Qi (Chinese)

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Qi (sometimes spelled chi and pronounced chee) is a Chinese word (simplified Chinese: 气; traditional Chinese: 氣) that is commonly translated into English as vital energy or life force. Used in discussions of Chinese medicine, health, and martial arts, some scholars argue that this is one of the most fundamental and yet difficult to translate concepts of Chinese medicine. English translations and Chinese medicine texts often devote considerable time to explaining this foundational concept, reminding readers, Chinese medicine students, and scholars interested in language and translation of the embodied experience, or what Pritzker (2012) calls "living translation," of how English speakers learn to engage with Chinese medical concepts. Although energy and life force function reasonably well as translations, the concept itself is more than either of these. Rather, it implies not just a noun but also a state of being and becoming (Kaptchuk, 2000). Qi is a term that is used by itself and in combination with other practices (e.g., qi gong — Chinese martial arts) and Chinese medicine concepts (e.g., huo qi or spleen qi deficiency).

As an object of study for language and social interaction scholars, qi has been examined as the foundation of a speech code used by acupuncturists in Seattle, Washington (Ho, 2006). Coming from an ethnography of communication perspective, and using speech code theory (Philipsen, 1997), Ho presents a way of speaking that binds together a community of practitioners who position acupuncture as requiring Chinese medicine vocabulary and theory. Although scientific/biomedicine may have explanations for acupuncture using modern medical concepts these explanations (e.g., neurological responses or endorphin release) are deemed incorrect for these practitioners. The code requires at a minimum a basic Chinese medicine vocabulary including concepts such as yin and yang, qi, and the energetic organs (liver, heart, spleen, lungs, kidney, etc.) and more importantly, those concepts have to be used correctly in accordance with Chinese medical theory.

The discursive force of the qi-based speech code can be seen in the social drama that Ho (2006) depicted around a *Newsweek* magazine with a cover-story about acupuncture. The magazine, while acknowledging qi as *one* explanation for acupuncture, also included stories of newer biomedical and scientific explanations for how acupuncture *might* be explained, which these practitioners vehemently denounced. Qi not only distinguishes Chinese from western or biomedicine it is also, scholars have argued, what binds together East Asian medicines more broadly (Scheid, 2013). Although the labeling of medicines is tied to modern nation-states (e.g., Chinese medicine or Japanese acupuncture) one area of scholarly discussion is on the categorization

The International Encyclopedia of Language and Social Interaction, First Edition.
Karen Tracy (General Editor), Cornelia Ilie and Todd Sandel (Associate Editors).

DOI: 10.1002/9781118611463/wbielsi085

and naming of East Asian medicine as a loose family of practices that share such concepts as qi. Although not always specifically interested in issues of language in social interaction, researchers from medical anthropology focused on Chinese and East Asian medicine have also confirmed the importance of qi as a concept separating biomedicine and Chinese medicine.

The qi-based code stands in contrast with other ways of talking about and practicing acupuncture. One important distinction can be found in medical acupuncture. A branch of acupuncture for already-licensed medical physicians (MD) and doctors of osteopathy (DO), the medical acupuncture license only requires 100 hours of additional didactic training and 100 hours of clinical training. Compare these requirements to California's acupuncture and oriental medicine licensing requirements of 1,255 hours of didactic training and 240 hours of clinical experience on top of 350 hours of basic science requirements. Other states have similar licensing requirements. Many licensed acupuncturists argue that medical acupuncture is merely teaching needling techniques and locations to be used on biomedical illnesses and treated in a biomedical way and talk such as this would fall into the qi-based speech code.

Besides differentiating between real and fake acupuncture, the qi-based speech code was also used to differentiate between experienced and novice practitioners and between practitioners and clients (Ho, 2006). Acupuncturists who were considered true experts not only used qi in their talk but were also described as being able to "feel the qi." Student acupuncturists talked about feeling qi better as a marker of their own growing and embodied expertise. On the other hand, clients were not expected to feel or even really understand qi.

