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Behold the Power of *Qi:* The Importance of *Qi* in the Discourse of Acupuncture

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Traditional Chinese medicine (TCM) has recently gained a great deal of popular and scholarly attention. However, little work in this area has examined how people actually talk about TCM as a health care system and its implicit assumptions about health, illness, and treatment. Based on ethnographic fieldwork conducted in an acupuncture community, I describe a *Qi*-based speech code examining the importance and necessity of *Qi* (most simply translated as energy) in acupuncture discourse. Proper descriptions of acupuncture require explicit mention and acknowledgment of *Qi* as well as a grounding in its philosophy and explanatory system. Practitioners are taught to *feel Qi* and use this phrase as a discursive marker of expertise. Finally, *Qi* is also used in the competing rhetorics of Chinese and Japanese acupuncture. This study has important implications for understanding the culturally situated nature of health and illness in the United States and the consequences of these particular constructions as elucidated through close examination of conversations between practitioners.

> Acupuncture aims to restore the smooth flow of "Qi." With the insertion of needles at one or more of the almost 400 acupuncture points on the body, it brings the body back to a balanced state of health.
>
> —Good Fortune Acupuncture Clinic[1] (GFAC) Pamphlet

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It was December 23, 2002, and I went to the GFAC like I had every Monday morning for almost 2 months. A colleague had mailed me the December 2nd edition of *Newsweek* with a cover titled "The Science of Alternative Medicine" ("Health for Life," 2002). Depicted on the cover was a large close-up of a woman's face with three acupuncture needles inserted between her eyes. I was excited to show the magazine to the practitioners at GFAC and hear their reactions to this nationally recognized media portrayal of acupuncture.

When I presented the magazine, Kate and Beth, both acupuncture student interns working at GFAC, informed me that they had already read the articles. Beth remarked that her husband loved the piece and thought it was great. She explained that for the general public, the magazine shows acupuncture in mainstream media in a positive light. Although Beth also criticized the piece for being too simplistic, she was impressed that some important components of traditional Chinese medicine (TCM)—such as *Qi*—were mentioned. Kate's reaction was much more critical and vehement. She stated very clearly that she was "really unhappy with some of the things they said." I asked her if it was because of its science bias and Kate answered, "exactly!"

Kate and Beth's strong reactions to the article's use (and misuse) of *Qi* served as a social drama (Philipsen, 1997) that highlighted not only the inability of scientific explanations to capture how acupuncture works but also the importance of *Qi* as part of the speech code (Philipsen, 1997) of this particular speech community (Fitch, 1998, 1999). Based on ethnographic fieldwork conducted at a teaching acupuncture clinic, I examine three aspects of this code. First, proper descriptions of acupuncture require explicit mention and acknowledgment of *Qi.* Second, practitioners use the practice of feeling *Qi* to claim expertise and separate themselves from novices and clients. Finally, *Qi* works to differentiate forms of acupuncture, most notably Chinese and Japanese acupuncture. After I present a brief description of speech codes theory (Philipsen, 1997) as it informed this study, I present some background and history on TCM as a health care system.

SPEECH CODES THEORY

One way communication scholars have studied the culturally situated discourse practices of specific groups or speech communities is through the

ethnography of speaking (or ethnography of communication; Hymes, 1972; Philipsen, 1975, 1976, 1992). The ethnography of communication historically uses the speech community as the social unit of analysis (Hymes, 1972). However, Milburn (2004) recently examined the utility of the speech community concept in communication research. Although not limited to this use, the term *speech community* has often relied on locating a geographically bounded and unified group of people (e.g., Philipsen, 1976). Although TCM users and practitioners are quite diverse and not necessarily geographically bounded, it is possible that this group can still be considered a speech community "on the basis of shared ways of speaking that cut across subgroups" (Fitch, 1998, p. 23). In this article, I follow Fitch's (1999) description of speech communities as "a string of people who share a symbolic code of speaking practices and meanings for those practices, although they may be separated by distance as well as race, class, gender, age, and so forth" (p. 46). Within these communities, tension may exist as participants struggle with whether or not they belong to the group or share codes of speaking (Carbaugh, 1996; Milburn 2004), but that does not mean that speech codes are not analytically useful for describing how people accomplish socially meaningful action.

For ethnographers of communication, the focus is on finding these culturally valued ways of speaking or codes of symbols and meanings and cultural ideology that can define a speech community (Philipsen, 1992). *Speech codes* are defined as the "system(s) of socially constructed symbols and meanings, premises, and rules, pertaining to communicative conduct" (Philipsen, 1997, p. 126), and they serve as resources for making sense of what interactions mean and do. In his theory of speech codes, Philipsen (1997) presented five propositions regarding speech codes: (a) they are distinct from one another; (b) they implicate "a culturally distinctive psychology, sociology, and rhetoric" (p. 138); (c) they are necessary for understanding the meaning of communication; (d) their terms, rules, and premises can be found in speaking; and (e) they have discursive force. These propositions provide a theoretical basis for understanding both how a distinction is interactionally accomplished between the *Qi*-based speech code and a scientific-based biomedical acupuncture code and the implications of this distinction for how practitioners understand acupuncture practice and negotiate that practice with clients. The purpose of this research was to find out whether and how such a code was used and to examine the discursive resources participants drew on to make sense of this particular health practice.

THE TCM HEALTH CARE SYSTEM AND *QI*

Like speech codes, health care systems have also been studied as culturally valued symbolic systems (Kleinman, 1980). Based on research conducted in Taiwan, Kleinman (1980) explained,

> In all societies health care activities are more or less interrelated. Therefore, they need to be studied in a holistic manner as socially organized responses to disease that constitute a special cultural system: *the health care system.* In the same sense in which we speak of religion or language or kinship as cultural systems we can view medicine as a cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions. … The health care system, like other cultural systems, integrates patterns of belief about the causes of illness; norms governing choice and evaluation of treatment; socially-legitimated statuses, roles, power relationships, interaction settings, and institutions. (p. 24)

Whether the health care system in question is biomedicine or traditional Chinese medicine, it is important to recognize that both systems are made up of symbolic meanings; are constituted in communication; and maintain certain patterns of belief regarding the body, illness, and proper treatment. Although Kleinman (1980) and other medical anthropologists have focused on understanding the health care system itself, language and social interaction research pays greater attention to how people actually go about constituting these systems through their talk and the social consequences of such talk. An ethnographic perspective provides an important yet missing voice to ongoing conversations about these particular health practices by focusing not just on the relevant health issues but rather on how people understand those practices and health issues through their communication. All communicative action is socially consequential, and discourse in TCM should be no different. Communication is at the core of understanding TCM as a health practice. Research that examines how people accomplish socially meaningful action, in this case in delivering a certain form of acupuncture, provides an important and previously understudied perspective to current research on TCM.

