

**ACUPUNCTURE, EDUCATION, AND IDENTITY
AT A UNIVERSITY OF NATURAL MEDICINE**

**A FOOT IN BOTH WORLDS AND BALANCE IN NEITHER?
ACUPUNCTURE, EDUCATION, AND IDENTITY
AT A UNIVERSITY OF NATURAL MEDICINE
IN THE UNITED STATES**

By

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ABSTRACT

This dissertation presents the results of ethnographic research conducted between September 2006 – August 2007 at Emeritus University; a large, multidisciplinary institution of natural medicine in the United States. Since its inception in 1978, Emeritus University has emphasized an integrated model of medicine and collaboration between practitioners of natural medicine and their allopathic counterparts. By focusing upon curriculum change and the process of learning among first year students in the Master of Science in Acupuncture and Oriental Medicine (AOM) program, I explore the ways in which increasing emphasis upon integration with biomedical models of education, practice, and research influences the AOM curriculum, the professional values inculcated within first year AOM students, and their sense of professional identity and position within the US medical landscape. In addition, this research elucidates how the interests, goals, and decisions of first year students shape and influence the curriculum and the identity of AOM. My research was informed by critical medical anthropology, which situates schools of medical education, and the experiences of individual students, within the historical and political structures of medical pluralism, state regulation, professionalization, biomedical dominance, and the capitalistic world system.

This research contributes to our knowledge of the evolution of a complementary/alternative medicine (CAM) modality within the US, the roles played by a school of CAM in the transformation of AOM's identity; the socialization of students and the process of learning; the role of agency; and the implications of integration for the identity of AOM, its practitioners, and health care in the United States. Emeritus University's emphasis upon integration has resulted in an increasingly standardized and biomedically based curriculum. While participants perceived such changes to be part of the 'Americanization' of AOM, from the perspective of critical medical anthropology, integration has serious implications for the identity of AOM and its practitioners. Far from advancing the critique of Biomedicine and the medical system embodied by the holistic and alternative health movements of the 1960's and 70's, Emeritus University may serve to replicate the hegemony of Biomedicine, underscore the primacy of its practitioners, and pave the way towards co-optation of acupuncture and Oriental medicine in the United States.

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Chapter 1

Introduction

Prologue

It is impossible to say when the school year began, in that symbolic and often indefinable way, for the first-year students of acupuncture and Oriental medicine among whom I conducted my research at Emeritus University of Natural Medicine¹. But for myself, it began on a Wednesday in late September, with the ceremonial distribution of a rough grey rock and a piece of string.

We were all still awkward around each other on the day of the welcoming ceremony, despite the ice-breaking exercises of orientation held on September 19 and 20. We flowed up the gently sloping hill behind the university to the designated place: a broad grassy field flanked by firs laden with chocolaty brown cones and alders whose golden leaves hinted at summer's slow decline into the picturesque autumn of the Pacific Northwest.

It was not what I had expected of a ceremony welcoming students to an nationally recognized institution of research and teaching in the natural health sciences. Into the midst of our ever-widening circle stepped a shamanic practitioner and founder of a local spiritual institute. With a warm smile and a spontaneous laugh, she greeted us and spoke of the school as a sacred community, to which we had been gathered to become healers. Drum in hand, she welcomed the spirits of the four directions and their gifts, thanking the sky and the earth, the masculine and the feminine. The rhythmic drumming and wafting incense seemed strangely incongruous with the five-story brick institution of science-based natural medicine below us: an early indication of the chronic tension between modern science and traditional medicine that characterized Emeritus University.

Moving slowly around the circumference of our circle, the shaman solicited our pledge for the year ahead, slipping a black string around our wrists to serve as a reminder of the commitment we had made to healing. Along with the string we were each given a small grey rock, which while bearing more than passing resemblance to gravel filched from the parking lot, signified the rough edges – our edges - to be tumbled smooth over the coming weeks, months, and years of study. I slipped my rock into my pocket, its angular surface dusty, sharp, and foreign. Twelve months later I came to see that the many angles, both rough and smooth, are precisely what define an object or experience, and the fingers that caress the angles work meaning into them. The multitude of research possibilities and directions that presented themselves during those first months became, with handling, less daunting, their angles and edges part of an endlessly intriguing whole.

¹ Names of both institution and participants, including faculty, students, and administrators, have been changed.

*

Acupuncture and Oriental medicine (AOM) is one of several programs offered at Emeritus University, and on the first morning of orientation, September 19, the hallways and cafeteria reverberated with the voices of naturopathic, exercise science, health psychology, and nutrition students; all, like me, searching for their registration booths. As nine o'clock approached, forty or so first-year students of AOM gathered together in a large lecture room for an introduction to the program that would occupy their days for the next three and a half years. Smiling benignly at us from the front of the room were seven members of the School of AOM's "core faculty," four of whom were Chinese. Of the Chinese faculty, three had received their training and extensive practice experience in both Biomedicine² and Chinese medicine at Chinese universities. Of the three non-Chinese faculty present, two had received degrees in the field of science prior to their training in traditional Chinese medicine (TCM). Three faculty members, one Chinese and two non-Chinese, had recently completed the Doctorate in Acupuncture and Oriental Medicine through Emeritus University's newly accredited program. The dean's qualifications included a diploma from an East Coast school of acupuncture as well as a Master of Public Health from the same state.

Following the faculty introductions, the incoming students were required to do the same; rising one by one, a little nervously, to share insights into their lives while the rest of us began to marry faces to names. *Mostly young*, I noted, *and mostly women*. When the time came for me to stand and introduce my project, I spoke about anthropology and about research into complementary and alternative medicine. Then I told them about what I hoped to accomplish with their assistance: to gain insight into the process of learning acupuncture and Oriental medicine. Happily, obligatory fears of rejection and marginalization appeared to be unfounded: later that morning I was approached by four first year students, all expressing interest in my research and the desire to participate.

The following day, the entire student body converged in the cafeteria for a breakfast hosted by the university's president, an eloquent and charismatic man who had held the position of president and CEO of a rehabilitative hospital. From his position alongside a banquet table laden with a healthy repast of fruit, cheeses, baked goods and juice, he graciously welcomed each and every student as they drifted in from the hallway. Already, and rather uncannily, he seemed to know many by name.

An information session covering the details of registration followed in the auditorium, and then representatives of each of Emeritus University's different programs participated in a "round table discussion covering all natural health modalities." The topic of discussion was diabetes, and each faculty member spoke about the value of their particular modality but also how all modalities could be integrated to provide optimum care for patients. Lunch was followed by an impassioned address given by the university's President Emeritus about the history and identity of Emeritus University.

² Gaines and Davis-Floyd (2004:95) suggest the capitalization of Biomedicine in order to denote its identity as the "professional medicine of the West," distinguishable in both origins and philosophical foundations from the professional medicines of other cultures, such as Ayurvedic medicine.

Later, the first year AOM students coalesced again for a lecture on the importance of joining the state Acupuncture and Oriental Medicine Association, and an overview of the popular internship elective program in China, available to students in their third year of studies. There followed a session of “Qi Gong” during which we were encouraged to pummel each other as part of some as-of-yet mysterious procedure called “Tui Na massage.” Prior to applying pressure to a point below the scapula, we were instructed to ask each other (with serious attempts to be professional and only some giggling) if we were pregnant, since this point, we were told, could prematurely “descend the baby.” We were reminded of the fundamental importance of confidentiality in the clinical encounter, and amongst ourselves as a class. We were instructed how to thank each other for the lavish physical attentions and the personal revelations concerning our fecundity, so we shuffled and bowed in two slowly revolving circles, hoping that we weren’t, by merit of a single misplaced tone, saying “diarrhea” instead of “thank you.”

Much of the remainder of the afternoon was taken up by less exotic pursuits: information sessions concerning financial aid, student services, parking passes, locker hire, ID photos and library tours. Emeritus University was a hive of activity as students began the process of settling in, and I, too, found myself swept along in the myriad irresistible currents generated by the churning wheel of Academia: locating classrooms, making introductions, and sorting through schedules and swathes of orientation material in preparation for my research.

The evening of September 20 brought AOM faculty and students, both first and second years, together for “The Emperor’s Feast,” a potluck started by a current faculty member during his second year as a student at Emeritus. This less formal setting provided further opportunities to meet and mingle over tables groaning with the weight of the Northwest’s finest salmon marinated in an awe-inspiring diversity of sauces. The President himself attended, regaling us with a humorous anecdote concerning his first experience of acupuncture. The dean of the AOM program was also there, as was the Vice President for Academic Affairs, and members of the Basic Sciences Department including the dean. In what I interpreted as a noble attempt to break down barriers of authority, they had interspersed themselves among the students. I sat next to a young woman from New York State who had moved across the country with her boyfriend in order to pursue her studies in AOM. “I don’t know anyone,” she said a little apprehensively. It was a sentiment shared by many of us, although good food, as ever, provided the mortar with which the first tentative bricks of friendships were laid.

The first day of classes, held on the 25th, offered “sunrise yoga” and the “All University Convocation,” both events which, in different ways, united the Emeritus community. We giggled our way through postures impossible to execute with grace at 7:00 in the morning; we lit candles in the chapel to mark the beginning of a new academic year while a gospel singer belted out “*He ain’t heavy, he’s my brother.*” And with that, orientation concluded, and classes commenced.

Thesis statement

My ethnographic exploration of Emeritus University was guided by the question: How does increasing emphasis upon integration with biomedical models of education, practice, and research influence the curriculum of a program of acupuncture and Oriental medicine, the professional values and aspirations inculcated within first year students of AOM, and their sense of professional identity and position within the medical landscape of the United States? Following the concern of critical medical anthropology for individual action and agency, a second question emerged: how do the interests, goals, and decisions of first year students shape and influence both the curriculum and the identity of AOM?

The emphasis placed by Emeritus University upon a model of “integrated medicine” has resulted in a program that heavily emphasizes specialization, professionalization, and biomedical science as part of a three-part strategy of gaining acceptance, legitimacy, and status vis-à-vis the dominant model of allopathic education and practice. While students of AOM express great interest in collaboration with their allopathic counterparts, they question how they, and their medicine, “fit” within this evolving health care system, and the implications of increasing biomedical content of their curriculum for the identity of AOM. Far from being limited to students of AOM, such questions of identity beleaguer the profession itself as practitioners, medical professionals, regulators, researchers, and students claim and contest the future of AOM in the United States.

By focusing upon curriculum change and the process of learning with which students of AOM are engaged during their first year of study, the following thesis presents a critical analysis of the concept of integrated medicine as one which privileges the skills, knowledge, and values of Biomedicine, including scientific research, collaboration and communication, and clear delineation of scope of practice from those of biomedical professionals. Far from creating a level playing field for practitioners of AOM and Biomedicine, integration carries with it the possibility of co-opting the techniques of AOM while discarding the dross of its theories; establishing AOM practitioners as subordinates to their biomedical colleagues and their techniques as adjuncts. Ultimately, it is argued, integration of alternative medical modalities with Biomedicine will silence the former’s critique of the technological, iatrogenic, expensive, and impersonal aspects of Biomedicine and the US health care system.

Background to the research and outline of chapters

The presence of forty incoming AOM students from all across the United States posed questions which formed the foundations of my research for the next several months at Emeritus University: who were they? Where had they come from? Why had they chosen acupuncture and Oriental medicine? Why Emeritus University? While researchers

have explored the historical progression of, and contemporary issues concerning, Chinese medical education in China (Farquhar 1994, Field et al. 2006, Hsu 1999, Lam et al. 2006, Scheid 2002a), much less has been written about its institutions of education in the United States and their faculty and students. Exceptions include Ho's ethnographic study of the discourse of traditional Chinese medicine (2004) and Tu's study of professionalization at the New England School of Acupuncture (1999).

My research question concerning integration and the identity of AOM arose from a long standing interest in the implications of "integrated" medicine for the education of complementary and alternative medical students and the identity of complementary and alternative medicine (CAM). Chapter 2 presents a historical overview of CAM generally, and Chinese medicine specifically, in the United States as well as its current regulation and professional status. I also review the literature concerning CAM education and the connections between education and professionalization. Emeritus University has evolved within a medical landscape shaped by the rise of CAM, the decline of biomedical authority, and the movement toward integration with allopathy as a strategy for increasing public and professional legitimacy and acceptance. The first year students of AOM with whom I worked were attracted to Emeritus in part by their interests in integration and collaboration with allopathic practitioners, and in Chapter 3 I introduce their backgrounds and motivations for pursuing a career in AOM. The changing demographic of AOM students reveals a good deal about complementary and alternative medicine's increasing status and acceptance.

Chapter 4 explores the curriculum of the first year acupuncture and Oriental medicine program as well as the changes it has undergone in the past decade; changes which indicate increasing emphasis upon science and research, as a reflection of the importance accorded to integration by Emeritus University. As Chapter 5 discusses, such emphasis is part of the project of professionalization by which CAM modalities hope to achieve acceptance, legitimacy, and status vis-à-vis the dominant biomedical model of education and practice.

Although students expressed considerable awareness of the value of science in furthering the acceptance of their medicine, many expressed the belief that scientific validation was unnecessary because AOM represents a unique system of medicine that works on principles different from those of Biomedicine. Further, many expressed concerns that the emphasis placed upon Western medicine impeded their ability to learn Chinese medicine: basic science courses detracted from, rather than added to, their training as acupuncturists. It was felt by several students that the gains in terms of acceptance and status achieved through scientific validation must be carefully weighed against potential losses in terms of the identity of AOM as a unique and autonomous system of medicine. Chapter 6 explores this "paradox of integration" that results from increasing biomedicalization of the AOM program. In Chapter 7, I consider the topic of "integration" between Chinese and Western models of medicine in greater detail, noting that the process of integration is complicated by the lack of a similar physiological foundation and understanding of the human body. While students perceived reconciliation or integration to be impossible at a philosophical or physiological level,

they acknowledged that the human body itself provides the bridge between East and West, and that integration occurs at the patient's bedside if not in the classroom.

The movement toward a standardized and science-based model of Chinese medicine at Emeritus University is part of the Americanization of Chinese medicine, and represents the response of one CAM modality to increasing pressures to demonstrate its legitimacy, efficacy, and safety vis-à-vis Biomedicine. Chapter 8 explores these ideas, as well as the roles of students in shaping their educational experience, the identity of acupuncture and Oriental medicine, and health care itself in the United States.

In Chapter 9, I present a critical examination of professionalization, scientization, and the Americanization of acupuncture and Oriental medicine. While the movement toward integration with allopathic medicine presents students of AOM with opportunities for collaboration, research, state licensure and insurance reimbursement, it also poses challenges to the identity and autonomy of AOM. Far from being unique to students of AOM, such concerns are expressed by the profession itself, as a previously "alternative" medicine becomes increasingly mainstream.

Contributions of the research and limitations of the study

Research into the area of complementary and alternative medical education has burgeoned in recent years, addressing the socialization of students (Boon 1998, Kelner et al. 1980), the integration of complementary and alternative medicine into medical practice and education (Barrett 2003, Burke et al. 2004, Faass 2001, Giordano et al. 2002, Giordano et al. 2004, Goldner 2000, Harris 1995, Hassed 2004, Highfield et al. 2005, Hui et al. 2002, Jonas 2002, Pearl and Schillinger 1999, Stuttard and Walker 2000, Verhoef et al. 2004, Wetzel et al. 2003, Wolpe 1999), the role of university validation and CAM (Mills 1995, Stuttard 2002, Wilkinson 1997), the attitudes of medical school students toward CAM (Baugniet et al. 2000, Furnham and McGill 2003), and the role of education in maintaining biomedical hegemony (Eisenberg et al. 2002, Goldstein and Donaldson 1979, Shahjahan 2004). While allopathic schools have received considerable anthropological and sociological attention (see for example Becker et al. 1961, Becker et al. 1972, Bloom 1965, Fox 1988, Good and Good 1993, Haas and Shaffir 1987, Hall 1948, Konner 1987, Lock 1993, Merton et al. 1957), schools of CAM have been insufficiently studied (Baer 2001:97, Giordano et al. 2002:897). This neglect serves to sustain an impression of these schools as passive agents in the transmission of knowledge. My research demonstrates that this is far from accurate: through Emeritus University's position on the frontlines of professionalization, its collaboration with research and funding bodies, its substantial investment in integration with Biomedicine, and the demands of its students, it is a dynamic key player in the evolution of Chinese medicine's identity in the United States and a bridge between ideas of tradition and modernity; East and West, alternative and conventional. These dichotomies are at the heart of Chinese medicine's complex and conflicted identity. Focusing on the ways in which Emeritus University represents itself is instructive of the ways in which Chinese

medicine is itself evolving and re-imagining itself in the West. In addition, my focus upon the socialization of students of complementary and alternative medicine not only adds to our knowledge of this process, but provides insight into what the changing demographic of students indicates about acupuncture and Oriental medicine's acceptability and increasingly mainstream identity.

While the concept of professionalism in allopathic medical education has been addressed (see for example Jotterand 2005, Rothman 2000, Swick et al. 1999, Wynia et al. 1999), little research has been conducted on the identity and transmission of professional values in schools of alternative medicine (although see Wild 1978, Harter and Krone 2001, and Coldham 2003). My research serves to address this gap by identifying collaboration and communication with allopathic practitioners, the delineation of boundaries between medical modalities, and scientific research as being values associated with CAM education.

Lastly, my specific focus on integration brings explorations of complementary medicine up to date with the larger movement in health care toward an integrated model of medicine. It sheds light upon the transformation of the curriculum in response to increasing emphasis on integration with allopathy and increasing alignment with an allopathic model of health care, and the impact of integration on the identity of AOM and its practitioners. While the holistic approach embodied by my research views curriculum change resulting from integration as a response to many interrelated factors including the concerns of professional organizations, biomedical professionals, and insurance companies, my research builds upon the work of critical medical anthropologists in elucidating the impact that larger forces have on individuals and the ways in which individuals themselves shape the macrolevel processes that impact them. This concern for individual agency serves as "an important corrective to the tendency to assume that, because power is concentrated in macrolevel structures the microlevel is mechanically determined from above" (Lazarus 1988:47, Singer 1990:185). I demonstrate how the interests, goals, and decisions of first year students can shape and influence both the curriculum and the identity of AOM. My research therefore contributes to our understanding of the ways in which students are active participants in the transformation Chinese medicine in the United States.

Limitations of the study

As discussed by Pelto and Pelto (1990:278), "clinic populations should never be considered as representative of the general population." Emeritus University is one of over fifty accredited institutions in the United States that offer programs in acupuncture and Oriental medicine. As noted by the Associate Dean for Clinical Education in the School of AOM, Emeritus, like all programs of AOM, presents students with its unique interpretation of the official curriculum guidelines prepared by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM). In addition, the presence of faculty members trained specifically in the People's Republic of China

traditional Chinese medicine (PRC-TCM) model of acupuncture and Oriental Medicine means that this is the perspective transmitted to students during their education at Emeritus. Finally, Emeritus University's location within a West Coast state known for its progressive and liberal political tendencies should be taken into account. Since 1996, this state has upheld a law requiring all licensed health care providers – conventional or complementary – to be covered by carriers of health insurance. This law, in combination with long-standing licensure (since 1985), has probably resulted in a greater atmosphere of public and professional acceptance than interior states in which acupuncture is not yet regulated. It cannot therefore be said that Emeritus University represents all other schools of AOM in the United States, nor can the trajectory of AOM in this country be drawn with accuracy from Emeritus. However, the size of Emeritus University, coupled with its identity as a university of natural medicine and the positioning of AOM administrators and faculty in various professional organizations, ensures that the school will exert significant influence over the emerging identity of AOM.

Secondly, beyond recognition of the origins of TCM in 1949 and its evolution as the most recognized and standardized form of Chinese medicine taught and licensed in the United States, I have not peered eastwards. The lack of a China-US comparison ignores the fact that there are many connections between Emeritus University and Chinese universities, established both through the Chinese faculty and the popular internship in China program. However, as Barnes discusses (2003:268), “Most European American practitioners...locate themselves in the field of what has come to be called “American Acupuncture.” Further, they “frequently understand themselves to be generating a new version of an older system into which they have introduced elements that do not necessarily characterize PRC-TCM” (Barnes 2003:268-269). Hare's fieldwork indicates that “an urban US variety of Chinese medicine may be emerging from the ground up; that is, from the consumers and therapists who are most intimately involved with the system” (1993:30). The degree to which acupuncture in the United States is linked to, or represents, PRC-TCM in China is therefore questionable, and while several core faculty members at Emeritus University were Chinese and trained in China, they themselves have adapted their styles of teaching, and in some cases material, to suit their American students. The longstanding acceptance of acupuncture, moxabustion³, Tui Na⁴, and herbal medicine in China contrasts with a very different historical and political landscape in the United States, and American practitioners face very different obstacles to the acceptance and practice of AOM in this country (Barnes 2003:283). For these reasons, my study focuses exclusively on the characteristics and development of AOM in the United States.

Thirdly, my research captures a snapshot of the educational experience of students enrolled in their first year of classes. While I did establish very positive rapport with students, the degree to which I was able to witness, first-hand, the impact of

³ Moxabustion: “The application of heat from certain burning substances at the acupuncture points” (Kaptchuk 2000:107-108). The most common substance is mugwort (*Artemisia vulgaris*), which may be used packed into cigar shaped wands or loose.

⁴ Tui Na: Translated as “push-grasp,” a form of bodywork similar to massage but based upon the theories and principles of Chinese medicine.

extracurricular activities, relationships, and interactions (including those between patients and students) upon students' process of learning is limited. In addition, I did not follow these students through later years of their studies, and am therefore unable to discuss the ways in which their perspectives, interests, and visions of the future may have changed. This is unfortunate, since it is my belief that much greater understanding of their roles in the evolution and Americanization of AOM could be gained through such a long-term study. Originally I intended to include students in later stages of their academic studies in my project in order to compare their attitudes and experiences with those of first year students. Becker et al. (1961:23) discuss the benefits and drawbacks of "intensive versus extensive" study, and I decided to focus exclusively upon first year students with the intention of gaining in-depth insight into their experiences of socialization. Certainly, time and efficiency entered into my decision; as noted by Becker et al. (1961:23). Attending the classes, labs, and clinic shifts of first, second, and third year students, combined with interviewing them and their faculty, threatened to demand an exorbitant amount of observation time and promise too diluted a final analysis.

Fourthly, while I originally intended to focus my research upon the gendered nature of AOM education, my focus shifted to integration and identity of the medicine and its practitioners. This was mainly due to the use of "unstructured techniques" discussed by Becker et al. (1961:18). While I entered the field with specific questions and interests, I tended to allow students to direct the topic of interviews and focus groups, resulting in the narrowing of my focus to include matters that were important to my participants, one of which was the issue of integration and the identity of AOM. That I do not delve into the intersection of gender, complementary medicine, and education is perhaps the greatest limitation of this thesis, particularly in light of the degree to which this area of study has been neglected (Annandale and Hunt 2000:4, Doyal 1995:17, Doyal 1994, Foley and Faircloth 2003, Lewin and Olesen 1985:9, Nechas and Foley 1994, Ratcliff 2002:286, Rosser 1994). At the time of my research, it very quickly became obvious that the hallways, classes, and clinics of Emeritus University were populated predominantly by women, reflecting a much broader trend in the field of CAM. As of December 2007, 65% of licensed acupuncturists in the state were female (631 out of 971). Of the 41 students registered in the first year AOM program, 25, or 61%, were women. As a field of medicine dominated by women in use, practice, and study, Emeritus University presents an ideal opportunity to explore the ways in which female students conceptualize their roles, their motivations for pursuing a career in CAM, and the challenges they face over the course of their studies. While my interviews and focus groups with female students revealed that they conceive of themselves as pioneers, advancing the future of health care in the United States, they also wrestle with the challenges of balancing their personal lives and goals with academia and careers (Broadhead 1983). While this study of CAM and education remains largely gender-blind, I hope to consider this important area of study in future publications.

Fifthly, researchers have noted that we know very little about patterns of CAM use among racial or ethnic minorities and immigrants (Upchurch and Chyu 2005:6). While several first year students of AOM at Emeritus University were from Vietnam, Korea, China, Taiwan, and Japan, I did not focus upon ethnic differences in their

experiences of learning AOM. My interviews with these students did, however, raise interesting questions for further research concerning patterns of use, the influence of family and culture in their decisions to pursue AOM, the influence of previous experiences and training in shaping their understanding of AOM, their visions of the future as practitioners within conscribed ethnic communities, and their views of the ways in which acupuncture had been adapted for practice in the United States.

What's in a name? A note on terminology

One of the first challenges of my research proved to be pinning down an appropriate name for the practice of Chinese medicine in the United States. Following Scheid (2002a:3), I use the term “Chinese medicine” to refer to the heterogeneous body of medicine from China that evolved over thousands of years, “during the imperial era and also to the subsequent transformations of this medicine in the course of the republican, Maoist, and post-Maoist periods” and which includes the practices of acupuncture, moxabustion, herbology, and body work. In the United States, an American version of the PRC-TCM has become the most commonly taught, licensed, and practiced form of Chinese medicine. In addition, students who write the National Certification Commission for Acupuncture and Oriental Medicine board exams must know the theories, diagnostic methods, and classifications of traditional Chinese medicine.

The term “traditional Chinese medicine” poses a dilemma to academics. Scheid avoids the term for several reasons, the first being that the Chinese in China themselves do not refer to Chinese medicine as “traditional” (2002a:3). It is, instead, a term created in the 1950's “for use in foreign-language publications only with the explicit aim of generating a certain perception of Chinese medicine in the West” (Scheid 2002:3). In addition, “the term ‘traditional’ invokes the inappropriate sense that Chinese medicine is unchanged or unchanging, neither of which is true” (Scheid 2002a:3). Throughout this thesis, I use “TCM” in a pragmatic sense to indicate the form of Chinese medicine predominantly taught in many US schools, including Emeritus University.

In addition to TCM, students at Emeritus University and at other colleges are often exposed to several other forms of Asian Medicine, either directly or indirectly, such as Five Elements / Worsely style acupuncture⁵, Japanese style acupuncture⁶, Korean style hand acupuncture⁷, and Tibetan medicine. During the course of their studies, students may take elective classes, such as the Five Elements style acupuncture taught at Emeritus. Less directly, they may be exposed to different styles by clinic supervisors who utilize other forms of Asian medicine in their practice, “brown bag” lunch seminars, and workshops held by well-known practitioners. In recognition of this diversity, the

⁵⁻⁷ See Glossary Pp. 278

term “acupuncture and Oriental medicine” is used by many schools in the US as well as professional organizations such as the American Association of Acupuncture and Oriental medicine (AAAOM). In light of Said’s (1978) critical analysis of the term “Orientalism” as part of an imperialistic and prejudiced Western academic and historical tradition of disparaging, exoticizing, and essentializing the East, scholars may have much to say about the widespread use of this term to describe Chinese medical practices. However, Barnes notes that “rarely do acupuncturists evince awareness of the political complications attaching to the term “Oriental” (2003:294). Therefore, for the purposes of my own research, (academic criticisms of the term acknowledged), I utilize the term “acupuncture and Oriental medicine” to refer to the program at Emeritus University and the eclectic field of practice in the United States.

Lastly, a word or two must be written about the terms “Western” medicine, “allopathic” medicine, and “Biomedicine” on one hand and the terms “alternative” medicine, “complementary” medicine, “complementary and alternative” medicine and “integrated” medicine on the other. Following Gaines and Davis-Floyd (2003:95) I utilize the term “Biomedicine” in most places throughout this thesis to refer to this “preeminently biological form of medicine” (2003:95), as distinguished from the energetically-based model of Chinese medicine. I also utilize the terms “Western” and “allopathic” medicine throughout, with the recognition that both are not entirely satisfactory. While Western or “scientific medicine” was catapulted to its prominent position by virtue of scientific discovery and laboratory experimentation in the West, the term today implies that Western medicine is exclusive to the Western hemisphere and has remained free from cross-fertilization with other non-Western forms of medicine. The term, “allopathic” medicine originated with the founder of homeopathy, Samuel Hahnemann, a German physician who dubbed “regular” physicians “allopaths” to indicate “that they, too, had an exclusive dogma, cure by opposites, the reverse of homeopathy” (Starr 1982:100). The designation has been criticized by physicians for its negative, misleading and restrictive connotations (Berkenwald 1998, Gundling 1998), although as Gaines and Davis-Floyd note “the term ‘allopathic’ is still often employed as it designates the biomedical tradition of working ‘against pathology,’ wherein the treatment is meant to oppose or attack the disease as directly as possible” (2003:95). Like the term “Oriental,” both terms “Western” and “allopathic” medicine were utilized interchangeably by faculty, administrators, students, and promotional material at Emeritus University with little concern for their origins and connotations.

Several researchers have bemoaned the lack of a standardized definition for what I most often refer to throughout this thesis as “complementary and alternative medicine,” abbreviated as “CAM” (Nienstedt 1998b, Wardwell 1994, Wiseman 2004, Wootton 2005). Barrett et al. (2003:937) notes that CAM practices are defined in relation to Biomedicine. They write:

CAM therapies that are used instead of conventional medicine are termed ‘alternative.’ CAM therapies used alongside conventional medicine are said to be “complementary.” ‘Integrative medicine’ results from the

thoughtful incorporation of concepts, values, and practices from alternative, complementary, and conventional medicines.

All terms are problematic. As noted by Nienstedt (1998b:23), some practitioners eschew the term “alternative” medicine due to perceived negative connotations and, as one naturopathic practitioner explained to me, its implied suggestion that patients pursue some forms of medicine at the expense of others. Other practitioners prefer the term “alternative” medicine in order to “implicitly assert a belief that their medicine is good enough on its own to serve health care needs” (Wiseman 2004:328). In any case, all three terms “define the medicines they denote in relation to the dominance of biomedicine” (Wiseman 1994:328), and the historical relegation of the diversity of CAM practices to “residual categories” is, in Wardwell’s phrasing, “especially unsatisfactory” for the purposes of study (1994:1061). Both he and Wootton (2005:777) warn that “a consistent classification” for CAM practices is necessary for both research and education.

The terms “alternative,” “complementary” and “complementary and alternative” medicine were utilized (seemingly interchangeably) by students of AOM. I elected to use the term “complementary and alternative medicine,” which seems to strike a compromise between “complementary” and “alternative.”

Theoretical orientation

For nearly eight decades, sociologists have explored the process of socialization into the medical profession (Becker et al. 1961, Becker et al. 1972, Bloom 1965, Fox 1988, Haas and Shaffir 1987, Hall 1948, Lella and Pawluch 1988, Lock 1993, Merton et al. 1957, Wild 1978). The first of such accounts was undoubtedly William Waller’s “sociology of teaching,” which was published in 1932. Following World War II, studies shifted in emphasis from individual students and their “traits,” including their attitudes and how to measure them, to “the student and his social environment” (Bloom 1965:146), including innovations in medical education (Bloom 1965:144). Exemplary is the work of Robert Merton et al. (1957), who championed a functionalist approach to, and survey techniques in, the study of medical education. Also influential has been Howard Becker et al. whose seminal work “Boys in White” (1961) was characterized by a symbolic-interactionist approach and emphasis on the method of participant-observation (Boon 1996a, Olesen 1974:7). Symbolic-interactionism

Assumes that human behavior is to be understood as a process in which a person shapes and controls his conduct by taking into account (though the mechanism of “role taking”) the expectations of others with whom he interacts (Becker et al. 1961:19).

The theoretical influences typified by Becker and Merton have been such that, three decades later, sociologists and anthropologists alike orient themselves according to

one or the other of them. Becker et al. and Merton et al. conducted their research at two very different medical schools, and obtained (perhaps not surprisingly) two very different sets of results, stemming from their methods of research, their theoretical orientations, and their conceptualizations of the medical school, as either “an institution within the medical profession,” in the case of Merton et al. (1957), or, in the case of Becker et al., as “a more separate and distinct institution in its own right” (Bloom 1965:154). Both research teams differ considerably in their interpretations of student status, student-faculty relationships, and the transmission of professional values (Bloom 1965:153-163). The functionalist orientation of Merton et al. (1957) “highlights the links between the medical school and the medical profession” (Bloom 1965:154), which led them to emphasize

the processes whereby the school functions as the basic institution for initiating and conveying to its future members the “body of agreed and transmitted ideas, values and standards toward which members of the profession are expected to orient their behavior” (Merton et al. 1957 in Bloom 1965:154).

These values, skills, knowledge and “professional attributes” are transmitted to students through the formal or “manifest” curriculum and examinations (Sinclair 1997:12), and students are regarded by their faculty as junior colleagues on a journey toward “full partnership in medicine” (Bloom 1965:155).

By comparison, in the symbolic-interactionist tradition of Becker et al. (1961), students “are not assumed to be passive receivers” of the values, skills, and attributes of the profession; “in other words, it is possible for individuals to shape their own social roles rather than simply accepting the roles as given” (Boon 1996a:16). The process of socialization is one in which students, who occupy a subordinate status as “Boys in White,” must learn the “informal or ‘hidden’ curriculum to help themselves and each other get through medical school any way they can” (Sinclair 1997:12). I found this perspective to be particularly salient throughout my research, as first year students of AOM tailored the program of AOM to suit their perceived needs, goals, and interests. In addition, Becker et al.’s (1961) characterization of students as active players in their educational experience fits well with my own discovery of the ways in which first year students of AOM perceived themselves to play roles in the evolution of AOM in the United States.

While these two very different approaches and theoretical orientations have stirred considerable dialogue in the field of sociology, Bloom suggests that “the issue between them is no longer *which* is the *most* correct, but *what are the effects* of each on the socialization of the medical student in the social role of the physician?” (1965:163). Such a question usefully directs our attention toward understanding how medical school culture affects the attitudes of medical students, as well as the relationship between the medical school and the medical profession, and how the former inculcates its students with the values of the latter (Bloom 1965:163,169-170).

Despite their interests and involvement in medical education from a “clinical” perspective, often with an applied bent (see for example Cartwright 2003, Todd and Clark 1985, Dougherty 1985), medical anthropologists have been less inclined to examine the process of socialization that occurs during medical training, although this is changing and fascinating analyses of the medical academy have been conducted by Good and Good (1993), Konner (1987), Lock (1993), and Sinclair (1997). For the most part, anthropologists have followed theoretical paths well-trodden by their colleagues in sociology, and the studies conducted by Merton et al. (1957) and Becker et al. (1961) continue to provide the theoretical foundations for contemporary studies, both sociological (Boon 1996a, 1998) and anthropological (Sinclair 1997).

While Gaines and Hahn suggest that sociological studies tended to focus upon “the nature of professional roles, role socialization and the powerful influence of institutional ideology and settings” (1985:8), anthropology has deepened our understanding of the “cultural contextualization of Biomedicine” and “the cultural principals that organize medical thought and action” by merit of its cross-cultural, comparative approach to health and healing.

The research conducted by Good and Good (1993) at Harvard medical school is illustrative of an anthropological concern with “historical, structural, and phenomenological aspects of medicine and medical education” (Good and Good 1993:81): “how,” they ask, “are distinctive medical worlds constructed experientially so that they appear singularly convincing, natural, objective, the only way to imagine the world?” (Good and Good 1993:83 – 84). How is the medical world and “the objects of the medical gaze” built up; how are the subjects of that gaze, physicians and students, “reconstituted in the process,” and how are “distinctive forms or reasoning about that world” learned (1993:83-84)? Their research sought to “examin[e] ethnographically the ‘process’ of coming to know rather than simply the ‘structure’ and to examine the construction of medical knowledge as intersubjective reality in the context of highly organized interpersonal and institutional relationships” (Good and Good 1993:84).

Foucault’s theories concerning the historical and epistemological roots of objectification, the “medical gaze,” have become *de rigueur* in anthropological analyses of medical practice and education. Good and Good (1993) draw upon Foucault’s analysis of discourses “as practices that systematically form the objects of which they speak” (1972:49, in Good and Good 1993:84). In her study of first year medical students practicing at a free clinic for the homeless, Davenport blends the theoretical perspectives of Foucault (1994, 1995), Good (1994), and Giddens (Williams and Calnan 1996:1612) in her account of the students’ uneasy movement between “witnessing” and “gazing” (2000). Like the examples mentioned, Davenport’s research exhibits the characteristic anthropological concern with “illuminat[ing] the practice of medical education in the micro-settings of clinical encounters” (2000:312). In his ethnographic account of a London teaching hospital’s basic medical training (1997), Sinclair aligns himself with Becker et al. (1961) and the “Chicago School” but goes beyond their theoretical framework by expanding their concept of “perspectives” through “psychological schemas” and by incorporating Bourdieu’s concept of ‘habitus’: acquired patterns of

thought and behavior known as “dispositions” which guide, and are constantly shaped by, the choices of the individual students within the field of medical education.

The classic studies of medical socialization conducted by Becker et al. (1961) and Merton et al. (1957) provided useful ways of orienting my own study at a school of CAM. However, schools of CAM represent historically, politically, and culturally different institutions of medical education from schools of Biomedicine, and, as such, require a modified theoretical framework derived from the holistic, systems approach characteristic of anthropology and more suited to the holistic nature of CAM itself. The orientation of critical medical anthropology positions schools of CAM in a broad historical and political context and acknowledges their unique development in reaction to, and under the profound influence of, Biomedicine.

Critical medical anthropology: Origins and contribution to this research

Note Lazarus and Pappas (1986:136): “Anthropology’s unique contribution to the social science of medicine” is its perspective of medicine as “a cultural system” and medical knowledge and practice as social phenomena (1986:136). Trained to focus upon “the subtle details and unique social and cultural configurations of individual cultural cases” (Singer 2003:24), medical anthropologists found employment predominantly within medical institutions where their research concerned the application of anthropological analysis to the everyday dilemmas of medical care. Throughout the 1980’s and 90’s, political-economic theory gained popularity as a corrective to what many felt had become a myopia in medical anthropology. In 1979, Morsy’s review essay, entitled “The missing link in medical anthropology: the political economy of health” laid the foundation for considerable growth of interest in the ways in which individuals or social groups are connected to “the larger regional, national, and global human society” (Singer 2003:24). In the early 1980’s, the theoretical perspective of critical medical anthropology emerged as a response to the tendency of medical anthropology to focus upon micro-level explanations of health-related behavior and beliefs (Singer 2003:24) and medical anthropologists to accept the dominant assumptions and values of Western medicine and to focus their research upon improving clinical relationships and patient compliance, rather than seeking to elucidate the social causes of sickness (Lazarus and Pappas 1986:136) and the ways in which social inequality and power are “primary determinants of health, health-related behavior, and health care” (Singer 2003:25). Writes Singer (2003:24) “traditional approaches...tended to ignore the wider causes and determinants of human decision-making and action,” concealing larger community, national and global structures and social relationships that influence and constrict individual action and behavior and choices. Critical medical anthropology attempts to link the macro-level concerns of the political economy to the micro-level beliefs, behaviors of individuals and social groups interpreted by medical anthropologists. Writes Singer (2003:25-26):

As Morsy (1996) notes, the critical approach to health in medical anthropology is distinctive not simply because of its scope and concern with the macro-level, but more importantly by its commitment to embedding culture in historically delineated political-economic contexts. The goal is not to dismiss the contributions of microanalysis of illness and healing but rather to extend the realization of the relevance of culture to issues of power, control, resistance, and defiance associated with health, illness, and healing.

Adherents to this theoretical perspective seek to “uncover the social / historical dimensions of medical knowledge and clarify the value-laden nature of scientific knowledge,” examine the place of medicine in society, the shaping of medical practice, and “the way that possibilities for change and improvement are limited and circumscribed” (Lazarus and Pappas 1986:136).

The theoretical perspective of critical medical anthropology is well-suited to the study of complementary and alternative medicine and its institutions of education for several reasons. First, critical medical anthropology recognizes that the status of medical modalities and their relative power vis-à-vis each other is constantly in flux. In the United States, the dominant position held by Biomedicine is entrenched in state laws that grant its practitioners “a monopoly over certain medical practices, and limit or prohibit the practice of other types of healers” (Baer 2003:111). In recent years, interest in CAM has increased on behalf of consumers (Andrews and Boon 2005, Barnes et al. 2004, Burke et al. 2006, Eisenberg et al. 1993 and 1998, Kaptchuk and Eisenberg 2001, Kessler et al. 2001, Romanow 2002:8, Tindle et al. 2005), the state (Dean 2001), practitioners of conventional medicine (Ben-Arye et al. 2007, Botting and Cook 2000, Caplan and Gesler 1998, Frenkel and Borkan 2003, Halliday et al. 1993, Hopper and Cohen 1998, Jump et al. 1999, Lewith 1997, Lipman et al. 2003, Scherwitz et al. 2004, Verhoef and Sutherland 1995, Wharton and Lewith 1986), insurance companies (Barrett 2003, Cleary-Guida et al. 2001, Goldstein 2002:50, Tillman 2002, Watts et al. 2004), funding institutions like the National Institutes of Health National Center for Complementary and Alternative Medicine (Hui et al. 2002, Whorton 2002:292-295), and pharmaceutical companies (Baer 2004:147). Indeed, it is a Golden Age for CAM users and researchers alike, with 89 million research dollars budgeted by the NCCAM in 2001 (Whorton 2002:295). Practitioners, too, have benefited from the increased status and legitimacy of their medical modalities afforded by professionalization, a topic well-studied by social scientists (see for example Albrecht and Levy 1982, Baer et al. 1998, Baer 2004, Barnes 2003, Cant 1996, Cant and Sharma 1996, Mitchell 2002, Saks 1992, Saks 1995, Saks 1999, Saks 2000, Winnick 2005, Wolpe 1985 and 1999), many of whom have argued that part of the project of professionalization involves a movement toward integration with orthodox medicine as a means of attaining legitimacy and support through association with the dominant paradigm. In recent years, “integrated medicine” has emerged as a powerful political and economic model for the practice of medicine and collaboration between “regular” and CAM practitioners has become increasingly commonplace. While the medical landscape of the nineteenth and early twentieth

centuries was characterized by policies of “staunch and often vigorous opposition to a wide variety of alternative or heterodox medical systems” (Baer 2004:89), Whorton notes that by the mid-1990’s, “orthodox practitioners were demonstrating an extraordinary openness toward alternative therapies” (2002:299). Surveys and studies point to a dramatic increase of interest in complementary medicine on the part of family practice physicians, as well as faculty and students of allopathic medical schools (Ben-Arye et al. 2007, Botting and Cook 2000, Caplan and Gesler 1998, Frenkel and Borkan 2003, Halliday et al. 1993, Hopper and Cohen 1998, Jump et al. 1999, Lewith 1997, Lipman et al. 2003, Scherwitz et al. 2004, Verhoef and Sutherland 1995, Wharton and Lewith 1986). In addition, many schools of allopathic medicine now offer courses in complementary medicine or have developed policies of integration (Caspi et al. 2000, Frenkel et al. 2007, Highfield et al. 2005, Hui et al. 2002, and Mykelbust et al. 2006). In the United States, 2002 saw “at least 81 out of 125 biomedical schools offer instruction in CAM, either in required courses or as electives or both” (Baer 2004:98). These developments can be seen as a challenge to Biomedicine and to the capitalist system of which it is a part. As will be discussed, a critical eye, however, may read in the language of “integration,” may see in the process of “professionalization,” and may hear in the calls for “scientific research,” a strategy of co-optation that threatens the identity of CAM and its contribution to health care.

Second, critical medical anthropology seeks to situate schools of CAM and their students within the macro-level historical and political structures of pluralism, state regulation, professionalization, and biomedical dominance that have shaped their emergence and evolution. While the roots of complementary and alternative medicine can be traced to the radical holistic and women’s health movements of the 1960’s and 70’s, today schools of CAM and practitioners must accommodate the biomedical model of education, practice, and professionalization in order to attain legitimacy, status, and acceptance. Students attending Emeritus University confront a curriculum shaped by many hands, including funding and research bodies such as the National Center for Complementary and Alternative Medicine (Jonas 2002, Nienstedt 1998a:39), state regulation, and insurance companies (Baer 2004:147, Giordano et al. 2004:904, Saks 2000:236). What students learn and how they learn it; the structure of their examinations; the process of licensure and accreditation; the ways in which the profession of AOM is organized and the issues it seeks to address; and ultimately, the identity of AOM in the United States, are all influenced by larger social, national, and global structures. The changing nature of the curriculum, from one emphasizing the energetic aspects of AOM to one heavily emphasizing and privileging the values, skills, and knowledge of Biomedicine, must also be understood within a broad social, historical, and political context. The School of AOM at Emeritus University is not passively transmitting the knowledge and skills of AOM nor is this knowledge and skills arbitrarily determined: instead, students are socialized into the values, roles, responsibilities, identity and place within the medical landscape vis-à-vis Biomedicine and its practitioners. While the acceptance of, and demand for, complementary and alternative medicine continues to grow, current debates within the profession of AOM concerning the future of the practice in relation to integration with Biomedicine speak to the continuation of a deeply

entrenched antagonism between CAM and conventional medicine. These tensions can be perceived from the level of state and national organizations to the classrooms and clinics occupied by first year AOM students. As I shall discuss, increasing emphasis upon biomedical science and research in the curriculum represents a double-sword for the profession of AOM, and gains in acceptance must be weighed against losses in the identity and potential of this CAM as an “alternative” to the dominant system of Biomedicine.

Third, as the above discussion implies, the central concern of critical medical anthropology with the “re-examination of the microlevel of the individuals...within the context of macrolevel structures, processes, and relations” (Singer 1989:1196) was profoundly influential in my research. Critical medical anthropology brings issues of structure (macro) and agency (micro) to the fore and seeks to connect them (Pappas 1990). By focusing on the intermediate level of an institution of CAM education, a critical medical anthropological perspective allows us to begin to connect the microlevel of student experience with the macrolevel of the political and economic system which shapes and constrains the practice and learning of AOM in the US. Seen through the lens of critical medical anthropology, the classroom becomes the ideal location to explore how larger forces impact the education and professional development of students. In the following chapters, I examine students’ perspectives on this process, their attitudes toward curricula changes and increasing conformity with a biomedical model, and how they themselves influence the development of curricula and the identity of AOM in the United States.

Finally, my research aligns with the concerns of critical medical anthropologists for advocacy and agency. Critical medical anthropology has been criticized for assuming that the micro-level is “mechanically determined from above” (Singer 1989:1199, also Scheper-Hughes 1990). As such, critical medical anthropology is concerned with the agency and experience of individuals. In keeping with this concern, my research indicates that individual students can and do shape the identity of the curriculum, the program, and the identity of Chinese medicine in the US, through their choice of elective courses, and their efforts to tailor the program to suit their individual interests, philosophies, and goals. Several students evinced awareness of the “hand-in-glove” relationship between capitalism and the US health care system (Singer 1986:129), and had made the decision to pursue education in an “alternative” form of medicine as a way to protest and revolutionize what they perceived to be an inaccessible, inequitable, and inhumane medical system. Such a focus on advocacy, change, and the role of critical medical anthropology in addressing social and political inequality underlying health has been a focus of this theoretical perspective since its inception (Baer et al. 1986, Singer 1995:82). Critical medical anthropology aligns itself with the concerns of individual students struggling to understand their place and their role within the US medical system; their responsibilities for, and the possibilities of, change. As I shall discuss, the curriculum and the perspectives of faculty did not align with students’ revolutionary aspirations. The results of research framed by the theoretical orientation of critical medical anthropology might advocate for the inclusion of alternative models of practice and reimbursement that are sensitive and supportive of student’s goals and interests.

Methods

Singer (2003:23) notes that “since its inception, medical anthropology has had an applied orientation” and has been criticized for lack of theoretical development (Brown 1998:9, Colson and Selby 1974, Polgar 1962, Scotch 1963). Pelto and Pelto (1990:270) note that the increasingly interdisciplinary nature of medical anthropological research and the collegial relationships forged between medical anthropologists working within medical schools and other institutional settings may guide their choice of research methods and the nature of the research question in an applied rather than theoretical direction. My own research questions were developed in part through discussion with the dean of the program and other administrators, and by my desire to place results (stripped, of course, of any identifying information) at the disposal of the AOM program. During my earliest correspondence with the dean of the School of AOM, I noted that research concerning students’ backgrounds, expectations, and experiences could be of value to Emeritus in coming to a better understanding of their target populations, an interest later seconded by the dean, who noted that the use of qualitative data could identify what she described as “pockets of prospective students,” traits, and patterns for admissions. While a debriefing with the dean occurred after the conclusion of my research, our discussion focused mainly upon my perceptions of potential areas for program improvement, as well as gender relations in light of an incident of sexual harassment which occurred early in the fall quarter. In the end, my research focused more upon a theoretical analysis of the implications of integration for the identity of AOM and its practitioners in the US.