The notion of qi as something felt gives a certain tangibility to the concept of qi. Although qi is not typically seen, practitioners did provide examples of when the effects of qi were seen. In a dramatic example, a practitioner described how she placed (not inserted) a needle on a corresponding point on a girl who had been stepped on by a horse and instantly saw the swelling reduce (Ho, 2006). As the practitioner described, even she is amazed by these situations just as the working of qi likely amazes clients who are unfamiliar with Chinese medicine.

As a speech code, qi works to unite practitioners around a particular way of not only talking about but also practicing Chinese medicine. However, as Ho (2006) explained, the code also engages competing rhetorics of Chinese and Japanese acupuncture, reinforcing a unified concept of qi while simultaneously showing disagreement about how best to use qi and thus demonstrating the heterogeneity of globally used East Asian medicines. Japanese acupuncture, also called *Toyohari*, is a gentle form of acupuncture that uses thinner, silicone-coated needles, or no needles at all. Invented by a blind acupuncturist there is an even greater reliance on *feeling* qi since sight was not available. Unlike Chinese acupuncture, which clients typically experience as stronger, sometimes more painful, and certainly more stimulating, *Toyohari* is a specialized form of acupuncture practiced by some but not officially part of US licensed acupuncture. Given the importance of the qi-based speech code among acupuncturists, the division between Japanese and Chinese acupuncture is a useful site for understanding the implications of this code. In discussions between acupuncture supervisor Yuri and intern Will, Ho described how Will used qi to argue for the relevance of Chinese

acupuncture. By claiming to be "all about big qi!" and not "that Japanese stuff," Will used a particular kind of qi as a way of promoting a particular kind of acupuncture, in this case, traditional Chinese acupuncture versus Japanese acupuncture.

The qi-based speech code relates similarly to a broader holistic way of speaking that is often used in conversations between clients and practitioners (Ho & Bylund, 2008). While Ho (2006) focused on provider qi-talk, Ho and Bylund (2008) concluded that when speaking to clients, practitioners focus on holism more than qi. By using terms such as "the whole you," practitioners glossed over Chinese medicine concepts such as energy or fluids, never mentioning terms like qi. One consequence, however, of using holism to frame acupuncture interactions is that the client often understands holism to mean a mutualistic or collaborative practitioner–client relationship. In such a relationship, the practitioner takes time to listen, educate, and develop a one-to-one bond with the client. Based on practitioner talk, Ho and Bylund argued that in fact, acupuncturists sometimes promoted this relationship and other times functioned quite paternalistically, focusing on what they deemed was important and moving quickly to finish the visit. Even though the interaction did not promote collaboration acupuncturists still operated in a larger qi-based holistic frame in which their practice was guided by Chinese medicine's holism, which focuses on balance and equilibrium rather than on talking.

The qi-based speech code does not require a holistic/collaborative provider–patient relationship (Ho & Bylund, 2008) despite scholarly literature that emphasizes the link between holistic health and a more patient-centered provider relationship and communication (see Geist-Martin et al., 2008). One reason for such an assumption is that the larger holistic health care movement in the United States offers a strong critique of biomedical paternalism. However, specifically for Chinese medicine there is also an important translation consequence. The way Chinese medicine is practiced in the United States takes on a particularly American form. One way this occurs is through translation. The English term "holism" is often used to explain Chinese medicine theory to Americans but the term carries with it a particular resonance in US health care that may not be equivalent to Chinese medicine's "holism." In other words, practitioners may use "holism" to mean a focus on balancing yin and yang and promoting qi, while consumers understand it to mean a health system that spends more time with each individual in a caring personal way. Both parties may be using the same word but imply completely different psychologies and sociologies (Philipsen, 1997).

The topic of translation as it relates to qi and Chinese medicine more broadly has been extensively studied in medical anthropology. The work of Sonya Pritzker on translation in Chinese medicine education in the United States is especially relevant for language and social interaction scholars interested in qi and Chinese medicine. Pritzker draws attention to the interactional ways translation occurs in talk and how meaning is actually produced out of previously nonexistent concepts. Moving beyond the referential functions of translation, her anthropologically grounded theory of translation focuses on how acupuncture trainees learn how to practice Chinese medicine through learning how to talk about Chinese medicine in English and sometimes with a mix of certain Chinese terms (Pritzker, 2012). In this way, acupuncture students work through alternative ways of speaking with some using the terms in Romanized Chinese (such as yin),

some using odd English translations from textbooks (such as rheum), some students settling for a close equivalent (mucus), and yet others creating their own translations created through experiencing this new concept.