To understand the importance of *Qi,* I briefly describe the history of Chinese medicine, especially as used in the United States; provide an admittedly superficial explanation of how TCM works[2]; and then briefly summarize some current research in the area of TCM to provide a context for understanding some of the communicative questions that are important to this area of study. Most of this current research is based in the health

arena. However, this research provides a useful basis for understanding the larger health-related context in which this *Qi*-based speech code is situated.

TCM in the United States

The use of acupuncture and Oriental medicine dates back to 1000 BC (Way & Chen, 1999) and is currently in use in over 140 countries (Scheid, 1999). Described using the names TCM, Oriental medicine, East Asian medicine, and others, the evolution and migration of these practices has led to some quite different forms of health care.[3] In mainland China, TCM, in its current state, is a relatively new health care system that was originally standardized and codified by Mao Zedong in the 1950s and given equal status with Western biomedicine only after years of scientific and clinical testing (Kaptchuk, 2000). Mao's new medicine purged the so-called superstitious aspects of Chinese medicine such as demonic and Buddhist temple medicine (Unschuld, 1985). Some even use the title TCM only for this Mao-endorsed set of practices that excludes the more spiritual, mental, and emotional components of an older Chinese medicine that still exists in Taiwan, Korea, Japan, and elsewhere (Eckman, 1996). This more scientifically based and relatively new TCM was what reporter James Reston encountered on his trip in 1971 to cover President Nixon's visit to China. This popularly cited origin of TCM's arrival in the United States was based on Reston's use of acupuncture for surgical anesthesia and subsequent reports of a "miracle cure" for pain (Barnes, 1998; Eckman, 1996; Ehling, 2001; Ulett, J. Han, & Han, 1998b). Although Chinese medicine arrived in the United States much earlier through immigration (Wooton & Sparber, 2001), it is this highly publicized media event that often serves as the beginning of widespread national attention and usage of acupuncture and TCM in the United States, the subsequent education and licensing of practitioners, and health insurance coverage.

In the United States, acupuncture and TCM practices vary greatly due to state licensing and educational institutional differences. For example, in Washington, where I conducted this research, acupuncture licensing only covers acupuncture practice, whereas in California, an acupuncture license also requires knowledge and experience in prescribing herbal remedies. In addition, acupuncture schools themselves vary quite a bit in terms of both focus of study and philosophical differences. The purpose of this brief history is to recognize the wide diversity of healing forms both in the United

States and throughout the world that fall within the larger label of TCM and acupuncture.

TCM Basics

There currently exists quite a large and sometimes conflicting body of both scholarly and popular literature explaining traditional Chinese medicine in English. In this overview, I present some of the most commonly accepted basic practices and principles of Chinese medicine. As Kleinman (1980) describes,

> Classical Chinese medicine regards most diseases to be caused by disharmony to man, while Western medicine regards most diseases in terms of the organ-specific lesions they produce. Classical Chinese medicine speaks in a "functional" language of imbalances in the body's *yin/yang,* of disharmony in the systematic correspondences of the Five Evolutive Phases (*wu-hsing* [*pinyin, wu xing*], also rendered Five Elements—wood, fire, earth, metal, water), including the integrated functioning of the five interrelated internal organ systems (*wu-tsang* [*wu chang*], Five body Spheres), and of blockage of the balanced circulation of *ch'i* [*qi*] (vital essence)" (p. 91).

TCM practitioners assess imbalances and disharmonies through an examination that includes an intake history, feeling pulses, and examining the tongue. TCM practitioners' own bodies (through touch, sight, and smell) serve as the tool or measurement device for diagnoses. The role of a TCM practitioner in treatment is to bring clients into balance using herbs, certain foods, acupuncture, or movement and breathing practices such as *Tai Qi* and *Qigong.* Healthy *Qi*[4] circulates and flows along meridians (invisible but palpable paths) in the body that are regulated by energetic organs.[5]

This background provides a basic overview for understanding the placement of *Qi* within the larger health care system of TCM. Although a clear definition of *Qi* would be useful, the only agreement regarding definitions of *Qi* is that it is very difficult to translate and therefore difficult to define. A reading distributed in the introduction to Chinese medicine course I attended as part of my fieldwork explained that "The way 'Qi' is translated also depends on the particular view point taken" (Maciocia, 1989, p. 36). Mention of *Qi* is used in everything from diagnosis (imbalances and stagnations in *Qi*), to talk about treatment (need to move *Qi*), to descriptions of health care practices (*TaiQi, Qigong, Tai Chi Chuan*). Despite the difficulty in translating and explaining *Qi,* Kaptchuk (2000) explains,

> For the Chinese, everything in the universe, inorganic and organic, is composed of and defined by its Qi. … Qi is not so much a force added to lifeless matter but the state of being of any phenomena. … Qi is the thread connecting all being. … Qi is the fundamental quality of being and becoming. (pp. 43–44)

Because it is more a state of being than a substance, descriptions of *Qi* are always somewhat incomplete. Other research has compared *Qi* to the Greek and New Testament notions of *pneuma* or wind (Ogawa, 1998). *Qi* has also been described, in a study of *qigong,* as a mind-in-body practice (Kerr, 2002). As these and other studies have demonstrated, *Qi* is a complex and difficult to understand concept that is essential to the TCM health care system.

Communication in Current TCM Research: Setting the Context

As evidenced by the *Newsweek* ("Health for Life," 2002) cover story described in the introduction, the study of complementary and alternative medicines (CAM)[6] for healing has become mainstream. Two areas of current research in TCM that would benefit from a more explicit examination of communication are the scientific testing of TCM[7] and research looking at the population of TCM users and their self-reported reasons for using such medicine (see Cassidy, 1998a, 1998b; Sirois & Gick, 2002; Vincent & Furnham, 1996). None of these bodies of work has examined how people actually talk about TCM. However, a closer examination of this research reveals how embedded and taken for granted communication concerns are to understanding TCM within the larger health context.

An extensive body of TCM research—the scientific testing of TCM efficacy[8]—has regarded biomedicine as the yardstick for the true or best form of health care and has not taken into account that it is but one of many ethnomedical health care systems used throughout the world and throughout history (Gordon, 1988; Hahn, 1995; Kleinman, 1980; Lock & Gordon, 1988; Rhodes, 1996). This approach is reinforced by organizations such as the National Center for Complementary and Alternative Medicine (NCCAM; 2004) whose $123 million Fiscal Year 2005 budget was dedicated to "exploring complementary and alternative healing practices in the context of rigorous science; training CAM researchers; disseminating authoritative information to the public and professionals" (para. 2). The

problem with treating health as solely a biomedical endeavor is that biomedicine becomes normalized while other areas are simultaneously ignored or delegitimated. Instead of trying to understand this health care system from the perspective of the TCM community, these research studies have worked to legitimate a specific form of scientific TCM.

