Invitation to Descend:

Towards an Ethics of Touch in Classical Chinese Medicine

Lacey Jacoby
An Honors Thesis Submitted in Partial Fulfillment of a Degree in Sociology/Anthropology
Lewis & Clark College
Portland, OR
Advisor: Professor Sepideh Bajracharya
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Acknowledgements

I don’t have the words to thank Sepideh for the effort she has put into making this a meaningful experience for me. Her guidance has deeply shaped my final thesis, and for that, I am indebted to her. I am also grateful to each student and practitioner for sharing their knowledge with me without reservations. Beth, in particular, has served as a critical guide during my travels into Chinese medicine. Finally, I would like to thank my friends, family, and thesis section for their generous support and advice throughout this process.
Abstract

In this thesis, I consider how patients, students, and practitioners of classical Chinese medicine negotiate embodiment through the practice and instruction of touch. Drawing upon Csordas’ “somatic modes of attention” (1993), I ask how practitioners’ understanding and cultivation of certain touch sensibilities shape the healing encounter. I explore these questions through participant observation and interviews at the National University of Natural Medicine in Portland, Oregon and a pulse diagnosis workshop led by one of its faculty members. In conversation with Das’ concepts of “descent” and “ascent” (2007), I propose that the touch sensibilities of CCM are based on a philosophy of “descent.” By cultivating these touch sensibilities, practitioners put forward an “ethics of touch” based on the renegotiation of embodiment. Much like Foucault argues that care of the self ethically precedes the care of the Other (1998), practitioners understand their ability to care for their patients as dependent on practices of self care and cultivation. Finally, by attending to patients in this way, practitioners aspire to engage in an embodied conversation. This “ethics of touch” challenges the standardized touch aspired to by biomedical technologies; particularly diagnostic techniques that obscure the practitioner’s body and posit the patient as a passive body to be diagnosed. As an ontology, I argue that biomedicine encourages an “ascent” from the body. Patients are understood to heal by escaping the ill body, and practitioners are understood to practice more effectively by cultivating detachment. By encouraging patients and practitioners to attend to their embodied selves, CCM generates an ethics of touch that enables possibilities for healing to become an embodied, cultivated and interactive encounter with, rather than a denial of, pain.

Key Terms: Pulse diagnosis, classical Chinese medicine, touch, embodiment, biomedicine
Introduction

On my first day shadowing at the National University of Natural Medicine (NUNM) in Portland, Oregon, I immediately noticed the practitioners touching patients in ways that surprised me. My field notes from that day reflect my struggle to find the right word to describe the touch: “gentle,” “delicate,” “affectionate.” Following the shift, I tried to explain my surprise to the supervising doctor:

Lacey: I’m struck by how, I don’t know, how, I guess I don’t know the right word, but how delicate the touch is. Like even taking the pulse and how gentle it is. I don’t know, I’ve worked a lot at OHSU and in very biomedical contexts.
Beth: Oh and it’s a lot more—
L: Gentle and almost affectionate? I don’t know.
B: Yeah!
L: If you could say that. Caring?
B: Yeah. It is openly affectionate that way. You’re just kind of stroking people’s arms.
...
B: Yeah, it is really beautiful. And I like to role model that with them. They’re already good because there’s so much bodywork they’re trained in.
L: That’s great, that’s really great.
B: But to kind of have, yeah, that contact.
L: Which is huge and, like you said, so intimate even if you try to put on gloves and make that barrier, it’s still—
B: It’s still there. Yep. Yep. And then that’s gonna bring them places where they were last touched, if they haven’t been touched, or it was rough when they were a child. I mean there’s all that. That is happening.

This was just the first of many conversations I had with Beth about the nature of touch, but it helped me begin to appreciate the intentionality behind the way she touches her patients. The qualities I observed were not accidental, nor were they simply a reflection of Beth’s personality (though that deeply shapes her practice, as well). Instead, these touch sensibilities were informed by a constellation of beliefs about the nature of suffering, healing, and the body, as well as a set of practices that Beth engages with in an effort to better herself as a practitioner. To engage with
these ideas, this thesis centers around the question: how do practitioners’ understanding and cultivation of certain touch sensibilities shape the healing encounter?

My exploration of this question began at NUNM, where Beth works as a practitioner and professor. Founded in 1956, NUNM is “the oldest accredited naturopathic medical university in North America” (NUNM 2016). The university, which made the transition from college to university during my fieldwork, consists of a number of academic and clinical buildings along the Willamette River near downtown Portland¹. Students can earn graduate degrees in naturopathic medicine or oriental medicine, and recently, their programs have expanded to include subjects such as global health, nutrition, and undergraduate degrees (NUNM 2016). Most students I worked with were pursuing a graduate degree in either naturopathy or oriental medicine. A small group of students studying both referred to themselves as “dual students” and often took an additional (fifth) year to complete their studies. In addition to coursework, education at NUNM also emphasizes clinical experience. Students act as observers during clinical shifts for two years before becoming “interns” during a third and final year of clinical shifts. As interns, they begin to treat and diagnose patients, though still with a partner intern and under the supervision of a professor-practitioner.

All of NUNM’s programs in oriental medicine teach what they refer to as classical Chinese medicine (CCM), rather than Traditional Chinese medicine (TCM). TCM’s origins and history are complex, but Mao Zedong, founder of the People’s Republic of China, played a significant

¹ For ethnographic studies on the practice of Chinese medicine within China, see Judith Farquhar’s work, including Knowing Practice: The Clinical Encounter of Chinese Medicine (1994). For more on how Chinese medicine is negotiated and practiced differently in different transnational contexts, see Mei Zhan’s Other-Worldy: Making Chinese Medicine through Transnational Frames (2009).
role in both TCM’s naming and structuring, particularly during the 1950’s (Taylor 2005). He stated that, “Chinese medicine also has to transform itself. We must accept this slice of our old heritage critically” (Taylor 2005:35). In order to do so, he proposed a unification of Western and Chinese medicine and advocated for Western doctors to study TCM, eventually leading to what he envisioned as a single new medicine of the future. Many scholars understand Mao Zedong’s intervention in medicine and his support of schools of TCM as a reflection of political and economic strategy, rather than a belief in the efficacy of Chinese medicine, per se (Taylor 2005).

It is against this unification, standardization, and aspiration to unify with Western doctors that NUNM defines itself. More specifically, the NUNM students I worked with often distinguished CCM for its emphasis on the classical texts. Coursework involves returning to and studying these ancient texts for knowledge that can be applied today. NUNM’s website describes CCM’s “mission of restoring the original nature of Chinese medicine:”

Most Chinese medicine schools worldwide emphasize a systematized form of the medicine developed over the last century, commonly referred to as “Traditional Chinese Medicine,” or TCM. This standardized approach to the medicine is readily taught in a classroom setting. However, when one explores the ancient roots of TCM, one finds a highly complex system of knowledge (codified in books referred to as the classical texts) that can be learned only through the cultivation of deep respect for nature and a highly individualized relationship with the medicine. In ancient times, such a relationship developed through study of the classical texts in combination with the direct transmission of knowledge, skills, and awareness from a master in a lineage-based system. (NUNM 2016)

This distinction from TCM is critical to how students at NUNM are taught and is the foundation for the lineage-based system. Students generally choose a professor-practitioner (or a few) whose practice most interests them and then learn from them through courses and shifts. This emphasis on the transfer of knowledge from master to student also removes some pressure for professors
to standardize their teachings, instead encouraging each professor to develop and teach their own individualized style of practice.

Beth, for example, learned pulse diagnosis from Dr. Leon Hammer and Dr. Brian La Forgia and now teaches this system through regular workshops. Despite the specificity of the system she practices, Beth’s understanding of the body reflects broader tenants of classical Chinese medicine. In our conversations, she frequently returned to the question of how patients and practitioners relate to their bodies, which I understand as a dialogue about “embodiment.” She has spoken to me about her own “internal momentum” and her efforts to “slow way down” with regards to her “movements” and “speech.” For her, slowing down is critical to being “increasingly perceptive, increasingly sensitive, increasingly vulnerable”—all qualities that improve her ability to diagnose and treat. She thus sees her experience of her body as the starting point from which she practices medicine. With regards to her patients, she also recognizes the relationship between embodied experience and healing. She’s especially interested in how illness can be experienced as a “defended” body, whether through “doing drugs,” “talk[ing] really fast,” or “sleep[ing] all the time.” Again, she understands the patient’s experience of their body as the starting point for both illness and healing. My conversations with other practitioners and students have suggested that, like Beth, each of them negotiates the concept of embodiment in their practice and instruction of medicine.

In writing this paper, I am also drawing upon a rich phenomenological literature concerned with “embodiment.” Desjarlais and Throop summarize the phenomenological approach to embodiment as follows:
The body is not only an object that is available for scrutiny. It is also a locus from which our experience of the world is arrayed. The body is not only a corpse- or text-like entity that can be examined, measured, inspected, interpreted, and evaluated in moral, epistemological, or aesthetic terms…; it is a living entity by which, and through which, we actively experience the world. (2011:89)

Csordas adds that, “the paradigm of embodiment means not that cultures have the same structure as bodily experience, but that embodied experience is the starting point for analyzing human participation in a cultural world” (1993:135). Taking this as my foundation, I begin and end with the body—not as a text for analysis, but as the way-of-being-in-the-world. The form that this way-of-being-in-the-world takes is not assumed but, rather, is my point of questioning. I am thus concerned with individuals’ sensory perceptions and clinical encounters as experienced through their embodied selves.

Even by accepting embodied experience as the starting point for being-in-the-world, though, I do not mean to obscure the body itself as a locus for reflection. After all, though the body is “not only an object that is available for scrutiny” [emphasis added], it still is an object available for scrutiny by ourselves and others. As Csordas writes,

Because attention implies both sensory engagement and an object, we must emphasize that our working definition refers both to attending ‘with’ and attending ‘to’ the body. To a certain extent, it must be both. To attend to a bodily sensation is not to attend to the body as an isolated object, but to attend to the body’s situation in the world. The sensation engages something in the world because the body is ‘always already in the world.’ Attention to a bodily sensation can thus become a mode of attending to the intersubjective milieu that give rise to that sensation. (1993:138)

In my analysis, then, I hope to hold both of these at the same time—the ways in which individuals attend to their bodies and the ways in which they attend with their bodies. These are not easily distinguishable notions, though. As Desjarlais and Throop point out, language often proves limiting in phenomenological approaches:
Much of this ambiguity relates to the difficulties and challenges posed by the language we use and on which we have come to rely. It is important to avoid creating or reaffirming any false dichotomies or problematically conventional ways of categorizing the world. Using terms that invoke clear and rigid differences between, for instance, subjective and objective, subjectivity and intersubjectivity, experience and political economy, interiority and exteriority, culture and experience, the particular and the general, or the phenomenal and the psychological runs the risk of suggesting that these elements are quite distinct in life, when in fact they are words that we use to categorize situations that are terrifically complicated, fluid, and manifold in their features. (2011:93)

I acknowledge these limitations and hope to interrupt these dichotomies, as well as any that may appear tempting in my approach: biomedicine and Chinese medicine; embodiment and dis-embodiment; self and relational self.

