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American Chinese Medicine

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I, Tyler Phan confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Abstract

This thesis explores the power structures which shape Chinese medicine in the United States. Chinese medicine had two incarnations: migrant Chinese practice and its professionalized form. From the 1880s to the 1940s, Chinese medicine was practiced by the Chinese diaspora to serve their communities and non-Chinese settler populations. From the 1970s onward, Chinese medicine professionalized under the agency of acupuncture. Through the regulation of acupuncture, groups of predominately white Americans began to create standards of practice based on the enactment of what I have referred to as “orientalized biopower.” Orientalized biopower is the process where America’s predominately white counterculture began to encompass an orientalism which romanticized a form of Chinese medicine constructed in the 1950s by the People’s Republic of China called Traditional Chinese medicine (TCM). With the adoption of TCM in the United States, they also formulated measures which marginalized Asian Americans practitioners. The profession then labelled itself as “Oriental Medicine” embodying Edward Said’s concept of Orientalism. Along with this form of orientalism, the counterculture used the State to push for a standardized epistemology of TCM. In return, the State encompassed standardized Chinese medicine as element of biopower.

My research is informed by a cross-country ethnography of schools, regulatory bodies, and private practices around North America. Through my investigation, I discover the power structures of Chinese medicine, contained within the regulatory bodies and schools, are mostly dominated by white Americans. Combined, they construct a profession and determine the “legitimate” and “illegitimate” forms of Chinese medicine, which constitutes the criteria for who can and cannot practice legally in the country.

Table of Content

Abstract	3
Table of Content	4
List of Illustrations	6
Acknowledgments	8
Chapter 1 Introduction	9
1.1 Method of Application	10
1.1.1 Position of Research	10
1.1.2 Chinese Medicine	14
1.2 Contributions to the Field	17
1.3 Limits of Research	20
1.4 Outline of Chapters	26
Chapter 2 Historical Context	29
2.1 Orientation of Orientalism	29
2.2 Patrician Orientalism: Chinoiserie and Acupuncture	31
2.3 Migration and Medicine	34
2.4 Commercial Orientalism	37
2.5 Pacific Coast	40
2.5.1 San Francisco and Oakland, California	41
2.5.2 Los Angeles, California	45
2.6 Rural Encampments	47
2.6.1 Fiddletown, California	48
2.6.2 John Day, Oregon	48
2.6.3 Boise, Idaho	49
2.7 Political Orientalism: Labor, Racism, and Chinese Exclusion	51
2.8 “Regular” and “Irregular” Medicine	62
2.9 Chinese Medicine’s Persecution	71
2.10 Conclusion	75
Chapter 3 Orientalized Biopower	77
3.1 The Construction of American Chinese Medicine	77
3.2 “In the Right Place at the Right Time” or Opportunism?	81
3.2.1 The Spread of the UCLA Cohort	84
3.3 Orientalized Biopower	87
3.3.1 Counterculture Orientalism	92
3.3.2 Biopower	105
3.4 Chinese Medicine as Cultural Appropriation?	113
3.5 Conclusion	117

Chapter 4	Professionalization	119
4.1	Chinese Medicine as a Profession	119
4.2	History of National Regulatory Bodies	121
4.3	NCCAOM	129
4.4	ACAOM	133
4.5	CCAOM	143
4.6	California	146
4.7	Nevada	153
4.8	Maryland	157
4.9	Conclusion	159
Chapter 5	Traditions	163
5.1	Traditional Chinese Medicine (TCM)	163
5.1.1	Herbs	182
5.1.2	Acupuncture	185
5.2	J.R. Worsley's Five Elements	195
5.3	Classical Chinese Medicine (CCM)	212
5.3.1	Nguyễn Văn Nghị and Sean Marshall	213
5.3.2	Heiner Fruehauf	217
5.3.3	Jeffrey Yuen and Jade Purity	220
5.4	Conclusion	223
Chapter 6	Decoding Chinese Medicine (Conclusion)	224
6.1	Who Practices American Chinese Medicine?	224
6.2	Standardize a School's Legitimation	228
6.2.1	First-Professional Doctorate (FPD)	230
6.3	Titles in the Profession	236
6.4	Debt and Gainful Employment	239
6.5	Is Dry Needling Acupuncture?	244
6.6	Community Acupuncture and Liberation	251
6.6.1	Lincoln Detox Center	254
6.6.2	Taiwanese Traditions	258
6.6.3	Combating the Financial Bubble	260
6.7	Solutions from Britain?	262
6.8	Final Thoughts	264
Bibliography		265

List of Illustrations

Figures

- Fig. 2.1 Fortified Door and Wooded Block Embedded in the Floor at Kam Wah Chung
- Fig. 4.1 NCCAOM's Governance
- Fig. 4.2 The Evolution of Regulatory Bodies
- Fig. 5.1 "Pattern differentiation" (*bianzheng*) according to the *Outline of Chinese Medicine*
- Fig. 5.2 Six Sections of the Tongue
- Fig. 5.3 Pulse Positions
- Fig. 5.4 "Big Picture"
- Fig. 5.5 Steps of a Practitioner for Diagnosis and Treatment
- Fig. 5.6 Comparison Between Honma Shohaku's Five Element Chart (Left) and J.R. Worsley's Five Element Chart (Right)
- Fig. 5.7 Basic Model of Five Elements from Five Element Tradition
- Fig. 5.8 Five Element Based on the Five Antique Points Within an Element: Worsley (Left) and Honma (Right)
- Fig. 5.9 Three Levels of the Body

Tables

- Table. 1.1 Treatments at Different Sites
- Table. 4.1 NCCAOM's Pre-Graduation Hour Requirements for Taking Examinations
- Table. 4.2 NCCAOM's Content Outline
- Table 4.3 ACAOM's Master's Degree/Master's Level
- Table 4.4 ACAOM's Master's Degree/Master's Level Program Length
- Table 4.5 ACAOM's Postgraduate Degree Programs
- Table 4.6 Comparison of CALE Content Percentage
- Table 5.2 *Zangfu* matched with the Corresponding Phases
- Table 5.2 Pulse Qualities
- Table 5.3 Ten Interview Questions
- Table 5.4 Commonly Used Texts for Exams and Curriculum from 1980s-1990s
- Table 5.5 *Zangfu* Pattern Differentiations with Acupuncture & Herbal Treatment
- Table 5.6 Herbal Actions/Strategies
- Table 5.7 Formula Strategies of CALE
- Table 5.8 Classical Order-Circulation, Phase, and Number of Points on Each Meridian
- Table 5.9 Worsley's Numeric Organization of the Officials (*Zangfu*)
- Table 5.10 Five Antique Element/Phase Correspondence
- Table 6.1 Class Demographics of Chinese Medicine Schools
- Table 6.2 ACAOM's Fees for Accreditation
- Table 6.3 Doctoral-level Schools in the United States
- Table 6.4 Common Title Abbreviations of Chinese Medicine Practitioners

Table 6.5	Profession's Title
Table 6.6	Gross Annual Income
Table 6.7	Satisfaction of Chinese Medicine School Preparing Students for a Career
Table 6.8	Chinese Medicine Schools Listed as "Fail" but the U.S. Department of Education "Debt-to-Earnings" Criteria
Table 6.9	Herbal Formula Prescribed

Graphs

Graph. 6.1	Racial Demographic for Chinese Medicine Practitioners in the United States
Graph. 6.2	Gender Demographic for Chinese Medicine Practitioners in the United States
Graph. 6.3	Age Demographic for Chinese Medicine Practitioners in the United States
Graph. 6.4	Student Loan Debt Among Graduates

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Chapter 1.

Introduction

This thesis focuses on the power structures which shape Chinese medicine in the United States. It begins with my own experience as an acupuncturist when I realized the insertion of hair-thin needles into someone for therapeutic value involves multiple systems of control. The mechanism of this system led me on a four-year journey through a compulsory education, followed by a year preparation for a national board examination, and thousands of dollars in debt. Once finished, I found myself in a world my school did not prepare me for, small business ownership.

In hindsight, the vast majority of my educational experience did not relate to the safety of the patients, as often boasted by state¹ licensures and regulatory bodies. I was expected to memorize and reiterate abstract medical theory based on orientalist assumptions and translations of Chinese ideas such as *qi* or *shen*. The frustration I and many others encountered was the inability to relate the information from the national boards examination to live patients. Years later, this disconnect resurfaced in academia as an anthropologist. Viewed through the lens of the social sciences, many of what my Chinese medicine friends and colleagues deemed as “political,” were issues concerning culture, society, technology, and economics. The tedious process I experienced as a young adult led me to interrogate the process anthropologically and examine the cultural and historical significance of the medicine.

As an alternative system of care, Chinese medicine has always been positioned as a healing modality different from the conventions of allopathic biomedicine.² Through self-reflection and critical analysis of what would

¹ Capitalized “State” refers to as the organized political community living under a single system of government or used in “United States.” It can be synonymous used as “government.” Lowercase “state” or in the rare case “State of...” refers to the constituent political entity of the United States.

² I use the term “allopathic biomedicine” instead of “biomedicine” since practices such as chiropractic, physiotherapy, and naturopathy are considered “biomedical” practices rooted in the biological sciences.

assemble as a “profession,” I came to understand Chinese medicine as part of a systemic issue in higher education, corporatization, and student debt. Concerning issues of policy and the actual lives it effects, I felt it was necessary to approach the subject from an applied anthropological framework.

1.1 Method of Application

1.1.1 Position of Research

As a licensed acupuncturist and descendent of a Vietnamese lineage of traditional physicians, I found my position as a researcher had both limits and benefits. As a licensed acupuncturist, I was aware of the nuances of the profession and the role of the regulatory bodies. It could be argued with my position as an acupuncturist, I am of a particular bias in favor of the profession. This presumes the profession has a uniformed ideology: nothing could be further from the truth. Chinese medicine is heterogeneous and so are its practitioners. The views on patient bodies, policy, and institutions vary from practitioner-to-practitioner and as I cover in detail, even the consensus on what to call the medicine is contested.

I began my ethnographic fieldwork in 2014 and since then, Chinese medicine as a profession has substantially changed. Over the course of my research there were changes to the educational institutions: American College of Traditional Chinese Medicine (ACTCM) merged with the California Institute of Integral Studies (CIIS), North Eastern School of Acupuncture (NESA) was bought out by the for-profit Massachusetts College of Pharmacy and Health Sciences, and one of the oldest schools, TAI/Tai Sophia, almost fully transitioned leadership to the Maryland University of Integrative Health (MUIH). In all three cases, the schools shifted from institutions meeting only the criteria for national accreditation, overseen by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM), to a higher standard of education required by regional accreditation. At first sight this may seem to be a positive direction for a school’s legitimacy, but as I uncover in later chapters, this will have numerous negative consequences.

The power structure has dramatically changed in the past decade. One of the nation's most powerful regulatory bodies, the California Acupuncture Board (CAB), has set in motion the process of resigning its power to "approve" Chinese medicine schools by its own standards to ACAOM's requirements. Evidence shows CAB may relinquish its authority to provide the state's unique licensing examination to the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). These changes define an evolution of internal and external influences affecting Chinese medicine. In 2008, the for-profit firm Quad Partners bought nearly half of America's largest Chinese medicine school, Pacific College of Oriental Medicine (from now on PCOM) (PCOM, 2008). It also dissolved the acupuncture program at the Manhattan-based Swedish Institute. Both schools became focused instead on biomedical health sciences.

Since much of my focus is on professionalization and policy, I am using applied anthropology as my theoretical and methodological frame. Applied anthropology specifically addresses the various issues of policy and serves as a lens to critically analyze the medical culture of Chinese medicine within the United States.

Anthropologists Gary Ferraro and Susan Andrea described applied anthropology as "problem-oriented research" which "attempt[s] to apply anthropological data, concepts, and strategies to the solution of social, economic, and technological problems, both at home and abroad" (Ferraro and Andrea, 2010, p. 50). The anthropologist who coined "applied anthropology," John van Willigen, simply describes the method as "anthropology put to use" but also addresses the setting and content of its particular function as the *domain of application* (van Willigen, 1986, p. 7). As van Willigen adds,

By domain of application we mean that knowledge and technique which is relevant to a particular work setting. The domain of application consists of two major components: the methodology of application, which maps the relationships between information, policy, and action; and the context of application, which includes the knowledge relevant to a particular problem area and work setting" (van Willigen, 1986, p. 9).

This thesis is informed by various policies enacted and implemented within the culture of Chinese medicine in the United States. It considers the

historical contextualization of Chinese medicine from Chinese diasporic practice to professionalization through regulation of acupuncture by white middle-class Americans from the counterculture. This shift is as much political as it is social for the issue of race and its power structures define how the medicine is practiced.

Throughout the thesis, I use the term “white” instead of “Caucasian.” I chose “white” for two reasons. First, the common term “Caucasian” is historically racist and geographically inaccurate. Its first usage as a racial category for white people can be traced to two German scholars from the University of Göttingen during the late-18th and early-19th century, Johann Blumenbach and Christoph Meiners. Blumenbach believed racial categorization and hierarchy was based on human skulls where “Caucasian variety” of skulls from Mount Caucasus was the “most beautiful” compared to the “ultimate extremes” of “Mongolian” and “Ethiopian” which were “ugly” (Blumenbach 1865, 265). Similarly, Blumenbach’s colleague Meiners divided humans into two groups, “Tartar-Caucasian” and “Mongoloid.” The former being “beautiful” and the latter “ugly” (Zantop, 1997, p. 23). American historian Nell Irvin Painter points out the absurdity of “Caucasian.”