According to "scientific studies" of TCM, the reason acupuncture works is because the insertion of needles stimulates neuropeptides in the central nervous system, resulting in positive physical changes (Ulett, S. Han, & Han, 1998a). This explanation has led to the conclusion that "the ideas of the ancients have in a sense been validated but reformulated in terms of modern neurobiology" (Ulett, J. Han, et al., 1998b, p. 1116). Although Ulett, J. Han, et al.'s (1998b) biological explanation for acupuncture is certainly important if the goal is to integrate acupuncture into other scientific forms of health care, what remains unexamined in these studies is a recognition of the ways—whether it be through science, TCM specific explanations, or something else altogether—that acupuncture practitioners and users discursively construct this health care form. Little research has actually looked at real interaction to see how the practitioners and users communicatively call into play different discourses of healing (of science and neuropeptides or of *Qi* and energy; for some examples, see Farquhar, 1994; Hare, 1993).

The second major area of research has focused on asking patients to self-report on the reasons they find TCM and other holistic medicines appealing (Cassidy, 1998a, 1998b; Sirois & Gick, 2002; Vincent & Furnham, 1996). Some common answers include improved symptoms beyond biomedicine (Cassidy, 1998a; Sirois & Gick, 2002; Vincent & Furnham, 1996), a focus on overall well-being (Cassidy, 1998a), patient centeredness (Cassidy, 1998b), better communication (Vincent & Furnham, 1996), and allowing for clients to take an active role in health care (Sirois & Gick, 2002; Vincent & Furnham, 1996). In addition, both Cassidy (1998b) and Vincent and Furnham (1996) have concluded that one reason users of TCM are drawn to its practice is because of its emphasis on holism and its holistic care. Although holism is certainly a part of TCM theories, participants in Cassidy's (1998b) survey study did not use TCM terminology such as meridians and/or *Qi* in their self-reports. The Cassidy (1998b) study focused on users' self-reports regarding TCM usage. However, no research has yet examined how TCM users themselves actually talk about their experiences with this healing practice. Whether and how a TCM-based (or holistic) vocabulary is actually integrated into talk about TCM is a discourse-centered

question that language and social interaction scholars are well equipped to examine. That question is important to understanding how TCM is understood—or misunderstood—within the broader community. In this article, I argue that TCM practitioners utilized a specific valued way of speaking that centers around the notion of *Qi.* This *Qi*-based speech code works to not only validate a specific kind of practitioner of acupuncture, but also a specific kind of practice.

METHOD

I collected the data presented in this study using participant observation and informal interviewing over an 8-month period of ethnographic fieldwork from October 2002 to June 2003. The primary site for participant observation was GFAC, the clinic described in the opening story. GFAC is very small and quite informal compared to other acupuncture clinics in the area. Housed within a larger Asian social services agency (the Southside Asian Agency [SAA]) in a large metropolitan area in Washington State, the clinic "space" was actually a multipurpose room that was transformed every Monday into an acupuncture clinic. The space was about 30 ft × 40 ft with a walk-in closet and kitchen attached. All three of these spaces (main room, closet, and kitchen) were used for meeting and treating patients. In the larger open space, two treatment areas were divided by paper screens and a large six-foot long folding table served as a conference area. It was at this table where I spent most of my time and where student interns discussed treatment options with the clinic supervisor Yuri.

Yuri was the only licensed acupuncturist, and she served as supervisor to the interns who worked, 2 to 6 at a time, at GFAC. Of the 15 or so interns that I met, they ranged in age from the mid 20s to mid 50s, with slightly more women than men. They were either ethnically White, Asian, or Asian American, and some had previous health careers working as nurses, massage therapists, and counselors. Ethnically and nationally Japanese, Yuri was bilingual and had lived and worked in the United States for 10 years in a variety of public health settings providing free and low-cost acupuncture. Trained both in Japan and the United States, she was licensed as a Chinese acupuncturist but specialized in Toyohari-style Japanese acupuncture. I discuss the importance of this distinction later in this article. However, in talking to Yuri, she described her public health work delivering acupuncture to the poor and otherwise underserved as more definitive of her iden-

tity than her background in Toyohari. The clients seen at GFAC were either SAA clients who were ethnically Asian (mostly Vietnamese) or SAA employees who were mostly White. Treatments were priced much lower than the average area acupuncturist fee of $50 to $75 per session, costing $5 for SAA clients and $10 for employees.

Opened in 2001, the clinic served as a site for Asian Medicine College of Washington (AMCW) students to acquire clinical experience. The students were all in their last year of acupuncture school, finishing up clinic hours, and preparing for their licensing exams in June of 2003. Interns worked in pairs to interview, consult with the director, treat patients with acupuncture, and file patient chart notes. To the extent that all of the interns and Yuri were trained by the same AMCW professors, I expected that their way of speaking about acupuncture might be similar or at least based in a similar foundation. Unlike some other acupuncture colleges, students at AMCW were not required to be fluent or even well versed in Chinese. Instead, they were given the option of taking an elective medical Chinese class. Some other acupuncture schools either require Chinese fluency and/or require medical Chinese language courses for graduation.

Between October 2002 and June 2003, I visited GFAC 25 times. I was at the clinic an average of about 4 to 5 hr (usually splitting both the morning and afternoon shifts) taking copious field notes and leaving an audio recorder constantly running at the conference table. I was able to ask Yuri and the other interns informal interview questions that were recorded along with other conversations that occurred around this area.

In addition to the data from GFAC, I also received permission to attend part of a quarter long (10 weeks) Introduction to Chinese Medicine course being offered by a local holistic healing university as part of their curriculum. I attended for 8 weeks and audio recorded seven of those class sessions. Another area university presented a History of Alternative Medicine course with a guest speaker on acupuncture that I attended and recorded as well. All field notes and transcribed audio were uploaded into Atlas.ti (Muhr, 1997) qualitative data analysis software.

I approached the data inductively, looking first for recurring themes or native terms that seemed particularly important or salient in conversation. Looking for cultural norms, premises, or symbols, I also focused on incidents in which cultural norms seemed to have been violated. As Philipsen (1992) explained, the existence of a patterned way of speaking does not necessarily mean that speakers will communicate predictably or determin-

istically. Instead, what Philipsen (1992) argued is that these patterns are seen to exist precisely when violations occur and participants comment on those violations. The *Newsweek* ("Health for Life," 2002) story I described in the beginning of this article was just such a violation and served as a kind of social drama (Philipsen, 1997) in which a violated rule elicited comment. The depiction of acupuncture as scientific and not based on TCM notions such as *Qi* drew impassioned comments, such as those presented at the beginning of this article, from many GFAC members pointing to an important cultural norm.

In addition to the *Newsweek* ("Health for Life," 2002) social drama, I listened for invocations of *Qi* and talk about *Qi* because, as mentioned earlier, of its difficulty in translation. Not only is the concept difficult to translate, but in talking with people at GFAC and elsewhere, I immediately noticed both the prevalence and the diversity of instances in which *Qi* was invoked, for example, in naming (e.g., there is a *Qigong* or *TaiQi* class offered), and in diagnosis (e.g., *Qi* stagnation or deficient *wei Qi*). Along with open coding field notes and transcripts (Glaser & Strauss, 1967; Strauss & Corbin, 1998), a pattern emerged in which, as I present in the next section, *Qi* was an essential component in talk about how acupuncture works or functions. At this point in the analysis, I used Spradley's (1980) domain analysis to categorize all coded instances of *Qi* using the function relationship (*X* is used for *Y*). In this case, the relation most useful was "talk about *Qi* is used for *Y*." I continued to analyze the texts searching for any mention of *Qi,* paying special attention to instances that supported or disconfirmed the importance of *Qi* as part of the discursive explanation for acupuncture.