In his work, Csordas has moved embodiment from a study of the individual to an intersubjective approach that accounts for the culturally elaborated ways in which individuals learn to attend to themselves and one another. He defines these as “somatic modes of attention,” with “somatic” acknowledging the body as the source from which attention springs and defining attention (drawing upon Schutz) as “a conscious turning toward an object” (1993:138). This definition is useful because “this ‘turning toward’ would seem to imply more bodily and multisensory engagement than we usually allow for in psychological definitions of attention” (1993:138). These definitions draw heavily upon Merleau-Ponty’s phenomenological understandings of attention and the body:

If, as Merleau-Ponty says, attention constitutes objects out of an indeterminate horizon, the experience of our own bodies and those of others must lie somewhere along that horizon. I suggest that where it lies is precisely at the existentially ambiguous point at which the act of constitution and the object that is constituted meet—the phenomenological ‘horizon’ itself. It that is so, then processes in which we attend to and objectify our bodies should hold particular interest. These are the processes to which we allude with the term somatic modes of attention. Somatic modes of attention are culturally elaborated ways of attending to and with one’s body in surroundings that include the embodied presence of others. (Csordas 1993:138)
Critical to Csordas’ definition of “somatic modes of attention” is that “the ways we attend to and with our bodies, and even the possibility of attending, are neither arbitrary nor biologically determined, but are culturally constituted” (1993:140). Indeed, this very claim makes the study I undertake here possible. In addition to invisible and “culturally constituted” modes of attention, I am also working with modes of attention that are “consciously cultivated” by practitioners and students.

If we accept the embodied self as the origin of all experience, then no one can be dis-embodied in a literal sense. We are our bodies, and it’s impossible to talk about the self without talking about the body (whether implicitly or explicitly). When I use the terms embodiment, dis-embodiment, and re-embodiment in this thesis, I do not mean to suggest that some people’s experiences of the world are less tied to their embodied selves than others. After all, experience cannot be separated from the body. Instead, I mean to concern myself with the different ways in which we attend to our embodied selves. Csordas elaborates this in the following passage:

On the level of perception it is not legitimate to distinguish mind and body, since the body is itself the ‘general power of inhabiting all the environments which the world contains’ (Merleau-Ponty 1962:311). Beginning from perceptual reality, however, it then becomes relevant to ask how our bodies may become objectified through processes of reflection. Likewise, in the lived world, we do not perceive others as objects. Another person is perceived as another ‘myself,’ tearing itself away from being simply a phenomenon in my perceptual field, appropriating my phenomena and conferring on them the dimension of intersubjective being, and so offering ‘the task of a true communication’ (Merleau-Ponty 1964:18). As is true of the body, other persons can become objects for us only secondarily, as the result of reflection. (1993:149)

My interest is consequently three-fold. I am interested in the perceptual (embodied) reality that Csordas establishes as a methodological foundation for all human experience; the particular ways in which this might manifest in different cultural, political, and social contexts; and the ways in which we subsequently reflect on our bodies and the worlds they inhabit, particularly with
regards to the healing encounter. Even if we are our bodies, it’s certainly possible to deny this relationship and to embrace a culturally and situationally encouraged aesthetic of dissociation and disengagement of mind from body as opposed an aesthetic of integration. In Csordas’ words, “It is a truism that, although our bodies are always present, we do not always attend to and with them” (1993:139).

Drawing upon the work of these authors, I hope to continue their efforts of “grounding their theorizing, description, and analysis in close examinations of concrete bodily experiences, forms of knowledge, and practice” (Desjarlais 2011:90). I also intend to take up the goal of “detail[ing] the contours of ‘local phenomenologies,’” (Desjarlais 2011:92) concerning myself with somatic modes of attention as they are understood and applied by my subjects, rather than as they are elaborated by any particular theorist.

In this paper, I propose that in the ethnographic contexts I have explored, the conscientious practice and instruction of touch creates specific forms for how patients and practitioners attend to themselves and one another; it invites a renegotiation of embodiment. Specifically, I suggest that touch in this context invites both patients and practitioners to descend into their bodies, a contrast to the dis-association they experience in biomedical contexts. In using the terms “ascent” and “descent,” I am drawing upon Das’ introduction of the concepts in her ethnographic study of violence and the everyday (2007). Building upon her argument about descent into the “everyday,” I consider descent and ascent as particular ways of experiencing one’s body. By cultivating these touch sensibilities, I argue that practitioners put forward an “ethics of touch” based on the renegotiation of embodiment. Much like Foucault argues that care of the self
ethically precedes the care of the Other (1998), practitioners understand their ability to care for their patients as dependent on practices of self care and cultivation. Finally, by attending to patients in this way, practitioners aspire to engage in an embodied conversation. This “ethics of touch” challenges the standardized touch aspired to by biomedical technologies; particularly diagnostic techniques that obscure the practitioner’s body and posit the patient as a passive body to be diagnosed. As an ontology, I argue that biomedicine encourages an “ascent” from the body. Patients are understood to heal by escaping the ill body, and practitioners are understood to practice more effectively by cultivating detachment. By encouraging patients and practitioners to attend to their embodied selves, CCM generates an ethic of touch that enables possibilities for healing to become an embodied, cultivated and interactive encounter with, rather than a denial of, pain.

In speaking of biomedicine, I am turning to the framework laid out by Robert Hahn and Arthur Kleinman. I understand biomedicine to be “a sociocultural system” (Hahn et al. 1983:306). This indicates that, just as the other medical traditions considered here, biomedicine is “an ethnomedicine” grounded in cultural ideas (1983:306). Again following Hahn and Kleinman, I use the term biomedicine to mark this particular medical approach. In contrast, “its practitioners (and its patients) refer to it simply as ‘medicine.’ (It is the medicine, real medicine; only other ethnomedicines are specially denominated, ‘osteopathic medicine,’ ‘Chinese medicine,’ ‘homeopathic medicine’)” (Hahn et al. 1983:312). Finally, rather than just a singular medical approach, I understand biomedicine to be an entire system of values that influences how individuals relate to their bodies well beyond the clinic. As Deborah Gordon has pointed out, biomedicine “draws upon and projects cosmology (ways of ordering the world), ontology
(assumptions about reality and being), epistemology (assumptions about knowledge and truth), understandings of personhood, society, morality, and religion and understandings of personhood, society, morality, and religion (what is sacred and profane)” (1988:19). The biomedical system therefore emerges not only during clinical encounters in biomedical institutions, but also any time that an individual engages (consciously or not) with this constellation of values.

In the following section, “Methodology,” I outline my personal investments, goals, and ethical considerations for this project. In the next section, “The Patient: Dissociation, Descent, and Transformation,” I consider how the practitioner’s touch leads the patient to attend to themselves in a particular way. Dealing specifically with the pulse seminar, I ask what type of body the patient inhabits—and how they reflect upon that body—during different diagnostic procedures. Specifically, I focus on the Shen-Hammer pulse system and an imagined patient receiving an x-ray. Drawing upon Veena Das’ work on violence and the everyday (2007), I argue that the practitioner’s touch during pulse diagnosis puts forth an “ethic of touch” based on patients’ “descent” into their bodies, creating possibilities for the integration of pain into the everyday. In the section after, “The Practitioner: Self-Care and Receptive Touch,” I consider how learning the Shen-Hammer system of pulse diagnosis leads practitioners to attend to themselves in particular ways. I argue that this pulse system is grounded in the practitioner as a receptor of sensory information. In learning this diagnostic procedure, students engage with what Foucault calls “care of the self” (1998) and cultivate descent into their bodies. In the third section, “The Healing Encounter: A Third Space of Conversation,” I move from a consideration of how patients and practitioners attend to themselves to a consideration of how care of the self may ethically inform care of the Other (Foucault 1998). Beginning with a conversation with Johnson,
a practitioner-professor at NUNM, I develop a framework for touch as conversation and compare this with Nicola Gale’s theory of “body-talk” (2011:237-251). Finally, I conclude with a clinical encounter I witnessed while observing the supervising attendant at a clinic for transitory populations in downtown Portland. Though the touch in this encounter was not that of pulse diagnosis, it brings together the concepts I’ve addressed and reveals their ability to create different possibilities for healing that rely on a certain renegotiation of embodiment. In the “Conclusion,” I open up the discussion to other sensory modalities and also consider implications for biomedical education.
Methodology

Prior to beginning this project, I had already spent a significant amount of time in other medical contexts. As an anthropology-biology double major on a pre-medical track, I have worked in multiple departments at the Oregon Health & Science University, a research and teaching hospital that takes pride in its adherence to biomedical principles. At the time of writing this paper, I continued to volunteer in the pediatric emergency department, and previously, I volunteered in pediatric oncology and interned in vascular surgery. My experiences in biomedical contexts have been greatly mixed. In a practitioner role—as a volunteer and intern—I have largely enjoyed my experiences, enough to pursue an education as an MD. As a sister of someone with severe chronic health issues, though, my experiences have been, at times, devastating. My sister has repeatedly been subject to the limitations of biomedicine as a patient with the exact types of issues biomedicine is ill-equipped to deal with: pain, chronicity, and complexity. These experiences certainly affected the topics I was drawn to during my time at NUNM—what surprised me and what I took note of.

I have a number of goals in writing this paper. First of all, I hope to contribute to the anthropological and clinical literature on “embodiment,” considering what it means for patient and practitioner to attend to one another in a particular, cultivated way. As a student with personal and professional stakes in biomedicine, I’m particularly interested in alternative models of care and healing. How could touch look? How could healing look? With that in mind, I hope to contribute to the conversation around medical education and its reform. What are the implications of these findings, not only for teaching students of Chinese medicine but also MD’s? Practitioners’ hands have an astounding potential to heal, but I have also been witness to
the various ways in which hands meant to heal can hurt. I’m invested in practitioners’
responsibility to ask why one of Beth’s patients began crying because her touch was “just so
kind.” What does it mean to touch your patient with “kindness?”

In considering this question, I invoke the concept of an “ethics of care.” The conversation around
the “ethics of care” began with Carol Gilligan, a psychologist, whose book, In a Different Voice
(1982), suggested “‘a different voice’ in the way many girls and women interpret, reflect on, and
speak about moral problems” (Held 2006:27). Namely, this was a voice concerned with care.
The term has since been taken up by a number of feminist philosophers\(^2\) and aims to build
“concern and mutual responsiveness to need on both the personal and wider social level” (Held
2006:28). More recently, Arthur Kleinman, an MD and medical anthropologist, has addressed
the ethics of care as it applies to illness and caregiving. Specifically, he has reflected upon his
experience as the primary caregiver for his wife, who suffers from a neurodegenerative disorder:

…caregiving is also a defining moral practice. It is a practice of empathetic imagination,
responsibility, witnessing, and solidarity with those in great need. It is a moral practice
that makes caregivers, and at times even the care-receivers, more present and thereby
fully human. If the ancient Chinese perception is right that we are not born fully human,
but only become so as we cultivate ourselves and our relations with others…then
caregiving is one of those relationships and practices of self-cultivation that make us,
even as we experience our limits and failures, more human….And if that Chinese
perspective is also right (as I believe it is), when it claims that by building our humanity,
we humanize the world, then our own ethical cultivation at the very least fosters that of
others and holds the potential, through those relationships, of deepening meaning, beauty,
and goodness in our experience of the world. (2010:29)

I, too, am concerned with the ethical implications of the clinical encounter between patient and
practitioner. Drawing upon this “ethics of care,” I frame the topic of touch as an ethical question.

