workshop on Chinese herbs and "immediately decided that I needed to study Chinese herbs." (Edie also soon married the herbalist teaching this first workshop, Subhuti Dharmarana, who is a leading proponent of Chinese medicine in the United States and owner of ITM, a primary manufacturer and distributor of Chinese herbs and educational materials in this country, Canada, and Europe.)

In the midst of graduate studies and her own self-education in the Chinese herbal format, Edie became ill.

And then I was sick; I went to Mexico and I got Montezuma's Revenge, and I couldn't get better. I was really depleted and it was exam time, and somebody said, why don't you try acupuncture. Well I have a fear of needles, so I said, NO WAY. But then I was sick, sick, sick, so I said, I don't care, just stick me. So I went and had acupuncture and I was better within like six hours. And I thought, hmm, I'd better go to acupuncture school.

While still pursuing studies at the Naturopathic College, Edie enrolled in OCOM and pursued both graduate programs simultaneously, though slowing down her naturopathic program. She ended up finishing acupuncture school first, soon followed by her naturopathic degree.
Like her education, her practice does not separate the two health care modalities she is now proficient in.

For me, I learned them together and it's very hard for me to separate them. . . . I was an acupuncturist first. And most people know me as a Chinese herbalist and an acupuncturist. But if you were with another acupuncturist, someone who is only an acupuncturist, you would see a very big difference. I take blood pressures and I take a different type of history, and I give, like if someone has a cold, I might give them Iliix 15 [a homeopathic formula] and I'd tell them about wet socks [also a common naturopathic remedy, especially for fevers], and I'd tell them about no sugar, no alcohol, and then I'd do acupuncture, and then I'd do hot and cold [treatments] on their chests [also a naturopathic cold remedy]. And that, I mean all of that . . . when does acupuncture start and naturopathy end? It's very hard. Like with high blood pressure, you take the blood pressure, which in itself is more naturopathic, then you do the acupuncture but you [also] give the high blood pressure meds, like herbs and diet stuff and exercise, which is naturopathic. Together, they work to bring about the desired result.

Like many alternative health care practitioners, Edie considers herself more a teacher than a doctor, making one of her primary goals "to teach everyone how to take care of themselves, and only in emergency situations would they need to see you." Believing that "the body is very vital by itself," Edie employs her unique combination of therapies "to do the least to achieve the most." She affirms that the core of the "alternative" in health care that she offers is the opportunity "to explore your own body."

When I met Edie in 1992, she was the general manager of the An Hao Natural Health Care Clinic in Portland, employed by her husband's company, ITM, and also the clinic's busiest practitioner. I worked as her assistant, making it possible for her to see as many as 15 patients in a day. In my role as assistant, I also became a kind of apprentice. Edie taught me to remove needles and cups, to apply hot poultices gently to tender areas, and to wave a moxa stick
to warm up cold, painful areas and facilitate the spread of qi. I learned when to talk to patients and when to remain silent. I learned what questions to ask as part of "intake" when a patient first arrived. And I learned that even with her incredible pace, Edie Vickers was able to be completely present for each person during the time she was with them. She was open to their needs and adept at integrating her intellect, compassion, and skill.

Since 1992, Edie has gone on to do federally funded research on the effects of acupuncture on AIDS and HIV-positive patients.

Mary Scott, Licensed Acupuncturist and Herbalist, Naturopathic Doctor
Portland, OR

Also trained as both a naturopathic doctor and a licensed acupuncturist, Mary Scott had only been in practice for six months when I first met her in Portland. Working part-time and as a temporary replacement at various clinics in the city, Mary was in the midst of a kind of internship since her graduation. Hired to substitute for Edie Vickers during a rare vacation, Mary was unaccustomed and very grateful to have an assistant. Her conversation was filled with the enthusiasm of a new practitioner, thinking deeply about her daily clinical experiences. I noticed immediately that she had a very different needling style than Edie and spent more time in the room with patients, manipulating ("twirling") the needle. This became a focal point for our conversations:

You're question kind of came [at a good time]; I've been thinking a lot about that myself, because I've been working at a lot of different clinics. In the spring and summer, I worked at my own and went to three others, and I've observed at each of the three clinics before I've gone in because I
wanted to see how they approached [their work]. . . Every practitioner has a different technique. And different tools that they use and different modalities that they combine. [laughing] So when you asked about it, it just brought up this sort of schizophrenic crisis. What is MY technique? I've tried to adapt to the different techniques, so that it's not a sudden shock to a patient when they go from a size 3 needle to a size 5 needle or a 1 to a 5; the qi gets transmitted in really different ways.

Mary's professional training in health care began with massage therapy and naturopathy. When she first moved to Portland, she went to a naturopathic clinic for treatment when she got sick or hurt herself. "I always felt like that was my medicine." The shift from patient/client of naturopathy to student/future practitioner occurred as she helped her chronically ill brother to die in 1980.

When he died, I just realized that his death was a mistake of medicine; it was a condition that hadn't been seen early enough and hadn't been prevented and hadn't been dealt with.

Her hands became a focal point for her as her brother died:

When he was dying, we didn't have a very good relationship, but when he was dying, I would rub his back and I felt like that was more connection than we'd had through most of our life. Through touch. And that was the message that I got. That touch can connect where other things can't.

Mary then began to study massage therapy on her own, without a classroom-based program. She studied for six hours a day until she passed the licensing exam and then practiced part-time for several years.

I realized there was so much I didn't know that people asked me about. I really wanted to know. Then I started thinking about doing physical therapy or doing naturopathic medicine. But I didn't believe that I could. I don't have any science background and no women in my family had a profession, ever! And I just really didn't think that I could. And then it took a few years to realize that I didn't want to just go to naturopathic doctors, but that I wanted to be one.

During her first week of naturopathic school in Portland, several students from the neighboring acupuncture school came to Mary's classroom and
announced that anyone interested in experiencing acupuncture could have a
free visit at the school’s clinic.

I had always been real interested, but I was scared of needles, so I
decided to go that day. At lunch break, I went and had a treatment, and I
ended up getting treatments twice a week for three months. And really it
helped me, both physically and emotionally. I pretty much fell in love with
acupuncture.

Like Edie, Mary decided to attend both schools simultaneously, but she
did not slow either program down, completing her naturopathic degree in four
years and her acupuncture and herbalist licensing in five years. She was
compelled to study both modalities by her perception of the compatibility of
acupuncture with naturopathy.

I was just fascinated with the philosophy. . . . Where I see a similarity,
especially in philosophy, is that both of them stimulate the person’s
energy, the person’s own vitality. In naturopathy it’s called the vital force.
[Question: “Is this qi in Chinese medicine?”] Probably the best translation is
the person’s own sense of vital health. . . . both systems stimulate the
person’s ability to heal.

It is that ability to heal, to stimulate one’s own vitality, that forms the core of
Mary’s philosophy of health and healing. With a strong belief that healing
involves change, especially conscious change, Mary regards acupuncture
primarily as a tool for facilitating change.

With acupuncture, you can get immediate results. You can feel things
moving. Even if that’s just the door cracking open, it’s a sense that
something can change, which is wonderful. And even if it slams back shut
again after the treatment, they’ve had a sense that something changed
and then that’ll affect their consciousness and then that allows the person
to change.
Relying more and more confidently on her own experience of healing change through acupuncture, Mary has begun to embrace her role as an example to her clients.

Where [acupuncture] really helped me was emotionally. I was really stuck in grief about my brother. It would have been about six or seven years at that point. There's all kinds of things that you go through when grieving, but there was a lot that I hadn't gone through, and it really accelerated that process, and I just burst open during one of the treatments. . . . It was very profound. . . . and I felt like nothing had done that before. . . . As I become more comfortable being a practitioner, especially in terms of knowing how much I can reveal, how it's okay to be there emotionally for patients, it's really helpful for me to know that that happened to me and that I can tell someone that the healing can happen on an emotional level.

Mary has now had her own naturopathic and acupuncture practice in Portland for five years.

Susan Cushing, Licensed Acupuncturist
Viroqua, WI

A practitioner for only two years when she chose her own home territory of rural Wisconsin to start a new practice, Susan Cushing quickly found that her previous veterinary work was more relevant than some of her very “urban” acupuncture training. She includes an expanding veterinary practice in her clinical work, addressing the health care needs of horses, dogs, and exotic animals, as well as of people. Susan’s background in health care includes working as an Emergency Medical Technician and a homecare provider for elderly and disabled patients. Although she had interests in going to medical school and in studying with a traditional healer or shaman, Susan had misgivings
about both approaches. Both felt as though she would be "stepping out of my reality."

Before deciding on a new career path, Susan fell ill. As in many tribal cultures with shamanic systems of healing, Susan Cushing became an acupuncturist after experiencing extreme illness.

I got into acupuncture because I was pretty sick for a long time. Nobody knew what was wrong. It was just this crazy thing where you feel like you're going to die, but nobody thinks anything's wrong with you. Apparently what I had was a kidney problem. I was diagnosed with a kidney problem in Chinese medicine, too. But Western doctors didn't find anything like that. I had lots and lots of bizarre symptoms and a lot of pain. I really was a fibromyalgia patient, which means all-over body pain that is systemic, and it's not from an ulcer or a tumor or anything. For years that wasn't a term that was real. It didn't exist. So I struggled with what was going on with me, from cancer to diabetes, and nothing ever fit with the Western diagnosis. . . . I felt like I was dying. I was waking up on the floor in different places, just blacking out like that. Waking up with these splitting headaches, unable to eat, and a whole list of symptoms. But when I started blacking out, I thought this is really serious.

Even while providing homecare for other fibromyalgia patients, Susan never recognized her own symptoms in the people she was caring for. Meditation and yoga were already regular parts of her life, so "I was already oriented [towards] . . . trying to find a balance in things." Feeling that acupuncture was less invasive than more conventional treatments, Susan sought out a practitioner.

I found this acupuncturist who's in Madison now, and it just made an amazing change in one treatment. The first day it was like my head was stuck on another body for about three days. It just wholly changed how my body felt. But of course that went away. Then you go back and you start really working on it. It took years to really regain my health. But it showed me that there was someone who could make sense out of this kind of thing. It was all brand new. The transformation was amazing in three months of working with this person. And even though I didn't understand the terms that were used, it felt like it made sense. So I worked with it, and I saw other people who went and got treated and the changes that happened.
Working in her acupuncturist's office while thinking about pursuing veterinary medicine, Susan finally decided that acupuncture school was "the only profession that really looked like it was health-oriented, and I'd stay sane learning it and doing it." She attended a small Chinese school on Vancouver Island, Canada, traveling often to workshops in Seattle, Washington, to learn the Japanese treatment style that her interests gravitated towards. With 80 acupuncturists in a town smaller than Madison, Susan soon found herself pursuing the other side of her passion: healing animals. Working in a regional veterinary hospital in Victoria for several years during and after her schooling, she found her work with birds, cats, horses and dogs to be a "dream come true."

Upon moving to the area she had grown up in, around Viroqua, Wisconsin -- a town with many recent urban immigrants, an alternative Waldorf school, and several other alternative health care practitioners -- Susan expected a clinical practice similar to that of a conventional urban setting to develop.

I really thought I would see mostly women. My focus was on women's health and related things and some emotional issues. But I am seeing at least half men. And it's not the crowd I thought it would be. There are a lot of new immigrants in the last few years who are urban people coming out here. I thought that's the people I would be seeing. But I'm seeing the farmers and the construction workers and the farm wives. Those are the people I'm seeing. I'd say the majority of my practice, without question, is those people. Which is quite interesting. I had to go from a training in internal disease to musculo-skeletal work. My teachers thought pain was for beginners. That's surface stuff. Let's go in there and work on the cancer and heart disease and stuff like that. So I'm sitting here with all this training in that kind of stuff, and they come in with all this rheumatism. And I do not have extensive background in pain treatment. So I have just been working really hard to get up to speed with those kinds of treatments. It was just a rude awakening. I didn't think that those people would look to something different like this, but in fact, many of them are driving two hours from Madison for a treatment, and the ones that aren't
have seen it on TV enough now, and they're sick of the medications that
don't work, so they don't have any problem with it.

Treating primarily problems like arthritis, sciatica, headaches, digestive
disorders, addictions, and environmental sensitivities, Susan is also pursuing a
new veterinary practice. While "the pets in the barnyard are not going to get that
kind of care," she has begun to learn about working with cows in this dairy state
and has continued her work with horses and some dogs. She describes some of
the differences in working with animals as compared to people:

You can't ask them, so you have to be a very good observer. You have to
know the animals very well. The pulses are very difficult. It's hard. I've
got a lifetime of training dogs and horses, handling wild animals and other
domestic stock. So I really know general anatomy, a lot of other general
health, the way they communicate. If they don't look right, I know it. And
that gives me an edge in trying to do an acupuncture treatment that
someone else might not have. So I work really well with the vets; I know
the medical terminology. That's important, otherwise you're just kind of
guessing. You've got to know something about the animal physiology and
health.

Acupuncture work -- for humans and animals -- seems to integrate many
facets of Susan's life.

I've been looking for years for ways of working with people in closer
contact and to be more integrative with my other practices in life -- my
spiritual practices, the other work I do. I practice Akido, and the work I do
with horses is basically Akido with horses. And so with everything I do,
I'm trying to integrate into the question of how do we get centered and
balanced and just get the energy to flow in the right way, because when
that happens it sorts itself out. Rather than trying to make something
happen. So it's a way to play in that field and it fits in with the other things
that make sense in my life.

After two and half years of practicing in Viroqua, Susan has become involved in
a multi-practitioner chronic pain team as well as beginning to serve as staff
acupuncturist at a rural hospital. She has continued her veterinary work and
spends two days of the week in her own clinic. With an avid interest in research and teaching, Susan hopes to contribute to the growing scientific research on acupuncture care.

**Terry McCormick, Licensed Acupuncturist and Herbalist
Winona, MN**

An advocate for "the holistic health movement" since he was a teenager, Terry McCormick's graduation from OCOM last year made him the school's youngest graduate. At 28, his poise, intellectual confidence and easy manner inspire confidence in his small-town and semi-rural clients, almost all of whom have never experienced acupuncture before. In narrating the development of his relationship to acupuncture and Chinese medicine, Terry begins his story with a moment of awakening in his early adolescence.

There was a shift when I was about thirteen years old. The only people left in my family are my mother, my brother, and me. When I was growing up, there was this ritual of going to funerals at least twice a year. I got kind of numb to it after a while. But [I got] to the point at about twelve or thirteen, where I started questioning, "Well, what's the deal here? What can I do to make a difference?" I started realizing that a lot of this stuff was lifestyle related in terms of why relatives were dying -- it was cirrhosis of the liver, lung cancer, and other types of cancers. You can't say that lifestyle was the only factor, but it definitely was a significant factor in why these people were passing away. So I said, "What can I do to make a difference? What can I do to prevent this from happening to me?"

Terry and his mother began to subscribe to health magazines that focused on preventive medicine and alternative therapies; they also began to shop at the local natural foods store. While it wasn't a food co-op with locally grown produce or bulk items, "just getting decent bread, getting beans and tempeh, and some really weird stuff [like] sea vegetables" brought his focus to the nutritional
dimensions of health care. Dietary recommendations based on classical Chinese medical and TCM nutritional precepts are now a core aspect of Terry's treatment style. In his adolescence, he found that "gradually as the health food movement grew in the early 80's, then my understanding and my lifestyle kind of grew with it."

Laughingly calling his adolescent self a "bible-banger for holistic health,"
Terry describes how important the new focus on health care was for him and his early attempts to "heal" others:

When I was in high school, I never would take the bus, because I thought, well, you're sitting on your butt in school all day; you should get some exercise. So as a teenager I...[would say] like, why are you taking the bus? You're standing there waiting for the bus, totally out of shape. Which was kind of neurotic. I mean it wasn't really a balanced approach toward health. I was kind of obsessive-compulsive about it, being this militant vegetarian and exerciseaholic.

In college, Terry pursued a public health degree, though he remained unsure of a career choice. Through his reading, primarily of alternative health care magazines, he wanted to become an alternative health care practitioner, and yet recognized that "a lot of the alternative health fields were looked at as sort of new-agey, kind of not really accepted fields. And I thought I don't really jibe with this." Deciding that massage, especially the growing field of sports massage combined his interests with a recognized alternative health care modality, he began to study at the New Jersey School of Massage at night, while still in college. In this context, Terry first encountered acupuncture:

After I had gone through a year in the massage school, I responded to an ad that I saw there on the board, for an acupuncturist who wanted some sort of apprentice or assistant. I thought this was a great opportunity. At the time I thought that this guy was out of the kindness of his heart letting
me learn an apprenticeship with him for nothing other than to clean up his office and help him out in his practice. But now I realize! Now that I'm an acupuncturist myself, I realize well, that would be great if I could do that here and I could have somebody doing all this moxa, removing needles, and if I had a busy practice, I could see twice as many people. . . . Anyway, it was not a paid apprenticeship. The experience was the pay. That's what he told me, he said, "you're going to get an invaluable experience." So that was my springboard into Oriental Medicine.

While he had heard of acupuncture before, Terry remained very skeptical.

Through his apprenticeship, he began to feel persuaded by this modality of providing health care:

So that was my first exposure to acupuncture. I was seeing people coming in to the clinic, and they were people with various complaints. Peter was very professional in the way he presented himself. He called himself a doctor, and he was one. He was trained in China, so he could call himself a doctor. So he gained my respect right away, even though I didn't really respect the medicine very much. I had studied acupressure, I knew the points, but even though I was doing shiatsu, I really couldn't believe that the points had that much physical benefit, the treatment. It was kind of hard to believe. It felt good and it helped relieve muscle tension.

But then when I really saw the acupuncture, it made a lot of sense. How could something so simple do so much? That kind of got my attention, and I realized that this is what I wanted to do. I realized that my time as a massage therapist would be limited. I was still practicing massage, and Peter ended up utilizing me in his office. I wound up doing specific acupressure and T'ui Nah for him.

Realizing that massage was a limited profession, and having gotten a taste of practicing "on the fringe of treating disease" (massage therapists are not legally supposed to diagnose or treat disease), Terry decided to use his massage therapy training while pursuing graduate work in acupuncture. His mentor directed the rest of his college education, encouraging him to pursue projects and coursework that led to research on acupuncture detox and geriatric health care through acupuncture.
Upon moving to Portland and beginning graduate studies at the Oregon College of Oriental Medicine (OCOM), Terry found that

I was the only person in my class, and the only person in that school, who had come right out of college and gone right through the program non-stop. It was good, because I was still fresh. A lot of people who were not still in the student mode were not as there, not as responsive. I was the youngest person to graduate from my acupuncture school and a lot of the people had gone through other fields, nurses, chiropractors, people who were burnt out and wanted to do something else. So I was very fortunate.

Choosing OCOM primarily for its extensive program in Chinese herbology, Terry decided

If I was doing the program, I wanted to do the whole thing and not just do acupuncture and end up like this acupuncturist I was working for who knew nothing about Chinese herbs and now was having to go back to school to learn the stuff. And he had studied in China, too, and learned in hospitals, but he never studied herbs. So I wanted to get it all out of the way, and that was the school to do it. They had one of the best curriculums that I saw. So it was useful because the herbal training was valuable.