While Pelto and Pelto (1990:270) suggest that “it is possible to examine a great many issues in methodology of medical anthropology without direct commitment to a particular theoretical position” and that “the basic methods of data gathering are the same regardless of the theoretical system adopted by the investigator,” my theoretical orientation did shape my research question and my methods of gathering data, including the questions I asked and the targets of those questions. My decision to interview individual students, their faculty, and members of the AOM program’s administration, including the dean and the Associate dean for clinical education, reflects the interests of critical medical anthropology in discovering the links between macro- and microlevels of study. Baer, Singer, and Johnsen (1986:96) present a model for conceptualizing and analyzing these levels of study: in the case of my own research, the individual level consists of student experiences studying AOM; the microlevel concerns the interactions between students, faculty, administration; the intermediate level addresses the influence of administration, professional organizations, and the state in shaping the curriculum and AOM policy, and the macrolevel focuses upon Biomedicine as the dominant medical system embedded within the capitalist world system.

Many of the questions I posed to students, faculty, and administrators (see appendix 2) were also shaped by my theoretical orientation, and point to my interests in the changing definitions and understandings of alternative / complementary / integrative medicine; the evolution of the program; the integration of Western and Eastern medicine in the curriculum and student perceptions of this process; the changing nature of

qualifications needed to practice AOM; the interconnection between gender and CAM; relationships between faculty and students; and perceptions of the future of AOM in the US. Many of these questions relate to the issues raised by critical medical anthropologists in relation to the situation of a complementary / alternative medical modality within the biomedically dominated landscape and the ways in which students envision practicing within this landscape. Do students approve of the biomedical components of their curriculum? Do they envision practicing in an integrative setting? How do they imagine relating to other practitioners? What do they imagine their roles to be? How do they conceptualize AOM / CAM in relation to Western medicine? The exploratory stages of my research involved interviewing as many students as possible, with the first interview being more structured in order to elicit basic demographic information and establish a baseline of student interest and experience. Later interviews closely approximated the “unstructured techniques” discussed by Becker et al. (1961:18) designed not “to see which of two or more alternative answers to a question someone will pick but rather which questions he himself will ask.” While I entered the field with very specific questions and interests, I tended to allow the students themselves to guide the general direction of my research and to identify the issues of importance to them. As themes concerning the integration of Western and Chinese medicine within the program emerged, I tended to interview more regularly students who had expressed conflicts, tensions, and difficulties with respect to the process of learning AOM and integration with Biomedicine.

The questions I asked administrators were also guided by my interests in the evolution of the program, the future of AOM, and the larger forces that impact the AOM program at Emeritus University; the role played by Emeritus University in changing the medical landscape in the United States; the changing nature of students expectations, and the influences that shape the structure and content of the curriculum. Similarly to the situation discussed above, I tended to re-interview faculty members who expressed strong opinions and ideas concerning integration.

In some cases my questions bordered on activist ethnographic research, discussed by Lyon-Callo (2000:333) as engagement in “a constantly evolving dialogue” with research participants: “By activist research,” Lyon-Callo writes, “what I am referring to is an ethnographic method of openly challenging each other’s ideas in an effort to think more critically about all of our views and practices.” This was particularly evident in certain interviews with the Associate Dean of Clinical education, which bore greater resemblance to discussions than interviews. At the time I worried a great deal about the potentially leading nature of my questions and statements, couched as they were in my own opinions, yet in the context of our discussions and debates, this form of interviewing resulted in some of the greatest insights into the nature of macro-micro relationships between students, the administration, and larger forces that impact the program of AOM. While taken out of context, the following example demonstrates how my research questions were shaped by the perspective of critical medical anthropology and how at times questioning bordered upon activist ethnographic research:

Researcher: Yeah. I think it's going to be fairly challenging over the next year for myself to understand how exactly this process [of learning AOM] occurs in students, especially with the confusion that I have about understanding the concept of truth, and if one system can in fact be applied to another system. And I believe that you said that the evidence-based medicine system can't in fact be logically applied to Chinese medicine, so they have to be kept separate. And yet it seems like the push is -- in schools and education and research -- to overlap them and to say, "We need to find a basis for acupuncture that fits within our western model." Do you think that's possible, or desirable?

In addition to my choice of participants, the classes I elected to attend reflected my theoretical orientation towards the evolution of the curriculum, integration, and the identity of AOM. While I attended nearly all of the core courses (TCM Pathology, Fundamentals of TCM, TCM Diagnosis, and Meridians⁸ and Points⁹ among them), in terms of the Western-based courses I favored attending those classes which seemed to bring tensions of integration to light over those which did not: as a result, I more regularly attended Western Pathology because of the instructor's explicit attempts to connect TCM and Western medicine, while I did not attend Biochemistry I, nor Introduction to Botany.

Critical Medical anthropology has been criticized for failing both to generate empirical research and to develop methods that can bridge the micro – and macrolevels of concern (Lazarus 1988:49, Lazarus and Pappas 1986, Pappas 1990:199, Singer et al. 1990, Singer et al. 1992:77). While the volume of research generated by critical medical anthropology (see for example Bates 1990, Fabrega and Miller 1995, Lazarus 1988, Lock 1986, Lyon-Callo 2000, Morgan 1990, Singer et al. 1992, Whiteford 1990) refutes the first criticism, a methodology which unites broad global macrolevel processes and systems to the microlevel of the individual remains less clearly defined. In the case of my own research, I sought to link broad social and political forces with the experiences of individuals students. Notes Singer (1989:1200):

The means of appropriately analyzing micro-macro relations must be addressed. While ethnographic research provides us with rich data from the microlevel, there is a tendency in the critical medical anthropology literature to assert rather than to specifically demonstrate determinance by structural factors outside the local setting...Critical medical anthropologists must enhance the corpus of research and analytic methods suited to this task, including, perhaps, the development of research approaches designed to simultaneously investigate linkages between several levels of health and social systems.

⁸⁻⁹ See Glossary Pp. 278

In response, Lazarus (1988:47) suggests focusing on the *intermediate level* of the institution and the “interactions within institutions” as a way of bridging microlevel explanatory models and ethnographic observations with macrolevel critical political economic approaches to the study of medicine (1988:54). I selected to observe and interview a research population from within a clearly defined institutional setting, focusing directly on the activities and interactions of students, faculty and administration. Direct observation therefore became an important methodological focus as I sought “to define more precisely the interactions that occur in therapeutic encounters.” (Pelto and Pelto 1990:277). In keeping with my theoretical orientation I linked these findings to the macrolevel of institutional administration, and, through my interviews with faculty and administration, to the levels of professional organization and state regulatory bodies that shape the identity of acupuncture and Oriental medicine in the United States.

Access to Emeritus University was first sought in June 2005, when I spoke with, then emailed, the dean of the School of AOM. In my email, I introduced my program of studies and interests in both medical and applied anthropology, using as an “in” the fact that my husband had attended Emeritus as a student of AOM in 2004. The “ample time” I had spent wandering about the grounds and meeting students had indeed led me to become “utterly fascinated and impressed with the school” and its expansive library. “In particular,” I wrote,

I am fascinated by the process of ‘learning’ alternative medicine, such as acupuncture; the stages of understanding that students encounter; the shifts in perception of health and the body. I am interested in the stories that students have to share about their backgrounds and their interests; what drew them to Emeritus along many winding roads. These ‘micro-level’ processes must be framed by macro-level changes, too, such as movements towards professionalization, changes in health policy and educational requirements; all of which might affect students and the curricula.

I pointed out that while many studies have been conducted of biomedical students and biomedical schools, very few at all of CAM academies exist, a deplorable gap in our understanding of education and transmission of alternative knowledge. My research would, I further informed her, last for a full school year, from September to August and would require my immersion into the daily routines and activities of first year students, whom I would ‘follow’ for the duration of their studies. Initially, I expressed interest in observing clinic shifts, but this was deemed ethically problematic and my observations were limited to clinic preview / review sessions that took place before and after each shift at the Emeritus Center for Natural Health. With the exception of this and a minor hiccup requiring me to negotiate my presence in classes and labs that were fully registered and therefore “full,” the process of gaining acceptance was pleasantly smooth.

I journeyed from Ontario to the West Coast in the depths of February to meet with the Dean of the School of AOM, the Admissions Officer, the Vice President for

Academic Affairs and Research, and the Director of the Office of Research Integrity. At this time I presented administrators with a formal proposal, which was reviewed by the Office of Research Integrity and eventually approved with only minor changes, one of which involved shoring up procedures for the protection of confidentiality. Permission to conduct research at Emeritus was partly contingent upon the use of pseudonyms for the institution and all participants. As noted by the Director: "In reporting the data, you will have to be careful with confidentiality: this is such a small institution that descriptors such as age and gender, especially with respect to faculty members, could effectively identify individuals." The prominence of Emeritus University did make concealing its identity, and therefore the identity of faculty and administrators, a challenge. As noted by Ervin the use of pseudonyms for communities and institutions, while "standard...is never completely foolproof...yet what is most important in maintaining confidentiality is the protection of individuals and potentially vulnerable subgroups" (2000:34). With this in mind, I made a special effort to grant anonymity to student participants, many of whom expressed concern that their frustrations and criticisms of the program might reach the ears of faculty or administrators. Consent forms for faculty were rewritten with special note of the potential risks of participation caused by Emeritus University's size, renown, and their prominence as faculty members, and these risks were stressed again before interviews. In hindsight I would have approached the issue of ethics differently, with frank discussion with gatekeepers concerning the realistic benefits and drawbacks of pseudonyms for well-known institutions and, with their permission, greater willingness on my behalf to involve participants in the data-collecting process. As it stands, I am in agreement with Ervin, who notes that when an institution's or community's name is disguised "the knowledge contained in the report cannot be used by other researchers as part of an accumulating body of data about the community or region" (2000:34).

Like Becker et al. (1961), my primary means of data collection occurred through participant-observation, which involves the immersion of the researcher in the lives and activities of participants. Over the course of my research at Emeritus University, I gathered data from a diversity of sources and settings: classrooms, clinic preview / review rooms, the cafeteria, the garden, brown-bag lunches, seminars, and teaching labs. In order to gain an insider's view of the first year AOM program at Emeritus University, I attended nearly all the first year classes required by students, as well as an elective course, sitting and scribbling furiously in my notebook alongside them. I sat with students during their lunch periods in the cafeteria, where we were awed by how many ways the ubiquitous cafeteria food, tofu and tempeh, could be prepared. I car-pooled to the student clinic with students, and sat, for four hour shifts, in the preview / review rooms where I observed their interactions with second and third year students and with their faculty-member supervisors. My field notes, recorded in ten 5 ½ by 4 inch 180 page spiral bound notebooks, formed the basis for my analysis. Each page was numbered and mined for ideas which were later consolidated and organized as recurring themes including "identity of Chinese medicine versus Western medicine," "evolution of Chinese medicine's identity," "inculcation of skills," "process of learning," "professionalism / professionalization," "socialization and role," "integration," and "Americanization." Research questions and ideas to pursue were also recorded

throughout my study, and at the end of the school year these questions formed the basis for final interviews with faculty and students.

Occasionally, the notebook stayed at home and I ventured forth in a less professional capacity, celebrating the milestones of the year: birthdays, apartment-warmings, Halloween parties, and an engagement. I attended a student production of the *Vagina Monologues*, starring two of 'my' first-years. I volunteered to scuttle about, black-robed, in the undergrowth of the State Park bordering Emeritus University for their annual Halloween fund raiser. And I and my husband, at that time an acupuncturist licensed in Canada but completing his second year at Emeritus University, hosted dinner parties, birthday parties and a picnic to celebrate our first anniversary. These myriad ways of building rapport and gaining insight into the lives and experiences of first year students could be easily synthesized under the term "participant-observation." But when this term is written on an application for funding or ethical clearance, the researcher hardly expects the many and diverse forms their participation will take; or the ways in which observations will be gathered.

Nor can we know how our best laid plans can – and will – go awry. In the sterile language required by research proposals I wrote that: "During classes, I will maintain an unobtrusive presence at the back of the classroom, making notes and observations in a notebook." It very quickly became obvious that an "unobtrusive presence" was not desired of me by either students or faculty. Instructors seemed eager to absorb me into their class and adopt me into the more digestible role of "student." Students wanted me to be "one of them," and my early impulses to retain a marginal identity conflicted with the human instinct to seek out the normal interactions and relationships of everyday life. Marginality was swiftly defeated. My research demanded that I put it, and attempts at unobtrusiveness, aside in favor of friendship and connection. I was thus required to navigate a fine line between the roles of objective researcher and student, and my identity was in a constant process of redefinition. I suspect that I wrestled with this issue far more than did the students and faculty, who quickly accepted me as another student and whose lives and experiences continued whether or not I wrote about them in my notebook.

Over the course of the year, I interviewed 36 out of 41 first year AOM students registered in the AOM program (25 female, 11 male). Many of these students I interviewed more than once; and 20 I interviewed during 2 or more of the school year's four quarters. Of these 20, 13 were female students and 7 were male. I also interviewed 7 faculty members, the Dean of the program, the Associate Dean for Clinical Education in the School of AOM, as well as the Senior Admissions Officer. All interviews were audio taped with the permission of the participants and transcribed.

Focus groups provided a wealth of insight into student experiences at Emeritus University. I conducted two general sessions and one specifically for female students, and found, as Slaughter suggests, these interviews allowed students to "choose the vocabulary of their discussion and issues important to them within the framework of the research question" (Slaughter et al. 1999:3). Focus groups also enabled students to explore issues, ideas and concerns that did not emerge during participant-observation or interviews and helped to guide my research question.

I also distributed a questionnaire at the end of the academic year (see appendix 3), seeking to obtain an overall sense of the educational experience as well as basic demographic information pertaining to gender, age, ethnicity, and educational background, the development of interest in acupuncture, involvement in this practice or other CAM modalities¹⁰. A final method that I employed was analysis of admissions data for the AOM program and historical statistical information pertaining to the number of students who graduated each year and their ages and gender. This data was helpful in illustrating general trends in enrollment. Curricula and promotional material produced by the school were also analyzed, with an eye toward recent and ongoing changes in the structure and requirements of obtaining a degree in acupuncture and Oriental medicine.

¹⁰ Due to low rates of return, the results from this questionnaire were not analyzed.

Chapter 2

“I have seen the past and it works”: Chinese medicine in the United States

Chinese medicine’s evolution from obscure and oft-maligned “alternative” to a widely accepted modality partaken of by more than one million Americans (Hui et al. 2002:347) is really one chapter in the much longer history of alternative medicine in the United States. Prior to the nineteenth century, the state played little role in regulating health care in North America (Cant and Sharma 1999, Kelner et al. 2004:81, Nienstedt 1998a), and indeed state legislators were loathe to restrict medical freedom (Whorton 2002:231). The absence of licensing requirements meant that patients could choose between competing medical systems in the United States and the medical landscape of the eighteenth and early nineteenth centuries was dominated by diverse and eclectic forms of medicine. But by the end of the nineteenth century, the situation dramatically shifted. The scientific discovery of microscopic, disease-causing entities combined with medical school reform and the emergence of powerful physician-led medical associations like the American Medical Association sounded the death-knell for many alternatives to “regular” medicine. It was not until the 1960’s and 70’s that many re-emerged as part of the holistic health movement, which arose in North America as a reaction to the reductionist, technological, and dispassionate model of Biomedicine. The holistic nature of Chinese medicine and the “contemplative, non-violent spiritual traditions of the Orient” (Whorton 2002:256), such as Buddhism, transcendental meditation, and yoga, formed a central tenet or philosophical core of the holistic health and New Age movements (Levin and Coreil 1986:894). Hui et al. (2002:345) note that principles of Chinese medicine “can be frequently found throughout the field of CAM.”

As noted by Barnes (2004), Kaplan (1997) and Whorton (2002), Chinese medicine’s introduction into American culture can be traced to a time long before the blooming of flower power in the 1960’s. During the 16th century, Jesuit priests who entered China left with knowledge and first-hand experience of acupuncture, making the “discovery” of acupuncture in the 1970’s more accurately a “rediscovery” (Whorton 2002:259). By the end of the 1700’s, “the [medical] profession had become generally aware of the practice” (Whorton 2002:259), and the decades following saw patients suffering from a broad spectrum of ailments, from rheumatism to hiccups, run through with sewing needles of dubious cleanliness, and with little attention paid to any underlying philosophical or theoretical foundation (Whorton 2002:259-261). Despite – or perhaps because of – the forays of physicians into the uncharted territory of acupuncture, the practice seems to have fallen out of favor among Westerners until over two centuries later.

With the raising of the “bamboo curtain” in the 1970’s and renewed relations between America and China, a stream of Eastern knowledge poured forth to be devoured by indiscriminating Western minds and filtered through Western preconceptions of the Chinese people (Taylor 2004:96). Although Chinese immigrants brought their medicine

with them to America in the early nineteenth century (Barnes 2004), it was in 1971 that acupuncture and moxibustion made their dramatic debut in American consciousness, when *New York Times* reporter James Reston's first hand experience with the procedure made front page news and acupuncture became "an overnight sensation" (Porkert 1990:31-32). A combination of images and ideas provided the West's first impression of Chinese medicine: dramatic media reports and photographs of patients undergoing surgery while stuck full of needles, People's Republic of China presentations of traditional Chinese medicine, teachings of Chinese practitioners who had come to the United States, and the discoveries of a stream of American enthusiasts who journeyed to the East (Barnes 1998:415).

The attitudes of biomedical physicians progressed through stages of skepticism and condemnation as they struggled to reconcile biomedical paradigms of anatomy and physiology with the foreign theories and methods of acupuncture (Taylor 2004). Walter Tkach, Nixon's personal physician, accompanied the President to China in 1972 in order to "discern the trick behind the startling reports" (Whorton 2002:257). After interviewing the Chinese physicians and their patients, and observing various surgeries performed under the influence of acupuncture, he proclaimed, "I have seen the past, and it works" (Whorton 2002:257).

Meanwhile, in the United States, the holistic health movement was gaining momentum, resulting in the erosion of Biomedicine's "professional sovereignty" and its social and cultural authority (Wolpe 1985:415). As it became obvious that public demands for acupuncture were unlikely to decrease and its effects became impossible to dismiss, medical professionals reassessed the situation, and a strategy of integration emerged (Winnick 2005:39). Professional organizations popped up like mushrooms in Europe and America. Often excluded from their ranks were the Chinese themselves, as Western physicians sought to draw on the skills and knowledge of Oriental practitioners "without seeming to associate themselves with such marginal groups" (Wolpe 1985:415). Initially, the practice of acupuncture was restricted to licensed medical doctors and doctors of osteopathy. Writes Whorton (2002:267):

Thus not only was it against the law for most alternative practitioners to use acupuncture...but since acupuncturists who had immigrated to this country from China were not licensed as physicians, it was also a violation of the law for the technique to be employed by the only people who were thoroughly trained in it.

Barnes (2003) and Whorton (2002) both write of early acupuncture clinics, established by Chinese acupuncturists, which were forced to close due to the restrictions. Nevertheless, in 1973, Nevada, Maryland and Oregon became the first states to license acupuncturists (<http://www.aaaomonline.org/default.asp?pagenumber=12#GenInfo>). By 2008, 44 states and the District of Columbia had followed their example, (<http://acupuncture.com/statelaws/statelaw.htm>), making the practice "the most rapidly accepted form of alternative/complementary medicine in the United States during the past 25 years" (Mitchell 2002:375).

Even so, the regulatory landscape of complementary and alternative medicine in the United States, including acupuncture and Oriental medicine, is complex, and the present situation of acceptance was a hard-fought victory. Legal and regulatory policies concerning “alternative” medicine were, until the twentieth century, shaped by “sectarian rivalries” between the “regular” medical establishment and its competition (Cohen 2002:3). It was not until the late twentieth century that US courts “affirmed the rights of CAM providers to practice and patients’ rights to make autonomous therapeutic choices outside Biomedicine” (Cohen 2002:3). In the US today, each state is responsible for regulating health care, including regulation and licensure of CAM practitioners and their scope of practice. Such regulations can vary dramatically from state to state, and are constantly in flux, as “regulatory goals adjust to meet the changing social consciousness” (Cohen 2002:6).

There are, at present, three key national organizations in this dynamic landscape, “established to set standards of practice and regulate the field of acupuncture” (Hui et al. 2002:348). The first, the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM), was established in 1982 by educators and professionals as “a voluntary membership association of accredited and candidate acupuncture and Oriental medicine colleges” (Mitchell 2002:378). According to Mitchell (2002:378-379), the CCAOM

Develops academic and clinical guidelines and core curriculum requirements; provides programs in faculty and administrative development; supports research, translation, and other academic work in Oriental medicine; provides guidance in institutional development for member colleges; and supports member and non-member colleges in their work towards accreditation.

To become members, colleges must meet the fourteen requirements of the ACAOM, discussed below. In 2008, fifty-three colleges were members of the CCAOM (<http://www.ccaom.org/MembersByState.asp>).

The second national organization, the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM), was established by the CCAOM in 1982 as a private, not-for-profit national organization responsible for accrediting schools of AOM. The ACAOM is recognized by the Department of Education and the Council on Higher Education Accreditation (Mitchell 2002:377). It accredits both Master’s level programs and the more recently approved Doctoral level program in acupuncture and Oriental medicine (www.acaom.org). Schools applying for accreditation must satisfy fourteen “essential requirements” that set standards regarding (1) educational purpose, (2) legal organization, (3) governance, (4) administration, (5) records, (6) admissions, (7) evaluations processes, (8) program of study, (9) faculty, (10) student services, (11) library and learning resources, (12) physical facilities and equipment, (13) financial resources, (14) publication and advertising (Mitchell 2002:377). In 2008, over fifty schools were accredited (<http://www.acaom.org/accprgs.asp>) while several were in “candidacy status” (<http://www.acaom.org/Candidateprgs.asp>).

Lastly, acupuncturists are certified nationally through the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), which was also established in 1982. Certification requires passing a written examination on acupuncture, Oriental medical theory, clean needle technique, point location (Mitchell 2002:379), and, more recently, Biomedicine. Students wishing to become certified in Chinese herbology must also pass an examination on Chinese herbs. The importance of achieving accreditation has become considerably more pronounced: as of July 1, 1999, students must be graduates of accredited schools in order to write the NCCAOM exams (Hui et al. 2002:349), which allows “state regulators to use national standards and avoid the high cost of local examination development and administration” (2002:379). As of 2002, only California, Louisiana, and Nevada failed to recognize NCCAOM certification, but certification is far from uniform across the United States. Mitchell points out that “states use the NCCAOM in different ways. Some grant licensure based solely on NCCAOM certification through examination or Credentials Documentation review (grand parenting)” (Mitchell 2002:379). The NCCAOM may also be used by some states in addition to their own requirements.

As noted by Cohen (2002), at the state level, the regulatory situation concerning AOM becomes considerably more complex. The same flexibility that the profession has adopted concerning “local legislative philosophies and needs...has resulted in a wide variation in the scopes of practice, titles of practitioners, governing structures, required interface with other health care practitioners, and so on” (Mitchell 2002:380). Hui et al. (2002:348) point out, “although efforts are underway to standardize the field of acupuncture, regulations vary from stringent to nonexistent.” Acupuncturists in most states are licensed or registered as independent practitioners, meaning that they can practice independently of a physician’s referral or supervision, although almost one third of states do require “some form of allopathic medical intervention or oversight” (Mitchell 2002:381). Scope of practice also varies considerably from state to state, with all states including insertion of acupuncture needles in their statutory definition of acupuncture (Mitchell 2002:381). No uniform licensing requirements exist to practice other forms of Chinese medicine (Hui et al. 2002:348). Many states include moxabustion, cupping¹¹, and various forms of stimulation, such as electrical, Oriental bodywork and Chinese herbology, but only some include Western herbology, homeopathy, and Western nutritional supplements (Mitchell 2002:381). In addition, states vary in their approach to structurally organizing acupuncturists. Depending on where they live, practitioners of AOM may find themselves regulated under independent boards of AOM, or the Board of Medical Examiners, or the Department of Health, Licensing, Professional Regulation, or Education (Mitchell 2002:381). An acupuncturist may be a primary care provider if they happen to live in California, Florida or New Mexico; in eight states including Alabama, Kansas, Mississippi, Oklahoma and Wyoming, acupuncturists are not licensed. Again, depending on where they reside, an acupuncturist may enjoy the title *Doctor*, while a practitioner in Florida will be called *Acupuncture Physician* (Mitchell 2002:381).

¹¹ See Glossary Pp. 278

Turning to the schools of AOM themselves, one finds anything but uniformity: while they must teach traditional Chinese medicine theory in order to meet the NCCAOM requirements, a diversity of Asian and European approaches to the practice of acupuncture are represented across the United States, including Korean, Japanese, French, and Five Elements. A perusal of the CCAOM internet site (<http://www.ccaom.org/members.asp?sort=state>) illustrates the flourishing of tremendous local variation within a movement toward national standardization. Stated Dr. Jacob Silman, the Associate Dean for Clinical Education in the School of Acupuncture and Oriental Medicine:

The only reason why we still hew so strongly to TCM is *primarily* because so many of our teachers...are from the People's Republic [of China]. But on the East Coast, which is closer to Europe, there are a half a dozen schools that have a strong European influence...acupuncture and Oriental Medicine at Emeritus -- is not the same thing as acupuncture and Oriental Medicine in the United States. That's a very *broad* thing. That's a highly *varied* thing. And I've been in China twice now, and it all looks very different than it is in China.

Schools of CAM in the 21st century: Reviving pluralism

As previously noted, prior to the nineteenth century a great many systems of medicine flourished in the United States. Some of these, such as homeopathy, eclecticism, and osteopathy had established schools which offered relatively short programs of education (Riska 2001:37). But the same forces that led to the gradual reduction of this diversity also resulted in the elimination of schools of irregular medicine. Highly influential in this process was the Flexner Report: a survey of medical schools commissioned by the Carnegie Foundation for the Advancement of Teaching, but initiated by the American Medical Association, which was published in 1910 (Starr 1982:118). In addition to schools of regular medicine, Flexner (along with the secretary of the AMA's Council on Medical Education) also surveyed homeopathic, eclectic, physio-medical, and osteopathic schools, finding "none truly adequate and most sorely lacking" (Whorton 2002:227). Biomedically-based examinations and curricula eventually resulted by the end of the 19th century in the "convergence in practice and education of heterodox practitioners...and the evolution of American medicine from pluralistic to dominative" (Baer 2001:38-39).

Exemplary is the case of Washington State before and after the signing of a "basic science act" in 1927, which required "applicants for a license in any field of practice to pass an examination in anatomy, physiology, pathology, and other areas of science fundamental to understanding health and disease before taking the licensing test in their special system of therapy" (Whorton 2002:231). Prior to this act,

There had actually been more chiropractors licensed than MDs (forty-seven allopaths, forty-eight chiropractors, forty-four sanipractors, and thirty-eight osteopaths). In the two years following the act, the numbers were eighty doctors of medicine, six osteopaths, one chiropractor and no drugless healers (Whorton 2002:231-232).

The emerging biomedical monopoly was upheld by the state, which both directly and indirectly restricted medical practice by outlawing alternatives as well as withholding funding for education and research, and excluding alternative services from insurance schemes (Cant and Sharma 1999:128). Only schools which adhered to the germ theory of disease and which based education upon laboratory research received government support and private funding from philanthropic foundations such as the Rockefeller and Carnegie Foundations (Baer 2001:34-35, Goldstein and Donaldson 1979).

Not all schools of irregular medicine were swallowed up. After a period of upheaval, the professions of osteopathy and chiropractic overhauled their educational programs; adopting rules that required incoming students to have two years of college pre-requisites, expanding facilities, lengthening their curricula from one to four years and employing basic science instructors (Whorton 2002:232-233). Such changes eventually enabled osteopathy and chiropractic to achieve the US Office of Education's approval to have their colleges accredited, as well as eligibility for federal funding (Whorton 2002:234). It was not, however, smooth sailing from that moment on, as the case of osteopathic medicine demonstrates. Pressure from the American Medical Association was considerable, including a section in its code of medical ethics which prohibited regular doctors from associating with osteopaths (Whorton 2002:236). The sound medical training exhibited by osteopathic doctors and their closer alignment with an acceptable allopathic model of medicine eventually resulted in the repeal of this section in 1961, the same year that the California Medical Association offered to magically transform Doctors of Osteopathy granted by the Los Angeles osteopathic school to Doctors of Medicine if the school allowed itself to be converted into an allopathic institution (Whorton 2002:237). Hoping for greater prestige, income, referrals, and insurance payments, over two thousand California osteopaths (as well as the Los Angeles school and over sixty osteopathic hospitals) made the conversion, to the viscous denigration of those who did not (Whorton 2002:237). Warned Northrup (Whorton 2002:238) in the *Journal of American Osteopathic Association* (1961), "if other DOs were to follow their adulterous example, the whole profession would shortly be recognized and 'accepted and approved into oblivion'."

In recent years, the state-upheld medical monopoly enjoyed by physicians has been gradually eroded. Consumer demands for "alternatives," forceful lobbying by CAM practitioners, and state interests in employing CAM for cost-containment, have combined to bring about tremendous change in the North American medical marketplace. A milestone in the battle by complementary medicine practitioners to practice in the United States was the establishment, in 1992, of a National Center for Complementary and Alternative Medicine (NCCAM) under the auspices of the National Institutes for Health (NIH). This provided CAM with much needed federal, state and consumer support; the

latter due to the initiative's aim of "increasing consumer access to CAM" (Cohen 2002:3). In 2001, the NIH allotted eighty-nine million dollars toward researching "the most promising" alternative therapies (Whorton 2002:295). And in the Canadian province of Ontario, the Regulated Health Professions Act was passed in the 1990s in order to "open the door to new health occupations and go beyond the monopolistic framework which had previously governed the self-regulated health professions" (Kelner et al. 2004:918). The boom in CAM professional organizations, including those concerned with AOM, scientific research and publications, and government funding has to some extent resulted in the "mainstreaming" of CAM.

Paralleling these developments has been the proliferation of schools of complementary and alternative medicine as practitioners seek professional status based on the reservation and transmission of a "specialized body of knowledge" (Barnes 2003:272). Professional schooling conveys status, legitimacy, identity, and authority (Freidson 2001:84), and confers the all-important credential, which attests to the qualifications of the practitioner (Eisenberg et al. 2002:965). Indeed, the completion of a period of lengthy training in order to attain esoteric knowledge has been described by Saks (2000:223) and Freidson (2001:83) as one of the key characteristics of a profession. The fact that all three of the National organizations concerned with regulating AOM in the United States (CCAOM, ACAOM, NCCAOM) are concerned with education emphasizes the connections between professionalization and formalized training noted by many scholars (see for example Freidson 1986 and 2001, Last 1990, and Saks 2000).

Integration at Emeritus University: Bridging the medicines of East and West

The growth and transformation of Emeritus University mirrors, on a small scale, the rise of complementary and alternative medicine itself in the United States. Founded in 1978, Emeritus was originally a college of naturopathic medicine. Ten years later, the Master of Science in Acupuncture (MSA) and Master of Science in Acupuncture and Oriental Medicine (MSAOM) programs were established by several Chinese practitioners, who are still core AOM faculty. Over time, other programs were added including Nutrition, Herbal Sciences, Health Psychology, and Exercise Science and, in 1994, the name was changed to Emeritus *University*, to indicate its identity as a multidisciplinary institution. The location changed as well: from humble beginnings in a small downtown building, the school relocated to a five story educational institution complete with student residences, auditorium, library, and cafeteria on a beautiful 51 acre campus set within the boundaries of Samaritan State Park. Not only has the size of the building increased: the number of students enrolled in the AOM program saw a jump from 2 officially registered students in 1989, to 213 in 2006.

Since its inception, Emeritus University has emphasized integrated medicine as strength of its programs and its identity as, according to one of its founders, "a science-based school of natural medicine." The very first catalogue, published in 1978, when the

university was still a college of naturopathic medicine and long before there was a program of AOM, noted in its introduction:

The curriculum is designed to provide the student with a thorough scientific understanding of the structure, function, and diseases of the human body, while maintaining an appreciation of each patient as a unique human being in his / her chosen environment. The student will be well prepared for future advances in scientific research and medicine. The integrated approach to the curriculum presented here was chosen to assist the student in assimilating the enormous quantity and diversity of information needed to be a competent naturopathic physician...the objective of the school is to train students to become humanistically oriented family physicians, using natural therapies harmoniously with nature's healing forces. Students are trained to recognize those cases in which other modes of therapy are in the best interest of the patient, and to make referrals to colleagues in the allied health professions.

Over the course of my research, I amassed a substantial pile of promotional materials emphasizing the integration of "modern science" with "traditional Chinese medicine." The material I gathered included the admissions package mailed to prospective students, the orientation package distributed to registered students, information brochures available at the Emeritus Center for Natural Health, and sundry promotional brochures gathered at various Open House and conference or seminar related venues. Taken together with the university's website, this material demonstrated that the face that Emeritus University wished to show to the world was clearly both Eastern and Western. Noted the Introduction to the Undergraduate Program brochure: "The integration of modern science and traditional healing methods underlies the entire curriculum," and the AOM program was described as one which "integrates the rich history of Chinese acupuncture methods with the study of modern medical sciences and the contemporary practice of acupuncture and Oriental medicine." Oriental medicine itself was presented in a way which clearly emphasized integration, as "a discipline that bridges the medicine of East and West." Further, the School of AOM graduate / undergraduate informational brochure touted Emeritus University as "the leading university for natural medicine in the United States, where a multi-disciplinary curriculum integrates the knowledge of modern science with the wisdom of ancient healing methods and traditional cultures from around the world." Students were promised "Rigorous professional training in Oriental medicine with a strong foundation in Western science."

Integration was also stressed during orientation. As mentioned, a "round table discussion covering all natural health modalities" was held during the second day of orientation, which presented the views of Emeritus University department heads concerning the treatment of diabetes. The auditorium was packed with students from different programs, eagerly listening as the seven experts discussed the ways in which they, as acupuncturists, nutritional counselors, or naturopaths, would approach the

condition and how their treatments and suggestions could be integrated. Questions from students in the audience concerning the need for “support that transcends [individual] disciplines and support for team approach to care” clearly indicated their interest in the concept of integrated medical practice.

Later occasions were also used by the university administration to stress the importance of integration. During the February Open House, the President of Emeritus University discussed Emeritus’s evolution as a school of integrated medicine and emphasized collaboration with Western medicine in order to avoid making “too big an enemy of the system out there.” In his introduction to the AOM program, Dr. Jacob Silman, Associate Dean for Clinical Education in the School of AOM, emphasized opportunities for students to experience integration and collaboration with other practitioners and modalities during their clinic shifts at Emeritus. He told prospective students, “The mixing of medical cultures here is a strength of Emeritus.” Emeritus had made great efforts to build connections with both a local medical and nursing school and allopathic practitioners nationwide, through the provision of input into CAM courses (Sierpina 2003 in Baer 2004:100). In addition, “CAM camp,” a month-long Emeritus initiative designed to teach allopathic medical students about complementary medicine, has been running since 2002. During the program, students from medical schools across the United States are exposed to a range of topics, including acupuncture and Oriental medicine, naturopathic medicine, whole foods nutrition, naturopathic midwifery, Ayurvedic medicine, meditation, homeopathy, herbal medicine, spiritual care, yoga, and Qi Gong. The Dean of the School of AOM’s speech at the graduation ceremony in December, entitled, “What is integrated medicine, and are we there yet?” was also illustrative of the university’s emphasis on integration.

Alignment with an allopathic model of clinical education was also evident during my research. During my first meeting with the dean of the program, I was informed that there was not just one, but three physicians in the AOM program, clearly a matter of pride and prestige. The university’s teaching clinic, the Emeritus Center for Natural Health (or “the Clinic,” as it was commonly known), was modeled upon allopathic institutions of medical education. Besides the fact that needles, hollow globe-like balls used for cupping, and the fragrant sticks of moxa burned during moxabustion were being utilized in the AOM wing of the Clinic, a patient might have been forgiven for thinking they had stumbled into an allopathic medical clinic; where students and supervisors wore the white coat uniform of a doctor, and treatment rooms bore a striking resemblance to the tidy, sterile rooms in which any physician might examine their patient.

The Emeritus Center for Natural Health exposed students to an integrated model of medicine and the need to cooperate with practitioners of other modalities. Certain shifts, such as the Immune Wellness Clinic, were designed specifically to promote an integrated approach to treatment. The importance of a strong foundation in Western medicine was made clear in the Clinic, where patients would often bring their medical charts and diagnoses to their AOM practitioner. It struck me during my first quarter in the Clinic that students and supervisors of AOM were working under the watchful eye of an Absent Physician, whose presence was keenly felt and whose treatments, diagnoses, and prescriptions must be navigated by the students and practitioners of AOM.

Allopathic drugs, diagnoses, and treatments formed a backdrop to many, if not most, TCM interactions I observed, although some supervisors put more emphasis on the Western medical diagnoses than others. In many cases, patients were seeing several practitioners of medicine: chiropractors, physical therapists, and naturopaths in addition to their allopathic physician. Part of becoming a practitioner of AOM involved navigating these multiple modalities, and learning how to collaborate with other practitioners, particularly allopathic physicians, whom they may never meet. Emeritus University placed great emphasis upon teaching precisely this skill. The Undergraduate Programs brochure for 2005-2006 reads:

Modern acupuncture and Oriental medicine professionals are increasingly called upon to practice alongside conventional Western medical practitioners. Emeritus University's acupuncture programs train graduates who are prepared for these new opportunities. They are qualified for licensure as acupuncture practitioners and trained in safe and effective care of their patients, whether working independently or in collaboration with other health care professionals in an integrative medical setting.

Similarly, the glossy, full-size School of Acupuncture and Oriental Medicine brochure states:

The future of health care lies in integrated medicine. An exceptional Emeritus faculty will fortify you with rigorous didactic and clinical training, emphasizing an interface with Western health care disciplines. You will graduate as a highly qualified practitioner, trained in safe and effective care of your patients and equipped with in-depth knowledge and skill in traditional Chinese medicine methods and modalities. And as a twenty-first century professional in the Oriental medicine field you will be ready to practice alongside conventional Western medical practitioners. Emeritus University's programs are committed to training graduates who are prepared for this changing environment and who are respected among their health care peers, dedicated to service in their communities and leadership in their profession, and equipped for life-long learning.

Under a section in the same brochure entitled "Your career in acupuncture and Oriental medicine," students were assured that:

The acupuncture field has expanded dramatically over the last ten years. Emeritus graduates now have the choice of independent practices or collaborative clinics where insurance is often accepted and acupuncturists work side by side with other health practitioners. Nationwide, a number of hospitals have integrated acupuncture, and more government programs include acupuncture at the state and local levels.

Throughout the first year, faculty (both from the Department of Basic Sciences and the School of AOM) expressed support for the concept of integrated medicine and the value of collaboration, both of which were nothing new to the Chinese faculty, who had studied at medical schools with departments of Western medicine and Chinese medicine including herbs, acupuncture, and Tui Na. Faculty members often recounted their own experiences of working with allopathic doctors in the United States. Noted Dr. Jacob Silman:

The profession's changing in amazing ways. When I was first in practice, many medical providers were actually hostile to acupuncture and acupuncturists. That's not true anymore, and I've seen cases where collaboration's at a high level.

Like the students of chiropractic studied by Kelner et al. (1980), students of acupuncture and Oriental medicine were inculcated by their faculty with the value of collaboration, team work, and mutual support throughout the first year of their studies, which encourages "positive attitudes toward working on a co-operative basis with other health practitioners." Writes Kelner et al. (1980:80):

They accept their teacher's view that "chiropractic is one slice of the healing arts pie," and "a necessary part, but only one part, of the health professions." They look forward to eventual integration into health care teams, and report that when established in practice, they expect to refer at least one third of their patients to physicians. They also hope to work with other health practitioners such as dentists, podiatrists, physiotherapists and social workers.

In summary, acupuncture and Oriental medicine has undergone significant transformation since its introduction to the United States through Jesuit missionaries returned from China. From a faddish and exotic novelty to a marginal "alternative," condemned by practitioners of conventional medicine, it has become a popular complement to Western medicine, its practitioners licensed and its procedures regulated in nearly all states; its students taught at nationally accredited schools such as Emeritus University. Promotional material, the structural organization of clinic shifts, and the endorsements of faculty and administrators reveal that great emphasis is placed upon integration with Western medicine and collaboration with its practitioners, through the presentation of a program which straddles both East and West. In the following chapter, I explore the backgrounds and motivations of first year students for pursuing education in acupuncture and Oriental medicine at Emeritus University.

Chapter 3

Coming full-circle, wanting to help: The decision to study complementary and alternative medicine

There was something about Emeritus University that reminded me of an airport; a place in-between where its students had been and where they were going; a stop-over on a journey began, for many, years earlier. For a few, enrollment represented the realization of a dream whose origins were shrouded in the misty recollections of childhood. For others, it was the *Eureka!* moment that proceeded years of searching for a way to combine their interests and satisfy long-standing altruistic goals. In this chapter, I explore the reasons given by students for pursuing a career in medicine and, secondly, their motivations for studying a less conventional medical modality.

Much has changed since the 1950's and 60's when sociologists presented the typical medical school student as young, white, Protestant, provincial, and male (Becker et al. 1961, Merton et al. 1957). In the twenty-first century, students of acupuncture and Oriental medicine have a good deal in common with their allopathic counterparts, who are increasingly older, of diverse ethnic backgrounds, and female (Beagan 2001, Dickstein 1996:5, Sinclair 1997:75). In 2006, of the 41 first year students enrolled in the AOM program at Emeritus University, 25 were women (61%). While many Emeritus AOM students were in their thirties and forties, according to Emeritus University's records, between fall 1997 and fall 2007, the median age of first year MSAOM / MSA students has decreased from 35 to 26. Students, administrators, and faculty alike recognized a trend toward enrollment of younger students and suggested that AOM's increasing legitimacy and mainstream acceptance was partly responsible for the changing demographic. In addition, according to my estimates of the first year class, approximately 15% were Asian. Several were married, many were in long-term relationships, and a few were parents. Many had traveled to Emeritus University from all over the United States: from The Eastern states of New York and Ohio to the Midwestern states of Colorado, Utah, and Arkansas.

As they gathered for the welcoming ceremony in late September, I wondered "*why are they here?*" This same question has been asked, in various forms, by sociologists and anthropologists for decades. In 1957, Rogoff wrote:

One of the more enduring questions in the sociology of occupations and professions concerns the processes by which persons select a career. When social norms allow relative freedom to choose any occupation, it is a matter of some cogency to discern the prevailing patterns of choice, for these will illuminate questions of occupational recruitment, of social opportunity and mobility, and, more generally, of the relation of the occupational sphere to other parts of the social system (e.g. education, the family, the status order) (1957:109).

While Emeritus University is an institution of medical education quite unlike its allopathic counterparts in terms of its historical development and programs, I make frequent comparisons between allopathic and complementary medical education throughout this thesis. This is because the increasingly heavy emphasis placed upon Western medical science and research in the curricula of CAM programs, as part of the project of professionalization, suggests the existence of similarities between the educational experiences of allopathic and CAM students. Indeed, a comprehensive study of Canadian naturopathic students and practitioners conducted by Boon (1996a) led her to note that “naturopathic college socialization was far more similar to medical school than has previously been assumed” (Boon 1996a:45).

Like the naturopathic students studied by Boon (1996a), and the allopathic medical students studied by Sinclair (1997), students of acupuncture and Oriental medicine expressed “widely diverse personal reasons for doing medicine” (1997:79). These included long-standing interests in medicine, health, and healing; and altruistic motivations. Unlike their counterparts in allopathic medical schools, a combination of factors, including negative experiences with allopathic medicine, positive experiences with CAM, and criticisms of the philosophical, moral, and practical underpinnings of Western medicine, had influenced first year students of AOM to pursue training in a very different medical modality.

“I was born to do this”: Long-standing interests in medicine and altruistic motivations

Sinclair notes that applicants tended to answer the question of why they wished to enter allopathic medical school by stating that they had “always wanted to do medicine” (1997:92). The occurrence of what Rogoff (1957:119-120) terms “youthful deciders” is not limited to allopathic medicine. Many students of AOM expressed a long-standing interest in the practice of complementary medicine or in a less focused notion of becoming a “healer.” Said David: “It’s always been a compassionate urge for me. I can’t *stand* to see people suffer. I just can’t stand it. And I think -- I really, truly think I was born to do this.”

Grace, too, expressed a long-standing interest in herbs and what she described as “energy medicine,” which began for her in the second grade. She told me:

[w]hen I was little -- like six or seven years old -- I *loved* working with herbs...not because any of my family does it or anything. It was just something I did. Like with flowers, I would take them and put them in water. And the smell of them -- I would make all kinds of concoctions to test on my siblings.

Although their recollections were less clear, several other students expressed the conviction that they had “always” been interested in medicine and healing. Explained Caitlin: “I have always had an interest in medicine in general. In going through high school and getting into college, the first few years of college, I knew that I wanted to do something with medicine but I wasn’t 100 percent sure what that was.” Helen, too, said “I was always inclined to learn more about [natural medicine].” According to Boon’s study (1996a:131-132), such certainty was also common among naturopathic practitioners and students, who described it in terms of a “calling.” Stated Laurel:

I’ve been told in language of healers that I’m an Indigo Child...It’s like a group of people that are lost, but that were put here for a certain reason, to be able to conceptualize things in that way, to be able to draw together the world and make change happen.

Laurel’s enrollment at Emeritus University represented the culmination of a life-long search for a practice that would resonate with her values and world view, and the sense of a greater purpose that revolved around increasing “accessibility to resources” and confronting inequality.

Several students of AOM spoke of special empathetic, psychic, and healing abilities that had, from an early age, shaped their decision to pursue medical training. David spoke of an ability to “reduce cold sores by touch,” and not only could Evan see the “auras” of people, but he claimed to possess “a very strong sixth sense,” or a “psychic twinkling” as well as an ability to “feel the emotions of other people”; skills that would, he believed, “really help me in this area of work.”

Several students of AOM had pursued their early interests in medicine and healing, and had trained or worked as practitioners of a variety of therapies. Caitlin had trained as a midwife, Helen and Claire had worked as massage practitioners, and Elaine was a nurse. Other students had studied or worked in health or science-related fields. Both Helen and Evan held Bachelor’s degrees in psychology, and Helen had been employed as a researcher at a children’s hospital. Richard had obtained a Master’s degree in clinical and counseling psychology and completed his internship in a rehabilitative hospital. His experience in health care also extended to nutrition and lifestyle counseling, biofeedback, as well as exercise and fitness consultation work. Many students traced their interest in AOM back to more general interests in health, nutrition, and fitness, a fact also noted by Boon in her study of naturopathic practitioners and students (1996a:69). For several male students, including Alex, Evan, and Josh, martial arts had been their gateway to snippets of Chinese medical philosophy (such as holism, yin, and yang) and some of its techniques, like acupressure.

For many students with previous experience in health care, acupuncture and Oriental medicine represented a way to expand their knowledge and healing abilities. Although she had been working as a massage therapist for five years, Claire expressed dissatisfaction with her work and its perceived limitations:

I was getting my associate's in physical therapy. Then I just felt like that was still sticking with the massage and it wasn't enough. I wanted to treat everything, not just specific ailments, so -- just too limiting. I don't like that feeling...There's so much, just psychologically going on that affects the physiology of the body, and if you don't correct that, then I don't see how just manipulating physically is going to help them, which is another reason I wanted to branch out of massage.

Richard, too, viewed acupuncture and Oriental medicine as another tool to add to his previously achieved skills in counseling and physical therapy:

Chronic pain people have a lot of bound up stuff and it's like...they're really disconnected from their heart and their brain, energetically. So when I came over and was here looking at the place and I started looking at the energetic medicine and reading about acupuncture, I thought -- well, that would certainly help maybe make that connection a little bit better. So that's kind of like the piece in between.

Like Richard, acupuncture seemed to provide David with an answer to a long-standing question of how to effect healing and expand his knowledge and abilities. Although not formally trained as a practitioner of CAM, David had "dabbled" extensively in the field, but became frustrated with the lack of physical effects of his work: "I would try to heal people," he told me, but the effects were temporary. The answer, he had come to realize through his studies of Qi Gong at Emeritus, lay in being able to "condense" the subtle spiritual energies "into a more physical form to actually effect physical change."

Not all students expressed long-standing interest in complementary medicine. Joe had never considered the field until his father, who worked as an engineer at a hospital, became interested in herbs and began seeing a chiropractor. Neither did Joe possess any knowledge of Eastern philosophies or practices, and seemed to have a somewhat skeptical attitude toward them:

I have a problem sleeping...People have always said, "Try meditation." I'm just like, [sarcastic tone] "Yeah, I'll try that." Never meditated a day in my life. And I don't even know how I would go about that. It's just a totally new concept for me. They'll be like, "Oh, well you should try breathing exercises when you're laying in bed." Breathing exercises? What the hell? You know?

Rogoff's study of allopathic medical students led her to comment that "an early decision does not always represent a 'speedy' decision" (1957:124). Many students of AOM had traveled a circuitous route dotted with unsatisfying careers and shadowed by doubt and a sense of being "stuck." Despite David's long-standing dream of being a

healer, he spent many years working “menial jobs” and searching for a way to make his dreams a reality. “Professionally [I] didn’t advance much,” he told me:

It’s taken me quite a bit of time to come back to the point where I realized I need to develop myself, I need to get into the field I want to be in. You know, it was -- straight out of high school was mostly survival...So I spent quite a bit of time finding myself, figuring things out...So I’ve come full circle now.