THE ESSENTIAL NATURE OF *QI*

During my fieldwork, when I asked acupuncturists and interns to explain how or why something in acupuncture worked the way it did, they consistently mentioned *Qi* as one of the foundational concepts underlying acupuncture. However, as a concept foreign to my ears, *Qi* also proved to be one of the hardest concepts to put into words. I did not seem to be the only one who struggled with how to deal with *Qi* as a student intern (Erin) explained how difficult it is to understand *Qi* because of its nonphysical and invisible nature:

[GFAC Clinic January 13, 2003]

1	Erin:	It's s::o esoteric I mean it's just very ethereal an (.) it's hard to grasp
2		something that you can't (.5) physically
3	Evelyn:	mm hmm
4	Erin:	see (.) And qi is s::o
5	Evelyn:	Ri:ght
6		(.5)
7	Erin:	I mean [unless you do Qi gong] or Tai Qi
8	Evelyn:	[but there's a lot of things that there] yeah=
9	Erin:	=it's something that you're not familiar with

In lines 7 and 9, Erin claims that one needs to have experience and familiarity with *Qi* to grasp it. However, this can be achieved either through the practices of *Tai Qi* or *Qigong* (line 7) or as other practitioners explained to me on different occasions, through experience and training to be an acupuncturist. What is notable here is that Erin's response was not explicitly about a lack of knowledge in terms of language skill or even translation but rather about experience. As a native English speaker, Erin's own experiences with *Qi* were a result of her education and practice as an acupuncture student. Although ethereal and foreign, acupuncture community members found concrete ways of talking about *Qi* in English, and it is these ways of speaking that make up the *Qi*-based speech code. The use of this code worked to accomplish a certain way of practicing acupuncture and TCM. In the following sections, I present three aspects of the *Qi*-based speech code and uncover how this code discursively constructs TCM as a unique health care system with specific requirements and entailments. Specifically, I focus on the absolute necessity of *Qi* in any talk about TCM, the use of "feeling *Qi*" as a sign of expertise, and the place of *Qi* in the interaction of Chinese versus Japanese acupuncture.

"At Least They Mention *Qi*"

The discursive force of *Qi* demonstrates its place as one of the most central concepts to traditional Chinese medicine, and this was brought to light most vividly in the reactions to the *Newsweek* ("Health for Life," 2002) story violation/social drama I described in the introduction. Both because *Qi* is not physically recognizable and perhaps because it does not have an easy English equivalent, *Qi* does not hold as important a place in

Western understandings and discourses of TCM. In fact, medical research has often tried to provide alternative explanations for how TCM works by neglecting *Qi* altogether. I present this information because practitioners were constantly contending with this alternative scientific viewpoint or scientific code[9] of acupuncture. This scientific mission was echoed in an article on integrative medicine (Cowley, 2002) published in the previously mentioned *Newsweek* ("Health for Life," 2002). This article generated quite a bit of conversation and drew both criticism and praise among the interns at GFAC. As Cowley (2002), author of the title article, explained,

> The short-term goal is to identify the CAM practices with the greatest benefits and the fewest hazards, and to make them part of routine clinical practice. But this movement is more than a search for new remedies. Its larger mission is to spawn a new kind of medicine—an *integrative* medicine that employs the rigor of modern science without being constrained by it. If the dream is realized, the terms "complementary" and "alternative" will become meaningless, proponents say. We'll have one health system instead of two, and healers of every stripe will work together while being guided by science. (p. 48)

The focus of Cowleys' particular article, on integration, relies on science's ability to unite the currently oppositional groups of biomedicine and CAM. Because *Qi* does not fall into the category of modern science, it cannot be part of the integration and is forced out for the sake of science in what can be understood as a form of professional or disciplinary boundary work (Gieryn, 1983, 1999). I elaborate more on this point in the following sections.

The GFAC practitioners' responses to this article demonstrate how important *Qi* is to discussions of TCM and the inaccuracy of descriptions lacking *Qi.* The overarching complaint from the practitioners at GFAC was that acupuncture was being oversimplified. However, practitioners also recognized the benefit of these kinds of articles for those with little knowledge of TCM. Although acupuncture has been well recognized in Washington, intern Ryan told me that "In our eyes it'll [popular press articles about acupuncture] never be too much or old news. It's amazing on the West coast here. It's [acupuncture] so much more accepted here." The idea that any news about acupuncture is good news was defended but also further qualified in another conversation at GFAC. As Yuri, Kate, and I discussed, it is better to have simplistic, yet positive, articles than to not have them at all:

[GFAC Clinic December 23, 2002]

1	Yuri:	Well at least they pick it up (.) the story
2	Evelyn:	mm hmm
3	Yuri:	not talking about don't g::o or
4	Kate:	No uh huh yeah no they actually (.) and they're trying they talked about
5		stagnant liver? Qi I mean yet they're trying to [(describe th]at that pool
6	Evelyn:	[Oh really?]
7	Kate:	that none of us can) (.2) You know
8	Yuri:	Really
9	Kate:	They they try (.) I have to say that (.) Eh ha ha
10	Yuri:	really trying
11	Kate:	they talked about Q::i
12	Yuri:	There you go ((flipping pages 2.5)) ((In a sing-song voice)) They ta?lk
13		↑about Q:::i ((more flipping))

The part of the article (Underwood, 2002) that Kate was referencing in line 5 about "stagnant liver Qi" was a paragraph in which the author describes TCM's nonbiochemical and nonpathological explanatory system. The paragraph stated,

> In addition, good health requires the life force or vital energy that the Chinese call *qi* ("chee") to flow smoothly through the body along 14 major channels, or "meridians." Put this all together, and it means that a traditional Chinese doctor wouldn't diagnose peptic ulcers, but "deficient yin of the stomach," "damp heat affecting the spleen" or "disharmony of the liver invading the spleen." Acupuncture or herbs might be needed to unblock "stagnant qi." (p. 55)

This paragraph appears immediately before a much longer section that reviewed many of the scientific studies of acupuncture and its connections to endorphins. Kate and Yuri's earlier sentiments then can be read as a reminder that TCM descriptions must first include TCM concepts and vocabulary such as *Qi*. However, as a second step and as the comments following demonstrate, proper use of the *Qi*-based speech code requires more than the mere mention of *Qi* and other TCM-based diagnoses. Instead, this code requires an adequate grounding in the theory behind TCM. For this reason, the *Newsweek* (Underwood, 2002) article does not fall within the proper use of the code and receives criticism from the GFAC acupuncturists. Later in the same day, I read aloud a section from the same *Newsweek* article (Underwood, 2002) explaining that acupuncture works by stimulating connective tissue and Kate responded very harshly:

[GFAC Clinic December 23, 2002]

1	Evelyn:	Dr. Helaine Langeman from the University of Vermont (.) In December
2		blah blah blah blah basically that acupuncture points tend to correspond
3		with where connective tissue is the thickest?
4	Kate:	Yeah they try to
5	Evelyn:	What is that?
6	Kate:	They totally miss the whole point (.) about Qi (.) It's not about
7		connective tissue

The resounding reaction was that this *Newsweek* author (Underwood, 2002), in oversimplifying her description of TCM, had not stayed true to TCM specific theories. Merely mentioning *Qi* was not adequate because further descriptions of how TCM worked ignored the presence and effects of *Qi* altogether. In other words, talk about acupuncture that fails to properly use the *Qi*-based speech code were unacceptable in this particular speech community because it failed to grasp and to promote the (albeit ethereal) actual driving force behind this health care system.