Like Mary Scott, Terry pursued a type of internship after graduating from OCOM. For a year before moving to Minnesota, he worked at the Public Health Clinic in Oregon, focusing mainly on Chinese herbs and herbal formulations.

Coming to Winona for Terry means “the first time I’m practicing alone and on my own without being supervised by a Chinese doctor,” as well as coming to terms with his role in a community where no acupuncturist has ever practiced before.

It’s challenging. Part of it is convincing people. They’ve been convinced enough to come in and make an appointment. That’s the biggest step. But then to convince them that it’s actually going to help them, that it’s doing something. It’s difficult, because there isn’t this pool of people that have benefited from acupuncture, like somebody in the street going, "Oh,
yeah, try acupuncture, it helped me with this! . . . It's easy in a small
town, because the word travels fast, but there's also difficulty just starting
out, because you have lots of inertia that's keeping things from moving
along. You have people that have doubt, that have skepticism, who are
not as informed as people in metro areas where there are lots of
acupuncturists.

Setting himself the goal of working at establishing a practice for two years before
evaluating whether or not the community can sustain an acupuncturist, Terry
regularly offers short free classes on Chinese medicine and acupuncture, with
his wife, Jenel Harris, acting as a demonstration model to show what a needle
treatment looks like. He also teaches regular six to eight week Qi Gong classes,
which are primarily attended by previous or current clients.

I try to educate people the best I can. I try to explain things [during]
treatment time in the best way possible, but having the opportunity for
people to come in, having a block of time each week for people to just
take a brief class with me is useful. And then using my Qi Gong classes
to support what the theory of Chinese medicine is all about is useful as
well. Often it's people that have seen me then who are taking the Qi
Gong class. So they get more information, they get experience of what qi
is and what it is in terms of how it can be manipulated. So it gives them
more information, more knowledge, to share with people. I think that's the
only way there really is . . . .

Sarah Wilson, Licensed Acupuncturist
Minneapolis, MN

On a warm spring day, Sarah Wilson throws a softball with neighborhood
children on her front lawn. Her slight build and casual ponytail make you look
twice to recognize the mature stance and steady gaze of a seasoned
acupuncturist. Returning to the neighborhood in central Minneapolis where she
grew up, Sarah works out of her home and does not advertise. Committed to
keeping her practice small, she sees only 18 - 25 people per week. Sarah's
clients find her through word of mouth. She treats whole families that live right in her neighborhood while some clients travel from as far as Duluth or Mankato for her treatments.

Sarah went to Central High School in the Powderhorn neighborhood where she now lives. As a magnet school, Central had functioning for special language courses like Russian, Swahili, and Chinese.

So I took Chinese for no other reason than that my friends were taking it. In fact Marta Hanson was in that class, too [a friend of Sarah's who has just completed her doctorate in ancient Chinese history]; we knew each other from high school. A lot of people from that class went into Chinese studies.

The Chinese language teacher also included cultural films in her class and brought in a T'ai Ch'i teacher. So Sarah began a life-time T'ai Ch'i practice while still a teenager. A documentary film on acupuncture anesthesia made in China made a big impression on Sarah.

I was very impressionable as a young teenager. . . . That [documentary] was a big influence on me too. People were sitting there, getting a brain tumor removed, totally awake, drinking tea. Of course, they didn't show that really when you do anesthesia, somebody is stimulating the needles for forty-five minutes before you get the surgery. So that was a big thing.

At nineteen, Sarah had her first acupuncture treatment for hip pain from biking.

I went to Dr. Yu who was a Chinese woman who practiced out on Excelsior Blvd. She's not there anymore, but a relative of hers was a teacher of mine in California, and she ended up moving out to California. She treated me for a half hour with the needles in and then took the needles out and put some kind of herb compress on my hip for another half hour, and she said, if it gets bad, call me. It never got bad. It was one of those treatments -- and I've experienced that with some of my clients, too -- where it really does the trick, and it did the trick. It worked for about two years. Then I had an accident and it got bad again.
After following other paths in her life for a few years, but keeping up with her T’ai Ch’i practice, Sarah realized she was ready to go to school and that she wanted to study acupuncture. Choosing the San Francisco College of Acupuncture (no longer in existence) as much for its location as for its program, Sarah found a wealth of clinical experience to be a strong foundation of her training. California insurance laws allowed for the coverage of acupuncture care, so the school’s clinic was always busy, and clients’ class and economic backgrounds were diverse. A solid Asian-American community formed a good teacher base for the school. As a student, Sarah was learning a health care modality that directly addressed the needs of the homeless, persons with AIDs, and those with other serious illnesses.

Upon graduation in 1991, Sarah returned to her neighborhood with a commitment to keep acupuncture accessible to a diverse population. She uses a sliding fee scale that makes her treatments accessible to lower-middle and working class clients, and devotes five hours per week to the local Indian Women’s Resource Center. Most clients of the Resource Center live in poverty.

That's real satisfying work, too. That's the agency that works with Native American women and children. They have an outpatient treatment, and they have all kinds of programs -- sexual abuse, child care, advocates, tons of programs. I’m there to see anyone in any of the programs. I even see staff. I’m there for two and half hours, and we schedule it so that it’s after meetings and people are free to come. There are eight beds or eight couches, and they can get acupuncture, acupressure (if it's busy, not for very long), ear beads, herbal teas, and any kind of health consultation. I've opened it up. I don't want it to be this kind of [reductive focus on] chemical dependency. I wanted it to be, "Let's talk about your health" and learn about things.
The pace is hectic during the two and a half hours, twice a week, that Sarah devotes to the Resource Center. Returning to her home, the pace slows down. She sees one client at a time, using an upstairs bedroom as her treatment room. The room is simple, a massage table with pillow and clean white sheets, a chair, a space heater, and a small table on which stand two boxes of disposable Chinese needles and a container of moxa. She uses "smokeless" moxa after yellowing the walls a bit over the years with traditional moxa. Sarah notes that at least fifty percent of her clients come for pain, keeping her moxa stick very busy (she uses moxa on 80% of her chronic pain patients). There are no charts on the wall, just two beautiful Oriental-style paintings. On the windowsill, some brightly colored, Chinese-lettered boxes contain a warming oil that Sarah also frequently uses for musculo-skeletal pain.

In her six years as a practitioner, Sarah has continued her training and thinking through acupuncture and Chinese medicine. Taking workshops with leading teachers around the country, she has continued to develop her intellectual and practical relationship with Traditional Chinese Medicine. Recently, though, her work with Native Americans has drawn her into a new direction. She has been asked to give talks at reservations, describing acupuncture and the work she does. These talks have made her uncomfortable, as she finds herself asking, "well, why am I doing this, because I'm telling them about all this stuff that I do but they don't have access to it." The time Sarah once devoted to TCM study, she is now devoting to developing an accessible program for Native American communities:
I'm kind of gearing my self towards where I'm needed. And I want to train people to do the work. It might not be poking needles. It might be: what are the questions you ask when somebody comes in with a headache. This is more basic stuff, and I have a talent with that, and I like it. I like working with the population and it would have a big effect. So I've decided to go a little bit into that direction. . . . Getting some money to work on curriculum for that [is my goal]. And I'm really happy about that. But it's different. It's a little bit more broad. And once again, little steps are big steps. A big step would be getting somebody to take a Chinese formula. But I would never get that far. If I can get somebody to drink three less cups of coffee a day and to drink more water and to exercise, and they do that the rest of their lives, well, that's a big effect.

Seeing her work in this community as oriented more towards public health than acupuncture, Sarah Wilson has adapted and revised her role as a health care practitioner to fit the needs of those who have turned to her for healing work.

Like many acupuncturists in the United States, Sarah has met this challenge with a commitment to educating and training clients, so that health care providers like herself -- who in the context of reservation life are not accessible anyway -- are rendered obsolete.

Dr. Chengde Wu, Traditional Chinese Medical Doctor
Houston, TX

Arriving in Houston in 1989, Dr. Wu and his wife, Madame Wang Jurong first came to America upon invitation from the United States Chinese Martial Arts Council for a national martial arts competition held in Houston; both served as judges for the event. The Houston Institute of Chinese Martial Arts and Medicine then invited them to stay. Their decision was influenced by two daughters already living in the States, and an invitation for Madame Wong to continue her
internationally reputed work as a skilled competitor, teacher, and competition official in Chinese martial arts:

We came here because we want to promote Chinese martial arts. They wanted a formal official [for] competitions. So they want to invite a Chinese martial artist and a very authority for the judge of competitions. My wife is this kind of person. . . . She organized the national competitions in China. She has a lot of experience. And we already both retired. So we think that is a good time for change. Retired means that we can start work!

In Shanghai, Dr. Wu had been the director of the Traditional Medicine department of the Shanghai Institute of Chinese Medicine, as well as serving as director of the Trauma and Orthopedics department for Longhua Hospital. Upon arrival, Dr. Wu assumed that “here no more patients,” and began to teach workshops and seminars in Chinese medicine and in Qi Gong through the Houston Institute. I first met him when I participated in one of his seminars. As one of his first clients, I saw Dr. Wu's occasional acupuncture practice blossom into a full-time clinical practice in a very short time. At first, he felt torn between continuing to teach and setting up a clinical practice that, due to regulations limiting the practice of professional (i.e., non-physician) acupuncture in Texas\textsuperscript{32}, would demand that he be sponsored by a physician:

Just at the beginning they say you must have the M.D. to do treatment; we'll get a sponsor for you. This I have a problem with. By my heart, I'm proud. In China, I sponsor students, they come and learn from me. Why should [someone else] be sponsor for me? I don't want. They say, Dr. Wu, this is smart, insurance can't cover. You can get more patients. I say, no, I am old. I prefer no sponsor; he sponsor you, you must listen he. Do this way, do this way. I say, I'm retired. In China, I lead a big department and because if he sponsor you, you can't say something he don't like. I don't like those conditions, so I say no. I teaching a class and I still have people asking me teaching. Basics. . . .
Then I do some treatments and little by little, I get more patients. Only way you do good is I trust. I treat 30 more years, no problem. Why I need insurance? I never have. They say you must have insurance. Here the school is like my landlord. If I don’t get insurance, he can’t get insurance. So, I say, okay, okay, I do it. Otherwise, you can check my record; never have problem. It’s different here. [chuckles] In America, no problem [is still problem...]

Dr. Wu was faced very quickly with a new problem. The growing demand for his acupuncture services far exceeded the “retirement” practice he had envisioned:

My hopes were very simple. . . Sometimes only one patient! Sometimes zero!
. . . [now I] work long time. I don’t want to work long time, but usually about 9:00 to 6:30 five days and Saturday, I finish 5:30. I have no choice. Patients say, “oh, Dr. Wu, daytime, I can’t.” For me, I say, I want to help people. Coming in for patient, they coming in for me. I really don’t want to come in for lunch time. I know lunch time hurt my health; I eat always on regular time in China, and I always emphasize [the importance of] eating at regular times. Now lunch time, they coming. So I say lunch time, I’ll do. After work, I’ll do. I could [say no] . . . but that’s no good. I go home, only watch TV. Sometimes I finish and my wife still teaching and I wait for her. So why not patient coming in while I waiting for her? . . . But my health is very good. Back home, happy, healthy, still eat very good, you know, sleep sound, so I don’t care.

Conditions that the new American clients presented him with at first were injuries and allergies. Later a local psychologist began to refer patients to Dr. Wu for depression and emotional stability, and his practice began to expand as “patient is feeling easier, good. So she will also say, go to Dr. Wu, go to Dr. Wu.” He began to enjoy the diversity of presenting conditions that people brought to his little clinic.

In China, longtime I treated neck and back problems; neck cervical problems. Only that. I wanted to do something like here. Here I couldn’t do that; if I only treat [neck and back], there’s not enough patients. . . . Later people ask me to treat for baby [fertility]. In China, maybe they say, you’re crazy, you don’t know how to do this! But I very succeed. . . . I have a lot of people for fertility. . . . This year I have two [fertility cases]. Two new babies!
Describing why he became a doctor as a young man, Dr. Wu notes “In China . . . we do doctor job because we want to save the people, help the people.” Trained first as an apprentice to an established practitioner of traditional medicine in China, Dr. Wu’s education precedes the establishment of TCM as a unified set of practices. Quickly becoming a teacher while still an apprentice as schools began to open, he probably took part in the process of constructing and disseminating TCM. Today, he still regards “helping the people” as his measure of success, especially as compared to American ethics of capitalism:

I feel most of the people I do good job. So I help the people. . . . I treat patients and always get good results; this means I succeed. If I say, more business, fancy office, I no succeed. I no car! So I no succeed. . . . I define success when you treat patients and most patients are satisfied with you and like you and say good words. Then I say I succeed. If you want only for buy house, I no succeed. I still live in apartment!

As much teacher as doctor, Dr. Wu emphasizes a kind of “right livelihood” to his patients and follows it himself:

I emphasize regiment. If you work too hard, you have stress, you have high blood pressure, you’re sick and have many things. [It all] depends on how you think of your life. You like happy life. I always say to patients, I really do say, “don’t worry, be happy.” I teach patient; this is difficult. I do [this]. I treat and I don’t worry. If I can, I don’t argue, no mad, no upset, no complain. No complain how God no good treat me. No complain that earth [?] not good, not nice to me.

. . . Health[y] person must have more energy, emotions are very happy, you eat different foods. These kind of people sleep very sound; these kind of people, I say health[y]. How teaching this? I always teaching my patients prevention. Do qi exercises, do yoga. I asking if they do, or I suggesting that they do. They sometimes working hard, and I say, must do exercise. Sometimes I teaching them Qi Gong exercises. . . . How do I take care of myself? That Mitra know. [chuckles] I always practice Qi Gong Tai Qi everyday.
Mediatory Thematics

In the culture of acupuncture practice, acupuncturists develop their own identities as healers. The choices they make along the path to and with acupuncture influence the mediatory role they play in the body politics of acupuncture care. Positioned between individual clients' emergent bodies and the larger technocratic culture of biomedical health care, practitioners influence and are influenced by both realms. Their own experiences with health care seeking when they are ill may contribute to the decision to pursue acupuncture as a life path. As mediating bodies, practitioners may also facilitate models of “integrated medicine” and transformations in client-practitioner relationships, as well as transformations in the bodily being of their clients.

Experiences with Illness

In the stories above, Edie Vickers, Mary Scott, and Susan Cushing all become acupuncture practitioners in large part because of experiences with illness. These experiences highlighted their intermediary role with their own clients through the shift from patient/client to student/practitioner, from healing to healer. Edie tried acupuncture for the first time during her graduate work at the National College of Naturopathic Medicine, and overcame her fear of needles out of sheer desperation -- “I was sick, sick, sick, so I said, I don’t care, just stick me.” Mary had already deemed alternative health care as “my medicine” and sought naturopathic care when she had a flu or other mild illnesses. For her, a
trial acupuncture treatment initiated because she felt she ought to know what acupuncture was like, led to a regular treatment regimen that fostered a deep sense of release from the grief claiming her since her brother's death. After recovering from extreme illness through acupuncture care, Susan began to work in her acupuncturist's office and realized she was compelled to make the shift from patient/client to practitioner. For all three practitioners, their experiences with acupuncture care convinced them of the effectiveness of acupuncture treatment, influenced their choice to learn acupuncture, and gave them a solid base out of which to relate with clients. For instance, Mary notes that she feels comfortable now telling a client "that healing can happen on an emotional level."

**Integrated Medicines**

Acupuncture is directly integrated with other health care modalities, especially for the naturopathic doctors, Edie Vickers and Mary Scott, and the chiropractor, Abbie Dring. All see the complementarity of their multiple therapies and sometimes don't distinguish where one modality starts and another ends. For those practitioners who are solely licensed acupuncturists, they often integrate therapies from other alternative health care practitioners. The wife and husband team of acupuncturist and chiropractor (Karen and Doug) exemplify this integrative approach to a single client's health care. Susan's work with a local chronic pain team also shows how therapies may be integrated cooperatively by multiple practitioners. These models of integrative medicine are especially interesting from the standpoint that many clients see multiple practitioners to begin with. For some of those practitioners to work together and consult with
each other breaks out of the hegemonic hold of a solipsized technocratic
medicine. While Terry McCormick regards himself as an alternative health care
practitioner on the margins of American health care, he, too, constructs a solid
ideology of integrated medicine. Borrowing spatial and attitudinal structures from
allopathic medicine, Terry has created an environment for his clients -- almost all
new to acupuncture -- that is reassuringly familiar and comfortable.

Client-Patient Relationships

Breaking out of the hegemonic story that characterized doctor-patient
relationships within biomedicine is another characteristic aspect of American
acupuncture. Almost all practitioners mention at some point that they see
themselves as teachers more than as doctors. One of Edie Vickers’ central
goals is to make the need for her work obsolete:

My philosophy of healing is basically to do the least to achieve the most. . .
I believe the body is very vital by itself and usually will work it’s way
through stressors, environmental, emotional, spiritual, or whatever, with
minimal interference. . . . If someone comes in with a cold, [for example,] I
basically teach them how to treat a cold, so the next time it comes up,
they don’t have to come and see me. They can do what I taught them.
The goal is to teach everyone how to take care of themselves, and only in
emergency situations would they need to see you.

Sarah Wilson also talks about “train[ing] people to do the work” and moving from
TCM to public health in just trying to “get somebody to drink three less cups of
coffee a day and to drink more water and to exercise.” Upon arriving in the
United States, Dr. Wu initially saw himself as primarily a teacher. When clients
began to seek his services as a practitioner, he did not forsake this integral
aspect of his identity and began to teach clients some fundamentals of Chinese
traditional regiments of nutrition and exercise. In Frank Fischer’s (1990) terms,
this doctor as teacher model of health care is a participatory and collaborative model of expertise:

In contrast to the traditional superior-subordinate relationship, alternative health services are designed to promote nonhierarchical, cooperative associations between practitioners and clients. (369).

The emphasis for each of these practitioners on empowering the client -- offering the opportunity “to explore your own body” (Edie Vickers) -- on pursuing a form of public health education, transforms “the expert” into a facilitator (Fischer 1990:366) or consultant (ibid.: 368):

As facilitator, the expert’s task is to assist clients in their own efforts to examine their own interests and to plan appropriate courses of action. . . . In short, professionals must become experts in how clients learn, clarify, and decide. (ibid.: 367, emphasis in original).

This raises unique role demands on the expert, ranging from theoretician and expert to colleague and coproducer of knowledge. (ibid.).

**Facilitating Transformation**

Working collaboratively with patients fits well with a general ethic of change and transformation, also expressed by almost all the practitioners.

The most fundamental a priori assumption [of acupuncture practice] is the possibility of change. Things are not fixed, flux is the enduring reality in human life. (Kaptchuk 1997:xiv).

Because Yin and Yang create each other in even the most stable relationship, Yin and Yang are always subtly transforming each other. This constant transformation is the source of all change. (Kaptchuk 1983:11).