A re-assessment of his life and goals was triggered by the end of a relationship.

I just kind of looked at my life and said, “What the hell am I doing? I mean, this is stupid. This is *not* what I want to be doing for the next 20 years. It’s okay now, but my heart isn’t in it, and I’ve always wanted to be a healer.” But to do that, had to get an education, of course. Couldn’t do it and realized, “You know, I could do that now.” So here I am.

Evan’s story of how his direction changed from majoring in music to psychology is also exemplary. He explained:

Originally the reason I became a music major in undergraduate is because I had no clue what I wanted to do with my life. I was supposed to -- when I was seventeen they said, “You’re supposed to know what you want to do for the rest of your life.” And I said, “Well, that’s *bullshit!*...It’s b.s. because there’s no way at that time in my life I was developed enough and comfortable enough with myself and other people to decide what I was going to do with my life. It was a ridiculous idea. But I loved music. I played trumpet.

Evan considered teaching music, but decided that he wanted to “to actively, hands-on, help someone.” This desire to help people combined with long-standing interests in mind-body-spirit interactions led Evan to change his major from music to psychology, which, due to its reliance on pharmaceutical interventions, left him disillusioned and drifting between menial jobs. Evan spent some time living in the country with friends, which, he explained, “gave me a good time to really settle and think about what I wanted to do.” An internet search eventually led him to the website for Emeritus University and the discovery that: “Wow, this is what I want to do. This is a way I can help people hands-on.”

For many students, acupuncture and Oriental medicine presented itself as an epiphany which they described in terms of everything “clicking” or coming together. This experience is so common among students of AOM that the Admissions Officer described it in detail during our first meeting. “Maybe,” she told me, “they have had

previous experience with acupuncture,” but with or without such experience, many of the students with whom she had spoken during her years in Admissions seem to have woken up one morning knowing that, in her words, “I want to be an acupuncturist!” The prevalence of the “epiphany experience” has been confirmed by other researchers of complementary medicine and education, including White and Skipper (Wild 1978:39) who note that “belief in the value of chiropractic was analogous to a religious conversion.” (1971:303). Boon’s “converters” to naturopathic medicine went through “a dramatic conversion experience” (1996a:46). Such was the case for Josh. Although an interest in sociology led him to pursue a degree in social work, like Evan he soon became dissatisfied with the lack of “hands on” experience. Like David, Josh experienced great frustration and uncertainty regarding his life path, and a pressure to make a decision which only increased. He said: “We get going into 2006 and I’m just not doing it. I’m stuck, totally stuck.” The answer finally came, in a round-about fashion, through his involvement in martial arts, when an internet search concerning pressure points led him to acupuncture and something of an epiphany:

All of a sudden it clicked and the wheels started turning. It was the moment I had been waiting for, for something to just go, *click!* And I literally went, “That’s it. That’s it!”

Other students saw enrollment at Emeritus as a return to their original interests and intentions. Although Rosalyn had been interested in health care for many years, disillusionment with Western medicine led her to careers in law, community development, and journalism. Now, many years later, she saw her decision to study AOM in terms of coming “full circle of wanting to go into some healing practice when I was in college, that I had put aside for personal reasons.”

Acupuncture and Oriental medicine represented a dramatic career change for several first year students at Emeritus University. While Sinclair’s study of allopathic medical students in the U.K. led him to note that the majority entered medical school straight out of college, research into the socialization of CAM students suggests that many are older and have a good deal of career experience already under their belts. Chiropractic was a second career for most students studied by Wild (1978), and Boon found that among students of naturopathy, “a significant proportion of each class...were mature students. Their previous careers included law, business, medicine (foreign graduates), nursing, pharmacy, and other health-related careers” (1996a:138). AOM was a second career for several first year students at Emeritus University. Kimberly, Claire, Helen, Caitlin, and Richard had all worked, or had received training, as health care practitioners. Amy was a medical technologist and worked in a laboratory and pharmacy. Jana was a successful Human Resources manager. Rachelle worked in health research. Paul had been an engineer for an aviation company. Carol had worked in plastics design. As Haas and Shaffir (1987:25) note, “career-switchers” are also to be found among allopathic students. They write: “Always the explanation for the change hinges on the expression of lack of personal fulfillment and a desire to contribute more to society at

large.” Indeed, without fail, the most commonly expressed motivations for pursuing education in AOM were altruistic.

Kimberly’s story of how she came to Emeritus is exemplary of the ways in which her desire to be of service to others led her to forgo further training in dentistry for a career as an acupuncturist. Elements of her account echo Josh’s, in particular her dissatisfaction with her job, and her feeling of being “stuck.” While she greatly enjoyed working as a dental assistant, a change in staff led her to the conclusion that “Now’s the time to make a change.” Kimberly quit her job and worked at a camp for disabled people for a summer, then traveled around Europe for a couple of months, before joining AmeriCorps¹². For a year, Kimberly traveled around the Southeastern US providing “manpower” for non-profit organizations. As with Josh, AOM eventually presented itself as an answer to a long-standing question of how to combine her “love of travel, medicine and patient care” with the communication skills she had gained through AmeriCorps. The goal of helping people retained its primacy: “I want to feel good at the end of the day,” she told me, “feel like I did something that meant something to someone.” She considered Doctors Without Borders “and things like that,” then decided to go to dental hygiene school. But, in her words, “After a while I was like, ‘You know, is that really what I want to do?...So I started looking around.’” Kimberly decided to explore other types of medical practice by shadowing practitioners, including a dermatologist and a chiropractor. During the last quarter of her pre-requisite studies, before dental hygiene school, she found herself asking “What am I going to do? What am I going to do?” The timely arrivals of a recruitment team from Emeritus University prompted Kimberly to pursue a career in AOM.

David, too, expressed altruistic motivations for studying AOM:

I guess I have a little bit of a save-the-world complex but -- I said I want to alleviate suffering wherever I found it, and I meant it. I know I can’t always succeed. I know that. But I want to at least try.

Said Caitlin: “That’s the biggest reason I’m here and doing it-- I’m here for the healing aspects and I’m here to help people.” Noted Grace: “I like taking care of people. I like helping them. I like making them feel secure and safe...it’s like just wrapping a big hug around them.”

Although altruistic motivations were held in common by students of other CAM modalities, including chiropractic (Wild 1978), and naturopathy (Boon 1996a), they are by no means unique to students of CAM, as demonstrated by the studies of allopathic medical students conducted by Becker et al. (1961), Sinclair (1997:92), and by Haas and Shaffir (1987:25-26) who write: “Medicine is frequently described as *the* career that most perfectly combines the opportunities for personal satisfaction and, more importantly, personal service.” But rather than leading the first year students in this study to

¹² Founded in 1993 by President Bill Clinton, AmeriCorps is an American network of non-profit organizations, public agencies, and faith-based organizations (<http://en.wikipedia.org/wiki/AmeriCorps>).

allopathic medical school, their altruistic motivations brought them instead to Emeritus University. This decision was the result of many factors, the most clearly articulated of which was dissatisfaction with “Western” medicine and its philosophical, practical, and moral underpinnings.

Doctors or healers: The “push” of allopathy and the “pull” of CAM

Most first year students of AOM at Emeritus University had at some point in their lives been interested in a conventional medical career. “I always wanted to be a doctor,” said Joe, “E.R. [Emergency Room, NBC dramatic television series] was my favorite show. I watched it religiously. I just always wanted to be right there with them doing that.”

By the time I interviewed them, all such interest had vanished, to be replaced for the most part by scathing criticisms and harrowing stories of personal or familial experiences with dispassionate, money-oriented physicians and a pharmaceutical industry run amok. Their discussions of allopathic medicine and the criticisms they contain point to a “push-and-pull” phenomenon widely recognized by other researchers (Andrews et al. 2003, Andrews and Phillips 2005, Diehl et al. 1997, Hog and Hsu 2002, Siahpush 1999). Often, the decision to utilize or practice CAM is based on negative experiences with, or perspectives toward, conventional medicine or the medical system which “push” the patient or practitioner away from it, and the simultaneous “pull” of positive experiences, toward complementary and alternative medicine and its practice (Andrews 2003a, Andrews 2003b, Diehl et al. 1997). Evan’s harrowing account of botched and painful toenail surgery was exemplary of the influence a negative experience with Western medicine could wield over a student’s decision to “look at other options.” Alice had been diagnosed with arthritis when she was 14 years old, and had for years endured heavy doses of steroids, anti-depressants, and sleeping pills which rendered her “a zombie for three years” before she eventually found a practitioner of acupuncture. Within a short period, Alice was able to eliminate the drugs from her daily diet, and experienced an “amazing turnaround.” Still, allopathy and the “arrogance and ignorance” of physicians had left her deeply scarred: “How could he *do* that to a fourteen year old child?” she asked me. Not surprisingly, her vision of the future involved continued study of “ancient medicines” that were non-invasive and preventative.

David, too, spoke of negative experiences with Western medicine and positive experiences with CAM as a reason for his interest in pursuing a career in the latter. He explained that as a child, he had suffered frequent urinary urges. Despite the negative results of various tests, his doctor prescribed antibiotics for what he felt sure was a bladder infection. When antibiotics failed to relieve David’s problem, the doctor declared it psychosomatic: “It’s all in his head.” A chance visit to his mother’s chiropractor finally brought relief as well as opening David’s eyes to both the limitations of allopathic medicine and the potential of a career in complementary medical practice: “for a long time I thought I wanted to be a chiropractor,” he told me.

Claire, who had trained as a massage therapist, also discussed her attraction toward CAM in terms of negative experiences with Western medicine and positive experiences with massage. She stated:

I think with the massage it kind of opened my eyes as to the natural aspect of it, that there was other resources besides Motrin and Methocarbamol...That's actually why I went to massage school, because I was having horrible back spasms and all they did was prescribe medication. And it frustrated me because it wasn't doing anything but masking it.

The pull toward CAM exerted by a positive healing experience has been noted by Boon, who found that "health problems figured prominently in more than 50 per cent of the students' decisions to enter the naturopathic profession" (1996a:139). In her study of chiropractic students, Wild, too found that a healing experience was profoundly influential (1978:39).

Coupled with the "push" of negative experiences with allopathic medicine was the "pull" of the holistic, personalized, and empowering qualities of complementary medicine. Barrett et al. (2003:937) note that the four themes of holism, empowerment, access, and legitimacy "characterize CAM and contrast it with conventional medicine." Often allopathic and complementary medicine were construed by students as polar opposites and discussed in terms of dichotomies: for example, complementary medicine is warm and caring, allopathic medicine is cold and impersonal; Western medicine is unnatural and dangerous, CAM is natural and safe; Western medicine is disempowering, CAM is empowering; Western medical thinking is linear and reductionistic, CAM is holistic. Said Evan of his doctor's office:

They have the big, bright fluorescent lights, and the white room with the butcher paper...Like, all the doctors I ever went to, they had no personal touch. They never talked to you...It's just *cold*. There's no warmth. There's no personal energy being exchanged. All it is, is just cold, hard -- "You're number 26 and you're giving me money. Oh, here comes 27. He's giving me money, too." That's how it always felt.

A female focus group participant spoke of the empowering qualities of CAM that distinguished it from Western medicine:

It's empowering, I think, to have another language or another set of tools to be able to look at our own bodies, so that we're not just limited to things that someone told us once, or having to go see someone every time something comes up. It's like, we're in control and we can help ourselves, and we can start to think about helping other people. That feels so great.

Claire's narrative illustrates a tendency to contrast "unnatural" Western medicine with "natural" CAM:

People that get massage, I've found, really want to help themselves, and that was encouraging. Whereas there's a lot of people -- they want to turn to the drugs. They want the quick fix and -- So it was nice to know there was another demographic of people out there that actually was interested in going back to the natural way. And I feel like the shift, with the herbs and the energies -- I feel like it's going back to the nature.

In addition, Andrews et al. (2003:157) note "the greater time spent in consultations, the spiritual dimension to Chinese medicine, and its perceived safety (Verhoef et al. 1998, Vincent & Furnham 1996, Wysong 1998)" to be important "pulls" toward CAM. Write Hog and Hsu (2002:216-217):

Many patients recounted long odysseys of treatment seeking, migrating from one form of treatment to the other. The illness appeared like a voyage, the patient like a migrant, 'pushed away' from biomedical care due to disillusionment and its perceived ineffectiveness for treating the condition from which he or she suffered, and/or due to the requirements of unacceptable drug intake or surgical procedures, or due to exorbitant costs. Some were 'pulled towards' the alternative medicine out of curiosity, or because they wanted to live in accordance with a particular perception of personhood, a 'holistic' lifestyle, or because they were in search of an emotionally more rewarding 'lost' world, or due to financial constraints, and, in many cases, also because of the perceived effectiveness of alternative treatment.

Certain similarities emerged from students' criticisms of Western medicine. In particular, the side-effects of treatment, a perceived tendency to over-prescribe drugs, the lack of good bedside manner, and the methodological and philosophical limitations of Western medicine were discussed. Kimberly's experiences as a dental assistant had made her highly critical of the way in which drugs were prescribed to dental patients:

People come in to the dentist and, in fact, before they even *get* into our office they'd say, "I have dental pain." "Okay, we're calling in a prescription. You can go pick it up. You get antibiotics, a heavy dosage, and some narcotics." You haven't even *seen* that person. That seems wrong...I didn't like that approach, and the way that the medical system is going.

“Bedside manner” also came under fire. Josh was critical of the tendency of allopathic physicians to possess “the personality of a wet paper napkin”:

Even though some of those doctors are good, you tend not to want to go back to them. You get someone who’s great personally and knows his stuff, you’ll go back to him before you’ll go to the other guy, I would think.

By contrast, complementary medicine was constructed as a warm, personal, patient-oriented approach, and characterized by a more egalitarian relationship between the practitioner and patient. Caitlin criticized the bedside manner and tendency of allopathic doctors to present themselves as “superior beings” who treated only the symptoms of a problem, as opposed to CAM practitioners who exhibited “more of a personal take on this individual as -- you know, emotionally and spiritually as well as physically.”

Evan’s experiences with the allopathic doctor-patient relationship as one being motivated by greed, devoid of emotional investment, and unintelligible by the average patient had galvanized him to want to practice a very different kind of medicine:

If it’s able to be done, then I want people to be like, “He’s the best acupuncture practitioner I’ve ever been to.” And not only for the healing aspect but for the personal aspect. They feel like somebody actually cares about what they’re saying...if you’re just a good acupuncturist and a good businessman, that don’t mean jack if you can’t talk to somebody and let them know that you’re really listening to what they’re saying. Because they’re used to the Western medicine way. They’re used to their symptoms being treated, nobody really listening to what’s actually wrong with them, not realizing that emotional problems and mental problems *can* affect the body, different parts of the body. I want to be able to -- with all my experience and what I’m getting ready to learn -- treat people the best way possible.

In addition to perceived shortcomings of bedside manner and treatment, several students also spoke of the limitations of Western medicine’s philosophical foundation. In her 1996 study, Boon found that naturopathic practitioners and students could be divided into those with “holistic world views” and those with “scientific world views.” Those in the former camp place equal weight upon emotional, psychological, spiritual and physical aspects of health, and “emphasize the importance of maintaining a balance in all aspects of one’s life.” Illness is viewed “as the consequence of some disharmony in the cosmic order and the restoration of harmony or balance (within nature and human relationship) is the goal of all therapy” (Boon 1998:1216). Boon contrasts this holistic world view to that held by “scientific” practitioners and students, who adhere to the “scientific method,” attribute great importance to scientific investigation and objective research, and conceive of health and health care “in terms of the biomedical model which is based on the belief

that disease is the result of the malfunctioning of the biological mechanism at the cellular or molecular level and that the doctor's role is to intervene to correct the specific malfunctioning mechanism" (1998:1216).

None of the AOM students with whom I spoke described the "scientific world view" as it is characterized by Boon. Many were highly critical of the philosophy and methodology of Western medicine and Western science. They often discussed the "scientific" approach of Western medicine in negative terms. Explained Alex: I've always been turned off by that kind of cold, left-brain, linear rationale of Western science. Or I just felt that it wasn't the whole picture, and I wanted to know more, different things." In answer to my question as to why he "rejected" a career in allopathic medicine, David presented a critique of the philosophy and methodology of "Western science" as being "blinded by its own restrictions and scientific method, and by its insistence on empirical data." This does not mean that students expressed no interest in research: to the contrary, several did so and had selected Emeritus because of its emphasis on research in the newly-accredited Doctoral Program in AOM. But greater importance was accorded to the personal and unquantifiable experience of fundamental concepts – like *qi* and the invisible meridians along which it travels the body – that had to be taken on faith. Said Amy:

You can only go by feel, and it's not a solid feeling. It's like pushing -- your hands through air. You know air is there, but you can't really see it... It's like, there's no way of knowing. It's not something you can assess, really.

Explained David:

The idea of the meridian is ignored by Biomedicine experts because there *is* no meridian. You cut open the body -- you can't find it. It's not there -- except that acupuncture works...The other day we were doing -- in Meridians and Points -- a stimulatory point here on the hand, and I could *feel* something in my arm appear...Now, I have not studied that meridian. I have *no* way of knowing that stimulation here, I should feel here. I shouldn't know that. It can't be a placebo effect...I look at [the instructor], I said, "I feel something here." He says, "Yeah, that's where the meridian goes." There's *something* there. Whether Western science can define it or not -- it's not my problem. It's still there.

Andrews et al. (2003:157) has noted that users of CAM are often pulled toward it by the consistency between the philosophy of CAM and "their own personal values and philosophical orientations toward health (Astin 1998, Siahpush 1999), or because it forms part of a wider identification with an alternative ideology or subculture" (see also Fulder 1996, Kelner & Wellman 1997a, Pawluch et al. 1994). Boon's study (1996a:130) demonstrates that students and practitioners chose naturopathic medicine because "it was

consistent with their personal philosophy.” Many students of AOM had been pulled toward complementary and alternative medicine by its resonance with their holistic philosophies of health and healing. Grace had originally considered pediatrics and psychiatry, “but,” as she explained, “the more I looked at allopathic medicine, the more I realized you’re not healing the person, you’re just covering the symptom so they go away.” A belief in “healing as a whole” coupled with the fear that allopathic medicine would corrupt this belief drew her instead towards alternative medicine. While Western medicine certainly had its place as an emergency intervention, “when it comes to the healing I want to do, I want to work with the whole person. I want to work on an energetic level, on an emotional level, and on a physical level. And as a pediatrician you just can’t do it. There’s not room for it in our culture.”

For David, too, health was more than “the absence of disease”:

I think that’s just not enough. It’s just not enough. You could take a person, for instance, with a set of symptoms -- Take a man with night sweats, recurring impotence, irritability problems, insomnia -- and certainly Western science could say, “He’s suffering from stress,” but what does that mean? It doesn’t tell you anything. There’s no biological definition of stress. There’s no disease to cut out. There’s no one area to attack. What he has is a set of symptoms but no disease...Whereas in Eastern medicine, or other traditions, that person’s terribly sick, even though they don’t have a disease. So there’s a difference between “lack of disease” and “health.” And I really think that Western medicine focuses on disease care, not health care.

Richard had briefly considered allopathic medicine and, like David, his explanation for rejecting this path was interwoven with criticisms of Western medical science and its tendency toward reductionism:

They don’t deal with health. Meaning, they’re not health care practitioners. They’re medical doctors. They’re chemical doctors. They treat the symptom. They narrow it down to the smallest thing and they try to treat and affect the symptom. And they don’t really look at the repercussions backwards, what it does to the person’s overall health...That’s what I like about Chinese medicine. It’s looking at the whole of things and then treating the underlying imbalances, and -- to facilitate the body’s doing what it should be doing.

Caitlin had considered pursuing a degree as a nurse-midwife, but, as she explained,

The thing that held me back from doing that was -- as I was learning more and more about alternative methods, I kept thinking, "It'll drive me crazy to go through a Western medical nursing program...because I know too much now about spirituality and treating the whole person, rather than just symptoms and physical.

Students chose AOM not only because of its fit with their lifestyles and personal philosophies concerning health, but because of its fit with their environmental, social, and political values. As will be discussed in detail in chapter 8, it was not uncommon for students to perceive their decision to study CAM to be part of a much broader vision of health care and political change.

Visions of the future: Collaborative practice

Interestingly, despite their criticisms of allopathic medicine, many students of AOM expressed considerable interest in collaboration with allopathy and had selected Emeritus partly because of the university's emphasis upon integration. Said Alex: "I would love to work in a clinic or hospital or some integrative setting where I am -- I'm one modality, or one practitioner among many." Rosalyn, too, spoke of an interest in either working at a university or pursuing the doctoral degree through Emeritus and working in a hospital. She stated:

I don't think you can study a medical system coming from a culture without understanding the culture. But what I knew from Emeritus is that they were really trying to do a foot in each, and that's what was attracting to me. And I wasn't sure that the other school had that bridging going on. Not only in terms of, like a knowledge base, like medically Western view and Eastern view, but also in terms of staff and in terms of culture.

Said David:

My *dream* would be that you have collaboration. It's not enough to just be in the same office, so that you can cross refer. I want true collaboration. I want to be able to have -- Okay, we've got this client. Let's open up his chart. And I'm an acupuncturist/herbologist and next to me is a kinesiologist, and next to me is a naturopathic doctor, and next to me is a medical doctor, and next to me is a nutritionist, and next to me is a Chinese dietician. And we're all looking at this and trying to get to the root of the problem. You know, what can *you* do? What can *you* do? What's the *best* way to make this person better?...And really, truly form a collaborative effort.

Kimberly, too, expressed interest in “a collaborative practice with a bunch of other practitioners” in order to “be able to offer as much as I can to someone that walks in the door.”

While this desire to collaborate with the practitioners of a medicine so many had roundly condemned initially presented itself as something of a paradox, my research revealed that positive personal experiences with an integrated model of medicine had shaped several students’ visions of practice. After a car accident, Kimberly’s care had included chiropractic, massage therapy, and acupuncture services provided under one roof, an “awesome” and “well-rounded” approach to care that lead her to state: “I would like to be able to say, ‘Go to the room next door and talk with so-and-so about this,’ or ‘Go down the hall and then you can see so-and-so about that.’”

Helen’s experience working as a massage therapist alongside an acupuncturist who was heavily involved with an integrated practice had been profoundly influential in shaping her vision of future practice. She saw herself “joining a group outside of the practice” and coming together with them regularly to discuss cases and cross-refer patients.

Christopher, too, spoke of his positive experiences at an integrated clinic which housed the practices of both allopathic and Asian medical doctors: “they were in the same building...And they both accepted each other. It’s a wonderful idea,” he told me.

In summary, students of acupuncture and Oriental medicine, like their allopathic counterparts, expressed long-standing interests in, and strong altruistic motivations for, pursuing medical education. Unlike students of allopathy, however, a combination of negative experiences with Western medicine, positive experiences with CAM, and criticisms of the practical, moral, and philosophical underpinnings of Western medicine had drawn them instead to the study of acupuncture and Oriental medicine, a practice which many regarded as being holistic, personal, compassionate, and empowering.

Somewhat paradoxically, despite their scathing criticisms of Western medicine, many students of AOM expressed considerable interest in collaboration with allopathic practitioners and had selected Emeritus University because of the institution’s promotion of integration. This interest can, in part, be explained by positive personal experiences with integrated medicine. As will be discussed in chapter 5, a second explanation for students’ interests in collaborative practice relates to their concerns for acceptance, status, and legitimacy accorded by association with the dominant system of Biomedicine. As I shall discuss in the following chapter, the AOM curriculum at Emeritus University is biomedically intensive, designed to provide students with a foundation for referral and a language of communication with allopathic practitioners in order to enable collaboration and increase the acceptance of AOM.

Chapter 4

“A journey into Eastern medicine firmly grounded in the Western sciences”: The AOM curriculum at Emeritus University

Students wishing to graduate with either a Master of Science in Acupuncture (MSA) or a Master of Science in Acupuncture and Oriental Medicine (MSAOM) must complete three (or three and a half) years of rigorous and intensive study of both traditional Chinese medicine and Western basic science courses. This chapter explores the first year AOM curriculum that confronted students in 2006, as well as the changes that have occurred in the curriculum over the past decade. As will be discussed, such changes are in keeping with the university's emphasis upon integration with Western medicine through the provision of a science-based education.

The school year at Emeritus University was divided into four “quarters.” The fall quarter began on September 25 (although orientation was held the week earlier), and while final exams concluded on December 8, students were required to attend their “interim” clinic shifts at the Emeritus Center for Natural Health until December 23. The winter quarter ran from January 8 until March 31. Spring quarter began April 9 and ended on June 23, and the summer quarter commenced on July 9 and officially concluded with the closure of clinic on September 15. Not all students had the same schedules, and a good deal of flexibility was built into the curriculum, with both morning and evening sections of some courses available. Schedules also varied depending on whether students were enrolled in the MSAOM program or the MSA program. Students in the latter program did not attend classes during the summer quarter of the first year. In addition, students could choose from a variety of elective courses in order to fulfill the requirements of their degree. The following account of each quarter is based on my own schedule, which is representative of that enjoyed (or endured) by most students.

Fall Quarter:

The year began with “Meridians and Points 1,” which, according to the syllabus, provided

An introduction to the meridian system and specific acupuncture points of traditional Chinese medicine. The purpose of this course is to help the student develop a strong foundation in the areas of acupuncture anatomy, channel physiology, and begin the study of acupuncture therapeutics as it relates to anatomy and physiology...the fall quarter will cover the points and meridians in the Lung, Large Intestine, Stomach, Spleen, Heart, Small Intestine, and Du meridians.

“M&P,” or simply “Points,” as it was commonly known, was taught by Dr. James “Takoda” Mason¹³, whose eclectic style of teaching, (involving an amalgamation of Native American beliefs, Doaist philosophies, and experimental physics), was matched by the uniqueness of his wardrobe: most mornings, he would arrive resplendent in tailored silk waistcoats of gorgeous Asian designs and colors. Takoda (as he was called by students and faculty alike) was a recent graduate of the Emeritus AOM Doctoral Program who had also received his Master of Science degree from Emeritus University in 1999. After the M&P lecture, there followed a two hour laboratory section designed to reinforce classroom knowledge with hands-on experience palpating, locating, and sketching the energetic pathways, and students rushed to change into the required dress: shorts for both genders and, for women, bikini tops or sports bras. Two hours later, they would emerge with that day’s meridian of study drawn upon their bodies in colorful streaks of washable marker, and sometimes with a sticky paper dot or two (used to indicate acupuncture points) still lingering undetected at the base of the scalp, behind an ear, in the fold of an armpit, or the crevice of a knee.

Tuesday and Wednesday seemed to be the most challenging weekdays for many students, when concept-intensive courses were arrayed back-to-back in two hour blocks from early in the morning until 5 o’clock in the afternoon. Tuesday began with “TCM Fundamentals,” which, according to the syllabus, “provides an introduction to basic TCM theory,” including “Yin Yang¹⁴; Five Elements¹⁵; Qi¹⁶, Blood¹⁷, and Body fluids¹⁸; Zang Fu¹⁹; etiology and pathogenesis; prevention and treatment principles of the TCM basic theories.” Fundamentals was a two hour, twice-weekly class taught by Dr. Huilang Song,²⁰ who had received her MD and MS degrees from Shanghai University in China, an RN degree from a university in the United States, and had worked as a neurosurgical and organ transplant nurse at US medical centers. In addition to twenty five years’ of experience practicing both Chinese and Western medicine, Dr. Song had over fifteen

¹³ While Dr. Mason was not a Native American himself, he had studied for many years with “Native teachers.” The answer to a spiritual question posed to Takoda by one such teacher provided him with the name “Takoda.”

¹⁴ - ¹⁷ See Glossary Pp. 278

¹⁸ A note concerning professional titles used in this thesis: Older and well-established Chinese faculty were *always* referred to by their title “Doctor.” By contrast, younger Chinese faculty were often known to students and faculty alike by their first names, as were the American faculty, whether from the TCM or Basic Science Departments. When I asked the Dean about this difference, she stressed the importance of using first names, instead of titles, to establish rapport, encourage approachability, and ease communication between students and faculty. This is in contrast with the findings of Becker et al. (1961), who note the hierarchical distinctions between students and faculty, and in keeping with Merton et al.’s (1957) description of students as respected “junior colleagues.” She also acknowledged that in the case of the older and established Chinese faculty, the title “doctor” was a sign of respect and more culturally appropriate than the use of first names.

years of teaching experience. Along with her teaching position, role as a supervisor at the Emeritus Center for Natural Health, and private practice, Dr. Song also served as a member of the National Certification Commission for Acupuncture and Oriental medicine (NCCAOM). During the first class, she inspired students with a dramatic tale of her experiences during the Cultural Revolution in China. Her father's criticism of the government had resulted in her removal from comfortable upper-middle class life to a collective farm, where she toiled for five years. After her internment, she was given the opportunity to attend Shanghai University of TCM, an opportunity she jumped at because, as she told us, "very simple: anything is better than a farmer." Originally, Dr. Song had wanted to study Western medicine, because "I came from very scientific family" and admitted that she didn't understand the Chinese concepts of Five Elements, yin and yang. All of that changed after she became sick and went to see a Chinese medical practitioner at the university teaching hospital. She was given a five day supply of herbs, which, despite their bitterness, resulted in a full recovery. "Whah!" she exclaimed, "I feel so good! This stuff real works!" transmitting to us in her heavily accented English the sense of surprise, awe, and excitement that had altered the course of her studies so many years ago. "So from then on, I believed the TCM," she concluded.

Following lunch, most students had "Biochemistry Overview 1," unless they had previously taken this course through a college Associate or Bachelors' degree. Biochemistry was taught by Dr. Angarika Naidu, a Postdoctoral Fogarty Fellow at the National Cancer Institute, a member of "the international Who's Who Among Professionals (2002)," and recipient of the award for the Women of Color Excellence in Science in 2006. In addition to her stellar research record and teaching duties for students in multiple programs, Dr. Naidu was the research laboratory director at Emeritus University. I often bumped into her outside the conference room on the fourth floor where I had a desk and computer. The windowsill was always bright with hibiscus plants or African violets which she had placed there, and once there was a huge plastic Tupperware container of soap, handmade by her chemistry students over the summer, free for the taking. Designed as an introduction to biochemistry, the course syllabus noted that the educational objectives were:

To utilize the fundamentals of General and Organic chemistry to understand the basic biological molecules of the cell and the biochemical reactions that allow it to function. Organic chemistry will be integrated into Biological chemistry so that the student understands the chemical reactions that are fundamental to life.

While students often complained about Biochemistry, very soon into the first quarter another basic science prerequisite, "Living Anatomy," became the bane of most students' academic existence: a three hour behemoth of anatomical and physiological information, as well as practical palpation exercises, followed by an hour of observation in the gross lab where students clustered around two prosected cadavers to see for themselves the structures that they would soon be needling.

On Tuesdays, Living Anatomy or Biochemistry (depending on scheduling) was followed by “Clinic Entry,” which, from an anthropological perspective, provided fascinating insight into the inculcation of professional values and the delineation of roles, scope of practice, and boundaries; all topics to which I shall return in chapter 5. Clinic Entry was taught by Dr. Jacob Silman, whose many other roles included: Associate Dean for Clinical Education in the School of AOM, Program Director for the Doctorate in Acupuncture and Oriental Medicine program, clinical faculty member at Emeritus Center for Natural Health, site visit chair for the Accreditation Commission for Acupuncture and Oriental Medicine; Chair of the Core Curriculum Committee; Co-Chair of the Clean Needle Technique Committee; and liaison to the NCCAOM for the Council of Colleges of Acupuncture and Oriental Medicine. Somehow, he still found time for five interviews with me.

Clinic Entry had undergone a radical facelift since 2004, expanding from an intensive weekend to a full quarter course, designed to provide students with “an introduction to an overview of the clinical segment of the AOM program at Emeritus University.” The syllabus read: “In the course of Clinic Entry the student develops many of the procedural skills and knowledge base needed to be a successful clinician at the Emeritus Center for Natural Health, as well as the external clinics associated with Emeritus University.” Over the next ten weeks, students toured the Clinic, learned about HIPAA²¹ privacy policies, billing procedures, and the ubiquitous paperwork of the Clinic. In addition, they were versed in safety policies, the process of charting their “subjective” and “objective” findings, patient management, referral and follow-up. Much of this material seemed largely irrelevant to many students, sitting in a classroom, their experience of the Clinic and the roles of a practitioner limited to the four appointments and observations of the “preview” and “review” sessions of cases that students were required to attend. It was not until the following quarter that these procedures and policies would become a weekly reality. Said Dr. Silman during the first class: “It doesn’t gel until you actually see bodies in clinic.”

Wednesday morning many students had “Qi Gong.” Qi Gong (described by the professor as “managing *qi*”) and “Tui Na” (a Chinese form of bodywork similar to massage but much more painful, and, we were assured, effective) were both taught by Dr. Niran Kunchai, who was born in Thailand but studied in China, where he graduated in 1992 from a six year program of Western and Chinese medicine. He had been teaching at Emeritus since 1995, and professed a great love for his job. Niran, as students and staff alike called him, recounted a dramatic personal experience of healing which changed his life and course of studies, as well as his appreciation for energy work and Chinese medicine. Like Dr. Song, Niran had initially been skeptical about Chinese medicine. One day during his program, a friend woke him at six in the morning and forced him to go to a nearby park where a renowned master was preparing to teach Qi Gong. The Master looked Niran up and down then told him that he had a problem with

²¹ The “Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data” (<http://www.cms.hhs.gov/HIPAAGenInfo/>).

his left knee (the result of a motorcycle accident some years before) that would need to be healed before he could practice Qi Gong. She instructed Niran to put his feet in her footsteps. Instantly, he felt a trembling, vibrating energy in his abdomen and his knee was healed. Like Dr. Song, Niran came to believe, through his own healing experience, in the power of Chinese medicine and the importance of regular Qi Gong practice. "People who don't practice Qi Gong don't have *dantian*," he told us, *dantian* being "the sea of *qi*," a repository for *qi* located "three fingers below the belly button and three fingers behind the skin." The importance of *dantian* could not be stressed too highly: "If you don't work, you don't have income. You can still survive, because people may give you money, but you have no bank account." *Dantian*, Niran explained, is like the bank account into which students can deposit their "income," or *qi*, accumulated during practice of Qi Gong. The more Qi Gong they practiced, the bigger their account. "When we deposit our *qi*, we can just use the interest," he said.

Thursday provided another early-morning shot of Biochemistry followed by the second weekly installment of TCM Fundamentals. The week concluded with Tui Na on Friday morning, during which students learned and practiced the techniques of "pushing," "grasping," "pressing," "kneading," "rolling," and "rubbing" designed to balance yin and yang, open the meridians, move blood, release adhesion, "lubricate joints," and "regulate the tendons."

Winter Quarter:

As autumn ebbed, the color and warmth drained slowly from the days, to be replaced by cool, lengthening nights and gray, rainy mornings. A pale mist clung to the fields above the school, across which a small family of deer occasionally picked their way, dissolving into the shadowy forest as the campus came to life. January ushered in a period of cloudless skies and crisp white winter days, when a freshly fallen blanket of snow accentuated the beauty of the campus in a way no less lovely than the abundant green of the previous summer.

Monday morning we sat through three hours of "TCM Pathology," taught by Dr. Fang Li, who, like Dr. Song, had been educated at Shanghai Traditional Chinese Medicine University, from which he received his MD in 1977. Interestingly enough, Dr. Li had also received his Doctor in Naturopathic medicine from Emeritus University in 1989. He had been teaching at Emeritus for twenty years, and was a founder of the AOM program. As such, he had seen many changes: looking out over his 2006 class of over forty students, he reminisced about how, two decades ago, there had been only one or two students officially enrolled in the AOM program. In addition to his teaching roles at Emeritus, like his colleagues Dr. Song, Takoda, and Niran, Dr. Li was a clinical supervisor and ran a private practice. The "major course educational objectives" of TCM Pathology outlined in the syllabus clearly built on the TCM Fundamentals course of the previous quarter, and were listed as follows:

- A. Classify all the excessive and deficient patterns in the *qi*, blood, and body fluid system; 8 patterns in the lung and large intestine system; and the multiple organs relationship. B. Understand the TCM vital substances and internal organ system. C. Demonstrate the TCM clinical applications. D. Recognize the TCM patterns in the case studies.

It was, as the syllabus warned, an “intensive” course.

After lunch, students regrouped in the same classroom for “Anatomy and Physiology 1,” taught by Dr. Margaret Stiller, from the Department of Basic Science. Dr. Stiller held a PhD in Life Sciences and a Master of Science, and had been an associate professor of biology, with almost ten years of experience teaching undergraduate biology, anatomy and physiology. The syllabus for “A&P,” as it was usually called, read:

This three quarter series examines the structure and function of the human body utilizing the integration of lecture, discussion and laboratory observation, dissection and experimentation. The structure and function of cells, tissues, organs and organ systems will be emphasized. Structure and function are so intimately related that an understanding of one is not possible without an understanding of the other.

Tuesday morning began bright and early with “Meridians and Points 2,” which picked up where M&P 1 finished, with the Urinary Bladder, Kidney, Pericardium, San Jiao, Gall Bladder and Liver meridians and points. The lecture was again followed by the corresponding M&P lab. After lunch, there followed another two hour session of A&P and a two hour lab, the subject of which generally followed the topic covered in class. Students observed cells, tissues, and skin; dissected brains and examined the anatomy of the spinal cord, peripheral nervous system and endocrine glands; and conducted simple reflex experiments.

Wednesday began, for most students, with “TCM Techniques.” After three months of watching needles being inserted, hearing all about needle insertion, and palpating points of insertion, TCM techniques held the promise, both exciting and terrifying, of hands-on experience needling and being needled. TCM Techniques class was held in the same place as M&P labs and Tui Na; a long room lined with massage tables. Every week, students crowded toward the front to observe the instructor demonstrate on a student volunteer how to locate, insert, manipulate, and withdraw the acupuncture needles. TCM Techniques was taught by Dr. Lin Mingyu, who, like many students, had traveled a circuitous route to a career in AOM, having completed her undergraduate degree in physiology and commerce. During the first class, Lin (as students and faculty called her) explained that she had always harbored an interest in Chinese medicine because she had grown up with it. Her longstanding interests had led her to Emeritus University, where she received her Master of Science in Acupuncture in 1999, a certificate in Chinese Herbal Medicine in 2000, and a Doctor of Acupuncture and Oriental Medicine in 2006. Lin was also a clinic supervisor at the Emeritus Center for

Natural Health and a private practitioner. The course description for TCM Techniques read:

This course covers a review of needling and biohazard safety, needle insertion technique, needling angle, depth and manipulation, tonification and sedation, and demonstration of techniques of freehand needling as well as learning proficiency with tube insertion...an emphasis will be placed on safety issues and the proper technique for needling specific acupuncture points.

After an introduction to the “tackle box” (acupuncture needles and supplies were housed by most students in large plastic fishing kits) we became familiar with the needles themselves. Lin spoke for some length about the historical evolution of the acupuncture needle from a thin-ish shaft of bone to the stainless-steel, individually packaged and sterile instruments of today. The pace of learning would be gradual: students would first needle a stuffed roll of material layered with fabric and tissue paper to get a “feel” for different layers and tissues and to develop “finger power,” then in later classes they would progress to needling themselves, then their partner. The excitement felt by students as the time drew close for them to insert needles, for the first time, into their bodies, was palpable. From an anthropological perspective, it provided one of the finest examples of the challenging re-conceptualization of the human body as an object to be worked upon (Good and Good 1993, Davenport 2000, Lella and Pawluch 1998, Carter 1997).

Following TCM Techniques, many students had Tai Chi class, although a conflict with my research schedule prohibited me from attending this course.

Thursday brought all students back together for “TCM Diagnosis 1,” taught by Dr. Song, who began by praising our Gall Bladders, the strength of which had (from a TCM perspective) enabled students to survive the first quarter. Building on the foundations of TCM Fundamentals and TCM Pathology being concurrently laid by Dr. Li, TCM Diagnosis provided “an introduction to TCM diagnostic methods, which are: inspection, auscultation and olfaction, inquiring and palpation.” TCM works, Dr. Song told us, because signs and symptoms manifested by the patient provide clues as to what might be wrong. Students would need to develop their skills of observation, touch, smell, and hearing; learning to rely upon the information received through their senses as much, if not more, than any information conveyed verbally by the patient.

For most students, the winter quarter was also their initiation into the Emeritus Center for Natural Health as “secondaries” or student observers, paired with a “primary” second or third year student responsible for performing the treatments. This step from classroom to clinic was a most satisfactory and exciting one; for many first year students, it affirmed that their decision to study AOM had, in fact been correct: “I’m so glad that we have clinic the first year,” effused Helen, “you get to apply it -- your knowledge. And...it’s fun to discuss the cases with the supervisor.” Their first interactions with actual patients, and not just fellow students, served to clarify and focus their altruistic intentions and visions of their own future practice.

The 2006-2007 Emeritus Catalogue provided the following information about the Emeritus Center for Natural Health:

Emeritus Center for Natural Health is the largest natural health clinic in the Northwest. As the teaching clinic of Emeritus University, the center provides patient clinical services and student training in a professional clinical setting that emphasizes a holistic approach to care...the center serves the health care needs of a diverse patient population, which includes young people, growing families and senior citizens from throughout the area. In 2004/2005, student teams, along with their supervising faculty, served nearly 34,000 patient visits.

In addition to acupuncture and Chinese herbal medicine, many other health services were provided by students and faculty from Emeritus University's other programs, including naturopathy, nutritional counseling, homeopathy, and physical medicine. Clinical exposure is, of course, a vital part of medical education, both allopathic and complementary. Notes Kelner et al. (1980:81):

As interns, chiropractic neophytes have had the opportunity to try out the role of practitioner, under supportive supervision and without any great risk. Their experiences in a clinic with its white coats, the deference and confidence of their patients, who usually refer to them as "doctor," have encouraged students to feel like practitioners. They also have had a chance to assess what becoming a chiropractor will mean for them on a day-to-day basis; they have been able to picture their daily round of work, and how they will cope with the demands of their new career.

Emeritus University also provided students with exposure to many different clinic locations specializing in different segments of the population (including low-income, the homeless, women, children, and seniors, as well as patients of diverse ethnicities and sexual orientations) or in the treatment of specific conditions such as chronic disease and HIV/AIDS. Sites were continuously added or subtracted from the roster, and in 2006 sixteen external learning sites were in operation, eight of which were available to acupuncture students. The diversity of clinic sites provided students with exposure to a great range of patients and illnesses, as well as opportunities to hone their skills and interact with students in different stages of the program and clinical faculty, the latter of whom brought their individual style of supervision and often considerable experience to the preview / review table.

The Clinic itself was impressive: built to conform to strict environmentally friendly guidelines, it was the bright, shiny new, ultra-modern flag-ship of Emeritus University, replacing in 2006 a smaller center a few blocks away. Upon entering the automatic sliding doors, patients were greeted by a beautiful floor to ceiling water feature and a waiting room painted in subdued earth tones and decorated with tastefully placed

plants and Asian-style artwork. Adjacent was a well-stocked retail space in which visitors could browse for natural health products and gifts as well as pick up their prescriptions from what was promoted as the northwest's largest dispensary of natural medicine.

There was a definite "front stage / backstage" element to the Clinic, the floor plan of which consisted of four interconnected corridors. The reception area was located at the junction of two of these corridors. Upon their arrival, students would pass through a set of double-doors separating the reception area from a corridor lined with faculty offices. Turning right at the end of this corridor, students passed a lunch room and lounge, a library with computer terminals, and the preview / review rooms in which they and their clinic shift supervisor would discuss cases before and after each shift. Leaving the preview / review rooms, students continued along the corridor to another set of double doors, through which and to the right was another corridor lined with storage facilities, copy machines, supply cabinets, and four treatment rooms. Again turning right, students continued along a corridor lined with five more treatment rooms, plus two rooms for herbal consultations, at the end of which was another set of double doors leading back into the reception area.

The "backstage" hallways and rooms were a hive of activity, with students and supervisors in white laboratory coats and name tags striding purposefully from one destination to another. None of this activity was seen by the patient. Once they had checked in at the reception desk, a message was sent to the computer located in the appropriate preview / review room, alerting the students and supervisor that their patient had arrived. Students would promptly meet them in the reception area, and then bring them through the double doors leading to the treatment rooms. A clinic shift was four hours long, during which time students might see up to three patients. The more, the merrier so to speak – in order to pass a clinic shift, students were expected to see a minimum of seventeen patients, although in order to graduate, a total of 400 patient contacts were required, which works out to be substantially more than seventeen per shift. Over the three or three and a half year program, students complete four "observation" shifts (during the first year) and 14 to 16 primary shifts, depending on whether or not the student is enrolled in the MSAOM or MSA program. Students in the former must complete additional Chinese herbal medicine shifts.

I attended shifts at the Clinic throughout the winter and spring quarters. I selected specific shifts for a number of reasons, including their fit with my own research and class schedule, the number of first year secondaries in each shift, the supervisor's requisite permission to attend their shifts, as well as my ability to car pool to and from the Clinic with other students. My ethical clearance did not extend to observing student-patient interactions, and I limited my research at the Clinic to talking with students and supervisors as well as observing the case preview and review sessions, which took place during the first and last half hour of each shift. During preview, students took turns presenting their cases for the shift to the supervisor and other students, including details of the patients' case, treatment protocols, and outcomes to date. The supervisor would provide input into the diagnosis and treatment, but the students themselves performed the "intake" and evaluation based on the principles of traditional Chinese medicine. At some

point during the intake the supervisor would arrive and the primary would present a synopsis of the patient's main complaint, history, appearance of pulse and tongue, and other pertinent information. The supervisor might then ask the patient a few questions to clarify their case, and would also take the pulse and observe the patients' tongue. After the intake, students would return to the preview / review room to discuss the case and acupuncture point selections with the supervisor, who would either approve or modify them before signing the patients' treatment form to indicate their approval. Students would then return to the patient to perform the treatment. While every supervisor's style differed, they would usually join the students at the beginning of the treatment to observe the needling technique and placement, although as supervisors became familiar with their students' styles, they would often check in on the patient sometime later in the treatment. Reviews took place during the final thirty minutes of the shift, and students once again assembled in the preview / review room to discuss their experiences, air their concerns, share lessons learned, and plan for future treatments.

The roles and responsibilities of first year secondaries varied depending on the supervisor and their primaries, but typically the secondary was expected to arrive at clinic with enough time to review the charts and set up their primary's treatment room – checking to make sure needles, sheets, and all other equipment were on hand. Primaries conducted the patient intake and the treatment, but most allowed their secondary to ask the patient questions, check the patients' pulse and observe their tongue, swab points to be needled with alcohol, or help with cupping and moxa therapies. Occasionally, a secondary with interest in massage or Tui Na would be allowed to practice on the patient while under the watchful eye of their primary. Clinic supervisors, too, generally included the secondaries in the preview and review sessions, soliciting input, asking questions, and testing aspects of their knowledge in a way vaguely reminiscent of the techniques employed by allopathic faculty during hospital rounds.

Spring Quarter

The spring quarter, with its almost incessant rain, saw the fields above Emeritus University transformed into marshland, the woodland trails into rivulets of mud. Seemingly overnight, the swollen buds burst into leaves and the gardens became bright with crocuses, daffodils, and tulips. The resident turtles emerged from the muddy depths of the courtyard pond and frogs filled the woods with a chorus of chirps and croaks. On the first day of the new quarter, students re-connected with each other, chatting before class and in the hallways and cafeteria, some looking bright and excited, others a little groggy - their heads on their desks and cups of coffee or tea within easy reach.

The quarter began with "TCM Pathology 2," a three hour class taught by Dr. Li, and focusing on

The path-physiological models of the liver, spleen, heart, and kidney systems according to the TCM Zang Fu theories. Through the review of

basic organ physiology, the presentation of TCM syndromes with special case studies, students learn to analyze etiology, pathogenesis, symptoms and signs, clinical patterns and treatment plans systematically and respectively in the above areas.

Following an hours' lunch break, students returned to the same classroom for a very different 'take' on the human body presented by "Anatomy and Physiology 2," taught again by Dr. Stiller. This quarter, the course covered the structure and function of blood, as well as the lymphatic, immune, cardiovascular, respiratory, digestive, renal, and reproductive systems. Corresponding labs, designed to reinforce classroom concepts, took place every Wednesday from 3:00 p.m. to 5:00 p.m., during which time students might expect to examine the anatomy of the heart, blood vessels, and other systems, as well as explore blood pressure and urinalysis in detail.