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\(^2\) See also: Nel Noddings, Eva Kittay, Diana T. Meyers, Marsha Hanen, Kai Nielsen, Annette Baier, and
Virginia Held.
What “ethics of touch” guides the practice of CCM practitioners? How do CCM practitioners understand the “ethical cultivation” of particular touch sensibilities?

My fieldwork on these questions began in the summer of 2016 when I joined a research group led by my professor, Sepideh Bajracharya. It included another Lewis & Clark student and a recent graduate of NUNM, as well. Each of us came with a shared interest in trauma—the starting point for our exploration—and a shared investment in questions of healing. With the help of Sepideh, who was already conducting research at NUNM, each of us began to shadow one four-hour shift each week at a NUNM-affiliated clinic. As a group, we also met twice a week to discuss designated readings and our experiences in clinic. Rather than contributing to a single project, each of us pursued our own interests and forms of representation. Outside of clinic, I continued my conversations with students and practitioners in the form of semi-structured interviews. Following the summer, I no longer shadowed at NUNM but continued to conduct semi-structured interviews with students and practitioners. I was also invited to join a beginning pulse seminar taught by Beth, and I attended the first weekend of the two-weekend workshop in September/October 2016.³

As a part of its teaching, NUNM runs a number of health centers throughout the Portland metro area and also has relationships with other clinics. At these centers, NUNM’s faculty supervise shifts with approximately eight student interns. As explained earlier, there are “observation” shifts and “internship” shifts depending on students’ experience levels. During my research, I shadowed at two locations, and both were internship shifts.

³ The names of all practitioners, students, and patients have been changed in order to protect their privacy.
The opening conversation is drawn from a shift at the Health Center located on the main campus (referred to throughout as the NUNM clinic or simply NUNM) supervised by Beth. The clinic is located just down the street from the main academic building. A pale, discreet building, the clinic would not stand out were it not clearly part of the campus. Surrounded by intentional landscaping—and a lush garden just behind the clinic—it’s easy to forget how close you are to the freeway. When you enter the clinic, you are greeted by a check-in desk on the right with a large sign explaining your insurance options. Next to the desk is a clearly labeled “medicinary.”

The waiting room is small but open, with around 20 chairs. On the TV screen in the corner, a number of informative slides flash through. Some are in Spanish, advertising a clinic in Beaverton, and others share interesting facts from the medicinary (like how a ginger pill is as effective at relieving menstrual pain as Tylenol). Interns come to retrieve patients when the room is prepared, and they follow them up a spiral staircase to the patient rooms. In the back of the second story are a few conference rooms that practitioners and interns share during their shift.

The interns work in pairs and treat three patients during each four hour shift, with each appointment lasting an hour and fifteen minutes. My shift included Beth, eight interns, myself, and a resident (which most shifts don’t have). My second shift, supervised by Landon, took place at Outside In, a Portland organization that serves the homeless and marginalized, which I will describe in the last section. Finally, I attended a pulse workshop led by Beth and hosted at an off-campus community center, which I will describe in further detail in the following section.

Although I encountered many students and practitioners during my research, a few individuals in particular profoundly shaped my thesis. Clinically, Beth and Landon served as guides for how
these concepts are applied in practice. Another practitioner, Johnson, teaches courses on “Palpation and Perception” at NUNM and helped me to frame my approach to these questions. Finally, I worked closely with three students in particular. Matthew and Amy were interns on Beth’s shift, and Natalie graduated during the course of my research. Natalie was also part of my summer research group and provided a resource for information on CCM throughout the course of my entire project.

Each of the practitioners with whom I worked are also professors, and they often talked to me as a student, referring me to texts or videos they send to their students. Because of my position as a student-ethnographer (both in conversations and in the pulse seminar), I have taken a particular interest in the student perspective. My access to the patient perspective was limited due to privacy and ethical considerations, though in attending to questions of healing, I inevitably address the patient, as well. It’s also important to note that my relationships and conversations happened within the context of NUNM and reflect individuals’ professional (though not necessarily broader) perspectives.

During the clinical shifts, I acted as a participant-observer and observed diagnoses and treatments. I would like to address the ethical consideration of my presence during patient appointments. Prior to conducting participant observation at NUNM, I completed HIPAA training. At the beginning of each shift, I asked the interns whether or not I could shadow them and which appointments they felt might be most appropriate. Before sitting in on an appointment, either the intern or I asked the patient’s permission, and I would briefly explain my project. The interns with whom I worked were remarkably insightful about their patients (many
of whom they had known for weeks or months) and generally did not hesitate to turn down observers, myself included. I am grateful for their commitment to their patients’ well-being and feel that this double layer of consent helped to minimize my presence from intruding.

Between appointments, I conducted unstructured or semi-structured interviews with the student interns in the main conference room. When possible, I also met practitioners and students outside of our weekly shift for semi-structured interviews. I recorded my conversations with permission from students and practitioners and also took fieldnotes during each component of my research. In writing my thesis, I have chosen to include both direct excerpts from my fieldnotes (where indicated), as well as edited passages based on my fieldnotes but written later. In quotes from my conversations and interviews, I have made minor edits (removing filter words) for narrative flow.
The Patient: Dissociation, Descent, and Transformation

“...I want to reenter this scene of devastation to ask how one might inhabit such a world, one which has been made strange through the desolating experience of violence and loss.”

–Veena Das

In this section, I’m interested in how a CCM practitioner’s touch during pulse diagnosis shapes how a patient attends to their own body. When working with patients, Beth often asks herself, “Where are they defended? What’s making them sick?” In this section, I argue that Beth defines both sickness and healing in terms of her patients’ lived, embodied experiences rather than external, biomedical measures of health. I place this understanding in conversation with Veena Das’ study of violence and her argument for the healing power of “descent” into the everyday (2007). I argue that Beth understands sickness as ascent from the body (what she calls “defenses”) and, like Das, believes healing happens through descent (back into the body, in this case). I begin the section by considering pain and overflow as barriers to descent and suggest that pulse diagnosis intends to overcome these barriers. I then contrast this with the biomedical diagnostic technique of x-ray through an imagined scene constructed from my experiences in the emergency room. By comparing these examples, I argue that Beth uses pulse diagnosis to encourage patient healing through descent, in contrast to healing through ascent in biomedical modalities.

The Pulse Seminar

There are still a few minutes until we begin the first day of the pulse seminar. We are sitting in a large classroom in a local arts center, and the tables have been arranged into a U-shape and

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4 Veena Das, Life and Words: Violence and the Descent into the Ordinary, (Berkeley: University of California Press, 2007), 89.
draped with tablecloths. One table is covered with glass mason jars that we can claim for the weekend, along with a rich assortment of teas. The nervous small talk is punctuated by the sound of hot water brewing in the background. In the coming days, the table will ebb and flow with breads and pastries and nut mixes, homemade by different participants in the class. Beth will encourage us to take breaks as we need also—to step outside and get some fresh air—and the schedule will be fluid, changing depending on how we all feel.

I had shadowed Beth during her summer shift at NUNM, and following our summer together, we brainstormed ways to continue working with each other and settled on the pulse seminar. A professor at NUNM, Beth has been taking the pulse for around 25 years and incorporates it into her teaching in class and clinic. This was her first time teaching a beginning Shen-Hammer pulse seminar. Tall and thin, with long, black curly hair, Beth radiates kindness and openness. She’s gentle, speaking softly, touching softly, and wearing soft clothes—only her laugh catches you off guard, strong and surprising. Perhaps most striking are her eyes—bright, open, and taking in the world with focused attention. Her black glasses seem permanently perched atop her head, only coming down on the rare occasions she uses a computer.

Open to anyone, the seminar consisted of about 10-15 participants, all students or practitioners of Chinese medicine (besides myself). Beth had also invited a number of her students to assist during the seminar, and throughout, she looked to them to add their own advice and perspectives. Over the weekend, we bounced back and forth between taking each other’s pulses and listening to lectures led by Beth that introduced the background, positions, and qualities.
Changing Pulses

The Shen-Hammer pulse system is remarkably complex. It assesses rate, rhythm, stability, volume, depth, size (width and length), and shape. Different pulse qualities (e.g. cotton, empty, leather, and so on) are used to describe the sensation felt when talking the pulse, both overall and at specific positions on the wrist. At each position, there are also three depths (from top to bottom: qi, blood, and organ). These depths are actual depths—the practitioner pushes their fingers further down into the wrist to reach deeper depths. Each quality has a different clinical significance, which varies depending on at what depth and position that quality is felt. It’s also important to note that the pulse is visualized and experienced as a wave that continuously rises and falls. Students are encouraged to “ride the wave” up and down as they move through the three depths.

When we began taking pulses on the first night, we quickly discovered that some of our pulses were not static. Instead, they changed as you held your partners’ wrists, with the wave sometimes slamming into your fingers but then barely reaching the qi depth on the next wave. Or perhaps you would feel a smooth vibration at the qi depth, but a few minutes later, it seemed more leathery. As beginners in pulse-taking, we questioned whether the qualities were actually changing or if we were just gradually recognizing the sensations.

When we came back together as a group, Beth acknowledged that some people do have changing pulses, and these are particularly challenging to take when you’re first learning this pulse system. Max, one of Beth’s student helpers, spoke up, adding that the pulse provides a limited space for the body to communicate. As the student handbook we were given during the seminar explains,
“The pulse is a means for the body to communicate its urgent messages to the practitioner. In order to fully appreciate the import of these messages, it is necessary to devote ample time” (Bilton 2016:9). Max explained to the class that the pulse may change while you’re taking it in order for the body to share everything it has to share. He explained that this is also dependent on the practitioner. If a patient(‘s embodied self) feels comfortable and safe with the practitioner, they may reveal more of themselves as the pulse-taking progresses, which manifests as a change in the pulse.

In this approach to diagnosis, the patient is not understood as a passive or object-ified body to be examined and tested. Instead, they are acknowledged as an active, embodied being. The recognition of the patient in this way does not occur in a verbal or abstract sense. Rather, the practitioner grounds the patient through an attunement to what the body has to share. This is not just any touch, though, but a particular orientation—one that emphasizes, in Beth’s words, “hanging out” and “drinking people in.” Consider also the gesture of pulse-taking. In Beth’s practice, at least during her first appointment with a patient, she generally takes the pulse for between 20 and 40 uninterrupted minutes. The posture itself is also very intimate, with the practitioner sitting very close to and directly across from the patient, taking the patient’s wrists gently in their two hands.