*Change* is a tacit category in many of the stories above; it is a given that it should be a goal in treatment, and practitioners discuss which treatment practices yield change more readily or more immediately than others. Karen Levine notes that in her early experiences with acupressure, she “learned that by holding [certain]
points, I would be able to really experience a lot of change and could help people to change.” The “immediate results” that most practitioners associate with acupuncture may not be lasting but their import is in “cracking the door open . . . a sense that something can change” (Mary Scott). While a change in clients’ immediate physical condition is a goal of treatment, it is only one layer. The “change” that Karen refers to above is not only of a presenting condition, but also of unhealthy behavior patterns, such as addictions. Emotional and personal growth are objectives of treatment for most of these practitioners; all regard acupuncture as a tremendous support for deepening a person’s engagement with her or his bodily life.

Conclusions

Through a commitment to an integrated approach to healing, an emphasis on revolutionizing the conventional hierarchical structure of physician-patient relationships, these acupuncture practitioners can clear a space in which clients’ own healing capacities and transformational abilities can emerge. Turning now to these emergent bodies, I will explore clients’ experiences of bodily transformation in the next two chapters.
CHAPTER FIVE
EMERGENT BODIES:
GEOGRAPHIES OF SENSATION AND TRANSFORMATION AMONG
AMERICAN ACUPUNCTURE CLIENTS34

To me, I think that one of the most astounding effects of acupuncture is that it literally pins the person down to having to be with themselves. Where they can’t move, they can’t really fidget, they can’t be distracted. They just have to be with themselves, and I think it’s a real opportunity for most of us to be in that position. Because there’s no where else to go! There’s no where else to go but in.

-Karen Levine, Licensed Acupuncturist, Portland, OR

Once the needles were in place, ... a relaxation comes over the body that’s near impossible to explain without conjuring up narcotic references. The needles remained in place for about 20 minutes, during which time I felt my eyes close and the racing thoughts that had plagued me drift from my mind.


Throughout fieldwork, I was struck by the relationship between storytelling and embodiment. After interviews or in clinic situations when I listened to clients’ stories, people often thanked me for the opportunity to think and talk about their experiences. “I never thought about things this way before,” said one woman at the end of an interview in which we had both shared our experiences with menstrual pain and acupuncture care. Like Jane Sugarman’s ethnographic experience with Albanian Prespa singers (1997), I too found that interviewer and interviewee co-created new understandings, new knowledges, and sometimes even new vocabularies about the context of experience and about the experiences themselves:

As I spoke more intensively with individual singers, however, their comments and observations became increasingly idiosyncratic. Often we found ourselves negotiating a new vocabulary in order to discuss ways of
thinking about singing that they had never before verbalized, perhaps, or even explicitly thought about. (Sugarman 1997:22)

The clients of acupuncture care with whom I spoke were often articulating ways of thinking about and understanding their bodies that they had not verbalized or perhaps even thought of before. I often participated in this process during interviews, offering my own “new” or “transformed” body narratives. Words like “pain,” “uterus,” and “body,” itself, developed new meanings as we talked. This experience raised the question, how do we talk our bodies? In what ways does narrating our bodily experiences entail an embodiment? Clearly acupuncture treatment, in and of itself, allows for and encourages experiences of embodiment as exemplified below. But narrating those treatment experiences also accomplishes a kind of embodiment, though a very different one from that experienced while lying on the treatment table. I found that people, myself included, needed to develop a body story that made sense to them and that was deeply meaningful.

This relationality between storytelling and embodiment is also explicitly gendered. Most of the people I interviewed are women. In the Portland clinic, in acupuncturists’ offices, among my friends, women were readily and enthusiastically creating body stories, often approaching me and asking me to participate in this project. While I began this project with a non-gendered interest in how acupuncture clients embody the “translated channels” of Chinese medicine(s) as well as their own transformations, I found that the women I met were often more likely than the men to articulate and to express enthusiasm about articulating processes of embodiment. Women are also known to be the
primary consumers of health care in the United States, accounting for two-thirds of all visits to physicians (Strong 1993). The acupuncture practitioners I worked with also consistently stated that the majority of their clients are women. In what ways do women narrate their bodily beings and bodily experiences of acupuncture care? From my own experiences and those of other women for whom the flow of qi adapted itself well to our body stories of menstruation and reproductive health, I found that acupuncture can “point the way” back to/in our bodies.

Arthur Kleinman has popularized the distinction between disease as the health care practitioner’s perspective and illness as the lived experience of patients, developing also a medical anthropological focus on illness narratives, especially among chronic pain patients (1988). Because illness narratives now are often co-opted by physicians and other medical practitioners (Henderson et al. 1997), I am interested here in distinguishing clinical narratives -- what the practitioner (including the physician) diagnoses as the problem, from body narratives -- how clients integrate their own bodily experiences with diagnosis, with their bodily pasts, and perhaps also with multiple conventional and alternative clinical narratives. Following, tracing, helping to co-create, recording, interpreting, thickly describing these body narratives has become the focus of my ethnographic work. What I have found in these stories is the impulse to create an integrated bodily identity -- an identity that can account for multiple perspectives, including those of alternative and conventional health care
practitioners and including the multiple perspectives (sometimes of alienation and relationality simultaneously) of the clients themselves.

The ethnographic material for this chapter is based on depth interviews with nine clients of the practitioners appearing in chapter 4, as well as clinical fieldnotes about 27 other clients from conversations with them during my work as a clinic assistant in Portland. Quotes from fieldnotes are necessarily more limited than those from tape recorded interviews. Many of the interviewed individuals expressed an interest in reading and revising their interview transcripts. I only shared transcripts with people who expressed this interest, although I also repeated my request for their permission to quote interview material once interviews were done. People seemed grateful for this reminder, especially after very personal and sensitive issues had been raised during the interview. No one asked me to excise any material. At the Portland clinic, I informed all the clients in whose care I participated as a clinic assistant that I was also an ethnographer and I requested permission to make notes on their experiences and quote from those notes in this work. All consented to participating in the project.

I have attempted here to discern some of the themes common to many of the body stories. In structuring this chapter in terms of common themes, I am interested in the particulars of storied embodiment: how do people talk their bodies? The body stories that emerged in my fieldnotes and transcribed interviews included combinations of central themes. Drawing from fieldnotes during my clinic assistantship in Portland, I present the following story of one
clients’ bodily experience to exemplify the themes that will be developed in this chapter.37

Jean, a woman in her mid 40s from working class roots, was a construction worker in Portland in the mid 1970s when a 500 ton mold frame for a tank fell on her, crushing her shoulders, lower back and hips, and pinning down her legs. She has had innumerable surgeries. Her ankles were fragmented; they are now “fused.” Jean lives in constant chronic pain and has sought relief regularly from acupuncture care. Like most chronic pain patients, she has come up against the limits of what biomedicine can do to alleviate her condition. The second ankle surgery occurred just a few weeks before I met Jean in a treatment room at the Portland clinic. I assisted acupuncturist Mary Scott by applying moxa heat to Jean’s aching hips and lower back and by removing needles and applying a hot poultice at the end of her treatment. Jean told me that she has spent much of her life since the accident on crutches. During treatment, I found Jean to be very sensitive to acupuncture and very aware of her body. The pain in her hips and back is so constant and strong that she actually knows the pressure points very well and articulates when they’ve been engaged. She clearly feels pain, but laughs her way through it: “OOOhh, yeah, that’s it! HEL-lo!” Creating a very interactive treatment situation for herself, Jean clearly views herself in partnership with her practitioner, often directing Mary to placement and depth of needle insertion:

When Mary can’t find a particular point, Jean says, ‘It feels like you’re real close, but it’s like it’s running away from you!’ Mary manipulates the needle some more, going a bit deeper, until Jean tells her it’s the spot. When I return later to apply moxa, she is totally relaxed. ‘I’ve been
melding with the table,' she remarks with her throaty chuckle. She likes
the heat of the moxa and poultice very much and remarks that while I
have not let the area get too hot, she can still feel it very strongly. She
says she feels sensations going down a meridian on the front of her body,
although I am working on her back. (Fieldnotes, 7/14/92)

"Pain" is a constantly shifting category for Jean; she describes the pain she feels
during acupuncture, as compared to the constant chronic pain of her bodily
being, as "a good pain," one that spreads relaxation.

The themes that emerge from Jean's story include the following. Paths to
Acupuncture -- how do clients come to choose acupuncture care as a health
care alternative? For Jean, living with chronic pain led her to explore treatment
alternatives long before such alternatives began to move towards the
mainstream. Stories of Relief -- clients express satisfaction with acupuncture
care at the level of getting relief from symptoms, as well as other kinds of relief.
Pain relief, however temporary, is central to Jean's continued use of
acupuncture. Practitioner-Client Relationships -- how do clients characterize
this relationship and what do they valued about it? Jean constitutes this
relationship as a partnership, often clearly client-centered. In what ways do
clients and practitioners work together, not only for optimal treatment of
symptoms, but also to create a treatment space that is alternative to biomedical
models of physician-patient relationships? Geographies of Pain -- how do
clients map and re-interpret experiences of pain, sometimes shifting "pain" to a
new category, that of "sensation"? Jean's delineation of a category of "good
pain" demonstrates this kind of shift. "Acu-Land" or relaxation -- clients create
an emergent category of benefit from acupuncture care while also revising and
newly defining what is meant by “relaxation.” Through each of these themes, body stories evoke an experience of transformation, of emergent bodily being. A central theme throughout, then, is Emergent Transformations -- clients' bodily experiences of enacted transformations. These transformations are also gendered, and in the final section of the chapter, I will explore more specifically the gendered nature of emergent bodies through an analysis of how acupuncture “points out the body” for three different women seeking acupuncture care for the increasingly common menstrual disorder known as endometriosis.

**Body Talk: Paths to Acupuncture**

Almost all interviews with acupuncture clients began with a question like “what drew you to try acupuncture?” Like acupuncturist Edie Vickers' story of trying acupuncture for the first time -- “I was sick, sick, sick, so I said, I don’t care, just stick me” -- some people’s stories begin out of a sense of desperation. Kristen is a 22 year old college student from a lower middle class family (her parents come from working class families). She has suffered intermittently from excema since childhood. Matilda is a 29 year old graduate student from a working class Chicago family. She and Kristen are close friends and were interviewed together. When Matilda sought acupuncture treatment, she had no clear biomedical diagnosis. She was suffering from extreme fatigue, depression, and chronic colds and flus.

Kristen: I was in a very desperate state of mind; I was miserable. I had excema all over my face, all over my body, and I knew the doctors couldn’t help me anymore, because I’d been to the doctors for a couple of years. Five or six times. They all gave me hydrocortizone cream and
said, well, you just got to wait it out. It just wasn't doing it. I mean it helped some. The skin rash wasn't as bad, but the hydrocortizon cream was too painful to put on my skin. And water was too painful to wash my face. It was just horrible. It itches and it hurts and you're uncomfortable constantly. So I was just really desperate for anything.

Matilda: I was totally desperate. All the tests I was taking were coming up negative. . . . I just had had it. Basically [after running all the tests], they [the doctors] said that I was just depressed, that this was all in my head. I said, that may be true, but physically there's something wrong with me. I'm not right. So I laid in bed. . . . The fact is I needed help. I didn't know that there were alternatives. I wasn't aware of them. I mean, I knew acupuncture existed, but at that moment, that didn't even enter my horizon. I hate to say this, I hate to admit it, but I was just lying in bed, really waiting to die. I had given up.

For both Kristen and Matilda, seeking an alternative emerges in the context of running up against the limits of biomedicine. Other clients explicitly critique biomedicine as a limited health care modality. Michael is in his mid-30s, a recovering alcoholic, with chronic back pain. He is a postal worker in Portland. Carolyne is a 38 year old college professor in Chicago, from a Southern Baptist family. She has suffered from chronic and debilitating headaches since childhood. Phil is a 63 year old retired Burlington Northern train dispatcher. With lifelong diabetes, he sought acupuncture treatment for sciatic pain from two herniated discs. All three explicitly regard biomedicine as limited and have closed it off as a treatment option:

Michael: I used to think it [acupuncture] was voodoo.
Mitra: What's different now?
Michael: You know when you've eaten food, you feel full, your body is satisfied and all that? Well, all doctors give you is a bowl full of steam!

Carolyne: You know, when you hurt you just want to feel better, and I really am so skeptical of the medical profession. They're of no help to me on these things.
Phil: [Question: Have you continued to see your orthopedic specialist?]
No. Once I started with Sarah, I stuck with her all the way.

Jane, a 25 year old middle class college student, responds to biomecine, after years of seeking a diagnosis which finally emerges as “endometriosis” with treatment options that she finds problematic, with anger and a sense of betrayal:

Jane: I discovered that the material the pharmaceutical companies give you is what they want you to know, not what you need to know. And that surprised me. I was so angry! I thought, I'm not doing this anymore. After seeing all the doctors that I saw for a year before I was diagnosed who told me that it was just a little cyst on my ovary, or it was just this or just that. I thought, no way. I felt like, or now in retrospect, I think I've had endo [endometriosis] for a long time.

However, some clients responded to the question about what drew them to try acupuncture, with a very complementary model of medicine. Several clients combined acupuncture with biomedical treatments. Delia is a 26 year old waitress and student of shiatsu massage therapy. She comes from an upper middle class Minneapolis family, whose members regularly complement their biomedical therapy with alternatives. Delia herself originally sought acupuncture care for mental focus and body pain. She currently combines physician monitoring of a benign facial tumor with regular acupuncture treatments. Jill is a 42 year old teacher and mother of two, who lives with her family on a farm in rural Minnesota. She began acupuncture care during radiation treatments for breast cancer and continues regular treatments to support her health. Jill found the combination of acupuncture with biomedicine’s prescription for breast cancer kept her healthy and free of the side effects common to radiation treatments. Both Jean and Claudia sought acupuncture while also pursuing biomedical surgery to fuse joints due to injury (Jean) or to rheumatoid arthritis (Claudia).
Other clients combined homeopathy (Jill), chiropractic (Kristen, Matilda), shiatsu massage (Delia), and other alternative health care modalities with their acupuncture care. If there is a particular profile of acupuncture clients in America, it seems to be a group of people who are making health-care choices as if the United States were organized at the national level in a plural medical system. . . . Cost savings . . . can occur if patients use practices selectively, for what they do best. . . . limited data from the qualitative section [of this study] suggest that these consumers are using the range of health care available to them selectively and astutely to achieve their health care goals. (Cassidy 1998:10)

An aspect of seeking health care alternatives to biomedicine -- embarking on a path to acupuncture, for instance -- whether abandoning biomedical care completely or not, clearly entails developing skills for managing multiple health care options and making appropriate treatment choices.

Acupuncture "entered the horizon" of most people's treatment options after a trusted friend or family member recommended it to them. "My friend, Clothilde, had gone; so I knew a little bit about what to expect" (Jill). "I started hearing from other friends that they were having positive results" (Claudia). "My son recommended Sarah to me after the physical therapy really didn't help" (Phil). "Matilda told me that we're so used to Western medicine, that it doesn't necessarily heal, and that there is other medicine that people use that is just as good. She told me about [acupuncture], and I was just like take me there now because I'm willing to try anything!" (Kristen). "So this friend of mine from work, she really set up the appointment, and it was good that she did, because I couldn't. . . . I really needed someone to set up everything for me" (Matilda).
Such impressions of acupuncture care following initial treatments ranged from “I thought it was voodoo” (Michael) to “[laughingly] this is a miracle!” (Matilda). First impressions of acupuncture treatment sometimes included a sense of alienation from the practitioner:

Jill: What I do remember is that I felt like I was direly unhealthy. Just from the way he [acted]. And part of it was certainly that I knew I had a serious illness [breast cancer]. But I wanted to be told, ‘Oh, you’re totally healthy; that was just a fluke.’ Then he kept asking me all these questions like, ‘Do you have dizziness or spots in front of your eyes?’ And I just thought, gosh, it looks like I should have all these terrible things! ... I felt like he didn’t answer my questions that well.

Upon encountering the “culture” of acupuncture care, Jill, a student of homeopathy and daughter of two doctors, also felt alienated by the “foreign language” of Chinese medical terminology used by her practitioner:

I thought, god, now I have “liver stagnation” problems and stuff. Because the liver is kind of important in breast cancer, because that’s where it metastasizes too quite often, and so that was like, well, the liver part was really depressing to me.

Gabriella, a 40 year old college university professor sought acupuncture care for a chronic kidney problem and found her first treatment incredibly painful.

Gabriella: I felt an engulfing pain in my kidneys. It made me very doubtful of my capacity to work [on my health] this way.

In a town that never had an acupuncturist before, Jane’s first impression when she sought treatment for endometriosis was that

I thought it was kind of kooky at first because I didn’t know that much about it. ... The first treatment I was not very relaxed. It was so new and I was kind of nervous ... The first needle he put in was right up by my big toe. ... that’s the first one I remember. ... I totally flinched. ... The first two treatments, now that I’m remembering it, they were kind of difficult. The second treatment, I went in and he said, ‘Let’s work on your breathing here,’ so he knew that it was not easy for me, and that I needed to calm
down and work on my breathing. So he went very slow and was very patient those first two times.

While first treatments were painful and sometimes alienatingly difficult to understand, these clients ended up returning for further care for many reasons, many of them detailed below: they valued the close practitioner-client relationship, they found relief from their symptoms, and/or they experienced deep transformations in their bodily beings.

Other clients embraced acupuncture immediately, often even when they did not perceive immediate relief from their symptoms.

Matilda: I walked out, and [my husband] was elated. I walked out and my eyes were wide awake; I'm like [laughing] this is a miracle! I was so excited that I did some reading that night, just pleasurable reading, and I was up until 12:30. The next day I had a crash. But it gave me the sort of confidence and hope that I continued to pursue it, and then slowly but surely I got better. It took a long time, but even by the third session, I was improving.

Kristen: It [the excema] didn't really get worse; it didn't really do much. It didn't start going away until maybe a month after I started seeing her. It took like two months for it to be completely gone from my face [and longer for my arms, etc.]

Mitra: If it took a month for the first signs to clear up, what made you want to continue?

Kristen: Because she said it would take time. . . . she said, because you've had it so long, it's going to take a long time to get rid of. But it was not just like I've got this thing on my skin, let's get rid of it. It was something emotional. It was something beyond going to the doctor and having someone say, 'it's going to take a long time, blah, blah, blah.' There's something about her [the acupuncturist] that's nurturing.

Patricia, a 26 year old graduate student from a lower middle class family from Southwestern Ontario, sought acupuncture care after reaching what she felt were the limits of biomedicine. Refusing to undergo diagnostic surgery to confirm what she and her physicians suspected was endometriosis, Patricia
describes herself as “operating without a diagnosis” and describes her first acupuncture experience in terms of the character of her practitioner as well as the powerful and unusual sense of relaxation accompanying her treatment:

   Patricia: He [the acupuncturist] is just a really nice person. The needles didn’t hurt me at all. He turned out the lights and the thing that happened immediately is that he put a pin directly in the center of my abdomen, where I imagine my uterus must be, and I felt something immediately. I could feel, I had sensations beyond the confines of my body, or beyond what I had until that point imagined my body to be. . . . I was very relaxed. And I came out of there with that, it’s not a numb feeling, but I guess relaxation like I’d never experienced; almost like a deep sleep, where you wake up completely mentally aware.