Tuesday began at 8:00 a.m. with "Meridians and Points 3," which, according to the syllabus, covered "the points and meridians in the Du, Ren, Chong, Dai, Yin qiao, Yang qiao, Yin wei, and Yang wei channels as well as miscellaneous points and the sinew channels." This was the third and final installment of M&P, and, as in the fall and winter quarters, the lectures were paired with two hour lab sections. There followed an unpopular back-to-back combination of Anatomy and Physiology and "Western Pathology," the latter of which was taught by Dr. Harold Taylor, a core faculty member of the Department of Basic Sciences. Dr. Taylor (or "Harry" as he was known) possessed a PhD in pharmacology and had conducted post-doctoral research in the field of immunology. In addition to his full-time teaching role at Emeritus in the naturopathic, health psychology and AOM programs, Harry was deeply entrenched in research projects examining the immunological effects of medicinal mushrooms, and had "lectured frequently to MDs, nurses and other health professionals" on this topic as well as drug-herb interactions. A charismatic individual, whose teaching style was described by one student as resembling a "gatling gun," Harry had instigated the bizarre winter tradition of "Splash and Dash," which involved running from the campus to the shores of nearby Lake Samaritan for a dip in its chilly waters. From a TCM perspective, such behavior was contraindicated as a prime way of allowing the entry of pathological "cold-damp" into the body. Yet every year, at least a handful of hardy souls joined him. I was not one of them.

Whether or not they jumped into Lake Samaritan, students were expected to get their feet wet in the sometimes murky waters of Western Pathology. Designed to be an introductory course for students of AOM, the course focused on "the most important diseases" including heart disease, diabetes and cancer and the "possible interventions that can be made in the disease process." The expectations, outlined in the syllabus, were that "Each student should understand the underlying mechanisms of disease processes and to relate the molecular details to the clinical diagnosis and nutritional treatment of the whole person."

On Wednesday, many students had "TCM Techniques 2," taught again by Dr. Lin Mingyu. This quarter, the course covered

The major TCM techniques including ancient needling technique, cupping, moxibustion, seven-star needling²², bleeding technique²³, ion pumping cord²⁴, electro-acupuncture²⁵ and needling of points on upper extremities. Purpose of this course is to help the student develop practical skills in the various techniques utilized in Chinese medicine.

Following this two hour class and an hours' lunch break on Wednesday, students re-grouped for Dr. Song's "TCM Diagnosis 2" course. Building on TCM Diagnosis 1, the second installment of this course introduced students to fundamental methods of diagnosis in TCM, including the all-important "Eight Principle differentiation," which provides "a conceptual matrix that enables the training physician to organize the relationship between particular clinical signs and Yin and Yang" (Kaptchuk 2000:215). Over the course of the quarter, students studied the four pairs of "polar opposites" that compose the Eight Principals: exterior / interior syndromes, cold / heat syndromes, deficiency / excess syndromes, and yin / yang syndromes.

Thursdays were a lighter day, at least for the researcher, and Friday rounded out the school week with another early-morning dose of Western Pathology, from 8:00 a.m. to 10:00 a.m., followed by "TCM Diagnosis Lab" from 10:00 a.m. to 12:00 p.m. This lab, taught by a licensed practitioner of acupuncture and recent graduate of Emeritus, provided students with the opportunity to develop their skills in two of the most important means of TCM diagnosis: pulse and tongue diagnosis. According to the syllabus: "Students will review and practice the skills of tongue and pulse diagnosis, conducting interviews, and differentiating patterns in terms of eight principles, zang-fu, qi-blood-body fluids, 6 channels, 4 stages, and 3 jiaos²⁶." These subtle skills of observation and touch were some of most difficult for students to master in their study of AOM.

Summer Quarter

The campus of Emeritus University was in its glory during the summer quarter, when the herbs and vegetables in the garden greened and ripened and the flowers bloomed prolifically in the border beds. In keeping with the long warm days, the summer quarter, which began on July 9 and ended eight weeks later on August 31, adopted a slower, calmer pace than the others. The school was visibly less crowded; students abandoned the cafeteria for the sun-browned fields and gardens, lolling in groups or individually beneath the trees, their text books pushed aside in favor of less arduous

²² - ²³ See Glossary Pp. 278

²⁶ See Glossary Pp. 278

pursuits. Inside, classroom windows were flung open and the ubiquitous water bottles often held sprigs of freshly picked mint from the herb garden.

The AOM class dwindled in size, too, with several students opting to pursue their Master of Science in Acupuncture, instead of in AOM, meaning that they would not take the Chinese Herbal Medicine component of the program. Jack headed north to work as an outdoor guide. Jana returned to her job in Human Resources. And, due to her dissatisfaction with the program, Grace withdrew from Emeritus altogether.

“Chinese Materia Medica” began the quarter on Monday morning, taught by Dr. Ning, who had received her Doctorate in Oriental medicine from a university of traditional Chinese medicine in China, in 1983; and a Master of Science in TCM from the same institution in 1988. Like Dr. Song and Dr. Li, she had gained considerable experience practicing in China, having worked for over ten years as a physician at university hospitals. She had been teaching at Emeritus since 1996, worked as a clinic supervisor at the Emeritus clinic, and ran her own private practice.

Most students entered Chinese Materia Medica with a sense of trepidation, having already heard from students in later years about the demanding nature of the course, and the necessity of memorizing vast amounts of information about herbs, three hundred of which they were required to learn over three quarters. During her introduction to this four hour a week course, Dr. Ning did little to put these fears to rest, assuring students that “This class is going to be really intense...it’s really going to be stressful...you better prepare for it.” Nevertheless, Dr. Ning went out of her way to help simplify the material using pictures and flow charts as memory aids and encouraging students to do the same each week. The experiential aspect of Chinese medicine was clearly demonstrated, as each week, students were instructed to smell or taste tiny portions of herbs from a thick sample folder with pages and pages of little square plastic pockets holding strange bits of dried herb. It was always great fun to witness the class reaction and hear the cries of “bitter!” or “cold!” or sometimes simply “eww.” Certainly the tasting and smelling of the herbs accomplished Dr. Ning’s goal of encouraging students to make connections between the physical properties of the herb and their use in clinical practice; herbal knowledge was quite literally embodied through the act of ingestion. But another, equally important goal of medical education was accomplished: students bonded over the sample packets, united in their surprise, revulsion, and occasionally, delight in discovery. There were plenty of encounters with the exotic, and some exoticizing of the familiar: during one class, I popped a wizened, rock like chunk of dried aloe juice – that common house plant with the harmless, juicy leaves - into my mouth and noted in my field book (perhaps a little melodramatically): “it imparts the bitter taste of death itself. Not even the sure-fire sugar delivery system of a piece of candy can dull the lingering horror.” While learning the different ‘language’ of Chinese herbal medicine caused a great deal of stress for many students, particularly as the volume of information to memorize blossomed through the quarter, it was also unfailingly enjoyable...at least, to the researcher, who did not necessarily have to sample anything ever again.

The first of three parts, Chinese Materia Medica 1 focused “on the Chinese herbs that release exterior, clear heat, and downward draining; drain dampness, and dispel wind-dampness.” A requirement of this course was that “students will be able to

pronounce, write, and understand Pin Yin and pharmaceutical names of Chinese herbs.” In this, students were aided to some extent by “Medical Chinese,” a three hour course taught by Dr. Lin Mingyu, on Thursdays. The syllabus read:

This course is the first part of the Medical Chinese. We will introduce fundamentals of modern Chinese language. The focus of this class is Pinyin system, the characteristics of Chinese characters, use of a dictionary, basic TCM terms and greetings.

Students were warned to expect quizzes every week, consisting of dictation, plus two tests on dictionary usage and translation. Every week, the classroom reverberated with tones and phrases, echoed back to the instructor with greater or lesser amounts of certainty. Although they were long classes, held on warm summer afternoons, Lin did her best to make it interesting and enjoyable, and students seemed to appreciate the overlap between Materia Medica and Chinese language, often stopping Dr. Ning to ask her if she could indicate the tone of the herbal names as she wrote them on the board.

As a bonus, the Medical Chinese course also clarified a language issue that had often amused or confused students: “Do you know why Chinese faculty often confuse ‘he’ and ‘she’?” asked Lin before explaining that the distinction is not made in Chinese as it is in English. “*Oh*,” rose an enlightened murmur from the students.

The only basic science course during the summer quarter required by students seeking their MSAOM was “Introduction to Botany” which, according to the syllabus, “provides a balanced introduction into the science of Botany and its disciplines such as anatomy, systematics, physiology, ecology, ethnobotany, and genetics.”

And with these three courses, the first year of the AOM program was rounded out. Not mentioned above are the elective courses chosen by students: some of whom completed a “Five Elements” course, an “Overview of TCM and Physics,” or further training in Tui Na, Tai Chi, Qi Gong, and Thai massage. David and Kimberly bravely shouldered the added burden of an extracurricular Massage Intensive program with the hope of being able to expand their scope of practice. I attended few classes during the summer quarter except for Chinese Materia Medica, using the time instead to conduct final interviews with students, and therefore my discussion of Botany and Medical Chinese must be limited to the overview provided above.

The curriculum that confronted first year students in 2006 differed in many ways from the curriculum of 1997 – 98, in terms of both core courses and the availability of electives. In the following section, I present a summary and analysis of these changes.

Core Courses:

In 2006, Year 1 of the AOM program remained fairly similar to that of 1997-98 in terms of both number of credits and core courses. Many of the changes in the first through third years of the program were superficial in nature: an increase in a credit value

here, a decrease there; the carving of one course into two courses worth the same credit value; the combining of two courses into one. "Acupuncture Therapeutics" went from being a 3 course series in 1997-98 to a 6 course series in 2006-07, but the number of credits remained the same. Two separate courses, "Clinic Preparation" and "Clinic Entry," both valued at 1 credit each in 1997-98, were combined in a 2 credit "Clinic Entry" course in 2006-2007. A "Biochemistry Overview" course offered at 5 credits in the spring quarter of the first year of 97-98 was replaced by a two part course with the same name at 4 credits.

More telling were the courses that had been eliminated from the core curriculum since 1997-98: including a 2 credit "Five Elements" course, "Qi Gong II," "Organic Chemistry," "Medical Terminology," and "Disease Processes." In addition, a 2 credit "Introduction to Chinese Herbal Medicine" was eliminated. Also interesting were the courses that had been added to, or more heavily emphasized, in the core curriculum. These included an increase in the credit value of an AOM Department offering, "Survey of Western Clinical Science," which was adjusted from a two course series at 4 credits in 1997-98 to a three course series, at 8 credits, in 2006-07. "Living Anatomy" also jumped from a meager 2 credits in 1997-98 to 5 credits ten years later. It appears as though a more formal microbiology lab component was added to "Microbiology" in 2006-07, but the number of credits remained the same as in 1997-98. A Western-based "Nutrition and Dietary Systems" course appears in the 2006-07 curriculum at 3 credits, and a "History of Medicine" course, previously an elective, was in 2006-07 a core requirement for third year students.

Two changes seemed to indicate an increasing emphasis upon research and concerns for litigation. In 2006-07, a 3 credit "Research Methods in AOM" course appears in the curriculum, the description of which reads:

This course provides an introduction to research, including basic concepts of scientific methodology and statistics. Also explored are the state of AOM research and its interface with the research world. Emphasis is placed on gaining an understanding of how to read and evaluate AOM/medical literature.

In addition, the 2 credit "Practice Management and Ethics" course offered in 1997-98 became, in 2006-07, two separate courses, one of which was a 1 credit "Jurisprudence and Ethics" course which covered "medical ethics and legal considerations in relationship to patient care and privacy issues." This was previously an elective for students wishing to become licensed in California. The second was a 3 credit "Practice Management" course. In addition, a 3 credit "Counseling" course offered through the School of Psychology in 1996-97 was divided into a 3 credit "Patient Communications" course and a 2 credit "Motivational Interviewing" course, described as "an advanced interviewing course designed to help students further develop their therapeutic skills at motivating clients for treatment and increasing treatment compliance."

A new requirement in 2006-07 was an “AOM Preceptor Observation,” which involved students pairing with a “practicing professional” located either in state or elsewhere, by permission of the School of AOM, in order to gain first hand experience in the day-to-day management of a practice and the techniques of a professional practitioner.

The greatest change in the curriculum involved the severe pruning of what was in 1997-98 called the “*Qi* Practicum,” a five course series consisting of Qi Gong I and II, Tui Na, and Tai chi (“short form” and “advanced.”) Ten years later, it had been reduced to a single required course in Qi Gong, a single required course in Tai Chi, and a single required course in Tui Na. While the total number of credits was reduced from 5 to 3, the real change lies in the shift of emphasis. Reads the 1997-98 course catalogue:

This series of practical, experiential classes explores *Qi* for self-healing and medical therapy and its *vital role in the practice of Traditional Chinese Medicine*. *Qi* is literally the core of all that is vital in Chinese medicine. Qi Gong refers to manipulation of this vital energy, harnessing and proper directing of *Qi* for self use and as a valuable medical resource. *Qi* Practicum is an ongoing series of experiential classes exploring the practice of Qi Gong for self-healing, medical therapy, and an enriched understanding of *the core of Chinese medicine*. Tai Chi Chuan is an important system of movements designed to harmonize and build one’s spirit and body. Tai Chi Chuan is introduced as a tool for self healing as well as a tool important in therapeutic plans. *Together Tai Chi Chuan and Qi Gong are integral aspects of TCM and provide critical elements in the growth and knowledge base of the student* [emphasis added].

This lengthy description, emphasizing as it does the “vital role” of these classes in the study and practice of TCM, contrasts markedly with the four line description of Qi Gong found in the 2006-2007 catalogue:

Qi Gong refers to the building, harnessing and proper directing of *qi* (energy.) Through proper exercise and instruction, students experience Qi Gong as a valuable resource for self healing and building energy.

Tui Na was is presented as:

A therapeutic massage modality that originated in China. The application of the various Tui Na techniques is based on the theories of TCM, and Tui Na’s effects can be utilized for acute conditions, as well as for constitutional disharmonies. In this course, students are introduced to various techniques, as well as fundamental principles for common therapeutic applications. Both practical and theoretical aspects are emphasized.

Tai Chi is described as “an important energetic system that utilizes specific movements and exercises designed to harmonize and build one’s spirit and body.” Also interesting was the down-grading of “Five Elements” from a two-part, 4 credit core requirement to elective status.

2006-2007 was a big year for the School of AOM at Emeritus University, with the successful accreditation of its Doctoral Program, the first of its kind in the United States. Emeritus’s emphasis upon integration, collaboration, and research was exemplified by the addition of a series of three “Research Practicum” courses for DAOM students designed to “provide students with a forum to discuss contemporary research topics” as well as internships at a local cancer treatment and wellness center or hospital in order to “give students a strong foundation in traditional Chinese medicine care within an integrated Western clinical oncology setting.”

Electives

Certain electives had been added since 1997-98, including a TCM diagnostics course for naturopathic students, a “TCM Nutrition Lab,” “Foot Reflexology Massage,” and two “Thai Massage” electives. Others illustrated the program’s emphasis upon research and specialization: a series of three “Neuromusculoskeletal Therapeutics” courses had been added, which focused on “the TCM differential diagnosis and treatment of pain,” including “site-specific neuromuscular problems.” Reads the course catalogue:

Acupuncture’s successes in treating pain are among the most well-documented and researched. Conditions of chronic pain or pain related to injury such as whiplash are most likely to be covered by insurance, and patients suffering these conditions are more often referred to an acupuncturist by their physician.

Also exemplifying the program’s focus on integration was the addition of a series of three “Integrated Therapeutics” courses, which

Emphasize integrated therapeutics used in naturopathic medicine, Chinese medicine, and Western medicine for difficult and complicated diseases. Each course covers a variety of diseases. Etiology, pathophysiology, signs and symptoms, and differential diagnoses are discussed through the differing points of view of Western and Eastern medical systems. The advantages and disadvantages of each medical system in treating diseases are compared. Students may take one or more classes in the integrated therapeutics series; each course covers different diseases.

Many electives had disappeared entirely from the offerings by 2006-07, including several that presented diverse Asian medical therapies. Gone were “Visual Diagnosis of Constitution,” “Acupuncture Energetics²⁷,” “Shiatsu massage,” and “Cranio-Palpation²⁸.” A series entitled “Auricular Therapy Overview and Clinical Auriculomedicine²⁹,” was no longer offered (although a single course entitled “Auricular Therapy” was required by second year students). An elective course in “Moxibustion,” the essential but de-emphasized partner to acupuncture, was also gone, and two courses focusing on “Japanese style acupuncture” were no longer listed.

At regular intervals throughout the first year, I interviewed the Associate Dean for Clinical Education in the School of AOM, Dr. Jacob Silman, whose many and diverse professional positions provided great insight into the source of curriculum changes at Emeritus University and the impact of these changes.

According to Jake (as he was usually known to both faculty and students), the curriculum at Emeritus was shaped by many hands. The initial curriculum for acupuncture and Oriental medicine in the United States had been a rather haphazard affair, the product of deliberation among the founders of the profession in the US, permutations of which “initially made it into state law.” Nowadays, the curriculum was based more upon the “accreditation standard” devised by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM), which is composed of nine members, including public members, institutional members, and acupuncturists. These commissioners are responsible for developing policies and accrediting schools of AOM. In order to achieve accreditation, programs or schools of AOM must meet 14 “Essential Requirements” laid out by ACAOM, number 8 of which is “Curriculum.” While every school interpreted those requirements in their own unique way, the guidelines developed by ACAOM represented “the bar.” Said Jake: “every school had to include that information, those ideas...and it’s evolved as Emeritus’s unique interpretation of Essential Requirement 8.”

At present, the profession was enduring what Jake described as a “painful change” from a “descriptive standard for curriculum” to an “outcome standard”; meaning that a previously prescribed number of hours and courses in so many subject areas was being replaced by consideration of the question “What are the knowledge, skills, and attitudes a graduate should have to meet the needs of their profession?” This, in turn, was determined by “occupational analysis” conducted regularly by the National Certification Commission for Acupuncture and Oriental medicine (NCCAOM). Practitioners across the United States are surveyed about what they do in their practice and the knowledge and skills they consider important. “Mostly it works,” said Jake, although the process was not without its challenges. For example, although the number of schools that teach

²⁷ Described in the catalogue as a “palpation-based acupuncture” based upon “concepts and techniques used in contemporary Japanese acupuncture.”

²⁸ Described as a workshop “designed for acupuncture students wanting to integrate craniosacral “listening” skills into their diagnostic framework.”

²⁹ Described as presenting “the French system of ear acupuncture developed by Paul F. M. Nogier, MD, a complete system of healthcare which differs from Traditional Chinese Medicine.”

shiatsu massage as part of their curriculum is limited, should enough practitioners mention it in the occupational analysis, it will “wind up having a presence on the exam.”

In addition, the lack of homogeneity within the field of acupuncture and Oriental medicine also posed challenges for creating a national standard:

There's immense diversity in the curricula of acupuncture programs. They are not all the same. Now, medical school curricula are not, quote-unquote, “all the same” either, but they *look* much more similar to each other than acupuncture schools. Acupuncture schools can be *perversely* different. So -- and there's been a number of long, *painful* discussions between the Council of Colleges and the NCCAOM over the fact that we don't all look like that.

My interviews with Jake led me to perceive that two major changes had occurred concerning the curriculum, not just at Emeritus, but within the field of AOM. One of these concerned the expansion of the program from a thousand hours to something bordering on four thousand. Jake perceived this growth to be both normal and expected; the result of a movement away from an informal, apprenticeship style of education toward a model based upon allopathic medical education:

In the beginning, acupuncture schools were founded by entrepreneurial practitioners and now, as schools mature, more and more schools have educators in key positions with education backgrounds and expertise in learning objectives and competencies and curriculum. And this body of knowledge brings with it people who are prone to assessment, and then adding material to the curriculum as the assessment shows that these things are needed...And there seems to be an inexorable tendency for professions to get longer curriculum. At one point in Europe and in the New World, to be a physician you apprenticed yourself with a doctor. Then there was a six-month program, and now a couple centuries later...it's a four-year doctoral training plus an extensive residency...So acupuncture and Oriental medicine is tracking the same way.

This ballooning of the program is related to the second major change: the increasing emphasis placed upon science and research in the curriculum. During the fall quarter, 8 out of 20 credits were related to basic science courses, and during the winter, spring, and summer, basic sciences accounted for 9/24, 7/21, and 3/11 credits, respectively.

Of course first year students of acupuncture and Oriental medicine are inculcated not just with the knowledge and skills imparted by their studies of TCM and basic science. In keeping with Becker et al.'s (1961) research concerning the process of learning medicine as a process of grappling with a ‘hidden curriculum’ not explicitly tested or taught, first year students of AOM were inculcated with the values and identity

of AOM practitioners working within the medical landscape of the United States. While I shall return to this point in the following chapter, it should be here noted that the increasing emphasis upon science, research, and integration seen over the past ten years represents such values. At the same time, energetic and experiential aspects of Chinese medicine have been substantially downplayed and courses focusing upon diverse systems of acupuncture – such as Japanese, Five Elements, and French-style – have been eliminated from the curriculum or relegated to the status of electives. The rigorous, science-intensive curriculum that confronted first year students in 2006 is a direct consequence of Emeritus' identity as a university of science-based natural medicine and reflects a growing tendency of CAM professions to achieve acceptance, status and legitimacy by modeling their training and practice upon allopathy and emphasizing “integrated medicine” and collaboration over “alternative medicine.” As I shall discuss in the following chapters, from the theoretical perspective of critical medical anthropology, such emphasis represents a movement toward a standardized model of Chinese medicine amenable to integration with allopathy and stripped of its revolutionary critique of Biomedicine.

Chapter 5

In search of acceptance: Professionalization, specialization, and science

Concern for acceptance as practitioners of an unconventional medical modality emerged as a central theme during my research among students of acupuncture and Oriental medicine at Emeritus University. In particular, acceptance by, and collaboration with, allopathic practitioners was perceived by many students to be pivotal to their success as practitioners of AOM. As discussed, Emeritus University is promoted as a school of integrated medicine, and, as this chapter demonstrates, students were exhorted by faculty and administrators to seek collaboration with their allopathic colleagues. The increasing emphasis upon basic science in the curriculum is a reflection of this emphasis.

My research, as well as the recent research of other scholars, clearly indicates that students and practitioners of complementary medicine desire greater collaboration with their allopathic counterparts (Frenkel and Borkan 2003, Highfield et al. 2005, Myklebust et al. 2006, Scherwitz et al. 2004). *How*, exactly, to go about achieving this and *what*, exactly, such a collaborative venture would look like, however, remains less clear (Ben-Ayre et al. 2008). A good deal of research has explored the challenges faced by CAM practitioners who attempt to enter “the well guarded fortress” of allopathic medical institutions (Goldner 2004, Hollenberg 2006, Mizrachi et al. 2005, Shuval et al. 2002, Tovey 1997). This chapter explores the strategy of gaining access adopted by one school of AOM through the inculcation of values amenable to biomedical practitioners, including delineation of boundaries between modalities, specialization, and science.

As previously noted, many students had selected Emeritus University because of its emphasis upon integration and Western medicine. Said Richard:

That was one of the things I asked about when I interviewed with them, because I have worked in clinical settings and I've worked with medical doctors. And I wanted to know...how well is the Oriental medicine accepted with the medical doctors that they work with?

Richard's final interview exemplifies students' concern with achieving acceptance, legitimacy, and status vis-à-vis Western medicine; a concern which ultimately led him to pursue the Dual Track naturopathic / acupuncture and Oriental medicine degree, a decision which extended his program at Emeritus by two years. When I asked him why he had made this decision, he replied:

All right, I'll give it to you bluntly. I want the damn piece of paper on the wall that says I'm a doctor, so I can say, “Fuck off,” if anybody says, “Hey, what gives you the authority to do that kind of treatment?”...In [this state] an ND is a Primary Care Physician. And the reality is, if you're a

doctor -- allopath or naturopath -- most people...don't challenge and question too much of what you do.

For Richard, the expanded and inclusive scope of practice granted by a naturopathic license was worth the extra two years of study in a program so intense that students, faculty, and administrators alike only half-jokingly questioned the sanity of the students who decided to pursue it.

While he stressed that the "label" and status of "doctor" was unimportant to him, Christopher, too, was weighing the pros and cons of eventually pursuing an MD in order to expand his scope of practice and achieve greater acceptance: "It's all kind of going to have to do with how the world turns," he told me, "and if people start respecting the education of a Master's degree in acupuncture a little more." Others students expressed similar desire for acceptance and respect. Said a male focus group participant: "it would be nice to be trusted, and not a second opinion."

In keeping with the findings of researchers, students of AOM recognized that poor communication, stereotypes, and prejudice might be barriers to integration with Western medicine (Barrett et al. 2004, Brussee et al. 2001, Caspi et al. 2000, Frenkel et al. 2007). Said David:

It might be a little more difficult to find and integrate a Western doctor, because he wouldn't have a language to communicate with us, and we'd have to -- We can speak his language; he can't speak ours -- kind of thing. So that would take a little work.

According to Laurel, a "huge power" lay in learning how to explain the mechanisms of acupuncture to Western-trained practitioners. "I think where you come against the most barriers and challenges," she stated, "is because of a misunderstanding or a lack of understanding...about acupuncture."

Kimberly expressed concerns about lack of open-mindedness and education concerning acupuncture as possible barriers to collaboration. While she had received positive feedback concerning acupuncture from one doctor, "others were like, 'That's a bunch of malarkey,' and you just have to keep your mouth shut...I just hope that it becomes more accepted and recognized as a legitimate practice," she concluded, "unfortunately, they just don't know that it would help. They don't understand it. They don't know."

Like Kimberly, David expressed concerns for lack of acceptance and prejudice on behalf of allopathic practitioners: "some Western medical doctors are just not going to respond well to me, and that's them. I can't help that. A lot of them are still convinced that what I'm going to be doing is quackery," he told me. In addition, challenges might come from other practitioners of complementary medicine, such as chiropractors, who, in some states, could take "a 300-hour course on acupuncture -- and then they can *call* themselves an acupuncturist." David was quick to stress the difference:

What they are is using acupuncture as a pain relief tool and a muscle relaxing tool. They're doing neuro-muscular acupuncture within the scope of their own practice, but they are not an acupuncturist. It may not be as big an issue in this state, but I see that that *may* become a conflict at some time.

Like David and Kimberly, Jack expressed concern for acceptance by allopathic practitioners, and noted negative stereotypes of CAM providers as poorly trained, tree-hugging hippies unable to communicate in the logical, "linear kind of fashion" recognized by allopathic practitioners. His previous practice of massage had brought him into regular contact with Western medical practitioners whose opinions concerning acupuncture he often solicited:

Whenever I found out that they were a doctor or a nurse or physical therapist or somebody in the massage field, I'd ask them what they thought of acupuncture. You know, some of the old-school doctors were like, "Eeh! There's no such thing. It doesn't work." But most of the younger doctors were like, "Yeah, the studies are out there. We believe in it. We definitely work with an acupuncturist or a massage therapist," if they had somebody that knew what they were doing.

Kimberly had experienced the stereotypes of CAM practitioners caricatured by Jack during her work as a dental hygienist:

It's downright funny, sometimes, because I have to watch what I say, and like what Takoda says, you start talking about *qi* and they're like, "La-la-la," you know. So you have to find ways of talking about it. And one of the assistants I was working with goes, "Don't mention anything about magnetic therapy, or you're out of here!" I was like, "I don't even *know* about magnetic therapy, *God!*"

Evan's experiences growing up in a southern US state had also inculcated a concern for the acceptance of Chinese medicine and negative stereotypes associated with the practice of "alternative" medicine. While he felt that the future of AOM in the United States was "looking a lot better than it has ever" due to its efficacy, public and political support and affordability, he noted that a barrier to its full acceptance lay in the fact that

People don't want to do something they don't understand. A lot of people still view that acupuncture is voodoo witchcraft. I've had people within my own circle, like at church and other places, kind of get freaked out like, "Acupuncture, oh!"

Open-mindedness and respect for the validity of both forms of medicine was stressed during a focus group by a male participant:

The second we go, “All right, they’re confused and they have this wrong system, and we are the enlightened wisdom ancients coming here to teach them the right way,” *not* going to work!

The onus, suggested several students, fell upon practitioners of AOM to bridge the differences between medical models and prove the efficacy of AOM. Said one focus group participant:

We also need to gain a really heightened level of awareness and knowledge to be able to talk with Western medical doctors...and be able to explain what we’re doing in a way that’s so civil and humble and compassionate and open, and...totally respectful. And that, for me, is what I feel like’s going to be the biggest challenge.

Not all students were optimistic that a mutual respect could be achieved. While he agreed that neither Western nor Chinese models of medicine could lay exclusive claim to “truth,” suggested David:

The biggest difference between us, as Eastern practitioners, and the typical...stereotype of the Western practitioner, is that we acknowledge the *validity* of the two models, and very often they don’t. They insist that their model is not only correct, but *the* correct model -- and our model is not.

“I think that’s the biggest problem,” he said, “we, as a group, [the Chinese medical community], are perfectly willing to acknowledge and include the Western model of medicine, but the reverse is not true.”

The concerns for political marginality expressed by students of acupuncture are not unique to this group, but have long shaped both the professionalization and education of CAM practitioners. Notes Wild (1978:34):

The ideological and attitudinal patterns which emerged from the chiropractic student’s educational experience are quite different from that of the traditional medical student. Whereas the medical student is being trained to take his place as a member of one of the most (if not the most) prestigious and powerful occupations in the United States, the chiropractic student is being socialized into a considerably more socially marginal status.

Wild found that students of chiropractic

Are clearly seeking professional recognition, community status, and personal esteem, and yet they are perfectly cognizant of the social, economic, and political strains between chiropractic and the community – between chiropractic and the “legitimate” professions (1978:41).

Much has changed since 1978, and even then Wild suggested that “the notion of marginality has become, in its current usage, a little outdated” (1978:43). Social marginality has been transformed into ever increasing public acceptance of complementary medicine, as indicated by a survey of CAM use conducted in 2007 by the National Center for Complementary and Alternative Medicine. According to the results, based on data from more than 23,300 interviews with American adults, “approximately 38 percent of adults in the United States aged 18 years and over and nearly 12 percent of U.S. children aged 17 years and under use some form of complementary and alternative medicine (CAM),” the fourth most common form being chiropractic or osteopathic manipulation (<http://nccam.nih.gov/news/2008/121008.htm>). Other professions previously ghettoized as “alternatives” – homeopathy, massage, and diet based therapies among them – are enjoying increasing political acceptance as well (Baer 2001, Meeker and Haldeman 2002, Cant and Sharma 1996, <http://nccam.nih.gov/news/2008/121008.htm>). In the case of acupuncture and Oriental medicine, increasing acceptance is due, in part, to a strategy of professionalization that clearly delineates boundaries between AOM and allopathy, and emphasizes the values of specialization and science in order to further collaboration and communication with allopathic medical practitioners.

Professionalization and the transmission of values associated with CAM

For nearly six decades, social scientists have studied “the processes by which medical students selectively acquire the attitudes and values of the physician’s social role” (Bloom 1965:143; see also Becker et al. 1961, Colombotos 1969, Jotterand 2005, Rothman 2000, Shapiro and Lowenstein 1979, Wynia et al 1999). Notes Lowenstein (1979:95):

Although socialization for the physician’s role begins before medical school, students often focus on graduate medical education for development of their professional identity. In this intense period of training, “the values to which the individual has been exposed in medical school and the hospital are most likely to find their final internalized form and become the basis on which the new physician begins to make decisions for himself” (Bloom 1963).

A survey of 125 US medical schools conducted by Swick et al. (1999) “recognized as essential elements of professionalism” four core professional values: “(1) subordinating one’s self-interest to the interests of patients; (2) adhering to high ethical and moral standards; (3) responding to societal needs; and (4) evincing core humanistic values (ex. empathy, integrity, altruism, trustworthiness).” In recent years, a good deal of concern has been raised pertaining to the degree to which these values are inculcated in medical students within the ever-shifting medical landscape of managed care and the ethically grey area of pharmaceutical company involvement (Rothman 2000), time constraints and practitioner burn-out (Satterfield and Hughes 2007), and the increasing socioeconomic and ethical diversity of the student body (Swick et al. 1999, Beagan 2001). Writes Rosenberg: “the learning environment of today’s medical schools – technically oriented, highly structured, time pressured, competitive, and unrealistically demanding intellectually – may serve to foster certain attitudes and discourage others” (1979:81). The recognition that “informal process[es]” of teaching professional values and behaviors during medical school and residency no longer suffices has led researchers and medical school administrators alike to offer “explicit learning activities that will inculcate in students and residents the knowledge, values, attitudes and behaviors that characterize the medical profession” (Swick et al. 1999:832). Likewise, Satterfield and Hughes (2007) and Elder et al. (2008) draw attention to the need for institutions of medical education to address professionalism as an explicit part of the established curricula.

Less research has been conducted on the identity and transmission of professional values in schools of alternative medicine. Exceptions include Wild’s 1978 study of the emphasis placed by chiropractic students upon social skills, “bedside manner”, integrity, and “recognition of one’s own limitations” as “significant characteristics associated with the successful practice of chiropractic” (1978:37). In addition, Harter and Krone examined the attitudes of osteopathic students “toward the role of communication and the expression of emotion in health care delivery” (2001:66) and in 2003, Coldham studied “whether the processes and values developed in the program [of acupuncture and homeopathy] are carried forward into practice” (2003:795). In light of the movement within allopathic schools to preserve and transmit the core values of the profession, what, I wondered, are the core values of the profession of AOM, and how is Emeritus University, as a self-professed leader in the natural health sciences promoting them?

While the core values of the profession of AOM were never isolated and taught to students didactically, the “Acupuncture and Oriental Medicine Oath” recited during the ceremony of graduation seems to provide a summary:

I promise to follow the way of my teachers; I will live harmoniously through the laws of yin and yang; I will strive for life long study in medicine; I will hold myself to high ethical standards; I will be compassionate toward my patients; I will be devoted to promoting and preserving health; I will be devoted to healing illness; I will strive to relieve suffering; I will be humble with my successes; I will keep an open mind; Above my own rewards, I place the care of my patients.

Not surprisingly, several of these values resemble those of allopathic medical practice outlined by Swick et al. (1999).

My extensive observations of classes, labs, and clinic shifts; interviews with first year students, faculty, and administrators; and examination of promotional material relating to the University and the AOM program illuminated a set of core values quite unlike those noted by Swick et al. (1999) as fundamental to the biomedical profession. They are, instead, values unique to the emerging professions of complementary medicine and related to the project of professionalization with which many forms of complementary medicine, including AOM, are engaged. The core values I recognized include the delineation of boundaries between medical modalities, specialization, and science as a means to facilitate communication and collaboration. These values are associated with Emeritus University's movement towards integrative medicine as a means of achieving professional status and legitimacy vis-à-vis the dominant biomedical paradigm.

Delineation of boundaries

According to the neo-Weberian model of professionalization, professions are based upon the concept of "social closure," defined as "the process by which occupations seek to regulate market conditions in their favor, in the face of competition by outsiders, by restricting access to a limited group of eligibles" (Saks 2000:224). The resulting social and economic monopoly, based on credentialism, is supported by the state (2000:224).

Related to "social closure" is the strategy of delineating boundaries between medical modalities that I observed during my research. Over the course of the first year, students of AOM were inculcated with a keen awareness of the scope and limitations of AOM, and the vital importance of referring patients beyond the scope of their practice to biomedically trained professionals. As previously discussed, orientation day included a presentation for first year students of AOM concerning the importance of joining the state Acupuncture and Oriental Medicine Association in order to protect the professional territory of AOM practitioners. Stressed one presenter:

We are the *only* people there in the state government defending your right to practice in the state, defending how you practice in the state, defending who is allowed and not allowed outside of our community to practice in the state, and that's another big issue, with other fields wanting to practice acupuncture or modalities of acupuncture like cupping or other things when they really shouldn't be, they're not trained and they shouldn't be.

A major concern was “other people doing [acupuncture] and...telling us what we can’t do and can do. Trying to infringe on our law.”

The lions’ share of membership dues was used, we were told, to pay a lobbyist to review legislation affecting practitioners of AOM in the state and recommend political action. To illustrate the importance of a strong state organization, the presenter recounted an incident in another state where the organization had been “caught snoozing” and as a result, chiropractors were “now allowed to practice acupuncture with little or no training.” Other challenges to professional sovereignty loomed: according to the presenter, the American Medical Association was “pushing this new Bill to investigate what they call ‘limited licensure professions’ and we’re fighting that on a National level.”

Faculty members frequently discussed professionalization as a means of strengthening AOM’s acceptance by allopathic institutions. During a class of “TCM Diagnosis,” students were regaled with dozens of images of tongues (the appearance of which constitutes a primary diagnostic tool in TCM), all photographed in Chinese hospitals. A student asked Dr. Song why they couldn’t go to a local hospital to examine patients’ tongues and pulses like doctors of TCM do in China. She replied:

The issue for instance, we go to the in-patients, we talk to the President, we talk to the Nurse Manager “can we take the picture of your patients?” They are so clear: “No.” Because you not belong to them. That’s the problem. So. We are not strong enough yet. We need more strong and then all the hospitals open the door for us, then we can do anything we want.

Clinic Entry class provided excellent insight into the inculcation of boundaries and scope of practice. Explained Dr. Jacob Silman:

So we were talking about things you’re supposed to ask your patient, things you’re supposed to say to your patient. There are a few things that you’re *not* supposed to say, and these include the “unlicensed psychotherapist”: “How do you interpret your feelings about this problem?” You should not ask a question that does not have diagnostic significance within your training...You need to be really careful about this. Please don’t go there. You can ask a person if they’re depressed. You want to know if they’re depressed because you want to *refer* them to a psychotherapist, as well as their points for soothing liver *qi*.

In addition to the “unlicensed psychotherapist,” students were counseled against playing the role of the “unlicensed pharmacologist,” which could include talking patients out of taking prescription drugs. Cautioned Dr. Silman, “Not only is this out of your scope of practice, not only is it inappropriate, but it can be fatal.” Issues concerning medication, he stressed, were “between them [the patient] and the appropriately licensed provider -- a medical doctor, a nurse practitioner, whoever it is.”

Very clear boundaries were drawn between the scope of AOM practice and allopathy in the case of medical emergencies and “ominous signs” that suggested immediate referral to “a medical professional.”

During TCM Diagnosis, Dr. Song was also explicit about recognizing the difference between conditions appropriate for treatment with AOM and conditions that needed to be referred – immediately – to a biomedical physician:

Acute conditions – not belong to us. Could be serious...The issue is we should know what we should do. More important is, we should know what we should *not* do. Okay? So it's not belong to us. What's the principle? Kick out as soon as possible! Because we cannot save that patient's life, let somebody save their life. Because in the Western medical care, patients [with] critical conditions, time *is* life.

Referral to practitioners of other modalities was also stressed during Meridians and Points by Dr. Takoda Mason, who said: “if you can't treat the patient, it's unethical [to keep seeing them] – you need to refer them [to someone else],” whether that practitioner was another TCM practitioner, a Five Elements practitioner, or a practitioner of another modality altogether. During Tui Na class, Niran reminded students that in cases of acute distress, call 911: “Don't rub heart area when patient is having cardiac arrest! Don't say Niran told you!” Similarly, Takoda regularly drew boundaries between emergency medicine and Chinese medicine in his labs and classes. While the point Heart 6 could be used for angina pectoris, “if a patient comes to you with sharp stabbing heart or chest pain, you don't use Heart 6, you call 911!” Stressed Dr. Li: “Every medicine has value,” and part of the skill of the practitioner is to know when one form of medicine might be more appropriate than another.

Students were exposed to instances of boundary demarcation during their shifts at the Emeritus Center for Natural Health, and it was here, as well as in class, where they learned the scope of their practice and to navigate the fine line separating it from the practice of other professionals who might also work at the Clinic and see the same patient later that very day. Treatments were not always compatible: during one shift the supervisor recommended that the student practitioners should contact the homeopath being concurrently seen by their patient in order to ascertain whether acupuncture might interfere with the homeopathic treatments. In another instance, a patient with sciatica was referred to a practitioner of physical medicine or chiropractic after the supervisor suggested that his sacrum might be rotated. “Acupuncture can re-align the muscles by relaxing tight muscles,” she noted, “but sometimes you need help from a chiropractor.” During Clinic Entry class, students asked Dr. Silman how, and when, to make a referral, and to whom; whether practitioners at the Emeritus Center for Natural health or elsewhere. He replied: “While you're in the program, working with patients, you must remain under the scope of practice of the supervisor.”

Professors often recognized that the decision of when to refer could be a difficult one. Noted Jake during Clinic Entry, high fever coupled with neck pain could “just be a really lousy case of the flu.” But it *could* also be meningitis. Similarly, “unexplained

weight loss” was most probably benign, but it *could* be related to HIV or cancer. “The point is,” said Jake, “if you’re not sure, you need to find someone who *can* be sure...It doesn’t mean you can’t treat the patient with the unexplained weight loss. It means you have to make sure you follow it up by someone [in] the appropriate [field].”

Throughout the first year of their studies, students were repeatedly reminded, cautioned, and advised to pay careful attention to the scope of their practice and not to cross the invisible and sometimes shifting boundary between their areas of expertise and that of other practitioners. Dr. Song’s frequent exhortation to “kick out patients” that “didn’t belong to them” was sometimes followed by tales of what could happen – legally – if they did not. During Chinese Materia Medica class, Dr. Ning stressed the necessity of having a patient supervised by a primary care physician because of the risks of getting into trouble with the law. Whereas in China, hospitals combine Western medicine and Chinese medicine, “here,” she told the class, “The most important work is done by doctors...Always keep in mind protecting yourself.” When a student questioned Takoda about the ability of TCM to treat cancer, Takoda emphasized that a patient must be under the care of a primary care provider or oncologist. TCM providers were primarily responsible for treating side effects and keeping the patient’s immune system strong: however unpleasant chemotherapy is, he said, “it’s more effective and precise than TCM.” Like Dr. Ning, Takoda recognized that herbal medicine could pose a legal threat, reminding students to be particularly careful prescribing herbs which increase or produce estrogen when treating patients with cancer: “There’s no evidence it increases metastasis, but you still need to be careful in these days of litigation” he said. Takoda’s version of Dr. Song’s “kick patient out” was “CYA,” an acronym for “Cover Your Ass.” “CYA” was frequently invoked to remind students of the need to tread carefully. “There’s always three people in the [treatment] room,” he said, reassuringly, “you, the patient, and their lawyer.”

Interestingly, half of learning what AOM *is* and what its practitioners *can* do involves learning what AOM *is not* and what its practitioners *cannot* do. Socialization into the roles, values, and identity of a practitioner of AOM is very much a process of navigating this grey area, made greyer by the legal restrictions placed on practitioners of AOM in the state, who, unlike those in California, are not licensed as Primary Care Providers, and are therefore unable to diagnose a biomedical condition. Nor are they able to request biomedical tests. This means that practitioners of AOM have to tread very carefully in their interactions with patients. Explained Jake during Clinic Entry:

You can do a *TCM* diagnosis; you can do a *limited* biomedical assessment...you’re playing in a gray area. You can’t diagnose cancer, but if your patient reports that she has a bump in her breast, you can refer her to an oncologist or to a clinic...to rule out breast cancer.

During TCM Diagnosis lab, students were confronted with a case study involving an older patient with a family history of polyps or colon cancer. The instructor acknowledged that while he might need to be referred to a specialist for a colonoscopy, “because of the scope of our practice, you don’t want to seem like you’re recommending

a Western medical procedure, but you should ask if they're seeing an MD for regular check-ups." During another lab, the instructor made the same point, noting that students should ask a patient with irregular periods if she's seeing a Western medical doctor and if she would consider having her hormonal balance checked out. "A lot of our patients don't trust doctors," he said, "but we can't do blood work...the ball's not in our court to decide whether or not it's right for her to see a doctor." A student asked if they should try to help the patient "naturally" before sending her to a doctor for hormonal replacement therapy. "Of course, of course," added the instructor quickly, "I'm not saying 'take drugs,' but we can't do tests."

By the end of the first year, it was very clear through observations of students' questions and interviews that they had internalized awareness of the scope and boundaries of AOM practice. In response to my question concerning her role as a practitioner of AOM, Kimberly said:

Well, I think that, as an acupuncturist, we're sort of like a support system. We're obviously not primary care physicians and anyone that thinks they are is up on a high horse and needs to be beaten off of it, because they're not. We can only do so much, and I think admitting your boundaries is a huge benefit...it's called complementary medicine for a reason.

It was a mistake, explained Kimberly, for any practitioner to believe that their modality is the only suitable form of medicine: "It's a balance, and I don't think anyone should be saying that I'm the one that they need to see first and foremost, and I can fix everything, because you can't."

While Richard wanted to design "integrated" medical treatments for his patients, he acknowledged the importance of referral networks: "there's need for allopathic specialties sometimes," he told me, as in the case of diabetes: "I need to have that referral base. I need to have someone to work with to help co-monitor what's going on with their insulin in relation to my things...So if there's people that have special areas, I'm going to refer out."

David's final interview exemplified internalization of the scope and limitations of TCM: "I never thought that TCM was magic," he told me, "I knew there were limits on it, I just didn't know what they were." While theoretically, he explained, TCM could "treat" anything, "it doesn't necessarily mean it will treat anything *successfully*. There's a difference."

David's vision of the future also exemplified a somewhat idealistic desire for collaboration with professionals who understood and respected each others' limits:

I would love to have a clinic where all of us get together once a week, twice a week -- maybe even every day, I don't know yet...and literally, have a round table...People of the same discipline suggesting, "Have you looked at this?" "Is this a possibility?" "Hey, I was hoping you and the NDs could take a look at this because I think this is something that would respond well to --" Keep each other educated about our own fields so we

can become stronger doctors by feeding off each other. And knowing our own limitations, recognizing, “Okay, this is not something that I can deal with, but Bob over there can,” or whatever.

Participants in a focus group held during the spring quarter also discussed this desire for collaboration and exhibited awareness of boundaries between medical modalities. Said a female participant:

Think about if we all kept in touch, or if we are in touch with MDs, or we do develop a network of people that we can refer out to, that we can work in collaboration with, and that we don’t have to have all the answers for our patients because we know people that will specialize in all those areas. I mean, I think it’s *so* important that we don’t isolate ourselves in our own little worlds.

Added another: “What we’re taught is that acupuncture is *not* the only thing,” Successful treatment depended on the inclusion of other modalities: “You should be looking *holistically* and not just what we can provide,” she said.

“I think part of it is admitting when you’ve reached your boundary,” said another participant.

For Jana, “being aware of what your own abilities are and if you’re the best person to be treating them” and “setting expectations for care” was an essential part of professionalism; a professional practitioner of AOM is one who knows his or her place in the medical landscape.

Students were exposed very early in their education to the existence of professional boundaries separating them, as practitioners of acupuncture and Oriental medicine, from practitioners of other medical modalities, including allopathy. Professionalization involves this process of delineating and laying claim to the body of knowledge and skills necessary to practice AOM, thereby increasing the status and legitimacy of practitioners. The recognition of what practitioners of AOM *cannot* do is also an important strategy of gaining acceptance of AOM, by establishing its identity as a “complement” instead of an “alternative” to biomedicine, and the identity of its practitioners as team players, not competitors. Said a male focus group participant:

Naturopathic medicine kind of *competes* with Western medicine, and they have a fair amount of hard time -- it’s growing really, really slow. Acupuncture’s growing rapidly and a lot of it’s because it works to be complementary to the Western medical thing.

Specialization

Both the decision to study medicine and the career choices made by medical students has been examined by sociologists (Rogoff 1957, Kendall and Selvin 1957, Funkenstein 1979). In their study of medical students attending Cornell University, Kendall and Selvin (1957) found that students were “increasingly likely to express an interest in specialized training” as they progressed through medical school. Freshmen were less inclined to commit themselves to a specialization, due to their limited knowledge and experience. With time and training, they come to appreciate the tremendous breadth of the medical field and “feel compelled to select a particular field in which to develop their competence” (Kendall and Selvin 1957:174). Writing about a similar finding, Becker et al. (1961:367-368) note that:

Medical school, obviously, is not an end in itself. Students go to medical school in order to get education and training which will enable them, when they graduate, to do things for which that education and training are necessary...Specifically, the student looking toward the future considers these questions. What kind of career am I going to have? Should I go into teaching, research, or the private practice of medicine? If I decide to practice medicine, where should I practice? Whom should I practice with, or should I practice on my own? Should I go into general practice or get into a specialty? Where shall I intern? Students discuss these problems frequently and arrive at certain collective solutions...the perspectives students develop on problems they will face in the future have necessarily a speculative and hypothetical character. They consist of definitions of what things may or will be like and how student might behave when he gets to the point in time when things are like that. They are essentially playful, because they call for no action in the present.