In his study of the divergence of Greek and Chinese medicine, Kuriyama points out the significance of how practitioners touch during pulse diagnosis. In the development of these two different trajectories of medicine,

Theoretical preconceptions at once shaped and were shaped by the contours of haptic sensation. This is the primary lesson that I want to stress: when we study conceptions of
the body, we are examining constructions not just in the mind, but also in the senses. Greek and Chinese doctors grasped the body differently—literally as well as figuratively. (1999:60)

Beth’s understandings of the body are revealed in—and shaped by—the physical qualities of her pulse-taking as much as her spoken philosophy. In other words, she has come to perceive patients as active, embodied beings through her many years of taking the pulse and recognizing it as a wealth of information about an individual’s well-being. At the same time, she touches her patients in the way she does because of her understanding of them as embodied selves, rather than passive objects.

Beth explained to us that earlier in her career as a practitioner, she actually experienced some discomfort with this intense intimacy. One day, though, a new patient began to cry while Beth took her pulse. Surprised, she asked what was wrong. The woman responded that it’s “just so kind.” The interns and practitioners I’ve worked with often cite crying as one of many possible manifestations of release during treatment. What Beth seemed to imply was that this woman had been touched—in both a verbally conscious and literally physical sense—by the attentiveness of Beth’s act of taking her pulse. Beth understood this as part of the healing experience; her patient had been touched and experienced a release in her body that needn’t be verbalized. Beth explains that in that moment, she began to realize that people often don’t—particularly in clinical settings—receive that kind of sustained, intimate, physical attention. By attending to another’s body in that way, she believes that you let them know that they are deserving of that kind of focused attention, and that you give them permission to attend to themselves in that way. As she often says, taking the pulse is not just diagnostic; it is actually a form of “treatment.”
What is the nature of this “treatment” and how does pulse diagnosis lead to healing? In order to answer this question, it’s helpful to understand how Beth defines “sickness.” As I mentioned in the introduction, when treating patients, Beth often asks herself, “Where are they defended? What’s making them sick?” She explains that, “often it is kind of wrapped up in their defenses.” These defenses can take a number of forms. “It could be something as obvious as…they’re doing drugs because they don’t want to deal” or “maybe they sleep all the time.” These are all “defenses over their truer experience.” Looking at the examples that Beth provides—doing drugs and sleeping—it seems that she understands “defenses” as acts that take people out of their bodies. These “defenses” are not just symptoms or by-product of an illness. Instead, they are the actual lived experience of sickness. Beth therefore understands sickness as a particular experience of the body—what I argue to be a relationship of “ascent.” Through drugs, excessive sleeping, or other activities, she believes that patients ascend from their bodies as a “defense” against their embodied, “truer experience.”

In Veena Das’ ethnographic work on social suffering in India, she also addresses the concepts of “ascent” and “descent” (2007). Although her work focuses on violence and not illness, she is engaged with similar questions of healing as I am. In response to suffering, she writes against ascent:

This image of turning back evokes not so much the idea of a return, as a turning back to inhabit the same space now marked as a space of destruction, in which you must live again. Hence, the sense of the everyday in Wittgenstein as the sense of something recovered. How you make such a space of destruction your own not through an ascent into transcendence but through a descent into the everyday is what I shall describe… (2007:62)

The “space” of which Das speaks is the space of everyday life, altered by violence, from which one might wish to escape or get “outside” of (2007:62). In the context of medicine, I think this
idea of “space” can be applied to the human body. Like violence, pain and illness also possess the power of “destruction” and can mark a space—the body. Indeed, Beth seems to recognize activities of ascent by patients as “defenses” against the potential pain of “their truer experience.”

Das recognizes the possibility of “ascent”—or escape “into transcendence”—as a response to destruction, but she argues that healing occurs through “descent”:

What is it to bear witness to the criminality of the societal rule that consigns the uniqueness of being to eternal forgetfulness through a descent into everyday life—to not simply articulate loss through a dramatic gesture of defiance but to inhabit the world, or inhabit it again, in a gesture of mourning? (2007:62)

Speaking alongside Das, I propose that the “treatment” to which Beth refers is a treatment based on the philosophy of descent. She approaches healing as “a matter of getting to know them and with time working in some of that awareness where they can, at some point, peel back some of those defenses.” She points out this process may take years, but says, “when I look at people who heal, it’s often those that…don’t defend themselves all the time.” For her, healing is an act of inhabiting the world—or, in this case, the body—again. She recognizes the difficulty—and potential pain—of this process, though, as a “gesture of mourning” that individuals may engage in for years.

Beth attempts to encourage this descent through the touch sensibilities she has cultivated. Through the touch of the pulse diagnosis—and the focused attention it entails—she encourages patients to pay attention to their embodied selves. Rather than just an effort to inhabit the world again, as Das points out, Beth wants her patients to inhabit their bodies again, even if that looks like a gesture of pain, mourning, or release. Through gentle, inquisitive, and sustained touch,
Beth understands that she is inviting her patients to feel whatever they might be feeling, or, in other words, to be present with themselves as she is present with them. By inviting patients back into their own bodies, she suggests that practitioners can provide a model for how to do so: sit with yourself in this way; listen to yourself in this way; let your body speak; you are worthy of this form of attention.

Claire Cassidy, a practitioner and anthropologist, also speaks to this quality of touch in Chinese medicine. She writes,

> During treatment, the patient is helped to notice change. Every master practitioner emphasized how he or she trains patients to describe and track their experiences. This learning has downstream effects, mobilizing hope, and empowering healing as the patient helps to guide the intervention: together the practitioner and the patient form a dynamic health-seeking unit. (2004:81)

Cassidy recognizes that during treatment in Chinese medicine, “the practitioner continually seeks feedback from the body-person that he or she is treating and modifies his or her intervention in response to it” (2004:81). Like Beth, though, she points out that treatment isn’t just about how the practitioner “seeks feedback from the body-person” through touch; it’s also about teaching the patient how to do the same. By encouraging patients to recognize, track, and communicate their bodily sensations during treatment, practitioners attune them to their embodied experiences and encourage descent. In addition to healing through descent itself, Cassidy also suggests that teaching patients to relate to themselves in this way empowers them to guide their treatments.

As Cassidy describes, by training “patients to describe and track their experiences,” practitioners can use both touch and verbal communication to teach patients how to relate to their bodies. While doing pulse diagnosis, Beth also uses a combination of touch and verbal communication
to encourage patient “awareness” of the defenses mentioned earlier. In her experience, patients often feel less shame and responsibility for qualities detected in their pulse than they feel through direct questioning. If she asks a patient how many hours they’ve been sleeping each night, they might feel embarrassed, judged, or responsible for being sick. On the other hand, if Beth recognizes a quality in the pulse that indicates tiredness, she might pose the question, “I noticed this in your pulse; do you feel tired?” To which patients often respond, “You know, I have been really tired lately.” By doing this, Beth tries to teach her patients to attune to their body in the same way—to recognize how they are feeling without judgment. In this way, descent becomes possible through this particular touch sensibility, as well as Beth’s careful articulation of its significance.

Dissociative Diagnosis

To point out the salience of Beth’s inviting touch, it’s perhaps helpful to consider how a different diagnostic touch might compel a patient to reflect on their body in a dis-associative way. Although patients are always embodied selves, they can attend to themselves in a way that denies this:

On the level of perception it is not legitimate to distinguish mind and body, since the body is itself the ‘general power of inhabiting all the environments which the world contains’ (Merleau-Ponty 1962:311). Beginning from perceptual reality, however, it then becomes relevant to ask how our bodies may become objectified through processes of reflection. (Csordas 1993:149)

Here, I use “ascent” to address the final part of this quote—the processes by which patients’ bodies are attended to in a detached way and, thus, by which they are encouraged to attend to their bodies in the same way. I argue that biomedical diagnostic technologies, such as the x-ray, derive their legitimacy from objectifying patients. These technologies work most effectively
when patients are ascended from their bodies—whether through sleep or medication—as pain and excessive movement can actually interfere with the imaging. Moreover, I argue, these diagnostic technologies are understood to objectively collect all necessary information, so the patients’ lived, subjective experience is extraneous to the imaging process.

Let’s consider a specific example for the purpose of comparison. This example is imagined, but it draws upon my multiple threads of experience volunteering in the emergency room at a local hospital and taking my sister to the emergency room during her episodes of intense chest pain. In other words, this does not describe a single, real scenario, but I have seen this scenario many times. Imagine that a middle-aged woman presents to the emergency room with severe hip pain following a fall. As she lays on the bed, the doctor palpates her hip, pressing at particular points and asking whether she has tenderness in any of those points. At one spot, she cries out in pain, and the doctor documents the anatomical location that is tender to palpation. The doctor suspects a fracture, but neither the woman’s shriek nor his own touch is sufficient for a diagnosis.

Outside, he remarks to the nurse that the patient is “hysterical” (after all, the type of hip fracture that he suspects would never cause that much pain) before he puts in an order for an x-ray. The patient overhears his comment and, desperate to be recognized as legitimate, promises to herself to downplay the pain. The nurse enters the patient’s room, and in preparation for the x-ray, gives her a dose of pain medication to dull her pain. The medication is intended to increase the woman’s comfort, but also to prevent her pain (and cries and unpredictable jerks) from getting in the way of the x-ray. Her input is no longer needed. When the x-ray is complete, it’s read by a different doctor than the one who initially palpated the patient. Its effectiveness depends on its
objectivity—any-body could take the x-ray and any-body could read the x-ray and draw the same conclusion. The woman’s hip is not fractured, and she is sent home with instructions to follow up with her primary care provider.

In this example, descent into the body is neither encouraged nor advantageous. Das proposes “an ascent into the transcendent” (2007:15) as the opposite of descent, which we see play out in this example. The patient must ascend from her body for a variety of reasons. In order to receive recognition and legitimacy, she must disconnect from her pain. Instead of being legitimated as her felt-experience, it is discounted because it does not match the results obtained from the “objective” diagnostic test. Returning to Das, this woman is asking for acknowledgement of her pain (2007:40), which this healing modality denies her. Her only remaining option? To ascend out of the pain. Indeed, her practitioners help her in this ascension. She is provided pain medication to numb her sensations and distance herself from that happening in her body, not just for comfort’s sake but also for the sake of a more precise diagnostic test. Her objectified body needs to be imaged, but she does not.