Each of these stories convey elements common to many of individuals receiving acupuncture care: a clear, sharp memory of their initial (sometimes very first) treatment -- often months or years after the experience; an emphasis on the character of the practitioner -- “a really nice person,” “something about her that’s nurturing;” acupuncture as potentially a “painful” experience; acupuncture as potentially a “relaxing” experience; as well as some relief of the condition for which they sought treatment. The following sections take up each of these elements in turn.41

**Body Talk: Stories of Relief**

Relief of presenting conditions or symptoms is clearly a main reason why the clients participating in this project sought acupuncture care. Cassidy notes that 91.5% of 575 respondents reported that conditions or symptoms had “disappeared” or “improved” as a result of Chinese medical care (1998:6). While all the clients I spoke with experienced some kind of relief from their presenting
ailment, this section explores how body relief is narrated and how relief is constituted also as “emotional support” and as “staying healthy.”

Stories of relief often began with assurance that presenting conditions or symptoms were helped by acupuncture care:

Jill: I do notice one big difference. I do have swelling in my breast still and I had a lot during radiation. Right after an acupuncture treatment, it would be gone. That would be the only time that my breast felt like my other breast. . . . [So] I experienced a lessening of the swelling. I think it definitely made me healthier. They were saying that I was doing very well with the radiation. [seven weeks of daily radiation with weekly acupuncture care.] . . . sometimes it would be pretty dramatic [the reduction in swelling]. It’s not that dramatic now, but it really was [during the radiation].

At 50 Claudia had been dealing with rheumatoid arthritis for six years and menopausal hot flashes and sleeplessness for three years. She lives on a land cooperative in rural Minnesota and raises sheep, chickens, and garden vegetables. An avid hiker and kayaker, her chosen lifestyle was quickly becoming threatened by her physical condition when she decided to seek acupuncture care:

Claudia: I feel like I’ve had very, very positive results. The thing that I have experienced is that I’m not having inflammation in the way that I did before. I’ve cut back on my allopathic drugs. I have never taken any pain killers, but I take a formidable array of allopathic medication to control or try to manage the arthritis. . . . The acupuncture keeps the inflammation under control and it helps with pain management. Sometimes the pain is much more tolerable, especially in my feet. I leave appointments, and I am generally ‘pain-better.’ I don’t know that I’ll ever be ‘pain-free’ in my life.

Other stories of symptom relief also focus on pain relief:

Phil: After the second or third treatment, I began to feel better. I’m not entirely out of the woods, but [the acupuncture] alleviated a lot of the pain. I was having “charlie horse” cramps in my legs, my calves, a lot of sciatica [pain in sciatic region]. Sarah explains everything as she goes. It didn’t
hurt. I've been taking insulin twice a day for years; I'm used to needles. You feel them in certain areas more than others. It's alleviated a lot of the pain.

Jane: The most significant changes were the pain prior to my period and the typical premenstrual symptoms like breast tenderness and bloating and crankiness and stuff like that. That seemed to go away much sooner than anything else; that kind of stuff was alleviated really quickly. . . . within a month and a half to two months of treatment, I would say 60% of my symptoms were gone. . . breast swelling and tenderness, headaches. . . the clotting. I used to have huge clots. . . . I don't think I'm bleeding quite as heavily as I was prior to acupuncture. The only thing that's still there, that really hasn't gone away is the pain at the onset of bleeding.

Delia: Acupuncture totally helps keep my moods even. I used to feel angry, bent out of shape, all the time. Now I'm pretty even as far as my mood goes and my energy. And I don't wake up with pain. . . . I didn't have a lot of energy, and I was waitressing, and my shoulders hurt. I'd wake up and my whole body hurt all the time. It seemed really unnatural, since I'm 26. And I was feeling really spacey. I saw her for a long time, and it really helped with my focus. She did a lot of points, right here in my head to kind of get the qi circulating in my head. So that really helped. My shoulder pain gradually went away. It would get better for a couple of days and then it would come back. And after [consistent] treatments, I just didn't have anymore of that. It disappeared. You just have to be consistent to get full benefits.

These clients are affirming the physiological effects of acupuncture care, often in terms of relief from pain. Pain is the most common symptom that nationwide clients of acupuncture present to their practitioners (Culliton 1997).

While acupuncture clearly provides pain relief, clients like Delia above also discuss their care in terms of emotional support. Delia feels that she doesn't “feel angry, bent out of shape all the time” due to regular acupuncture care. Claudia eloquently narrates the relief from arthritis pain -- “pain-better” -- she experiences with regular treatments, and she, too, includes emotional pain in her story of body relief:
Claudia: Rheumatoid arthritis is very much triggered by emotions. . . . So when my partner and I separated, I knew that this could have negative effects on my body and be really hard on me. So I made a very conscious effort to take care of myself. . . . There was one particular [acupuncture] appointment where I silently wept the entire time I was there. I was really embarrassed at first, but I really had no control over it at all. [My acupuncturist] was fine. Every once in a while he would give me a Kleenex. I filled my ears with water as I was laying there. I just wept. It was a very bizarre experience. Afterwards I felt tired. Really, really tired.

Claudia finds, to her surprise ("it was very bizarre"), that acupuncture care can be healing for hurt emotions. Operating with a biomedical model of health care in which the emotions remain separate from the physical body, acupuncture clients find that emotions are a welcome aspect of a treatment modality that is holistic, i.e., that attends to the psyche, emotions, or mind as well as the body. Kristen identified acupuncture care as “something emotional . . . something beyond going to the doctor” and other clients have even noted that they feel a spiritual dimension to their care and to their experiences lying on the table during treatments.

Clients also narrate relief in terms of improvements in their overall health and well-being. Many identify a stronger immune system as the core benefit of continued acupuncture care. Stories of relief include:

Carolyne: I haven’t gotten as many colds and when I do I get over them quicker.

Matilda: [Even my family] noticed it. The fact that last winter I had anywhere from seven to eight colds, and they would last two or three weeks. Whereas this winter I’ve had one cold. It was in October, and it lasted me two days, and I was back on track.
Clearly individuals who describe fewer colds and a stronger immune system view even quotidian illnesses like colds as relational and holistic, a part of their overall bodily being.

**Body Talk: Practitioner-Client Relationships**

If acupuncture care provides “something beyond going to the doctor,” how do clients relate with their practitioners? How do they narrate their relationships with their practitioners? Interviews were full of references to the character and skill of practitioners. Clearly, the practitioners “bedside manner” and personality were as crucial as their skill and expertise in practicing acupuncture.

Kristen: There’s something about her [the acupuncturist] that’s nurturing. I go into that place and I immediately feel better. She gives off this energy that just makes you feel better! I mean I could go to sleep there and be happy as a lark, you know!

In a later passage, Kristen describes what it is about her acupuncturist that makes her feel so nurtured. In the process she makes a tacit comparison with the biomedical model of health care as conventionally practiced by physicians:

Kristen: I think that it's just the fact of someone caring about me. Not just looking at me like a technicality, like this is what you got, labeling me. But someone actually seeing me as a human being and caring about me. It's a very comforting thing.

In Cassidy's study of 575 survey respondents, she found that 17% stated that they were frustrated with biomedical care and explicitly sought acupuncture as an alternative because of that frustration.

Another tacit comparison with the biomedical model of health care emerges in the amount of time practitioners devote to talking with clients.
Several people found their first visits with acupuncturists memorable because of the emphasis acupuncturists placed on talking with new clients:

Matilda: I walked in there, and she explained things to me. She took a long time over this.

Jane: The first treatment, it was really neat. He talked to me . . . for almost two hours -- about my life, my habits, my social, personal, medical history, my education, my family.

Claudia: We talked about why I was there and what my expectations or desires or hopes were, and he explained what he would be doing. I think he’s really good in explaining and showing.

Many acupuncturists devote 45 minutes to one hour to each client, sometimes two hours for new clients. Other acupuncturists (especially in clinic settings), like Edie Vickers in Portland, see as many as 20-25 clients in one day. But to keep this in perspective, Edie herself notes that her father, a general practice physician, sees upwards of 60 patients per day. Acupuncture care, like much alternative health care, emphasizes client-focused care. As Frank Fischer notes,

In contrast to the traditional superior-subordinate relationship, alternative health services are designed to promote nonhierarchical, cooperative associations between patients and clients. . . . [P]rofessionals [are required to work] in closer contact with the client’s everyday experiences, language, and culture. (1990:369 & 373)

A parallel development is that in such an egalitarian environment, clients also get to know their practitioners better, often entering into the “everyday experiences, language, and culture” of their acupuncturists. While this often allows for the development of friendships between practitioners and clients, it also allows for a fluid milieu of translation in which “acupuncture” as particular, newly created and appropriated ways of understanding bodily being can be translated.
The issue of clients’ agency in the process of seeking health care so far seems to be one of empowerment. In this client-centered approach to health care, individuals -- especially those who have sought long-term acupuncture care -- often spoke of working in partnership with their acupuncturists, discussing their health care and even specific treatment choices in terms of “we addressed” or “we decided,” etc. But Kristen’s story moves into a direction that seems to undermine this client-centered focus. If a core concept of biomedical care is that the patient be passive and give her or himself over to the authority of the physician, why then does Kristen -- as a cultural critic of biomedical care -- go on to celebrate a clearly passive relationship to her treatment as a part of what she values in her acupuncture care?:

After being so stressed out, to go in there, and feel so relaxed. I've got someone here who'll think about me instead of me thinking constantly. I could let go of myself, you know. I'm like, all right, I don't have to think about myself anymore, and I don't have to worry about this, because I've got someone else doing it for me. . . . Just to lay down and have someone make your body feel better does something to your spirit as well!

At first I found this clear emphasis on having “someone else do it for me” quite confusing. Why was Kristen -- a cultural critic of the authority-driven model of expertise conventionalized by biomedicine -- choosing to celebrate a passive relationship with her health care? But this passage raises an interesting question that turned my attention to the notion of care. Throughout our conversations, the people I spoke with on all sides of American “health care delivery systems” have used the term care in health care as a given. But in what ways do doctors care for their patients and in what ways do acupuncturists like
Kristen’s care for their clients? Melvin Konner notes the instrumental connotations of the term *care* from a biomedical perspective:

humane acts not directly affecting ‘care’ -- a word meaning neither more nor less than medical and surgical intervention for the purpose of favorably altering the course of an illness -- are in short supply in the hospital world. (quoted in Henderson et al., 1997:213).

This opposition of biomedical “care” against “humane acts” is striking; for Kristen to take bodily and even spiritual sustenance from someone else taking care of her, especially after the instrumental way in which physicians had labeled and prescribed ineffective medicines for her, moves the term *care* to the realm of humane acts of concern between two human beings.

**Body Talk: Emergent Transformations**

A common metaphor among acupuncture practitioners that many clients quickly appropriate is “cooking.” While a client is lying on the table during a treatment, with needles in, many of the practitioners in this project will leave the room saying something about, “We’ll just let you cook for a while.” This period of “cooking” time is also the time that acupuncturist Karen Levine identifies in the epigraph above as the best opportunity to “be with yourself.” A person, says Levine, is literally “pinned down to be with themselves” while they are cooking. “Cooking” of course implies a transformation -- from the classically raw to cooked, inedible-unsocialized to edible-civilized, full member of society. While the realm of the social -- socialization into the culture of acupuncture, cultural translations accessing this realm -- are a part of this transformation, what Levine’s statement indicates is that this transformation also, and perhaps more
significantly, occurs on the level of individual attunement. To be "pinned down to
be with yourself" resonates with the "body that . . . remains unattended or left
behind" (Sheets-Johnstone 1992:14). What Sheets-Johnstone refers to as the
repudiated body, the body that has not been "given its due" (ibid.) is the body-
self with which individuals are pinned down. Body narratives include passages
of reclamation of this previously alienated body:

Kristen: It's just such a new concept that your body knows what's wrong
with it; it's just a matter of how to make your body talk! I think I've become
more in tune with my body. I was always in tune with what was going on
with me, but it's more so. I'm becoming more aware of my health and that
I have to eat and I have to relax and not take things so seriously.

Carolyne: I think the whole process was an education, and I'm more in
tune with how my body feels, both from having adjustments [and from
acupuncture] so I know what it feels like not to hurt. I think a lot of people
have alignment problems and structural pain. You kind of get used to it,
that's the way it is, and you don't know what it's like not to have it. So I
became much more aware of how much more productive I could be the
better I felt when I felt good.

The theme of "getting used" to pain, to "misalignments," to a body gone awry,
even to one's own contributions to that pain evokes the alienated body people
often strove mightily to leave behind:

Matilda: "I'm more in tune with my body than I ever have been. . . . In
terms of food, I ate a lot and I ate junk a lot of the time. My stomach was
screwed up. I would have this burning pain from too much acid, too much
coffee. I would drink coffee, [and it would hurt], and I would just continue
to do it! I have a very high tolerance for pain, and I just ignored it; . . . I
would just continue to do the same thing, even though I was in pain!

Carolyne's comment too that "the whole process was an education" is another
theme that Matilda develops further. The emphasis in acupuncture care for
these individuals, again is not just on relief from their symptoms, but on what
they have learned, how they have been educated through their encounter with acupuncture and acupuncturists:

Matilda: That’s what Abbie taught me, I think that’s what I’ve learned. There’s been a transformation in the way I eat, the way I treat my body. I’m so in touch with my body now that I know when I need to exercise. I know when I need to do something, because I feel it. That’s just amazing! I’ve never been that in tune with my body. . . . Being attuned to where you find yourself. Like you’re in this smoke-filled room and you don’t think this is going to affect you?!. When you think about it now it seems silly, but we approach life like this! It never registers, you block a lot out. Perhaps it’s a matter of survival in a world like ours, I don’t know. But I think that’s one of the most profound things that I learned.

In several body stories, this experience of education is followed by “taking responsibility for my own health.” Claudia, for instance, proudly describes how she can now lift and carry bales of hay out to her sheep that she could not carry on her own several months prior to acupuncture care. She also describes how she has taken responsibility for her own well-being:

I have made a very conscious effort to take care of myself: to eat well, limit coffee, and get plenty of rest. I drink Claire’s tea [a local herbalist’s recommendation for menopause] and parsley tea in the morning as a detox. I also see Terry specifically to build up my qi, to try and help my centering. . . . I go every other week. I also took his Qi Gong class to try to help my body go through this difficult time. I feel that Qi Gong is good for me. Anything that can help with the breathing and the calming and the centering is really important for me.

Jill describes combining meditation, a practice of visualization, homeopathic remedies, and regular acupuncture treatments during radiation treatments for breast cancer. She feels like she has taken responsibility and now has some control over her health, with the caveat, as she notes that “if it does come back, I’m not sure it’s because I did anything wrong.” She describes her own bodily attunement:
Just generally being unstressed and being as happy as you can with your life -- I really think that's the most important thing. I've read in a few places, especially homeopathy, about people feeling disconnected. When you start getting disconnected from the larger universe, and I can see how that was a slow process with me and what I was doing. And I can kind of see how your body would stop weeding out the bad cells. So I think all these alternatives are important, but think without a kind of spiritual peace, just an addition, it isn't a cure. That's the biggest thing to work on. And this other stuff helps me work on it. I mean acupuncture definitely puts me in that space.

Taking responsibility for their own health care and (re)discovering bodily attunement are fundamental transformations narrated by these clients of acupuncture. The next two sections of this chapter will examine how pain and relaxation are simultaneously transformed and transforming (agents of transformation) in this process of bodily attunement.

**Emergent Bodies: Geographies of Pain**

A central experience of transformation, of an emergent new body, revolves around the issue of pain. While acupuncture clearly provides pain relief, it also offers an “opportunity to explore your body” (Edie Vickers), pointing to a very different map of the body than most of us carry with us on a daily basis. Throughout my ethnographic research, a persistent question occupying practitioners and potential clients alike is: “Do the needles hurt?” While most practitioners among those with whom I have worked, maintain that acupuncture does not cause physical pain, first time clients of acupuncture sometimes experience intense pain.

Kristen: I felt sick, you know, when you’re hungry, but you look at the food and you’re like, oh, you don’t want to put it in your mouth. So I went in
and I didn't say a word, because I'd forgotten. Abbie put needles right here [gesturing to her upper arm, near the elbow; large intestine points], and it was so painful! I was like why are you putting needles there? All of a sudden, it just really fuckin' hurts! She's just like well, you're having trouble with your stomach and your lungs. And I'm like, you know, I am kind of . . . [laughs] that's really funny, Abbie, you know, because I can't eat.

One practitioner explains the experience of pain during needling as a kind of cultural error. Patients are not familiar enough with Chinese medicine(s) and therefore unaware of the concept of qi and do not recognize a qi response. “Any kind of sensation at the time of insertion is considered painful,” lamented this practitioner.

I know from my own experience with acupuncture care that my concept of what hurts, what counts as pain, has changed radically over the course of a decade of treatment experience. When friends and family ask me if the needles hurt, my answer is a such a mixture of “yes” and “no” that I know I have come upon rich ethnographic ground. Neither cultural error nor muddled ambiguity suffice to account for the translation and transformation of pain in the context of acupuncture care.

I have explored the ways in which needling pain is disclosed experientially to both practitioners and clients of acupuncture care. Again, I deliberately choose the term, disclosure, to indicate a “laying open,” an enacted transformation, rather than a “magic wand” transformation that occurs, without agency, from outside. Pain emerges as a cultural category that can be translated, transformed, and disclosed. I am especially interested here in understanding how an existential and cultural shift towards embodiment and
phenomenological disclosure can occur over the course of a developing encounter with acupuncture. This shift can be constituted as a movement from an experience of physical pain to one of sensation.

Physical Pain: “It Really Hurts”

First-time acupuncture clients and clients of Chinese traditional medical doctors may find that acupuncture “really hurts.” Dr. Chengde Wu is a Chinese medical doctor from Shanghai where he was a prominent physician and researcher. Now practicing in Houston, TX, Dr. Wu is known for his strong needling style; his patients sometimes do experience pain in their treatments. Dr. Wu uses larger needles than most American practitioners and his treatment style is based on frequent manipulation or twirling of the needles to elicit a qi response or what has come, in American acupuncture practice, to be called sensation. A one-time client visiting Dr. Wu after the popular Bill Moyers program, “The Mystery of Chi,” aired in Houston, proclaimed, “It was one of the most painful experiences of my life! My condition definitely worsened!”

At around the same time, another Houston resident sought Dr. Wu’s services for treatment of a chronic kidney problem. Gabriella, too, had an extremely painful first-time acupuncture treatment.

I had never tried acupuncture and I was curious about it. I was already generally disappointed by the allopathic model, and I wanted to learn what map of the body Chinese medicine worked with. . . . Dr. Wu placed needles right over the kidneys; I felt an engulfing pain in my kidneys. It made me very doubtful of my capacity to work [on my health] this way.
While Gabriella did return for regular treatments over the course of two years, most alternative health care practitioners would not find that offering an overtly “painful” treatment modality and having a successful practice are compatible.

First-time acupuncture clients are much on the minds of practicing acupuncturists and most current practitioners have given some thought to how they want to present this “new” mode of health care to people for whom it is largely an unknown. As Terry McCormick, the first acupuncturist to work in Winona, Minnesota, notes

It seems like people are more concerned about [the needles hurting] here than I’ve ever heard them being concerned about that anywhere. So I buy the most expensive needles. And those expensive needles tend not to hurt, because they’re silicon-coated and they’re laser-sharpened, fancy Japanese needles. They’re intended for Japanese acupuncture which is a very, very light insertion, shallow insertion. But I do Chinese acupuncture with Japanese needles. It’s tricky.