Once Blumenbach had established Caucasian as a human variety, the term floated far from its geographical origin. Actual Caucasians – the people living in the Caucasus region, cheek by jowl with Turks and Semites of the eastern Mediterranean – lost their symbolic standing ur-Europeans. Real Caucasians never reached the apex of the white racial hierarchy.... Somehow specificity faded while the idea of a supremely beautiful “Caucasian” variety lived on, eventually becoming the scientific term of choice for white people (Painter, 2010, p. 86)

The word “Caucasian” also has a legal context. In 1922, the U.S. Supreme Court case *Takao Ozawa v. United States* ruled Japanese-born Takao Ozawa could not obtain U.S. citizenship as a “free white persons” because he was not of the “Caucasian race” (U.S. v. Ozawa, 1922). The following year, the U.S. Supreme court heard another case, *U.S. v. Bhagat Singh Thind*. Since Bhagat Singh Thind was born in British Punjab, India, scientists such as Joseph Deniker, Augustus Henry Keane, and Thomas Henry Huxley considered this region as “Caucasus” and “Aryan.” Thind claimed he

was “Caucasian” and therefore “free white persons” based on his place of birth. The U.S. Supreme Court Justice George Sutherland ruled Thind was considered “Caucasian,” but it did not qualify him as “white” (U.S. v. Thind, 1923).

The term “white” demonstrates the dominant power structure engrained in American society and shapes much of its political landscape. The professionalized manifestation of Chinese medicine, American Chinese Medicine, is a product of the social condition in the United States. My use of the term “white” not only serves as an identity marker but contextualizes the dynamics of power.

As a first-generation Vietnamese-American, I am ‘betwixt and between’ the cultural and medical landscape. My initial experience with acupuncture and herbs was through my family and work at different traditional hospitals in Viet Nam. When in Viet Nam, I am considered a *Việt kiều* (“Vietnamese sojourner”), not accepted as a native Vietnamese. As an Asian American, my identity does not fit the black and white dichotomy. Asian Americans are also heterogeneous. The racial identifier “Asian American and Pacific Islander” can range from South Asians such as Indians and Bengali to various people from Polynesia. From my “in-between” position, I cannot fully claim my voice as a subaltern. This would betray the struggles of Vietnamese and other Asian Americans who are living and practicing traditional medicine in the margins. The discourse I present reflects musings grounded in Asian American and whiteness studies, with a critical analysis of a standardized medicine which has pushed diaspora practitioner to the margins.

The utilization of theoretical framework, reflects my position as a researcher and practitioner, which is shared by anthropologists such as Volker Scheid who described his lens as “scholar-physician” and Elisabeth Hsu’s more phenomenologically-centered approach she calls “participant experience” (Hsu, p. 1999, 15; Scheid, 2002, p. 25). My position also involves the engagement of policy. Van Willigen has proposed applied anthropology, “as a policy science.”

That is, all policy is concerned with values. Policy formulation involves specifying behavior which is to result in achieving a valued condition. In a sense, a policy is a hypothesis about the

relationship between behavior and values. It takes the form: if we want to be a certain way, we need to act this way (van Willigen, 1986, p. 143).

Policy led to and substantiated Chinese medicine's professionalization in the United States. Van Willigen's correlation between the intended valued condition and behavior reflects the regulatory bodies' envisioned outcome of controlling the profession. American Chinese Medicine is a system of care professionalized by the white counterculture of the 1960s and 1970s, its expression of policy reveals an attempt at an orthodox set of values held by allopathic biomedicine but with an unorthodox set of behaviors. The intended aim for uniformity through standardization, which is the inherent tendency in professionalization, goes against the heterogeneous nature of Chinese medicine. The result of this tension is continuous infighting and a lack of consensus to even the most basic definition of the medicine. With this confusion lingering in the background, it is necessary to have a working definition of what I mean by Chinese medicine.

1.1.2 Chinese Medicine

The most common designation of the profession by regulatory bodies and schools is "Acupuncture and Oriental Medicine" (AOM). This title is problematic considering the issues in postcolonial studies surrounding the term "oriental," which I cover throughout the thesis. If I suspended its colonialist contexts and presumed it meant "East," the term is still problematic because it would also encompass medical practices such as Āyurveda, Tibetan medicine (Tib. *Gso ba rig pa*), or Yūnānī, which are quite different in theory and practice from Chinese medicine. The term "acupuncture" is also limited because it can imply only the use of needles or encompass a range of treatment modalities such as the use of herbs, *gua sha* (刮痧), cupping (*ba guan* 拔罐), or moxibustion (*jiu* 灸). The common Chinese term for "acupuncture," *zhen jiu* (針灸), which literally translates to "acupuncture moxibustion," does not entail herbs. It is for this reason I use the term Chinese medicine.

I used the term “Chinese medicine” (*zhong yi* 中醫) to broadly describe an assemblage of various healing practices which originated from mainland China. It ranges from the practice of acupuncture and herbs to the use of shamanic rituals in exorcism. In this sense, Chinese medicine is not a particular subject but an assemblage of heterogeneous subjects which is traced from China. Volker Scheid describes the multiplicity of the term in his book *Chinese Medicine in Contemporary China*,

Throughout this book I use term “Chinese medicine” to refer to the medicine of the scholarly elite during the imperial era and also to the subsequent transformations in course of the Republican, Maoist, and post-Maoist periods” (Scheid, 2002, p. 3).

Historian Rhonda Chang narrowly defined “Chinese medicine” to represent the Maoist and post-Maoist strand of medicine which emphasized “pattern differentiation and treatment determination” known as *bianzheng lunzhi* (辨證論治). This is in contrast to the term *yi* (醫) which she described as the medicine prior to Western biomedicine, based on the theories of *yinyang wuxing* (Chang, 2015). My description of Chinese medicine does not conflict with Scheid’s definition but it can also be used in the same way Chang defines “*yi*” and “Chinese medicine.” I use the term in this thesis to describe the various manifestations of the medicine from its migration through Asia and its journey to the United States, following the footsteps of ethnically Chinese diaspora.

The term “Traditional Chinese Medicine” (TCM) has been used synonymously with Chinese medicine. Anthropologist Emily S. Wu in *Traditional Chinese Medicine in the United States*, understands the usage of both Chinese medicine and TCM, but allows the narratives of her informants to shape the terms.

It is, caution some Caucasian American practitioners, a system sterilized of the potentially spiritual language and concepts that were previously abundant in the classical Chinese medical literature, and the remaining materials became merely survival strategies implemented by barefoot doctors during the Cultural Revolution. In the context of People's Republic of China (PRC), TCM is a state-regulated medicine. With "superstitious" elements eliminated, clinical efficacy supported by scientific research, and epistemology explained with categories and criteria, there exists a PRC vision of modernized indigenous medicine that is

equivalent to and capable of being integrated with biomedicine, and is able to provide modalities that are often drastically less costly than Western biomedical treatments... In the attempt to answer the question of "What is TCM?" in the following chapters, I will use the terms traditional Chinese medicine, Chinese medicine, and TCM interchangeably to include all the interpretations of the listed above (Wu, 2013, pp. 6, 8).

"Traditional Chinese Medicine" or simply "TCM" was used in the United States by the majority of informants in the field to describe a specific tradition of medicine which was in contrast to Five Elements and Classical Chinese Medicine (CCM). Most informants and scholars (Taylor 2004; Karchmer 2004; 2010; Andrews 2015) have used "TCM" to represent the State-sponsored medicine of the People's Republic of China which was transplanted to United States. My fieldwork delineates Chinese medicine from the profession's use of "TCM" which was often synonymous with "Acupuncture and Oriental Medicine" (AOM). More cautious in the use of TCM, Volker Scheid highlights the potential critical use of the term,

First, the term "traditional" is not widely used in China itself when referring to Chinese medicine. The term "TCM" was created in the mid-1950s for use of foreign-language publications only with the explicit aim of generating a certain perception of Chinese medicine in the West. Second, the term "traditional" invokes the inappropriate sense that Chinese medicine is unchanged or unchanging, neither of which is true. Third, opposing pre-1949 Chinese medicine with post-1949 TCM generates perceptions of discontinuity that, although true in one sense are false in many others. It suggests that post-1949 changes within Chinese medicine are of an altogether different order than changes during previous periods (Scheid, 2002, p. 3).

For Scheid's above reasons, I have used the term "TCM" to describe the specific standardized model the regulatory bodies require students to learn to legally practice in the United States. "TCM" refers to both the medicine and processes perceived by Western practitioners. It denotes a seemingly static, discontinuous, and homogeneous model which distinctly encompasses *bianzheng lunzhi* as the basis of communication and practice. National and state regulatory bodies as well as schools use this standardized model to legitimate the medicine in the professional medical milieu. With the intent of creating higher standards of curriculum and practice, the standardized

practices of California and Nevada inadvertently reveal the heterogeneous formations of TCM in America. Despite TCM's attempt at uniformity, other epistemologies manage to survive on the fringe. In the case of Maryland, the predominance of a non-TCM epistemology changes the state's regulations.

When dealing with policy in the United States, it is important to understand a distinctly American concept, which is known as "states' rights," written in the Tenth Amendment of the Constitution. The idea of states' rights is the ability of states to govern with limited interference from the federal government. This does not necessarily mean there is no interaction with the federal government on the state-level. Instead, it provides states the ability to determine what laws, regulations, and institutions deemed acceptable. States' rights inherently change the practice of Chinese medicine. My thesis focuses on what I have labelled American Chinese Medicine, which encompasses the heterogeneous traditions of Chinese medicine as well as the interplay between the national and state regulatory bodies, schools, and the practitioners.

1.2 Contributions to the Field

Much of my work on American Chinese Medicine is an extension of previous contributions in the field. Anthropologist Linda Barnes has written extensively on Chinese medicine practices in America, specifically in the realm of acupuncture, and has set precedence investigating the various expressions of practice. She has uncovered the infighting amongst TCM and Five Element practitioners in the formation of Massachusetts' acupuncture profession (Barnes, 2003), the complicated issue of efficacy of acupuncture in America (Barnes, 2005b), the religious and anthropological tension of interpreting the psychological dimension of Chinese medicine in America (Barnes, 1998), the various framework which engages Chinese medicine from both Chinese and non-Chinese practitioners through the concept of *xin* (心) or "heart-mind" (Barnes, 2009), the role of race in the expression of Chinese medicine from its overtly religious expression amongst Chinese immigrants practitioners to the more "New Age" approach of white Americans (Barnes, 2005), and the historical analysis of Chinese medicine in the United States in the 18th and 19th century (Barnes, 2005a) as well as a brief analysis of its incarnation in the 20th

century (Barnes, 2013). Barnes has managed to situate Chinese medicine in both its anthropological and historical context, providing a range of expressions in practice and transmission. In two of Barnes' articles, she covers the contrasting epistemologies of TCM and Five Elements from the angle of representation, efficacy, and history (Barnes, 2003; 2005b; 2013). My work will expound on her contribution of these two systems and consider their overlapping historical significance through interviews with key figures of the primary forces.

Anthropologists Mei Zhan and Emily S. Wu have explored Chinese medicine in America through an emphasis on the narratives of Chinese practitioners in the United States as a juxtaposition to the accounts of non-Asian practitioners. In the former, Zhan explores the "translocal" relationship of Chinese medicine, using a multi-sited comparative ethnography of Chinese medicine practitioners in the United States and mainland China to unravel its "worlding." Zhan upholds Chakrabarty's critical analysis of Heidegger, "to use the idea of worlding to talk about the modernist and rationalist mode of knowledge production that privileges the social scientist's analytical relations to the world over lived ones" and instead identify ways through a host of interdisciplinary writers including Chakrabarty which "entail a redeployment of comparability – terms of cultural comparison – by attuning it to shifting spatiotemporal relations that elude the finality of globalism" (Zhan, 2009, 23). Zhan uses a comparative analysis of two different environments to reveal an alternative approach to methods of inquiry used by traditional European and American scholars. Wu approaches Chinese medicine in the United States from a more traditional ethnographic route where her primary focus is on the practice and curriculum at the various schools and clinics in California's Bay Area. Although Wu does in fact cover regulatory bodies such as California Acupuncture Board (CAB) and Nevada's acupuncture board as well as the challenges faced in schools, my focus is to trace the evolution of power within regulatory bodies and the role they had in shaping the contemporary practice and transmission of traditions (Wu, 2013, p. 31, 55-57, 64-66).

Similar to Wu, anthropologist Hannah Flesch investigates the minutia of the classroom experience by examining an anonymized school she refers to as "Emeritus University of Natural Medicine," where she utilizes a critical

anthropological method to explore how policy and state regulation influences curriculum and practices. My research is an extension of Flesch's thesis, where I examine the role of the regulatory bodies in the formation of Chinese medicine practices in the United States (Flesch, 2009). The primary difference between our work is the area of professionalization. My concentration relates to the standards of the profession. As a "house of cards," the profession's foundation is based on abstract Chinese medicine theory rather than safety. Flesch critiques the notion of safety along with efficacy and legitimation as a form of validation to biomedicine (Flesch, 2009, p. 86). I argue if there were to be standards to the practice of Chinese medicine in America the discussion of safety should have precedence over abstract Chinese medicine theory, especially in a country notorious for lawsuits.

In addition to Wu and Flesch, anthropologist Sonya Pritzker has also dealt with the Chinese medicine classroom, particularly focusing on the linguistic role in translating the Chinese medical nomenclature to English, which she identifies as "living translation." Influenced by Hans-Georg Gadamer, Pritzker used his lived hermeneutic of expression as a "living translation,"

Living translation weaves together morally situated desires for authenticity with culturally grounded notions of healing in everyday practices of writing and teaching about Chinese medicine. It is about learning specific words, but also about ways of speaking, ways of interacting, and ways of being (Pritzker, 2014, p. 9).

As a Chinese medicine practitioner from a linguistic anthropological approach, Pritzker illustrates the dynamic role of translation at a Chinese medicine school and the fluidity it has when the enactment of translation occurs. I contend the movement and flexibility of translation is threatened by standardization. When regulatory bodies attempt a mono-epistemology of Chinese medicine for the semblance of uniformity, it inherently marginalizes people and traditions. Similar to Pritzker, anthropologist Mitra Clara Emad approached the translation of Chinese medicine from a phenomenological angle at the Oregon College of Oriental Medicine (OCOM). Emad also asserts acupuncture in America signals a form of cultural appropriation,

I argue that the appropriation of a practice – like acupuncture – occurs betwixt and between hegemonies and subalterities, betwixt and between the outright seizure of a cultural form and the loss of culture so often identified with “whiteness” and “middle-classness” in American culture (Emad, 1998, p. 20).