Fifty years later, their observations remain applicable to students of acupuncture and Oriental medicine. Scholars have noted that part of the project of professionalization undertaken by practitioners of complementary and alternative medicine - including homeopathy (Cant and Sharma 1996), chiropractic (Meeker and Haldeman 2002), therapeutic massage (Oerton 2004) and acupuncture (Barnes 2003) - involves modeling their training, examination, and clinical practice upon allopathic medicine in order to achieve acceptance and legitimacy (Baer 2004, Barnes 2003, Boon 1996a, Whorton 2002:232-233). In addition to the increasingly biomedical curriculum, many students with whom I spoke were already considering specialization within the first months of their first year. A few had been attracted to AOM because of an interest in a particular specialty or the opportunity to pursue doctoral studies at Emeritus, which focused upon the areas of pain management and oncology. As might be expected, students with previous experience in health care had clearer ideas about specialization. Helen's clearly focused vision of a practice specializing in musculoskeletal issues and women's health,

particularly menopause, infertility, and pregnancy, was the product of her experience working with an acupuncturist who specialized in these conditions and her own exposure to these clients as a massage therapist. Caitlin, too, planned to combine acupuncture with the experience working with women that she gained during her midwifery training. Also like Helen, she expressed a desire to specialize in women's health, due in part to her perception that women are more inclined toward holism. In addition, Caitlin's identity as a lesbian was also strongly influential in her vision of future practice and interest in specialization. "There's a whole slew of issues around lesbian women getting pregnant and having children," she explained, "and it'd be really great to be somebody who's involved in that lifestyle and a practitioner for alternative lifestyles as well."

Inherent in Caitlin's interest in specializing was a critique of the regular medical system. In Caitlin's view, many practitioners of "regular" medicine lacked experience dealing with gay people, alternative lifestyles, and the issues surrounding conception and pregnancy for lesbians. Her future practice would address these issues, providing patients with a sense of "understanding" as well as "creating an environment of them feeling they can be more open and be able to relate in some way."

Richard's experience working with chronic pain patients had shaped his vision of a "combined practice" specializing in the treatment of these patients through acupuncture, physical therapy, and counseling.

Specialization presents an interesting paradox, since most students were attracted to AOM because of its *holistic* philosophy, and were sometimes critical of the reductionistic, specialized characteristic of allopathy. "We have oncologists and rheumatologists and gynecologists and...ENTs -- and all these specialists, and they don't generally work together very often," said Kimberly. "Everything's connected...Why don't we see and combine all these specialties and see if maybe there's a connection somewhere?"

Specialization is, however, a somewhat superficial paradox. Within the holistic philosophy of traditional Chinese medicine, a practitioner specializing in back pain will potentially treat two different patients presenting similar symptoms in two very different ways, depending on their general constitution. Therefore, specialization within Chinese medicine is not analogous to specialization within allopathic medicine, the diagnostic and treatment protocols of which are founded upon a very different philosophical basis. Unfortunately, I did not pursue this idea with first year students. I cannot say for certain what they meant by "specialization" during our initial interviews, and I suspect that their understandings of this concept within the holistic framework of TCM evolved considerably over the course of their studies.

I interpret the interest in specialization not so much as a challenge to, or rejection of holism, but as the response to students' concerns about their "place" within the medical landscape, and for the acceptance by both the public and allopathic practitioners, the latter of whom might be more approachable should students have a "specialty" or a doctorate. Indeed, the recently accredited DAOM program at Emeritus was promoted in a way that clearly emphasized the value of specialization, and had been

developed to meet the growing demand for increased collaboration between acupuncturists, physicians and other health care providers. Collaboration often occurs within a specialty area, and the Emeritus DAOM program focuses on two: oncology and advanced pain management. These two focus areas provide excellent opportunities for acupuncturists to gain the treatment skills they need for integrative settings while gaining deepened critical thinking and advanced clinical skills that will directly improve clinical practice.

Claire and Richard were explicit in their acknowledgement of the doctorate degree as a way to increase their standing. Initially, Claire had been attracted to Emeritus because of its doctorate program and the possibility of “actually becom[ing] a physician of natural medicine.”

“I’m definitely going to be a Doctor of Something, dammit!” she told me.

In addition to specialization, the emphasis placed upon the values of science and scientific research in the AOM program exemplifies the profession’s attempt to gain acceptance and legitimacy by modeling its education upon Western medicine.

Science

It was tempting, at times, to see parallels between Emeritus University and the Academy of Witchcraft and Wizardry made famous by J.K. Rowling. Indeed, more than once Takoda proclaimed: “The needles are not magic wands! This is not *Hogwarts*!” Like other complementary medical professions, acupuncture and Oriental medicine now finds itself increasingly called upon to demonstrate the efficacy, safety, and legitimacy of AOM vis-à-vis Biomedicine through scientific research and validation. In his zeal to put as much distance as possible between acupuncture and “airy-fairy” accusations of magic, Takoda was certainly not alone. In the past few years, multiple databases have appeared online that catalogue research concerning acupuncture and Oriental medicine, including *acubriefs.com* and *acupuncture.com*. Fan provides a categorized listing of “primary research resources,” noting that “Chinese medicine continually edges toward the mainstream of Western medicine and more serious research...is published in peer-reviewed journals” (2004:1123). The importance of biomedical knowledge is also reflected in the increasing biomedical content of the AOM curriculum discussed in the previous chapter and the relatively recent addition of a biomedical module by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM); the organization responsible for nationally certifying practitioners.

As the “archetypal profession” and the standard “against which all other systems of healing are measured” (Barnes 2003:264), Biomedicine has become “the prototype upon which occupations seeking a privileged status today are modeling their aspirations” (Freidson 1972:xviii). The inclusion of biomedical science in the AOM curriculum at Emeritus University is part of the project of professionalization, by which CAM

practitioners seek to increase their status and legitimacy by merit of association with the dominant biomedical model of education. Stated the Associate Dean for Clinical Education in the School of Acupuncture and Oriental Medicine, Dr. Jacob Silman:

Certainly we're seeing, I think, as a profession, both in the educational aspects of the profession and as practitioners, that research is very important...the reality is that it is in fact the biomedical research, however flawed it is, that has brought third-party payers to acupuncture...Insurance reimbursement, government reimbursement. Has brought increased licensure. Acupuncture is one of the most comprehensively licensed CAM therapies in the country. We are now licensed in 43 states and the District of Columbia. And when you compare that to other CAM therapies, our level of licensure is very, very high and research drove a lot of that. You know, in each state where we were licensed, it was over the dead body of the medical board, and being able to go to the legislature and say, "Gee, have we shown you all this research?" turned out to be compelling.

The importance of science as a tool to increase AOM's acceptance is threefold: first, it establishes legitimacy and a rational, "scientific" basis for acupuncture; second, it provides a common language for communication with allopathy; and third, it mollifies allopathic concerns for the safety of patients.

Much has been written in recent years concerning the value of scientific validation of TCM's methods and outcomes (Kaptchuk 2002, Pearl and Schillinger 1999) and the role of scientific research in furthering integration (Frenkel et al. 2007, Giordano et al. 2003, Zick and Benn 2004). Students were inculcated with the methods of scientific research during their first year. During Clinic Entry class, Dr. Jake Silman emphasized Emeritus's identity as a research university; and familiarized students with the various data bases of research, including Pub Med and Medline. "You must get good at Medline," advised Jake, "Medline is the 'gold standard' in Western medicine." Meridians and Points, and to a much greater extent the elective course "Overview of Physics and TCM," was peppered with scientific research articles and anecdotes that emphasized the need for scientific validations of TCM. Takoda began his first Meridians and Points lecture with an introduction to the scientific basis and explanations of Chinese medicine, including physicist Ernst Chladni's demonstration that sound affects physical matter, "morphogenetic fields," electromagnetism, and the "right hand rule" of physics, which Takoda drew upon to explain the movement of energy into or out of acupuncture points.

Takoda explained that despite Emeritus' emphasis on a "science based education," no-one at the University knew, or seemed interested in knowing, how acupuncture "worked." His doctoral research had addressed the physics of TCM, and the Overview of Physics and TCM elective course was an off-shoot of this research. "I stripped it down to the physics," he told students. The purpose of the seminar was to

increase students' understanding of the interrelationships between biochemistry, anatomy, physiology and TCM and the ways in which Western and Chinese models of physiology could be integrated. By helping students to understand the mechanisms of acupuncture, they could become better practitioners and communicators of TCM, thereby increasing the acceptance of the medicine.

Science was also regarded as important by faculty and students as a means to facilitate communication with practitioners of allopathy. In recent years, communication between practitioners of complementary medicine and practitioners of conventional medicine has become a topic of great scholarly interest (Barrett et al. 2004, Ben-Arye et al. 2007, Ben-Arye et al. 2008, Brussee et al. 2001, Caspi et al. 2000, Frenkel et al. 2007, Klimenko et al. 2006). Many researchers note that the increasing popularity and widespread use of complementary medicine has placed greater pressure on conventional medical practitioners to communicate with the practitioners of complementary medicine whom their patients may be simultaneously visiting (Barrett et al. 2004, Ben-Arye et al. 2007, Ben-Arye et al. 2008, Brussee et al. 2001, Frenkel et al. 2007).

At the same time, it has been acknowledged by several researchers that efforts must be made by schools of complementary medicine to instill basic knowledge of Biomedicine in order to facilitate communication between practitioners. Writes Frenkel et al. (2007:388): "At present, there is no standardized training for CAM practitioners and minimal exposure of CAM students to allopathic medicine." Such sweeping statements serve to lump together the tremendous diversity of medical practices grouped under the umbrella of complementary medicine, ranging from practices like Reiki or herbalism, which are unregulated in most states, to chiropractic and acupuncture, both of which enjoy regulation and professional status in many, if not most states, based upon standardized examinations and core curricula, which in the case of AOM include, as I have outlined, large components of basic science. Be that as it may, Frenkel et al.'s study (2007), and the findings of other researchers, serves to indicate that practitioners and students of complementary medicine are interested in being better equipped to communicate with their allopathic colleagues (Barrett et al. 2004, Ben-Arye et al. 2008).

Communication with Western medical practitioners was emphasized by basic science and AOM faculty alike. The "Western Pathology" professor, Dr. Harold Taylor, was adamant that students must have a Western science background in order to communicate with allopathic physicians. In general, students seemed to agree. During the introductory lecture, Harold asked the class "why is it important to take this class?" to which students suggested: "To be able to communicate with others in the field," "to understand the limitations of Chinese medicine," and "to know what doctors are talking about."

Dr. Stiller, the "Anatomy and Physiology" professor, also stressed the importance of a basic foundation in Anatomy and Physiology for communication with other medical professionals. During the first class, a student asked: "How is the content and the structure [of A&P]...carved to fit the AOM program?" Dr. Stiller replied:

The philosophy of your program is that although you are trained as – in acupuncture and Oriental medicine, you should have a solid background in Western concepts. And so what we did with your program is go through kind of the standard anatomy and physiology course and say what stays and what goes, so what is relevant to you guys in terms of –and I think of it more from the perspective again of your ability to communicate with folks who are not trained the same way that you're trained, in order to – if you have a patient, for example who comes in, often times they're not just seeing you as a patient, they may be seeing you as a primary care physician, they may have another primary care physician, they may have another specialist who is an allopath – so you're in a position, if you're giving them primary care medicine...to have to understand, kind of, the Western as well as what you're providing for them, so if they're on a particular medication, you have an understanding of what that medication is doing, whether you should talk to their physician, other physician, you know, can you take them off of this, or whatever. So it's really, from my perspective, a matter of communication.

During TCM Diagnosis class, Dr. Song stressed the importance of making a TCM chart legible to members of other health professions, including general practitioners, for example, by not writing “around GB 30.” “In Western medicine,” she reminded us, “it's called ‘sciatic pain’.” Dr. Song had incorporated Western medical terms into her TCM Fundamentals course in order to facilitate communication with Western patients and physicians: patients might not understand “wind invasion” but they will understand “upper respiratory infection.” Niran, too, spoke favorably of using the Western anatomical terms for bones instead of the Chinese common names in order to communicate with the patient, and Dr. Ning stressed the necessity of a Western medical foundation for communication.

Of all faculty, Takoda was the strongest proponent of communication between practitioners of TCM and conventional medicine. During an “Overview of Physics and TCM” class, he said:

If you say to a Western doctor “We're going to move *qi* down the meridians,” versus scientific terminology, they won't understand or respect you. You're talking in a different language.

Instead, he emphasized the importance of phrasing TCM concepts, diagnoses, and treatments in the language of Western medicine in order to make Western doctors more receptive to AOM.

An opportunity arose to witness such phrasings of TCM in the language of science during one of Takoda's clinic shifts. 2007 was the final year of a major funding project between a local university medical school and Emeritus, which allowed conventional medical students the opportunity to be exposed to complementary medical modalities like AOM. I arrived to find one such medical student, a young woman, seated

at the table in the preview / review room. She explained that the purpose of the program was to allow the medical school's students to gain greater understanding of complementary medical practices, so that if their patients were receiving complementary medical treatments or wanted a referral to a practitioner of a complementary medical modality, doctors "won't look at them funny." This comment clearly indicates increasing understanding on behalf of general practitioners that complementary medical modalities are being used in conjunction with allopathic interventions on an ever-increasing basis.

The student then asked Takoda to provide her with a basic introduction to the Chinese medical concepts of "heat" and "blood," which differ so completely from Western medicine. Drawing upon his doctoral and current research, Takoda presented her with an explanatory model based upon, and using the language of, physics. Meridians, for example, could be explained as connective tissue with a "liquid crystalline structure," that is to say, an alignment of water molecules along which protons are conducted, resulting in an electromagnetic wave, essentially the "*qi*," which can modulate cells. After Takoda left, I asked the medical student what she thought of it all. "Well," she said carefully, "I like the concept of balance."

Toward the middle of the first year, Takoda held a meeting with interested students to discuss the possibility of researching and writing a book about acupuncture and Oriental medicine from a "scientific" perspective that would be designed to appeal to allopathic practitioners. The proposal, entitled "fast tracking your career" emailed to students by this faculty member read as follows:

Many of you may wish to work in a hospital one day. Others may wish to work in a multidisciplinary clinic. Probably all of you will appreciate being referred to by practitioners of other forms of medicine. In order to make this happen, however, you will need to stand out. The question becomes "How will you stand out?" In nature or in business, it is always important to find and fulfill a niche that needs to be filled. The one that has stood out most glaringly is the fact that Western medical doctors have no idea what we do, how our medicine works and what we can contribute to what they are doing in the treatment of patients. This is mostly due to the fact that our language is foreign to them. If I told you that I wanted you to volunteer to help with a problem and I told you that we were going to "quifarle the betinken," you'd probably think I was nuts and quickly walk away and find something more important to do. When we tell Western practitioners that we tonify the *qi*, nourish the yin, rectify the yang, this is what we sound like to them. In this age of litigation and very high malpractice insurance, most doctors are not interested in taking a chance on something they do not understand and could possibly cause them stress, headaches and lawsuits. They are, however, interested in anything that makes them look better and increases their revenue and relationships with patients (as a good business does)

My proposal is that we help Western medical practitioners to understand exactly what our medicine is, how it works and how it can

complement and contribute to the work they are already doing. If within their eyes, we can help them see the benefits and decrease the perception that this is risky and unscientific, doors may open for us.

Takoda went on to propose that students, guided by himself and another faculty member, work together to “write a book on the physics and physiology of traditional Chinese medicine...In other words, we explain how it works from a Western scientific perspective.” Students would be responsible for conducting literature reviews of the scientific research concerning Chinese medical topics and compiling the information “into a meaningful paradigm.” In addition, the faculty members would hold lunch-time lectures on the scientific explanations of various Chinese medical topics, such as yin, yang, “damp,” and “wind.” Then, during the summer, they would teach an eight-week “Overview of TCM and Physics” course designed to explore these concepts in greater detail. As part of this course, groups of students would decide what they wish to research; submit an outline and scientific articles related to that topic. The end result would be a paper reviewing the literature for each topic, which could, theoretically, be compiled into an edited volume used to position students “head and shoulders above other schools and acupuncturists.”

Dr. Silman, too, emphasized the importance of using the language of biomedical science to communicate with physicians. He stated:

When I’m talking to students about how to communicate it, if I were to start suddenly talking to you in Chinese, in addition to your getting no information out of it, you’d be somewhat irritated that I was wasting your time. If you were completely naïve to Chinese medicine and I started talking about *qi*, yin, yang, -- whatever it is -- You’d look at your watch, right. So the idea is to speak to your audience and then help them in the direction you want them to go. And some physicians will have some idea of *qi*, and they’ll bring it up: “What about *qi*?” So then, that’s my cue. And then I can talk about Han Dynasty texts and traditional language and observable phenomena. But if you start out with that cold, and they have no idea what you’re talking about, it doesn’t work very well.

His biomedical explanation for the mechanism of acupuncture was as follows:

When you insert a needle in through the stratum corneum, the top layer on the top of the dermis, the outer most layer of the skin, you’re causing a local inflammatory reaction. You are stimulating a-alpha and a-beta afferent nerve fibers. These are (rapid conducting) touch fibers, rather the slow conducting a-delta pain fibers or the unmyelinated polymodal C pain fibers. And this stimulation goes to the sensory input in the dorsal horn of the spine. The signal from the a-alpha and a-beta fibers crosses over to the anterior-lateral track of the spinal column where it goes up the spine to the

thalamus and on to the sensory cortex, registering that acupuncture is happening. There's a mechanism that involves reduction in input from the a-delta and c-fibers via the substantia gelatinosa. There's also the evolution of endogenous opiates and serotonin, which have an analgesic effect. Acupuncture's been shown to have an impact on the messenger RNA for enkaphalins (endogenous opiates) and these effects have been shown to be quite specific. Analgesic, acting in specific areas of the brain, for example. The eye clearly seems to be directed and very precisely to the visual cortex, as an example. And there's functional MRIs to show this. That's the mechanistic view.

In addition to the role of science in establishing the legitimacy of AOM and facilitating communication, science was also used to mollify the concerns of allopathic practitioners that their acupuncturist-colleagues did not have enough knowledge to recognize ominous signs and symptoms. "A third of the curriculum is now in the Western sciences," explained Jake, "and a lot of this has to do with peaceful coexistence, learning about ominous signs, learning about co-management, learning about other modalities that a patient is involved with, learning about the appropriate basis for referral." He stated:

The area of ominous signs and biomedical assessment remains the greatest level of anxiety for non-acupuncturists in health care. So if you ask your physician what they're most worried about, it's not really quackery. It's that somebody's going to go to one of these idiots and miss something.

With its aim of graduating students capable of working alongside allopathic practitioners in integrated medical settings, students are increasingly called upon to know enough biomedical science to provide a foundation for referral to, and communication with, other allopathic practitioners who, according to Boon, express concerns that practitioners of CAM lack "sufficient medical training to recognize many medical conditions which may result in individuals deteriorating during therapy" (Boon 1996b:15). She writes:

The Canadian College of Naturopathic Medicine currently provides students with a knowledge of basic sciences, which is seen to be of primary importance in the production of graduates who are competent health care practitioners, trained to refer patients to other practitioners when necessary. An emphasis on science and the biomedical model also serves to counteract criticisms from allopathic medicine and ensure the continuation of naturopathic medicine politically.

Most students were favorably disposed toward the incorporation of basic science into the curriculum as a means of furthering acceptance of AOM by physicians and the public. As previously noted, several spoke of Emeritus's emphasis upon a foundation of basic science and integration as part of the reason they had selected this school over others in the US or surrounding area. In the opinion of one female student, the incorporation of Western sciences was part of establishing the identity of Emeritus as a legitimate school of medicine:

You are not at some university; you are at a medical facility, and that's the biggest thing, is that this is an ND school...That's kind of why I liked it a little bit, was to have more of an understanding so you can communicate with another medical professionals.

Said Alex:

The general public will not be receptive to a non-Western doctor for -- until years from now. Any one who has no background in chemistry or biology or anatomy or physiology won't be respected for a long time. So that's fine. So it's cool that I'll have some of that background, so I can use the language that makes sense to them.

Stressed Evan, the acceptance of AOM and collaboration could be furthered by proving the medicine's efficacy: "Like Dr. Song said, if you can prove to a doctor that you can help people, then they'll send people your way, but you have to show them."

For Helen, the ability to communicate with Western-minded patients and biomedically trained doctors was essential in order to build a relationship of trust between the patient and practitioner and to facilitate patient education. To this end, Helen appreciated Takoda's physics explanations of TCM:

I love it. I do. I think it's really important to kind of get an idea for why things might work, and I think that's really helpful when you have patients and they're like, "How does this work?" or "What's happening?" They want to hear *why*. People want answers, they want to be educated. So if you can kind of give them more of an idea of how it's working -- something they can wrap their brain around and figure it out -- it's going to make them feel more comfortable and have more confidence that the treatment is actually helping, and it's not just in their head.

Agreed David:

It gives me more to work with. And I'm fascinated, if we are in fact able to someday scientifically define a subtle body bioelectric field -- for lack

of a better phrase -- that can be manipulated in order to create health, that can only expand our understanding of the human being.

Both Laurel and Christopher had taken Takoda's "Overview of Physics and TCM" elective in the summer quarter, and expressed great enthusiasm for it as a means of opening lines of communication between practitioners of AOM and Western medicine. When I asked Christopher why he had decided to take this course, he replied:

To get a better understanding of TCM, open my linguistic repertoire up a notch. Now I have a few more tools to explain -- people with a more Western dialect, with a more modern science dialect preference -- I could communicate with them a little more articulately, without using flowery words that might turn them off... that's what I think Takoda's class offers us, is a little jargon enhancer.

Said Laurel:

I think it's a great class. I think it's a really important class...what we're trying to do is enhance our ability to understand with this language, enhance other people's ability to understand, who only speak that language.

Interaction with practitioners of different medical modalities was part of Caitlin's vision of practice and she recognized the value of being able to communicate with patients and doctors who might not necessarily be receptive to AOM:

I know I am going to need to communicate with Western medical practitioners a lot, and explain to them what I'm doing and why I'm doing it and how I see it might work for them. So, I guess that's a big piece of understanding the Western medicine side and being able to communicate with a Western medical practitioner.

Said Richard:

I want to make sure that I have a...solid grounding in Western pathology, *and* I can also understand how the Oriental medicine affects those Western systems, so that when I'm having to communicate with a primary care physician, I can say, "Yeah, I understand that this person has bronchitis, and that's going to affect whatever's going on in these systems, in your lungs. We know that certain treatments will help move that stuff." And to be able to relate what we can do to what's happening in what their concern is.

Richard appreciated the inclusion of Western sciences in the AOM curriculum in order to communicate with allopathic physicians: "The reality is," he told me,

If you want to be a practitioner you need to have good connections with primary care physicians. Because as much as *I'd* like to see that change, I don't see it changing that quickly in the next twenty years where -- MDs are still going to be the primary care physicians, and you have to be able to communicate with them.

Jack, too, appreciated the basic science component of the curriculum as a way of furthering communication: "You need to have organic chemistry, bar none," he told me:

If you can't have a scientific basis and a chemistry base, or a physical base, then people are going to be like, "Yeah, it might work but, you know, I'm going to go to that person who *knows* what the hell they're talking about."

It was precisely these concerns expressed by students for their ability to "know enough" Biomedicine that, to some extent, drove changes in the curriculum. While Dr. Jake Silman acknowledged that the pressure to increase biomedical content was coming from the profession of AOM and its practitioners, graduates and students also played a role in the evolution of the curriculum. "The programs," he explained,

Were intended to provide someone to, A, qualify for the licensing exam and, B, and begin a process of safely embarking on lifelong learning. But if you ask graduates, "Were you adequately prepared to practice?" they'll say, "No...I didn't know enough about this, I didn't know about that, and I didn't know enough about the other thing." So we'll put more of that in the curriculum. So this is a time-honored educational philosophy. You assess your outcomes and you modify your process to better meet those outcomes. But it's kind of like chasing a shadow between lampposts after a while.

The inclusion of training to provide pelvic exams provides a rather compelling example of what could happen when a small but vocal group of practitioners campaign for increasing scope of practice and training in biomedical procedures. According to Jake, after answering a survey question asking "Do you feel adequately trained to do pelvic exams?", several "poorly-informed" Californian practitioners had united to develop a "one-hour seminar on how to do pelvics" without bothering to ascertain whether or not acupuncturists actually intended to conduct pelvic exams. It was Dr. Silman's opinion that most would refer their patients to a gynecologist: "Someone who's got training and at least four years of an abusive residency in gynecology, having done hundreds if not thousands of them already."

The problem, explained Jake, lay in the difficulty of delineating the boundaries of biomedical knowledge necessary for students to learn. Whereas the body of Chinese medical knowledge is “relatively finite and the number of standard texts is relatively fixed,” the same does not hold true for Biomedicine. Jake had worked with the NCCAOM for two years on this issue “and it was like pulling teeth to get them to see that they can’t make virtually all of the Biomedicine as part of what’s included on that biomedical exam.” As they seek greater degrees of collaboration, the onus increasingly falls upon students to learn more and more Biomedicine at the expense of, worried some students, their knowledge of TCM.

In summary, concerns for acceptance by allopathic medical practitioners have led the AOM program at Emeritus University to pursue a project of professionalization that: 1). Clearly delineates boundaries between AOM and allopathy and establishes AOM as a complement to allopathy; 2). Encourages specialization within the field of AOM in order to position practitioners within specific allopathic medical settings; and 3). Emphasizes biomedical science in the curriculum and the value of scientific research in order to establish the efficacy, legitimacy, and safety of AOM and to facilitate communication and collaboration with physicians. My research reveals these to be core values associated with Emeritus University’s movement towards integrative medicine as a means of achieving professional status and legitimacy vis-à-vis the dominant biomedical paradigm.

While many students expressed a strong desire to collaborate with allopathic practitioners and appreciated the foundation of science as a means to increase the acceptance of AOM, many expressed equal concern about the implications of this emphasis for the identity of AOM as a unique, autonomous, and effective system of medicine. This “paradox of integration” has been the subject of discussion among critical medical anthropologists, who argue that collaboration more accurately resembles a strategy of co-optation (Baer 2004, Wolpe 1999) employed by biomedical practitioners, insurance companies, and other key stakeholders to neutralize both alternative medicine’s critique of, and competition with, Biomedicine. This becomes the subject of the following chapter.

Chapter 6

The paradox of integration

While many students expressed considerable appreciation for the foundation of basic science they received during their first year as a means to facilitate communication and increase the acceptance of acupuncture within the allopathic community, the movement toward a more rigorous, standardized, and biomedically intensive curriculum did not meet the whole-hearted approval of all. Several students questioned the implications of increasing emphasis upon science and scientific validation for the identity of acupuncture and Oriental medicine as a unique, autonomous, and effective form of medicine and their own identity as its practitioners. Such a dilemma has been noted by Barnes (2003) in her study of American acupuncturists and Boon's (1998) study of Canadian naturopaths. In Barnes' study, acupuncturists wrestled with the questions "who...is an acupuncturist *like*?" How do acupuncturists "fit in the biomedical food chain?" (2003:280) and what, in the process of seeking professionalization and acceptance by the dominant biomedical system, would acupuncturists lose? She writes:

If forced to adapt to an increasingly biomedical model – and, more specifically, to the financial structures that govern it- they fear that what is unique to Chinese practices will gradually be eroded to the point where the practice becomes a set of techniques divorced from the dimensions of spirit and healing that matter to them (2003:282-83).

My research at Emeritus University revealed the existence of a fundamental conflict between the identity of acupuncture as a "scientific" versus an "energetic" medicine. While I didn't ascertain the exact reasons, the Five Elements professor left shortly after my research commenced, and during an early interview she expressed concern that Five Elements had had been moved to elective status "in order to make room for more Biomedicine." Niran, too spoke with concern over the shift of "Qi Gong 2" from required core course to elective due to the same reason. Dissatisfaction with the lack of emphasis on the energetic aspects of the medicine eventually led Grace to leave the program in favor of a smaller school which placed greater emphasis on Qi Gong and, as she explained, "actually feeling the energy we're working with. We get a little bit here...in Takoda's class...but I've never seen it incorporated in the Clinic."

I asked her why the energetic aspects of the medicine were important to her:

It's what we're working with! Acupuncture -- the reason we insert needles is to work with the energy and to help straighten the body by aligning it. I mean, it's all about removing excess and tonifying deficiencies and just bringing balance and -- If we're doing that through

working with energy, I feel like we should understand it better, and know, on different levels, what we're doing and actually do it with intention.

Focus group participants, too, shared their concerns about the lack of emphasis placed upon Qi Gong in the curriculum:

"How can you do Chinese medicine without Tui Na?" asked one.

"Or Qi Gong?" added another.

While most students who attended this focus group seemed united in their perception of the value of Qi Gong, they also perceived that each individual practitioner would gravitate toward their own unique style of practice. Said one male:

I think a lot of us are going to be going in a different direction. You've got to find out what works for *you*. How can *you* be a better practitioner? Maybe some people can work better with the energy, some people can work better with the anatomical.

As previously discussed, Takoda's elective course, "Overview of Physics and TCM" was designed to explore the integration of Western and Eastern models of physiology and the scientific mechanisms of acupuncture. But it also provided students with an opportunity to express their concerns regarding the scientific validation of Chinese medicine, as well as their role as practitioners and place in the medical hierarchy.

Ryan, the co-instructor of the course, did not discuss *qi* in his private practice, privileging instead the "biomechanical forces of the body;" a tactic which he perceived to increase his ability to interact with doctors and receive referrals from them. He acknowledged that the challenge lay in "building a scientific model [of acupuncture] while being true to our model as it's been taught to us": preserving the unique identity of Chinese medicine while establishing a scientific model that meets the expectations of the scientific community. He suggested that it was important to keep the intent of the medicine and the model, but to also realize that there were many people who could benefit from AOM who wouldn't come unless students opened a door for them, through, for example, using the language of Western medicine with which most patients were familiar. Replied a student: "You can't separate yourself from tradition. You're selling out, not advancing the future [of AOM]." In response, Ryan noted the danger of letting pride get in the way of progress: "suck it up, put your pride aside, use a different language to get other people involved," a strategy which, he assured us, would have mutual benefits for the practitioner, the patient, and the medicine.

Said Takoda: "If this medicine is going to advance we have to start understanding what's going on." Biophysical explanations conferred "credibility to the Chinese concepts of points and meridians" and validated ancient Chinese knowledge. Even so, student response to a lecture concerning the scientific definition of *qi* indicated that some felt conflicted regarding the need and value of scientific proof: "it's not just science," said one student. Questioned another: "if we're using a science model doesn't that preclude the aspects of TCM that can't be explained scientifically?" Commented another

student: “the benchmark [of the model] should be patient outcomes, not which model is easier or more communicable.”

“If you start talking about love and destiny,” warned Takoda, “all they’ll do is roll their eyes,” to which a student replied: “I’d rather have them not understand it than deny part of it.”

“It would be a shame if we get too scientific,” concluded another.

In addition to science and research, Chinese medicine was constructed by faculty as a legitimate, efficacious medical practice in many ways over the course of the first year: through its venerable history (estimated between 1 000 – 5 000 years old, depending on the faculty member), through tradition and lineage, and through personal anecdotes and experiences.

Chinese faculty actively cultivated awareness of history, culture, and tradition as a means of presenting themselves as authentic repositories of Chinese medicine. Such tactics were also used as means of shoring up authority. From orientation onwards, Chinese faculty stressed their connections to large, renowned universities in China where they had completed over ten year’s of training, teaching and practice, as well as their historical and cultural connections to the medicine through anecdotes, personal memories and experiences. This technique of cultivating authority, authenticity and legitimacy was exemplified by Dr. Ning, whose reminiscences brought Chinese *Materia Medica* to life: memories of her father sprouting mung beans in the depth of the Northern Chinese winter as special gifts for family and friends; her grandmother weaving shoes from hemp fiber; her mother preparing ginger tea to sooth her stomach upset and menstrual cramps; the disturbing image of public toilets in China swimming with sinuous parasitic worms; her stories of treating her own children with the same remedies she received as a child. Said Niran to students during his first class of Tui Na: “in order to understand Chinese medicine, you must understand Chinese culture.” Like Niran, Dr. Ning, Dr. Song and Dr. Li presented Chinese medicine as inseparable from its culture, history, and tradition, and legitimacy was conferred both through scientific validation and through personal experience. Not only had Dr. Ning researched the herb “*ma bo*” at a Chinese hospital, but it also figured prominently in her childhood memories of her grandmother, who had spoken of this herb’s healing properties. Dr. Ning had included PowerPoint slides of Western pharmaceutical research in her Chinese *Materia Medica* class, but she rarely discussed them, privileging instead her own personal anecdotes, experiences, and the thousand-year history of Chinese herbal medicine. Dr. Song, too, privileged clinical experience over scientific research. During the first class of TCM Fundamentals, she discussed the history of Chinese medicine, stating that it emerged from, “and has been continually enriched and expanded,” through practice over its long history. “Is that good enough for now?” she asked the class: “Of course not. We need scientific evidence base of the medicine. But still working! That’s why Chinese medicine right now is so popular...we still try to figure out what’s, exact, going on.” While Dr. Song was the first to admit that the theory of Chinese medicine had developed in the absence of scientific knowledge and experimentation and was therefore subject to limitations, and that from a Western scientific standpoint some of the connections made little sense, she emphasized

that these connections and treatments *work* in the clinic: the “proof was in the pudding,” so to speak.

Like their Chinese faculty, while students of AOM acknowledged the benefits of learning scientific mechanisms and explanatory models in terms of communicating with Western-minded physicians and patients and advancing the acceptance of TCM, most were of the mind that scientific validation or “proof” wasn’t actually necessary. Instead, they stressed the importance of taking the medicine on faith. Most students with whom I spoke agreed that the fundamental concepts of acupuncture and Oriental medicine, the existence of *qi* and the pathways along which it flows throughout the body, could not be scientifically verified or proven: “Sometimes you have to live something in your life by faith,” said Evan, and Grace emphasized the importance of “just accepting” the teachings of Chinese medicine “for what they are.” This is in keeping with the students of chiropractic studied by Wild (1978:41), who writes:

Chiropractic, especially in comparison to more traditional “legitimate” forms of healing in our society, is seen by many as an art form, not even necessarily available to empirical observation or scientific validation...As such, many chiropractors view their profession not as antagonistic or inferior to the medical profession (other than in a very political sense), but as an entirely different mode of diagnosis and treatment – as an alternative to or even as a substitute for orthodox medicine – and insist on being evaluated as such.

While Christopher thought that he would probably incorporate the explanatory models learned during Overview of Physics and TCM in his own practice, he added:

I’m not going to go out and dedicate my life to connecting Western mechanisms to Chinese medicine. I have all the motivation I need for that it works, and why it works and how it works -- it’s fine with me. The ideas of *shen* and energy and stagnation and *qi* misplacement and -- that’s fine with me. I’m cool with that. But I know there’s other people out there who would like it in a little more tangible terms, and I’m willing to give it that. I’ve talked my father into Qi Gong by that mechanism.

Grace, too, thought scientific proof to be unimportant:

To me “scientific” is a measurable observation, or something of that sort. I don’t remember the exact definition. It’s something you can observe and measure. And I think if -- in Chinese medicine, I think it’s very scientific in the sense you have this many people come in with this problem, and you treat it with such and such points. If it works, there’s your science right there. So, I guess that’s where I’m -- I don’t need to break it down to the chemistry science, to the different chemicals and what’s happening. I

don't need it on such a minute level. But seeing the effects of it and seeing that it works, that to me is scientific data.

David was one of several students who expressed interest in the scientific study of AOM, but he didn't think it was particularly important to be able to explain the concepts of AOM in terms of Western science: "I don't care if there's any scientific proof that it works -- whatever. It doesn't matter to me. I just care that people get better," he said.

Caitlin, too, found the Western and physics explanations and theories of AOM discussed by Takoda interesting, but not particularly important. "I don't feel that it's necessarily helpful to me in understanding exactly how it works, she told me, "but that's mostly because I'm more inclined towards the -- I guess the holistic side of it, like the spiritual reasonings behind the medicine...rather than the scientific reasonings for it and why it works." She concluded: "If it works, it works, and that's great for me."

My interviews with students revealed a fundamental tension between recognition and appreciation of Chinese medicine's unique identity and the desire for acceptance contingent upon scientific validation. While Caitlin stressed the importance of a background in Western medicine and awareness of developments within that field, she added:

There is an issue of -- well, Chinese medicine, you want to keep it pure, so to speak. You don't want it to get too infiltrated with Western medicine...there is a line that you draw between being aware of what's going on with Western medicine and how much you're going to incorporate it as a practitioner.

Several students expressed reservations about the emphasis on science as being "disrespectful" to Chinese medicine. Said Claire of Takoda's physics course, which she later dropped:

I feel like it's questioning the medicine when you want to break it down that far and you want to get into the mechanisms of *every single point* and why they work that way. And I really feel like you're doubting -- I just feel like it's questioning it and I didn't like that...I mean, it's neat to know how it works, but I trust the medicine and I'm okay with feeling like that right now.

Alex's comments exemplify the tensions experienced by students resulting from their desire to communicate and work with allopathic physicians while simultaneously maintaining the unique identity of acupuncture and Oriental medicine:

Takoda's all -- he's generally that, "We're going to figure out the science of acupuncture in my book," and everything. But I kind of feel like, why would you do that? Why would you -- It seems sort of disrespectful.

Acupuncture is what it is, and has an extremely long tradition, and it's a comprehensive and internally logical system of thinking, and why do we need to put it in biomechanical -- biochemical terms? I mean, I think research is cool and I'll have to interface with Western doctors to some degree, so I think it's neat to have a good vocabulary of what they deal with, but I'm not interested in the science of acupuncture, you know, at this point. It's fascinating when I hear stuff and it seems like, "Oh, that's insightful." But there's a lot to learn in acupuncture without trying to color over it with science.

Like Grace, Alex decided to leave Emeritus in favor of a smaller, more classically-oriented school of AOM due, in part, to his dissatisfaction with the program's emphasis upon scientific validation. Such emphasis, he felt, drew his attention away from his studies of Chinese medicine. He explained:

Classical Chinese Medicine doesn't look to Western science to validate itself. It focuses on the texts and on studying and interpreting the texts in a clinical setting, which TCM -- We do that here a bit too, but we also learn biochem, and we learn all of the Western names of muscles and bones, which -- I'm still not sure how I feel about that because, back in the day I thought, "Oh, that's great," because I kind of wanted to do Western science to begin with. I thought that was kind of both. And then I got to a point where I was like, well you *can't* be kind of both. If I'm learning [Western medicine] I'll either be confusing myself, or taking away from what I could learn about acupuncture. And that's still kind of how I feel like, one, if I'm going to learn acupuncture, then learn it -- totally commit to that way of thinking, the history, and the literature. But then on the other hand, when I think about what my career, my future career might be, it will hopefully be interacting with other types of physicians. I mean, acupuncture's not going to rule the US ever. So I want to always work with allopaths and naturopaths...I'm learning a vocabulary that will allow me to communicate with people from a different field of study.

Lucy, too, expressed a sense of being torn between seeking scientific validation and approval from the Western medical community, and being true to the "spirit" and identity of the medicine. "I don't think the way it's [Chinese medicine] being integrated into Western things -- modalities and stuff -- is beneficial," she told me:

Like, I didn't get anything from Western Pathology...that's not how I want to think through my diagnoses and [the] pathology of someone -- I don't want to think, 'Oh, their red blood cell count is dropping.' I want to be able to think like the Chinese did.

She concluded: “I understand why it’s important to have it, but...that’s not what I need right now.”

Lucy’s decision to take the Physics of TCM course had been motivated partly by an interest in science and explanatory models for acupuncture, but she found the course largely unsatisfying: “I think [Takoda’s] just not explaining things I wanted explained,” she told me, “Like, I didn’t really care how *qi* flowed. I just knew that it flowed, and I understood because I had felt it, you know?” The focus of the class, she felt, was on “what you have to tell a doctor, kind of stuff. It’s not, ‘This is how the whole medicine works.’ This is just -- this is stuff you can take so you sound smart, and don’t get stomped on.”

Claire, too, acknowledged the importance of learning mechanisms of AOM in order to communicate with Western minded patients and physicians: “[it] just kind of qualifies our medicine, I guess, to the Western world, which -- it sucks that it has to be that way but that’s the way it is.”

Biomedical science occupies a curious position within the School of AOM at Emeritus University. First year students recognized its value yet questioned its relevance and criticized the tendency of basic science courses to siphon off time better spent learning the skills and knowledge deemed directly relevant to the practice of acupuncture. Helen’s statement is exemplary of the struggle endured by many first year students to balance basic science and TCM workloads:

I think the biggest challenge is the Western medicine portion...it really detracts from the TCM Fundamentals and learning lab and why we’re here and doing Qi Gong and doing Tui Na...you can’t really spend as much time as you want, like reading...and going over the [acupuncture] points. ...So yeah, I just would like to spend more time focusing on TCM

While Helen stressed that she understood the value and relevance of “the Western classes,” it was the sheer volume of material that was overwhelming: Taking twenty-one credits, she noted, was “just nuts!”

Like Helen, many students felt inundated by basic science material at the expense of TCM-related experience. TCM Techniques was a prime example. Students petitioned for a supervised lab to increase their amount of needling practice, and while I learned little of the shadowy underworld of extra-curricular needling (the practice of which constituted grounds for expulsion), students admitted that needling each other outside of class was by no means uncommon. When I asked Helen if she thought the curriculum was evenly balanced between the basic science and TCM material, she replied:

No. Because I feel like, for our lab, for Meridians and Points, we only have two hours. Are you kidding me?... and that really sucks, because then we’re studying four hours in biochem...It’s just hard, balancing it all the time. It’s tough. It’s all time management.

Later in the winter quarter, Jack approached me and dropped a stack of handouts, several inches thick, onto a table. "This," he told me, giving it a shove, "is only a small percentage of the stuff from A&P. This," he added, taking a relatively slender sheaf of notes from his binder, "is the stuff from TCM Pathology for the entire quarter." The latter, he took great pains to emphasize, was what students actually needed to know in order to practice. The former, by contrast, represented material of which students should have a basic grasp. It was a clear demonstration not only of disproportionate amount of work and time allotted to basic science, but of student frustration with what many perceived to be a serious imbalance in the curriculum, which, while not reflected in the number of course hours per quarter, was certainly felt during study. Jack spent six hours a week studying A&P, while TCM techniques absorbed a mere two hours of his time. By comparison, the TCM courses were sometimes described by students as "the real thing." "Knowing the points is my vocation," said Amy. By comparison, Living Anatomy felt "just like a regular class. It doesn't draw me to paying more attention to it. It doesn't make me feel like I have to, you know?"

Asked one student, rhetorically, "I'm not going to have to read an EKG, am I?"

The dilemma of balancing basic science and TCM in the curriculum parallels the larger dilemma of balancing scientific validation with preservation of the unique identity of acupuncture and Oriental medicine. This dilemma is not unique to students of acupuncture. Kelner et al. (1980:86) note that the relationship between students of chiropractic and science is "distinctive":

Although science now constitutes a significant part of the educational program which produces chiropractors, it does not generate chiropractic therapies. Even though selected sciences, such as biomechanics or kinesiology, have been extensively elaborated in some chiropractic colleges, it seems to the objective observer that chiropractic education is not as dependent on science and scientific research as medical education is. While a scientific background is essential for the carrying out of a diagnosis, chiropractic students can learn the art of the practitioner's therapies without scientific proof that they work. The newer students in Chiropractic College today feel an urgent need for scientific research which will validate the techniques and theories of chiropractic treatment, but even without this "proof" they can emerge from college as competent practitioners, capable of giving good chiropractic care.

The medical landscape, of course, has changed a great deal since 1980, and the increasing emphasis on integration with allopathy puts students and practitioners in the position of needing to scientifically validate a medicine that works on a very different principal than Biomedicine. Notes Boon (1996b:32):

In most of the Western world, medical knowledge is produced within the biomedical paradigm. Naturopathic students must learn basic medical knowledge if they are to function as competent health care practitioners,

yet they are also expected to practice within a philosophy which challenges, and in many cases opposes, the biomedical model.

Calls for complementary and alternative medicine, including acupuncture, to satisfy the criteria of a biomedical model of research and “evidence-based medicine” (Vickers 2001, Leibovici 1999) is exemplary of the challenge posed to AOM’s identity as a medicine with a very different physiological basis. Explained Dr. Jacob Silman:

Clearly, no medicine is solely based on evidence-based medicine...There’s a place for it. There’s a reality associated with it. I have a research background and I’m not opposed to evidence-based medicine as an idea. The problem is the assumption that all medicine is evidence-based...or should be...There are folks out there that are basically saying you can’t do it without RCTs -- random-controlled trials -- extant, and that would disable most physicians, let alone acupuncturists. It’s clearly not reasonable, appropriate, or possible but the mythology is now out there. I spoke of before, a small group of acupuncturists in California who are totally imbued with this to the point where they want to throw out classical text and throw out the body of Chinese medicine.

To illustrate the dangers and difficulties of forcing Chinese medicine to satisfy the same requirements of allopathic or evidence-based medical research, Jake used an example from his own experience specializing in the treatment of HIV / AIDS. Apparently, during the mid-1990’s research suggested that certain compounds found in Chinese herbs which had for years been used to treat HIV /AIDS might reduce immune function. But, he hastened to add, these studies has been conducted *in vitro* and lacked context. Nevertheless, the results had galvanized a group of acupuncturists to campaign “to stop the use of all Chinese medicinal substances.” Such attempts to “overlay evidence-based medicine” upon “traditional,” “pre-scientific, pre-industrial, pre-biomedical” CAM practices, such as Chinese medicine, would, warned Dr. Silman, continue to result in “unfortunate misunderstandings.”

Often times, explained Dr. Silman, research involving Chinese medicine was flawed by a lack of understanding of the fundamental principles of this medicine, so vastly different from Biomedicine. While scientific studies of the acupuncture point P6 revealed it to be effective in the treatment of nausea, the use of points like biomedical drugs – one point for one symptom (“a very Cartesian way to apply therapy,” noted Dr. Silman) – was a misapplication of the system of acupuncture and Oriental medicine.

“There are physicians,” he stated, “medical doctors, who take a 200-hour course and they understand it very narrowly, so their capacity for getting results is very narrow because they really don’t understand Chinese medicine.”

Critical medical anthropologists have explored the dilemma posed to alternative systems of medicine by seeking their validation through scientific research. Accommodating the biomedical model involves adhering to biomedical methods of

testing as a means of ensuring efficacy and the public's well-being. The rhetoric of "public safety" has been instrumental in the appropriation of alternative medicine by biomedical practitioners (Ning 1997:233, O'Neill 1994, Fulder 1996:62), replacing outright condemnation with the impression that physicians and the medical profession are open-minded and willing "to explore and evaluate new therapies" (Wolpe 1985:422), so long as this evaluation is carried out using biomedical methods. Ironically, scholars have noted that "much of orthodox medicine...is not always as rigorous with assessing its own evidence base as it asks CAM to be" (Hassed 2004:407, also McKee 1988:782). Nevertheless, the call for acupuncture and other alternatives "to face the test of the randomized, double-blind, controlled clinical trial" has become increasingly loud in recent years (Barnes 2003:284), although many scholars have argued that the paradigms of Chinese medicine and Western medicine are incompatible (Barnes 2003:286, Dean 2004:676, 678; Scheckenbach 1999, Wolpe 1985:416), and, from the perspective of critical medical anthropology, all systems of knowledge and methods of verifying them are culturally conditioned (Baer 2004:156). In Jake's opinion, the increasing emphasis upon evidence-based medicine represented an attempt by physicians to shore up their authority against the erosive forces of managed health care (Hunter 1994), the profession of nursing (Witz 1994), litigation (Dingwall 1994), the media (Bury and Gabe 1994), as well as the rise of alternative medicine (Saks 1994). He stated:

I think that -- I'm guessing. This is entirely supposition. But that one of the things that's accelerating the mythology of evidence-based medicine is the need by physicians to stake out a unique position here, because it's eroding.

Issues of adherence to biomedical standards of testing have caused considerable tension between practitioners and schools (Barnes 2003), and CAM practitioners have yet to agree upon adoption of biomedical standards of testing. Acquiescence on behalf of many attests to the "cultural authority claimed by biomedical science to determine the truth of a thing, to stipulate what does and does not count as both efficacious practice and evidence thereof, and to govern related research funding" (Barnes 2003:285). In the United States, the establishment of the Office of Alternative Medicine in 1991, a Congressional organizing body under the National Institutes of Health, proved to be a double-edged sword. As noted by Goldstein (Winnick 2005:54), on one hand, it provided complementary and alternative medicine with "societal legitimacy, intellectual acceptance, and financial stability," while on the other hand it allowed "the regular profession to become the final arbiters of CAM's validity." Wayne Jonas, who served as the third director of the OAM in 1995, notes that while funds for CAM have increased significantly, very rarely will projects that are not defined in biomedical terms receive them (Jonas 2002:34). Nienstedt (1998a:39) writes that "[r]ather than questioning the assumptions of the biomedical research model and concentrating on the development of a holistic paradigm, the research agenda instead reverts to a biomedical methodology in which alternative practitioners will constantly play serious catch-up." In sum, "the focus

of the office appears to be primarily on complementary medicine under the direction of biomedical methods and personnel" (1998a:39).