In his study of biomedical values, Laurence Kirmayer points to the dualisms that justify—and even encourage—this patient’s ascent. He argues that the Cartesian mind-body dualism was superseded by a dualism between “subjective awareness and direct observation” (1988:59). Under this dualism,

The patient’s subjective account of distress was deemed unreliable and essentially irrelevant to the physical diagnosis. Thus, the conscious awareness of the patient was subordinated to the physician’s privileged knowledge of the body acquired by direct examination. The body revealed its disease to the doctor without the need for the patient’s self-interpretation. (Kirmayer 1988:59)
Kirmayer argues that the patient's lived, embodied experience is considered illegitimate in the face of the doctor's objective knowledge and technology. Since descent aims to provide patients with precisely that kind of “conscious awareness,” descent becomes unnecessary in this biomedical value system. Patients don’t need to be attuned to their embodied selves because the practitioner alone has the tools to extract the necessary information. The touch sensibilities of diagnostic techniques like the x-ray reflect this belief, collecting information through “direct examination” rather than in a way that incorporates patient experience.

Kirmayer puts this dualism in other terms, as well:

The real dualism in modern medicine, Sullivan argues, is not between two substances but between the physician as active knower and the patient as passive known. This duality is captured in the distinction between disease and illness (Eisenberg 1977). Disease stands for the biological disorder, or, more accurately, the physician’s biomedical interpretation of disorder, while illness represents the patient’s personal experience of distress. In biomedicine, these two aspects of distress are accorded different status and it is ‘real disease’ that is viewed as the true object of medicine. (1988:59-60)

Again, we see that the patient must be “passive” in order to be known. I argue that this passivity is cultivated through ascension. A “passive” patient suggests a separation between the patient body, which the practitioner aims to “know,” and the patient mind, which contains the patient’s subjective experience. In the x-ray example I have given, the practitioners tried to separate the patient’s “mind”—her experience of pain—from her body, in order that the practitioner could focus on the disease alone.

In pulse diagnosis, though, Beth sees these concepts as inseparable. You cannot separate mind from body because the patient’s lived experience implicates their entire embodied being.

Therefore, perhaps the “treatment” Beth describes is acknowledgement. By acknowledging the
patient’s pain, the practitioner gives the patient permission to do the same. In contrast, biomedical diagnostic techniques (such as the x-ray described above) may obscure the experience of pain, leading the patient to dismiss their own lived experience in the same manner. In writing about women’s experience of violence in India, Das writes, “Through complex transactions between body and language they were able to both voice and show the hurt done to them as well as to provide witness to the harm done to the whole social fabric” (2007:59). In taking the pulse, Beth seems to understand herself as a witness to the patient’s lived experience. By acting as witness, she attempts to make space for patients’ embodied selves to “show the hurt” they are experiencing. Unlike the “passive” patient body in biomedicine, the CCM patient is actively engaged with their body throughout the entire clinical encounter.

In notes from a seminar on the classical Chinese medical texts, Claude Larre and Elisabeth Rochat de la Vallee note that the goal of treatment is to,

…”try to give a pattern for the equilibration and calming of the essences and spirits in the patient. The only way anyone can be cured is by the movement of the spirits. Remember, though, that you cannot make the spirits move—you can only let the spirits of the patient rectify themselves…. (1990-91:50)

Even in a more serious clinical circumstance where the spirits have departed from the patient due to prolonged emotion, the practitioner cannot simply reintroduce them into a passive patient body. Instead, the practitioner should “put your own willpower in the needles to rectify the spirits and give the patient an opportunity to reenter into possession of himself” (Larre 1990-91:50). Earlier, we saw how the Shen-Hammer pulse system is not based on the static diagnosis of a passive, objectified body. Instead, diagnosis manifests as an interaction between two active, embodied beings. Here, we see that this touch sensibility extends to the philosophy of CCM treatments, as well. Even at their most sick (i.e. when the spirits have departed), patients are not
passive bodies to be cured. Instead, they are active, embodied beings, and healing requires touching them as such. In conclusion, in contrast to biomedical touch sensibilities, CCM touch sensibilities encourage patients to heal through descent into their bodies, their pain, and their lived experiences. In this way, CCM practitioners put forth an ethics of touch based on a philosophy of descent.
The Practitioner: Self-Care and Receptive Touch

“The care of the self is ethically prior in that the relationship with oneself is ontologically prior.”

-Michel Foucault

Conversations about health and healing often focus on the question, what is the patient suffering? However, what if we inverted this question, asking what the practitioner is suffering, and contemplated this as having a relationship to healing? I address this question in the following two sections. In this section, I focus on how practitioners learn and cultivate their skill in the Shen-Hammer system of pulse diagnosis through practices of what Foucault calls “care of the self” (1998). In the next section, I consider how CCM practitioners’ cultivated attunement to themselves shapes how they touch patients. I argue that, in contrast to biomedicine, the care of oneself is considered critical to CCM. This relates to Foucault’s notion that “the care of the self is ethically prior in that the relationship with oneself is ontologically prior” (1998:287) and that care of the self is critical to care of the Other (1998).

In this section, I argue that the Shen-Hammer system of pulse diagnosis is a sensory mode of diagnosis grounded in touch. Because pulse diagnosis relies on receptivity through the fingers, practitioners are trained to cultivate descent and to trust their felt-senses. They understand this gesture as ethical because these acts of self-care improve their ability to diagnose and treat patients. In contrast to this aesthetic of descent, I argue that biomedicine encourages practitioners to cultivate ascent from their bodies. In studies among nurses and caregivers, the risk of “compassion fatigue” has been attributed to “their proximity to patients” (Austin et al. 2009:195-

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214), as well as “an unwillingness or inability to detach from the caregiving situation” (Day et al. 2011). However, one of the symptoms of “compassion fatigue” is withdrawal and detachment (Day et al. 2011), suggesting that practitioners will inevitably and must necessarily and advantageously detach (ascend) either sooner (healthy boundaries) or later (pathological “compassion fatigue”). I argue that CCM provides a different model than biomedicine for how practitioners can ethically attend to themselves. This section begins with my conversations about pulse diagnosis with Beth, who reflects on how it feels to practice when dis-engaged from one’s body, as well as the sensorial and embodied aspects of “receptivity.” I then consider how first-year medical students in an MD program learn to touch the cadaver and to cultivate detachment.

_Sensitivity and Receptivity_

Before we took pulses on the first day of the pulse seminar, Beth began with a lecture about the history and basic principles of the Shen-Hammer pulse diagnosis system. Throughout her introduction, she repeatedly emphasized the significance of sensitivity to pulse diagnosis:

> And this is because we rely so much, there’s so much regard to sensation, so in a way what we’re doing here is we’re kind of learning the subtlety of that by studying and organizing and recording pulse qualities. So this system is really a lot about sensation. It kind of all goes around about that. It’s like that’s its central thing. And by sensation I don’t mean, I mean really your felt experience of it, just what you’re gathering, your receptivity. That’s at the nuts and bolts foundation of this stuff. Interpretation can get a little tricky and that comes with time but again and again I’m going to mention it, it really is what you’re gathering with your fingertips that’s most essential.

In Beth’s definition, sensations seem to be dependent upon the practitioner’s bodily experience of them. Sensation is not external. Rather, it is internal and subjective in the sense that it relies upon the practitioner’s embodied experience. Diagnosis is based on “your felt experience” “what you’re gathering,” “your receptivity.” With this in mind, it becomes meaningless to talk about sensitivity without also talking about the practitioner. Moreover, discussions of “sensitivity”
always imply the practitioner’s fingertips and embodied awareness. Beth also echoed this during our conversations in clinic: “There’s no way I could have any real authentic connection or a sense of the patient if…it wasn’t coming through me.”

If the practitioner’s body serves as the gateway for sensations, then regardless of skill, the practitioner can be in a temporary state of enhanced or reduced sensitivity. Throughout the seminar, Beth reminded us time and again to “hang in there with patients,” put our hands on the pulse and then “take a breath,” “wait for it,” and practice “patience.” Although sensitivity does relate to where and how the practitioner positions their hands, it also goes beyond the simple mechanisms of methodology. In writing about the divergence of pulse-taking in Greek and Chinese medicine, Kuriyama explains how two vastly different forms of the same diagnostic procedure emerged:

Two people can place their fingers on the ‘same’ place and yet feel entirely different things. Where Greek doctors latched onto the pulse, Chinese doctors interrogated the mo. The divergence was as much a matter of experience as it was of theory. Greek and Chinese doctors knew the body differently because they felt it differently…Greek and Chinese doctors grasped the body differently—literally as well as figuratively. (1999:55)

In both Beth’s advice and Kuriyama’s analysis, it is evident that becoming skilled at Chinese pulse diagnosis is not simply a matter of learning standardized technique. Students must also come to know the body in a particular way, the details of which I argued in the previous section. This understanding of the body also shapes how practitioners attend to themselves. As mentioned above, during the pulse seminar, Beth instructed us in how to attend to our bodies—through our breath and patience—in order to increase our sensitivities.
She also frequently encouraged us to slow down. In her words, she tries to practice more and more slowly every single year. I met her at the clinic early before our shift one week to ask her how speed affects her practice and sensitivity. As she sat on a patient bed and answered my questions, I couldn’t help but notice the irony. Even as a practitioner, Beth seems to have a skill for placing herself in her patients’ position. All of her efforts—to attend to herself in a particular way—are efforts on behalf of her patients, and she always maintains an awareness of how her presence affects her ability to heal.

When I asked Beth how it feels to slow down, she responded that:

I feel like you know almost like an internal momentum lots of times and what I often track is where it starts to kind of amp up. And when I’m really conscious of actually that and how disruptive that feels and how that kind of, like, can kind of mute my sensitivity and stuff. But it gets into, kind of, almost like a fear mind, like, oh my god, I’m really busy. Oh my god, I’m behind. It can kick in.

For Beth, speed affects the way in which she is present. When she has too much internal momentum and begins to move too quickly, she is no longer present in the way she strives to be, and her sensitivity is reduced. She points out that sensitivity is affected by a number of other factors, as well:

You know you we, we doubt it [sensitivity], we occlude it, our running around in life, or too much coffee or whatever, you know we can kind of block it but the truth is it’s right there and it just takes a little attention and time and patience and it’s in a way it’s I don’t want to say being resuscitated because it really hasn’t gone anywhere. It’s just unavailable…I feel like I had to really spend time with just relaxing myself in order to really feel stuff and what’s so cool is there’s so much space in this system to do that.

In Beth’s experience, fear, business, running around, or drinking too much coffee all can mute practitioners’ sensitivities.
In the previous section, I explained how Beth defines sickness in terms of a “defended” body and encourages her patients to let go of those defenses in order to heal. Likewise, as a practitioner, she strives to practice from “an undefended place.” I argue that the presence she teaches against—of “internal momentum,” “defenses,” and “tension”—is one of ascent. Just like patients, she suggests that practitioners can defend themselves against their truer experience by detaching from their bodies. She cautions students against “trying to struggle to be in another place” and instead encourages them to attend to themselves in the same way they teach their patients to attend to themselves; by developing an “awareness” of where they (in relation to their bodies) are and “accepting” that without judgment. These acts of ascent are not abstract. Instead, they manifest concretely in the form of muted “sensitivity” in the fingertips; practitioners are literally dis-connecting from their bodies, and it hurts their ability to feel.