Acupuncture as practiced by professionally trained acupuncturists has only been legal in Minnesota since 1996, a few months before McCormick’s arrival.

Educating Winona area residents about the nature and function of acupuncture care occupied more of his time during the first few months than actually practicing acupuncture.

Reassurance as to the safety of alternatives like acupuncture often plays out in relation to pain. Fostering a sense of safety and familiarity is central to the success of alternative health care clinics in bringing in new patients. Often the first thing many Americans think of in response to acupuncture needling is whether or not the needles can be felt and whether it will be painful.
Claudia: Of course you can't help but wonder, how's this going to be? This person's going to poke needles in my body. How painful is this going to be? What's it going to be like?

During the filming of his 1993 PBS series on alternatives in health care, Bill Moyers watched a Chinese woman receive acupuncture treatment in Beijing. The woman noticed his expression and reassured Moyers, "It doesn't hurt."

Moyers responded, "It hurts me!" A young construction worker I assisted at the Portland clinic where I worked as an acupuncturist's assistant, lay stiff and tense on the acupuncture table because the awareness that there were needles in his belly made it impossible for him to relax. His concern not to "disturb the needles" was a fear that any kind of movement could potentially make those needles cause him pain. A student-observer at the clinic remarked,

Some of the people who come here for the first time really need help relaxing. They're nervous, I mean these are needles, for god's sake. I don't know what it is, especially with Americans, I don't think Europeans are this sort of "stuck about needles"! These are just sort of small, hair-thin things and they just scare the hell out of people!

Several of the brochures produced by the Portland clinic and routinely given to new acupuncture patients answer "commonly asked questions" such as: Can I feel the needles? and Is treatment painful? Another brochure, entitled "The Way of Chinese Medicine: a Patient's Guide," gives the following description of needling:

Acupuncture needles are quite thin -- nothing like hypodermic needles. They are usually inserted quite shallowly so that they do not hurt at all. Occasionally, there will be a slight prick as the needle enters, but the discomfort disappears as soon as the insertion is complete. . . . Instead, what the acupuncturist is looking for is a sensation of tingling or a dull, achy feeling. This is called "obtaining the qi". . . . The sensation is not painful and, in fact, is considered a positive sign.
These brochures begin the process of cultural translation, opening new clients to a potentially transformed understanding of pain. A shift from physical pain to sensation is evident discursively in describing needling as producing “mild discomfort” or a “slight prick” and then emphasizing that “what the acupuncturist is looking for is [--- not for the client to feel pain, but ---] a sensation of tingling or a dull, achy feeling.” This transformation from pain to sensation is underscored then in the last line, “The sensation is not painful. . .”

**Sensation: Qi Response**

In the currently most popular cultural translation of Chinese medicine and acupuncture to American readers, *Between Heaven and Earth*, Harriet Beinfield and Efrem Korngold describe how the needles will feel during an acupuncture treatment:

> Since the needles are extremely fine, minimal pain accompanies insertion. Sensations such as tingling, heaviness, soreness, and pressure are not only common but desirable, because this indicates that the *qi* is present and being summoned. Sensations may occur around the acupuncture point as well as along the channel of which it is a part. Sometimes people feel the *qi* moving far from the point of insertion. (1991:244).

This description teaches a distinction between pain and sensation. Feeling the *qi* entails a new geography of the body -- one that includes channels and meridians that at times may be physically discernible in the form of sensations. During needle insertion, practitioners describe the needle becoming dense, immovable, it has been “grabbed.” Practitioners refer to this as “obtaining the *qi* “ or with the Chinese term, *deh Qi*. The experience of *deh Qi* during a first acupuncture treatment, especially, can be a powerful and for many Americans extremely painful experience.
Terry McCormick: People that haven’t had acupuncture before, new patients, I sometimes will have to go to an easy qi obtainable point, just so they can see what it feels like. . . . the main thing is, do you feel a sharpness, . . . a sticking, a needle sticking in your body? They go, “Oh, that’s painful,” and I say, “does it feel like a needle? Does it feel like a burning or a pointing?” And they say, “Oh, no, no, no. It feels like it’s really aching.” Well, that’s qi. And I don’t necessarily consider that to be pain. But I think it’s the limitations of the English language. Anything that’s uncomfortable is immediately ‘pain’.

Sarah Wilson: If I’m trying to get women at the Center [the Minneapolis Indian Women’s Resource Center] to get acupuncture, I’ll say, ‘It doesn’t hurt,’ and I’ll use all the techniques I have to make it not hurt, which is pressing and . . . Or I’ll choose the very first point to be the non-painful point. I won’t go for the ears, I’ll do Large Intestine 11.
Mitra: And then do you manipulate?
Sarah: No. To get them comfortable with the needles [I don’t manipulate].

I asked clients if the needles hurt during their first experiences with acupuncture care. Jane’s response demonstrates the transformative quality of the physical experience of needling:

During my first treatments, [I often felt] a real sharp pain, but not like I had been stabbed. It was a real sharpness. And then when he moved [the needle], I felt exactly what he described: my energy grabbed it. When he was explaining this, I thought, yeah, okay, people’s energy grabs it, but you don’t feel it. And I felt it. I surprised myself.

Jane felt the deh Qi response, a sensation that acupuncturists in China and some in America turn their clients’ attention to with the question, “Do you have it?” Acupuncturists like McCormick often note that with new clients, deh Qi is immediately understood as “pain.” McCormick and other acupuncturists clearly find themselves in the position of operating as cultural translators, introducing their clients to the concept of qi and distinguishing feeling qi -- which is described using the term, sensation, or qi response -- from pain. In this vein, I asked
acupuncturists Mary Scott and Karen Levine if they thought there was such a phenomenon as “good pain:”

Mary Scott: I think so, yeah. And it also doesn't last. That kind of pain. I mean you can insert a needle too deeply and walk out of the room and it keeps hurting. Or you can manipulate the needle and get a qi reaction and then the energy moves and it's not painful. And [clients] appreciate the results.

Karen Levine: See, we don’t call it pain; we call it sensation. So, pain to me is when the needle has a burr, or when the needle isn’t sharp enough and it creates some kind of pain like you're feeling a hypodermic needle. Sensation, to me, is when you can feel the electricity or the energy of the channel moving.

Similarly, when I asked Dr. Wu’s client, Gabriella why, after such a painful first treatment, she continued seeking acupuncture care, she delineates a similar transition from pain to sensation.

I felt that he was probably right based on his theory of qi energy and blockages, that there was something blocked, and the first treatment functioned to kick in the kidney system and release this blockage. The narrative he gave me made sense, so I think I did experience it that way. . . . subsequent treatments [were not as painful]. If he put a needle in, I could feel a pain all the way up my leg. [It told me] where I was in my body. That sensation located something within my body which I didn't know. I wasn't familiar with. This coursing of this qi, feeling it there, I could work with it, not tense up or reject it; it was a very interactive experience. . . . There's so much more to learn about your body and we do it through sensations. These are not all pleasurable, but there is a certain pleasure in understanding, in knowing how something works.

Gabriella undergoes an experience with and through her body that fundamentally changes her experience of pain. What she refers to as pain at the beginning of her story (“I could feel a pain all the way up my leg”), changes into sensation in her next sentence -- an indication of a transformation in her experience. She talks about non-pleasurable sensations and distinguishes these from pain. It is through these sensations, she comes to believe, that a new
knowledge of and relationship with her body becomes possible. Through the cultural translation and appropriation of qi and emergent body sensations, clients of acupuncture have the opportunity for embodiment as an enacted transformation.

**Emergent Bodies: Acu-Land**

Another common metaphor (especially among TCM practitioners) that appears in conjunction with “cooking,” is “Acu-Land,” an affectionate term some practitioners use to describe the state of consciousness clients often slip into during the 10-20 minutes that needles are left in. While some people readily fall asleep during this time, others experience a shift in consciousness, a state of “relaxation,” that is somehow different or “more than” relaxation. Even those that do nap in Acu-Land, find upon waking, a different sense of having rested than they normally experience.

The shift from pain to sensation and the spreading release following the deh Qi response are integrally linked with relaxation. Clients explicitly seek acupuncture care to achieve an experience of intense relaxation:

I am in a treatment room with Alice, who has just had a chiropractic treatment with Doug and now is getting acupuncture with Karen. I have never met her before. After introductions, while I light the moxa stick, she asks me if I mind that she ‘just slip back into Acu-Land.’ I say, ‘of course you should, that’s what you’re here for.’ I glance up at her face occasionally while working on her shoulder and a deep calm has settled there. After seven minutes of moxa treatment, I put out the stick and quietly leave the room without disturbing her. (Fieldnotes 8/19/92)

This is an external view of “Acu-Land;” the deep calm of a face that is not sleeping, yet deeply relaxed. How relaxation is defined in different contexts --
stress relief for a college student, an ability to focus on her healing rather than her fear for a breast cancer patient -- can also reveal something about individual appropriations of acupuncture care. In response to questions about why they continue to seek acupuncture care, even after some of the initial complaints have subsided or disappeared, clients often expressed the pleasure of this particular state of relaxation, and the nurturing feeling of their practitioners' care:

Carolyne: I loved it, I love those treatments. I thought it was just a pleasure. I felt very nurtured. Abbie could just sweep you away. I really enjoyed going to her [very] much.

Jill: I enjoy the treatments themselves, because I get really relaxed. A lot of times I feel a lot better, kind of cleansed a bit. So that's another reason I keep going. . . . because I can see a difference. And also I enjoy lying there with needles in me. It sounds sort of silly. But it's so relaxing, and I feel like, well, I don't have to meditate today. I feel like I'm doing something good for myself that way.

Jane: I seemed to always pick my busiest days to go in, which was great because right in the middle of the day I would get to go and relax completely and be forced to take a time out, to take care of myself and let someone else me take care of myself. It was very relaxing when I was on my back, but when I was on my stomach and he was treating my back, I would fall asleep. . . . It was so nice.

Delia: [After treatments] I feel kind of relaxed. I remember when I first started getting acupuncture, once all the needles were in I started to feel kind of like I was floating. Kind of high in a way. I don't feel that as much now, but I used to feel that all the time. It's amazing. Usually I feel better when I leave. It's not really drastic. I try to just go home and relax afterwards, not do anything stressful. . . . Plus I really like Sarah. I think I deserve some treat every week. So that's what my treat is right now.

Relaxation emerges as a physiological response to needling as well as a crucial aspect of the "nurturing" environment of acupuncture care.

The phenomenon of relaxation during acupuncture treatments seems to deepen people's experiences of themselves and their bodies. Karen Levine
describes this kind of embodiment as “one of the most astounding effects of acupuncture; . . . it literally pins the person down to having to be with themselves.” Lying on the table during treatment, one doesn’t move, not because of any stated rule regarding lying still, nor necessarily for fear of pain. One lies still -- and here I am clearly speaking from my own as well as others’ body stories -- because one’s body’s incessant tensions and movements have been stilled and the mind’s incessant chatter has been stilled. As Levine continues,

   There’s no where else to go but in. And I see that with just about everyone I treat: everybody heals in some kind of way primarily because of the experience and sense of relaxation, and of being still, being quiet, and of letting the energy move and letting the points do their work.

This “going in” may be regarded as an abstract, meditative stance, a movement away from the body. But clients often expressed quite literal narratives of “going in:"

   Jane: When Terry would do the points in my abdomen, I felt like my organs and muscles and connective tissue were just kind of sinking and relaxing. And just able to be healed. [It felt] very open with lots of space in there instead of contracted and tight.

The “self” which Jane is pinned down to be with is her bodily being. She is “in” with her organs, her muscles, even her “connective tissue.” She is in her body. Acupuncture here literally “points the way to the body.”

   The peculiar state of relaxation experienced and sought in acupuncture treatment is often described as “something I’d never experienced before” (Patricia), something welcome and refreshing: “I could go to sleep and be happy as a lark!” (Kristen); “almost like a deep sleep, where you wake up completely
mentally aware” (Patricia). Acupuncturist-writer, Mark Seem describes Acu-Land and the refreshment and mentally acuity with which people emerge from it as a “sink[ing] into a parasympathetic relaxation phase . . . often more profound than one is usually accustomed to” (1990:13). Seem compares this sensation of “sinking” to the peace of a baby sinking into its mother’s arms after playing and discovering all day:

This parasympathetic sinking down into its undifferentiated self enables the infant to emerge the next day or after the nap ready for more activity, learning, and growth. In like fashion, acupuncture seems to facilitate a client’s movement inward, into that same safe place, relaxed and ready to emerge better equipped for activity in the world. People emerge from treatment revitalized yet calmer. (ibid.)

**Pointing Out the Body: Acupuncture and Women’s Health**

For women seeking acupuncture care, lying on the table, “pinned down to be with yourself,” having no where else to go but in, acupuncture can literally “point out the body.” Women’s bodies have been consistently medicalized and marginalized in mainstream medicine (Strong 1993). Many of the women whose stories are narrated above have sought acupuncture because they feel biomedical care has inadequately addressed their needs. As the primary consumers of health care in the United States, women are on the forefront of exploring and supporting alternatives in health care. The women’s health movement sparked by the second wave of the women’s movement in the 1970s initiated cultural critiques of the passive patient role demanded by a patriarchal medical system and began publicizing information about health care alternatives (Hare 1991:50; Elston 1981). The alternative health movement of the 1980s
largely grew out of this women's movement advocating consumer education and radical change in health care for women (Burg 1996). Physician-advocate, Michelle Harrison notes

    Women's health care will not improve until women reject the present system and begin instead to develop less destructive means of creating and maintaining a state of wellness (Harrison 1993).

The great majority of acupuncture clients are women (Bullock 1997; Cassidy 1998). While no specific studies have been done detailing why American women seek acupuncture care, Burg notes that "persons with chronic, nonspecific, hard-to-treat illnesses are likely to be frequent users of complementary [alternative] medicines" (1996:486). Women's "presenting complaints," such as those falling into the category of premenstrual syndrome, endometriosis, and even menopause, itself, are frequently regarded as nonspecific, chronic, or hard-to-treat (Strong 1993). While women's reproductive lives have become increasingly medicalized in this century (Martin 1987, 1990; Davis-Floyd 1992), women are often not finding relief from painful and debilitating symptoms through conventional allopathic health care. As Lock and Schepet-Hughes point out,

    Medicalization inevitably entails a missed identification between the individual and the social bodies and a tendency to transform the social into the biological. (1990:53).

When women's bodily cycles and processes are medicalized, results include: menstruation is treated as failed production (Martin 1987, 1990), pregnancy and labor are illnesses that place future members of technocratic society (fetuses) in grave danger (Davis-Floyd 1992), and menopause is treated as a hormonal
deficiency that threatens the well-being of all women (Northrup 1994). The medicalization of women’s bodies supports extreme forms of treatment that have become normalized in a biomedical gender gap; uterine fibroids for instance remain largely unresearched, and the first treatment option offered to most women is hysterectomy (the third most common surgery in the United States). As one outspoken critic of biomedical treatment of women, physician Karen Johnson, puts it:

Can you think of a single benign disease in men, let alone one in the genital region, for which organ removal is the treatment of choice? (quoted in Strong 1993:4).

The biomedical move to medicalize women’s bodily experiences accounts for American women seeking alternatives in health care. Many of the women interviewed for this study talked about finding a health care modality that “didn’t treat things so independently” and regarded them as whole persons, not as bodily fragments or isolated organs.

While working at the Portland alternative health care clinic, I saw women coming in everyday seeking acupuncture and naturopathic care for reproductive problems: menstrual pain, PMS, endometriosis, menopausal hot flashes, pregnancy, infertility. For these women, the flow of qi is commensurate with menstrual flow, and acupuncture’s emphasis on change and transformation is commensurate with menopause. For many women, even if they sought treatment for other complaints, they often ended up also getting what I have come to call “points in the belly.” While not all “points in the belly” pertain to reproduction -- they can relate to digestion, elimination, sexuality, and overall
health -- they are often associated with transformative sensations by clients of acupuncture care.

Jane: When he would do the points in my abdomen, I felt like my organs and muscles and connective tissue were just sinking and relaxing and able to be healed. That's kind of the feeling that I got. Very open, lots of space in there instead of contracted and tight and not feeling good.

In Chinese traditional medicine, one system, such as the reproductive system, is never treated in isolation; treatment for one system has effects in the totality.

**Points in the Belly I**

I originally sought acupuncture care when a gynecologist suspected that my severe monthly menstrual cramping and heavy flow were due to a condition in which endometrial cells begin to appear outside the uterus, commonly known as endometriosis. Endometrial growths can cause extreme pain, adhesions, and infertility. This diagnosis is generally confirmed through a surgical procedure called a laparoscopy, during which surgeons also remove any visible endometrial adhesions. I balked at proceeding with this surgery and decided to pursue an alternative therapy. A friend suggested acupuncture, and after six months of treatment, my gynecologist could no longer palpate any potential endometrial adhesions.

Like many women, my story does not end here. Acupuncture never "cured" me of my intense menstrual pain and heavy flow. On occasions, though much less frequently, I continued to have many of the symptoms that had originally brought me to my gynecologist's office. Now, ten years later, I have learned new bodily practices, such as yoga and eating a diet of whole foods, and honored new bodily modes of being that, along with acupuncture care, make
my menstrual cycles a part of my life that I often celebrate and enjoy, even when those cycles are not entirely “pain-free.”

Rather than simple and absolute symptom relief, what I gained from my own experience with acupuncture care was a transformative experience of my body. I found that the acupuncture points and needles, “points in the belly,” literally pointed me towards another experience of my body. They pointed me to my belly, to my uterus; there it is, right there, pay attention. And I became aware of my body; I could actually feel my uterus in a way that I never could before. Through acupuncture care, I became aware of my uterus and felt myself making it a part of my whole bodily being. I don’t think I could have felt, where my uterus is or what it feels like or what’s going on with it if the needles hadn’t pointed me to my belly.

“I’m at My Wits’ End with Endo”

After my own experience with intermittent relief from endometriosis coupled with deep transformations in how I related with and viewed my body, I was curious about other women’s experiences. Two women, Jane and "Patricia, who were seeking acupuncture care for endometriosis with two of the practitioners participating in this study, were willing to talk into my tape recorder at some length about their experiences with endometriosis.46 Recently, like both Jane and Patricia, I also began to subscribe to the Internet listserv called “Witsendo” and have begun to read the daily international postings through
which women with endometriosis share their intensely painful experiences and support each other with information, conversation, and emotion.⁴⁷

For Jane, as for many of the subscribers, Witsendo “was my support group.” Often feeling muted by clinical narratives that do not legitimate endometriosis sufferers’ experiences, the women on this listserv create a space for storytelling through this electronic medium that validates and eases their experiences. Interestingly, Jane used Witsendo to evoke her bodily experiences to a boyfriend who “wasn’t willing to learn about” why she suffered so excruciatingly every month:

I spent most of my spare time in a computer lab, just reading what women wrote and conversing and learning and learning and learning. . . . And so he would find me in the computer lab and look over my shoulder and read what these women had written and it blew him away. There were a lot of things that I couldn’t verbalize myself, but another woman’s writing it, and I’m like that’s my story and so is that one and so is that one and this part of this one. And it was really a lot easier for me to share with him that way, and easier for him to learn that way.