Although recent calls have been heard to re-evaluate the ways in which CAM modalities, including acupuncture, are studied (Hammerschlag 2003, Ritenbaugh et al. 2003), in research, practice and education, biomedical concepts continue to be privileged. Transcendental meditation studies must be "framed in biomedical terms that are standard for behavioral medicine" (Jonas 2002:35); Chinese medical concepts of "yin-yang and Five Phases Theory" become explained in biomedical terms of "the regulatory and dynamic feedback mechanisms in various physiological systems" (Hui et al. 2002:511), while acupuncture and meditation are modified to treat symptoms of pain, addiction, and stress "rather than employed in their more holistic applications" (McKee 1988:776).

And yet, despite its limitations, Dr. Silman was adamant that scientific research had not only increased acceptance and licensure of AOM, it had also persuaded insurance companies to cover acupuncture with increasing regularity. This represented a huge shift in the medical landscape since Dr. Silman graduated a decade earlier and also posed challenges as well as benefits to the profession:

When I was first licensed you were expected to go out and hang out a shingle and be a sole practitioner in a small practice with other providers. And now we're in hospitals, we're in medical centers, we're in community clinics. We more successfully are reimbursed for insurance, depending on the state. We have more complex relationships with the other health care providers in the United States. And that brings good news -- we're more widely recognized -- and it brings bad news -- we're also more frequently abused by the same people that have been abusing physicians for years. So, for example, insurance companies -- it is, in some places, a crippling issue for physicians and we wanted in, and now we can be abused right along with physicians. So there's some good news and some bad news. The good news is that you get to be abused just like medical doctors, and the bad news is you're being screwed.

Far from being unique to students of AOM, these concerns are echoed by the profession of AOM itself. As previously discussed, beginning with orientation, students were introduced to professionalization, including the vital role played by the state acupuncture and Oriental medicine association in securing their future as practitioners of AOM and protecting professional turf. The state Acupuncture and Oriental Medicine Association's fall meeting, and the organization's website, provided insight into the profession's concern with identity, status, and acceptance. The organization's slogan, "Preserving our heritage, ensuring our future," captures the sense of importance accorded to maintaining the unique identity of AOM in the shifting medical and legislative landscape. Among the accomplishments listed were achieving the status "Licensed Acupuncturists (L.Ac.)," in the state, a title denoting their ability to practice independently of physician referrals and oversight. In addition, the association succeeding in preserving the term "Oriental medicine" within the scope of practice in the

state. This became a hot-button issue in 2008, when practitioners were called upon to rally against the Department of Health's proposed changes to their scope of practice, particularly the ability to practice Oriental medical theory, a change which would have serious implications for the identity of acupuncture and Oriental medicine.

In addition to the state acupuncture and Oriental medicine association, the American Association of Acupuncture and Oriental Medicine (AAAOM) is concerned with issues of professional boundaries and identity. It was established in 1981 "to be the unifying force for American acupuncturists committed to high ethical and educational standards, and a well-regulated profession to ensure the safety of the public" (<http://www.aaaomonline.org/default.asp?pagenumber=12#Mission>). Rather ironically, internal divisions caused the organization to splinter into two national organizations in 1993. Concerns for the identity and sovereignty of acupuncture and Oriental medicine while advancing its acceptance and integration with allopathy were evident in both the promotional material for the AAAOM and at its international conference, held in October of 2007. The purposes listed on the AAAOM website (<http://www.aaaomonline.org>) include:

1. To establish, maintain and advance the professional field of Oriental medicine, with acupuncture and other modalities, as a distinct, primary care (ability to exercise professional judgment within the scope of practice) field of medicine;
2. To integrate acupuncture and Oriental medicine in to mainstream health care in the United States;
3. To advance the science, art and philosophy of acupuncture and Oriental medicine;
4. To protect the body of knowledge acupuncture and Oriental medicine.

To this end, the AAAOM is involved in legislative and public policy activities, including lobbying for state regulation, the enactment of new practice acts and the expansion of scope of practice.

I attended the AAAOM 25th Anniversary International Conference and Exposition in October of 2007; considered to be a milestone in the history of the profession, representing, as it did, the merging of the two separate national organizations. The event was met with much fanfare and the proclamation that "a new era in Acupuncture and Oriental Medicine leadership has arrived" (<http://www.aaaomonline.org/default.asp?pagenumber=12#Mission>). In recognition of this reunion, the conference was entitled "Strength Through Unification," and strongly focused on both the profession's past and its future, with an interactive panel entitled "Charting the Future of AOM," held by Dr. Adam Burke, which solicited audience input into the priorities, actions, and initiatives of the AAAOM.

Concerns for the identity of Chinese medicine in the face of the profession's drive toward integration were well illustrated throughout the conference, as speakers stressed the importance of presenting a unified front to the medical establishment, of advancing the medicine through increased public and professional acceptance, of protecting professional territory from practitioners of other modalities (including physicians) who

may have taken “a course.” Also highlighted was the challenge of balancing a perceived need to standardize the medicine (its terminology, point locations, and diagnostic codes) in order to smooth its transition into the global health care system while simultaneously maintaining, nurturing, and preserving diversity of practice within the field and the identity of AOM as a unique, autonomous medical system.

A conference session held on October 21 entitled *Integrating Acupuncture and OM into the Hospital Setting*, presented by Jeannette Painvich, a licensed acupuncturist employed at a hospital in California, stimulated very good discussion concerning how the language and practices of Chinese medicine can, or should, be transformed in Western medical settings. “Graceful integration,” we were told, requires communication skills: practitioners of Chinese medicine must learn to speak the language of evidence based medicine, restrict the use of Chinese medical terms, and translate obscure Chinese medical terms to be into the language of Western medicine: “Don’t be overly attached to Oriental medicine” read a PowerPoint slide. Asked one audience member in response: “How do you talk about our medicine *without* talking about *qi*?” Another pondered aloud whether the benefits of getting a foot in the hospital door might be worth risking the “cultural inaccuracy” inherent in translating Chinese medicine into Western terms. Mused another: are the short term inconveniences and growing pains of integration outweighed by the long term goal and the importance of being part of a movement toward truly integrated health care?

In addition to its terminology, the restriction of certain techniques associated with AOM, such as moxabustion, within the hospital setting also raised some concerns. While “collaborative medicine” implies equality between medical systems and practitioners, it is unclear how such equality can be achieved when integral elements of AOM, herbs and moxa, must be left at the hospital door. This concern for control in the clinical encounter was echoed by Ben-Arye et al (2007:570), who found that:

Physicians favored a physician-directed model whereas practitioners favored a co directed model...this discrepancy is not remarkable because teams composed of professionals from different fields may experience conflicts relating to status, power, and different understandings of the concepts and nomenclature used in different modalities.

Hollenberg’s study of two newly established “integrative health care” centers in Canada (2006:731) demonstrates that:

Biomedical practitioners enact patterns of exclusionary and demarcationary closure...by (a): dominating patient charting, referrals and diagnostic tests; (b) regulating CAM practitioners to a specific “sphere of competence”; (c) appropriating certain CAM techniques from less powerful CAM professions; and (d) using biomedical language as the primary mode of communication.

CAM practitioners respond in turn by, for example, “appropriating biomedical language and terminology,” “increasing their professional status by working with Biomedicine” and establishing referral networks amongst themselves (2006:731). Hollenberg concluded that “when attempts are made to integrate Biomedicine and CAM, dominant biomedical patterns of professional interaction continue to exist” (2006:731).

While many in the field, including Dr. Jacob Silman, accepted integration of alternative medicine as being inevitable (Giordano et al 2002:899, Barrett 2003:417), it is seldom questioned whether the process is desirable, or whom it will benefit. Indeed, recent research suggests that CAM practitioners retain their marginal status vis-à-vis their allopathic colleagues even in integrated and collaborative health care settings (Shuval et al. 2002, Mizrahi et al. 2005). Although CAM practitioners may use such associations with Biomedicine to enhance their professional status (Hollenberg 2006), increased status and legitimacy conferred by integration with Biomedicine is balanced by medicalization of practice and training, and loss of the alternative systems’ philosophical underpinnings and cultural critique. This has been called by Saks (1992) “the paradox of incorporation.”

Students also expressed concerns that acupuncturists working in integrated medical settings may be reduced to the status of “technician.” Said a male focus group participant: “that’s something that also has to be understood, that it’s not a mode of treatment. It’s a system of medicine.” Students questioned the “fairness” of having to change, translate, or prove their medicine in order to accommodate Western practitioners, as well as the implications of such translations for the authenticity and identity of TCM. Kowtowing to Western medicine was not always popular with students, and several bucked against it. In Helen’s home state, patients had to be referred to an acupuncturist: “I don’t want to kiss the MDs’ butts back there,” she told me, “because you *know* it [acupuncture] works and you *know* that it could be very valuable.”

Although she was a vocal proponent of integration, Laurel had become “more critical” of the concept and her own responsibility, as a future practitioner, to consider how integration can be accomplished “without losing the autonomy of what traditional medicine is and the foundation within the holistic concept...and not just fitting into a cookie cutter model in order to be within Western institutions.”

On the other hand, several students, as well as Dr. Jacob Silman, expressed the perspective that if acupuncturists want to play in the allopathic ballpark, they would have to play by the allopathic rules: “They have the ball,” he stated, “so what am I going to do? Get invited [to play].” Dr. Silman’s upcoming agenda included talking to a biomedical group about acupuncture for oncology, “what every patient needs to know about Chinese medicine,” and the mechanisms of acupuncture. “If I walk in and only used Chinese medical terms, nobody’s going to get it, and I will be wasting their time -- as well as making a bad impression,” he concluded.

“Biomedical providers do not have any obligation to put Chinese medicine in their curriculum,” Jake reminded me, although he admitted “that’s slowly changing,” whereas “We are required by the needs of our profession to understand a little bit of chemistry and biochemistry and Western medicine.” Recognizing the dominance of the biomedical paradigm, Cant and Sharma (1999:432-33) write:

Biomedicine is still the most powerful single health-care profession and is unlikely to cease to be so: those forms of alternative medicine that have been most successful in terms of gaining greater public recognition and legitimacy are, on the whole, those that have had the approval of a sizeable section of the medical profession.

Said Dr. Silman:

An acupuncturist in the United States is basically always trapped between Chinese medicine and Western medicine. So, they're practicing a non-indigenous medicine in a culture with a very strong indigenous medicine...So they can't ignore Western medicine...the reality is, in order to be successful, they're really trapped between two medical systems.

It was this position of being "trapped between two medical systems" – two very different physiological perspectives and theoretical orientations – which posed one of the greatest challenges for students of AOM: that of integrating the paradigms of Chinese and Western medicine into a model of clinical practice.

In summary, while first year students of acupuncture and Oriental medicine recognized the importance of Western medicine in order to communicate and collaborate with allopathic practitioners, many expressed concern that the volume of basic science detracted from their studies of AOM. For many, while scientific research provided a language with which to speak to patients and physicians, "proof" of acupuncture's efficacy was not necessary: AOM is an autonomous and complete system of medicine with an energetic, rather than scientific basis, that must be taken on faith. Such a belief was also expressed by several biomedically trained Chinese faculty members, who drew upon their own clinical experiences and the history of Chinese medicine in order to validate its efficacy. In addition, many students felt that the emphasis upon scientific research and validation was disrespectful to AOM, a system of medicine which, like its practitioners, should be accepted for what it is.

As I have shown, science occupies a curious position at Emeritus University and also within the field of complementary and alternative medicine. Increasingly, CAM practitioners are being called upon to validate the results of their medicine using biomedically derived trials and protocols. As discussed at length by Dr. Jacob Silman, attempts to squeeze CAM modalities, such as acupuncture, into a biomedical mold risk deforming these systems of medicine beyond recognition. Nevertheless, as schools and professions of CAM become increasingly reliant upon funding, support, accreditation, and reimbursement by the state, insurance companies, and organizations such as the National Center for Complementary and Alternative Medicine, the calls for scientific validation and evidence become increasingly difficult to ignore. From the perspective of critical medical anthropology, a school of CAM such as Emeritus University becomes an ideal setting in which to observe the impact of these larger, macrolevel forces upon the microlevel of student experience.

Critical medical anthropology perceives the relationships between the dominant system of Biomedicine and other medical modalities in a pluralistic society to be constantly in flux. While acupuncture has increased in acceptance, students and administrators alike perceived the playing field to be far from level: while integration may be inevitable, its implications for the identity of AOM remain to be seen. Critical medical anthropologists argue that the subtle shift from the term “alternative” to “complementary” or “integrative medicine” represents a strategy of co-optation (Baer 2004, Wolpe 1999). Baer argues that “complementary” and “integrative” medicine are biomedical constructions that, while appearing to retain holistic philosophy, actually “function as a style of health care in which Biomedicine treats alternative therapists as subordinates and alternative therapists as adjuncts” (2004:xix). Ethnographic studies of integrative clinics seem to support this observation (Hollenberg 2006:731). Colgate argues (Barrett 2003:423) that the success of certain “alternative” modalities in terms of acceptance and integration rests partially upon their similarity to certain aspects of Biomedicine, including their “ability to fit into the existing diagnosis-based system,” “willingness to be viewed as complementary rather than alternative,” “willingness to accept legitimacy standards such as educational and accreditation standards, licensure, and clinical practice guidelines,” and “adequate and appropriate evidence of efficacy.” Seen in this light, integration would indeed seem to be less about collaboration than co-optation and appropriation; the maintenance and perpetuation of the hegemony of Biomedicine; the neutralization of competition posed by an increasingly popular system of medicine. The successful student of AOM emerges inculcated not simply with the necessary medical knowledge and skills, but with less explicitly taught values concerning their place in the medical landscape, respect for science, and deferment to the dominant system of medicine.

From the perspective of critical medical anthropology, the elimination of energetically focused and diverse forms of Asian medicine coupled with the increasing emphasis upon biomedical science and research within the curriculum poses a significant challenge to the unique philosophical and theoretical basis of AOM and to its identity as an autonomous system of medicine. Students graduate from Emeritus not just versed in the language of science with which to communicate and collaborate with allopathic practitioners, but as practitioners of a standardized and biomedically sanctioned form of Chinese medicine, carefully sanitized of the concepts and philosophies that confound Western medical explanations and models of treatment.

Fundamentally, questions concerning the place of science within the AOM curriculum at Emeritus University are questions about the identity of acupuncture and Oriental medicine in the United States. Far from being limited to students of AOM, they are being asked by the profession itself: How can the models of acupuncture and Western medicine be combined in clinical practice? What do acupuncturists risk losing in terms of their autonomy and identity in their struggle to gain allopathic acceptance? Can practitioners of AOM ever hope to achieve equality in biomedical settings?

According to promotional material published by Emeritus University, students of AOM will graduate with the best knowledge and skills of both worlds: Eastern and Western. In the following chapter, I explore the challenges they face as they sought to

straddle these worlds and the divergent models of medicine and the human body they encompass.

Chapter 7

New ways of thinking: The integration of Western and Eastern models of the body

The stress is coming...save those acupuncture treatments until midterms when the Liver *qi* becomes stagnant and the lingering Godzilla-like Liver hunches down and batters the pathetic cowering Bambi-like Spleen, and the Liver draws too much from the now prune-like Kidney *qi*, and the Kidney *qi* fails to grasp adequately the Lung *qi*...there are whole formulas on how to pull the liver *qi* off the throat of some other pathetic organ.

Dr. Jacob Silman, Clinic Entry Class

As the above quote indicates, it was not simply the *amount* of material that posed a challenge to first year students of AOM, but the *nature* of it. This chapter explores the challenge experienced by students associated with the straddling of two very different medical worlds required by Emeritus University's focus on integration.

It was widely recognized by professors and administrators alike that in addition to integrating Eastern medical courses and biomedical sciences, the study of TCM required adopting a new mindset; a new way of thinking about the body, disease, and health. The Dean of the School of AOM expressed the belief that the most challenging aspect of the first year was "the non-linear thinking" characteristic of Chinese medicine and the tendency of students to try to "take Chinese medical concepts and land them in a Western construct, rather than being comfortable sitting there in a different paradigm." During his introduction to Meridians and Points, Takoda told students:

This is a totally different view of the world, and most of you won't get it until the beginning of the third quarter [when] the light bulb goes on. It takes a little time to shift your perceptions and start to see things the way the ancient Chinese did.

Learning acupuncture and Oriental medicine involves learning, and integrating, two new languages: that of both Chinese and Western medicine. Certainly there is an explicit level to this multilayered concept. Students learn medical Chinese, for example. In addition, Chinese herbal medicine, Meridians and Points, and TCM Fundamentals present students with numerous Chinese medical terms like "hun," "shen," "wind," "damp," "heat," and "cold"; all ideas with no relation to their English and Western scientific counterparts. The concept of "*qi*" proved especially challenging, as it has to scholars of Chinese medicine (Kaptchuk 2000:43-44; Scheid 2002a:48, Unschuld 1985:72). *Qi* is the foundation of Chinese medicine, yet it confounds English translations: neither "energy," nor "life force," nor "breath" can adequately convey its meaning. The Chinese pictogram can be translated as "vapors rising from food," or, as Dr. Li told the class, "steam rising from a pot of cooking rice." This image of a swirling,

drifting, intangible substance, continuously in motion, nebulous and ephemeral yet constant, seems to capture the mysterious, elusive, and beautiful nature of *qi*. Nevertheless, “energy” was often used interchangeably with *qi* by both faculty and students, probably for the sake of convenience and to establish some basis of mutual understanding.

In addition, students encountered some very strange sounding translations of Chinese medical concepts during their first year, including “chicken eyes” (defined roughly by Dr. Song as “night blindness”), “ghost-cut-the-hair” (sudden hair loss), “steaming bones” (translated as a ‘bone-deep’ heat in the body) and “running piglet syndrome,” (an evocative phrase defined as “almost like a panic attack”: a rapid rising of energy that causes palpitations and makes the sufferer feel like they’re going to die). They also confronted concepts that flew in the face of Western ideas and logic: during later classes and quarters, students were advised to avoid “raw” foods, including salads and other uncooked vegetables (a staple of the North American healthy diet approach). During TCM Pathology, Dr. Li told students that during the construction of the Great Wall of China, when laborers ran out of mortar, they used rice. “You don’t eat cold rice,” he cautioned us, “Or you build Great Wall in your intestines.” A handout entitled “Diet According to Chinese Energetic” distributed by Dr. Li during the spring quarter classified foods by their “cold,” “cool,” “neutral,” “warm,” and “very warm” qualities and effects on the body: among the familiar listings (lettuce, sugar, tofu, cucumber, olive oil, orange, beef, and shrimp) were some examples not commonly found at the American dinner table: lotus root, horse milk, towel gourd, logan pulp, horse meat, jelly fish, and sea cucumber among them. Vegetarian and vegan students had a particularly rough time defending their dietary choices in the face of Chinese medical advice that consuming animal products, especially red meat or organ meat, was necessary for “building blood” and sustaining mental function. Dr. Li launched an attack upon national dietary treasures of the United States, including ice-cream and barbeque, especially the moist, juicy, undercooked burgers and meats highly prized by backyard chefs from coast to coast. Similarly, students were counseled by Dr. Song against any exercise which would produce too much sweat, eliciting a stream of questions from students raised with the idea that the more sweat, the better. Finally, the concept of “normal” or “adequate sex” (in Chinese medicine considered to be once or twice per week, depending on age, to preserve Kidney Essence) was met by cries of “boring,” hoots, and groans from an audience not overly enamored with such stringent limits.

There is also an implicit level to the concept of learning a new language: over the course of the first year, students learn to speak of health, illness, and the human body using the symbolic language of both Western and Chinese medicine. Note Good and Good (1993:97):

‘Learning a foreign language’ is a central metaphor for medical education...on the surface, the meaning is clear. There is a huge vocabulary to be learned, a working vocabulary as large as most foreign languages, and competence in medicine depends on learning to speak and read the language. Here too, however, there is a subtext. Learning the

language of medicine consists not of learning new words for the commonsense world, but the construction of a new world altogether.

For students of allopathic medicine, this new world “is a biochemical world, a world of cell biology and of physiological systems as well as of discrete diseases” (Good and Good 1993:98). By contrast, the new world into which students of Chinese medicine must enter is a world of energy and energetic pathways, body fluids, heat, and cold; a world in which wind “invades” the body, “phlegm” mists the mind, and liver “fire” upsurges to inflame the heart. Entry into such a body is not granted through Western anatomy and physiology. Medical education begins in Meridians and Points, with the description of an energetic body criss-crossed by pathways and scattered with acupuncture points through which this invisible life force *qi* might be accessed and augmented. Such a body must be taken on faith: it is not until the laboratory session of M&P that, through careful palpation, observation, measurement of physical landmarks, and their first tentative attempts to feel the subtle energetic shifts above the acupuncture points, students can begin to map this new and foreign body: placing their sticky paper dots and connecting the meridians with colored markers, making visible what can never be seen with the eye.

Students initially attempted to reconcile these two very different models of the human body: a more familiar “Western” body presented in Living Anatomy and Anatomy and Physiology classes, described in terms of cells, bones, muscles, tendons, and tissues, and a stranger energetic “Chinese medical” body. However, like blueprints of two very different houses superimposed one upon the other, the fit was not very good. Writes O’Connor: “the models of bodily composition, organization, and function of TCM and Western biomedicine cannot be mapped onto each other in any set of direct correspondences” (2000:48).

The Chinese instructors of TCM were very clear about the necessity of separating Western and Chinese medical thinking. During the first class of TCM pathology, Dr. Li asked “What is the key difference between Western medicine and Chinese medicine? When you study Western medicine what is the most important class?” Some answered: “anatomy and physiology.” “Very good,” replied Dr. Li. “Anatomy is the most important because it is the Western medicine foundation, the study of human structures.” He went on to explain that in Western medicine, the cell is the most important, most fundamental unit. “What’s the final purpose of studying anatomy?” he asked, then answered “to make people well.” He drew a diagram on the board of very basic cell physiology, with carbohydrates, proteins, and fats entering a cell where they are transformed into ATP/ ADP (energy). “Energy,” he explained, “is the fundamental basis of all medicine; all medicine is related to energy.” He continued: “What is Chinese medicine’s fundamental unit? Not cell! *Qi*! *Qi* is also energy,” he explained, but

There is no word that can translate *qi*, like *tofu*. Not energy, not vital force. If you study Western medicine you’ll be good on material, good on structure, but in Chinese medicine the *qi* is most important...you have to focus on the *qi*. The most important is the *qi* concept. Never, never use

Western concepts of structure [in Chinese medicine], don't look for material, structure – you must look for *qi*. *Qi* is the basic material of the universe. [In Chinese medicine] the basic unit of the body is not the cell, *it is the qi!*

By comparison, in Living Anatomy, Anatomy and Physiology, and Western Pathology, the cell as the fundamental unit of the body was stressed. “It all starts with the cell,” we were told, and throughout their first year of studies, students were inundated with basic science material emphasizing this cellular, reductionistic model of the body, health, and disease characteristic of Western medical science and medical education (Good and Good 1993:97-99). The colorful mobile used in Living Anatomy was probably the most ‘reduced’ depiction of the human body I have ever encountered – yellow, purple, red and pink spongy shapes dangled from a frame, symbolic representations of the various organs, with four rectangular sheets suspended around them to represent the tissues. The first Anatomy and Physiology class provided an exceptional example of the mechanistic and reductionistic approach of biomedical science to understanding the human body as well as the emphasis placed by basic science faculty upon the primacy of the cell. Dr. Stiller talked students through the structure and function of the cardiovascular system beginning with at the gross level of the blood vessels and progressively narrowing her focus to consider the smaller and smaller components: the smooth muscle of the blood vessels, the cells of the smooth muscle, and finally the chemical reactions within the cells themselves. “From the perspective of the whole course,” she told the class, “we’re actually kind of starting here, this quarter, with the cell level, and then thinking about the cells in general and the basic tissue types and what they do, and then we’ll work up to various organ systems and how they function.”

Whereas the medical world explored by allopathic students is “wonderfully reductionistic” (Good and Good 1993:97), faculty in the Chinese medicine department expressed to students the necessity of adopting a *holistic* view and way of thinking about the individual within the context of the universal. Dr. Song’s introduction to the TCM Fundamentals course presented the human body in terms of yin/yang theory, with the “talking, lecturing, thinking,” functioning aspects as “yang” and the “nutritious substance” of the body as the “yin” aspect. Yin and yang are interrelated opposites that are constantly transforming one into the other in a dynamic balance that constitutes a healthy human being. In stark contrast to the biomedical body, which can be dissected and examined down to the microscopic level of the cell, the body discussed by Takoda in Meridians and Points class was something to be comprehended philosophically, energetically, and spiritually using the concepts of balance, holism, and connection. “Chinese medicine is all about balance,” he told students, “yin/yang, fire, water; everything in balance.”

While the difference between Chinese and Western medical paradigms began with the fundamental unit of the body, it certainly did not end there. The difference between the structure and function of organs exemplifies the challenges of reconciling Western and Chinese medical models of the human body. During the first quarter, Dr. Song emphasized the “functional” concept, rather than the “anatomical concept,” of

organs. It is not my intention to provide a thorough discussion of the Chinese versus Western body. Some basic points must, however, be made. According to Scheid (2002a:27-28):

No single term in classical Chinese corresponds to the English “body,” with its implicit meaning (shared with other Indo-European languages) of a vat or container and its categorical opposition to “mind”...[it is] not an aggregate of discrete morphological substances linked to each other anatomically by means of mechanical structures and physiologically by way of interactive functional systems. Rather, it is a complex unit of functions and a site of regular transformations.

The body is understood through metaphors and allegories of leadership and nature, such as “the waterways that were essential to transportation and communication in China, the climate and seasons, and the other myriad interactions between heaven and earth” (Scheid 2002a:28). In Chinese medicine, there are six ‘Zhang’, or ‘yin’ organs (Heart, Pericardium, Lung, Spleen, Liver, and Kidney), six ‘Fu’, or ‘yang’ organs (Gallbladder, Stomach, Small Intestine, Large Intestine, Urinary Bladder, San Jiao or “Triple Burner”), and six “Extraordinary Fu” organs (Brain, Marrow, Bones, Vessels, Gallbladder, Uterus). Not only does the anatomical location of these organs sometimes differ between Western and Eastern medicine, Chinese medicine recognizes organs that do not exist in Western medicine and confers excessive importance upon organs regarded to be insignificant by biomedical standards. Chinese medicine does not recognize the pancreas, lymphatic, endocrine, or nervous systems, but attaches fundamental importance to the Spleen, Gallbladder, and Pericardium, as well as the mysterious, non-quantifiable substance *qi* which travels through the body along an invisible network of energetic channels. Writes Kaptchuk (2000:78):

China’s lack of a refined anatomical theory like the West’s does not mean its system is quaint or primitive, it means only that there exist alternative systems of thought, one Eastern, one Western...In the Chinese system, the Organs are discussed always with reference to their function and to their relationship with the fundamental textures [*qi*, blood, fluids, spirit, and essence], other Organs, and other parts of the body.

In Chinese medical theory, the Liver, for example, “is defined first by the activities associated with it,” versus the Western liver, which is defined “by its physical structure.” And an organ like the San Jiao, or “Triple Burner,” is “a function without a physical correlate” (O’Connor 2000:45). In keeping with the philosophy of Chinese medicine, which views all phenomena, including the human body, as interconnected parts of a greater whole,

Precise anatomical locations and structures of organs and bodily systems (the central concerns of anatomy in biomedicine) are of relatively little interest or concern by comparison with the functions of and relationships among bodily constituents and systems (O'Connor 2002:43)

The liver, heart and brain emerged as exemplary of organs familiar to students which were redefined in Chinese medical terms and made foreign. During TCM Pathology, students learned that “the Liver is the house of the soul [Hun],” which functions to control the flow of *qi*, stores blood, and aids digestion. In TCM pathology, Dr. Li noted that both Western and Chinese medicine understand that toxins accumulate in the liver, but in the latter, it is on an energetic level: the liver has both a physical and an energetic component. Later that afternoon, students regrouped for Anatomy and Physiology, and learned from Dr. Stiller about the liver’s function from a Western perspective, for example, producing clotting factors in the blood plasma. The contrast between TCM and Western medical perspectives was made especially pronounced by the fact that the two classes took place in the same room, the information written on the same board.

In Chinese medicine, the brain is understood to be an “extraordinary organ,” poetically described as “the sea of marrow,” with very little function or importance. An interaction between Dr. May Cheng, substituting for Dr. Song in TCM Fundamentals, and a student, exemplifies the challenge faced by students attempting to reconcile their Western, biomedical anatomy with the new body being constructed in their Chinese medical classes:

Dr. Cheng: Are you guys, in your mind, when you hear the word ‘thinking, memory, mental activities’, are you thinking ‘brain’ from a Western perspective? You are. Is it kind of weird to think of ‘heart’ takes care of all this in Chinese medicine? Understand in Chinese medicine, when we talk about thinking, we don’t think with our brain, we think with our heart. So when we think in Chinese culture, this is what we’re talking about. We think with our heart. That is why when the *shen*³⁰ is not present, thinking is kinda skewed.

Student #1: How does that – how did they relate that to organic brain function?

Dr. Cheng: Way back then, they – brain was -- remember brain falls under [the category of] “extraordinary organ” – they didn’t really place a whole lot of emphasis on that. They just thought, the brain was something that just sat in the head, it was nothing. So everything comes from here, from the heart. There was no correlated link with thinking, mind, and organic brain.

³⁰ Shen: loosely translated in English as “Spirit.”

Student #1: Okay, but under current medical understanding it can't have taken too much observation to notice that if someone gets hit in the head they lose mental function.

Dr. Cheng: So if somebody gets hit in the head and loses mental function what are we saying? That there's something wrong with the heart. The heart has been damaged. The King is not home³¹.

Student #2 (To student #1): Don't compare them! It's not fair. It's like comparing two cities. You know, they're not the same city...comparison is a destruction of the understanding of this medicine.

Dr. Cheng: Exactly. This is thousands of years ago. So I stress to you guys: when we're talking about Chinese medicine, I understand how a lot of this is just – where is it coming from? It doesn't tie in with Western medicine, you have to stop comparing and take it for what it is and how it was developed.

This was easier said than done. Asked a student with a nursing background “how does working with the *heart qi* help the blood vessels? It's hard for me to remove my Western thinking and thinking about, like, coronary artery disease and sclerosis and things.” Queried another during TCM Fundamentals class: “If the gallbladder is removed, can you still treat it from a TCM perspective?” To all such questions, Dr. Song replied (and this became something of a mantra): “TCM don't know that yet,” meaning that the ancient Chinese founders of this medicine had no knowledge of such systems and physiological phenomena. Even today, she told me, TCM does not utilize modern Western medical concepts, and she stressed the completely separate nature of TCM and Western medicine.

The experience of confronting and processing simultaneously two fundamentally different models of medicine was challenging for students of AOM, requiring a shift in culturally-conditioned understandings of the human body. “You have to learn [Chinese medicine] in a different way,” explained Evan, “You don't learn it the same [as] you learn Western medicine, because it's cultural...you come here and you're starting as a baby.”

Other students expressed similar sentiments. Joe's lack of experience with Chinese medicine concepts or philosophies presented a challenge to his experience of learning during the first quarter:

It's not like opening an American government book and studying those concepts, and then closing it and opening a Chinese medicine book and studying those concepts and being like, “Oh, they were pretty equal.” It

³¹ “The King is not home”: In Chinese medical theory, the heart is known as the King.

doesn't happen. It's been tough for me, I mean, just to kind of grasp them and...make sense of them...it's difficult because it's so new and it's -- I've never seen it before.

Josh also discussed the challenge of reconciling Western and Eastern mindsets: "There's a lot of things that we don't think about the same way," he told me, "like, 'The liver is associated with wood.' Huh? What's wooden about the liver, you know? Things like that."

Kimberly explained:

One of the hardest things...is the combo of Eastern and Western thoughts we're getting right now. Like, we're in biochem and anatomy, but we're also taking TCM and Meridians and Points...it's just like this *bizarre* combo that we're supposed to understand.

Echoing Haas and Shaffir, who suggest "that the traumatic and dramatic nature of culture shock experienced by students in the early stages of their medical education is not unique to medical students but rather is characteristic of the professionalization process generally" (1987:37), Alex commented: "I feel like I'm in the middle of culture shock right now." But it is a double culture shock with which students of AOM must grapple during their first year of studies.

The Dean of the program was quick to note that great efforts had been made by the School of AOM and the Department of Basic Sciences to integrate first year courses such as Meridians and Points and Living Anatomy in order to aid the process of learning: for example, the first meridians studied in Meridians and Points traversed the arms and shoulders, which were the first structures studied in Living Anatomy. Nevertheless, a fundamental challenge faced by students simultaneously learning Western and Eastern medicine lay not in integrating the TCM and basic science courses, but in keeping them separate. Richard used the concept of "blood," the functions of which differ considerably between Chinese and Western models, to illustrate this challenge:

I hear people talking about it all the time, and when they're talking they're confusing -- they're using blood and they're talking about blood in the Chinese thing, but they're using it like they're talking about it in a Western circulatory system thing. And they're losing -- I don't know -- some depth to what they should -- what's really going on there. And that, I think, that takes people a while to hash out...When we're talking about it, you have to stay over here in the Chinese medicine thing and not blend them...They're two different *systems*. This system works based on these principles of *this* system. This system works based on these principles of *this* system.

Many times during the first year, the Chinese faculty stressed the vital importance of not equating one Chinese medical disease with one Western medical disease. At the beginning, student questions asked in class indicated attempts to reconcile Western and Chinese medicine, for example, asking if a Chinese medical condition *was* a Western disease. Is “Spleen *qi* deficiency” hemophilia? (No, explained Dr. Li – disorders of the blood like hemophilia could be related to multiple conditions in Chinese medicine). Is “Liver rising” high blood pressure? Does a certain point, which “benefits the eye,” mean that it helps myopia or infection? In response to this latter question, Takoda advised students to avoid trying to “throw Western symptoms on here”: “you’re trying to bring *qi* to the eye or pull out a blockage, you’re not treating a disease, you’re treating a movement of energy that underlies a disease.” “Never,” Dr. Li exhorted students, “say one Western medical disease is equal to one Chinese medical disease! Hypertension is not equal to Liver *qi* stagnation! One Chinese pattern can manifest as many Western diseases!” Stroke *could* be a “Liver wind” condition, but so could a grand mal epileptic attack. A Western disease like hypertension could manifest as several types of Chinese patterns, and a Chinese syndrome could present as many Western diseases. A few moments later, a student asked him: “could Parkinson’s’ disease be wind?” Reminded Dr. Li: “Don’t just think Parkinson’s equals Liver wind!”

Not equating Western and Chinese diseases was a complicated and often confusing business, made more so by the mixed messages that students occasionally received from faculty. Said Grace:

I find that a lot of people -- teachers included -- do associate Chinese medicine with Western-identified illnesses, like joy being a manic-depressive syndrome.

While Takoda cautioned students not to overlay Western diseases on top of Chinese medical diagnoses, he also stressed the importance of “thinking physiologically” in the Clinic, encouraging students to translate their TCM diagnosis into a Western medical explanation in order to facilitate communication between the medical practitioners. “Heat consuming body fluids” becomes the loss of water through breathing and sweating due to increased metabolic reactions. Dizziness, understood in Chinese medical terms to be caused by, for instance, “Blood deficiency” – was translated by a student as “hypertension.” His goal, he told students during the Clinic preview session, was to get us thinking in both Western and Eastern terms: “the Chinese system is interdependent with Western physiology, and if you put them together, you have a much better understanding of what’s going on.” Takoda stressed that TCM and Western science are not separate: “They are two different perspectives on the body.” “You can’t forget the basic cell physiology because it’s pertinent to TCM,” he told students.

Dr. Harold Taylor was also a vocal proponent of bridging medicines and often attempted to translate TCM concepts like “inflammation” into Western pathological terms. An overhead during a lecture in early May presented a list of both Western and Chinese anti-inflammatory botanicals and Harold made a consistent effort to integrate Chinese concepts into his discussion of the inflammatory response and other

physiological and pathological phenomena. At one point he asked students: “what is myocardial infarction? A slowing of the blood flow. What is the slowing of blood in TCM? Heart / blood stagnation, so we can start to connect them, so we can have a common language here.” A discussion of cell injury and death provided an excellent example of Harold’s attempts to bridge Eastern and Western medicine and also the ‘mixed’ nature of the messages conveyed to students about the possibility of translating Chinese medicine into Western medicine:

The moment when a cell is no longer in a so-called reversible and is now in irreversible injury, why is that important for you to know? [No answers...] Well think about it, if you’re trying to assist the healing process, if you’re trying to bring somebody back in balance, if you’re trying to adjust...what would that be? That thing with the “Q”...um...some kind of *qi*? So if you’re trying to do that, then this is a critical point in time, because in fact, once a cell’s dead, you’re not going to be re-adjusting it anymore, right?

During a later interview, Harold willingly admitted that he knew very little about the workings of Chinese medicine, or what the TCM diagnoses might mean in Western medical terms. His goal, was, however, to get students thinking about the ways they interconnect.

Several times his attempts to connect Chinese medical pathologies with Western medical pathologies seemed to conflict with Dr. Li’s admonitions not to equate one Chinese medical disease with one Western disease. Does blood stagnation equal a myocardial event? Does the TCM diagnosis of Spleen *qi* deficiency, manifested as fatigue, weakness, depression and loss of appetite equal “chronic inflammation at moderate levels”? Students, too, sometimes demonstrated their allegiance to the TCM model of disease. During one class, Harold asked students why fluid stays in blood vessels. A student replied, “Because of Spleen *qi*.” Harold smiled a little indulgently, and said, “I’m looking more for the Western explanation.” Another time, Harold discussed the role of stress in the immune system response. In reply to his question of “what’s a strong immune system?” a student shouted out “Good *wei qi*!” to the amusement of all. “What does it mean in Western medicine?” asked Harold, and “why does stress impact immunity?” To this, a student responded: “because the Liver overacts on the Spleen!” “Yes, that’s the *Chinese* explanation,” said Harold, becoming perhaps a little annoyed, “What about the Western explanation?”

All arguments aside concerning the validity of comparing a system of medicine founded on the study of the cell with a system of medicine founded on the concept of *qi*, students seemed to appreciate his attempts to connect the paradigms. Said Evan: “He’s brilliant, and he’s really open -- unlike some of the teachers -- open to the Eastern medicine. Heck, he’s doing the mushroom studies.” The connections drawn by Dr. Taylor between Western and Chinese physiology and theory were, however, taken with a grain of salt. A conversation between several students after a Western Pathology class which traced the metabolic pathways of Chinese herbs for cancer treatment led Jack to

ask, rhetorically, “That’s not the way TCM works, is it?” There was some consternation that Harold didn’t acknowledge the very different diagnostic paradigm of TCM, including the fact that a practitioner of Chinese medicine would never prescribe just one herb, and scientific research must consider the entirety of the herbal formula, not one constituent. Further more, a TCM practitioner wouldn’t prescribe a herb formula on the basis of its metabolic or cellular actions, because in TCM, the basis on the medicine is *not the cell*. Noted David, in TCM, the diagnosis wouldn’t even be cancer: it would be phlegm or blood stasis, for example. “There’s a tendency to oversimplify,” he told me, “‘The inflammatory response is heat.’ True -- but heat is not the inflammatory response. You know? You’ve got to be careful. So there’s not a direct one-to-one correlation.”

Students were highly critical of professors who did not attempt to bridge the medical paradigms. According to Evan and Rosalyn, “Anatomy and Physiology” could have been improved by the addition of (in Evan’s words) “a teacher that wasn’t so against Chinese medicine.”

“Anytime you tried to mention Chinese medicine or tried to ask questions, she always just kind of shoved it under the table, because she didn’t understand anything about it and she didn’t try to understand anything about it,” he told me. “If you can’t relate to a student they aren’t going to learn.”

Throughout the first year, not only did students struggle to reconcile their own role and identity vis-à-vis Western medical practitioners: they also struggled to reconcile the identity of AOM vis-à-vis the Biomedicine that they were simultaneously learning.

“You have to go in with two mindsets,” said a male focus group participant, “You can’t take your Eastern mindset into the Western classes, and vice versa. We’re learning how to separate that... you’ve got to learn how to switch them.”

Said Evan:

I don’t think it’s integrated at all. I think that there’s the Eastern, then there’s a line, and there’s the Western. And I think if you want to integrate you’re going to have to be like Takoda and come up with your own theories and try to integrate it yourself, because it’s not going to happen within a school setting, because nobody agrees with how it integrates in the first place. If nobody agrees with how it integrates, how are they going to teach integration?

Many students eventually made their peace with this dilemma – not by “figuring out” how Chinese and Western medicine really could be integrated in terms of physiology and anatomy, but by accepting that while these two models might be incompatible theoretically, integration and reconciliation occurred at the bedside in a practical, hands-on model of clinical practice. Explained David:

It’s not that they’re [Chinese and Western models of the human body] mutually exclusive. It’s that within their own frameworks they’re incompatible. You cannot use Chinese phenomenon to explain Western

biochemistry. You cannot use Western biochemistry to explain Chinese phenomenon. It doesn't work. If you try, you fail. You get some kind of null equation -- metaphorically speaking. Today we're talking about the Spleen *qi*, for instance. It's responsible for converting food and air into nutrigen *qi* for the body. If you tell that to a Western biochemist they're going to say you're insane. The spleen has nothing to do with body nutrition, nothing at all. But the anecdotal evidence, though, is that if you treat -- within the Chinese model -- the spleen, for these digestive problems, you get a result. So, if the spleen has nothing to do with it, why are you getting a result?

Evan expressed considerable admiration for the Chinese faculty's breadth of knowledge of both Western and Chinese medicine, which, in his opinion, made their attempts to integrate the two models much more relevant in terms of how to treat a patient. For the same reason he found Takoda's use of case studies and emphasis on translating one set of signs and symptoms into another model to be "brilliant"

Because it's what you're going to see. Somebody comes your way. They have medical reports of what they've been diagnosed with. They have their tests, and you have to be able to translate that and then decide how you're going to treat them within an Eastern setting. So I think that's been integrated quite well. [Researcher: So, for you, there's this integration practically, and then there's integration philosophically?] Evan: Yeah, which doesn't exist.

Nevertheless, even if the models are incompatible, students seemed united in the conviction that knowledge of both was still necessary in order to communicate. Said David:

The models don't overlap real well, but they do touch on each other. And I really think having that expanded awareness of Western medicine is really helpful, especially since...most people are going to come to me, at least the first time, when Western medicine has already not succeeded. And knowing what they've been diagnosed with is going to be helpful in understanding what that means. Like, "Here's what's going on in your body." What that means in Chinese medicine is probably this, and then, of course, continue with the diagnosis and say, "Okay, it looks like this model, so let's go that way." I think it's really helpful.

The degree to which communication with allopathic medicine was stressed by faculty and students led me to shift, early in my research, from consideration of Chinese medicine and Western medicine in rigid terms of being different systems that cannot speak each other's language to how they *are* communicating, every day at Emeritus and in practice at the Clinic; not the reasons they *shouldn't* be able to speak to each other, but the ways in which they do. Several students expressed the perspective that even if the underlying mechanisms are different, the fact that they both "work" is the point – the human body itself provides the bridge between Western and Chinese medicine.

In summary, the emphasis upon integration placed by the AOM program at Emeritus University posed a significant challenge to first year students; namely, how to reconcile the languages and models of medicine (one holistic, the other reductionistic; one *qi*-centered, the other cellular; one symbolic and functional, the other anatomical and mechanistic) with which they were confronted. For many, this process resulted in culture shock and a need to re-evaluate taken-for granted assumptions about the body, health, and illness.

The fact that TCM does not work on the basis of the same physiological principles as Western medicine complicates the integration of Chinese medicine with Biomedicine in the AOM program. Students were presented with mixed messages from faculty concerning the possibility of equating one system of medicine with another and at least as much effort was directed by students toward keeping the two systems separate as it was toward integrating them. By the end of the first year, it seemed that many students had ceased their attempts to reconcile incompatibilities in theory and philosophy with an appreciation for the ways in which AOM and Western medicine could be practically used together in the clinic to treat what was, after all, the same individual patient. Many appreciated the attempts made by faculty to integrate Western and Chinese models of medicine in this practical sense, as well as the emphasis upon being able to translate Chinese medical model into a biomedical model in order to facilitate communication and collaboration with allopathic practitioners. As I shall discuss in the following chapter, while integration and translation offered the possibility of increased acceptance, they also posed a dilemma in terms of preserving the unique identity of acupuncture and Oriental medicine, and are part of a movement toward an "Americanized" version of traditional Chinese medicine.

Chapter 8

The Americanization of Traditional Chinese Medicine

In its biological sense, “evolution” refers to the slow, continual process of change in organisms over time. These changes may occur in response to the environment, and if they render the organism more suited to its surroundings, then it will survive and more successfully reproduce, equipping new generations with these beneficial adaptations. Over great time, a population of organisms may become so completely different from its progenitors as to be labeled a new species altogether. In the following chapter, I explore student and faculty perceptions of Chinese medicine’s role and identity in American society in relation to the movement toward an integrated model of medicine.

Traditional Chinese medicine’s long journey from China to the United States has indeed required it to undergo change in both form and function to suit the demands and expectations of Americans. Faculty provided numerous examples of differences between TCM in China and the US in order to illustrate these changes, one of which involved the frequency of treatment. Americans typically visit their acupuncturist once a week, as opposed to the Chinese, who will often seek treatment once a day until the condition resolves. And, in China, the emphasis lies upon prevention rather than treatment of acute conditions. In addition, faculty were quick to acknowledge the inability of Americans to tolerate discomfort and pain (otherwise known as “*strong qi sensation*”) during their treatments, versus China where the adage “no pain, no gain,” or in the case of herbs, “no bitter, no better” applies. In China, we were told by Chinese faculty, patients expect to experience discomfort during acupuncture or massage as an indication of the practitioners’ skill in “getting the *qi*.” Certain herbal formula ingredients were not generally appreciated by American patients, explained Dr. Ning, including cockroach, donkey skin gluten, pig bile, and gallstones from cattle. Americans, she explained, prefer their herbs in granular form, (labeled by the Chinese as “chicken dirt,”) as opposed to bags of large (and sometimes unfortunately recognizable) pieces.

The transformation of Chinese medicine to suit its North American users, practitioners, and regulators has been termed *Americanization*, a manifestation of which involves its “psychologization,” or reconfiguration “as simultaneously fulfilling medical, psychological, and religious functions” (Scheid 2002b:137, Barnes 1998). Since the 1970’s, there has been an increasing emphasis on the psychological or spiritual in the United States and Europe, where “Chinese medicine is reshaped by its associations with peculiarly Western understandings of concepts such as holism, energy, and spirit” (Scheid 2002a:33). A New Age preoccupation with “energy” and its “blockage” has resulted in the reformulation of alternative healing systems, including acupuncture, to “unblock” the stagnation of energy, often and erroneously defined as “*qi*” (Unschuld 1987:1024). Reformulations of Chinese medical concepts and techniques, such as acupuncture, are used in concert with psychotherapeutic approaches not consistent with Chinese medical practice (Kleinman 1980, Kleinman and Kleinman 1985). The Chinese,

according to Barnes, “do not tend to think of these [psychological] matters as belonging in the medical arena,” leading “the encounter with non-Chinese patients in the United States” to be “an unsettling experience” for many Chinese practitioners unused to dealing with emotional problems (1998:419).

Certainly many first year students of AOM at Emeritus University expressed interest in this aspect of medicine. Said Grace:

With fibromyalgia all the time, there’s the underlying emotion of grief and a huge trauma. And I think that’s true of almost any physical ailment, is that there is an underlying emotion attached to it. So I want further studies on that.

Takoda often spoke of the separation between “Five Elements” style acupuncture, which takes a more psychological and emotional approach to treatment, and the more physiological TCM, which he perceived had occurred at Emeritus. And, as noted in chapter 5, a strict division was drawn between the scope of practice of acupuncturists and psychologists, with students of AOM counseled to refer patients exhibiting psychological disturbances to a psychologist or counselor. In response to a student’s question concerning the more spiritual and psychological aspects of Chinese medicine, Dr. Song replied:

Well, that’s American TCM...now talk about spirit and stuff. Because it’s in the clinic real hard differentiate this is belong to spirit, this is belong to emotion...it’s way beyond my TCM thinking.

“So how do you address the negative state of mind?” queried a student known for his strong interest in Five Elements style acupuncture, “How do you view it with TCM? Because that obviously impacts their health.” While Dr. Song expressed great interest in these psychological matters, she made it clear that this was beyond TCM: “it’s very complicated issue...It’s real beyond my class, beyond my profession.”

According to a clinic supervisor, this division between psychology and physiology was one of the main differences I would encounter were I to sit in on a Chinese faculty member’s clinic shift (which, due to scheduling, I was unable to do). “If anyone shows any emotional disturbance they’re written off as a crazy person,” she said in a slightly tongue-in-cheek tone, versus the Western approach, which in her opinion had “pulled emotional, spiritual, and psychological healing together, and that’s what most people come for.” Interestingly enough, this same supervisor was very clear about the importance of delineating boundaries between the scope of AOM practice and psychology, advising students confronted with emotional disorders to “be present, reinforce that this is a safe place, and inform them about counseling. You don’t want to be the sole source of support, because that’s too much responsibility for you and the institution.”