I can understand Emad’s premise, though Chapter 3 of my thesis complicates the idea of cultural appropriation with its heterogeneous expressions as well as the blurred delineation between exchange and appropriation. Emad’s work, nevertheless, expresses a rich phenomenological investigation of acupuncture in America through practitioners’ engagement with bodies.

Lastly, sociologists Marian Katz has written on the subject of Chinese medicine in the United States from a more patient-centered analysis through the exploration of patient-practitioner dynamics. Throughout her exploration, Katz identifies the various stages of treatment and fluctuations as well as how care from Chinese medicine practitioners differs from allopathic biomedical physicians (Katz, 2011). In Katz’s exploration, I stumbled upon limits to my own research and incidentally developed a method of understanding patients’ perceptions of care by electing myself as a patient and receiving treatment at the various schools and clinics throughout the country.

1.3 Limits of Research

Throughout my research for the thesis I came up against a few limitations, some of which questioned the ethics of the institutions. The first and most common limitation was access to patients. In almost all schools I researched, many of the administrators cited the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as a reason to not observe patients. Despite my insistence for the anonymization of patients and full cooperation with the schools’ Institution’s Review Board (IRB), my request was still denied. As I discovered later, either the school had no IRB or did not know how to file an ethnographic survey of patients. This led me to pursue an augmented method of observation which resembled sociologist Erving Goffman’s participant observation at St. Elizabeth’s Hospital in Washington, D.C. (Goffman, 1961). I positioned myself as a patient and received, in most cases,

acupuncture treatments at various schools and clinics, with a baseline of symptoms I experienced throughout the ethnography,³ seen in Table 1.1.

Date	City/State	Diagnosis: Pattern Differentiation	Treatment
11/18/15	Portland, Oregon	(1) Sp Qi Xu -> Damp accumulation & Lu Qi Xu (making more sensitive to damp & cold) (2) St Yin Xu -> Heat	CV-9, Lu-9, Sp-3, Kd-27 (ah shi), Kd-26 (ah shi), St-36 + Sp-9 (R), Lr-3, St-44 (L)
11/24/15	Portland, Oregon	Taiyin Disharmony, Sp Qi Xu, Yangming Heat	Tonify Earth Oil: Lu-9, SP-3; Low OM Earth Forks: Lu-9, Sp-3; In-out tonification: Lu-9, Sp-3, Tonify Metal Oil: LG?-1, Tuning Forks: Kd-1, St-36
12/5/15	Culver City, CA	(1) Local Qi & Xue Yu for all 3 neuromuscular / Joint Pain (2) Liver Qi Yu w/ heat (Liver Qi Stagnation w/ heat) (3) Kidney Yin Xu + Lung Qi Xu (Kidney Yin Deficiency + Lung Qi Deficiency)	(1) L-side: SI-12, 13, 14, Ashi pt. (2) L-side: LI-12, 11, 10, Ling gu and Da Bai (3) R-side: Lu-5, 7, PC-6 (4) R-Side: St-36, GB-34, St-44 (5) L-Side: Ki-4, Sp-4, Liv-3, Ren-17, Shuitong - Jin B/L
1/2/16	Santa Fe, NM	Lung Qi Xu with Liver constraint	Ear: Shenmen, SCALP: Foot Motor/Sensory, LI-11, KI27 or CV21-17?, LU8, LU7/KI6, LR4
1/26/16	Gainesville, FL	Fire (SI) CF	Song of the 7 Internal Dragons a/k/a IDs, I-7 Spirit Gate (HT-4) and II-4 Wrist Bone (SI-4).
2/2/16	Gainesville, FL	(1) Ht Qi Agitation - (stable) (2) Kidney Yin Deficiency (3) Lung Qi Deficiency (4) Lung Blood Stagnation (5) Stomach Heat (6) Heart Yin Deficiency	K4, Lu9, BL13, 23, 17, P6, 2 Ah Shi pts underneath Left scapula
3/11/16	Sugar Grove, NC	Kidney failing to grasp Lu Qi w/ Small Intestine tendino muscular channel blood stasis	SI-15 threaded downward, SI-11 + SI-12 + SI-13 manipulated until muscle fasciculation was observed, Huatojiaji @ T5 threaded to T6, GV-9, SI-3, SI-1, Sp-21, Lu-9, Kd-3, Kd-7, XB-6, Sp-4, BL-49 [fire needle]
3/12/16	Asheville, North Carolina	Lu Qi Constraint, UJ/MJ Dampness	Gua lou shi [18g] Hou po [12g] Zhi shi [12g] Zhi zi [9g], Sang bai pi [9g], Fu ling [9g], Ban xia [9g], Chen pi [9g], Gan Cao [9g]
5/5/16	Pittsburgh, PA	Metal not Feeding Water	K24, 7, Lu1, 8, GV-4

Table 1.1 Treatments at Different Sites

Some limits to this method came when practitioners knew my identity. When identified as an anthropologist and acupuncturist, I noticed a certainty and confidence in approach, as if veteran practitioners. When I remained

³ Baseline symptoms: Asthma, forgetfulness, pain in left scapula, pain on both tibia tuberosities, knees pain, dry/oily skin, weight gain, weak shoulders. The Diagnosis and Treatment will be explained throughout the thesis.

anonymous and requested my medical file, suspicion arose among practitioners. In one situation my identity was exposed and noticeably affected how the practitioner viewed me as a patient. In roughly a half dozen treatments, I still have not received my medical file, which posits either ethical issues or a lack of communication.

Since I elected myself as a “human guinea pig,” it presented the possibility for me to experience adverse reactions to treatments. While in the field, I ran into a complication with an individualized herbal formula at a school, which exposed the lack of safety procedures and a breach of ethics from numerous actors in the profession. This echoes what anthropologist Joseph Calabrese describes as “cultural paradigm clashes,” which is not only the *paradigm clashes* presented by Thomas Kuhn, but extends to culture.

The paradigms in cultural paradigm clashes have long cultural histories, are assumed to be factually supported by either side, and remain largely unquestioned and impervious to conflicting evidence until a crisis arises. This term is usefully applied to cultural experiences because socialization so often produces humans who accept the native realist illusions that their cultural paradigms directly mirror reality rather than filter and construct it (Calabrese, 2013, p. 14).

A common cultural paradigm about Chinese medicine in the United States is the impression it had no side effects and is extremely safe. My adverse reaction is not an isolated event. Adverse reactions to Chinese herbs happens on occasion and can have lethal consequences. Herbs such as aristolochia (*guang fang ji* 广防己), aconite (*fu zi* 附子), and ephedra (*ma huang* 麻黄) have been linked to toxicity, misuse, and death.

Incidences from aristolochia in Chinese medicine have been identified as causing “aristolochic acid nephropathy” (AAN). The aristolochic acid contained in the plant, has also been linked to urothelial carcinomas of the upper urothelial tract (UTUC) or upper urinary tract cancer (UUC). It was first reported in Belgium when one hundred and five patients who were treated for various degrees of nephropathy, were linked to weight-reducing pills which contained the herb, which was inadvertently used in supplements as a substitute for *Stephania tetrandra* (Nortier et al., 2000). There have been subsequent reports of aristolochia linked UUC in Taiwan (Chen, et al., 2012)

as well as in the Balkans (Grollman et al., 2009) and potential risks from a particular species found in India, which is sold widely on the market and used through traditional healers (*Kavirajes*) in Bangladesh (Michl et al., 2013). Further investigation is warranted into links of UUC with other species of *Aristolochia* found in China and the Balkans (Heinrich et al 2009).

Aconite can have immediate lethal consequences. Toxicity related to aconite indicates cardiotoxicity and neurotoxicity amongst patients (Chan, 2009). Fifty-three deaths were reported from the use of aconite from 2004 to 2015 (Liu et al., 2016) and seven known cases from 1998 to 2008 (Liu et al, 2011). Although soaking and boiling aconite can reduce the risks by hydrolysis, there still remains a potential lethal risk. In the field, aconite was indicated for removing “wind/damp” (*feng/shi* 風/湿) issues. But, *aristolochia* and unprocessed aconite are mostly banned in the United States. The most controversial Chinese herb is *ma huang*, which is commonly referred to in America as “ephedra.”

Particularly in the United States, ephedra has been linked to the highest number of Adverse Events (AE) and Serious Adverse Events (SAE). From 1994 to 2000, the *Washington Post* found thirty-three lawsuits settled from adverse reactions to the herb ranging from nervousness and insomnia to more severe reactions such as cardiac arrhythmia, elevated blood pressure, seizures, and strokes. The *Washington Post* also found upwards of sixteen deaths from the supplement (Gugliotta, 2000). Ephedra has been marketed both as an energy-booster and weight-loss supplement. It has since been scrutinized in the media for wrongful death cases, more publicly with the death of professional baseball player Steve Bechler, which resulted in the bankruptcy of Cytodyne Industries and the ban on ephedrine (Schmuck, 2003). In 2004, the Food and Drug Administration (FDA) banned ephedra as a supplement and the following year it was listed as an ingredient used to manufacture methamphetamine or amphetamine under the Combat Methamphetamine Epidemic Act of 2005 (CMEA) (FDA, n.d.). This did not stop the sale of the ephedra as a raw herb used in Chinese medicine.

Further complications in my research included interference in data collection. At one site, I had to completely suspend all of my recorded data

because a senior administrator [gender anonymized] consistently interrupted my one-on-one interviews with students and faculty practitioners by interrogating informants, asking them confrontationally, “You’ve said only good things about the school, right?” Despite my explicit request for private one-on-one interviews with student and faculty informants, they sat as an observer. As a general method of data collection, I asked all schools I researched to send surveys to faculty and students. This was a problem for one particular school whose administrators had threatened legal and occupational repercussions to any informant who filled out the survey. Through personal communication and the data collected I discovered the school did not distribute the survey to its students and alumni. When I posted the survey on social media, numerous alumni from the school private messaged me and stated they never received the survey. This was an apparent attempt to suppress any information relating to perceptions and data of the field. Ironically, administrators and faculty of the school have complained through social media and directly to me about the lack of data on the profession.

My use of social media to communicate with the profession also presents another limit to my research. Besides interviews and field notes, information outside of the profession is limited to the contributions of social science scholars. Many of the publications related to American Chinese medicine were found in the Chinese journal, *Journal of Integrative Medicine*, which was known prior as the *Journal of Chinese Integrative Medicine*. The journal is affiliated with Elsevier and is published through the Chinese-based Science Press. It contains interviews which have helped me navigate the often-disputed histories of American Chinese Medicine. Most articles I have encountered showed a lack of critical analysis or peer-review vetting. Most information passed through and about the profession was limited to a few journals such as the British-based *Journal of Chinese Medicine*, *The American Acupuncturist*, and the monthly magazine *Acupuncture Today*. The primary medium for discussion among senior and amateur practitioners has been forums on social media, primarily Facebook. This platform provides a raw look at the various ruminations of the professionals and consists of opinions from predominately white practitioners in the United States, Canada, and various countries in Europe.

The last noticeable limitation to my research was trust amongst informants. As an example of heterogeneity in Asian American diaspora, I found Chinese practitioners and faculty members were receptive to speak with me informally, but were guarded when they discovered I did not speak Cantonese or Mandarin or realized my country of origin from my surname. I experienced the opposite response when approaching Vietnamese and Vietnamese-American practitioners, where there was a mutual comradery. Through the trust of the Vietnamese and Vietnamese-American practitioners, I discovered a whole world of unlicensed practitioners, which is too vast a subject to possibly cover in this thesis. In my correspondence with various Vietnamese practitioners, the question of lineage was brought up several times.

In Vietnamese, my position as an acupuncturist is known as a “bloodline doctor” (*bác sĩ di truyền*).⁴ My granduncle introduced me to acupuncture and herbs when I was a teenager. As my mother always stressed, “Your family’s medicine tradition is passed through your blood. It is your destiny.” From my interaction working with traditional physicians in Viet Nam and communicating with family members involved with the medicine, their sentiment seems to welcome white Americans to practice acupuncture and herbs, but frown on their claims for “heredity” or “lineage” of a certain Vietnamese tradition. I cannot say that the same sentiment is shared by Chinese towards white Americans, but I did discover a few white practitioners who aligned themselves to certain traditions despite having limited experience with a teacher. I can best describe the transmission of Chinese medicine in the United States as a “McDonaldization,” where the standardized transmission is often through a packaged medium of a school or week-long seminar, branding a tradition similar to a franchise. White practitioners who travel abroad and study with an Asian teacher, often add this to their legitimation. I argue throughout the thesis, traditions are constantly transformed through the transmission process and “authenticity” of a tradition is uniquely shaped by those who spread it. The core of my critique is regulatory bodies and systems of power inherently shape the

⁴ Different from “heredity doctor” or “lineage doctor” (*bác sĩ cha truyền con nối*).

transmission process as well as the traditions. This characteristically affirms the medicine's assemblage as American Chinese Medicine.

1.4 Outline of Chapters

The thesis is broken into three developments: migration and exclusion, orientalized biopower, and professionalization. Chapter 2 covers the historical context of the medicine from the 1850s to the 1950s when it was primarily practiced by Chinese diaspora. I focus on evolving sentiment in the United States towards Chinese, from its fascination with China and Chinoiserie by the patrician class to the position as a scapegoat for organized labor's disparity. By the 1880s there was growing animosity towards the Chinese, and practitioners were in a liminal position as "merchants," where the slightest indication of them treating patients was grounds for deportation. Amid the rise of the American Medical Association (AMA) and the professionalization of medicine in America, Chinese medicine was repudiated worse than the already frowned upon "irregular" medicine. This chapter situates Chinese medicine and its practitioners on the fringe, but also as an asset to the various settler encampments and burgeoning communities throughout the West.

Chapter 3 examines the 1970s and 1980s when predominantly white members of the counterculture express a specific form of orientalism which simultaneously romanticized Chinese medicine through the practice of acupuncture, while introducing legislation to professionalize the medicine. This resulted in the arrest and marginalization of Asian American practitioners. With this tension, the countercultural pioneers began to forge the path towards professionalization by standardizing Chinese medicine, literally labelling it as "Oriental Medicine," through the regulatory bodies. In turn, Chinese medicine became another mechanism of the State's control of populations and bodies, which Michel Foucault referred to as biopower. This unique arrangement of orientalism and biopower, which I label as orientalized biopower, served as the template the profession carries to its current manifestation.