Just as there are practices that mute sensitivity, there are also ways to cultivate and strengthen sensitivity. Even throughout the brief three-day pulse seminar, Beth provided us examples of how to do so. During breaks, she encouraged us to step outside and breathe in some outside air. Despite the seminar’s early start time, she discouraged us from drinking coffee. At one point, we all paused and she led us in practicing *qi gong* before taking more pulses. Through these practices, she encouraged us to slow down, regain awareness of our embodied selves, and, in doing so, descend back into ourselves.

I would now like to return to Larre’s notes from a seminar on classical Chinese medical texts, introduced in the first section. The following two passages are commentaries on the Su Wen section of the Huang Di Neijing (Yellow Emperor’s Classic of Internal Medicine):
Diagnosis through the sense organs relies on the deep examination of yourself. Through that examination, you are able to clear blocks in understanding and to make a good diagnosis—to lift the veil. Even the tools of diagnosis (fingers, eyes, ears) must be in perfect condition. To see, for instance, is not just having enough liquids and blood in your eye, but also having the presence of spirits there. The presence of the spirits is due to the inner position of your own life. (Larre et al. 1990-91:16)

Virtue is the activity in you coming from your deep relationship with yourself. If as a practitioner you are waiting for magic forces from outside to help you, you cannot express your own virtue because you cannot touch your own spirit. Thus, you cannot touch the virtue of the patient. (Larre et al. 1990-91:17)

Beth’s emphasis on the practitioner’s cultivation of an attunement to themselves seems to reflect a broader ideal in CCM, which is put forth in this classical text. As Larre writes, CCM encourages practitioners to attend to themselves through “deep examination” because it’s based in diagnostic procedures that come “through the sense organs.” From this perspective, practitioners cannot practice pulse diagnosis effectively without actually attending to themselves first. They must prioritize attending to themselves and cultivate this touch sensibility in order “to lift the veil;” only then can they diagnose effectively. In the second passage, “virtue” emerges as a term for defining this particular relationship to and practice on the self. I argue that this “deep relationship” with the self is based on a philosophy of descent into the embodied self. Again, Larre makes clear that a practitioner cannot hope to “touch the virtue of the patient” until they have first attended to themselves. Thus, I argue that practitioners are understood to have an ethical responsibility to attend to themselves prior to attending to their patients.

Caring for the Self

I understand these practices of “deep examination” of the self as aligned with that which Foucault defines as “care of the self”:

...a precept for which the Greeks had a specific word, epimeleia heautou, which means taking care of oneself. It does not mean simply being interested in oneself, nor does it
mean having a certain tendency to self-attachment or fascination. *Empimeleia heautou* is a very powerful word in Greek that means “working on” or being “concerned with.” … That which a doctor does in the course of caring for a patient is *epimeleia heautou*. It is therefore a very powerful word; it describes a sort of work, an activity; it implies attention, knowledge, technique. (1998:269)

I distinguish this definition of self-care from somatic modes of attention because of the effort behind it. “Somatic modes of attention” is a more general term that describes all the ways in which individuals can attend (or not attend) to themselves or others. Foucault’s “care of the self,” on the other hand, is an intentional practice, or cultivation, of the self that requires a certain discipline. He emphasizes these practices in his definition of self-care:

> It is what one could call an ascetic practice, taking asceticism in a very general sense—in other words, not in the sense of a morality of renunciation but as an exercise of the self on the self by which one attempts to develop and transform oneself, and to attain a certain mode of being. (1998:282)

By encouraging us (the pulse seminar participants) to engage in these practices of relaxation and slowing down, Beth was engaging us in this “ascetic practice.”

This raises the question, what “mode of being” are students and practitioners aspiring to?

Returning to my earlier conversation with Beth regarding her internal momentum, she provides a useful description: “A lot of it is this internal feeling of bringing back that momentum of being out and forward and more, like, in and deep and almost circular, like, you know, up and down through me and not so much this propelling.” Here, we again see the emergence of the concepts of ascent and descent. Beth experiences internal momentum as decreased sensitivity in her fingertips and as “out and forward.” Due to stress, fear, or business, she ascends “out” of her body, and it hurts her ability to recognize sensations in her body. When she engages in ascetic practices, though, and focuses on slowing down, she experiences this as “deep and almost
circular,” or “up and down through me.” She aims to descend into herself, and her ability to effectively practice pulse diagnosis actually relies on her cultivation of this type of presence.

The ascension that Beth describes—“out and forward”—echoes the renunciation of the self that Foucault contrasts with care of the self:

In the philosophical tradition inaugurated by Stoicism, *askesis* means not renunciation but the progressive consideration of self, or mastery over oneself, obtained not through the renunciation of reality but through the acquisition and assimilation of truth. It has as its final aim not preparation for another reality but access to the reality of this world. The Greek word for this is *paraskeuazo* (“to get prepared”). It is a set of practices by which one can acquire, assimilate, and transform truth into a permanent principle of action. *Aletheia* becomes *ethos*. It is a process of the intensification of subjectivity. (1998:238-239)

Beth strives—and encourages her students to strive—to cultivate this “intensification of subjectivity” by becoming more attuned to the sensations they experience in their fingertips while taking the pulse. As both a healing modality and touch sensibility, then, pulse diagnosis attempts to heal patients by delving into this reality (both the patient’s lived experience and the practitioner’s felt-sense) rather than transcending to an alternative, disembodied reality.

**Touching Death**

If pulse diagnosis encourages practitioner descent, then what relationship with the self do biomedical touch sensibilities engender? In order to answer this, I draw upon an ethnographic study conducted by Joseph Lella and Dorothy Pawluch (1988). To study how MD students are taught to relate to and touch the body, these researchers conducted research with first year medical students working with cadavers at McGill University. Since dissection is a foundational component of biomedical education (and not of CCM education) it allows us to consider a uniquely biomedical touch sensibility. I argue that, in contrast to the practitioner descent
encouraged in CCM pulse diagnosis, biomedical students learn to ascend and cultivate a detached touch through their work with cadavers.

The authors began by asking students about their initial reactions upon entering the cadaver lab. Most students experienced a visceral response:

> Emotional responses were occasionally accompanied by physical reactions including nausea and dizziness. Though many described the urge to run out of the laboratory none admitted to doing so. They did admit to having difficulty with meals for the next few days… (1988:129)

As time progressed and they gained more experience in the lab, though, students learned to suppress these reactions:

> Whatever their initial responses, all our respondents eventually were able to function more or less comfortably in the lab. However, several mentioned the constant vigil required to keep their emotions in check. (1988:133)

I argue that the structure of their education encouraged these students to detach from and suppress these embodied reactions. Had they been unable to do so, they likely would not have completed and passed the course, preventing their continuation in the program.

Based upon the students’ comments about “the constant vigil required to keep their emotions in check,” it seems that, like CCM students, they also cultivated practices in order to be present in a particular way. However, rather than a presence of descent and engagement, they strove for detachment and neutrality—in both their emotions and their physical sensations. As the authors write, “In one sense, the ability to objectify and become emotionally detached was a source of gratification and pride for the students. They were learning ‘how to be doctors’” (1988:133).
The authors argue that this ability to detach is actually necessary for the medical world into which they are entering. Consider a surgeon who, upon cutting into human flesh, experiences a shooting pain in the same location on his own body; would he make an effective surgeon? The desensitized surgeon, then, inhabits his body in the way required by his task. “Success” in the case of the medical students working with cadavers is also desensitization, or a lack of sensations (dizziness, nausea, etc.). Instead of Foucault’s “care of the self,” we see his “renunciation” of the self in practice.

Indeed, the development of a desensitized touch is not a side effect, but rather a direct goal of their training:

Perhaps our students and these analysts have touched upon some of the real reasons (aside from departmental power) for the survival of dissection. Perhaps they perceive a purpose somehow intended by medical educators… Perhaps anatomy, taught through dissection, with little explicit reference to what we have called ‘feeling and philosophy’ is an important initiation rite. Perhaps the cutting of preserved human flesh, the resulting spiritual, cognitive, and emotional disturbances, their private resolution and students’ concomitant actual and symbolic identification with medicine and its norms are crucial reasons why dissection and its pedagogy remain as they are… (1988:142)

Those who are unable to detach, or ascend, in the proper manner are prevented from continuing their education on the basis that they are unlikely to make effective practitioners. Perhaps this is why these particular students are exposed to cadavers in their first year of medical school, rather than later.

Although these students cannot be faulted for cultivating the qualities required of them by this healing modality, their detachment does beg the question, how does ascent affect their interactions with patients? Foucault argues that the care of the self is actually critical to the care of the Other: “The care of the self is ethical in itself; but it implies complex relationships with
others insofar as this *ethos* of freedom is also a way of caring for others” (1998:287). If students are practicing self-renunciation, as opposed to self-care, in what ways will they care for the Other?

The students Lella and Pawluch worked with recognized these implications and expressed concerns about their ability to care for the Other:

It worried me that the cadaver could so quickly cease to bother me at all. Deep down, I was disappointed with myself for “losing touch” with my feelings so easily. Would I end up just as easily setting aside the compassion I might feel towards my patients as well. (1988:133)

I recognize the callousness working with the cadavers foments, and I worry about it being transferred towards living humans. I am concerned about my development as a physician and the way I’ll relate to my patients. If it is so easy to suppress my feelings while dissecting the cadaver, perhaps there will be the temptation to do the same when dealing with patients. (1988:133)

I have found myself not only cutting off my feelings in the lab, but out of the lab as well. In quest of being truly objective I remember ruthlessly quizzing my girlfriend as to the exact nature and extent of her lower abdominal pain she was experiencing. So absorbed was I in attempting to diagnose her ailment, I had blinded myself as to how much pain she actually felt. I was quite surprised when she soon started to cry and asked me to stop questioning her. (1988:133)

In these examples, the Other is spoken of as everyone the students interact with—current patients, future patients, partners, and so on. Having learned to touch cadavers in a way that no longer upsets (or even affects) them, they wonder how they might touch living humans. It’s unclear how these concerns will manifest in practice, but they raise questions that need to be addressed.