For Jane, this electronically created space for storytelling also becomes a medium for communication between herself and her boyfriend, without which she remains muted and alienated. Both Jane and Patricia appropriate the “lingo” of the listserv into their own body stories, describing their paths to acupuncture in terms of desperation:

Jane: I went to one of those informational classes, . . . and I was really impressed by it [acupuncture]. I was at my wits’ end with endo and thought I would try it.

Patricia: I was working on some things with [a friend] and I think I was just at my wits’ end and started telling her about that [pain from endometriosis] and she was the one who recommended that . . . I might want to check out acupuncture.
As indicated by Jane’s experience of mutedness with her boyfriend, simply narrating the experience of endometriosis is difficult. Both women repeatedly stated that “there aren’t words for it,” or “language fails” in trying to describe their persistent and painful bodily experiences. Here are some quite eloquent attempts to put into words experiences that clearly occur outside the realm of language, that literally bring women to their wits’ end:

Jane: When I’m in this extreme pain, I don’t want to stretch, I don’t want to do a yoga pose, I don’t want to do any deep breathing. All I want is that freaking hot water bottle and some Advil. . . . One time, I was so angry I was crying and I tore my glasses off my face and threw them at the wall and broke them. The pain, it would just torment me.

Patricia: The pain is an unusual kind of pain. . . . It’s almost as though it has an epicenter, and it spreads out. I would have that kind of pain where my abdomen all the way through to my lower back would just be all cramped up. . . . The endometriosis pain would be such that it would come on me and it would engulf my entire midsection. I would salivate, sometimes throw up, diarrhea. . . . You’re sitting on the toilet and you’re bent over the sink at the same time. You don’t even know where it’s going to come out. . . . Sitting is unbearable. Lying down is moderately unbearable. The only thing is to pace. . . . A total, complete, engulfing pain.

Conventional treatments for endometriosis, beginning with laparoscopic surgery, commonly include birth control pills and injections of Lupron or Depo Provera to induce a state of pseudo-menopause. For endometriosis sufferers like Jane and Patricia, deciding whether or not to follow biomedical treatment recommendations becomes the ground, not only for seeking health care alternatives, but also for taking responsibility for their own health care, often through research.

Jane: For years, it [my treatment] was birth control. I had a laparoscopy when I was 21, and they did some cauterizing. After the laparoscopy I think the growths came back or maybe didn’t even go away. I started
having the pain and symptoms again within three months. I called my doctor and he said, ‘well, there are some options you have. You can go back on birth control or you can try Lupron.’ Some of the women [on Witsendo] had taken Lupron and had become part of the Lupron Victims' Network. I did a lot of research before I decided not to take drugs, and that was the first time in my life, at 21 and 22, that I had taken hold of something relating to my health, and it felt great.

I wanted a second opinion so I went to Mayo Clinic and saw a reproductive endocrinologist. I felt like I knew more about endometriosis than this guy did.

Then I realized that I needed to stop all this stuff. I was feeling just weak, I think. It was just a sense that I could be a lot stronger and I could be doing more things for my body. So that's when I started looking for things and that's when [the acupuncturist] showed up in town.

Patricia: When I was about 16, I went on the pill for birth control reasons and also it improved my periods considerably. Not to the point where I was having no pain, but at least it was tolerable, and I could knock it out with Naproxin or something. It was a lot easier to live.

I was on the pill for about six years, even after I didn't need it for birth control. I stayed on it because of the periods. It controls things in such a nice way. [Then] I decided I didn't need to be on it for birth control reasons, and I also began to be concerned about future fertility. . . . Over the course of about a year and a half, my menstrual cramping got steadily worse. . . . It was affecting my school work, it was affecting my life in general. I felt I couldn't make plans with people because I never knew around my period if I would have to bow out. . . . I became much more isolated.

I went in to see [the university health care center's doctor]. . . . She told me that I probably did have endometriosis and that I needed to have the laporoscopy immediately and that they would probably take stuff out at the same time. . . . I remembered that my mother had been diagnosed with endometriosis . . . . I just began to think, I don't even need to diagnose this, I know what it is. They gave me this literature at the health services that was fifteen years old! When I started doing my own research, I started reading things and found conflicting literature. I found women who had had multiple surgeries with very little relief of their symptoms. That brought me to the point where I started seeking other alternatives. You know, I was really mad. I was really angry.
For both Jane and Patricia, conventional treatment options lead them to undertake their own research, opening the way to investigating alternative treatments. Both women become angry during this process. Jane's initial anger is sparked by the realization that “the material the pharmaceutical companies give you is what they want you to know, not what you need to know” followed by a sense of betrayal by the doctor she had trusted all the way through a surgical procedure which had no real impact on her condition. Patricia notes that “I really started to get pissed about it all” when the pamphlet on endometriosis she received at her university health services was fifteen years old. For Jane and Patricia, anger fueled their drive to take responsibility for their own health care.

This new sense of responsibility transformed both women into seekers of health care alternatives. Paths to acupuncture included a free informational class for Jane and a friend's recommendation for Patricia. Both found their first treatments to be quite memorable. Jane’s first experience was acupuncture was painful:

The first treatment I was not very relaxed. It was so new and I was kind of nervous and so I wasn't very relaxed. The first needle he put in was right up by my big toe, . . . that's the first one I remember. . . . I totally flinched. . . . [It was a] real sharp pain, but it wasn't like the stab [of a needle]. It was a real sharpness. And when he moved it [the needle], I felt exactly what he described [in the informational class], my energy grabbed it. When he was explaining this in the class, I thought, 'yeah people's energy grabs it, but you don't feel it,' and I really felt it. I surprised myself by feeling.

In subsequent treatments, Jane's acupuncturist works with her to help her breathe deeply during needle insertions and “feeling the qi” became a more
familiar sensation, one that Jane quickly began to associate with the intense relaxation she experienced during treatments.

Patricia’s first treatment experience was not painful and yielded a transformation in how she regarded her own body:

Oh yes, I remember it [my first treatment] very well. . . I think that because I didn’t feel like I was just going out on my own -- [names friends who had sought care with the same acupuncturist] -- so I felt confident in that way. And then, he [the acupuncturist] is just a really nice person. The needles didn’t hurt me at all. He turned out the lights, and the thing that happened immediately is that he put a pin directly in the center of my abdomen, where I imagine my uterus must be and I felt something immediately. I could feel, I had sensation beyond the confines of my body, or beyond what I had until that point imagined my body to be. My legs were apart, and I could feel a sensation between my thighs. I remember that my eyes were closed and somehow I could feel this energy or whatever it was between my legs as this sort of greenish, bluish hue. It wasn’t that I could see it, [but] . . . that’s how I perceived it. . . . That was really cool. I was very relaxed. And I came out of there with that, it’s not a numb feeling, but I guess relaxation like I’d never experienced; almost like a deep sleep, where you wake up completely mentally aware.

This transformation in how they experience themselves as bodily beings takes on a narrative primacy for both Patricia and Jane.

Both women experienced relief from their symptoms after initial treatments, each finally experiencing one completely pain-free menstrual cycle.

Jane’s response to her pain-free cycle illustrates the complexity of understanding pain in a cultural context which vilifies all pain:

You know when the cramping started to be relieved, I missed it. . . . I mean ever since I was twelve years old and got my period, that’s what it was every single month. . . . Being able to let go of that pain was like letting go of a good friend. Even though it wasn’t a great friend, it’s been there for thirteen years. It was weird. The first period I had that was completely pain-free, . . . I was like this is so bizarre. What’s wrong here? I was thinking what is wrong here that I’m not feeling this pain. I was thinking this is really dumb. I’m thinking there’s something wrong because there’s nothing wrong! It was hard to let go.
Later in her interview, Jane talks about pain in broader terms. As an adolescent, Jane was raped by a boyfriend followed a few months later by a cousin, who repeatedly sexually assaulted her over several months. Her immediate response was to hide the abuse and to hide her feelings. Along with developing the classic symptoms of endometriosis, Jane also became bulimic. Deborah Perlick and Brett Silverstein argue for the historically traceable existence of a “forgotten syndrome” that includes menstrual pain and irregularity, disordered eating, and deep questioning of gender identities in the face of social limits on women’s education and success (1994). Jane clearly articulates a connection between a sudden flourishing of her endometriosis and disordered eating just as she blossomed into independent womanhood:

When I was 21, it was right about when I was feeling, well, I’m not living at home anymore, feeling really independent, having a lot of independence and exerting a lot of that. And that may be a connection as to why I had this onset of severe symptoms all of a sudden. . . . I was writing poetry. I was making friends in new groups that were really progressive groups of people and finding my place at school and at work. It was really a turning point in my life. I think that’s when I started to grow up.

Jane herself questions “if these things are really connected or not,” concluding that “how can they not be? I’m all one person, and all of these events and actions are me.” Perlick and Silverstein suggest that “the forgotten syndrome” continues to afflict women in modern times “to an extent that has not been fully recognized, because the syndrome has been subdivided into multiple diagnoses” (1994:79). Jane struggles with such diagnostic subdivisions; while, they are clearly “not me” in terms of her bodily experience, they remain powerful
hemeneutic categories that leave her wondering about the validity of her own experiences.

While she found that she could talk openly about being raped during counseling sessions she pursued during this transformational period of her life, she could not take her bulimic behavior out of hiding. She has now been in recovery from bulimia for a year and a half. When she talks about the intense menstrual pain of endometriosis, she whispers quietly during the interview, “I feel like I’ve brought it [the pain] on by doing something wrong. Isn’t that terrible?” A good friend, though not a great one, pain has been her steady companion as Jane embarked on womanhood.

For both Jane and Patricia, and in my own experience, our symptoms began to recur after some much improved (and at least one pain-free) cycles, though not persistently and not to the extreme extents that had first brought us to seek acupuncture care. Both women expressed frustration that acupuncture could not completely “cure” their conditions. Patricia and I talked at one point about why she felt angry with her practitioner. I quote this conversation at some length to illustrate the difficulty of revising hegemonic prescriptions for doctor-patient relationships. Patricia’s anger with her practitioner is concomitant with her assumption that success or failure in treatment lies completely in the hands of that practitioner. While she questions this approach in other parts of the interview, like Jane, she is not readily willing to relinquish its hold over how she understands her bodily being.
Patricia: [My treatments were] fine, but I was still having cramps with my periods. I would tell [my practitioner], and he would be very surprised. My periods actually haven’t been so hot. And [he] is always surprised.

Mitra: How does that make you feel?

Patricia: Well it makes me feel really weird and a little bit angry. The last thing he said to me, and you know, I just adore him so it's hard for me to be angry with him. But the last thing he said to me is “well, I think you’re too busy.” Which is true. But at the same time, I felt like, yeah, but that doesn't help much. He said, “you’re going through a change.” He said, “I'm not worried,” and I said, “well, I am and so is [boyfriend’s name].” And he laughed and you know. But I think he has this confidence and maybe this plan that I guess I don’t trust as blindly as I did or as much as I did in the beginning.

Mitra: What do you think specifically it is that he has so much trust in?

Patricia: His own ability.

Mitra: You think so?

Patricia: I do. I mean I think he has a great deal of trust in his abilities. I wish I understood better sometimes what his plan was. And I'm very hesitant to ask.

Mitra: I guess the reason I’m asking is because I’m wondering if what he has so must trust in is the regenerative power of your own qi, of your own body. Rather than his particular powers of healing or expertise.

Patricia: I think you could be right.

Mitra: I'm just curious if you get that impression at all or if that's something you feel you can discuss with him.

Patricia: Yeah, I think that's a good point. It's a good way to think about it . . . . because I don't think disease is linear and I don't think that healing is linear either.

Patricia then goes on to narrate another experience of embodiment, of transformation in her bodily being during a recent treatment in which she became aware of the way in which she holds herself, the ways in which her body “clenches” and how relaxing those tensions during treatment often led to feeling
“out of control.” Feeling in control as a bodily-oriented event has been analyzed by feminists writing about eating disorders (Fallon, Katzman, & Wooley 1994) and is clearly a gendered experience of being bodily. Patricia turns to a story of embodiment in which she relinquishes control in response to my question about where her practitioner’s trust lies. Relinquishing control and taking responsibility for her own bodily (well)being may seem incompatible, yet for both Patricia and Jane, “letting go of a good friend,” whether it is pain or “clenching” or the belief that someone else can heal you, the passivity of control yields the emergence of bodily responsibility, the emergence of healing through one’s own bodily attunement.

Conclusions

While acupuncture clearly relieves symptoms, especially chronic symptoms for which biomedicine often has no recourse, it can also open the person experiencing acupuncture care to a new understanding and experience of herself as a bodily being. Through a partnership relationship with their practitioners, through shifts in what counts as “pain” and transformations in their experience of “relaxation,” clients narrate their emergent bodily beings. Literally “pointing the way to the body,” acupuncture can become the basis for particular experiences of embodiment, experiences that are transformative -- not only to the initial condition or illness, but also to the client’s own disclosive relationship with being bodily.
For many of the clients narrating their bodies in this work, appropriation and cultural translation make a disclosive experience of embodiment possible. Gabriella has appropriated the experience of acupuncture through a rendering of the *qi* concept into a hermeneutic category that makes sense to her, that she could feel in her body. Through a commitment “to help my body go through this difficult time,” Claudia has enacted her health care, taking responsibility for her own bodily understanding and bodily being. Kristen enacts a deep experience of care in allowing her body to be nurtured by her acupuncturist. Delia does “everything I possibly can to learn whatever lesson from this [recurrent and benign] tumor,” and Michael eats heartily from the sustaining bowl of acupuncture care that he and his practitioner cook up together.

For individuals experiencing, narrating, and creating their emergent bodily beings, *appropriation* emerges as another level of action than an unnegotiated seizure; appropriation here embodies an enacted and engaged negotiation. The ownness-making of appropriation implies an action upon something, something that through the making process inevitably changes.

Through her hermeneutic relationship with the concept of *qi*, both the acupuncture client — in terms of her relationship with her body — and the concept of *qi*, itself, change. Jane’s, Patricia’s and my own encounters with acupuncture constitute an “ownness making” through the “flow” of menstrual cycles translated along channels of flowing *qi*. *Qi* can not remain a firm, stable category within such an appropriative encounter; it is made into something new each time someone experiences acupuncture and makes it his or her own.
CHAPTER SIX
TWIRLING THE NEEDLE: REFLEXIVITY AND DEMARCATING THE FIELD

Instead of learning conceptual categories and then, through fieldwork, finding the contexts in which to apply them, those of us who study societies in which we have preexisting experience absorb analytical categories that rename and reframe what is already known.

-- Kirin Narayan. “How Native is a ‘Native’ Anthropologist?”

Opening with “feeling the qi” and closing with “twirling the needle,” the body of this text moves along translating channels of four appropriative bodies. The notion of “twirling the needle” allows me to return to the issue of enactment which I emphasized throughout my own paradigm of embodiment. Twirling the needle often occurs mid-way through an acupuncture treatment to move energy that may be stagnant, blocked, creating dullness and pain. Twirling the needle during an acupuncture treatment creates a deep sensation, sometimes a tingling, sometimes a flash of sensate bodily awareness in a meridian-like line from one area of the body to another. Acupuncturists characterize this sensation as a qi response, what I have called “feeling the qi.” In this final chapter, I suggest that we anthropologists move in a similar way from the pinch of a needle inserted to the surface of our skin to the deep sensation of energy moving, and the enactment of an emergent body. The field -- especially the field(s) of medical anthropology -- pin us down to be with ourselves. We must be still and quiet to hear, not only the stories of health and illness that we have come to listen to, that we are allied in and through, but also to enact (through thinking/awareness/mindfulness) our own emergent bodies.
Twirling the needle does not happen in all styles of acupuncture
treatment. Some practitioners do not want their clients to experience any
sensation that may be construed as pain. I have written here and elsewhere
(Emad 1995) about the cultural construction of pain and how this is transformed
through long-term acupuncture care. Anthropologists too, through long-term
engagement, experience a transformation in what counts as painful, what counts
as body, what counts as health. Through the practice of ethnographic writing
and reflexivity we train ourselves and become skilled at a particular mindfulness
of that transformation. This is what I am arguing is an enactment of
transformative experience, i.e., disclosure. Attending to fieldwork as an
embodiment of disclosure raises the question, where are our bodies in the field?
This chapter explores how “the field” is demarcated by reflexively attending to my
own positionings as a body in the field.

**Fields**

Traditionally anthropology entails leaving home in order to go into the
field. You know you are in the field when you are not at home, when your
experiences feel uncanny, *unheimlich* (literally, “un-home-like”). When writing,
anthropologists establish ethnographic authority by conveying the sense of
“being there,” in that place of otherness. This process of traditional fieldwork is a
rite of passage within the discipline itself, a ritual initiation, on the other side of
which students become professionals. Exotic fieldwork -- or at least any fieldwork
that takes place *somewhere else* -- becomes a disciplinary rite of passage, during
which a discipline is exerted over and through the fieldworker. The goal of such
fieldwork is to become completely at home in the strange and exotic, to convert it into the familiar. Those of us researching alternative health care modalities in the United States, whether we have done “traditional fieldwork” in the past or not, are faced with the challenge of redefining and newly imagining this traditional conception of fieldwork. Fieldwork in the United States – anthropologists’ “archetypal home” – is considered “a poor approximation of the field” (Gupta and Ferguson 1997:14). The assumption that “domestic” fieldwork occurs at home, geographically as well as existentially carries the concomitant assumption that “home” does not include “things that are unfamiliar, ‘different,’ and ‘local’” (ibid.: 16).

I am not a native-born American; having grown up in an immigrant family, some degree of an outsider’s perspective is always with me. For me, fieldwork is an extension and articulation of the tacit engagement with a social world that has always seemed somewhat alien to me. In conducting fieldwork in one’s own primary cultural context anthropologists have suggested that our goal as “domestic” fieldworkers is to render the familiar strange. For me, it is articulating that strangeness and not succumbing to the immigrant’s urge to assimilate, that proves most challenging.

**Autoethnographic Reflexions**

I feel that I already went through a kind of fieldwork as initiation as a young child immigrating to the U.S. with my parents. Rendering the strange familiar, being cast or marked as other while making sense of the otherness of those around oneself are all part of the immigrant experience for many new Americans and constitute a shaping force in my early childhood and formative years. So my attraction to cultural anthropology has never been the popular one of wanting to visit foreign places, finding the other, exploring the exotic. Fieldwork, for me, has always been about
figuring out where I already am. Figuring out my own positioning. Figuring out who I am with and what our relationality is. Really questioning the dailiness, the familiarity, the "quotidian," the "domestic." There is no initiatory model possible for me; rather it is a sense of homecoming in being able to ask questions and examine people deeply -- having, finally, an appropriate venue for it.