In addition to the psychologization of Chinese medicine, my research among first year students of AOM and their faculty indicated that Americanization occurs through a process of standardization. This refers to the movement away from a diverse curriculum offering a range of Asian medical modalities and approaches to acupuncture, and toward a biomedically-based, science-heavy curriculum in order to facilitate the integration of TCM with Western medicine in the United States. Such a transformation was regarded by several students as being essential to AOM's acceptance in the United States. "We're not going back to China," said Helen, "we never will, I don't think, but incorporating that into what we have and, like making a new type of medicine, I think is where we're going, in a sense."

Laurel was adamant that Western or Chinese medicine didn't have to be taught "at the expense" of one another, although the shaping of Chinese medicine to suit Western patients made sense to her:

We are in the Western world where Biomedicine is the dominant field. It's institutionalized; it's everywhere. It's truth; it's what people believe. It's like our form of government. I mean, it is what you grow up with; therefore it is real. It makes sense...If we really want to have an effect with this sort of new field of traditional medicine that's evolving in the West, I think we have to give a little.

In Christopher's view, the ideal relationship between Chinese and Western medicine approximated that of marriage: "Neither of them are perfect," he explained, noting that "the Eastern...doesn't fit right into America", but by coming together, both forms of medicine could "make each other a little more perfect."

Richard spoke at length about the evolution of TCM within the cultural, environmental, and political milieu of Communism in China, and the need to reformulate it for its American audience:

You can't take a treatment that was formulated based on what worked on people 400 years ago saying, "The pulses say the person has this. Let's use these points." ...I don't think you need to say, "Here are these traditional treatments. They worked 500 years ago."

For Richard, the successful practice of acupuncture in the United States would involve adjustment of treatments in consideration of the Western lifestyle. Agreed Evan:

It's going to be people here in America that lead Chinese medicine to the next step, because with the Communist mentality nothing will ever really move beyond where it's at...So I think that Chinese medicine is going to spring forward in this country or in Western society in general, because I think that we have the questioning mentality and the drive to push it on to

other places that it hasn't been before, to work with people that haven't been worked with before, and to come up with new theories.

Jack saw the movement toward specialization within AOM as part of a natural growth and progression of the medicine in the United States:

I think if they [Emeritus] really want to become the world's leading university for natural health, they're going to have to be like every other medical school, where you have departments of oncology, departments of physical therapy, and departments of this and that, all within the same realm of medicine. Because America is -- Everybody's a specialist now. That's just the way it is...We don't live in China. We live in America.

The identity of Chinese medicine, and the role of its practitioners, had radically changed since Dr. Jacob Silman graduated from a college of TCM in California a decade ago. The "myth of the barefoot doctor in her Birkenstocks, with the incense burning, sitting in the...office with the rattan mats on the floor and the gong music playing" had been replaced by "a high-level of professionalism...and a willingness to learn this complicated world," explained Dr. Silman:

You rarely have physicians just all by themselves in these little practices with these cover paintings from the Washington Post on the wall, cute little sayings, and the elderly family practitioner with that one nurse doing everything in the office. Non-existent. They're all in group practices in complex systems with complex billing and software, dealing with exactly the same issues.

Like his students, Dr. Silman perceived the changes in the curriculum and practice of AOM to be a part of the natural progression of the medicine and its adaptation to the United States: "All medicine changes," he told me, noting the existence of a pervasive myth within Chinese medicine that "this is the real medicine":

It's been all over the world and in each situation it's very different...So what's happened is, it's evolved. It's changing. Every generation in each location will, in fact, profoundly change the medicine. The people that you will be working with here -- the students you will be working with here -- will, in fact, change the medicine.

It was Dr. Silman's belief that closer alignment with allopathy and an allopathic model of health care and education and practice was inevitable, and he was highly optimistic that the relationship between allopathy and AOM would only continue to improve:

Things are, in my opinion, getting better. I think that the world of the acupuncturist is divided up into a majority that think things are mostly getting better, and a still-robust minority who are unwilling to let go of the early phase in the development of the profession -- both educationally and in practice. They want to have small degrees, they want to be independent practitioners, they want nothing to do with physicians. And I think that there's a slow inexorable shift towards greater integration, greater collaboration, and I think, for good and for ill, we are more intertwined with the broader medical community. And it was inevitable that that would happen, and I don't think that's a bad thing. So it just means that, in that respect, we are more likely to experience some of the challenges the rest of health care is experiencing. Do I think it would be wise even if we could turn the clock back? No, I don't, because I can do more now than I could fifteen years ago. I can collaborate more, I can provide more options to my patients... There's greater -- more *trust* on all sides. There's greater *interest* in what each other's doing.

The bottom line was that "graduates today will step out into a better practice environment, but an infinitely more complex practice environment."

Taken together, changes in the practice and education of Chinese medicine represent adaptation of the medicine to suit its American audience, but they also problematize the concept of Americanization. The movement toward a more standardized and biomedically intensive curriculum, and away from an eclectic, energetic, emotionally and psychologically focused Chinese medicine, brings TCM at Emeritus more in line with universities of TCM in China and could therefore be thought of as a form of *Orientalization*. But this is not the complete picture. Standardization of Chinese medicine in the United States through scientific research and validation represents a response to forces unique to the United States: they are changes that align Chinese medicine with an allopathic model of research, education, practice, and insurance reimbursement in order to increase the acceptance, legitimacy, and status of Chinese medicine in this country and to further integration, a non-issue in China where hospitals frequently provide acupuncture, herbal medicine, and Tui Na modalities alongside Biomedicine.

Students are at the receiving end of a curriculum shaped by many hands, from National organizations like the ACAOM and the NCCAOM, to professional organizations of allopaths and acupuncturists, to the school itself. But far from passive victims of change, students perceived themselves to be active agents in the evolution of Chinese medicine in the United States.

Changing medicine: The role of students in shaping the identity of AOM and health care in the United States

The people that come into this health care system – their rewards will not be in the smoothness of the business of health care. Their rewards will be one patient at a time, at the bedside, and in studying medicine [Dr. Jacob Silman].

The Americanization of Chinese medicine occurs not only through the actions of large, powerful state and professional organizations and the schools themselves. The identity of Chinese medicine in the United States is also shaped through students' interests and concerns, as well as the actions taken by individual students to tailor the program to suit their goals. Jack, for example, had decided not to study herbs in favor of specializing in pain management, sports medicine, and physical therapy. In keeping with his interests, Christopher was enrolling in Five Elements and Pediatric Acupuncture courses. Caitlin intended to combine her knowledge and training in midwifery with AOM. Other students were pursuing further study in Qi Gong and meditation. Laurel and Alex's voluntary work at community acupuncture centers impacted their professional development. David and Kimberly completed a massage intensive course over the summer in order to broaden their scope of practice. These students will graduate as diverse representatives of a Chinese medicine that has been adapted to suit their goals and their patients. Said a female focus-group participant:

What we're being given is -- a key to a door that we can open, to make a choice of which way we want to go, of what books we want to look for outside of class, what programs we want to look at...or how it is that we want to approach the medicine. I feel like it's *our* responsibility to do that, and I feel great about it.

In addition, students played an active role in shaping the identity of Chinese medicine in the United States by adapting it to ameliorate the problems they perceived as endemic to the US health care system, including its expense and its inaccessibility. Many students thought of themselves as pioneers and advocates, advancing a new frontier of compassionate, affordable, and accessible health care in which acupuncture played a key role because of its holistic, preventative, low-tech, and low-cost nature. Indeed, many had been "pulled" to a career in AOM because of its alignment with their philosophical, political, and environmental views. Micozzi discusses the "push and pull" phenomenon in terms of broader issues in health care:

The push, for both consumers and health professionals alike, is the current crisis in our health care system—a crisis of costs, confidence, conscience, and consciousness. And a crisis that commands greater utilization of self-care and guided self-cure. As such, complementary/alternative medicine represents significant public health challenge and opportunity. The challenge is to produce good data on the safety and efficacy of complementary/alternative medicine. The opportunity is nothing less than to help solve our current health care crisis (1995:319).

It became apparent very early in my research that students of AOM were well aware of both the crisis and the opportunity noted by Micozzi. Complementary medicine, in particular AOM, was seen to be an antidote to the practical and philosophical shortcomings of medicine as practice, and business, as usual. Students envisioned being a part of a movement toward a different system of health care, and in this chapter, I explore their personal and political “visions of the future.”

Becker et al. term the “general notions about medicine and the medical profession that freshmen bring to medical school their “long-range perspective” (1961:69); an “emotionally intense” but “necessarily vague” vision based not upon experience but upon early perceptions of the profession and their goals within it. The paucity of detail, “emotional intensity,” and idealism of this perspective noted by Becker et al. (1961) were all discernible among first year students as they expressed their visions of the future. Several spoke liberally of “changing the world,” admitted to suffering from “save the world complexes,” or compared their goal to that of various spiritual leaders like Mahatma Gandhi. In keeping with their holistic philosophies, most students expressed a desire for change when I interviewed them; not just in medicine, but in the political, social, and environmental system that encompasses health care.

Medical pioneers and revolutionaries: Advancing a new system of medicine

Many students were highly optimistic about the future of AOM and saw themselves riding a wave of the medicine’s increasing acceptability. Said Evan, “I’m excited about being able to help people through something that’s worked for years and years and years...I’m excited about being a part of that as a group of people.” Simply by merit of choosing a career in AOM instead of allopathy, students exhibited independence and foresight, as well as a willingness to take risks, realizing that while acupuncture may no longer be exactly “alternative,” it is still not entirely mainstream, and does not yet enjoy the ubiquitous insurance and regulatory privileges of allopathy. Said one:

It’s easy to stay in one place and do the same thing that’s always been done. That’s the easiest thing to do. To be proactive means to do something that isn’t being done and step out on a limb and know that that limb may break.

There was, in this expression of independence and risk-taking, a pioneering spirit; a desire not just to reap the benefits of increasing acceptability but to actively manipulate the health care system to better suit their philosophies and visions of health. The following statement from Laurel exemplifies the enthusiastic desire to be part of the emergence of a new system of health care:

I feel like it's so exciting that I'm getting into this field right now...we're on the brink of something huge. Not only are we on the brink of the downfall of our health care system...we're on the brink of something else that's opening up this *space* where complementary and alternative medicine has the power to move in.

Claire echoed Laurel's sentiments regarding being part of a larger change in medicine that was interconnected with a shift in environmental and social consciousness:

I do feel like there's a big shift, and I feel like that's why a lot of people are being drawn more and more towards the natural aspect of medicine and -- I feel like we're stepping away from that industrialized everything and just getting back to the way it's supposed to be and the way -- I don't know. It just feels better to be one with the society and environment and nature.

Like Claire, David perceived the acceptance and expansion of acupuncture in North America to be related to a shift in human consciousness, a "psycho-spiritual paradigm shift" of which he was a part, related to the realization "that we're just not getting out of the world what we want to. There's still more to this. And that goes to a *whole* new realm of thinking -- from environmentalism to -- in our relationship with the other living things on the planet."

This pioneering spirit was not limited to first year students of AOM, but is instead reflected by the profession itself, as was demonstrated at the 2007 International Conference and Exhibition of the American Association of Acupuncture and Oriental Medicine (AAAOM), which honored "pioneers and leaders in this profession." Attendees received a "Commemorative Book of Challenge and Courage," entitled "AOM Pioneers and Leaders (1982-2007, vol.1)," which consolidated interviews with 77 living "pioneers and leaders," as well as tributes to four who are no longer living. The foreword reads:

The endeavor to produce this commemorative book came about as a result of the desire to honor pioneers and leaders and teachers in acupuncture and Oriental medicine and its evolution in the United States....Studying acupuncture and Oriental medicine is easily accessible today, with many books, teachers, styles, schools and Master's and doctoral level programs available to the public. These interviews allow us to consider how our

forefathers risked jail-time merely for practicing, had needles embargoed, and had to search far and wide for teachers and information.

Although students with whom I spoke in 2006 were separated from these “forefathers” by many years, they still expressed the sense of being at the forefront of, and actively shaping, the future of AOM in the United States. Said one young male student:

You know, we are the future. We’re talking about the way Emeritus’s shaping us. We’re going to be shaping everything, because we are the future. Right now, we are the future of the profession. We’re it. And since we’re at one of the best places in the country, we are -- we have the opportunity to be the core of what this becomes. And we have to make sure we look at it at not from the Western -- I really believe that the Western view of success is dead. I believe that it is a broken system, and - - pride, money, and competition -- it’s a broken system. It’s just -- that’s what I’ve seen all growing up and it doesn’t work...And I believe that we have the opportunity to break that, and we have the opportunity to show people that there’s another way and that greed isn’t the only way -- that we’re healers.

As indicated by his comment, many students envisioned themselves not just as pioneers, advancing acupuncture and Oriental medicine, but in revolutionizing health care itself. Said Christopher:

I see gaps widening...What happens when people realize that they can make money off other people’s misfortune? The gap becomes wider between those two people until there’s enough resistance, and until there’s a revolution of some kind...so that something new can take over. I’m becoming more and more optimistic about the resistance that’s building up, because we’re not a squandered resistance. We’re a capable resistance.

Throughout my study, students considered what their roles, and the role of AOM, might be in the dynamic landscape of medicine. Their niche was, according to several students, the provision of community-based, preventative healthcare that included Western and complementary medicine. Christopher envisioned “creating a health care system of our own that will start from the ground up,” inseparable from the community itself, a community-center of sorts offering child care, activities for teens and handicapped individuals, locally-grown food, and sustainable community gardens in addition to medical treatment. Said Laurel:

I think the space that's opening up for integrative medicine to really take shape is within the community health centers, because that's where...people don't have health care insurance, and that's where people are in need of cost-effective, more empowering ways of dealing with their own personal health and understanding of their bodies and all of that.

As research emerged to validate the efficacy of acupuncture, and as shortages of doctors and patient dissatisfaction with conventional medical care continued to increase, Laurel was confident that "there's going to be more opportunity for Eastern medicine to squeeze in there."

In keeping with students' alternative values and holistic philosophies, many expressed awareness of the social, political, environmental, and economic determinants of health. Said Laurel:

I see the fact that our country profits off of people being ill and diseased, and the fact that certain communities of people, culturally and racially, are -- you know, really channeled into those areas of ill health and are not given a choice. People don't have a choice about their own well-being in their lives...And I just feel like it's such an important time for us to step up and to be involved and to understand what's going on.

For Laurel, part of her role as a practitioner of AOM involved becoming active in political and professional organizations that championed the goals of AOM, such as the state acupuncture and Oriental medicine association. Laurel's experience working with an anti-weapon lobbying group had opened her eyes to the importance of political engagement, and she envisioned becoming actively involved with professional acupuncture organizations and with increasing awareness among students of political activism: "if there's enough people activated," she told me, "and if people are increasingly taking -- advantage of their agency, I think it can have an effect."

Notes Colombotos (1969:18) "Interest in the political ideology of the professions and its implications for social change has a long history." It became apparent that students were drawn to complementary medicine not only as an "alternative" to conventional medicine, but because it offered the possibility of an alternative to the expensive and inaccessible US medical system. Said Alex: "I think it's ridiculous we pay for health care. So, whatever this [future] health care is, I think it should be low-tech, non-toxic, and very affordable, if not free." As noted, several students, including Laurel, Evan, and David expressed the desire "to get involved in community health clinics." The following passage, taken from my first interview with Claire, exemplifies the goal, expressed by many students, to provide an alternative to medical as "business as usual":

I'm interested in the whole Patch Adams thing. I want that kind of setup. I want to provide health care for people that can't afford it. That's my ultimate dream. I just want to do something where I don't have to charge

people, and I know that's impossible to even think about, but there's got to be some glitch or some way to get around it, so -- definitely, I'm interested in that. [Researcher: What do you think inspired that in you, to want to provide health care?] Claire: Because I think it's ridiculous that we have to pay for it. And I know, as a student and as a female, it's just hard for me to even pay for insurance...It's outrageously expensive to me, and it doesn't make sense. This is something that everybody needs...It's just -- there's no way they should be charging people that much. It's so discouraging. There's *so* many people out there that don't have it for that reason. It's too expensive.

Insurance companies bore the brunt of student criticisms. Like CAM practitioners surveyed by Klimenko et al (2006:266), students were not unaware of the impact of increasing insurance coverage upon their role, identity, and scope of practice and several expressed concern about how insurance companies might try to dictate how they practiced and what conditions were reimbursable. Developing a cash for service model or a sliding scale of payment would, suggested a male participant, make acupuncturists "more available."

Agreed a male participant:

Yeah, if you're looking for cash and you don't have to deal with an insurance company, you can actually treat what the person needs treated, not just whatever the referral question is.

Students bounced ideas around concerning what a new system of health care might look like and ways to avoid the insurance trap, including community models of acupuncture, which, according to Alex (who volunteered with one such organization), allowed costs to be considerably lower due to the group versus private model of practice. Such a model also held the potential of treating the "isolation sicknesses and disconnect from the community" by bringing people together during sessions: "it's a way to engage the community more than just a one-on-one private practice, which will be such a big part of what I do," he told me, "I don't want to just bring a patient into a room, treat them, see the next patient. I want it to be a community center, and -- I want it to have more facets than just, 'come here when you're hurt and I'll fix you up,' you know?" In addition, a community model "rules out the insurance companies," which Alex described rather evocatively as giant, parasitic "spongers" on health. "Culturally we need to get our health back in our hands," he said:

Insurance has strings on all of us, I feel like, as far as health care is concerned. But it's really empowering to know that -- to be able to work with acupuncturists, work with the physicians, and know that you can manage your health without a lot of the immense headache and expense of insurance.

Explicit in Richard's description of his future practice was a criticism of medical insurance, and a desire to practice medicine outside the restrictions of the current system. He explained:

I have fairly well decided to avoid doing anything that has to do with insurance, other than for people that that's their only option. I'd rather do it on a self-pay, sliding fee for people that can afford it, which gives me a lot of leeway. One, people don't understand how much it costs them to do insurance. They think, "Well, the insurance reimburses it at this rate; they're making a lot of money." But by the time you spend the time processing, waiting for the delayed payment, getting rejection notices, getting, "Well, we're only going to pay this much." You know what? I'd rather see four patients, kind of rotate through them with someone assisting, or whatever, have them pay \$25 a visit, than to see one person and have it reimbursed for seventy.

"What if you just charged so little money that insurance wasn't as much of an issue?" mused Christopher, suggesting that proving the medicine to the public might entail adopting "a bohemian artist's mentality": "Do it for the medicine, not for the money," he exhorted his fellow focus group participants.

"Yeah, why not be poor?" quipped another male focus group participant with slightly less enthusiasm.

"Well, why don't you do both within your practice?" Suggested a female participant.

"Okay, today's not an insurance day. A line around the block. We'll see how many people I can get in today. The next day, insurance," enthused a male participant.

"Or," added the female participant, "you can go to a community health center one or two days a week. You at least bridge the gap so that you make money initially, you can support a family or do whatever it is you're trying to do - pay your school loans. And then, on the other days, you elect to sacrifice a little."

In keeping with their altruistic motivations and idealistic goals for pursuing CAM, students were highly critical of financial motivations. Said a female participant:

A couple of acupuncturists I was talking to said that they are frustrated by those [practitioners] that don't have insurance, because they're undermining everyone else's practice [by] charging way below cost.

"That's greed," stated a male participant.

"Good!" effused another, mimicking an insured and expensive practitioner: "Oh my gosh, my rich practice is going under. I'm going to have to start charging less!"

The question was, how to make acupuncture as accessible – not as profitable – as possible. People, explained Evan, should not have to choose between feeding their families or accessing alternative medicine.

Receiving money for health care posed a challenge to the alternative values and philosophies held by students of AOM. This dilemma is not unique to the professions of complementary medicine (Rodwin 1993, May 1997), but is perhaps made more salient by the anti-commercial sentiments that are a part of students' alternative philosophies. Researchers have noted the existence of money-related tensions amongst practitioners of New Age healing (Bowman 1993, Drown 2001, Prince and Riches 1999). A study of complementary therapists in the UK conducted by Andrews et al. (2003) indicates that "over half of the therapists claimed that some form of tension exists for them between the caring and business aspects of their jobs" (2003:165). Like the New Age healers studied by Drown (2001), some students at Emeritus emphasized the primacy of altruistic motivations over the greed they associated with allopathic physicians and insurance companies. In their study of complementary therapists in the U.K., Andrews and Phillips found that "therapists' aspirations were financially modest and often caring and practice related" (2005:101), a characteristic also evinced by students: "You could earn a lot of money [practicing acupuncture]," admitted Amy, "But for me...I feel that money is going to turn around to help the people that can't afford it. I'll just have enough to make a living, pay off the car, go on little mini vacations -- nothing like a full month in China or a full month in Europe or anything like that."

My first interview with Richard also revealed a similar attempt to establish the socially-oriented identity of AOM in opposition to allopathy:

You have to make money at it, but I see it as...a social thing...Doctors expect certain things. They expect to have a nice car. They expect to have a nice home. They expect to have the status of a doctor, regardless -- You ask MD students. They still have in their minds: this is what a doctor looks like, not what a doctor does.

Said David:

I also believe that we have a societal obligation to ensure that health care is available to people. I really do. I'm a big proponent of universal health care...I don't know how that's going to look for my field, because...of insurance and that sort of thing. But I'm willing to take the risk. It's got to be done, got to be done -- in my not so humble opinion.

Many students viewed themselves as having a great deal of responsibility as practitioners of a different kind of medicine. Said Laurel:

My whole career is going to be about bringing this medicine to people, creating a sensibility around the world, and within urban areas when

people are sick, because urban environments are making them sick and they don't have accessibility with anything else...I just feel like because I have a certain amount of privilege I have an *enormous* amount of responsibility to work with that.

Despite their idealistic goals, students were aware of the difficulties of providing “affordable, if not free,” medical care within the structures of the existing medical system. They were faced with a dilemma, with which they often wrestled during our interviews, namely: how to provide health care in line with their alternative values while simultaneously fulfilling their own needs and obligations. When I asked David if he thought he would be able to practice in a way that was in line with his beliefs, he answered:

Not under the current system. I mean, I don't see how I could do it. I can't give it away. I just can't. I mean, the reality is, I've got to eat too. I have loans to pay, I have a house to buy, I have a wife. I'm going to have children. I can't ignore my own well-being to take care of everybody else.

“I will try to be as compassionate as I can,” he stressed, noting a desire to “initiate a sliding scale” of payment and become involved with “community health clinics” serving low income populations: “They should have access to alternative medicine, too, not just, ‘Take two aspirin and call me in the morning’,” he concluded.

For many, student loans weighed heavily on their thoughts of the future. Evan's awareness of this fact had tempered his goal of providing affordable care. While he expressed a strong desire to adopt a “sliding scale” model of practice born of the philosophy that “everybody deserves healing,” he intended to charge “something”: “I'm being realistic here,” he told me, “I'll be having to pay \$20,000 a year on my college loans when I get out, and...it takes *years* to get an established practice set up.”

As noted, Claire was adamant that medicine should be “attainable for everybody,” and envisioned her practice as being free. However, her experience as a massage therapist had tempered her idealism: “The \$24,000 a year -- how are we supposed to pay that back?” she asked me.

I asked my focus group participants if they thought the AOM program was adequately preparing them to meet the opportunities and challenges they had discussed. Several perceived that while they had had little exposure to new models of medical practice thus far, this might change over the course of the next two years, with Practice Management class, for example. But a male participant said:

I think it's going to try to really route us down the medical model of treatment. That's my opinion at this point...I've yet to hear of any alternative to the insurance format for a business posed by anybody at Emeritus.

Another male participant was obliquely critical of the lack of initiative on behalf of faculty and administration to address this:

I like our teachers a lot. I very much respect them. But I haven't heard any teachers say, "Hey, let's charge less money. Let's be poor...Let's isolate the idea that doctors are successful human beings. Let's forget about that successful nonsense. We need to be successful practitioners, which means we need to charge less money, and get out there and be more politically active and stuff like that"...but the school, I don't think, is facilitating that kind of motivation.

During our first interview, Richard noted the lack of emphasis on an alternative model of health care as a point of concern: "Even here," he told me, "they don't really teach you an alternate model of how to set up a practice."

David's decision to reconsider his initial goal of an integrated practice involving multiple practitioners of different medical modalities was stimulated by negative feedback he had received during the admissions interview. The obstacles, he had been told, were "largely financial":

I mean, if an insurance company is willing to say, "Okay, we'll pay \$65, or whatever it is, per session of acupuncture." But how do you divide that among six doctors?...You know, you can't do it. So -- I've had some ideas. I've had the idea of, like creating a health cooperative...where people pay a monthly fee to be part of the cooperative and they come in and talk to us whenever they want. That kind of thing. I'm still exploring it, and I don't know where the politics of insurance is going to go, or whatever, from here out.

During my focus group, this issue led to a very interesting discussion concerning whether the responsibilities for advancing new models of health care lay with the school or with the students. "I think it's *our* job to do it," said Laurel, who recognized that a diversity of practitioners with a diversity of styles and goals would graduate from Emeritus University, all of whom would attract a certain clientele. "I don't think it's Emeritus's responsibility to direct our practice," she concluded, "but I think if we don't take that responsibility, they will."

Agreed a male participant: "If you don't make your own [model of practice], I think that's the one that they -- that you'll get served."

All the same, Laurel expressed concerns that Emeritus University was prioritizing the appearance of its teaching clinic over the provision of affordable patient care. For her, "the essence of having a student-teaching clinic" was to "serve the community." She was not alone in her concern that the increasing costs of treatment (thought to be related to the costs of maintaining the beautiful new Clinic) would result in

a smaller and less diverse patient population, and consequently a less well-rounded educational experience for student practitioners. “But I also think that’s on us to take advantage of all of the different opportunities that are there and may not just be spoon-fed to us,” she admitted.

Laurel had composed a letter to the President of the University, requesting funding for a reduced fee day at the Clinic or requiring off-site shifts at low-income organizations, or a course required by all students to learn about health care access and affordability issues.

Both the Dean and Associate Dean of the School of AOM were by no means unaware of the problems associated with the US health care system. Said Dr. Silman:

The United States, I would say with virtual certainty, has the most dysfunctional medical system in the world. It is only slightly better than no medical system at all, in some respects. It is probably ten times more expensive than the next most expensive medical system in the world. And with that, a *huge* minority have virtually no insurance...And in spite of the fact that we literally dwarf much of the rest of the world in the amount of money we spend on health care, we are 25th in the level of industrialized countries, as far as the quality of life and the quality of health of the citizens...So part of this is, that when I chose to leave my previous career and go into health care, I bought into struggling with this professionally.

The dean herself had worked at a feminist women’s health center in Boston during the 1970’s, and admitted that the philosophy of equality and empowerment through education espoused by this movement remained with her. Now, as the dean of the School of AOM, she found herself caught between wanting to support students’ radical and revolutionary visions and goals, and providing what she felt was a sustainable and successful model of medical practice that would enable students to repay their loans and make a living as practitioners of AOM. Dr. Jacob Silman expressed the view that functioning outside of the mainstream model of insurance was somewhat naïve. As patient demands for insurance coverage and reimbursement increased, “the pool of people willing to pay cash for services is going to start to shrink even more...and the cash-only practice will get harder and harder to maintain,” he told me.

While students were aware of the challenges inherent in establishing a new system of medicine, they were far from stymied. What I heard was the voice of a new generation of medical practitioners no longer satisfied with following the beaten path. They conceive of themselves as pioneers, visionaries, revolutionaries on the cusp of dramatic change in American society.

In summary, faculty, administrators, and students at Emeritus University perceived that Chinese medicine had evolved – and was evolving – to fit American cultural and social norms as well as afflictions. As noted by Kaptchuk (2009), while neurological and musculoskeletal conditions comprise the majority of acupuncture and herbal treatments in Chinese hospitals, in the West, chronic pain, “psychosocial disorders, wellbeing and life-threatening illnesses” comprise the majority of ailments for

which patients seek acupuncture (1999:2). This is a consequence of the New Age and holistic health movements of the 1960's, 70's, and 80's which emphasized psychological, spiritual, and emotional connections to physical dysfunction. According to Kaptchuk, "the distinct cultures of East and West seem to have generated unique patterns in the scope and practice of Chinese medicine" (1999:2).

Students understood specialization and integration to be part of this process of the evolution, or "Americanization" of Chinese medicine, and they perceived themselves as playing important roles in shaping the identity of AOM in the United States. While they may occupy positions on the receiving end of a curriculum structured by many institutions, national, and professional forces, in keeping with the interests of critical medical anthropologists, the expression of students' desire to create a new system of medicine exemplifies their identity as more than passive recipients of the curriculum, but as active players in shaping the identity of acupuncture and Oriental medicine in the United States. Clearly, students of AOM were doing more than memorizing notes and studying for exams during their first year of studies. Learning acupuncture and Oriental medicine is simultaneously a process of learning how they, as practitioners of a not-quite-mainstream medicine, with a unique theoretical, philosophical, and physiological foundation, and a unique contribution to medicine, fit within the medical landscape. Involvement in provision of affordable, accessible, and preventative community-based medicine represents one such attempt to carve out a niche in the medical hierarchy; to position themselves as complementary, not competitive, practitioners vis-à-vis what all recognize to be the dominant medical paradigm.

Whether or not these visions of the future, idealistic as they are, continued to be held throughout the next two and a half years of their program, I did not learn. Somewhat paradoxically, despite the evidence that American patients seek relief from psychological and psychosocial conditions (Kaptchuk 1999, Cassidy et al. 1998a, Cassidy et al. 1998b, Burke et al. 2008, Paterson and Britten 2004, and Xue et al. 2008), my research reveals that AOM education is tracking towards a standardized, biomedically intensive and research-based model of medicine amenable to integration with allopathy. Indeed, changes in the curriculum, the emphasis placed by faculty upon an allopathic model of reimbursement, and the structure of the teaching clinic all conform to allopathic medical education and insurance requirements, leaving the possibilities of "alternative" models of practice to become increasingly unrealistic and unattainable goals. I conclude with a critical analysis of the implications of integration for the identity of acupuncture and Oriental medicine.

Chapter 9

A foot in both worlds and balance in neither? A critical examination of the implications of integration for the identity of acupuncture and Oriental medicine

My doctoral research emerged from long-standing interests in the implications of “integrated” medicine for the education of complementary and alternative medical students and the identity of complementary and alternative medicine (CAM). Since its inception in 1978, Emeritus University of Natural Medicine has emphasized the integration of medical modalities and collaboration between practitioners of natural medicine and their allopathic counterparts. My ethnographic exploration of the Master of Science in acupuncture and Oriental medicine program offered at Emeritus University was guided by the question: How does increasing emphasis upon integration with biomedical models of education, practice, and research influence the AOM curriculum, the professional values and aspirations inculcated within first year students of AOM, and their sense of professional identity and position within the medical landscape of the United States? In addition, how do the interests, goals, and decisions of first year students shape and influence both the curriculum and the identity of AOM?

These research questions and the methods selected to explore them were shaped and guided by the theoretical orientation of critical medical anthropology, which emerged during the 1980’s in response to perceived shortcomings of conventional, clinically oriented medical anthropology which tended to focus upon doctor-patient interactions and health care within defined communities. By comparison, critical medical anthropology seeks to synthesize “the macrolevel understandings of political economy with the microlevel sensitivity and awareness of conventional anthropology” (Singer 1990:181). From this perspective, health, illness, institutions of treatment, schools of medical education, and the experiences and goals of individual students must be situated within the historical and political structures of pluralism, state regulation, professionalization, biomedical dominance, and the capitalistic world system that shape them.

While critical medical anthropology has been criticized for failing to adequately bridge macro and microlevel concerns, my research builds upon the research of Lazarus (1988), who suggests that institutions (such as hospitals, clinics, and schools) which occupy an “intermediate” level between macro and micro levels of structure provide exceptional opportunities to explore the impact of broad institutional, professional, and national forces upon the microlevel of individual experience. The AOM program has been shaped by many hands, and represents the interests of a great many parties, including program administrators, insurance companies, funding agencies, biomedical institutions, and the profession itself. These broad, macrolevel forces impact the microlevel of student experience, including what they learn and how they learn it; the structure of their examinations; the process of licensure and accreditation; and their identity as practitioners of acupuncture and Oriental medicine in the United States.

I conclude this dissertation with a discussion of its contributions to our understandings of the evolution of a CAM modality within the US; the roles played by a school of CAM in the transformation of AOM's identity; the socialization of students and the process of learning; the role of agency; and the implications of integration for the identity of AOM, its practitioners, and health care in the United States.

A major contribution of my research lies in its expansion of our knowledge concerning the evolution of a CAM modality in the United States. From an obscure and much maligned 'alternative' to Western medicine, acupuncture and Oriental medicine stands today on the brink of mainstream acceptance. Opportunities for collaboration and the availability of research funding, coupled with increasing insurance reimbursement and public demand, serve as testament to this movement towards acceptance. In addition, there has been a significant shift in the way alternative, holistic medicine has been taught since the 1970's, when knowledge and skills were largely transmitted in informal settings through apprenticeship with charismatic practitioners (Cant and Sharma 1999, Cant 1996). Today, that knowledge must be codified, "demarcated from other knowledges that may be seen as illegitimate," and transmitted through large, accredited institutions of learning (Cant and Sharma 1999:61-62). At the time of my research, Emeritus boasted an enrollment of nearly one thousand students, 145 of whom were enrolled in the School of Acupuncture and Oriental Medicine. Statistical data also indicates that the age of students enrolled in the first year of the AOM program is decreasing, and several of my participants had entered the program directly after completing high school and the necessary college associate courses required for eligibility into Emeritus University's combined Bachelor and Masters Degree program. This trend was widely recognized by administrators, faculty, and students alike as demonstrating AOM's increasing acceptability as a first, and not particularly "alternative," career option.

Scholars of professionalization have suggested that this increasing acceptance of CAM is due to its alignment with biomedical models of professionalization, education, research, and practice. The incorporation of biomedical science into the acupuncture and Oriental medical program at Emeritus University is exemplary of a general trend amongst Asian medicine schools throughout North America to model themselves after institutions of allopathic medical education, and biomedical content is becoming increasingly necessary for students to pass acupuncture licensing examinations (Baer et al. 1998:534-35). Writes Barnes (2003:275):

Practitioners [of acupuncture] in the United States have not been able to completely ignore the legitimizing seal of science. This is not a new phenomenon. In the 19th century, advocates of practices as diverse as homeopathy, vegetarianism, herbalism, spiritualism and Christian Science...all laid claim to being scientific. Across the turn of the century, "science" became even more firmly entrenched as the core of cultural legitimacy...Even now practices such as chiropractic – aspiring to substantiate their status against the backdrop of biomedicine – try to show that the science requirements in their curriculum correspond to those of biomedical schools.

As noted by Boon's study of a Canadian college of naturopathic education (1996a and 1996b), the drive to achieve acceptance by emulating biomedical models of clinical education, examination, and practice has resulted in greater resemblance between programs of CAM and allopathy than one might initially assume would be the case. At Emeritus, the emphasis placed upon integration and collaboration, clearly demonstrated through promotional material, program catalogues, and the pronouncements of faculty and administrators, has resulted in a curriculum that places great emphasis upon basic science. According to the Associate Dean for Clinical Education, one third of the AOM curriculum is comprised by basic science, and the ability to straddle both Western and Eastern medical worlds - to become bilingual in the languages of both Western and Chinese medicine - is presented as imperative for students of AOM. Reads the syllabus for "Overview of Physics and TCM":

The future leaders in natural health sciences will require an ability to communicate credibly with Western medical practitioners and research scientists. Students of TCM who develop proficiency in the language and conceptual framework of modern scientific theory will be best prepared for the task of promoting their medical tradition in the broader community.

Students, as well as administrators, perceived that the increasing acceptance of AOM was due in part to the ability of AOM practitioners to speak the language of Biomedicine; to demonstrate, scientifically, the safety and efficacy of their medicine; to seek a niche through specialization; and to emphasize collaboration rather than competition. Indeed, despite their criticisms of Biomedicine's philosophical, practical, and moral shortcomings, many students had selected Emeritus University precisely because of the program's foundation in biomedical science. Such a foundation would, it was argued, enhance the position of acupuncture in American health care (Barnes 2003:276), open doors to collaboration with allopathic practitioners, and pave the way to employment within institutions of allopathic medicine.

Changes in the curriculum emphasizing basic science and integration with Biomedicine were seen by students, faculty, and administrators alike to represent the "Americanization" of Chinese medicine: a natural and inevitable process of evolution through which foreign concepts, words, and philosophies are translated and adapted to suit their American audience. My research indicates that Americanization occurs through the "standardization" of Chinese medicine. Since 1997 - 98, the diversity of Asian medical modalities available to students in the School of AOM has dramatically decreased, resulting in a curriculum that heavily emphasizes TCM, the dominant form of Chinese medicine taught and tested in the United States. While participants perceived such changes as necessary to prepare students to practice AOM within a health care system dominated by Biomedicine, from the perspective of critical medical anthropology, the movement towards a standardized, biomedically based curriculum amenable to integration with allopathy is not simply the result of attempts to better prepare students for employment as acupuncturists in the United States. Critical medical anthropologists argue that integration represents a strategy of co-optation and maintenance of biomedical

hegemony through absorbing successful, 'scientifically-validated' techniques while discarding their underlying philosophies and adherents (Alster 1989, Baer 2004, Lowenberg 1989, Montgomery 1993, Singer 1990:181, Wolpe 1999). Writes Porter (1999:65):

Orthodox medicine has often assimilated a fringe practice rather than losing patients en masse to marginal medicine. This usually happens through an astute filtering process: the metaphysical claims of the fringe practice are abandoned, while its practical techniques are absorbed.

A major contribution of my research to the literature lies in its demonstration of the ways in which an institution of CAM education reproduces biomedical hegemony and may ultimately pave the way towards the co-optation of acupuncture and Oriental medicine. First, as discussed, curriculum changes that emphasize biomedical science to the exclusion of diverse, energetically-oriented Asian medicine courses and philosophical concepts result in a standardized version of TCM that is amenable to integration with allopathy and easily assimilated by biomedical physicians and administrators; stripped for the most part of theories and concepts incongruous with those of Biomedicine.

Second, as demonstrated by my research, over the course of their first year, students absorbed not only the knowledge and skills of AOM, but the values associated with Emeritus University's emphasis upon integration: communication with allopathic practitioners using the language of science while downplaying the theories of TCM; the value of research conducted using biomedical models; specialization as a means of establishing a niche in the medical landscape; delineation of scope of practice and inculcation of a clear sense of place and role within the medical landscape. These values ensure that they (or their theories) will not pose any threat or challenge to the allopathic practitioners with whom they wish to work, or to the medical system and its scientific foundations. The elucidation of these values also represents an additional contribution of this research to the literature: while researchers have explored the nature of professional values transmitted to allopathic medical students, little research has been conducted concerning the identity of values associated with schools of CAM. My research demonstrates that they are shaped in large measure by acupuncture and Oriental medicine's relation to the dominant biomedical paradigm.

Third, Emeritus University serves to replicate and sustain the hegemony of Biomedicine by presenting students with a limited model of medical practice based upon biomedical models and insurance reimbursement. Far from challenging the system as did the earliest practitioners of alternative medicine in the United States, students are instructed to merge and integrate smoothly into the system as it exists. The AOM program's focus on a private practice model of medicine and reimbursement serves to shore up biomedical dominance and defuse CAM's critique of medicine as "business as usual." In effect, students of AOM are funneled towards conventional practice models; their visions of a future more consistent with alternative medicine's original philosophy, especially with respect to its empowering, affordable, accessible and patient-centered foundations, went largely unsupported and discouraged. In this way, the threat posed by

an alternative model of health care and its original critique of “the elitist, hierarchical, bureaucratic and iatrogenic aspects of biomedicine” (Baer 2004:x) is neutralized. Students seemed to be counseled that acceptance of AOM must occur on biomedical terms, and they must refrain from advocating for change or attempting to blaze new trails. Far from graduating as “alternative” therapists, they graduate as subordinates trained to make referrals and unquestioningly uphold the primacy of the biomedical diagnosis. This benefits biomedical practitioners, insurance companies, and medical associations.

In summary, while schools of CAM education have been relatively neglected by scholars in comparison to institutions of allopathy, a major contribution of my research lies in the re-conceptualization of these schools as much more than passive transmitters of knowledge and skills. Instead, Emeritus University is a key player in the transformation of acupuncture and Oriental medicine’s identity, and the identity of health care in the United States. The AOM program smoothes the path of co-optation through integration, by providing Western medical translations of problematic Chinese medical concepts, by inculcating the values of science, research and specialization associated with Biomedicine, and by cementing a biomedical model of referral, practice, and reimbursement. AOM students are encouraged to defer to the judgment and experience of doctors and to depend upon biomedical diagnoses; to communicate only using the language of science; to respect technological intervention; to remain within their biomedically conscribed scope of practice; and to practice a conventional model of health care in line with standard insurance reimbursement procedures. In these ways, Emeritus University serves to maintain biomedical hegemony instead of acting as a locus for social change, revolution, and critique of health care and the social system.

In addition to its contributions to our understanding of the roles played by an institution of CAM in the transformation of AOM’s identity in the United States, my research at Emeritus University expands our knowledge of the socialization of CAM students as a process that must be considered in relation to the dominant system of Biomedicine. Learning acupuncture and Oriental medicine involves the negotiation of divergent philosophies of medicine, the boundaries between medical modalities, and, ultimately, the identity of AOM vis-à-vis Western medicine. Emeritus University represents a point of convergence between two streams of historically opposed philosophies and models of health and medicine that co-exist, uneasily, within the same curriculum. As noted by Norris (1998:70), CAM emerged as an alternative “approach to illness that implicitly and uneasily calls into question the inadequacy of the biomedical model.” As such, Emeritus is a locus of considerable tension. During their first year, students must reconcile not only the different physiological models represented by AOM and Biomedicine, (the former of which recognizes an energetic basis to the human body and the latter of which considers a cellular basis for the functioning and treatment of the body), but fundamentally divergent philosophical principles: students are taught that AOM is based upon the principles of holism, balance, and interconnection, while they are simultaneously presented in their basic science classes with a reductionistic and mechanistic model of the human body. Students are confronted with other contradictory messages during the first year. They are simultaneously counseled to keep Western and Eastern models of medicine separate and to combine them; to conceive of their roles as

both autonomous practitioners of medicine and as complements to Western medical practitioners; to appreciate AOM as a system of medicine in its own right, incompatible with scientific explanations, while cultivating an appreciation of the necessity of scientific validation and research. In light of these fundamental differences in physiology and philosophy, one must consider whether or not, and under what conditions, Eastern and Western medicine *can* be reconciled. As I discovered, while students were unable to satisfactorily reconcile the philosophies and theories of AOM and Western medicine, many concluded that reconciliation could happen practically, at the bedside, in the care and treatment of their patients.

For students of AOM, the process of learning acupuncture and Oriental medicine is simultaneously a process of learning how they “fit” in the medical hierarchy vis-à-vis Biomedicine and of negotiating the identity of acupuncture and Oriental medicine vis-à-vis Western medicine. Students expressed concerns for the implications of increasing alignment with Biomedicine for the unique identity of Chinese medicine. In particular, they questioned the relevance of the basic science material and criticized its tendency to siphon off time better spent learning the skills and knowledge necessary to practice acupuncture and Oriental medicine. “I’m borderline angry,” stated one student, “because...I spend probably about two thirds of my time studying for my two Western classes -- *two thirds*. I spend one third of my time on the Eastern classes.”

“I think that’s what the real complaint is,” agreed another, “we’re trying to balance the two. I think we’re spending more time on the Western sciences, *at the expense* of our TCM classes...It’s not that we don’t want the Western classes. We need that...but we’re spending so much time on it, it’s lopsided.”

Similar issues were raised for Boon (1996b:36), who pondered: Is the art of naturopathic medicine being sacrificed as the educational program becomes more “scientific” while the profession strives for legitimacy in a health care system dominated by the medical profession? She writes: “Too much emphasis on the biomedical model may make it difficult for students to absorb the desired naturopathic professional ethic” (Boon 1996b:20-21). The same may hold true for students of AOM. Although trained to straddle two worlds, it occurred to several of the AOM students that they might graduate with balance in neither. Said one student:

I think, yes, it’s good to integrate, but at the same time, we have a specific goal...as graduate students. And we don’t want to come out and say, “I’m so well-rounded that I can’t do acupuncture well *or* Western medicine well.”

Like the acupuncturists studied by Barnes (2003) in Massachusetts, students at Emeritus University were forced by the emphasis upon science and Western medicine to confront issues of identity: Who were they like? What did they want to become? What was their scope of practice? Where did they fit in the medical hierarchy? Barnes writes:

The wars over science course requirements...pushed practitioners of all schools to look hard at how they wanted to define themselves and at how they wished to be perceived by others. Did they *want* to be classified as primary care givers defined by intensive training in biomedical science? The subtext, for a significant number of them, was the question of what this classification had to do with their own reasons for going into acupuncture in the first place as well as with their own understanding of, and commitment to, Chinese medicine as a system in its own right (2003:281).

The push for a doctorate program in AOM is illustrative of the movement within the profession of AOM to achieve status commensurate with practitioners of other medical modalities, as is the drive by a segment of the profession towards becoming primary care providers (PCPs). According to the Associate Dean for Clinical Education, both movements are controversial within the profession:

There are other acupuncturists in the country that are *opposed* to a doctorate, are opposed to being drawn into the system because each point of access that we have with the system changes who we are, and for some people this is good, and for some people this is not so good. So having privileges in hospitals, accepting insurance benefits, having more training, having an expanded scope of practice -- each of these things brings with them the status of having them and it also brings with them increased exposure to litigation, increased responsibilities, and increased demands on our programs.

My research at Emeritus University indicated that students, too, were debating the pros and cons of achieving primary care provider status. During a clinic shift, a student expressed interest in becoming a primary care provider,

"Doesn't that seem like a lot of responsibility?" asked another.

"Yes, but we've earned it," retorted the first.

"Well, I'm comfortable being an adjunct provider and with my scope of practice," admitted the second.

Another expressed the view that AOM students don't have the level of knowledge commensurate with the role as a PCP. In her opinion, any such position would require further education and training in order to bridge the gap from acupuncturist to PCP. Added another, the push toward becoming PCP's seemed to be skipping ahead of interesting roles that could be fruitfully pursued by AOM providers in integrated medical settings and community health care settings, working alongside other practitioners. In her opinion, the movement toward attaining full status as a primary care provider opened the floodgates for competition between allopathy and acupuncture in a way similar to naturopathy, and represented a step away from collaboration and co-operation.

Jack, too, recognized that attempts to increase the scope of practice and seek closer alignment with allopathic medicine posed a challenge for AOM. He interpreted Emeritus's movements toward increasing scope of practice and specialization as a "marketing tool" related to the profession's desire for increasing acceptance "by the Western allopathic community."

"I'm not really sure what they want because it seems like they want to be accepted so bad that they're possibly losing direction, of the transformation of the medicine," he told me.

The "loss of direction" due to increasing alignment with a biomedical model of education and practice emerged as an important concern among first-year students at Emeritus University and is shared by the profession as a whole. Concern for loss of diversity had resulted in the splintering of the American Association of Acupuncture and Oriental Medicine into two separate organizations, one of which, the National Acupuncture and Oriental Medicine Alliance, "claimed that the American association of Acupuncture and Oriental Medicine had ceased to represent the diversity of practices in the United States" (Barnes 2003:277). Increasing science content and standardization of the curricula was seen as an approach that "would lead to the indirect suppression of the variety of acupuncture traditions in the United States in general" (Barnes 2003:278). Both students and professional practitioners debated the pros and cons of gaining access to hospitals if that access was contingent upon the elimination of certain philosophies and techniques. Writes Wolpe (2002:169): "The conventionalization of CAM into the academic medical center is part of a long history of medicine gaining control over modalities by co-opting them." Indeed, research concerning integrative medical clinics demonstrates that the dominance of Biomedicine tends to remain intact, while alternative therapists are treated as subordinates and their therapies as adjuncts (Goldner 2000). Notes Baer (2004:114): "cross-cultural research has repeatedly indicated that the integration of biomedical and alternative medical systems tends to preserve rather than eradicate biomedical hegemony (Cant and Sharma 1999:183, Yoshida 2002)."

Finally, my research contributes to our understanding of the role of individual agency and advocacy. Critical medical anthropology has been criticized for assuming that the micro-level is "mechanically determined from above" and for conceptualizing individuals as powerless in the face of global forces (Singer 1989:1199, also Scheper-Hughes 1990). Writes Singer (1989:1200), quoting Frankenberg (1980:206):

In investigating connections among levels, we must cast our gaze in both directions...we must demonstrate clearly "what effects are produced at the local level by national and international social processes; and *what is coming from the local level in return*" (emphasis added).

In keeping with this concern, my research indicates that individual students can and do shape the identity of the curriculum, the program, and the identity of Chinese medicine in the US, through their choice of elective courses, their requests for certain clinic shifts, and their efforts to tailor the program to suit their individual interests, philosophies, and goals. In addition, it was recognized by the Associate Dean for

Clinical Education that end-of-term course evaluations played an important part in drawing the administration's attention to perceived shortcomings of, and dissatisfactions with, aspects of the program that could be addressed in later years.