Discursive Claim of Expertise: Feeling the *Qi*

As Philipsen (1997) explained, speech codes are not solely about communication but instead are also codes about social life and the nature of relationships and interaction. Speech codes implicate a cultural ideology (Philipsen, 1992) that together reveals how people should act. Because of the combination of classroom visits and clinic observations to which I had access, I was able to listen to how future acupuncturists were taught this *Qi*-based code as a way of establishing a certain level of professional expertise and identity. As an ethereal state of being as opposed to a physical object or thing, the only way to get a handle on *Qi* was through learning to feel its presence and movement. Because this was a learned skill, feeling *Qi* was a practitioner's job, and a treatment's success depended more on the practitioner's ability to feel *Qi* than on anything the client was doing or not doing and perceiving or not perceiving.

One reason *Qi* can so easily be left out of scientific descriptions of TCM is because of its invisibility. Instead of an external instrument used for measuring such as a stethoscope, X ray or MRI, the instrument for measuring in TCM is the practitioner himself or herself using the five senses. *Qi,* like any other physical bodily substance (blood, blood pressure, heart

rate) can be measured most commonly through a practitioner's feeling the pulse and looking at the tongue. However, unlike other bodily substances, one cannot really see *Qi.* Because the practitioner accesses *Qi* through feeling, one goal of acupuncture education consists of learning how to feel the *Qi.* Observing at the Holistic Healing Academy (another area acupuncture college) clinic, the supervising practitioner ended the day by asking each student "What did you learn today?" Almost everyone mentioned that his or her point location was getting better, and then one student said "I'm feeling the *Qi* more." Feeling *Qi* is, therefore, a skill to be learned like needle point location. However, unlike point location, which can be objectively verified by a supervisor, feeling *Qi* cannot. Because of this, the claim of "feeling *Qi*" also functions as an important discursive resource for students to verbally claim an increased ability or expertise in acupuncture practice.

Because one goal of acupuncture training is to become better at feeling the *Qi* and because feeling *Qi* serves as a discursive marker of expertise, feeling *Qi* was also used as a way of differentiating really good practitioners from novices. In a conversation with Jean, a Korean American intern at the GFAC clinic who had been working as a nurse for the last 15 or more years, she told me about a monk who introduced her to Buddhism. She described him in this way: "very intelligent, like a doctor. He knew about Buddhism but also *Qi gong,* Asian medicine, and he could look at you and tell you what was wrong with you because he could see and feel the *Qi.*" According to Jean, what made this practitioner successful was not only that he knew about various Asian practices but also that he could heal you because he could feel and see *Qi.*

As a client new to acupuncture and as someone who became highly attuned to *Qi*'s place in acupuncture talk, I struggled with whether or not I ever felt the *Qi* or recognized its presence. I discovered that it was not imperative to feel the *Qi* because I was merely the client. On one occasion, Erin, a student intern, was treating me and asked me how my treatment was. I answered "Oh great. I can really feel like everything's moving around in there now." I was hesitant to call what I felt *Qi,* but I continued by asking, "When you needle to move the *Qi,* the *Qi* that you feel, is that circulating from within or is there extra *Qi* coming in the point?" She said "you're the conduit [referring to the practitioner] and some people really take care of themselves and do Tai Qi and everything. But you're the conduit between the heavenly and earthly *Qi* and it comes through you and through your hands and into the needle and the point. And it's really hard being a student, well you know, and being able to really be grounded." As

Erin explained, treatment relies more on the practitioner's groundedness and ability to feel and conduct the *Qi* rather than on the client's recognition, or claims of recognition, of *Qi.* Although the interns nodded in agreement when I told them that I thought I was able to feel *Qi,* it seemed that this was done mostly because they were happy that I could recognize the treatment working and not because my claims to feeling the *Qi* added to the effectiveness of the treatment. Ultimately, what is important for treatment is the practitioner's expert ability to feel the *Qi* both in the client and as a conduit for *Qi* outside the client. At least in this realm of the treatment, the *Qi*-based speech code works to create a passive client and expert practitioner relationship.

Although *Qi* is most often felt by practitioners, it is the rare occasion, as Jean remarked about the monk, when *Qi* can actually be seen as well. I did not interrogate Jean about what she meant when she reported that the monk could "see *Qi.*" However, based on other accounts of seeing *Qi,* it seems that the closest way to see *Qi* was to visually observe *Qi* at work. These stories of seeing *Qi* serve as strong evidence for clients, especially those with biomedical understandings of disease, in defense of a *Qi*-based TCM. In the following story, Theresa, a guest lecturer in the History of Alternative Medicine course, described a dramatic and amazing situation in which she and others were able to visually see the immediate effects of *Qi:*

[History of Alternative Medicine Class December 12, 2002]

I've had patients this is probably the one thing that has been most dramatic in (.) convincing people that there's something to this concept of Qi (.) I've had several I had a a young girl twelve years old come in a horse had stepped on her toe (.3) And the toe (.) on one side is the spleen channel and on the other side is liver and we depicted we determined that it was more (.) That it involved the liver side more (.) So opposite liver time on the Chinese clock is a small intestine channel (.) And I used a very special 30 gauge gold needle (.) Not inserted (.) on the small intestine point (.) And you could visibly see the swelling reduce (.) Um and it just changed (.) And the pain completely went away (.) And that treatment took (.) 2 minutes (.) Uh it was extremely dramatic and I have many stories like that (.) Even I who am trained in East Asian medicine (.) I'm still a product of Western culture and I still get absolutely amazed when things like this happen

As Theresa states in lines 12 through 14, as a product of Western culture, she is "amazed when things like this happen." The *dramatic* story is compelling for the audience of biomedical students, presumably also products

of Western culture. The story relies on a notion that seeing is believing because it makes *Qi*— or more specifically, the effects of *Qi*—visual, material, and therefore convincing (line 2). Although equally effective in healing, *Qi,* which ordinarily functions invisibly, is not quite as amazing as when *Qi* also works visually.