Given the popularity of Chinese medicine globally, it is surprising that there is not more research from a language and social interaction perspective examining Chinese medicine talk. There are many fruitful areas for future research including more work on translation, work on practitioner–client communication, and comparative ethnographic studies on speech codes used for acupuncture and East Asian medicine in other languages or global locations. A language and social interaction perspective is essential to health research in this area with real consequences for people using acupuncture. Take, for example, the debates about real acupuncture efficacy versus sham acupuncture (needles inserted but in the wrong location or needles not inserted). Acupuncture is one of the most scientifically supported forms of complementary, alternative, or integrative medicine used globally. However, recent systematic reviews demonstrate that acupuncture functions as well as sham acupuncture (Moffet, 2009) *and* that real acupuncture is more effective than sham for chronic pain (Vickers et al., 2012). Some claim that acupuncture is just a placebo while others remain steadfastly supportive. In critiques of these sham studies, acupuncture supporters argue that the biomedical model does not fit acupuncture, that there is no one form of acupuncture, and that biomedical diagnoses do not correspond one-to-one with Chinese medicine diagnoses. Ultimately, these debates center around how Chinese medicine is practiced and which speech codes are valued (biomedical) and which codes get suppressed (qi). Especially in research about the placebo effect and acupuncture, language and social interaction research is well positioned to say something about how acupuncture is communicated by practitioners to clients.

SEE ALSO: Cultural Discourses of Health; Ethnography of Communication; Speech Codes Theory; Speech Community

References

Geist-Martin, P., Becker, C., Carnett, S., & Slauta, K. (2008). The call to Hawaii: Holistic practitioners' perspectives of their communicative practices of healing. *Communication & Medicine*, *5*(2), 133.

Ho, E. Y. (2006). Behold the power of Qi: The importance of Qi in the discourse of acupuncture. *Research on Language and Social Interaction, 39*, 411–440. doi: 10.1207/s15327973rlsi3904_3

Ho, E. Y., & Bylund, C. L. (2008). Models of health and models of interaction in the practitioner-client relationship in acupuncture. *Health Communication*, *23*(6), 506–515. doi: 10.1080/10410230802460234

Kaptchuk, T. J. (2000). *The web that has no weaver* (2nd ed.). New York, NY: Congdon & Weed.

Moffet, H. H. (2009). Sham acupuncture may be as efficacious as true acupuncture: A systematic review of clinical trials. *Journal of Alternative & Complementary Medicine*, *15*(3), 213–216. doi: 10.1089/acm.2008.0356

Philipsen, G. (1997). A theory of speech codes. In G. Philipsen & T. L. Albrecht (Eds.), *Developing communication theories* (pp. 119–156). Albany, NY: SUNY Press.

Pritzker, S. E. (2012). Living translation in US Chinese medicine. *Language in Society*, *41*(3), 343–363. doi:10.1017/S0047404512000280

Scheid, V. (2013). Constraint as a window on approaches to emotion-related disorders in East Asian medicine. *Culture, Medicine, and Psychiatry*, *37*(1), 2–7. doi: 10.1007/s11013-012-9300-0

Vickers, A. J., Cronin, A. M., Maschino, A. C., Lewith, G., MacPherson, H., Foster, N. E., … & Linde, K. (2012). Acupuncture for chronic pain: Individual patient data meta-analysis. *Archives of Internal Medicine*, *172*(19), 1444–1453. doi: 10.1001/archinternmed.2012.3654

Further reading

Gaines, A. D. (2013). Constraint 鬱 as a window on approaches to emotion-related disorders in East Asian medicine [Special issue]. *Culture, Medicine, and Psychiatry*, *37*(1).

Pritzker, S. E. (2011). The part of me that wants to grab: Embodied experience and living translation in U.S. Chinese medical education. *Ethos*, *39*(3), 395–413. doi: 10.1111/j.1548-1352.2011.01199.x

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