Doing “fieldwork” with acupuncturists and their clients in the United States immediately raises questions for me. What is my “field”? How do I demarcate it? If I take a ride in a Chicago taxi cab and the driver begins to tell me of his wife’s chronic arthritis and her trips to Chinatown for acupuncture treatments, do I suddenly find myself in “the field”? The question becomes even more blurred when I lie on the acupuncture table. Ought I to write field notes about my own experiences? About the sensations of acupuncture treatment? About my own sense of the effectiveness of this health care modality? What about talk with friends who were clients of the same acupuncturist; did that count as fieldwork? Both models of fieldwork -- the conventional exotic model and the domestic model -- suggest that you know when you are in the field when you are experiencing the strange, the uncanny. You are in the field when you are not at home. But what happens when you are studying the culture in which you are an immersed member? What then does the anthropologist do, how does she account for the experience of the field becoming home? I had only to mention my work cursorily on a bus, in a grocery store or a clinic waiting room to receive a font of stories of health, illness, and transformation. When was I in the field and when was I at home? What counted as fieldwork? How did I know when my fieldwork was finished?
I can demarcate my field in terms of the presence or absence of acupuncture practice. But if acupuncture practice were really my focus, I would probably engage in a large comparative study of several acupuncture sites (such as clinics, schools, and private practices) around the country. While there is at least one researcher that I know of who is approaching this kind of comparative depth and demarcation of the anthropological field of acupuncture research, this is not my project. I had never set out to collect nationwide data on acupuncture practice; my writing is based on a descriptive, phenomenological research model, the “data” for which consists in stories, experiences, and cultural critiques.

My apprenticeship in Portland to an acupuncturist-naturopath, that is, positioning myself as a student of alternative health care practices, made it quite clear to me when and where I was not at home. And paying attention to people's stories — whether they occurred in overt "field" situations or not -- taught me a mode of listening that opens up the telling of a story and does not reduce it to "data" or dismiss it as "irrelevant to project". As I began to listen to how people situated themselves discursively, to how they narrated their bodies and their identities as bodily beings, I realized I was beginning to take note of the previously unheeded, the strange, the uncanny. We narrate our bodies every day and yet this is such a quotidian part of life that we are not attuned to it.

**Autoethnographic Reflexions — Arrival in “the Field”**

After a Sunday meeting with Edie Vickers, a licensed acupuncturist and herbalist as well as a naturopathic doctor, I began working as her assistant the following Monday. I was very nervous at first, because Edie simply had me follow her around, often giving very little explanation of the work she wanted me to carry
I learned quickly that my purpose was to go into the treatment rooms once Edie had talked with and inserted needles for a patient; my job was to apply moxa heat to the needles, remove them after a prescribed time, and apply hot poultices to specific areas.

Early in the morning on my first day at the clinic, Edie showed me how to light the moxa stick without burning my fingers and where to tap the stick to release the ashes so that no hot fragments fall on a patient’s skin. She gave me very little instruction after that, and it wasn’t until she gave me a treatment, herself, several weeks later, that I really learned how to apply the moxa for the patient’s utmost benefit.

The minimal explanations I received, the anxiety about not understanding what was going on around me and what my role should be, the relaxation and release in discovering for myself -- largely through experience -- how to understand and act in the situation, all remind me strongly of classical anthropological experiences of “entering the field,” of arriving into the field for the first time.\(^{50}\)

For me, an embodied way of demarcating my field begins with Heidegger’s suggestion in *the Question Concerning Technology*: “let questioning build a way.” Gail Stenstad elaborates on this by pointing out that when we do not look for a theoretical resolution to the tension of “question-and-response,” we keep thinking in motion (1989:89):

To deliberately maintain fluidity in thinking is to resist the tendency to settle for one explanation, one voice. (ibid.)

The stories of awakening to the body, stories of emergent bodies that I listened to, engaged with, and traced might be another way of demarcating my field. And certainly I am also an emergent body in my own fieldwork.

**Autoethnographic Reflexions**

As I look down at the needles in my belly, I am still tempted to laugh. After nearly a decade of acupuncture treatments, the red-tipped plastic jauntily bobbing up and down as I breathe has always looked funny to me. I am in Wisconsin, in the treatment room of a rural acupuncturist who is just three months into her developing practice. After the birth of my first
I have had little time to seek out and regularly pursue acupuncture treatments and this first treatment feels like a homecoming to me. Why do I still seek acupuncture? As I lie on the table, I feel as though my body is an old friend with whom I have not visited for a long time. Today I am experiencing some menstrual tension -- cramping in my abdomen and a tightening frustration in my emotions. As I feel the energy release and flow along the meridians again, the tension disappears and my worries are met with renewed clarity.

**Anthropologists in the Field**

While pursuing ethnographic research and writing about the emergent bodies of acupuncturists and their clients, I began to wonder about the emergent bodies of anthropologists. Where are our bodies in the field? That is, what sorts of transformative experiences do our bodies undergo; how does disclosure, particularly bodily disclosure, occur in our ethnographic experience?

**Autoethnographic Reflexions — Cassandra**

I have asked a friend and colleague, “Cassandra”, to contribute her own autoethnographic “reflexions.” How did she come to acupuncture, both as a treatment modality and research site? I wondered, and Cassandra amiably wrote to me of her first experience with acupuncture treatment:

The first time I met my practitioner, I mainly answered an amazing array of questions. At first it seemed similar to meeting an MD for the first time, except that the waiting room was small and had free tea and coffee and her office was brightly decorated and had a big soft examination (massage) table in the middle, plus framed pictures of the meridians and points from several angles. We sat in chairs. She looked right at me, and smiled a lot, and had a sweet voice and an energy that hooked me. After a while, as she asked me things like “What season do you like best?” and its opposite, I found I had answers to things like that, and I became fascinated even at hearing myself speak my own story. The interview went on for one and a half hours. I was amazed she’d spend so much time. She was efficient without being in the least intrusive.
Positioning anthropologists as informants brings to the surface the parallel roles of ethnographers and informants. James Clifford describes informants as

> Insider-outsiders, good translators and explicators, they’ve been around. The people studied by anthropologists have seldom been homebodies. ... informants first appear as natives, they emerge as travelers. (1992:97).

All of Clifford’s description is also true for us. As insider-outsiders, we work at the craft of cultural translation, becoming teachers and explicators within our home cultural settings. Appearing first as travelers, we emerge as natives. What happens when we turn our questioning gaze at ourselves? Not in the horrid navel-gazing we are all so intent to avoid. But to examine how we are consciously and unconsciously positioned in our research and in our writings. What are the particular structures and relations of our nativization?

Clifford goes on to argue that in the traditional conception of fieldwork an anthropologist and an informant remain distanced; no parallel structure is allowed to emerge when the field is bracketed out “as a special kind of localized dwelling” (ibid. 98). The familiarity we sense in our best informants remains “unprocessed” (ibid. 97). Such a bracketed construction of “fields” highlights an “ethnography of initiation” while erasing or minimizing practices of negotiation and alliance (ibid. 113). Clifford delineates a shift in contemporary anthropology from an ethnography of initiation to a postmodern, travel-based ethnography of negotiation and alliance. Nativization in much contemporary anthropology seems to have less to do with becoming initiated into a localized culture as it does with negotiating multi-sited, transnational encounters and relations of
translation. It seems to me that an ethnography of such multi-sited, translatively
alliances is directly relevant for "domestic fieldworkers." "Domestic" fieldwork
requires, even demands, that we work through the "unprocessed familiarity" of
an ethnography of negotiation and alliance.

**Bodies in the Field**

Identity in the field is in itself complicated. George Marcus (1995:113), in
a review essay of the emergence of multi-sited ethnography, notes that fieldwork
in multiple sites creates multiple, often contradictory, identities in what he terms
an "ethnographer-activist." Such an ethnographer-activist forms alliances
through multi-sited translatively encounters. As a clinic assistant and student of
Chinese medicine(s), working *alongside the table*; as a client of acupuncture
treatment, lying *on the table*; and as an anthropological fieldworker, conducting
interviews *at the table* and observing treatments *without a table*, the thread
between and among the different sites and different identities is what Marcus
calls "the circumstantial activism involved in working in such a variety of sites"
(ibid.). I would like to suggest that another simultaneously unifying and
complexifying thread is bodily being.

**On the Table**

I am lying on a treatment table in one of the six or seven acupuncture
treatment rooms at the Portland clinic. Edie, the acupuncturist and naturopath
for whom I am working as clinic assistant and apprentice, is needling my
abdominal region and points on my legs -- the bladder meridian. Edie uses very
small, light needles and leaves them in with no manipulation at all; very different from the treatments I had received from a Chinese doctor of Oriental Medicine practicing in Houston. Like Dr. Wu, Edie asks me if I feel the qi as she inserts a needle. Depending on my response, she alters the course of treatment. She asks me if I am warm or cold, and may position a fan towards me or cover me with a blanket. Then I am alone for about 20 minutes. During that time I am aware of sensations in my body that do not accompany my everyday life. I am aware of places I have stored tension or anxiety in my body. I have learned -- become enculturated into -- a foundation of Chinese medicine(s) and acupuncture: that all illness is a matter of imbalance, of blockage in the normal, healthy flow of energy -- qi -- in the body. I become aware of how the needles seem to be releasing these blockages, and the sensation of energy flowing up and down “meridians” accompanies a deep relaxation. I find it possible (during most treatments) to experience a “quiet mind,” no longer thinking of the next task, the demands of the day, of relationships, etc. In that quiet I “find” my body, I encounter my bodily being in a new way. This transformation has become the stuff of my field interviews, notes, and conversations.

Autoethnographic Reflexions -- Cassandra On the Table

My practitioner listened to my whole story, depression, asthma and all, and said, “Well, I think ‘we’ can do something, but you must not expect quick or remarkable results. If you’ve had asthma for 40 years, you must expect that it will take several years to heal, too. But we can get you off those anti-depressants. We will move slowly.” I liked this message. At the time I didn’t ‘hear’ the part where she said ‘we’; now I see/hear it there and know its significance. But I did notice that she did not promise wonders, yet was firmly upbeat and supportive. I also noticed that she did not try
to talk me out of my positions, but simply listened and then acted to help.

At the second session (first needle session) she first talked to me for 30 minutes, then needled my back for 30 minutes. I just accepted this—didn’t think a thing about it. I was totally in the biomedical mindset and really didn’t have a clue what I was getting into. When she told me she was ‘clearing my energy’ and figuring out what to do next, I just accepted that, entirely without curiosity. I doubt I heard what she was saying in the essential sense of ‘heard.’

I now know [that]... [my practitioner] didn’t treat ‘asthma’ or ‘depression’ but my energy characteristics. She had questioned me in such a way that I told her—coming out from under the ‘depression’ label and into the symptomatology—that what I experienced was a rapid shift from anger to sadness, from blowing up to crying—she said, ‘yes, I know what that is’...and began to treat me on the Wood-Metal line. She drew me out on the ‘sadness’ issue, and slowly taught me to distinguish ‘sadness’ from ‘grief’ and ‘anger’ from ‘guilt’ etc. -- always not in the least like a psychotherapist. So I learned that I really suffered from grief, and there were lots of good reasons for that, and I must say, that was a revelation. Very useful! Pragmatically, she got me off the anti-depressants.

**Without a Table**

I am in Chicago observing my close friend, Matilda, get an acupuncture treatment from Abbie, a licensed acupuncturist who is studying for her chiropractic certification as well. At this time, I have been a client and friend of Abbie’s for three years. She asks me to sit down in the old leather chair with the rip in the seat from so many bottoms squashing into it over the years. A colorful woven strip of Guatemalan fabric covers the rip. This chair, at the foot of the massage table where clients lie for treatments, is where Abbie often sits to chat with me while I’m “cooking,” that is, while my needles are in place. It is also the chair I sometimes sit in when I first come in to tell her how I have been feeling
and what I would like us to focus on during the treatment. Since I am now occupying the chair, as an anthropological observer, Matilda perches at the edge of the treatment table and begins to describe her current condition. Abbie takes her usual wheeled stool, which allows her to cruise around to the client’s head and neck to do some massage.

I suddenly feel very self-conscious about being the “third wheel” in this room where the private duet of healer and seeker is rarely interrupted.

As Abbie begins to insert needles, Matilda lets her know when she feels only a surface and not a deep sensation. Abbie then manipulates the needle until it is a duller and deeper sensation. Wheeling her stool around to behind Matilda’s head, Abbie begins to do some neck and head massage. When Matilda’s treatment is finished, Abbie closes with what many of her clients refer to as “that hug!”

I show my notes to Abbie after Matilda leaves and she is very eager to read what I have written. When she comes to the part where I have noted the location on Matilda’s body where needles were placed, Abbie fills in my notes by writing in the names of the points (such as CV 4 or St 28). She also crosses out the word “depletes” and writes in “descends” in a description of Matilda’s yang energy. All in all, she seems quite pleased and not at all surprised with what I have written down on both sides of two sheets of yellow paper. Giving me one of those memorable hugs, she wishes me luck in my work.
At the Table:
In the clinic lunchroom, I sit at the round table with Karen, one of the
natural health care clinic's two acupuncturists. We are both sipping carbonated
fruit drinks and munching sandwiches made of the incredible cheese bread from
the bakery down the block. A tape recorder lies between us on the table. An
interview is underway. I am leaning forward in my chair, worrying that the tape
recorder is intrusive and that Karen will not have much time for this to be a depth
interview. I hardly touch my food and my hand rests on the notebook in which I
have listed the questions I hope to cover with this acupuncturist. Karen leans
back in her chair as she finishes her lunch. Her back is straight, but relaxed, her
legs uncrossed, and her arms open. Her eyes, amazingly blue against jet-black
hair, look intently into mine as she answers my questions. I can't help but feel
that the communicative power of her intense gaze is almost as palpable as her
verbal responses. I ask her a question about the effectiveness of acupuncture
treatments. "How do people heal through these treatments, how can we know
that acupuncture is effective?"

To me, I think that one of the most astounding effects of
acupuncture is that it literally pins the person down to having to be
with themselves. Where they can't move, they can't really fidget,
they can't be distracted. They just have to be with themselves, and
I think it's a real opportunity for most of us to be in that position.
Because there's no where else to go! There's no where else to go
but in. And I see that with just about everyone I treat; everybody
heals in some kind of way primarily because of the experience and
sense of relaxation, and of being still, being quiet, and of letting the
energy move and letting the points do their work.

She has sighed deeply before answering, considering the question carefully. But
now with a sudden and fluid movement, she stands and apologizes for rushing
off, but she has had a patient "cooking" while we've been talking and needs to return to him. I turn off the tape recorder and make notes on Karen's notion of acupuncture "pinning a person down to be with themselves" which has already grabbed my ethnographic imagination.

**Alongside the Table:**
At the Portland clinic, I am assisting Edie by taking "intake" notes on a regular patient's condition. He is a Vietnam veteran suffering from blood sugar instabilities and chronic stomach pains. After Edie comes in, looks at my notes and inserts needles, I continue to work with the patient by heating the area around the needles with moxibustion until the skin warms and reddens slightly. After the requisite time period -- about 15 minutes -- I leave the room to prepare a hot herbal poultice. I return and remove the man's needles carefully, and then apply the poultice gingerly to his abdominal area. He sighs deeply as the heat penetrates and relaxes him. I often converse with patients while applying moxibustion and poultices and much of my clinic "fieldnotes" emerge from these encounters in the treatment rooms.

**Anarchic Fieldwork and Implications for Research**

I find Gail Stenstad's notion of "Anarchic Thinking" a compelling way into reformulating the question of the field. To take note of the (previously unheeded) strange or uncanny within the familiar creates a tension that Stenstad identifies with the movement of anarchic thinking (1989:89). Stenstad identifies four elements of anarchic thinking. The most interesting one for this discussion
echoes an almost cliched anthropological field method. Anarchic thinking, for Stenstad means cultivating an alertness “for the presence of the strange within the familiar” (1988:89). Such a practice of alertness to the strange within the familiar decenters the familiar:

The effect of this making-strange is to decenter the familiar, the taken-for-granted, the true, the real, etc. The boundaries set for our thinking by familiarity are transgressed. The previously unthinkable becomes thinkable. (ibid. 89-90).

Our bodies, for instance, may be among the most quotidian aspects of our identities and relational experiences. So familiar that we barely notice it, the body elicits that “unprocessed familiarity” Clifford described in encounters with ethnographic informants. This crushing familiarity often remains unquestioned until illness strikes and we are brought to a “bodily mindfulness” that we are unlikely to seek or experience during times of relative health. During illness, the body is decentered, dis-eased, but also re-membered:

Most often something unforeseen stops us and it is only then we have the time to take a seat at life's kitchen table. To know our own story and tell it. (Remen 1996:xxv).

During ethnographic fieldwork, too, do we not find, as anthropologists, that our bodies are often decentered? That our familiar bodies suddenly become strange to us? That we are thinking/experiencing our bodies “anarchically,” i.e., outside conventional boundaries of bodyliness, “deviat[ing] from expected goals and methods, unpredictable by theory,” in a word, “wild” (ibid. 87).

For me, ethnographic fieldwork is also fundamentally about rendering the familiar familiar. This allows me as an immersed member of American culture to bring tacit or "concealed" phenomena (what the natives might refer to as "taken for
granted") into the storytelling encounter, into the open field. Perhaps this distinguishes the writing of ethnography -- adding another level in which familiar is rendered familiar -- from the experience of fieldwork -- where we are called to heed the unheeded.

Autoethnographic Reflexions – Cassandra

As the years passed more things happened, gradually. First, I stopped getting colds and thus also stopped getting bronchitis. This also meant, no more antibiotics. I stopped the inhalants...and that meant I got my voice back, including the ability to sing. I even was able to stop the allergy shots. I began to use homeopathic preparations to stop hay fever, so that, with acupuncture, tended to keep me OK from asthma, because hay fever sets off asthma. . . . Now she's got me swimming--she says swimming will allow me to exercise without heating up, and it's the heating up that releases the exercise-induced asthma. So now I'm going for three times a week--that's the newest addition to the regimen. As for the depression, she helped then, and began me on herbs. I still take a set of herbs--they do many things, but one is help mood, and the other is prevent all kinds of menopause-related symptoms. Menopause has been interesting--twice I've had hot flashes as often as 24 times per day...but acupuncture can stop them cold. It's remarkable.

...what [has] convinced me of [acupuncture's] effectiveness [was] not one thing, and not all at once, but like water over stones, slowly rubbing them smooth. That's what acupuncture is like--it's the water, I am the stone.

Research on alternatives in health care, like acupuncture, must pay careful attention to the positioning, experiences, and bodily transformations of the researchers themselves. Research that involves embodied beings is inherently anarchic. Rather than quelling this unpredictability through rigorous objective models of scientific research, we need to create and implement research models that welcome and thrive on the wildness of human bodily being.
Autoethnographic Reflexion

Working as a clinic assistant and apprentice for Edie Vickers, allowed me to develop an engagement with the comportment of a practitioner that has never left me. When people in my graduate program, colleagues at work, or friends, ask me what to do for their chronic back pain, for their allergies, for their menstrual pain or menopausal hot flashes, I don’t stand guard at the boundary between researcher and subject of research. I usually make recommendations of some kind: go to this acupuncturist, try this herbal remedy, spend a little time in your day breathing deeply. I treat my own child with homeopathic and Chinese remedies, viewing the ever-present pediatric remedy of antibiotics as a last resort.