One problem with stories such as the preceding one is that it establishes a precedent for out of the ordinary and dramatic visual miracles. Zhan (2001), in a study of traditional Chinese medicine in San Francisco and Shanghai, argued that TCM's marginal status both leads to and perpetuates its reliance on "clinical miracles" for legitimacy. Serving primarily to ease ailments that biomedicine has not been able to treat effectively, TCM's everyday healing practices were viewed as miraculous (Zhan, 2001). Although miracle stories are beneficial for drawing in new clients and maintaining acupuncture practices (Zhan, 2001), these miracles also work to discredit TCM in two important ways. First, they establish unreasonable expectations because like biomedicine, TCM may not always heal every person. As already established, *Qi* ordinarily functions invisibly through touch and not sight. However, these kinds of extraordinary stories, told to convince nonbelievers, can also work to reinforce the need for more extraordinary evidence. Second, and perhaps more important, these stories are told as *miracles* as opposed to being described as the everyday practice of acupuncture and Chinese medicine, undermining the *Qi*-based speech code used by the practitioners at GFAC.

The use of miracle stories also works to undermine TCM's complexity as a healing practice and further reinforces my earlier claim that a *Qi*-based speech code cannot only use TCM terms but must also incorporate TCM philosophy as well. This is demonstrated in a quote from Yuri, the clinic coordinator at GFAC. She was commenting to Kate (an intern) and me on the *Newsweek* magazine and said,

[GFAC December 23, 2002]

1	Yuri:	I've read this type of um (.) magazine before talking about acupuncture
2		talking about do this and do that and you're supposed to feel the Qi and it
3		feels good and you're cured and blah blah blah
4	Evelyn:	[((laugh))]
5	Kate:	[((laugh))]

In this exchange, Yuri is not criticizing acupuncture practice for its reliance on feeling the *Qi.* Instead, the critique is one of "this type of … magazine"

that reduces acupuncture into an overly simplistic, three-step process in which clients feel *Qi,* feel good, and are cured. I laughed at this description of acupuncture because I knew as a client of acupuncture, it never worked like this. Part of the problem seems to be that the focus is on the client's ability to *feel the Qi* that is supposed to lead to a cure (lines 2–3). In my experience at GFAC, very few clients ever mentioned feeling the *Qi,* but many clients did claim to feel better. Like the difference between feeling and seeing, it seems that *Qi* functioned independently of a client's ability to feel or recognize its role in treatment. In fact, because clients were not necessarily told or taught to feel *Qi,* Yuri's comment can also be read as reinforcing the importance of feeling *Qi* as part of an acupuncturist's expertise.

The use of the *Qi*-based speech code at GFAC was different from the use of the miracle story as told earlier. This difference could be a location of tension among different speech communities, or more likely, it is a discursive resource used to address a different audience. At GFAC, clients do not necessarily have to be lured in to use or accept acupuncture, as the clients have all voluntarily arrived to receive treatment. On the other hand, the classroom audience of health/science students was one in which the audience presumably demanded scientific and visual proof for any claims of success. Like the *Newsweek* (Underwood, 2002) article, there may be alternative acupuncture speech codes based on visual or scientific proof. Although these distinctions go beyond the scope of this article, what is important to recognize is that in the *Qi*-based speech code, practitioners use feeling *Qi* as a claim of expertise in acupuncture.

The Competing Rhetorics of Chinese and Japanese Acupuncture

GFAC is unique as a clinic because the supervising faculty member, Yuri, is a Japanese acupuncturist. In the United States, there is no licensing for Japanese acupuncture. Although the acupuncture board exams in Washington often have questions on some aspects of both Japanese and Korean acupuncture, the bulk of the exam covers traditional Chinese acupuncture. One acupuncturist recently described Japanese acupuncture to me as something of a cult, intimating that those who use and study it are very devoted to its unique practice. Although both Japanese and Chinese acupuncture rely on *Qi* as the basis for treatment and healing, these two forms of acu-

puncture demonstrate that competing rhetorics can exist within the *Qi*-based speech code.

Japanese acupuncture, also called *Toyohari,* differs from Chinese acupuncture in a variety of ways. Originally created by blind men, the focus in *Toyohari* diagnosis and treatment is on gentle touch. The Japanese acupuncturist not only uses the patient's pulse and presenting information to establish a picture of what is going on with a client, but she or he also palpates, touching the client's body. An important place to palpate is the stomach or *tummy,* which, like the hands, feet, and ears, is described as being a microcosm of the body. The diagnosis and treatment run together as the practitioner palpates various points while deciding which point needs treatment. Erin, a GFAC intern, described *toyohari* by saying "It's important to learn the different modalities because people's *Qi* runs differently. … Some are deep and others are right on the surface like mine." For those whose *Qi* runs close to the surface, the *Toyohari* practitioner is often so gentle that she does not insert the needles at all. She merely touches them to the skin. By performing this technique, described by Theresa like a radio antenna, "The practitioner feels all the *Qi,* not the patient." This falls well in line with the *Qi*-based speech code described thus far relying solely on the practitioner's expert ability to feel *Qi.* As Erin stated, these competing forms serve to help a practitioner diversify her or his talents to treat people with different levels of *Qi.*

The difference in *Qi* philosophy most materially manifests itself in the actual needles used in Japanese and Chinese acupuncture. Will and Beth, both interns at GFAC, were working on a woman's sciatica pain. Her pain had been present for many years, and the interns decided that *electro* (a mild electric current sent into certain needles) treatment might penetrate the deeper stagnation. From a practical standpoint, to use *electro,* the students had to use the Chinese needles that have metal tips that can conduct electricity. In comparison, the Japanese needles have plastic tips. When I asked the practitioners about the difference between these two needles, Will first said "Oh that's a PhD dissertation right there!" Reconstructed from field notes, the conversation continued:

> [Field notes from GFAC Clinic December 2, 2002]
>
> The Japanese needles are thinner and silicone coated and go in easier. Many people don't feel them. They have plastic tips. However, at the same time, some say that *Qi* doesn't go through the plastic. And since they are silicone coated, many people say they slice through everything. On the other hand, the Chinese needles you really have to work it in since they are thicker and metal. Well, they're both metal, but they're not

> coated. You can definitely feel them but at the same time because they're bigger, they push things out of the way like blood vessels, etc.

As Will described, each side sees its own tools for accessing *Qi* as superior. From a Chinese standpoint, the Japanese needles are presented as problematic for two reasons. First, the silicone coating and plastic tips are not conducive for moving *Qi.* This Chinese version of *Qi* more closely aligns itself with substances such as electricity as a matter that more easily flows through uncoated metal. Second, because they are so thin and so slick (with the coating), they *slice through* people and their insides. However, when I asked the interns if the Japanese needles really did "slice through," they commented that most of the time, because the needle insertion is so gentle and shallow, the needles rarely pierce anything more than the skin. However, the Chinese needles are still described as being more beneficial because they *push* delicate blood vessels out of harm's way. Will's presentation of both sides of the debate regarding needles uncovers how the different philosophical understandings regarding how to properly access *Qi* are played out in descriptions of the two practices.