In Chapter 4, I explore professionalization through a historical analysis of various structures of governance exemplified through the schools as well as the authority of the national and state regulatory bodies. The majority of the

states in America, excluding California and Nevada, rely on the interconnected national regulatory bodies to determine the legitimation of curriculum and practitioners. Through a detailed analysis of the criteria expected from the regulatory bodies, I uncovered the predominance of abstract Chinese theory and a lack of attention to patient safety, the primary function of most state licensures.

Identified as the profession's primary preoccupation, Chapter 5 analyzes the material transmitted through various traditions. With TCM as the predominant epistemology, I reveal its historical significance and the actors who construct its continuities. The primary characteristic Scheid, Chang, and Karchmer argue as distinctive to the PRC's state-sponsored Chinese medicine is *bianzheng lunzhi* (Scheid, 2002; Karchmer, 2010; Chang, 2015). In the United States, this element will serve as the basis for communication and theory of Chinese medicine. As a historical analysis of TCM, I also trace the British influence to the standardized medicine and the seeming contradiction of restriction on British pioneers to practice in the United States. The other tradition examined is Five Elements, which has an added psychosomatic view of the body through the idea of *shen* (神). With a more explicit British origin, the analysis of Five Elements calls into question the transmission of Chinese medicine and the different ways transmission is shaped and embodied. The chapter concludes with the various schools and interpretations of Classical Chinese Medicine. Limited to three specific examples, I investigate how the "Classics" are taught in the classroom and how students navigate the classical curriculum with the backdrop of TCM.

Looking at professionalization and traditions, Chapter 6 illustrates how the profession appears in its contemporary form. Without a clear definition or consensus on the name of the profession or the medicine, I propose American Chinese Medicine is actually shaped by antagonistic forces. I examine the internal contention with professional standards and how structures of power are fueled by debt. Externally shaping the medicine is the 'turf war' against the biomedicine community comprised of physiotherapists and chiropractors in the practice of "dry needling." I then demonstrate the defining influences of Chinese medicine have been through radical elements on the fringes of the medicine,

most notably from the Community Acupuncture movement, who were inspired by members of the Black Panthers at Lincoln Hospital, and marginalized practitioners of Chinese medicine. Though not an ultimate solution to problems which define Chinese medicine as a profession, the movement of Community Acupuncturists posits potential outcomes with focus on the needs and safety of the patients as well as the ability to access the medicine. Paralleled with my experience in the United Kingdom, I conclude by proposing a self-assessment of professionalization, the profession must accept an inevitable catastrophe or find an alternative to capitalist modes of operation. I affirm Chinese medicine's redemption is in its embrace of heterogeneity.

Chapter 2.

Historical Context

This chapter examines Chinese medicine in America from the Colonial Period, when techniques of acupuncture were employed by patrician colonists, to the post-colonial period when migrant Chinese workers went in search of gold. The chapter is based on John Kuo Wei Tchen's three categories of orientalism: patrician, commercial, and political, with most Chinese medicine practices manifested through commercial and political orientalism. The birth of Chinese medicine clinics in America would coincidentally occur during the process of legitimacy and eventual hegemony in biomedicine. With biomedicine's legitimation through the American Medical Association (AMA), it would be identified in popular culture as being "regular" medicine while Chinese medicine would be considered something far worse than "irregular" medicine. This medical categorization corresponded with a political orientalism marked by anti-Chinese sentiment, sanctioned by the 1882 Chinese Exclusion Act, thus influencing measures on behalf of the State to persecute members of the Chinese medicine community.

2.1 Orientation of Orientalism

The inception of Chinese medicine in America can be identified in the intellectual interest of early colonists and the actual practice of Chinese immigrants. Although early colonists experimented with acupuncture, the bulk of Chinese medicine from the 18th to early 20th century revolved around Chinese herbalism. Culturally, Chinese medicine was driven by different characteristics of orientalism. This chapter is broken into three sections which correspond with John Kuo Wei Tchen's *New York before Chinatown*, in which he expounds on Edward Said's concept of orientalism by situating it within an American context. Tchen identifies orientalism within its patrician, commercial, and political framework, all marked by specific epochs in American history.

Patrician orientalism was associated with aristocracy of the founding generation who "exchanged and collected rare consumer goods" from China to use "as a badge of taste and distinction and a means to sociability" (Tchen,

1999, p. xx). Tchen finds though patrician orientalism differed, “such various practices wove together an everyday life that helped define an independent occidental identity emulating China and drawing upon British patrician culture, but not too tightly to either” (Tchen, 1999, p. 22). The use of patrician orientalism would construct a ruling class culture in the Founding Era of America. As Tchen describes it,

This varied generation of founders shared and shaped an elite, patrician-oriented culture. This elite culture embodied an underlying consensus that the trade of goods and ideas with the empire of China would be beneficial to the building of distinction, independence, development, and wealth, and to the governing of the new nation (Tchen, 1999, p. 22).

Commercial orientalism was marked by the completion of the Erie Canal and the end of the Civil War. Tchen identified this period with mass urbanization and populist marketplace economics (Tchen, 1999, p. xxii). In particular, Tchen attributed much of commercial orientalism with print capitalism, specifically the penny press: a cheap, tabloid-style, mass-produced newspaper. The penny press for Tchen was an accessible way to unify seemingly foreign worlds and understand the growing metropolis of New York City.

Print capitalism in effect transformed a streetscape of diverse individuals into a public that increasingly viewed itself as living a shared New York City experience. The visually driven marketplace of “sights” fostered a distinctive form of orientalism in which images and beliefs were sold and bought by a public eager to make sense of its own place in this heterogeneous urban environment and of its nation’s place in the world. This was the New York in which Chinese were beginning to settle (Tchen, 1999, p. 64).

With the rise of print capitalism, Chinese migrants could engage with the non-Chinese population through the medium of the penny press. Images and messages conveyed through the medium of the penny press catered towards an imagined Chinese-ness of the era, through a self-orientalization process. This form of orientalism allowed non-Chinese populations to discover migrant Chinese cultures and engage with the imagined chinoiserie of the patrician.

Tchen’s last category is political orientalism, which deals with the era of Reconstruction and post-Reconstruction America whereby the country made a

shift from an appreciation of Chinese goods and the positive treatment of Chinese people to a rising Sinophobia of people and culture. It was an era of uncertainty for Chinese, where Tchen described perceptions around them as either “free labor” or in terms of their “assimilability” (Tchen, 1999, p. xxiii). Political orientalism was fueled by xenophobia which was built around the view of “Yellow Peril,” the fear of East Asians, with the passing of Chinese Exclusion Act in 1882.

Although Tchen’s categorization is historically accurate and suitable to distinguish the manifested orientalism of the time, I argue the treatment of Chinese medicine practitioners was a hybrid of commercial and political orientalism. Historians have argued because of their positions as members of the intelligentsia, Chinese medicine practitioners did not endure as much anti-Chinese violence as the typical Chinese laborer (Bowen, 2002, p. 189-190; Shelton, 2013, p. 267) and in some cases lived much wealthier lives as a part of the “merchant” class (Liu, 1998, p. 178; Liu, 2006, p. 45). Haiming Liu found Chinese herbal medicine was a “true ethnic skill” and despite the hardships that many Chinese had to endure with the anti-Chinese sentiment of the late-19th to the mid-20th century, many Chinese medicine practitioners were protected by their status as “merchants” (Liu, 2005, p. 46). Practitioners would still have to struggle to prove legitimacy and thereby protect their Other or “irregular” medicine from the hegemonic rule of biomedicine.

2.2 Patrician Orientalism: Chinoiserie and Acupuncture

Chinese medicine arrived in America in fragments. It began during the Colonial Period of the late-18th century with the patrician’s infatuation with the chinoiserie aesthetic. Chinoiserie was the late-17th century aesthetic in art, architecture, literature, and music based on European artistic interpretations of East Asia, but not originating from East Asia. Linda Barnes explains,

An imagined China became the space where well-to-do Europeans lived. Manufacturers copied Chinese technologies, modified for European tastes. During the 1680s, chinoiserie designs adorned British pottery and Chinese porcelain painters produced designs appealing to a European audience. A craze emerged for lacquer furniture, decorated with Chinese

landscapes through which Chinese figures moved (Barnes, 2005, p. 76).

As mentioned before by Tchen, chinoiserie was a symbol for the patrician class and though it was materially expressed through art and raw materials such as tea, many idealizations of East Asia, mainly from China, came from the writings of French Jesuit missionaries. In particular, Fr. Jean-Baptiste Du Halde's (1674-1743) translation of the *General History of China* (ca. 1736), which introduced the ideas and cultures of China. Architecturally, Du Halde's translation would influence Sir William Chambers to construct the Duke of Kent's Kew Gardens, which included a nine-story pagoda. In America, Thomas Jefferson also planned a similar pagoda in Monticello (Barnes, 2005, pp.133-34). Medically, Du Halde's the *General History of China* was one of the first attempts to theorize Chinese medicine and introduced Chinese medical diagnostic and treatment practices to Europeans (Barnes 2005, 74). Du Halde's writings on ginseng root influenced French botanists to explore a North America genus, which led to its cultivation by Native Americans and American pioneers (Barnes, 2005, p. 105).

Before Du Halde, much of the literature and research on Chinese medicine came from the Dutch East India Company. The most notable medical writers were Andreas Cleyer (1634-1697) who published *Examples of Chinese Medicine (Specimen medicinae sinicae)*, the German naturalist Engelbert Kaempfer (1651-1716) who wrote about acupuncture in *Charming Political, Natural Science, and Medical Exotica (Amoenitatum exoticarum politico-physico-medicae)*, and the Dutch physician Willem ten Rhijne (1647-1700) who spent two years in Japan studying acupuncture and wrote the first European medical paper on the subject, "De acupunctura" (Barnes, 2005, p. 75; Devitt, 2010, p. 14). The work of Kaempfer and ten Rhijne, exhibited an academic interest in Chinese medicine, specifically acupuncture, throughout Europe, but it was not until the beginning of the 19th century research interest in acupuncture began in the United States.

Influenced by much of the acupuncture research in Europe, the great-grandson of Benjamin Franklin, Franklin Bache (1792-1864), became the first physician to investigate acupuncture in the United States. It is unclear when Bache became interested in acupuncture, but in 1825, he received a copy of

Memoir on Acupuncture (Memoire sur L'acupuncture). This monograph was written by the physician M.J. Morand who trained under famed French physician Jules Germain Cloquet and cited both Kaempfer and ten Rhijne as his primary sources. Bache, in the same year, translated and published Morand's *Memoir on Acupuncture*⁵ to English. (Cassedy, 1974, p.893; Devitt 2010, p.14). At the time Bache was an assistant physician at Walnut State Street Prison in Philadelphia where he treated seventeen prisoners from June to December of 1825 focused on neuralgia, chronic pain, muscular rheumatism, and ophthalmia. He found out of the seventeen prisoners, seven were "completely cured," another seven found considerable relief, and three had no effect. The results were published under the title "Cases Illustrative of the Remedial Effects of Acupuncturation" in *North American Medical and Surgical Journal*. Bache's findings were the first published research on acupuncture in the United States (Cassedy, 1974, p. 895; Devitt, 2010, p.15).

Following Bache's findings, others in America had relative success with acupuncture such as in Philadelphia where physician J. Hunter Ewing treated a woman who had been suffering from neurological pain for eighteen months with one successful acupuncture treatment. In 1843, the "Father of American Physiology," and Thomas Jefferson's personal physician, Robley Dunglison, used acupuncture to "drain off the fluid from the cellular membrane in anasarca" and suggested acupuncture's use in other diseases. In Dunglison's 1839 textbook *New Remedies*, he devoted eight pages to an essay on acupuncture (Cassedy, 1974, p. 896; Devitt, 2010, p.16). By 1859, sentiment towards acupuncture shifted and research came to an abrupt halt. The so-called "Nestor of American Surgery," Samuel D. Gross, wrote about acupuncture in his best known work *A System of Surgery* which "its advantages have been much overrated, and the practice, which has been borrowed from the Chinese and Japanese, has fallen into disrepute" (Gross, 1859, p. 576).

The patrician's representation of Chinese medicine took various forms but mostly in fragments. Chinese medicine was influential in academic circles but its adoption in America was more as an orientalist novelty rather than an

⁵ Also published as *Memoir on Acupuncturation, Embracing a Series of Cases Drawn up Under the Inspection of M. Julius Cloquet* (Devitt 2010, 14).

actual medicine used to treat the public. Even with Bache's clinical application, its practice would not extend to a broader population. It would not be until the Chinese diaspora started practicing Chinese medicine where it would shift from medical discourse to a practice which would benefit numerous populations across the United States.

2.3 Migration and Medicine

It is difficult to date the first Chinese migration to America. From the Eighth Census of 1860, there were a little over a dozen Chinese who sporadically entered the country (Barnes, 2005, p. 229). The first noticeable record of Chinese migration to America's West Coast is typically attributed to the brig *Eagle*. On February 2, 1848, the *Eagle* docked in San Francisco Bay carrying two Cantonese miners and a woman housekeeper who accompanied a French missionary on board. In 1848, gold was struck at Sutter's Mill in the Mexican territory of California, which launched the "Gold Rush," bringing people throughout the world to California in search of gold. By 1850, word spread East to China labelling America as "Gold Mountain" ("*jin-shan*" 金山) creating a migration in the thousands to America's west coast (Muench, 1988, pp. 5, 36cf.). At the peak of Chinese immigration in the late-19th century, the 1880 United States Census showed 87,282 of the 105,464 total Chinese immigrants resided along the Pacific Coast (Schwartz, 1984, p. 8; Bowen, 1993, pp. 20-21). Out of the total Chinese migrants, 95% came from the Pearl River Delta (珠江三角洲) which consisted of Kwangtung (Guangdong 广东), Macau, and Canton (Choy, 1971, p. 268; Hom, 1983, p.127; Muench, 1988, p. 7; Bowen, 1993, p. 21).