So “the field” for me is also this sense of jumping in and swimming with the acupuncturists I’ve talked to over the years, instead of sitting at the shore and asking them how the water feels. Going to Portland and working at the clinic was the first time I really went swimming in those waters. I found that at times there is an undertow that can be frightening. Jumping into those waters means jumping into people’s lives.

Like anthropology, acupuncture care, after all, is most often about getting involved, about listening to stories. Stories of suffering, recurrent pain, and physical discomfort. Stories about broken relationships, lost jobs, recovery from addictions. Stories, too, about spiritual renewal, bodily transformation, and empowerment.

I have brought my own experiences and thoughts as a participant (seeker/client and assistant/apprentice) into this work in the spirit of both anarchic thinking -- a thinking/interpreting that remains fluid, open to ambiguities, and attuned to multiple voices -- and of situated knowledges -- modes of writing about my own positioning that take responsibility for my own enabling practices. In this text, my voice and my experiences sometimes emerge quite clearly and in other places blend in or remain hidden. My editorial hand has clearly made selections regarding what elements of people’s body stories to include. I have tried to attend with and to bodies in making these choices and to “somatically attend” to my own enabling practices and positionings. I was and continue to be another woman
attempting to render bodily experiences and traumas meaningful. I have chosen this multiple style of self-positioning to try to evoke the multiplicity inherent in the enabling practices of this work. During the course of the field experiences and writing experiences out of which this text emerges, I always experienced myself as a messy and cumbersome blend of anthropological researcher\fieldworker--acupuncturist's apprentice---seeker of health. I finally gave up trying to sort out which role predominated under which circumstances when I realized that it was precisely this messy blend of identities that enabled my path and practice of questioning and listening.

Learning this mode of listening, of allowing stories to open up and take me into a field, a field or a clearing in which we can openly encounter each other's deepest experiences, is the process that I believe ethnography traces. I am suggesting here that ethnography does indeed trace the process of the uncanny, the unheimlich becoming home, becoming the familiar, but this field can, if we wish to pursue it, open out into another field, that of our existential attunements in modernity. As such fieldwork -- as rendered through ethnography -- reveals and shows us not only something about anthropology and the nature of anthropological research, but also something about the process of disclosure as we grapple with the pushes and pulls of late twentieth century manifestations of modernity.
1 See Dumit 1993. Dumit delineates *seekers* less in terms of a kind of person, a “New Ager,” than in terms of engagement with “an activity, attitude or form of life” (20). Seekers of alternative health care, also should be regarded in terms of their active pursuit of and participation in alternatives to accepted, conventional health care practices.

2 I coin *disclosive* as an adjective to describe conditions under which enactments of openness can (but do not necessarily) occur.

3 Sites included two municipally-run acupuncture clinics for substance abusers, the practice of a Chinese acupuncturist newly arrived to the U.S., as well as the practices of a Chinese M.D., an American physician, and a registered nurse/acupuncturist.

4 While anthropologists have readily seen the problematic aspects of identifying the people they are living and learning with as “informants” (Schultz & Lavenda 1997), this remains the most acceptable appellation for those with whom fieldwork was conducted.

5 What counts as “tradition”? In chapter 2, I will examine the multiplicity of practices -- ancient, modern, and constantly re-negotiated -- that fall under the rubric of “Chinese medicine” in the United States. Given this multiplicity, I will refer to these practices in general as Chinese medicine(s). I will use the term “Traditional Chinese Medicine” or TCM only to refer to the very specific treatment style developed during the Cultural Revolution in 1950s and 1960s in China.

6 The practitioners involved in organizing Chinese traditional medicine as a profession worked anonymously until the death of Mao in 1976. The autobiographical resurgence of their identities following this period is the subject of Farquhar 1995.

7 The story was originally told by surgeon-poet Richard Selzer who was present during Yeshe Dhonden’s visit. However, Kaptchuk and Croucher do not reference a source for Selzer’s original narrative. The story has also been re-told in Knaster 1996, among other popular sources.

8 I use the term, *intractable*, to indicate an aspect of translation (cultural as well as linguistic) that remains unreachable by the strong arm of interpretation. This usage is influenced by Stefania Pandolfo’s work on “the intractable” (1997).

9 While I do not have the space to develop it, I am interested here in an archaeology of Euro-American discourse on things, people, and processes coded as “Eastern” or “Oriental.” A beginning point for such an endeavor would have to be Edward Said’s classic, *Orientalism*.

10 See chapter five for the rest of Patricia’s story.

11 Cf. the NIH Consensus Statement on Acupuncture discussed in the next chapter.

12 For most people acupuncture has already been culturally translated before ever entering the office or treatment room. Most clients pursue acupuncture care at a
friend's recommendation or through a brochure or flier. Both the perceptions of others who have tried acupuncture and the advertisements for it created by practitioners would be rich sources for examining cultural translation.

13 The acupuncturist I assisted is also a naturopathic doctor (ND). She and the clinic's other naturopathic doctor, as well as the clinic's chiropractor, were all referred to during staff-client interactions as "the doctor." Clinic practitioners who were solely licensed acupuncturists, who may not use the title "doctor" by state statute, were referred to by their first names. The valuation and privileging of the label and the structural position, "doctor," is also evident in Terry McCormick's description of the acupuncturist with whom he apprenticed as a young college student: "He was very professional in the way he presented himself. He called himself doctor, and he was one. He was trained in China, so he could call himself a doctor. So he gained my respect right away, even though I didn't really respect the medicine very much."

14 During an interview with Abbie, I asked about this neatly calligraphied sign, and Abbie explained, "You know people used to come in here and think we were all smoking pot in the back rooms. Like they never heard of incense before!"


16 Interestingly, the Peking Anti-Imperialist Hospital was established and run by the Rockefeller Foundation until it was nationalized by the Communist government in 1951. Prior to arriving in China, Reston had "coincidentally" been asked by the Chinese Medical Board of New York, which had been responsible for the building and running of the hospital until nationalization, "to inquire" about it; one of the prevalent features of his report is the journalistic excitement of an insider's account of a previously inaccessible institution.

17 Cf. David Eisenberg in an interview with Bill Moyers, as discussed below (Moyers 1993b).

18 The use of religious terminology to dismiss chiropractic and naturopathy can be read in terms of the bipolar relationship between religion and science. "True" science can never be religious. The history of chiropractic in this country has also resisted biomedical marginalization.

19 Martha Hare notes that in her fieldwork at multiple fieldsites in New York, "No patients voiced fear of discussing acupuncture or herbs with their biomedical physicians" (1991:303).

20 All references to Eisenberg 1997 on the following pages are taken from the American College of Physicians' website which published the article in conjunction with its paper publication. As I used the electronic copy for my discussion, I have not included page references. Interested readers are referred to www.acponline.org/journals/annals/01jul97 or to Eisenberg 1997.
21 I highlight this term with quote marks to clearly distinguish the juridical nature of Eisenberg's term disclosure from the phenomenological term disclosure that appears throughout this dissertation.

22 See footnote #23.

23 Note the clear distinction throughout the NIH Consensus Statement regarding "efficacy" and "effectiveness." Efficacy or efficaciousness refers only to the controlled clinical trial as outlined below, not to case reports or other "anecdotal" evidence of patient satisfaction or improvement, i.e., not to effectiveness.

24 Cf. chapter 5.

25 Labeling issues work both ways: the valuation and privileging of the word "doctor," as discussed in chapter 2, parallels and complements the structural positioning of "patients".

26 As the 1997 edition of Acupuncture and Oriental Medicine Laws, published by the National Acupuncture Foundation, went into press, an Illinois state statute proposed by Senate Bill 454 had passed both houses and was awaiting governornial approval. Apparently this statute would legalize acupuncture practice by professional acupuncturists, probably beginning in 1998.

27 There are now several Midwestern schools, in Chicago, Minneapols, and Racine.

28 This was to remain in large part an underground practice throughout Abbie's tenure in Chicago, because of lobbying efforts to change Illinois legislation legalizing acupuncture practice for professional acupuncturists remained unsuccessful until very recently. As in many states during the 1970s and 1980s, the health care professionals who were allowed to practice in the state -- physicians, osteopaths, and chiropractors -- were required to have no specific training to do so. Abbie's training included an apprenticeship, a certification program requiring several thousand hours of classroom and clinical experience, as well as passage of a national board exam. Nonetheless she remained in constant danger of being shut down by the state. To remedy this situation, Abbie began a training program to become a chiropractor in the early 1980s. While she was genuinely interested in chiropractic and motivated to expand her practice to include the potential benefits of another health care modality, Abbie also wanted legitimization from the state.

29 With a population of 25,000, Winona is neither a small town, major metropolitan setting, nor suburb. McCormick and his wife, a licensed massage therapist, chose this site for its proximity to family and precisely for its semi-rural/semi-urban lifestyle.

30 Note that Edie Vickers, L.Ac., N.D., for instance, regularly saw that many people in one day, with help from a full-time assistant. But to keep this issue in perspective, Edie herself notes that her father, a physician, regularly sees upwards of 60 patients per day.
31 Jennifer Hamilton and I conducted this field research in partnership. While I developed the interview format and question list (based on previous participant-observation fieldwork with Dr. Wu), she skillfully carried out the actual interview, working with some significant language difficulties. This narrative remains incomplete due to language difficulties and time and space constraints.

32 Texas did not pass legislation legalizing the practice of acupuncture by professional (non-physician) acupuncturists until 1993.

33 See chapter 3.

34 Previous drafts of sections of this chapter have been orally presented to the Second Annual Symposium of the Society for Acupuncture Research, September 17-18, 1994 and to the 96th Annual Meeting of the American Anthropological Association, November 19, 1997. A previous published version of selections from this chapter appears in Emad 1994.

35 72% of acupuncture clients in six different surveyed cities were female (Cassidy 1998). The majority of the clients whose narratives and experiences appear in this chapter are women. All are white. Class background is somewhat variable as indicated.

36 I am especially indebted to Claire Cassidy’s work and conversation for my developing awareness of the thematics of storied bodily experiences. Her analysis of quantitative as well as qualitative data from six acupuncture clinics in five states (1998 and forthcoming) has provided a “sounding board” for my own interpretive frames.

37 The narrative of “Jean” is in no way intended to stand as an “ideal type” or “archetype” of the acupuncture client. I offer this narrative -- my own rendition of Jean’s body narrative as she told it to me -- in an attempt to identify thematics that are “good to think” about clients’ experiences with. In what ways do diverse clients experience these thematics differently? I choose this narrative also to exemplify the ways in which I was involved experientially and intellectually in the construction of body narratives. Jean’s story also tells part of my own story of initiation into clinical work.

38 All names have been changed. All present-tense descriptions reflect the time primary fieldwork and interviewing with that person occurred (some as far back as 1991).

39 Indeed, Cassidy (1998) found that 54.4% of 575 nationwide acupuncture clients had used biomedicine during the three months prior to her study.

40 Both “pain” and “relaxation” are problematic terms, because what people mean by these terms changes as a result of treatment; these transformations in meaning will be taken up below.

41 While clients’ unusually clear memories of their first treatments is a fascinating topic, I do not develop an analysis of healing and bodily awareness in relation to memory here.
Cassidy has suggested that a possible medium for appropriations of acupuncture care is the notion of holism, which she defines as the sense that [the whole organism] is emergent, or more than the sum of its parts. . . . that health resides not just in the physical body of a person but also in his/her mental, emotional, spiritual, and social bodies, . . . and that the individual has some part in and must take some responsibility for both creating and alleviating his/her own ill-health. (forthcoming)

Cassidy concludes from her combined qualitative and quantitative study of six nationwide clinics that "American users of Chinese medicine are not selecting something 'exotic' or 'foreign,' but staying close to home and simply seeking practitioners who offer a culturally familiar, if not mainstream, . . . health care delivery system, that is, holism" (ibid.).

Martin 1994 explores the cultural construction of "the immune system."

Cf. OED pastiche on patient above.

After a painful first needling experience during his medical school exchange trip to China, David Eisenberg questions his mentor, Dr. Zhang, about what Chinese patients feel when they are needled. Eisenberg quotes Zhang as laughingly responding, "You foreigners react this way at first. You are not used to the sensations of acupuncture." Eisenberg then paraphrases Zhang's description of Chinese patients' sensations:

He told me that they should feel no pain associated with the piercing of the skin, but that thereafter, when the point is stimulated, they will experience pain, soreness, heaviness, numbness, pins and needles, or the feeling of electric shock . . . . " (1985:65).

This description has already been culturally translated by Eisenberg and one wonders how Chinese patients themselves would describe experiences of acupuncture needling.

During fieldwork at the Portland clinic, I also had several informal conversations with endometriosis sufferers and wrote fieldnotes about their treatment experiences.

Working with these Internet postings is a very recent aspect of this project and analysis of these electronic "body stories" remains beyond the scope of this dissertation. Hamilton 1998 offers an excellent preliminary analysis of Witsendo postings.

An earlier version of this chapter was published in Emad 1997.

Martin 1987, Traweek 1988, Perin 1988

Mary Louise Pratt contrasts the utopian renditions of the trope of arrival in classical ethnographies to the polyphonic quality of the trope in contemporary ethnography (1986).
SEMANTIC AND PHONOLOGICAL FACTORS IN SPEECH PRODUCTION:
EVIDENCE FROM PICTURE-WORD INTERFERENCE EXPERIMENTS

by

MARKUS FRIEDRICH DAMIAN

A THESIS SUBMITTED
IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
DOCTOR OF PHILOSOPHY

APPROVED, THESIS COMMITTEE

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WORKS CITED

American Medical Association (AMA)

American Medical Association (AMA) Archives
Historical Health Fraud and Alternative Medicine Collection, File #7, “Acupuncture 1955-1982.” Call #0015-16/0019-07. AMA Archives and Records Management, Chicago, IL.

Asad, Talal

Beinfield, Harriet and Efrem Korngold

Bullock, M.L., A.M. Pheley, T.J. Kiresuk, S.K. Lenz, and P.D. Culliton

Burg, Mary Ann

Cassidy, Claire


Clifford, James

Collins, Robert and Robert Schlitt

Csordas, Thomas J.


Churchill, Ward

Culliton, Patricia D.

Davis-Floyd, Robbie.
1992 Birth as an American Rite of Passage. U of California P.


Dimond, E. Grey.

Dumit, Joe.

Eisenberg, David M.


Eisenberg, David M., Kessler, R.C., Foster, C., Norlock, F.E., Calkins, D.R., Delbanco, T.L.

Ellis, Andrew, Nigel Wiseman, and Ken Boss.

Elston, Mary Ann.

Emad, Mitra.


Emad, Parvis.

Ergil, Kevin.

Fallon, Patricia, Melanie A. Katzman, and Susan C. Wooley, eds.

Farquhar, Judith.


1995 “Re-writing Traditional Medicine in Post-Maoist China.” In *Knowledge and the Scholarly Medical Traditions*. Ed. by Don Bates. Cambridge U P.

Fischer, Frank.
Flaws, Bob, Charles Chace, and Michael Helms.  

Foucault, Michel.  


Gupta, Akhil and James Ferguson,  

Halifax, Joan.  

Hamilton, Jennifer.  

Haraway, Donna.  

Hare, Martha.  

Harrison, M.D., Michelle.  

Hartglass, Craig.  

Heidegger, Martin.  

Heidegger, Martin.  

Henderson, Gail E., Nancy M. P. King, Ronald P. Strauss, Sue E. Estroff, and Larry R. Churchill, eds.  
1997 *The Social Medicine Reader.* Duke U P.

Hutchinson, Marcia Germaine.  
Jayasuriya, Anton and Felix Fernando. 

Kaptchuk, Ted J. 
1983  *The Web that has No Weaver: Understanding Chinese Medicine.* Congdon & Weed.

Kaptchuk, Ted and Michael Croucher. 

Kleinman, Arthur. 

Knaster, Mirka. 
1996  *Discovering the Body's Wisdom.* Bantam.

Konner, Melvin. 
1987  *Becoming a Doctor: a Journey of Initiation in Medical School.* Viking Penguin.

Kuriyama, Shigehisa. 

LeBaron, Charles. 

Lock, Margaret and Nancy Scheper-Hughes. 

Maciocia, Giovanni. 


MacPherson, Hugh and Ted Kaptchuk, eds. 
1997  *Acupuncture in Practice: Case History Insights from the West.* Churchill-Livingstone.
Marcus, George.

Marcus, George and Michael M. J. Fischer.
1986 Anthropology as Cultural Critique. U of Chicago P.

Martin, Emily.


1994 Flexible Bodies: Tracking Immunity in American Culture from the Days of Polio to the Age of AIDS. Beacon Press.

Marwick, Charles.

McGuire, Meredith.
1988 Ritual Healing in Suburban America. Rutgers U P.

McQueen, David V.

McWhorter, Ladelle.

Merleau-Ponty, Maurice.

Moyers, Bill.


National Institutes of Health (NIH).

Narayan, Kirin.
Northrup, M.D., Christiane.

Pálsson, Gísli, ed.

Pandolfo, Stefania.
1997 *Impasse of the Angels: Scenes from a Moroccan Space of Memory.* U of Chicago P.

Perin, Constance.
1988 *Belonging in America: Reading Between the Lines.* U of Wisconsin P.

Perllick, Deborah and Brett Silverstein.

Reed-Danahay, Deborah E., ed.

Remen, Rachel Naomi.
1997 *Kitchen Table Wisdom: Stories that Heal.* Riverhead Press.

Reston, James.

Said, Edward.
1979 *Orientalism.* Vintage.

Sault, Nicole.
1994 “Conclusion: Ransoming the Body.” In *Many Mirrors: Body image and Social Relations.* Ed. by Nicole Sault. Rutgers U P.

Schultz, Emily and Robert Lavenda.

Seem, Mark and Joan Kaplan.

Seem, Mark.

Sheets-Johnstone, Maxine.
   1992 “Charting the Interdisciplinary Course.” In Maxine Sheets-Johnstone, ed. 
   Giving the Body Its Due. State U of New York P.

Stenstad, Gail.

Strong, Marilee.

Sugarman, Jane.
   1997 Engendering Song. U of Chicago P.

Traweek, Sharon.

Turner, Victor.
   1967 The Forest of Symbols. Cornell U P.

Tyler, Stephen A.
   1986 “Post-Modern Ethnography: from Document of the Occult to Occult 
   Document.” In Writing Culture: the Poetics and Politics of Ethnography. Ed. by 
   James Clifford and George E. Marcus. U of California P.

Tyler, Stephen A.
   1987 The Unspeakeable: Discourse, Dialogue, and Rhetoric in the Postmodern 
   World. U of Wisconsin P.

Unschuld, Paul.

   1987 “Traditional Chinese Medicine: Some Historical and Epistemological 

Veith, Ilza, translator.
   1949 The Yellow Emperor's Classic of Internal Medicine. U of California P.

Walzer, Michael.
   1988 "Antonio Gramsci's Commitment." In The Company of Critics: Social 

Wolpe, Paul Root.
   1985 “The Maintenance of Professional Authority: Acupuncture and the 

Zito, Angela and Tani E. Barlow, eds.