As opposed to a more gentle Japanese *Qi,* the interns described Chinese *Qi* as a matter of work. As the interns I mentioned previously explained, you have to *work* the needles in because they are thicker and the metal is uncoated. The Chinese needles are designed precisely so that one must work to get them inserted, and the benefit of that work is to get *Qi.* Another incident reinforces this notion of Chinese *Qi* as a matter of work. Will asked Yuri if he could use a certain form of *moxibustion* (burning an herb called *mugwort* either on or near a person's skin). Yuri declined his request and explained that in the past, people had complained about the smell. Their exchange, reconstructed in my field notes, is presented:

> [Fieldnotes from GFAC October 2002]
>
> Will: But what if I just use a tiny amount?
> Yuri: People will still complain
> Will: How about just a really small bit right on the end, no one will even smell it
> Yuri: It's not that, the incense, it's so strong
> Will: What if I didn't burn it
> Intern: You could just put a bit on the end and then will it to work
> Will: If the intention is there?
> Yuri: You know intention is very important. Energy makes a difference
> Will: Yeah right
> Yuri: Use your heart

Will: ((In a playful tone)) No way. I'm all about Big *Qi!* Not that Japanese stuff! I'm about the TCM!

After being told that he cannot burn anything because of the smell, Will jokingly asked if he could still do the treatment without burning it. The other intern picked up on this joke and encouraged Will to "will it to work." However, Yuri responded seriously and reminded Will that intention is important and that the energy of using your heart can also heal people. This approach fits well with the Japanese model of acupuncture in which merely touching the needle to someone's skin can heal through subtle manipulations of *Qi.* By the end of the conversation, it became apparent that Will's understanding of treatment and of Chinese treatment must consist of doing something tangible and of working to get *Big Qi* or Chinese *Qi.* In this way, Chinese *Qi* is more akin to the visual effects of *Qi* described in the previous section because something big is happening. Although said in a playful manner, Will's devotion to harnessing *Big Qi* was further reinforced on another occasion when Anna, his treatment partner, joked with another intern saying that Will was like a "sewing machine" the way he stimulated the needles by pushing and pulling them up and down. The client receiving this style of treatment could hardly ignore the stimulation. Therefore, this raises the question of whether the client feels the stimulation as *Qi,* as pain, or as something else altogether. Ultimately, the reason this exchange is important is because it demonstrates how speech codes can encompass competing rhetorics. In this case, Yuri worked to promote the Japanese, energy-based, intentional *Qi,* whereas Will argued for the Chinese, work-produced, big *Qi.* In both cases, it is not the *Qi*-based code that is in question, but rather, it is the smaller details of what that code entails that are being negotiated.

Although Japanese and Chinese acupuncture differ in terms of equipment and notions of how to properly activate and feel *Qi,* the actual point locations and maintenance of the *Qi*-based code are very similar. Again, what separates them is the Japanese focus on being gentle and pain free, which derives from a philosophy that *Qi* can be activated in subtle ways. On the other hand, TCM, with its *Big Qi,* often results in a "no pain, no gain" type of treatment whose effect is to give the client a more conscious role in his or her treatment through the ability to recognize that something physically is happening. As intern Jeff described to me in an interview,

> Pain is a subjective thing. … It all has to do with what you expect. In China, they expect treatment to be intense and if it doesn't hurt then you're not a good doctor. In Japan, they expect treatment to be more gentle.

In this description, the terms *pain, intensity,* and *gentle* are mentioned but not *Qi.* It could be read that these terms all refer to the level of *Qi* reaction (as in Will's *Big Qi*). However, Jeff's claim could probably better be heard as a description of clients' experiences of acupuncture that focus more on physical pain and sensations as opposed to *Qi.* What this passage makes clear is that although still reliant on *Qi,* Chinese acupuncture requires both more physically recognizable action and more physically actionable speech, thus aligning itself closer to biomedical models of health and healing. Because the actual reaction or feeling is not comparatively measured, what is important is the way certain words such as *gentle* and *pain free* or *intense* and *work* are used to understand the actions of needle insertion.

The different expectations for pain serve as another important discursive marker for differentiating between Chinese and Japanese acupuncture. In the following conversation, Yuri and interns David and Noah were discussing treatment options for a client recovering from a stroke. Yuri explained that the client did not like his previous acupuncture treatments (at a different clinic) because they were painful. This was cause for concern because before Yuri joined the conversation, David and Noah were discussing scalp acupuncture, an often painful procedure. In the second half of the excerpt, they also discussed the implications of using more needle points:

[GFAC Clinic December 9, 2002]

Yuri: He used to go to acupuncture treatment for the stroke (.) and he didn't like it because (.) it was very painful (.2) So we are really aware w'like we can't ha hurt him eh ha ha (.)[you don't wanna make it too strong]
David: [So then might wanna] not wanna to do scalp acupuncture then
Yuri: .hh wah=
David: =Cause that's one of the first things [I was he]aded with
Yuri: [I know]
David: [Cause] that's gonna hurt (.) It hurts
Yuri: [N:oo]
(.3)
Yuri: It hurts? (.2) But we don't have t:o (.) do hurting scalp acupuncture (.) You don't have to do like thick needle usually you usually do like thick needles and twirling and stuff

[3.5 minutes omitted]

David: We're hitting a lot of points (.3) If he doesn't like pain we're hitting a lot of points
Yuri: yeah we just (.) No I think (.) he must have went to really hard core

21 TCM person or for sure
22 David: So that's gonna be like (.) That's gonna be like 13 points
23 Yuri: That's too many
24 David: mm hmm

In the exchange, it becomes apparent that it is not the technique of scalp acupuncture that was problematic or even painful. Instead, it is the way it is performed that needs attention. By placing emphasis on the "hurting scalp acupuncture" (line 12), Yuri established two different kinds of scalp acupuncture, the hurting and a nonhurting kind that consists of using thinner needles and not twirling them so much (line 14). Again, pain is the differentiating factor and not *Qi,* as the focus is on how the patient will experience the treatment. Later on in the conversation (line 18), David asked Yuri if they were proposing too many points. At first (line 20) Yuri began to agree with him but then she changed her position and said that the client must have gone to a "really hard core TCM person for sure." Yuri drew a parallel between strength (line 3) and TCM (lines 20–21) and provided yet another example of TCM as a matter of work. In addition, the use of terms such as *strength* or *intensity* to describe the reaction to Chinese acupuncture reinforces but never explicitly states the idea that good treatment requires more needles that result in more *Qi;* and conversely, for Japanese acupuncture, good treatment entails fewer needles yielding less *Qi* and less pain. *Toyohari*'s focus on being gentle and on relying on subtle changes felt by the practitioner can often be mistaken as treatment that is not doing anything, particularly by clients used to something more forceful. It definitely requires a more solid trust in the *Qi* system in that often nothing (even pain), from the point of view of the client receiving treatment, physically happens. In light of the licensing practices in the United States, it also makes sense that Japanese acupuncture, which relies on this unseen force, is not licensed, whereas Chinese acupuncture, which has some scientific backing and more physical reaction, is what is accepted and legitimated through national standards.