Although gold may have been the prevailing impetus to settle in the United States, other factors contributed to the migration. William Bowen attributes migration to the West in part to internal issues within China.

The economy of China was in ruins. Kwangtung [Guangdong] and Fukien [Fujian, 福建] were especially poor, and overpopulated... The Taiping Rebellion of 1851-1864 had left millions dead. Defeat had been suffered in the Opium Wars and China's closed door policy was no longer viable. Devastating

floods and droughts from 1846-1850 had wreaked havoc in the south of China . . . Massive governmental corruption was the general norm and had led to the gradual decline of the Ch'ing dynasty [Qing Dynasty]. Taken together, all these factors had left the people of South China in desperate straits. Hence, they saw the opportunity for wealth in America as a welcomed solution to their problems (Bowen, 1993, pp. 21-22).

With mounting instability in China, many left simply to ensure a better life. Once the Chinese landed in America many would find work outside of gold mining such as constructing the transcontinental railroad. From 1865 to 1869, roughly 12,000 Chinese migrants would laboriously work to build the nation's transcontinental railroad (Chinn, 1978, p. 3). As the result of Chinese labor on the railroads, gold exploration, domestic service, or agricultural work, migrants found themselves settling either in urban centers such as San Francisco and New York, or rural encampments near areas of labor. Along with their migration, Chinese brought their medicine in form of raw materials which would play an integral part of their lives while in America (Culin, 1887, p. 596; 1890, 198; Bowen, 1993, p. 23).

Chinese medicine was of great importance to the Chinese with evidence it was used for trade amongst Native Americans as exhibited by vials of medicine found in an archaeological excavation of a Native American encampment (Arkush, 1989, p.157; Bowen, 1993, p. 23).⁷ Chinese migrants were equipped with a basic knowledge of herbal remedies for minor issues and would seek help from Chinese medicine physicians for more severe issues. As the Asian American historian Haiming Liu mentions,

Many of them knew what herbs or herbal formulations they might need for certain minor diseases or injuries. If they needed to consult a physician for a more serious symptom, they would see one; otherwise, they just purchased the herbs they thought they needed (Liu, 2006, p. 138).

As Liu asserts later, Chinese medicine physicians in America were not all of the same status. In China, physicians had a hierarchical system which denoted the skill of the physician. Top physicians were known as “scholar-

⁷ As I will cover later in this chapter, a possible reason for their relationship was partly due to their shared subordinate racial status.

doctors” (*ru yi* 儒医), who were trained at the renowned Imperial Medical Academy (*taiyishu* 太医署) and upheld bureaucratic positions. Scholar-doctors also had years of education requiring rigorous examinations, and were well-versed in classical Chinese medical texts. The other designation was the “heredity-doctor” (*shi yi* 世医). Liu alludes to the Chinese saying: “*Yi bu sanshi, bo fu qi yao* (if a doctor does not have three generations in medicine, do not take his remedies).”⁸ They are important due to their skill in treating difficult diseases and use of secret formulas. Liu further maintains out of all Chinese medicine physicians in America during the late-19th century and early-20th century, only Yitang Chung was a “scholar-doctor” and the rest were either self-taught or apprenticed under other Chinese medicine physicians (Liu, 2006, p. 148).⁹ The “heredity-doctor” had familial ties which would be crucial in the transmission of Chinese medicine in the United States because Chinese herb stores were mostly family-run businesses. Notable Chinese medicine physicians in America trained and hired family members to assist, thereby preserving their family’s legacy and maintaining their status in the “merchant” class.

Essential to the Chinese migrant experience in the United States, this section explores the role Chinese medicine had on both Chinese and white communities during the late-19th and early 20th centuries. By examining specific case studies in both urban and rural settings, my analysis uncovers ways in which the medicine was used as an asset for the health and wellbeing of Chinese and white communities in the United States. In most urban settings, catering to whites also brought self-orientalization.

⁸ “医不三世, 不服其药”

⁹ William Bowen and Jessica Ching-Yi Kao list three physician categories: “scholar-physicians” (Wade: “*ju-i*,” Pinyin: “*ru-yi*” 儒医), “professional physicians”/ “heredity-physicians” (Wade: “*lang-chung*,” Pinyin: “*lang zhong*” 郎中), and “folk practitioners” (Wade: “*wu-i*,” Pinyin: “*wu yi*” 巫医). Bowen and Kao mention that the only scholar-physicians were Li Wing and T. Foo Yuen who both attended Peking Medical College (Kao, 1981, pp. 44-45; Bowen, 1993, p. 40).

2.4 Commercial Orientalism

Throughout this chapter I examine how the majority of Chinese medicine clinics (herbal pharmacies) in the United States, or at least those who made themselves public, served mostly white patrons. The first record of this was in 1858 when the Chinese physician Hu Junxiao (Tsun Yuen Wo) advertised his herbal pharmacy with English-language signs to attract white patrons (Liu, 1998, p. 180; Liu, 2006, p. 143). As expressed before by John Kuo Wei Tchen, print capitalism gave rise to commercial orientalism which, in this case, benefited the Chinese medicine clinics. Raymond Lou attributes the first strand of Chinese herbal pharmacy advertisements to the 1870s, and by the mid 1880s, physicians began using sketches of Chinese herbalists conducting pulse diagnosis on white patients. Full-page ads of competing Los Angeles Chinese herbal pharmacies were also apparent during the same time (Lou, 1982, p. 72; Liu, 2006, p. 144).

Along with the medium of print capitalism came a self-orientalism. Chinese medicine physicians presented themselves in a fashion which employed the orientalist gaze of whites to benefit their own business. Speaking of the process, Willian Bowen explains,

Either way, to be successful, an advertisement must appeal to some important cultural scripts or motifs. The advertisement must resonate with concerns and desires that are important in the cultural context of its production. Understanding an advertisement gives us an idea of the thinking in context of its production because an advertisement shares structural regularities with the context of its production (Bowen, 1993, p. 73).

Self-orientalism is explained by Koichi Iwabuchi in the following manner: “While Orientalism enjoys the mysterious exoticism of the Other, self-Orientalism exploits the Orientalist gaze to turn itself into an Other” (Iwabuchi, 1994, p. 70). Here, Iwabuchi argues self-orientalism was a tool used to benefit the Other but then, in-turn, transitions into an entity in itself.¹⁰ Bowen noticed

¹⁰ Later, I argue that the utilization of cultural scripts and motifs were important then as it is today for Chinese physicians.

beyond the overt lack of women physicians,¹¹ many of the physicians depicted themselves at a younger age and almost always younger than the patient. The most striking form of self-orientalism by the physicians was the depiction of them in traditional garb, but with “distinctly Anglo facial appearance,” which Bowen proposes was a means to diminish racial difference (Bowen, 1993, p. 74). Bowen’s description is an interesting example of “occidentalization” to appeal to white clientele. The simulacra of the Chinese physician in advertisements of the era can be argued to be an example of survival tactics in a hostile environment. By the 1870s, negative depictions and overtly racist caricatures of Chinese in newspapers would reinforce sentiments of ‘Yellow Peril,’ the generalized fear East Asians were a threat to the Western World, which inevitably led to Chinese Exclusion Act of 1882.

Bowen argues the advertisements during this era also encompassed a specific trope. In his analysis of fifteen advertisement from (mostly) the late-19th century with a few from the early-20th century, he found the majority were formatted as patient testimonials. Albeit personal testimonies are not uncommon. They were seen as a means to give credence to physicians (Bowen, 1993, p. 62). In some cases, the anecdotes came from esteemed members of society.

The patient testimonials form an important part of the advertisement and help the reader to imagine himself as a patient. Some of them are from well individuals, and thus, by way of association, the Chinese doctor is paired with high status patients. The perspective patient is thus also offered admittance into this matrix of status (Bowen, 1993, p. 74).¹²

In the East Coast, one Chinese physician in particular took advantage of this opportunity. June Ling Wau ran a practice at 40 East Fourteenth Street in New serving “many of the richest ladies of the City” (Tchen, 1999, p. 238).

¹¹ Since much of the reason for Chinese migration was manual labor, many of the Chinese women did not come to American until the 20th century unless it they served as housekeepers or personal help. In fact, according to the 2010 U.S. Census, there were 2,455 Chinese men but only 147 women (Liu 2005, 38).

¹² This dynamic still continues today but instead of newspapers, the medium is through television and the internet through celebrities such as Oprah and Doctor Mehmet Oz. I’ll discuss this further in the analysis of contemporary practices.

Wau's clinic and several notable clinics on the West Coast had in common were cultural intermediaries.

Cultural intermediaries were people who bridged the communication between Chinese physicians and non-Chinese patients. Bowen has shown how some physicians not only had their advertisements in Chinese script and English, but also in Spanish and in later cases Greek (Bowen, 1993, p. 70; Liu, 1998, p.181). Cultural intermediaries in the clinic were both Chinese and non-Chinese but knew how to speak English and in some cases were Spanish-speaking. Liu notes a case where a Chinese physician hired a Mexican intermediary to specifically cater to the Mexican clientele. (Liu, 2005, p. 60). From a practical perspective, cultural intermediaries played an important role in conveying the services of the clinic to the white public. Some intermediaries did not even speak the physician's native language. Mr. Holmes, who only knew how to greet in Cantonese, helped the notable Los Angeles physician Yitang Chung while another physician in the same city, Tom Leung, hired a Mr. Hollow who did not even know a word of Cantonese or Mandarin (Liu, 2005, p. 60). This is not to say cultural intermediaries did not serve a function.

As stated before, Yitang Chung utilized cultural intermediaries to help his business. In particular, he had two who were of great importance, his wife Nellie and a Mr. Holmes. Nellie (born Nellie Yee or also Nellie Yu), was an American-born Chinese who was fluent and literate in both English and Chinese. Nellie had knowledge of the different herbs and would help Yitang prepare each of the prescriptions he wrote for patients. Along with preparations, Nellie also helped teach the patients how to cook the herbs correctly (Liu, 2006,p. 152). Mr. Holmes played a different role, which concerned legal issues of the business.

After the Chinese Exclusion Act of 1882, and more specifically the Alien Land Act of 1913, Chinese were barred from owning property in the United States. To bypass this legislative hurdle, Chinese physicians had to be cautious. They entrusted cultural intermediaries, as in the case of Mr. Holmes, to handle the business' leases and official ownership of Chinese herbal pharmacies. More so, Mr. Holmes, as well as other white cultural intermediaries, were of significant importance when it came to being a witness for immigration issues.

In 1911, Yitang was detained while attempting to apply for the admission of a relative who was being kept in Angel Island. During his immigration trial, Mr. Holmes was presented as a witness in defense of Yitang as well as for a physician at the Chinese-American Herbal Co. As I will cover later in this chapter, the designation of “physician” was quite contentious, especially for a Chinese physician. But what is important was how Mr. Holmes presented both Yitang and himself. Holmes protected Yitang, by identifying Yitang’s responsibility in the company as “buying and importing” as well as an herbalist. In his own defense, Yitang never claimed to be a physician and never diagnosed patients. Instead, his responsibilities were only to purchase herbs (Liu, 2005, p.61).

Similarly, other Chinese physicians would defend themselves to maintain their practice. Self-orientalism, in addition to cultural intermediaries, were crucial for their business’s preservation. In the ensuing sections of this chapter, my analysis seeks to historically situate Chinese medicine in America and to understand the people who practiced it. Many of their experiences were shaped by the location and cultures around them as well as sentiments towards the Chinese. The greatest hurdle for Chinese medicine during this period would not be racist persecution, although it was apparent, but the defense against the burgeoning presence and authority of biomedicine. Once labelled “regular” medicine, biomedicine identified itself as an oppositional force to the multitude of medical practices which were labelled “irregular” medicine, including Chinese medicine, as well as chiropractic, osteopathy, and naturopathy.

2.5 Pacific Coast

With the advent of gold exploration and the construction of the transatlantic railroad, many Chinese found themselves in the Pacific Coast. Though some would venture eastward, the majority would settle in states such as California, Oregon, and Washington. This section examines the impact Chinese medicine had on both Chinese and white communities and explores how their location shaped their practices.

2.5.1 San Francisco and Oakland, California

San Francisco was the commercial and residential hub for many incoming Chinese migrants from the Pearl River Delta. In the late-19th century, Chinese made up 5-8% of San Francisco's population and Chinese in San Francisco made up 24.4% of California's entire Chinese population (Trauner, 1978, p. 72; Liu, 1998, p. 176). Even with the growing population of Chinese, little attention was given to their healthcare. Less than 0.1% of Chinese were admitted to hospitals in San Francisco, and if they were admitted, patients would be sent to wards which dealt with small pox or to a designated building exclusively meant for Chinese – although not mutually exclusive – which was later designated as the Lepers Quarter (Trauner, 1978, p.74; Liu, 1998, p.176). Historian Joan B. Trauner argues the reason Chinese were sent to small pox and leper wards was a negative change in sentiment towards Chinese Americans. Previously, Chinese were seen as harmless, but by the 1860s Chinese were treated as “medical scapegoats,” and blamed for the epidemics which plagued San Francisco.

The seeds for medical scapegoatism in California first appeared in the 1860's. Whereas in the 1850's the early Chinese immigrants had been admired for their industry and frugality, by the 1860's the Chinese were considered to be “an inferior race” and a “degraded” people. By the 1870's, the racist argument had broadened in scope, and the Chinese were viewed as “a social, moral and political curse to the community (Trauner, 1978, pp. 70-72).

In the years 1875 and 1876 a small pox epidemic hit the city and, as this was before the acceptance of germ theory, the Chinese were blamed. As a San Francisco health officer, J.L. Meares explains,

I unhesitatingly declare my belief that the cause is the presence in our midst of 30,000 (as a class) of unscrupulous, lying and treacherous Chinamen, who have disregarded our sanitary laws, concealed and are concealing their cases of smallpox (as cited in Trauner, 1978, p. 73).