In addition to their role in shaping the AOM program, students also play a role in shaping the identity of AOM in relation to the US health care system. As I have discussed in Chapter 8, several students evinced awareness of the "hand-in-glove" relationship between capitalism and the US health care system (Singer 1986:129), and had made the decision to pursue education in an "alternative" form of medicine as a way to protest and revolutionize what they perceived to be an inaccessible, inequitable, and inhumane medical system. Many students perceived themselves to be at the forefront of AOM's advancement in American society; for several students, the niche for AOM – and themselves as its practitioners – was community health care; a role perfectly suited to acupuncture because of its low-cost, low-tech, affordable, and accessible characteristics.

Concerns for advocacy, change, and the social and political inequality underlying health have been a focus of critical medical anthropology since its inception (Baer et al. 1986, Singer 1995:82). Critical medical anthropology aligns itself with the concerns of individual students struggling to understand their place and their role within the US medical system; their responsibilities for, and the possibilities of, change. I found that the curriculum and the perspectives of faculty did not align with students' revolutionary aspirations. While individual students are not simply passive recipients of the curriculum, if access to diverse forms of Asian medicine and alternative models of practice is denied in favor of standard biomedical models of education, practice, and reimbursement, it becomes difficult to see how they can realize their goals of creating a new system of medicine aligned with the original philosophies and critiques of the alternative / holistic health movements. Students expressed concerns that their biomedically-enriched schedules would not accommodate elective courses that interested them, such as Five Elements, which was being offered by a well-liked professor for the final time during 2006. Worried a focus group participant: "if I focus more time on the Eastern stuff that I really want to focus on, then I will *fail* anatomy and I will fail biochem, and that's just how it is -- I will fail."

The courses available to students, both in their core curriculum and electives, will influence their identity as practitioners and the identity of Chinese medicine in the United States. If biomedical requirements continue to squeeze courses with a more energetic, psychological, or esoteric focus from the core curriculum, or from the program altogether, (as was the case with Japanese style acupuncture course), students will graduate as practitioners of an increasingly standardized version of Chinese medicine and the profession of AOM will move further toward an allopathic model of education and practice. A role of this research, from the perspective of critical medical anthropology, is first, to draw attention to discrepancies that exist between the needs and goals of students and the educational outcomes of the program; and second, to advocate for the inclusion of courses presenting alternative models of practice and reimbursement that are sensitive and supportive of their goals and interests.

Whither AOM?

Researchers have long pondered the future of complementary and alternative medicine. The direction taken by AOM towards securing professional status and acceptance is not unique to this profession. Indeed, Baer (2004: x-xi) notes that “according to Roth (1976:40-41), as a new health movement grows, particularly in capitalist societies, it accumulates

‘More and more members who are interested in making a good living and raising their status in the outer worlds. In the health sphere, this means they become more concerned with obtaining respectable (or at least respectable-looking) credentials, providing services that more closely follow the medical model, and eventually even developing working relationships with the orthodox medical world’.

Wardwell (1972:763) writes that as they evolve, medical sects “tend to merge into the medical mainstream.” In addition to this avenue, Roth suggests that health movements may also evolve “into the dominant form of medicine,” decline towards extinction,” or become absorbed “by the dominant medical system as an auxiliary system.” Baer adds to this list two other possibilities, including evolution “into a parallel form of medicine,” such as osteopathy, “that has the same legal rights and closely resembles both philosophically and therapeutically the dominant medical system” (2004: xi). In addition, “a heterodox or alternative medical system may develop into a semi legitimate or even fully legitimate ‘limited form of medicine’,” the practitioners of which are required to limit their procedures and scope of practice in relation to those performed by Biomedical practitioners (Baer 2004:xi).

While its proponents have argued that alternative medicine holds the promise of “dramatic cures,” reductions in chronic illness, and increases in life expectancy (Baer 2004:150), many predict instead “the piecemeal assimilation of particular techniques into managed care settings and other large corporate providers on the basis of their ability to produce measurable, cost-effective outcomes in symptoms and client satisfaction” (Goldstein 1999:219). Writes Baer (2004:150):

Despite its initial promise to provide a counter hegemonic challenge to biomedicine, the holistic health movement appears to be in the beginning stages of its transformation into CAM or integrative medicine. It has to a large extent been tamed or co-opted by biomedical physicians and schools, the federal government, and, most recently, various private corporate bodies, particularly health insurance companies, HMOs, hospitals, health corporations, and pharmaceutical companies.

In light of my findings and the analyses provided by scholars of CAM, it is tempting to see something vaguely apocalyptic in the future of acupuncture and Oriental medicine: a future in which pressures from the profession of AOM, Biomedicine, insurance companies, and funding bodies result in increasing biomedicalization and standardization of the curriculum and the national board exams. This would lead students to graduate with limited knowledge of the theory and philosophy of TCM, their scope of practice limited to working as subordinates in hospital settings alongside allopaths who direct biomedically-determined acupuncture treatments for specific conditions proven, through clinical research, to be effective; their role restricted to taking off the hands of busy physicians patients suffering the diseases of civilization and industrialization untreatable by Biomedicine (Baer et al. 1986:97). Such a scenario should be softened by several caveats.

As noted by the Associate Dean for Clinical Education, Dr. Jacob Silman, Emeritus University does not represent all styles and schools of AOM in the United States, although by merit of its size, resources, and commitment to work with national organizations, it does exert considerable influence over the identity of Chinese medicine. The NCCAOM exams are still composed of two-thirds TCM and only one third Biomedicine (or, in the case of Chinese herbal medicine, three quarters TCM and one quarter Biomedicine). The problem, according to Dr. Silman, stems from the fact that the scope of biomedical knowledge is almost limitless; the boundaries of what is considered important for AOM practitioners in an allopathic medical world are ill-defined and shifting; and what should be taught and what shouldn't is still a matter of debate. This uncertainty reflects the profession's relatively new and growing stage and its current struggle to define its identity and its role in the US medical landscape. While the boundary concerning the scope of biomedically knowledge necessary for students of AOM has yet to be drawn by the profession, a three and a half year curriculum can only support so much Biomedicine before it becomes unwieldy and professional concerns shift to reflect wavering confidence in their ability to practice AOM.

In addition, instead of viewing "Biomedicine" as a single, autonomous institution, wielding power over the identity of a single, autonomous "complementary and alternative medicine," it is important to consider the diversity of perspectives, goals, and expectations of the individuals who practice under the banners of both. In the same way, it is important to consider "integration" not as a single set route pointing towards some clearly defined goal and serving a single agenda upon which all are agreed. What students of AOM envision when confronted with the concept of 'integrated medicine' might vary considerably from the understandings of this concept held by faculty, administrators, professionals, and doctors. We can only judge the trajectory of AOM's identity from the research concerning integrated medicine that has been conducted, which suggests that CAM practitioners work largely under the supervision and direction of their allopathic colleagues (Hollenberg 2006, Goldner 2004). Further research is needed to explore the diversity of forms that integration in practice might take.

Finally, the concerns and demands of patients must also be taken into account in any attempt to determine the future of CAM's identity. The fact that the majority of Americans who seek acupuncture treatment do so for emotional and psychological

conditions, including mood care, general wellness, wholeness, self-awareness and life-change (Kaptchuk 2008:2), suggests that these patients may be largely unsatisfied with a standardized, biomedical model of AOM, stripped of the very underlying philosophies and concepts that make it attractive to them in the first place.

It is not my intention to imply that integration is inherently 'bad' and destructive to the identity and autonomy of acupuncture and Oriental medicine. But what is missing from the AOM curriculum at Emeritus is a historical context of integration; a critical analysis and discussion of this concept and a more explicit debate concerning its implications for identity. This points to the value of critical medical anthropology in re-directing out attention to issues of power, a key concern of this theoretical perspective. Critical medical anthropology views "the clinical encounter, indeed the whole health system" as "an arena and a product of an ongoing social struggle among groups with historically opposed interests and marked differences in their capacity to mobilize institutional power" (Singer 1995:86). Emeritus embodies this struggle between the culturally entrenched and dominant system of Biomedicine and the politically and economically marginal alternative medicine which originated in the US as a challenge to Biomedicine. As discussed, this has resulted in the identity of Emeritus University as a locus of considerable tension between divergent philosophies and models of health. Promotion of "collaboration" and "integration" within Emeritus ignores the power differences that exist between Biomedicine and its practitioners and CAM and its practitioners: it is not an even playing field; as Dr. Jacob Silman admitted: if AOM practitioners want to play, they have to abide by the rules of Biomedicine. Ignored is the "history of political maneuvering" on behalf of the biomedical profession "to eliminate competitors and gain social statues and power" (Singer 1990:181).

What is not happening in the AOM program is recognition of the historical roots of Chinese medicine and its evolution in the United States as a practice and philosophy within the larger holistic health movement, a philosophy that guided many students to Emeritus and which contributes to the increasing acceptance on behalf of consumers. Instead students are confronted by a curriculum that acknowledges the primacy of Biomedicine and which seems to cement the role of the AOM practitioners as subordinates to their allopathic counterparts, advised and instructed to follow biomedical models of education, practice, and reimbursement that do nothing to uphold alternative medicine's original critique of the healthcare system and the hegemony of biomedical science.

Lastly, dooms-day prophecies concerning the future of AOM must be mitigated by an appreciation for the view that although there might now be considerable upheaval as AOM practitioners deliberate their roles and identities, AOM is, after all, a very young profession. The fact that collaboration is becoming increasingly commonplace opens the door to possibility of great and positive change in the medical system. Students, graduates, practitioners (both AOM and biomedical) and patients can, and will, have considerable say in the future of AOM.

At issue, however, remains the contribution of holism to medicine if medical systems that adhere to this philosophy, such as AOM, are simply grafted onto the existing biomedical system. Notes Singer (1989:1201) "its likely result is the extension and

reproduction of prevailing power relations” not the revolutionization of health care. Piece-meal approaches to integration ensure the alternative philosophy and practice of alternative medicine is neutralized and its practitioners safely absorbed into the bosom of Biomedicine. Paying lip-service to holism and accepting AOM practitioners into a hospital when their philosophies, techniques and autonomy must be left behind does nothing to change the system, but merely creates the appearance of change and advancement, ensuring that patient demands are being met without challenging the system of Biomedicine and capitalism in which it is embedded. The proponents of complementary and integrated medicine, writes Baer (2004: xix)

all too often treat the notion of holistic or integrative health care as rhetorical devices that serve their own needs, including professional and pecuniary ones, rather than as a substantive one that provides a critique of the existing capitalist world system, its role in contributing to disease, and nationally based dominate medical system under which biomedicine exerts hegemonic influence.

According to Singer, CAM in Biomedicine amounts to “systems-correcting praxis” in that it does not suggest major improvements in health care system; rather, it represents “a system-maintaining approach to tinkering and patching in health” (1995:88). This form of CAM is especially vulnerable to co-optation “by the dominant forces in a social system.”

What began as a social movement to protest and eradicate the underlying social and political causes of disease and illness (namely inequality) may become a set of techniques easily absorbed into the existing biomedical framework, *sans* critique or challenge. It is a narrowly defined form of AOM, largely eviscerated of its philosophies, that creeps gingerly and apologetically into the hospital, a shadow of its potential for criticism and change.

Ironically, the same strategies utilized by AOM professionals to secure their position in the medical landscape – scientific validation, increasing science content in the curriculum, adherence to insurance protocols, translation of TCM terms into the language of Biomedicine - are the very same characteristics that threaten the unique identity of Chinese medicine. The attractiveness of achieving professional status, acceptance and validation from mainstream academia and Biomedicine (Mills 1995:53) must be weighed carefully against the risks of increased influence of biomedical professionals and administrators over training and practice (1995:54) and loss of AOM’s identity. Warns Wolpe: “Alternative practitioners who rush medical centres may do well of study the fate of homeopaths, midwives, bone setters, osteopaths, and others who fell prey to the promises of establishment medicine, only to disappear within its clutches” (1999:12).

The questions remain: How can practitioners of AOM, and their medicine, which grew out of dissatisfaction with Western medicine, “serve counterhegemonic ends” while achieving respect, legitimacy, and acceptance for their medicine? What role should they play in the creation of a new medical system, and what should this medical system look like? While first year students expressed idealistic and revolutionary goals and visions of

the future and their role in shaping a new system of medicine in the US, they face an uphill battle against a system of medicine firmly entrenched in capitalism and powerful forces that resist change to the status quo. The challenge lies in moving forward without losing sight of the origins and critiques of alternative medicine; in determining an identity that is cognizant of its past and critical of its place in the dynamically evolving medical landscape of the United States. The profession itself must decide what it wants for its future. Practitioners themselves must answer the question of *what is an acupuncturist like?* What is – and should be – their role? Whose interests do they wish to serve? The only alternative is to have the answers to these questions – and their identity - determined for them.

Questions for further research

While a school of CAM education, such as Emeritus University, provides an ideal setting in which to study the microlevel of student experience against the backdrop of broader institutional, professional, and national forces, there can be no doubt that an in-depth study of these forces in relation to the school of AOM would provide greater insight into the specific ways in which the macrolevel impacts the micro. Further research might explore the influence and perspectives of Emeritus University's President and Board of Trustees; doctors and hospital / clinic directors with whom students of AOM interact during clinic shifts and who have helped develop integrative and collaborative relationships with Emeritus; allopathic students attending CAM-camp and Emeritus clinic shifts; board members from national organizations such as the NCCAOM, ACAOM and CCAOM as well as representatives of professional AOM and state organizations. These interviews would serve to clarify the sources and nature of pressures to provide an integrative educational foundation and increasing biomedical content, the degree of influence exerted by each, and what key stakeholders in the future of AOM's identity envision for the future of this medicine.

In addition, further exploration is needed concerning the role of student (and practitioner) agency in transforming health care in the US. A long-term study of students from first year of studies to first year of practice, similar to that conducted by Becker et al. (1961) concerning students of allopathy, would help to illuminate changes in attitude among students towards the health care system and their role within it. Do they graduate with interest in integrated medicine and collaboration similar to that displayed during the first year? Have their goals for the future changed? Do they still perceive AOM as a means to change the US health care system through, for example, community health care and provision of free services? In light of the financial concerns they expressed during my research, how are these goals realized? How has their increasing exposure to other clinic shifts, supervisors, and courses impacted their sense of identity? Are there additional professional values inculcated within them over the course of the program? Given that the AOM program at Emeritus is not representative of all such programs across the US, studies of other schools would provide a more complete picture of the

transformation and future of acupuncture and Oriental medicine's identity in the United States.

Finally, a further direction for research concerns the process of socialization. As discussed in Chapter 1, Foucault's theories concerning the historical and epistemological roots of objectification, the "medical gaze," through which the patient's body is separated from their personhood and identity and made an object for manipulation, have been influential in anthropological analyses of medical practice and education (Good and Good 1993, Davenport 2000). Little research has been conducted concerning whether or not this same separation occurs in the education of CAM students. Researchers (Good and Good 1993, Lella and Pawluch 1998, Carter 1997) have shown the gross anatomy component of medical education to be particularly influential in the reconstruction of the body as an object to be manipulated and worked upon and an integral part of the formation of boundaries between physician and patient. While the AOM program does not emphasize dissection or invasive procedures to the same extent as in allopathic education, the observation of prosected cadavers was equally significant to students of AOM, providing them, like their allopathic counterparts, with an intensely personal experience of transformation; a "necessary 'initiation' into medical objectivity and detachment" (Lella and Pawluch 1988:141) which often conflicted jarringly with the holistic perspective being cultivated in TCM classrooms. Gross lab was labeled "Dead Lab" by students in recognition of its contrast with their labs and classes that focused on feeling energy from living, breathing bodies. One student informed me that the gross lab component had the effect of objectifying the human body; of separating the practitioner from the object of their practice. The same result was observable during TCM techniques class, as students learned to insert needles into each other's body. The ways in which and degree to which students of complementary and alternative medicine learn to objectify and disassociate themselves from the bodies of their patients becomes a fascinating question for further study, in light of the holistic, patient-centered philosophy underlying CAM.

Concluding Thoughts: *Dantian* and the goose that laid the golden eggs

A well-known fable tells of a couple blessed with a goose that laid solid gold eggs. Not content to wait for the bird to lay each morning, they decided to kill it, certain that inside would be found a great cache of gold. But, to their great chagrin, upon slitting it open, they found nothing but entrails.

In recent years a good deal of scholarly research and experimentation had been undertaken concerning 'dantian': the sea of energy spoken of in ancient Chinese texts where *qi* both originates and collects; a 'bank account' of energy carefully cultivated by practitioners of Qi Gong to be drawn upon for healing (Wirth et al. 1997, Green et al. 1991, Tiller et al. 1995, Wirth et al. 1994, Li et al. 1990, Lim et al. 1993; Liu et al. 1990,

Proceedings 1988-1993, Wang and Xu 1991, Wirth et al. 1996, Xing et al. 1993). During a late summer class of Overview of Physics and TCM, Takoda and Ryan engaged the class in a discussion of what, exactly, dantian was, from a physiological perspective, and where, exactly, it was to be found. Said Ryan: "If you go into that area [of a cadaver] where dantian is described to be and you're looking for something physical - "

"-All you find are guts," interjected a student.

The moral of the fable of the goose who laid the golden eggs is, of course, *those who want too much risk losing everything*. While students, faculty, and professionals alike possess confidence that alignment with biomedical models of education, research, and practice will increase their acceptance and status in the United States, the question remains: do they risk eviscerating a unique and autonomous system of medicine; the stripping of mere "techniques" from their philosophical and theoretical foundations; the restriction of AOM's healing potential to certain insurance-approved procedures and biomedically trained practitioners? Will they learn too late to appreciate the unique identity, and potential contribution, of Chinese medicine to healing – and health care – in the United States?

One thing we may all agree upon is this: medicine is always changing, and the future identity of Chinese medicine will change, adapt, and evolve, too. The end-point of its journey – if there is one - is unknown and unknowable. For the most part, students, the perpetual optimists, seemed unanimous in their proclamation:

"The future is bright!"

Given the current state of health care in the United States, there is every reason to hope so.

GLOSSARY

Bleeding: According to Dharmananda (2009), bleeding peripheral points of the body by piercing the tips of the fingers, toes, or the tops of the ears with lancets or needles constitutes one of the oldest acupuncture techniques. The purpose of this technique, he writes, is to adjust the flow of *qi* and blood, although it may also be used to release pathogenic factors such as Wind or Heat from the body.

Blood: Kaptchuk described 'blood' as "the responsive, accepting, effortless, soft, and nurturing complement of the clinical *Qi*. *Qi* and Blood are the Yin And Yang of ordinary life activity" (2000:52). While 'blood' in a Chinese medical sense relates to the biomedical concept of a red, circulating, nourishing fluid, it is also regarded as "the material foundation for mental activities" (TCM Fundamentals syllabus 2006).

Body Fluids: Kaptchuk writes that "fluids are bodily liquids other than the Blood including the 'normal' body fluids of saliva, gastric juice, intestinal juice, "liquids in the joint cavities," tears, sweat, and urine. They originate from food and liquid consumed and are "regulated by the *qi* of various Organs of the body, especially the Kidneys." The purpose of these fluids, he continues, "is to moisten and partly nourish the hair, skin, membranes, orifices, flesh, muscles, Inner Organs, joints, brain, marrow and bones" (2000:66).

Cupping: Involves the creation of a vacuum in a small, rounded and hollow glass globe through the rapid insertion and removal of a lighted swab of alcohol or the use of a mechanical pump. Once applied to the body, the vacuum pulls the skin inside the globe. This technique is commonly employed to relax soft tissue "by relieving congested energy, blood and pain" (Hogan 2009).

Electro-acupuncture: A therapeutic involving the passing of a very mild electric current through the inserted acupuncture needles in order to stimulate the points and meridians (<http://www.thespiritualhealth.com/chinese-health/acupuncture-techniques.htm>, accessed January 22 2009). Most commonly used to relieve pain.

Five elements According to the syllabus distributed for TCM Fundamentals, the Five Elements theory considers the movement, generation, and control of the five "indispensable materials for living": wood, fire, earth, metal, and water. Natural phenomena such as seasons and the organs of the body are classified according to the principles of Five Elements: for example, the element 'wood' is associated with the liver, with spring, and with wind. It corresponds to the gall bladder meridian, the emotion of anger, and conditions affecting the eye and tendons.

Five Elements / Worsley style acupuncture: Credited to the studies and practice of J.R. Worsley, an Englishman born in 1923, Five Elements style acupuncture (commonly known as Worsley style acupuncture) is a system of acupuncture based upon the Chinese medical concept of the Five Elements (Wood, Fire, Earth, Metal and Water) perceived to exist in all things. Practitioners believe that humans are born with, or develop, imbalances in their elements that may lead to disease. Patients are diagnosed and treated by isolating the “causative factor,” or unbalanced element, through assessing subtle differences in the patient’s color, odor, sound, and emotion (Gumenick and Worsley 2006).

Ion pumping cords: A therapeutic technique involving the attachment of wires to the protruding tips of the inserted needles in order to “direct the body’s energy to flow in a specific direction” (<http://www.thespiritualhealth.com/chinese-health/acupuncture-techniques.htm>, accessed January 22 2009).

Japanese style acupuncture: According to Tanaka (2003): “Chinese acupuncture was introduced into Japan about 1500 years ago. The basic principles remained similar to the Chinese meridian system, but the treatment style became quite different. Although an acupuncture treatment procedure varies from practitioner to practitioner among ‘Japanese style’ acupuncturists, Japanese practitioners generally use much finer needles, stimulate more superficially and gently, and often do not consider the strong de-*qi* sensation of importance, while TCM acupuncturists tend to use bigger needles, deeper stimulation, and attempt to induce the de-*qi* sensation”(http://www.acupuncture-treatment.com/acupuncture_styles.html)

Jiaos: In Chinese medicine, the human body may be divided into three levels or parts: the Upper Jiao or part consists of the Heart, Lung, and Pericardium; the Middle Jiao consists of the Spleen, Stomach, Gall Bladder and Liver; and the Lower Jiao consists of the Small and Large Intestines, Kidney, and Urinary Bladder. Refers to the three parts of the body. Diseases may be diagnosed based upon their location in these three parts of the body.

Korean style hand acupuncture: “A modern technique that uses the hands as a holographic image of the body. The somatic map can be used by finding a tender spot at the area that corresponds to the patients’ symptomatic area. Treatment may be achieved using needles, magnets, laser, or electrical stimulation” (Marcus and Kuchera 2005:350).

Meridians: In Chinese medicine, the invisible lattice of interconnecting pathways that carry *qi* and ‘Blood’ (a substance with functions and characteristics distinct from the ‘blood’ of Western Biomedicine) throughout the body. There are twelve ‘regular’ meridians that run along each side of the body. These are the Lung, Large Intestine, Stomach, Spleen, Heart, Small Intestine, Urinary Bladder, Kidney, Pericardium, San Jiao,

Gall Bladder, and Liver channels. Two meridians, the Ren and Du meridians, run down the center of the body.

Moxabustion / Moxa sticks: Moxabustion refers to a therapeutic technique involving “the application of heat from certain burning substances at the acupuncture points” (Kaptchuk 2000:107-108). Most commonly, moxa is mugwort (*Artemisia vulgaris*), which may be used in loose form or packed into cigar shaped wands called moxa sticks.

Points: Refers to the points located along the meridians at which the *qi* can be accessed using acupuncture needles, pressure (as in acupressure), or heat (moxibustion). Writes Kaptchuk: “Classical theory recognizes about 365 acupuncture points on the surface Meridians of the body. With the inclusion of miscellaneous points and new points used in ear acupuncture and other recent methods, the total universe has risen to at least 2,000 points for possible use. In practice, however, a typical doctor’s repertoire might be only 150 points...each acupuncture point has a different therapeutic action” (2000:108).

Qi: A highly challenging concept to define; according to Kaptchuk (2000:43), “no one English word or phrase can adequately capture *qi*’s meaning.” In her TCM fundamental syllabus, Dr. Song defined it as “An ancient Chinese thought: *Qi* was the fundamental substance constituting the universe; all phenomena were produced by the changes and movement of *qi*.” And further: “In TCM *Qi* is an essential substance of the human body which maintains the body’s vital activities and also has its own functions; all vital activities of the human body are explained by the changes and movement of *qi*.” Much more than simply “energy,” with which it is so often correlated, *qi* occupies a shifting, amorphous space between matter and energy, “the cause, process, and outcome of all activity in the cosmos” and “one of the deepest root intuitions of Chinese civilization” (Kaptchuk 2000:44). There are different types of *qi* and different functions of *qi*. *Wei qi* for example, is known as “defending” or “protective” *qi*, which defends the body against invading pathogens.

Seven star needling: According to Hogan (2009), Seven star needling “utilizes a tapping instrument, containing seven tiny needles,” in order to “stimulate the channel/meridian overtop of the area to be treated” (<http://www.acupunctureab.com/index.php?option=articles&task=viewarticle&artid=4&Itemid=3>)

Tui Na: Translated as “push-grasp,” a form of bodywork similar to massage but based upon the theories and principles of Chinese medicine.

Yin / Yang: According to Kaptchuk (2000:7), “Yin-Yang theory is based on the philosophical construct of two polar complements, called Yin and Yang. These complementary opposites are neither forces nor material entities...rather, they are convenient labels used to describe how things function in relation to each other and to the universe. They are used to explain the continuous process of natural change.” Yin and Yang “represent a way of thinking. In this system of thought, all things are seen as parts

of a whole. No entity can ever be isolated from its relationship to other entities; no thing can exist in and of itself.”

Zang fu: Refers to the Organs of the human body in TCM. According to Kaptchuk (2000:78), there are five Zhang, or ‘yin’ Organs (Heart, Lung, Spleen, Liver, and Kidney, with the Pericardium sometimes considered a yin Organ), six fu, or ‘yang’ Organs (Gall Bladder, Stomach, Small Intestine, Large Intestine, Urinary Bladder, San Jiao or “Triple Burner”), and six “extraordinary fu” Organs (Brain, Marrow, Bones, Vessels, Uterus and Gall Bladder, which is considered to be both a yang Organ and an extraordinary Organ).

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Appendix 1:**Comparison between curricula for the Master of Science in Acupuncture:
1997-1998 and 2006-2007****Master of Science in Acupuncture (MSA) 1997-1998****Year I**

Qtr.	Cat. No.	Course Title	Crdt.	Lec.	Lab/Clin.
Fall	OM4120	Fundamental Principles Of TCM	3	3	0
	OM4106	Meridians & Points 1	4	4	0
	OM4310	TCM Bodywork: Tui Na	2	2	0
	OM4801	AOM Clinic Preparation	1	1	0
	OM4802	AOM Clinic Entry	1	0	2
	BC3120	Anatomy & Physiology 1 Lec/Lab	5	4	2
	BC3101	Organic Chemistry 1	5	4	2
	BC4107	Medical Terminology (AOM)	1	1	0
		Quarterly Totals	22	19	6
Wtr.	OM 4211	TCM Diagnosis 1	3	3	0
	OM4221	TCM Pathology 1	3	3	0
	OM4107	Meridians & Points 2	4	4	0
	OM4408	Qi Practicum 1 (Qi Gong 1)	1	0	2
	BC3121	Anatomy & Physiology 2 Lec/Lab	5	4	2
	BC3102	Organic Chemistry 2	5	4	2
		Quarterly Totals	21	18	6
Sprg.	OM4212	TCM Diagnosis 2	3	3	0
	OM4222	TCM Pathology 2	3	3	0
	OM4108	Meridians & Points 3	4	4	0
	OM4411	TCM Techniques 1	2	2	0
	OM4409	Qi Practicum 2 (Qi Gong 2)	1	0	2
	BC3103	AOM Living Anatomy	2	2	0
	BC3105	Biochemistry Overview	5	5	0
	BC4101	Disease Processes 1	3	3	0
		Quarterly Totals	23	22	2

Year II

Qtr.	Cat. No.	Course Title	Crdt.	Lec.	Lab/Clin.
Fall	OM5430	TCM Techniques 2	2	2	0
	OM5421	Acupuncture Therapeutics 1	4	4	0
	OM5311	Five Elements 1	2	2	0
	OM5433	Qi Practicum 3 (Tai Chi short form)	1	0	2
	CH5100	Chinese Herbal Medicine: Intro	2	2	0
	OM5103	Survey Of Western Clinical Sciences 1	2	2	0
	BC4102	Disease Processes 2	3	3	0
		Quarterly Totals	16	15	2
Wtr.	OM5431	TCM Techniques 3	4	4	0
	OM5422	Acupuncture Therapeutics 2	4	4	0
	OM5434	Qi Practicum 4 (Tai Chi advanced)	1	0	2
	OM5104	Survey Of Western Clinical Sciences 2	2	2	0
	BC4121	Microbiology (AOM)	3	2	2
	BC4131	Pharmacology Overview	3	3	0
		Quarterly Totals	17	15	4
Sprg.	OM5423	Acupuncture Therapeutics 3	4	4	0
	OM5461	TCM Therapeutic Nutrition 1	2	2	0
	OM5305	Topics In Medicine: Abuse and Detox	1	0	0
	OM5306	Topics in Medicine: HIV and AIDS	1	1	0
	PS5204	Counseling	3	3	0
		Quarterly Totals	11	10	0
Sum.	OM5300	Auricular Therapy	2	2	0
		Quarterly Totals	2	2	0

Year III

Qtr.	Cat. No.	Course Title	Crdt.	Lec.	Lab/Clin.
Fall	OM6110	TCM Medical Classics	2	2	0
	OM6311	Case Review/Grand Rounds 1	2	2	0
	OM6424	Acupuncture Therapeutics 4	2	2	0
		Quarterly Totals	6	6	0
Wtr.	OM6312	Case Review/Grand Rounds 2	2	2	0
	OM6425	Acupuncture Therapeutics 5	2	2	0
	OM6305	Survey of Biophysics & Electroacupuncture	2	2	0
	OM6102	Practice Management/Ethics	2	2	0
		Quarterly Totals	8	8	0
Sprg.	OM6313	Case Review/Grand Rounds 3	2	2	0
		Quarterly Totals	2	2	0

The following requirements apply to the MSA Program.

Elective Requirements: Master of Science in Acupuncture

Qtr.	Cat. No.	Course Title	Crdt.	Lec.	Lab/Clin.
variable	variable	Elective & Special Topics *	10	10	0
		Total Elective Credits and Hours	10	10	0

* Electives/Special Topics: The MSA program requires a total of ten (10) elective/special topics credits. Of this total, four (4) credits must include approved AOM elective/special topics while up to six (6) credits may include general university electives.

Clinic Requirements: Master of Science in Acupuncture

Qtr.	Cat. No.	Course Title	Crdt.	Lec.	Lab/Clin.
variable	OM4803-04	AOM Clinical Observation 1-2	4	0	8
variable	OM5803-04	AOM Clinical Observation 3-4	4	0	8
variable	OM5805-10	AOM Clinical Internship 1-6	12	0	24
variable	OM5811	Internship Vacation Clinic	2	0	4
variable	OM6801-08	AOM Clinical Internship 7-14	16	0	32
variable	OM6821-24	Clinic in China 1-4	[8]	[0]	[16]
		Clinic Totals	38	0	76
		Total Core Course Credits and Hours	128	117	20
		Total Elective Credits and Hours	10	10	0
		Total Clinic Credits and Hours	38	0	76
		Total Requirements	176	127	96

Master of Science in Acupuncture (MSA) 2006-2007**MSA YEAR I**

Qtr.	Cat. No.	Course Title	Crdt.	Lec.	L/C	Tot
F	BC3106	Biochemistry Overview 1*	4	4	0	44
	BC3134	Living Anatomy	4	4	0	44
	OM4106	Meridians & Points 1	4	4	0	44
	OM4118	TCM Fundamentals	4	4	0	44
	OM4315	TCM Bodywork: Tui Na	1	0	2	22
	OM4406	Qi Gong	1	0	2	22
	OM4800	Clinic Entry	2	2	0	22
		Quarterly Totals	20	18	4	242
W	BC3107	Biochemistry Overview 2*	4	4	0	44
	BC3135	Anatomy & Physiology 1 Lec/Lab*	5	4	2	66
	OM4107	Meridians & Points 2	4	4	0	44
	OM4211	TCM Diagnosis 1	3	3	0	33
	OM4221	TCM Pathology 1	3	3	0	33
	OM4411	TCM Techniques 1	2	2	0	22
	OM4803	Clinical Observation 1**	2	0	4	44
	OM5442	Tai Chi	1	0	2	22
		Quarterly Totals	23	19	8	297
Sp	BC3136	Anatomy & Physiology 2 Lec/Lab*	4	3	2	55
	BC4105	Introduction to Western Pathology	3	3	0	33
	OM4108	Meridians & Points 3	4	4	0	44
	OM4212	TCM Diagnosis 2	3	2	2	44
	OM4222	TCM Pathology 2	3	3	0	33
	OM4804	Clinical Observation 2**	2	0	4	44
	OM5430	TCM Techniques 2	2	2	0	22
		Quarterly Totals	21	17	8	275

MSA YEAR II

Qtr.	Cat. No.	Course Title	Crdt.	Lec.	L/C	Tot.
F	BC4120	Microbiology Lec*	2	2	0	22
	BC4120L	Microbiology (AOM) Lab*	1	0	2	22
	OM5321	Survey of Western Clinical Sciences 1	3	3	0	33
	OM5414	Acupuncture Therapeutics 1	2	2	0	22
	OM5415	Acupuncture Therapeutics 2	2	2	0	22
	OM5436	TCM Techniques 3	2	2	0	22
	OM5803	Clinical Observation 3**	2	0	4	44
		Quarterly Totals	14	11	6	187
W	BC4125	Pharmacology Overview for AOM	4	4	0	44
	OM4806	AOM Preceptor Observation***	2	0	4	44
	OM5322	Survey of Western Clinical Sciences 2	3	3	0	33
	OM5416	Acupuncture Therapeutics 3	2	2	0	22
	OM5417	Acupuncture Therapeutics 4	2	2	0	22
	OM5438	TCM Techniques Lab	1	0	2	22
		Quarterly Totals	14	11	6	187
Sp	OM5300	Auricular Therapy	2	2	0	22
	OM5302	Public Health Issues in AOM	2	2	0	22
	OM5323	Survey of Western Clinical Sciences 3	2	2	0	22
	OM5418	Acupuncture Therapeutics 5	2	2	0	22
	OM5419	Acupuncture Therapeutics 6	2	2	0	22
	OM5805-6	Clinical Internship 1-2	4	0	8	88
	OM6305	Survey of Biophysics/ Electroacupuncture	2	2	0	22
		Quarterly Totals	16	12	8	220
Su	OM5807-10	Clinical Internship 3-6	8	0	16	176
	PS5205	Patient Communications	3	3	0	33
	PS6100	Motivational Interviewing	2	2	0	22
		Quarterly Totals	13	5	16	231

MSA YEAR III

Qtr.	Cat. No.	Course Title	Crdt.	Lec.	L/C	Tot.
F	OM5405	TCM Whole Foods Nutrition	2	2	0	22
	OM6110	TCM Medical Classics	2	2	0	22
	OM6417	Acupuncture Therapeutics 7	2	2	0	22
	OM6801-3	Clinical Internship 7-9	6	0	12	132
	TR6105	Nutrition & Dietary Systems	3	3	0	33
		Quarterly Totals	15	9	12	231
Eligible to sit for the NCCAOM exam ¹						
W	OM4101	History of Medicine	2	2	0	22
	OM6310	Case Review	2	2	0	22
	OM6804-6	Clinical Internship 10-12	6	0	12	132
		Quarterly Totals	10	4	12	176
Sp	BC5140	Research Methods in AOM	3	3	0	33
	OM5836	Internship Interim Clinic ****	1.5	0	3.3	36
	OM6105	Jurisprudence/Ethics	1	1	0	11
	OM6113	Practice Management	3	3	0	33
	OM6807-8	Clinical Internship 13-14	4	0	8	88
		Quarterly Totals*****	12.5	7	11.3	201

¹ Upon completion of 350 clinical hours (observation, internship or Chinese herbal medicine) and at least 1100 didactic hours, students are eligible to sit for the NCCAOM exam (a requirement for licensure.)

*Prerequisite courses to the MSA program: The MSA curriculum has been designed so students missing one or more of these prerequisites may take a missing course(s) as a corequisite after matriculating at Emeritus University.

**Observation 1-3 can be taken in any of the five quarters preceding intern status.

***Preceptorship can be taken during observation or intern phase, once Observation 1 & 2 are completed.

****Students are required to complete a total of 36 interim clinic hours. (Usually students staff the shifts they were assigned to in the quarter just ended.) Students register and pay for this shift in their last quarter of attendance.

*****All students who plan to study in China must take the one-credit required elective Clinic Entry for China in summer quarter of year three, just preceding their China internship. This course may be counted towards the nine required elective credits.

Elective Requirements: MSA

Qtr.	Cat. No.	Course Title	Crdt.	Lec.	L/C	Tot
variable	Elective & Special Topics*****		9	9	0	99
	Total Elective Credits and Hours		9	9	0	99

*****Electives/Special Topics: The MSA program requires a total of nine (9) elective/special topics credits. These credits may be any general electives/special topics as long as the prerequisites for each course are met.

For students who choose to take an optional Clinic in China internship, eight (8) credits (16 lab hours) will be applied toward AOM Clinical Internship.

Total Requirements: MSA

	Crdt.	Lec.	L/C	Tot
Total Core Course Credits and Hours	102	97	10	1177
Total Prerequisites/Corequisites	20	18	6	253
Total Elective Credits and Hours	9	9	0	99
Total Clinic Credits and Hours	37.5	0	75.3	828
Total Requirements	168.5	124	91.3	2357

Curriculum and course changes in the 2006-2007 Emeritus University Catalog are applicable to students entering during the 2006-2007 academic year. Please refer to the appropriate catalog if interested in curriculum and courses required for any other entering year.

Appendix 2:**Sample interview questions****Faculty:**

- What is your educational background (conventional and alternative)?
- How do you think this background influences your understanding of AOM/TCM?
- How did you become interested in acupuncture / Oriental medicine?
- How do you define 'alternative', 'complementary', and 'integrative' medicine?
How do you define/describe the AOM program at Emeritus?
- How did you come to teach at Emeritus University?
- Tell me about the course(s) that you teach.
- Can you describe your teaching style?
- Has your course changed since you started teaching?
- How does your course integrate with the other courses taught in the AOM program?
- What do you consider to be the most important lessons that student learn in your course?
- What do you think are the most important things that a student learns while at Emeritus?
- Has the AOM program changed at all since you started teaching? If so, how?
- What do you think of these changes?
- How do the Western science courses integrate with the Eastern, Chinese concepts?
- How do you see the future of acupuncture/Oriental medicine in North America?
- Why do you think students enroll in the acupuncture and Oriental medicine program at Emeritus?
- Has the composition of the student body changed since you started teaching (Ex: age/gender/ethnic identity)?

- Do you think that the gender of students plays a role in their education? If so, how? Do you think there are challenges or special circumstances surrounding male or female students at Emeritus?
- Are there more women than men in your classes? If so, why do you think this may be?
- How does acupuncture work?
- What qualifications do you think should be necessary to practice acupuncture?

Students:

- What is your educational background (conventional and alternative)?
- How did you become interested in acupuncture? Had you experienced it prior to enrolling in this program?
- Are you interested or involved in any other forms of alternative or complementary medicine?
- What do the terms 'alternative', 'complementary', and 'integrative' mean to you? How do you define what you are learning at Emeritus?
- What does 'health' mean to you?
- (Has your understanding of health, illness and the body changed over the course of the semester?)
- Why did you choose the AOM program at Emeritus?
- What do you hope to get out of your first year in the AOM program?
- What is it like to be a student attending Emeritus? Is it different than what you expected?
- What is the most challenging aspect of this program?
- How would you describe your relations with other students? Teachers?
- What do you think of the courses you have taken at Emeritus? Do/did they meet your expectations?
- If you could change anything about the program, what would it be?

- (As a female student), do you think there are different challenges involved with learning alternative medicine or with the program at Emeritus?
- (As a female student) Do you think that your gender has influenced/impacted your educational experience at all?
- Why do you think that women tend to dominate many fields of CAM, including acupuncture?
- (As a female student) How does acupuncture/alternative medicine relate to your identity as a woman?
- What do you think are the most important characteristics of an acupuncturist?
- How do you think acupuncture works?
- What qualifications do you think should be necessary to practice acupuncture?
- What do you see yourself doing after graduation? What are your plans for the future?
- What do you see as being the future of acupuncture in North America?
- What is / was your favorite class and why?

Focus Groups:

- Let's go around the room and briefly tell each other who we are, and how you became interested in acupuncture and OM.
- What do the terms 'alternative', 'complementary', and 'integrative' mean to you? How do you define what you are learning at Emeritus?
- How does acupuncture work?
- What does 'health' mean to you?
- Has your understanding of health, illness and the body changed over the course of the semester?
- Why did you choose Emeritus?

- What is it like to be a student attending Emeritus? Is it different than what you expected?
- How would you describe your relations with other students? Teachers?
- What do you think of the courses you have taken at Emeritus? Do/did they meet your expectations?
- What do you think are the greatest challenges involved in this educational experience?
- If you could change anything about the program, what would it be?
- What do you think are the most important characteristics of an acupuncturist?
- What qualifications do you think should be necessary to practice acupuncture?
- What do you see as being the future of acupuncture in North America?
- Do you think that gender plays a role in the education experience? Why do you think women tend to compose the majority of complementary/alternative medical students and practitioners?

Appendix 3:**Questionnaire****Part 1: General Information****Age:** _____**Gender:** ☐ Male ☐ Female**Racial Identity:**☐ American Indian☐ African American☐ Alaska Native☐ Native Hawaiian☐ Asian☐ Pacific Islander☐ Black☐ Caucasian**How many credit hours were you taking during the following semesters?**

Fall 2006 _____

Spring 2007 _____

Winter 2007 _____

Summer 2007 _____

In which program(s) are you enrolled at Emeritus?☐ BS/MSA☐ MSAOM☐ BS/MSAOM☐ ND/ AOM☐ MSA☐ Other: _____

Are you currently licensed or certified to practice health care (either conventional or complementary / alternative) in [this] State, any other state, or country? For example: nursing, chiropractic, cranial sacral, massage etc.)

☐ Yes ☐ No

If yes, please list _____

Are you a member of a professional organization related to health care, either allopathic or complementary/alternative?

☐ Yes ☐ No

If yes, please list _____

Are you a member of any Emeritus University interest groups or clubs?☐ Yes ☐ No

If yes, please list _____

1. Which scenario(s) BEST describe your vision of how you want to practice when you graduate?A. ☐ Full-time (35 hours a week or more) ☐ Part-time (less than 35 hours per week)**2. Which scenario BEST describes your vision of your practice setting when you graduate? Please circle.**

A. My own private clinic

☐ With referral network with other practitioners ☐ Without referral network

B. An integrated practice with the following practitioners (Please check all that apply)

☐ ND☐ MD☐ Massage therapist☐ Nutritionist☐ Counselor☐ Chiropractor☐ Other acupuncturist(s)☐ Herbalist (Western or AOM)☐ Reiki practitioner☐ Cranial Sacral practitioner☐ Ayurvedic practitioner☐ OTHER [please specify]: _____

D. In an allopathic (conventional) hospital or clinic

E. Not sure yet

F. OTHER [Please specify] _____

3. Please rate the importance of the following skills/characteristics of a practitioner of AOM by checking the box:

	Not Important at all				Very Important
	1	2	3	4	5
A. Listening skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Communication skills (with patient)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Providing patient education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Technical skills – for example needling, precision, point location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Research skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Western medical diagnostic skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Traditional Chinese Medical diagnostic skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Background in history of Chinese medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Background in philosophy of Chinese medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Ability to manipulate energy / qi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Involvement in professional organizations that advance the interests of AOM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Involvement in local / community organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Communication with other practitioners of complementary and alternative / integrative medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Collaboration with other practitioners of complementary and alternative / integrative medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. Communication with allopathic (conventional) medical doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. Collaboration with allopathic (conventional) medical doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. Concern for accessibility / affordability of service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Please rate how important the following have been to your educational experience at Emeritus:

	Not Important at all 1	2	3	4	Very Important 5
A. School community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Support of family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Support of friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Financial concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Opportunity for involvement with professional organizations related to AOM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Opportunity for involvement in local community organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Opportunity for involvement in school clubs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Opportunity for involvement in school events [Ex: community day]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Opportunities for continuing education [on-campus seminars, brown bags, etc. or off-campus seminar / educational events]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Involvement in Qi-Gong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Ability to take electives in Other academic programs at Emeritus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Interactions with second year / third year students in AOM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Interactions with students in other programs at Emeritus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Interactions with faculty at Emeritus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Clinic experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. Involvement with student council	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. Natural setting of campus (For example, gardens and trails)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R. OTHER [Please specify] _____					

5. How often do you discuss AOM course material, concepts, philosophies, theories, and experiences outside class?

- ☐ Frequently [several times a day]
- ☐ Moderately often [Once or twice a week]
- ☐ Rarely [once or twice a month]
- ☐ Never [why would I?]

Who participates in these discussions? Check all that apply.

	I never discuss with	I sometimes discuss with	I frequently discuss with
<input type="checkbox"/> Other first year AOM students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> AOM students in later stages of the program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Graduated students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Practitioners of AOM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Students in other academic programs at Emeritus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> AOM faculty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other faculty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Friends not enrolled at Emeritus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spouses / partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. How important have the following aspects of CLINIC been to your educational experience?

	Not Important at all 1	2	3	4	Very Important 5
A. Interactions with primary/ies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Interactions with Supervisor/s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Interactions with patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Opportunity to ask questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Opportunity to practice diagnostic skills (tongues, pulses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Shaping my vision of what I want my future practice to be like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Shaping my vision of what I <i>don't</i> want my future practice to be like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Shaping how I envision interacting with patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Shaping how I envision interacting with other health care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Demonstration of how classroom concepts and theories translate into clinical practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. OTHER [Please specify] _____					

7. Please rate the importance of the following to YOU once you start practicing:

	Not Important at all 1	2	3	4	Very Important 5
A. Patient education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Education of the general public about AOM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Education of the general public about complementary / alternative health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Not Important at all 1	2	3	4	Very Important 5
D. Continuing my education in AOM or other forms of healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Continuing my education in other forms of healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please specify, if known: _____

F. Spiritual development (For example, involvement in energy work, meditation, prayer, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Please specify, if known: _____

G. Incorporation of previous training or experience into my practice (Ex: massage, cranial-sacral, physical therapy, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Please specify: _____

H. Working with other complementary / alternative health care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

I. Working with allopathic (conventional) medical doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

J. Involvement in professional organizations that advance the interests of AOM / health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Please specify, if known: _____

K. Involvement in community organizations (For example, environmental, economic, political, social, health)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Please specify, if known: _____

	Not Important at all				Very Important
	1	2	3	4	5
L. International travel to practice AOM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please specify, if known: _____

M. Teaching AOM at an accredited Institution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Please specify, if known: _____

N. Making enough money to cover everyday expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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O. Becoming wealthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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P. Gaining a good reputation within the field of AOM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Q. Gaining a good reputation within my community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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R. Providing services on a sliding scale or other system that ensures access for low-income recipients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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O. OTHER [please specify] _____

8. I would describe the program as [please circle]

- ☐ Very competitive
- ☐ Somewhat competitive
- ☐ Not competitive at all

9. Please rate relevance / importance of the following courses to you as a future practitioner of AOM. If you did not take the course, check N/A [Not applicable]

	Not relevant at all	Somewhat relevant	Very relevant	N/A
	1	2	3	
A. Anatomy and Physiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Biochemistry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Living Anatomy Lecture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Living Anatomy lab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Western Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. TCM Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. TCM Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Meridians and Points	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. TCM Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Qi Gong (I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Tui Na (I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Tai Chi (I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Please rate the interest / enjoyability of the following courses to you. If you did not take the course, check N/A [Not applicable]

	Not interesting /enjoyable at all	Somewhat interesting / enjoyable	Very interesting/ enjoyable	N/A
	1	2	3	
A. Anatomy and Physiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Biochemistry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Living Anatomy Lecture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Living Anatomy lab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Western Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. TCM Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. TCM Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Meridians and Points	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. TCM Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Qi Gong (I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

J. Tui Na (I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Tai Chi (I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Please rate the amount of work required by the following courses, in relation to other courses. If you did not take the course, check N/A [Not applicable]

	Less work than other courses	Same work as other courses	More work than other courses	N/A
	1	2	3	
A. Anatomy and Physiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Biochemistry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Living Anatomy Lecture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Living Anatomy lab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Western Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. TCM Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. TCM Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Meridians and Points	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. TCM Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Qi Gong (I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Tui Na (I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Tai Chi (I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Optional Questions:**1. The BEST thing about the program:** _____

2. The WORST thing about the program: _____

3. If I could change anything about the program: _____