CONCLUSION

Qi is a fundamental part of acupuncture, both in its practice and more important, in practitioners' talk about acupuncture. Talk about *Qi* is so important that attempts to neglect or not actually engage with *Qi* (such as the *Newsweek* articles) are met with heavy resistance. Although diffi-

cult to explain, translate, see, and even feel, *Qi* lies at the heart of acupuncture practice and discourse about acupuncture, separating novices from experts, authentic practitioners from inauthentic scientists, and practitioners from clients. Not only does *Qi* absolutely have to be mentioned and explained properly to accurately represent acupuncture, but the subtle nuances of *Qi* also work to construct different forms of acupuncture—notably establishing the difference between Chinese and Japanese acupuncture and creating competing rhetorics within a particular speech code.

As a speech community, what draws this group of acupuncture practitioners together is their common usage of a *Qi*-based speech code. This work builds on research that has argued that it is the code, and not geography, that holds speech communities together (Fitch, 1994). This code is not so homogenous that participants could not or did not find places of disagreement or tension. As revealed in the presentation of Chinese versus Japanese acupuncture, the boundary of the community is drawn around the usage of *Qi* both in practice and in speaking as the guiding factor in delivering acupuncture. It is the use of this *Qi*-based speech code that allowed practitioners to actively construct a boundary around themselves that excluded those who might practice scientifically based acupuncture. However, within that community, practitioners often disagreed about the finer points of the use of that code. Future research in this area can look more closely at these points of tension and negotiation.

Because I conducted the fieldwork mainly at one clinic in Washington, future research should focus on whether and how this code is used with a wider variety of types of acupuncture practitioners, among clients, and in other popular media accounts of acupuncture and TCM, not just in different regions in the United States but also throughout the world. Although this particular study is but one small view into the world of TCM as presented by practitioners and students, future studies in this area can also look across TCM practices, practitioners, and clients to assess the importance of *Qi* and other TCM specific notions across the diversity of acupuncture styles.

This study, as an exploration of the discourse of TCM, has important implications for both health communication and language and social interaction research. In the area of health, it is important for understanding the TCM health care system and health care more generally. However, these benefits in the area of health cannot be made without focusing on participants' discourse, its actions and its consequences. As this and other studies

(Cassidy, 1998b; Kaptchuk, 2000) have recognized, on a basic level, the language and concepts of TCM must be translated from Chinese into English for most Americans. How this translation occurs and the consequent actions and understandings that emerge from these are important language and social interaction questions. If terms get translated and presented only to serve as interesting reminders of the foreign origins of TCM, the larger TCM health care system with its own rules and explanatory models is left behind. Scientific studies of TCM work by imposing a different standard for explanation that neglects the *Qi*-based explanatory system completely, resulting in a scientifically sanctioned version of TCM that GFAC (and perhaps other) acupuncturists would not recognize nor promote. Future research should focus on how organizations like NCCAM and other scientific researchers discursively claim authority over their versions for how TCM works and the consequences of such constructions. Special attention should also focus on situations that call for the integration of the two systems, as this can add to knowledge about how speech communities come in contact with one another, negotiate borders, and establish themselves as bounded entities, especially in this case as professional ones.

By describing a distinctive system of meaning and ways of speaking that focus on the use of *Qi* rather than scientifically based substances/properties, the *Qi*-based speech code also works as a form of resistance to the scientific integration of TCM. The distinctiveness of this code offers the further advantage of illuminating, by providing a clear point of contrast, the usually invisible assumptions of Western biomedicine and biomedical practice that relies on scientific testing and biological views of the body. In this arena, scientific medicine's goal is to understand the precise pathway of effects of acupuncture needles on the body. It is not, as some have argued for, a *scientific* holistic medicine based on an empirical history of trial and error (Linde, 2000). Some holistic medicine proponents would argue that whether positive or negative in outcome, these types of studies are misleading because substances such as *Qi* do not conform to biomedically recognized characteristics (Tonelli & Callahan, 2001). What the GFAC practitioners have demonstrated is that science, no matter how it is defined, is not a part of the speech code of *Qi.* The precise definition of science is irrelevant. What this article adds to research in language and social interaction is a view of how one group works to elevate a particular speech code to separate themselves from competing codes (of science). By insisting on this code, practitioners also insist on practicing *Qi*-based acupuncture even though it is invisible, only felt by practitioners, and foreign. Just as some terms cannot be literally translated into English, so too are certain medicines difficult

to translate into science. As these acupuncturists demonstrated, TCM's explanatory model based in *Qi* provides a more coherent way of understanding and communicating this particular health practice than does scientific evidence. By speaking through a specific set of understandings surrounding *Qi* and its functions, acupuncturists utilizing the *Qi*-based speech code legitimate their practice in native terms.

NOTES

1 All names have been changed. GFAC is the acronym pseudonym for the Good Fortune Acupuncture Clinic. A copy of this pamphlet can be obtained by contacting Evelyn Ho at eyho@usfca.edu

2 For more extensive overviews of TCM, see Kaptchuk (2000) or Kleinman (1980).

3 For more detailed historical texts of TCM, see Eckman (1996), Ho and Lisowski (1997), Hume (1975), Leslie (1976), or Schied (2002).

4 Kleinman (1980) used the spelling *ch'i,* whereas I use *Qi.* Different translational systems use different spellings. Different Latin-based transliterations systems (e.g., Wade–Giles and Chinese Pinyin) use different spellings.

5 Organs are considered *energetic* in that although they correspond to physical organs, they do not function in the way scientific biological explanations describe organ function. This organ system, also known as *the five-phase system,* is one of the more contested areas of TCM practice (Kaptchuk, 2000). However, many practitioners still use the five phases along with the five corresponding organs to understand the relation and balance among the energetic organs of liver, heart, spleen, lungs, and kidney.

6 The terms *alternative* and *complementary* are often used interchangeably to describe a wide range of healing systems that are not mainstream Western, conventional, or biomedically based. Some common forms are TCM, homeopathy, massage, and chiropractic. Some have argued for a more positive term *holistic* medicine that focuses on drawing this body of health practices together through self-description as opposed to being named in opposition to or in comparison with biomedicine (see Schreiber, 2005).

7 Readers can see whole journals devoted to this such as *The American Journal of Acupuncture, Journal of Traditional Chinese Medicine,* and the *American Journal of Chinese Medicine;* Appendix E of Kaptchuk's (2000) *The Web That Has No Weaver;* or the National Institutes of Health's National Center for Complementary and Alternative Medicine (NCCAM) at www.nccam.nih.gov.

8 Chinese acupuncture is one of the more tested and scientifically confirmed forms of CAM (Ulett, J. Han, et al., 1998b).

9 I do not have adequate data to argue for a scientific speech code. However, from the acupuncturists' talk, it is clear that they were responding to a competing scientific discourse that has utilized scientific explanations for how acupuncture functions.

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