To the city government, San Francisco's Chinatown was the source of the disease. Some officials labelled it “a laboratory of infection” and attributed Chinese living conditions to the disease. As a result, the city felt the best way

to combat the disease was to have health officers order all Chinese houses be fumigated. Despite fumigation, smallpox still managed to infect 1,646 people and kill 405 (Trauner, 1978, p. 73). The Chinese were additionally blamed for leprosy and the bubonic plague. Various beliefs were espoused by health officers surrounding leprosy and the Chinese. One thought it was “simply a result of generations of syphilis, transmitted from one generation to another” while another contended it was inherently a Chinese disease and was passed to whites through the use of opium pipes touched by Chinese lepers (Trauner, 1978, p. 75). In March 1900, health officials ruled a body found in a Chinatown building had signs of the plague because of swollen lymph nodes. As a result, San Francisco’s Chinatown was quarantined for several months, Chinese who tried to leave the city were detained and a house-to-house inspection was ordered. All buildings in Chinatown were disinfected with sulfur dioxide and bichloride of mercury, and “Asiatics” (Chinese and Japanese) were refused tickets for interstate travel. By May 1900, travel restrictions were lifted when the Chinese Six Companies sent a petition to the U.S. Circuit Court in San Francisco. When bubonic plague actually did strike in 1907, the population was much more informed and the city launched a public health campaign to eradicate rats in the City. Out of the 89 deaths, only eight Chinese were killed by the plague (Trauner, 1978, pp. 77-79).

The mistreatment of Chinese coupled with Chinese mistrust of the American medical system, led Chinese to create their own autonomous medical facilities in the form of Chinese herbal pharmacies. In the 1850s, the Chinese established groups (*tongs*) which consisted of family clans or areas of regionalization. “*Tong*” (堂), means “hall” or “gathering place.” The *tongs* would codify in the 1860s under the Chung Wah Kung Saw, which later became the Chinese Consolidated Benevolent Association (CCBA) or the Chinese Six Companies. During the leprosy scare of the 1870s, most lepers were “debarred from hospital maintenance” and were sent by the city to one of the Chinese “hospitals” maintained by the CCBA (Trauner, 1978, p. 81).

In the nineteenth century medical care in Chinatown was largely provided by herbalists and pharmacies in the classic tradition of Chinese medicine. As late as 1900, no Chinese physicians appear to have been licensed to practice medicine in the state of

California; in fact, not until 1908 was the Medical Department of the University of California in San Francisco to graduate a physician of Chinese origin (Trauner, 1978, p. 82).

Chinese biomedical doctors were rare or non-existent in Chinese communities such as San Francisco Chinatown during the turn of the century and prior. The attempt to establish legitimate hospitals with white biomedical doctors in Chinatown was also rare. The construction of hospitals for Chinese at the time was not to benefit San Francisco's Chinese community but designed to isolate Chinese from other Americans. In reaction to the bubonic plague in San Francisco's Chinatown, the War Department wanted to quarantine patients at Angel Island while the surgeon general of the Marine Hospital service proposed to construct a "pest hospital" in Chinatown. In 1899, San Francisco Chinese incorporated The Chinese Hospital (*dong hua san yuan* 东华医院), with twenty-five beds and twelve white physicians. Originally known as the Tung Wah Dispensary, it was funded by Chinese Six Companies and in 1925 would officially be known as the Chinese Hospital. It has since been relocated but still operates in San Francisco (Trauner, 1978, p. 84).

With the lack of biomedical hospitals, many Chinese-run herbal pharmacies would serve as centers of medical treatment. During the late-19th century, herbal pharmacies were also sites of Chinese commerce and entrepreneurship. According to a San Francisco business directory in 1856, 15 out of the 88 Chinese businesses were Chinese herbal pharmacies with five herbal physicians, which was second in prevalence to the 38 grocery store businesses (Liu, 2013, p. 273). William Bowen has listed five Chinese medicine physicians in San Francisco; Lai Po Tai, Tong Ow Chy, Whey Fong, Tong Po Chy, Chuck Sal and one in Oakland, Fong Wan (Bowen, 1993, pp. 52-53). Two physicians, Li Putai (Lai Po Tai) and Fan Wan, stand out as the focus of contemporary historians.

Li Putai, from the Shunde District (顺德区) of the city of Foshan (佛山市) in central Guangdong Province was one of the first and most successful practitioners in California. It is unclear where Li was trained and it is speculated he was a barber back in China (Harris, 1932, p. 272). His office was located on San Francisco's Washington Street. The historian Liu Pei Chi wrote how Li was always booked and some patients from the East Coast traveled to receive

treatment from him (Liu, 1976, p. 415). Before his death in 1893, Li made a lucrative yearly income of \$75,000 and even earned enough to construct a joss house to pray to the god of wealth (Liu, 2005, p. 58; Liu, 2006, p. 143). For Li, Chinese medicine was a family business with his nephew (Tan Fuyuan also Tom Foo Yuen) and his son Li Wing, who were both trained at the Imperial Medical Academy [Imperial Medical College of Peking], forming a partnership in Los Angeles which catered mostly to English-speaking people (Bowen, 1993, pp. 43, 50; Liu, 2005, p.51).

Across the bay in Oakland, California, Fong Wan, the “King of the Herbalists” had a clinic on 10th Street. He ran his clinic from 1915 to the mid-1930s, treating patients from around the Bay Area and even employed a white attendant who gave tours of Fong Wan’s lavish clinic (Liu, 1998, pp. 178, 185). Fong claimed he was trained and passed the Chinese literary examinations at the Imperial Medical Academy with a first degree (Liu, 2006, p. 147). He was also known for his approach to treating white women. White American women felt more at-ease being treated by Chinese medicine physicians. As Haiming Liu writes,

The rational, objective, and nonmoralistic approach toward sexual matters probably helped make their female patients more comfortable as the women described their symptoms. In short, the herbalists were able to break into the European American female market because herbal medicine is effective, feeling the pulse is a noninvasive therapeutic method, and the confidential nature of their practice reduced the social distance between Chinese herbal doctors and their Caucasian clients (Liu, 2006, p. 151).

According to Fong Wan’s 1933 book *Herb Lore*, a female patient gave testimony how after taking his herbal prescription, several lumps on her breasts disappeared. Other practitioners such as Tan Fuyuan and Tom Leung would provide Chinese medical insights into women’s health than some Western biomedical physicians who were restricted because of social mores of the time.

2.5.2 Los Angeles, California

As stated earlier, Li Putai left a legacy in San Francisco, however, his nephew Tan Fuyuan, along with Li's son Li Wing, also made an impact in Southern California. In 1893, Tan Fuyuan and Li Wing moved to Redlands, California and opened an herbal company. Their company gained publicity in an unexpected way. With their arrival, many biomedical ["Western"] doctors felt the Foo and Wing Herbal Company was a source of competition and began to attack Tan and Li as "pseudoscience" in the *Redland Citrograph*, one of the local newspapers. In response, the competing local newspaper, the *Leader*, published positive patient testimonials of the herbal company. As a result, the competition between the newspapers brought attention to the herbal business so Tan was able to expand his business. He opened another herbal company called the Foo and Wing Herbal Company in Los Angeles as well as businesses in Oakland, California and Boston, Massachusetts. Tan would be the most notable Chinese physician in Los Angeles, his clients consisted of journalists, lawyers, businessmen, and even biomedical physicians and, in 1897, he published an English language book *The Science of Oriental Medicine* (Liu, 2006, p. 149). By 1899, Tan sent for his cousin Tom Leung to come and work as his assistant. He quickly learned the trade and within five years became the vice president of the Foo and Wing Herbal Company (Liu, 2005, p.54; Liu, 2006, p. 148).

In 1918 Leung, opened his own office at 711 South Main Street in Los Angeles. Controversially, Leung claimed he had studied at the Imperial Medical Academy [Imperial Medical College] and his grandfather was the court's doctor to the Emperor of China. His children question these claims and evidence points to him obtaining his knowledge from working with Tan Fuyuan, who would later become his rival (Liu, 1998, p. 182; Liu, 2006, p.149). Most of Leung's patrons were white and to attract them, he composed the book *Chinese Herbal Science*.²¹ Leung's wife Bing Woo Wong and their son Taft took over the business after Leung died in 1931. Bing, who had learned from Leung, knew how to prescribe formulas based on the symptoms her son Taft relayed to her. The business was not as successful as when Leung was alive and they

²¹ Liu refers to it as *Chinese Herbal Medicine* (Liu 2005, 67).

closed shortly after taking over (Liu 2006, p. 152). Later in this chapter, I will explain how much of Leung's legacy would revolve around his battle with the law and biomedicine.

Another pioneer in Los Angeles was Yitang Chung (Yick Hong Chung). Yitang was from Kaiping County (开平) in Guangdong province. At eighteen, Yitang left his home and worked at the Yuk Gee Hong herbal store in Guangzhou. He became well-versed in Chinese medicine and opened a profitable herbal business in Guangzhou which provided him with enough money to purchase properties in the city. His financial success allowed him to move his children from the country, to the city where they could receive a proper education (Liu, 2005, pp. 29-30). After nineteen years in Guangzhou, Yitang decided to move to America. He left behind a wife and three children because he felt his prosperous herbal company was too small and he could become wealthy in the United States, which was known as "the richest country in the world" (Liu, 2005, pp. 1-2). Yitang's departure from Guangzhou was also to help the economic situation of his clan, the Chang clan.

In May 1900, Yitang left Hong Kong with a "Section Six" certificate, which labelled him as a "merchant." After the Chinese Exclusion Act of 1882, only merchants were allowed into the United States and those possessing a "Section Six" certificate could use their status to help relatives immigrate into the country; something Yitang found useful later on (Liu, 2005, pp. 29-30). Yitang originally landed in San Diego but, uninterested in the city, decided to move to Los Angeles. According to the 1900 Census, 293 Chinese were living in San Diego while 2,111 resided in Los Angeles (Liu, 2005, p. 34). In Los Angeles, he started work at a Chinese herbal company owned by nine partners. Most of the partners were only interested in the investment, and Yitang's herbal expertise was an asset to the company.

In 1908, Yitang's first wife died and he remarried Nellie Yee in 1910, Nellie was 22 years old and Yitang was 44 (Liu, 2005, pp. 1, 38). He was lucky to remarry, since there were only 187 Chinese women in America at the time, a result of the 1875 Page Act which forbid Chinese women from coming to America. In a time when many Chinese men had to leave their families back home or had insufficient funds to support a family, Yitang married a woman half

his age and they had four children. Keeping with Chinese culture of the era, Nellie never met Yitang before they were married. Instead, Yitang made a good impression on Nellie's father while treating Nellie's older sister.

Yitang was resourceful and built relationships with other Chinese herbal pharmacies. He sourced herbs from many locations such as the Dock On Chung in Hong Kong, the Jop Lon Tong and Jon Ming Tong company in San Francisco, and the Tai Wo Tang (Tai Wu Tong) in Los Angeles. As Yitang got older, Nellie took a more pivotal role with the herbal company and was responsible for a host of tasks, such as grinding the herbs and driving the herbal formulas to patients. She was one of the few Chinese women who could drive a car (Liu, 2005, pp.62-63). Yitang received additional help fifteen years after his immigration to the United States from his eldest child Sam Chung, who worked for the Chinese government and also apprenticed in herbal medicine under Guan Chengbi in Guangzhou. Sam Chang immigrated to America to work on his father's successful asparagus farm but, because of the Chinese Exclusion Act, he had to officially travel as a "merchant" at Yitang's herbal clinic rather than a "farmer" (Liu, 2005, pp. 1-2, 45).

Much of Yitang's business came to a halt in the 1940s and then to a close in the 1950s. Two things led to the slow demise of the company: World War II and the Congress' extension of the Trading with the Enemy Act. During World War II, trade was cut because Japan had invaded parts of China which included Guangdong and Hong Kong. By 1950, Congress extended the Trading with the Enemy Act, which barred any trade with the newly established People's Republic of China and North Korea. Further, Yitang's health had vastly deteriorated and in 1952 he died (Liu, 2005, p. 69).

2.6 Rural Encampments

The Chinese often established rural encampments near their work in the gold mines and railroad construction sites. Usually starting as laborers, Chinese medicine practitioners would then provide medical care for the workers. This was the case with practitioners Fung Jong Yee (Fiddletown, California), C.K. Ah-Fong (Boise, Idaho) and Ing Hay (John Day, Oregon).

2.6.1 Fiddletown, California

Aside from San Francisco, Fiddletown, California was the second largest Chinese settlement in America. At the time of the Gold Rush, it was reported to have five to ten thousand Chinese (Liu, 2005, p. 47). The high concentration of Chinese in Fiddletown, created an opportunity to provide a health care option for the people. The most notable shop was owned by Fung Jong Yee and called Chew Kee Herb Shop. It opened in 1851 and remained in business for fifty-three years, until Yee's death in 1904 (Liu, 2006, p. 137; Liu, 2013, p. 272). Since many Chinese were well aware of how to prepare the Chinese formulas, general stores like Chew Kee Herb Shop were instrumental in allowing patients with a basic knowledge of the medicine to treat themselves (Liu, 1998, p. 174). After Fung Jong Yee's death in 1904, Chew Kee Herb shop was overseen by You Fong "Jimmy" Chow until his death in 1965 at the age of 80 (Hillinger, 1987).

2.6.2 John Day, Oregon

Another outpost which was both a Chinese herbal pharmacy/clinic and general store was Kam Wah Chung & Co. located in John Day, Oregon. Started in the 1880s, Kam Wah Chung & Co. was owned by the Chinese medicine physician Ing "Doc" Hay and entrepreneur Lung On. Ing Hay was born in the Taishan (台山) county of Guangdong, and in 1887 immigrated to Washington,²⁹ before relocating to John Day, Oregon, leaving behind a wife and children in China. At first, Hay started out as a gold miner then learned Chinese herbal medicine from Doc Lee (Liu, 2006, p. 148; Varon, 2016). Originally, Hay treated Chinese patients, but by the 1890s, many Chinese left John Day and his clientele became mostly local whites.