In attending to herself, Beth always has her relationship to her patients in mind. She attempts to cultivate descent precisely because of how she believes it will allow her to touch her patients:
That and I do think as practitioners I do think we’re part of the treatment. I really do think that. I do think there’s a lot about let me know things come through the channel that come through the needles and you’re just a vessel and that’s true and then there’s um you are present. You’re part of the treatment. You’re in the room. As soon as you walk in the room you know there’s an influence. Something’s happening. You hope it’s for the better, but there’s something in momentum right away, and and then I guess having the awareness of ourselves as part of that really does, it enriches the treatment…in a way that where you are when you’re needling is really makes a big difference. You know, like cause-effect. I mean this is really, it’s not just the fact that you’ve got the perfect protocol points. Its really, actually, really less significant than how you are with the needle…

She understands her grounded presence as critical to the treatment and critical to the patient’s ability to heal. So, how is she with the needle? Patient. Even as an experienced practitioner, she is “humbled over and over” by sensations that come out “slip through” right when she’s “just about to give up” or “just about to move on to the next position.” Sensitivity takes time—time to orient yourself to that particular patient, time to “drink them in,” and time for them to feel comfortable with you. Throughout the seminar, all of us, including Beth, expressed the moment of anxiety we felt when finding someone’s pulse and suddenly realizing we didn’t recognize any sensations. This anxiety—the pressure to feel something—actually reduced our sensitivity. However, by slowing down, breathing, and re-embodying ourselves, sensations began to emerge, and the care of the Other could begin.
In the previous sections, I have considered how a practitioner’s touch can invite a patient to come back into their body, feel what they are feeling, and tell their story. I have also considered how, as a sensory modality, pulse diagnosis depends upon the practitioner’s groundedness and sensitivity. Each of these sections has dealt with the patient-practitioner relationship but has approached it from the angle of one or the other. In this final section, I ask, what type of relationship does this type of presence (grounded and embodied) engender between patient and practitioner? I argue that healing takes place neither solely through the patient nor solely through the practitioner but, rather, through a third, intercorporeal space of conversation and transformation.

This section picks up where the last section left off, extending Foucault’s argument about “care of the self” to “care of the Other” (1998). Engaging this ethical question, I consider how CCM healing modalities encourage the avenue to healing as presencing (descending touch) into the Other through a descent into self. I begin with a conversation with Johnson, an acupuncturist and professor of “Palpation and Perception,” who lays the foundation for touch as conversation. I then move to a clinical encounter to consider how this relationship manifests in practice and the possibilities it opens up for healing. Throughout, I draw upon Gale’s theories of “body-talk” and
“body narratives” (2011)—emerging during her fieldwork with osteopaths and homeopaths—and Csordas’ model of intercorporeality (1993).

**Conversing with the Body**

I now consider a conversation with Johnson, an acupuncturist and professor at NUNM. Moving beyond how students develop touch perception, I consider Johnson’s understanding of the relationship this type of touch creates between patient and practitioner—one grounded in conversation.

Johnson and I first met at his practice in Southeast Portland, a small building that shares a lot with a glass company. The building is clearly marked as a space for alternative medicine, advertising acupuncture and herbs (with a separate entrance for each), and Chinese characters covering the door. The moment I walked in, I smelled warmth and spiciness—probably from the herbal side—and was offered tea while I waited.

One of the interns had suggested I reach out to Johnson based on my interest in “perception,” since Johnson teaches the “Palpation and Perception” courses at NUNM. Indeed, I had been struggling to write about perception. To begin with, what does it even mean to perceive an Other? What precisely is being perceived, and how? Particularly since Johnson’s classes on perception incorporate touch—“palpation”—into the title, I hoped he could help me make sense of this relationship.
Johnson found me in the waiting room and led us outside to a picnic table in a grassy patio area behind the clinic. He wore casual clothes, a grey t-shirt and plain pants. He has practiced clinically for about 15 years, and as we began to talk, he struck me as kind, straightforward, and funny. He seemed to prefer accessible explanations—grounded in practical examples—for what could easily become heady, theoretical concepts and even described himself as decidedly “normal.”

When teaching (and learning) information about or models of the body, Johnson always keeps one question in mind: “How is the body experiencing itself?” His response to this question contrasts with what he sees as the biomedical approach:

Our culture is dominated by a mechanistic metaphor, and we apply the metaphor of the machine to the body, and then we explain the body based on the machine, and then we think we understand the body…But all of that misses that the body’s not a machine, actually. The body’s something totally different, and then we have to ask, if the body’s not a machine, what is it? And then if it’s not experiencing itself as if it were a machine, how is it experiencing itself?

Johnson’s study of the nature of the body—and its experience of itself—is neither abstract nor objectified. Instead, he is very conscious that his (sensorial) understanding of the body manifests each time that he lays his hands on a patient. Every clinical encounter and every touch is his attempt to answer the question, how does the body experience itself?

And if we start to explore that, how would we approach the body differently? And from that place, there can, some exchange can happen. If I approach you as if you’re a machine with my hands, my hands probably aren’t gonna find very much out about you because you’re not a machine…

Critical to this “somatic mode of attention” (Csordas 1993) to his patients is the acknowledgement of an “exchange.” The patient is restored to the clinical encounter—not as object nor as a passive recipient of touch—but, rather, as an active participant in this interaction.
As Johnson makes clear, his mode of attending to another body is inextricably linked with his conception of that body and its experience.

Partway through my conversation with Johnson, a young woman named Eliza, who works at the clinic, came and joined our conversation. She was quiet and hesitant at first, but their close mentorship was evident through their casual touches and easy flow as they looked to each other to help finish each answer. She built on Johnson’s description of the patient-practitioner “exchange”:

What he’s developed, which is a really interesting way of studying, way of approach, which is like to learn about different maps of the body as it knows itself and those maps can be overlaid and intertwined and sort of like interchanged throughout a treatment session based on what that body is expressing and that fluidity of being able to I guess converse with the body in different levels, so levels of tissue or like levels of different systems that are interconnected. That allows just a, I guess it allows a more fluid exchange, it allows I guess treatment and therapy to flow in a way that is organic, which, the body is an organic system so it kind of needs it. There’s a meeting.

The maps that Eliza references are a particular way that Johnson has developed for approaching the body. Many of these maps are anatomical in nature—a map of the bones, a map of the muscles, a map of the connective tissue. When we think of anatomy, we may think first of the standardization that biomedical textbooks suppose/impose: a drawing of “the” (genderless, race-less) human body. Indeed, as Margaret Lock points out, “the medical gaze cannot be thoroughly standardized; bodies and their ailments are not exactly the same, but the goal of clinical biomedicine is nevertheless one of pinpointing internal bodily truths” (2010:42).

As Johnson uses, them, though, these maps are far from universalizing or objectifying. Instead, they provide different lenses—or different anatomical frameworks—for approaching each individual patient. They are not temporally static, as the different maps can be “interchanged
throughout a treatment” depending on how the treatment is progressing. Johnson also does not assume these maps to apply to every single body in the same way, instead adapting them “based on what that [particular] body is expressing.” This brings us back to the concept of conversation. The word “map”—which conjures a textual, static image—obscures how Johnson brings these maps to “a meeting” where he can “converse with the body in different levels.” I argue that these “maps” more closely resemble conversation starters. Johnson enters the clinical interaction with an idea in mind of how the patient’s body might look and might respond, but it offers a starting point for the exchange, rather than a concluding statement about how the body is (or ought to be).

If we are to propose the clinical encounter as a conversation, then we must consider the nature of language and communication. Johnson compares the dialogue that happens during treatment to a verbal dialogue between two people:

We operate from a school of thought where there’s a dialogue like we’re having now, but I can also put my hands here and now I’m having a dialogue with Eliza, her tissue. And I’m touching her in such a way. Just like we can make eye contact in such a way that starts to draw you towards me, you’re like, oh, wow I really want to talk to this person, or I can be like, and you can be like, woah, right? So we can touch in the same kind of way, same thing. So I can learn a means of contact that her tissue’s gonna go oh, that’s interesting and start to sort of come towards and then we start to end up in an exchange together.

For Johnson, there are certainly similarities between verbal communication and communication through touch—at least in the sense that we can talk about both as a form of “language.”

In her study of osteopaths and homeopaths, Nicola Gale introduces the concepts of “body-talk” and “body-stories” for discussing embodied narratives as language (2011:237-251). She defines “body-talk” as “the ways in which the embodied patient is able to communicate with the
practitioner,” acknowledging the “dialogical character of the therapeutic encounter” (2011:240). Perhaps the most critical similarity among these forms of “language” is the coming together of two active subjects. Even when structured, conversations are neither fixed nor controlled entirely by one subject. They inherently involve two people actively participating and choosing what to say. Gale points this out when she says, “This language used—‘dialogue’—highlights the extent to which osteopathic treatment happens at the point of interaction between two embodied agents, rather than being simply imposed on a passive patient’s body” (2011:241). When thinking of the patient-practitioner interaction in a biomedical framework, we may assume the practitioner to be an active participant, but CCM’s framework of “conversation” restores the patient to this inter corporeal action.

Unlike a spoken or verbal conversation, though, as Johnson points out, this narrative is unique because our body not only has (or tells) our story but also is our story:

So we’re talking about perception, story is an avenue towards perception. If you start to tell me your story, I start to be able to perceive you in a certain way, and then if I’m willing and open to integrating that into also the story of your body, then the two are together which is now then we’re back to how is the body experiencing itself? The body’s not experiencing itself separate from your story. Your body is your story. You are your body.

In his study of somatic modes of attention, Csordas describes the theoretical contrast between “the semiotic/textual standpoint of the body as representation” and “the phenomenological/embodiment standpoint of the body as being-in-the-world” (1993:136). Even if we take the phenomenological approach, we still have to consider how some somatic modes of attention actually more closely resemble the textual standpoint. In other words, though we are analyzing from a phenomenological standpoint, we may find that a practitioner attends to a
patient’s body as text, or representation. In the passage above, Johnson makes the leap from story as representation to story as being-in-the-world. Patients’ stories are neither representations nor abstract symbols; their bodies are their stories are themselves. “Listening” and “perception” both refer to cultivating an awareness of this body-story-self, then—an ability to invite and surface this narrative through touch. A touch that says, “I’m here, and I’m listening.”

So, what type of language is the patient using here, and where (in the body) does that language come from? As Eliza says, “I think the process of meaning making, making meaning out of the information is like developing a narrative, or kind of understanding just the embodied history that’s there in the tissue.” Again, this narrative—and language—is not abstract or removed from the body. Instead, it’s actually present in the tissue and flesh. Even more specifically, Eliza explains, these stories can center on each acupuncture point:

Both of those disciplines [the osteopathic tradition and the Chinese medicine tradition], they’re built on not really separating the physical form from a more energetic, emotional, or mental construct. So those things are, even in a little data point of information or location on the body, like a hologram, you can access, you can access a holism within each point. So the, yeah, within each contact point, so there’s like a field, a whole field of storytelling possibility in each.