Most of Hay's patients were either too frightened by the invasiveness of biomedical procedures or consulted him when the procedures were not successful (Shelton, 2013, pp. 269-270). Hay was particularly known for treating women. William Bowen believed a third of Hay's clientele were female

²⁹ Not to be confused with Washington, D.C.

but after reviewing patient's letters, historian Tamara Venit Shelton found closer to a majority of his patients were women (Bowen, 1993, p. 45; Shelton, 2013, p. 290). As Bowen points out, Hay treated a range of gynecological issues from "congestion" of the pelvic organs, to menstrual pains, to childbirth. Hay was also known to successfully treat blood poisoning, a common occurrence since farmers dealt with barbed wire and livestock (Bowen, 1993, pp. 45-46). Hay may have also provided preventative health measures for the residents at John Day, considering from 1915 to 1919, especially in Portland, thousands of people in Oregon were killed by a flu epidemic, yet not one person in John Day died from the epidemic. From 1919 to 1920, a construction crew was working near John Day and was hit with influenza. With the help of Hay, all were successfully treated with his herbal formulas (Liu, 2006, p. 150; Vernon, 2016). Hay was also known to send herbal formulas throughout the nation to patients who wrote letters to him about their ailments.

Long On died in 1940, leaving the Kam Wah Chung & Co. to become a solely Chinese medicine clinic. Shortly thereafter, Hay hired his nephew Bob Wah to help run the clinic. In 1948, Kam Wah Chung had to close because of Hay's ill health. Hay would spend the remainder of his life in Portland where he died in 1952. Hay was also known to be generous to his community. After his death, citizens of John Day found he had \$23,000 worth of uncashed checks, some written during the Great Depression (Vernon, 2016).

2.6.3 Boise, Idaho

Boise, Idaho is not typically associated with Chinese medicine but one of the pioneers of Chinese medicine, Ah Fong Chuck (also C.K. Ah Fong), moved there in 1889. Ah Fong was from Guangdong province and probably began to learn Chinese medicine from his father, Ah Whey, a physician. Ah Fong was said to have graduated from the Kung Guh Medical College³⁰ in 1867 and immigrated to the United States, with his father following shortly after. Both of them arrived in San Francisco the same year (Devitt, 2011, pp. 5-6). Like Yitang and Ing Hay, Ah Fong, also left behind his wife and two children, Herbert

³⁰ I could not find the Wades-Giles to Pinyin transliteration of "Kung Guh."

(Chuck Foot Sing) and Charley (Chuck Foot Wa). Ah Fong would later remarry a Chinese woman named Sing Yau, with whom he had an adopted daughter named Lena who would move with them to Boise.

Before Boise, Ah Fong parted with his father in San Francisco and moved to the Washington Territory in a town called Atlanta. In Atlanta, Ah Fong made trips to the mining camps in the mountains where he treated both Chinese and white miners who sought treatment for chronic illnesses, as well as traumatic injuries from working at the mines. Ah Fong's method of treatment varied but there is evidence he owned a copy of the 13th century *materia medica* written by Wan Hao-Ku (Wang Hao Gu 王好古) called *T'ang Yeh Pen Ts'ao* (*Tang Ye Ben Cao* 汤液本草) as well as the famous 3rd century treatises written by Zhang Zhongjing known as the *Shanghan Lun* (伤寒论). Ah Fong possessed such a great sense of Chinese herbal medicine, he began experimenting with indigenous plants and animal products within the Washington Territory to add to his pharmacopeia (Devitt, 2011, p. 8). With Ah Fong's knowledge and expertise in the region, his status in the community was elevated to "doctor." According to the 1880 Census, Ah Fong was listed as an "herbal doctor," which meant he was not just a merchant, but an actual physician (Muench, 1988, p. 9; Bowen, 1993, p. 47; Devitt, 2011, p. 6). He was the first and only Chinese medicine physician of his time to possess this designation and, as I will discuss later in this chapter, it was certainly a struggle to maintain.

When Ah Fong moved to Boise in 1889, he decided to focus his medical practice on women's health. Through an analysis of patient records, it becomes clear the majority of Ah Fong's patients were white women. It seemed he was particularly successful in treating women with sexually transmitted diseases, infertility, and other sexual dysfunctions. Since Ah Fong's clinic was positioned in the middle of what was considered Boise's red-light district, it could have been the location that drew his mostly-women clientele. Just as previously discussed with other Chinese medicine physicians in the United States, women gravitated towards Chinese medicine because of its non-invasiveness and frank treatment towards women's health (Devitt, 2011, p. 9). Michael Devitt argues Ah Fong also practiced acupuncture. Aside from Ah Fong's education and the books at his herbal pharmacy, no material evidence such as medical

records or advertisements were found to support Devitt's theory. (Devitt, 2011, pp. 7,9).

Ah Fong left such a legacy in Boise that on his death in 1927, newspapers hailed his contributions throughout Idaho. Just as with the majority of Chinese medical practitioners, Ah Fong's family, which comprised his two sons Herbert and Charley as well as his grandson Gerald Ah Fong, all took up responsibility for the herbal clinic after Ah Fong's death and continued operating it for the next thirty-seven years (Devitt, 2011, p. 11).

From Li Putai in San Francisco to Ah Fong in Boise, the practice of Chinese medicine became a part of the American experience and shaped Chinese American identity. Growing negative sentiment towards Chinese, racist laws, and the hegemonic rule of allopathic biomedicine would force Chinese, and in particular Chinese medicine physicians, to redefine their identity and challenge the dominant power structures for survival.

2.7 Political Orientalism: Labor, Racism, and Chinese Exclusion

Though print capitalism and commercial orientalism assisted Chinese medicine physicians, they were also detrimental. Earlier, I discussed self-occidentalization of Chinese physicians where they depicted themselves as looking more white. But, there was another possible reason for Chinese physicians to caricature themselves in this manner. During the late-19th century, orientalization of Chinese men as depicted by white Americans was exaggerated into a simulacrum of the Chinese as the Other. This fed racist sentiments of Chinese inferiority. As John Kuo Wei Tchen explains,

“They were mechanically reproduced by the aggressive commercial culture – on stage, in lithographic prints and photographs, and in other media. And each time real Chinese were mimicked, simulated, and reproduced, their post-culture experience was abruptly altered, reduced, and/or simplified... The resulting abstractions – narrow racialized types – were easily recognizable, and therefore highly salable. These images elicited different emotions – provoking laughter, assuaging fear, and forging solidarity between members of a paying audience by formulating a pan-European occidental identity in juxtaposition to the stereotype of a yellow face. Particularly popular images were pirated into endless chains of visual reproductions bearing

virtually no trace of the original quality, taking on new, stereotyped auras of their own. Such images, however, had a powerful effect on the real, everyday options of real, everyday Chinese; the representation became the real thing” (Tchen, 1999, p. 125).

Racist depictions of Chinese migrants in print-media fueled the already present anti-Chinese sentiment, which was equally related to labor as it was to race. The matter transitioned from the commercial to the political.

The formation of political orientalism could be found in California law as early as 1852, when California legislators enacted a foreign miner’s tax, also known as the “Tingley Coolie Bill,” which levied three dollars a month on every worker who was not an American citizen (Almaguer, 1994, p. 180). This tax was lucrative for California and provided from a fourth to half of the states’ revenue (Takaki, 1989, p. 82; Ancheta, 2006, p. 28). Then, almost a decade later in 1861, California passed “An Act to Prevent Further Immigration of Chinese or Mongolian to This State,” which after a year, was made into the law known as the Anti-Coolie Act of 1862 (also known as “An Act to Protect Free White Labor against Competition with Chinese Coolie Labor”). The Anti-Coolie Act was a piece of legislation which benefited white workers by imposing a tax on employers who hired Chinese immigrants (Ancheta, 2006, p. 28). Besides law, consumer boycott was a tactic used to protest Chinese labor. In 1859 cigar workers and shoemakers produced stamps and placards designating production by “white men” or “white craftsman” (Saxton, 1971, pp. 73-74).

Sociologist Terry Boswell found placer mines attracted Chinese and Mexican labor in competing for work against white miners. Work at placer mines consisted of “small surface digs of only the highest grade of ore” and required “... little skill or capital” when “picks, shovels, pans, and especially water were the primary means of production” (Boswell, 1986, p. 356). White miners took pride in being independent and having the ability to control the means of production. Chinese miners, on the other hand, were not considered “independent” laborers. Instead they were viewed as sojourners and labelled in print media as “coolies,” a term borrowed from the British and Spanish used to describe indentured servants who worked in exchange for loan payoffs or passage with minimal monetary compensation. As previously stated, most Chinese miners were from Guangdong and left because of its social and

economic disparity. Compared to their situation back in China, the earnings from “cheap labor,” mostly comprised of work white miners would not accept, were temporary hardships which eventually led to relative prosperity when they returned to China. From 1848-1867, roughly fifty percent of Chinese returned to China (Chen, 1980, p. 15; Boswell, 1986, p. 357). Chinese were also burdened with high passage loans, on average \$100 for a \$40-50 ticket (Zo, 1978, pp. 95-96; Boswell, 1986, pp. 356-357). And because of limited contacts in America, Chinese workers had to rely on the Chinese Six Companies, creditors, and/or gangs for employment (Zo, 1978, pp. 95-96; Bowsell, 1986, p. 358).

A significant factor in the Chinese Six Companies’ success was their political power. California gave the Chinese Six Companies authority to enforce their contracts with Chinese workers to the extent where they actually supplied the companies with police to stop any Chinese debtors from leaving the country (Saxton, 1971, pp. 8-9; Chen, 1980, pp. 27-29; Bowsell, 1986, p. 358). As Terry Boswell writes,

As a conduit of low-paid labor and a coercive collector of debts, the "six companies" functioned as middlemen in the interests of the capitalist class. By enforcing contracts and otherwise policing Chinese behavior, the "six companies" acted as an unofficial arm of the state which the white miners could not control through the electoral process. On the surface, a "coolie"- type exchange with private enforcement seemed to be taking place (Boswell, 1986, p. 358).

The Chinese Six Companies functioned as one of the first examples of “private security” where their existence was to ensure and enforce Chinese workers were treated as pawns by the capitalist class of tycoons and industrialists. John Kuo Wei Tchen and Andrew Gyory argued that the beginning hostilities towards the Chinese occurred around the passing of the 13th Amendment, which abolished slavery and brought forth the issue of contract labor (Gyory, 1991, pp. 28-29; Tchen, 1999, pp. 170-171). In 1864, the Contract Labor Act allowed industries and businesses to offer labor contracts to immigrants. Unscrupulous business owners and industrial tycoons initially exploited European and Chinese through contract labor. In 1865, Chinese were hired to work for the Central Pacific Railroad after the company first advertised

the hiring of thousands of white workers, but only 800 white workers applied for the job. Thus, the Central Pacific Railroad decided to hire Chinese. Besides the inability to hire white workers, Central Pacific Railroad also found the Chinese as assets to break strikes in both the steel mills which manufactured the rails as well as in the construction of the railroads themselves (Zo, 1978, pp. 160-164; Boswell, 1986, p. 361).

The animosity towards Chinese began to rise when anti-Chinese sentiment transformed unions into “anti-coolie clubs.” Historian Alexander Saxton found the emergence of anti-coolie clubs might have evolved from two separate events: the quartz miners’ union in Comstock, Nevada or the attack on Chinese laborers in San Francisco. It is unclear in the case of the quartz miners who had existing animosity directed at the Virginia and Truckee Railroad. The latter was a more apparent anti-coolie club, when in 1867, a mob of roughly four hundred white workers attacked Chinese workers on Potrero Street, throwing rocks at them and burning down their shanties throughout San Francisco. Ten assailants were arrested and convicted with stiff prison sentences, but released after a little over two months, due to workers pressure on then State Supreme Court attorney S.B. Axtell to release the convicted. These clubs would continue to incite violence against Chinese workers throughout the city (Saxton, 1971, pp. 72-73).

Until the late-1860s, organized labor’s issue with Chinese workers was mostly a West Coast problem. In the following years businessmen and industrialists in the East Coast would exploit Chinese workers and expand the anti-Chinese sentiment to a national level. While the West Coast was experiencing hostility towards the Chinese, much of the animosity in the East Coast was directed at the Irish as well as Eastern and Southern European immigrants. In 1868 when the National Labor Union held a meeting in New York City, it rallied around the unity of all workers (except Chinese) against the exploitation of workers by “immigrant companies” (Tchen, 1999, pp. 170-171). The noticeable anti-Chinese tone among organized labor became clear a year later in 1869. As Tchen points out in an edition of the *Workingmen’s Advocate*, editor Andrew C. Cameron writes of the coming threat of Chinese labor,

We warn workingmen that a new and dangerous foe looms up in the far west. Already our brothers of the Pacific have to meet it, and just as soon as the Pacific railroad is completed, and trade and travel begins to flow from across our continent, these Chinesemen will begin to swarm through the rocky mountains, like devouring locusts and spread out over the country this side . . . In the name of workingmen of our common country, we demand that our government . . . forbid another Chinaman to set foot upon our shores (as cited in Gyory, 1991, Tchen, 1999, pp. 171-172).

Opportunistic entrepreneurs capitalized on the backlash and emotion surrounding slavery and indentured servitude in the East Coast and South. They would employ “cheap” Chinese to bypass national organized labor (unions) and as a means to disrupt unions in the East Coast. On June 30, 1869, businessmen, industrialists, and “prominent and influential citizens” along with delegates from the South were invited to the Memphis Chamber of Commerce to formulate the New South ideology and, more importantly, discuss the prospects and necessity of Chinese labor. One such citizen was Mississippi railroad lawyer and Democratic Electoral College member J.W. Clapp. At the conference, Clapp voiced a tone of white supremacy foreshadowing the degradation of Chinese in the United States,

From Madagascar to Canada that country does not exist where the negroes engage in voluntary labor. They had him in the West Indies, and he converted them into a garden, but when the negroes ceased to be guided by the whites the Islands became a wilderness, and the inhabitants became savages again . . . As to the mixture of races—have we not a mixture among us now that cannot be worse? Have not the most stolid and ignorant race been made the governing power? . . . [The Chinese] don’t come among us to mingle in politics; they do not seek to be naturalized even. They come here from their teeming hives, and expect to go back, carrying with them the scanty pittance that they have earned . . . As to the internecine struggle between the Chinese and negro that we hear about, we don’t know that that is any affair of ours. I have a kindly regard for the negro, but I don’t want him to be hung as a millstone around our necks. Extermination is his doom. The supremacy of the white race must be vindicated under all circumstance . . . There will be no amalgamation. The superior race will not come down to the inferior (as cited in Jung 2006, 100).