An embodied conversation between patient and practitioner may be unpredictable and surprising, but it is not random or unstructured. In other words, the practitioner brings their own tools to the conversation—a knowledge of the body, of its “maps,” and of the contact points. As discussed in the previous section, the practitioners knowledge also takes the form of a grounded, sensorial-ly aware presence, but as seen here, that alone is not sufficient. Instead, patient and practitioner join together—as selves attending to their own and one another’s bodies in a particular way—and create something that neither could alone: a narrative, told and heard through touch.
The tools—or conversation starters—that the practitioner brings to the conversation are dependent on their understanding of how the body communicates. Returning to Kuriyama’s tracing of the divergence of Greek and Chinese medicine, he uses the concept of qiemo to discuss how practitioners of Chinese medicine listen to the body:

Qiemo, in other words, entailed touching a person in a manner parallel to the way we listen when a friend says, "I don't care anymore," but we hear in her tone the bitter lingering regret; when we listen, that is, not for the abstract impersonal meaning of single words, but hear the latent spirit behind them. Restated more generally, my thesis is that the history of conceptions of the body must be understood in conjunction with a history of conceptions of communication. When Greek and Chinese doctors palpated the body, they were guided not only by specific beliefs about the arteries and the mo and the organization of the body, but also by broader assumptions about the nature of human expressiveness. (1999:107-108)

As Kuriyama argues, practitioners approach and listen to the body in a manner that reflects how they believe bodies express themselves. Here, we return to my argument from the first section and see how it shapes the clinical encounter. If, as I argue, CCM practitioners see patients as embodied and focus on their lived experiences, then the touch sensibilities these practitioners cultivate will aim to listen to this type of body. Next, I consider this in light of a specific clinical encounter.

Towards Healing

Given the framework of touch as conversation, I’m now interested in how that might manifest in practice. Again, how are patient and practitioner attending to themselves and one another, and what type of relationship does this engender? To explore this, I consider a clinical encounter I witnessed while shadowing a shift led by Landon, a NUNM practitioner and professor who does acupuncture at Outside In.
During this particular treatment, Landon not speak, but we had a conversation about its significance afterwards. In that conversation, he used the word “trauma” repeatedly to describe what his patient suffered. However, he confided that he isn’t as interested in the specific notion of “trauma,” per se, but rather, in the way that term disrupts the mind-body duality. He appreciates the fields it has advanced, such as somatic psychology and our understanding of the neurological processes involved. Likewise, I’m less concerned here with defining “trauma” as such, or contrasting Landon’s understanding of trauma with more biomedical definitions. Instead, I would like to point out the limited vocabulary available for describing suffering in an embodied way and to use “trauma” as Landon has—to disrupt the mind-body duality.

While observing Landon during appointments, I was struck by his constant touch. He jumped right up on the bed with each patient, sitting hip to hip as if he had known them for years (which, for many, he had). As they talked, his hands were constantly finding them—taking their pulse, patting their back, or stroking the channels on their legs. After patients finished their stories, Landon would ask a few follow-up questions, close his eyes, motion his hands as he thought, and then list off a combination of points with a decided certainty. Students normally did the treatments, but with this patient, Landon did part of the treatment himself. I struggled to hear the conversation preceding the treatment; the woman mentioned she was still having nightmares but that they didn’t need to go into all that stuff again.

This particular encounter began like most of Landon’s appointments, with him sitting on the bed next to the woman. I struggled to overhear the conversation, but she mentioned that she was still having nightmares and that they didn’t need to go into all that stuff again. When I talked to
Landon later, he explained to me that apparently something had triggered her. Since he’s known her for a while, he seems to be able to zero in and “feel” or “see” where “it” (the trauma) is sitting in the body. After all, he points out, those things tend to situate themselves in the body.

Once he found it, he began treatment. He moved to the right side of the patient, standing beside her. He cupped his right hand in front of her, on her chest. He sort of pinched his left hand on her neck. He closed his eyes, but something wasn’t right. He went to the other side of her. Then he started to laugh: “What am I doing?” He looked at the intern and I. “It’s my left hand!” He waved his left hand and walked back around to the patient’s right side. He resumed the same position. He stood there, eyes shut, mouth open, silently for a short time (I’m not sure how long; the whole process probably only lasted one or two minutes). He was breathing deeply, and then his hands started visibly shaking. Though his eyes were closed, they seemed to roll back in his head. Suddenly and rapidly, in one swift movement, he pulled his left hand back, and you could tell even without an explanation that he was pulling something out of her. He sort of opened his hand behind her, as if to release whatever it was. She had her eyes closed throughout the whole procedure, and after he had pulled “it” out, she breathed a sigh of relief. He gently and affectionately rubbed her shoulders, looked into her now open eyes, and then left. The patient immediately laid down comfortably. Throughout the entire thing, Landon did not speak any words.

Afterwards, Landon explained that his history and relationship with this patient are critical to sensing her in this way. He recounts that one time when she came in, he immediately recognized that she had been triggered even though she didn’t realize that herself (at least not in a verbal,
articulated sense). He could see a rod sticking horizontally through her knee, so he pressed a needle in until he reached it and then pushed the rod out. She called him later and said that as soon as he did that, it released whatever it was. When I asked him what he meant by “feel” and “see,” he explained that it’s difficult to verbalize. Instead, he repeated the motions for me: his right hand is the hand that pushes it out (“push the eject button”) while his left hand sort of pulls it out the other side (he makes the same pulling gesture as he pops his mouth).

In making sense of this encounter, it’s helpful to return to Csordas (1993). In exploring potential somatic modes of attention, Csordas considers the role of a number of concepts, such as imagination and perception. Here, I’m interested in intuition:

I think it is not difficult to conceive of intuition as embodied knowledge. Then why not conceive of revelatory phenomena as sensory intuition? Healers as well as physicians not only share with their patients a highly organized set of bodily dispositions summarized by Bourdieu (1977) under the term habitus, but also acquire a cumulative empirical knowledge of the range of human distress as they expand their experience. (1993:147)

I argue that this is a possible outcome of a conversation between a patient and practitioner who recognize themselves as embodied—sensory intuition. Landon certainly is an experienced healer, and he is very sensitive to both his own embodied presence and that of his patients. He has undertaken the practices of “care of the self” described earlier, and he has learned to attend to himself as an embodied being. This can be understood as an ethical gesture. In writing of the Huan Di Neijing (Yellow Emperor’s Classic of Internal Medicine), Larre writes:

*Those who are good at speaking of men must be satisfied with themselves.* This is the third level of relationship, a consequence of Heaven plus antiquity. The first level (Heaven) is the unity of life in each being, the second level (Earth), the continuity of life from antiquity to the present. The third level (Man) is the multiple individual lives and their relationships. If you do not have a good relationship with yourself, you are unable to have a good relationship with another. You first must have a deep understanding of your own life before pretending to know life in another, especially the disturbances in the
Therefore, the time, practice, and conscientious cultivation Landon has undergone are ethical gestures intended to make caring for his patients possible. This manifested in this clinical encounter, in which we have seen how Landon opened up the possibility of healing through touch alone.

Landon explained that words weren’t necessary. “The fact is that we don’t need to go into the narrative of the circumstances because it’s in the body.” In other words, trauma may be “pre-verbal.” From Landon’s perspective, healing can take place through touch alone because both the narrative and the trauma are within the patient body. In other words, all of the information about the patient’s illness is available through the pulse—both the temporality and the nature of the trauma. Thus, there is no need for the patient to share the narrative verbally—or even to be conscious of it in a verbal sense—because they have shared it with him through touch. The trauma itself is also located in the body, allowing him to communicate with the body and to heal the trauma through touch. There’s no need to translate the trauma into verbal language because that place in the body (the rod) is not a symbol of the trauma but actually is the trauma. Thus, by re-embodifying both illness and narrative, we can imagine a healing interaction that takes place through touch alone. Indeed, Landon’s difficulty in articulating this process suggests that, even as a practitioner, healing in this embodied way doesn’t require translation back and forth between verbal and touch communication but can occur entirely through touch. In fact, Landon cautions against orality. He points out that even if you recognize the signs of trauma, such as in a patient’s pulse, you don’t want to bring their attention to something they’re not equipped to
manage. However, even in the non-verbal process of healing, he believes you are bringing their attention to a certain part of their body, which they can then heal.

In conclusion, this particular healing encounter is made possible through the touch sensibility that Landon has spent years cultivating. He has cared for the self in this way, and through this self-care, he has developed an intuition, or an attunement, to his patients that guides his treatments. In line with Foucault (1998), care for the Other has been made possible through care for the self. Were this woman to undergo a biomedical diagnostic test, it is possible the test wouldn’t indicate any measurable abnormality in her chest. She would have been left to question her experience of trauma and its legitimacy. However, by touching her in this way, Landon acknowledges her trauma as actual and invites her to descend into her experience of it—in the words of Das, “to inhabit the world, or inhabit it again, in a gesture of mourning” (2007:62).
Conclusion

In this paper, I have followed students beginning to practice CCM at their university, their experienced practitioner-teachers, and students learning the Shen-Hammer pulse diagnosis system in a weekend workshop. In my observations and conversations, I have taken particular interest in how patients and practitioners come to relate to one another and themselves through touch. Drawing upon Csordas’ “somatic modes of attention,” how does touch shape the ways in which patients and practitioners attend to themselves and one another? How does touch relate to healing, and what type of patient-practitioner relationship does this touch engender? I have proposed that touch—particularly through pulse diagnosis—invites both patients and practitioners to descend into their bodies. For patients, this gesture of descent involves integrating their pain into an everyday, embodied sense of their self. For practitioners, this gesture of descent involves cultivating a sensory awareness through one’s fingers. Finally, by attending to one another in this way, patient and practitioner create a third space of conversation, transformation, and healing. These modes of attention challenge the standardized touch aspired to by biomedical technologies, particularly diagnostic techniques that obscure the practitioner’s body and posit the patient as a passive body to be diagnosed. By instead relying on the relationship between practitioner and patient as particular, embodied individuals, touch in this ethnographic context opens up new possibilities for being with ourselves and others in clinical encounters.

Although touch factors significantly in pulse diagnosis and acupuncture, it is only one of the sensory modalities used for diagnosis-treatment. Further research is needed on the role of the ear
(such as the attention practitioners pay to patients’ voice—its pitch, rhythm, and tone), the
tongue, and the nose. Finally, it is important to bring in the role of speech and orality. For
example, Landon points out that some people do want or need to narrativize, and there’s
certainly room for that in the clinic, too. According to Natalie, the mouth is connected to the
heart organ, which explains why verbalizing pain can be such a critical part of healing. From this
perspective, we are no longer so concerned with the words themselves but, rather, with the
opening of the lips and the rise and fall of the tongue. Considering the mouth in this way—as
integral to the embodied self, rather than just a means to the higher end of orality—opens up the
entire body as an integrated narrative, rather than privileging verbal ways of knowing over
others.

Considering this approach to touch—and how students learn it—certainly has implications for
medical education. It particularly raises questions for MD’s coursework, which addresses touch
minimally, if at all. It could be argued that education reflects practice; if MD’s no longer even
need to touch patients in order to take the pulse (which pulse oximeters now do), then what value
is there in teaching that skill? If, however, as I hope I have shown here, touch is an extremely
powerful sensory modality for treatment, then perhaps we must reconsider the place of touch in
biomedical practice more generally. Does our aspiration to standardized touch through machines
best serve our commitment to heal, and how do we account for the power that affectionate
gestures still hold in hospitals—a pat on the back, a stroke of the arm? Particularly as we
incorporate new technologies that remove previously manual tasks, we will have to grapple with
these questions and their implications.
Bibliography