A few weeks later on July 13, 1869, five hundred delegates from California and a slew of Southern states met at the Greenlaw Opera House in Memphis “to devise ways and means to inaugurate the importation of Chinese or Asiatic labor” (Jung 2006, pp. 99-101). In June of 1870, seventy-five Chinese workers were brought from California to North Adams, Massachusetts to break a strike at the Calvin T. Sampson’s Shoe Factory. Similarly, Captain James B. Harvey sent sixty-eight Chinese from California to break a strike in Belleville, New Jersey (Rudolph, 1947, p. 24; Tchen, 1999, p. 175; Jung, 2006, pp. 99-100; McLennan, 2008, pp. 107-108).

On July 1, 1870, cries of fear towards Chinese and white supremacy reverberated from New York. This time it was from the voice of labor through editor John Swinton. Swinton wrote a sixteen-page article for the *New York Tribune* entitled “The New Issue: The Chinese-American Question.” It was published moments before a large rally was held in New York’s Tompkins Square Park by workers representing all of New York’s trades. In Swinton’s article, he wrote, “The Mongolian type of humanity is an inferior type . . . [C]an we afford to permit the debasement of the American race-type by intermixture with an inferior race? Can we afford to admit the transfusion into the national veins of a blood more debased than any we have known?” Swinton went on to attack Chinese women and men by saying the “. . . lewd Chinese women . . . are but little worse than the ship-loads of incestuous and Sodomite Chinese men” (as cited in Gyory, 1991, pp. 73-74). The article had an effect on the rally: the primary issue was Chinese “coolie” labor, where the fearful rhetoric of job insecurity was matched with anti-Chinese racism. The tone of white supremacy even trickled up to public figures such as the mayor of New York, A. Oakley Hall, who felt the Chinese were “debased in race, irreligious, and in many respects incapable of free reason” (Tchen, 1999, pp. 178-179).

Other rhetoric of white supremacy sought to show the inferiority of Chinese men by depicting them as effeminate. As Boswell points out, after the rush of Chinese working in mines, they then began what white Americans perceived as women’s work: housekeeping, laundry, and cooking (Bowell, 1986, p. 359). In the East Coast, the laundry industry provided a lucrative trade for Chinese. Tchen traced Chinese laundrymen in New York back to the 1870’s. The Chinese were hired from fear of striking Irish women, who were associated

with the laundry trade. Captain James B. Harvey employed 300 Chinese laundrymen in his Passaic Steam Laundry in Bellville, New Jersey to break the strike. Chinese proved to be just as non-compliant as Irish women and left their jobs shortly after starting. One of the brothers of a Chinese worker at Passaic Steam Laundry, Ong Yung, decided to open his own laundry in Manhattan, the first of its kind. With its success, he opened several more around the city. By 1879, a *New York Sun* article reported at least two hundred Chinese laundries in Manhattan alone (Tchen, 1999, pp. 250-251). It was also the Chinese success at another trade which further fueled anti-Chinese sentiment.

With the anti-Chinese position as a focal point, there was something an odd pairing of Americans could agree on. As Saxton and Boswell argue, anti-Chinese movements of the 1860s and 1870s would unify the New South Ideology of ex-plantation owners with labor, or, as Boswell writes, become a “bridge between anti-slavery populists and ‘Jim Crow’ southerners” (Saxton, 1971, pp. 132, 135-137; Boswell, 1986, p. 366). The anti-Chinese movement garnered more support, especially on the West Coast, and by the 1878, proceedings of the Constitutional Convention of the State of California made a referendum which passed 150,000 to 900 favoring Chinese exclusion (Saxton, 1971, pp. 138-139).

Chinese exclusion was a reaction to the animosity and fear labor factions had accumulated during the 1860s and 1870s and would inevitably pave the way for the Chinese Exclusion Act of 1882. This marked the first time in American history an entire group of people were prohibited from immigration based on race and class (Lee, 2003, p. 4). As historian Erika Lee writes,

Chinese exclusion as an institution that produced and reinforced a system of racial hierarchy in immigration law, a process of both immigrants and immigration officials shaped, and a site of unequal power relations and resistance. Immigration law thus emerges as a dynamic site where ideas about race, immigration, citizenship, and nation were recast. Chinese exclusion in particular, reflected, produced, and reproduced struggles over the makeup and character of the nation itself (Lee, 2003, p. 7).

As stressed earlier, the Chinese Exclusion Act did not ban all Chinese from entering the United States, only a particular class. In combination with the Page Act of 1875, the only Chinese who had access to American immigration

were Chinese men who were either merchants or officials. In other words, Chinese exclusion was just as much a class issue as it was racially motivated. Just because merchants and officials had access to enter America's borders, does not necessarily mean they were treated well. As Lee points out,

Nevertheless, Chinese merchants, students, officials, and travelers were never automatically admitted or given special treatment solely on the basis of their class. Immigration officials feared (sometimes with justification) that Chinese claiming exempt-class status were either laborers in disguise or likely to become laborers after being admitted . . . They thus judged the class status of Chinese immigrants through the lens of race, and race through the lens of class status. Chinese applying for admission were viewed as Chinese first and merchants, students, or officials second. Sometimes class provided protection from racial discrimination; often times it did not (Lee, 2003, p. 87).

To enter the United States as a merchant or official, Chinese were scrutinized based on their intellect and appearance. Merchants had to undergo literacy tests, on which standards were known to be particularly high. There were reports of some applicants who passed the literacy exam, but were denied on grounds they did not have "an extensive knowledge of business." On an aesthetic level, merchants had to "look the part" as immigration officials denied Chinese entry if their clothes were of "poor quality." Others would be denied upon physical examination if their hands were calloused or if their skin was too dark (Lee, 2003, pp. 87-90).

Erika Lee notes in 1901, the definition of the term "merchant" would narrow and exclude "Chinese salesmen, buyers, book keepers, accountants, managers, store keepers, apprentices, agents, and cashiers." By 1924 only those engaged with international trade were deemed as "merchants" (Lee, 2003, p. 91). As shown with Yitang's immigration trial, Chinese had to legally defend themselves by having at least two white witnesses testify during their trials to re-enter the United States (Lee, 2003, pp. 91-92). By the 1890s, white supremacist rhetoric was normalized and made its way to the Supreme Court when Justice John Marshall Harlan argued during the *Plessy v. Ferguson* trial,

There is a race so different from our own that we do not permit those belonging to it to become citizens of the United States. Persons belonging to it are, with few exceptions, absolutely

excluded from our country. I allude to the Chinese race. But by the statute in question, a Chinaman can ride in the same passenger coach with white citizens of the United States, while citizens of the black race [cannot] (as cited in Chin, 1996, p. 156).

Later, on the issue of Chinese immigration, Justice Marshall felt compelled to add his perspective again on the Chinese in relation to African Americans.

The Chinese are of a different race, as distinct from ours as ours is from the negro . . . [S]uppose there was a tide of immigration... of uneducated African savages-would we not restrict their coming? Would we desist because they are human beings & upon the idea that they have a right to better their condition? . . . [Chinese] will not assimilate to our people. If they come, we must admit them to citizenship, then to suffrage-what would become of the country in such a contingency . . . Under the ten year statute [i.e., the first Chinese Exclusion Act] we have an opportunity to test the question whether it is safe to let down the bars and permit unrestricted immigration – The Chinese here will, in that time, show of what stuff they are made. Our policy is to keep this country, distinctively, under American influence. Only Americans, or those who become such by long stay here, understand American institutions (as cited in Chin, 1996, p. 160).

Rhetoric turned into action throughout the 1870s and 1880s, as anti-Chinese violence spread across the nation. One of the first significant acts of violence against Chinese occurred in 1871 when seventeen to twenty Chinese were systematically hanged and killed by a mob of whites in Los Angeles in what were seen as revenge killings. Known as the “Chinese Massacre of 1871,” this is said to be the largest mass-lynching in American history (Newmark, 1916, pp. 432-436; Johnson Jr., 2011). Almost a decade later on October 31, 1880, Denver’s Chinatown erupted into a riot over a dispute at a saloon between two Chinese and three white locals. The few white locals exploded into a mob which then became a riot. This result in almost all Denver’s Chinatown burnt down and a Chinese man by the name of Lee Sing beaten to death and then lynched (Wortman, 1965, pp. 280-286; Toto, 2011). Denver was not the only city to have its Chinatown annihilated.

By 1885, the Chinese Exclusion Act had an enormous effect on anti-Chinese sentiment. Much of the violence stemmed from economic woes though to be a result of Chinese immigration. Places such as Eureka, California, once

relatively prosperous from timber production, experienced a depression from the Panic of 1873. But, much of the blame and anger was directed towards Chinese, who lived on the crime-ridden fringes of Eureka. Hostility between whites and Chinese in the town dated back to 1875 when a group of white men disrupted a Chinese New Year's celebration. The press in Eureka also negatively depicted the Chinese and their quarters as being overwhelmed with crime and disease. Because of these factors, much of the town was in support of Chinese exclusion. Then, on February 1885, a shooting between two Chinese men accidentally killed Eureka's city council member David C. Kendall. A meeting was held shortly after the shooting and a mob gathered and turned violent. All three-hundred and fifty Chinese residents were forcefully expelled from Eureka (Carranco, 1961; Bottoms, 2013, p. 183).

In November 1885, a group of white workers accompanied by the Knights of Labor, were so enraged by the presence of Chinese laborers in Tacoma, Washington where workers began to forcibly evict all the Chinese from Tacoma's Chinatown and, just as in Denver, burnt it to the ground (Bottoms, 2013, pp. 184-185). The following year, 1886, another riot broke out in nearby Seattle, where governor Watson Squire sent in ten companies of the Fourteenth Infantry to protect the Chinese. The federal troops, however, attacked them, and expelled 350 Chinese (Bottoms, 2013, p. 185).

On September 2, 1885 in Rock Springs, Wyoming, the Knights of Labor organized white miners to battle against Union Pacific. Union Pacific exploited the already existent animosity between the Chinese and white laborers during construction of the transcontinental railroad, as Chinese staged walkouts because whites were paid more for working fewer hours. As a result, Union Pacific encouraged Chinese labor, as opposed to white labor, to mine coal at Rock Springs. Union Pacific also used exploitation tactics to force the Chinese to work and cut off water and food supplies to 2,000 workers. A scuffle broke out between two white miners (Isaiah Whitehouse and William Jenkins) and a group of Chinese miners over a disputed space in the coal mine. The scuffle turned violent after one of the Chinese miners attacked Whitehouse with a pick but was immediately surrounded by white miners who killed him by striking his skull with a pick three times. Word spread among the white miners and a mob was formed which consisted of miners as well as railroad workers and drifters.

Now armed, the mob surrounded the Chinese section of Rock Springs known as “Hong Kong” and began to fire. Some Chinese managed to escape to the countryside of Bitter Creek while others were not as fortunate. The mob burned down most of “Hong Kong” and killed at least twenty-five Chinese in what is known as the “Rock Springs Massacre” (Wilson, 1967; McGowan Jr., 1986; Niderost, 2002, pp. 49-52, 72).³⁶

Violence spread throughout the Northwest, when three days later at Wold Brothers Farm in Washington Territory’s Squak Valley, a group of white hop pickers fired on Chinese worker tents, killing three Chinese and wounding another four (Bottoms, 2013, p. 184). Then, a few days later, on September 11 at Coal Creek in the Washington Territory, thirty-seven Chinese workers were forced out of their quarters, which were later burned down. Similar incidences occurred on September 17 and 29 when Chinese were driven out of Black Diamond and Franklin mines. On May 25, 1887 in Deep Creek on the Oregon side of the Snake River, anti-Chinese sentiment went to an extreme when thirty-four Chinese were massacred by six white thieves and schoolboys from Wallowa County, Oregon. This became known as the “Deep Creek Massacre” (Naylor, 2014, p, 51; Nokes 2006; 2016).

With violence against Chinese prevalent throughout Oregon, Ing Hay and Long On did not take any risks. Even though both men were considered “merchants,” violence against Chinese in John Day, Oregon did not discriminate. The primary reason why Kam Wah Chung, which is now a museum, was so well preserved for nearly fifty years was because Ing Hay and Lung On fortified the store-clinic with an iron door and windows to protect against any attacks. Further precautions against anti-Chinese violence in the region can be seen in everyday activities, such as both men chopping fire wood indoors on a wooden block embedded in the ground. As in the case of Ing Hay and Long On at Kam Wah Chung, racist violence towards the Chinese occurred regardless of a person’s trade. But, the most obvious persecution of Chinese medicine physicians came from those who would control the medicine.

³⁶ For a more comprehensive analysis of the Rock Springs Massacre, refer to Arlen Ray Wilson’s dissertation “The Rock Springs, Wyoming, Chinese Massacre, 1885” (Wilson, 1967).



Fig. 2.1 Fortified Door and Wooded Block Embedded in the Floor at Kam Wah Chung

2.8 “Regular” and “Irregular” Medicine

The legitimacy of Chinese medicine, which is a key theme of my work, relates to authority and power. Max Weber discussed legitimacy in terms of authority/domination (*Herrschaft*) where he categorized “Three Types of Authority” as: legal/rational, charismatic, and traditional. As Weber explains,

In the case of legal authority, obedience is owed to the legally established impersonal order. It extends to the persons exercising the authority of office under it by virtue of the formal legality of their commands and only within the scope of authority of the office. In the case of traditional authority, obedience is owed to the person of the chief who occupies the traditionally sanctioned position of authority and who is (within its sphere) bound by tradition. But here the obligation of obedience is a matter of personal loyalty within the area of accustomed obligations. In the case of charismatic authority, it is the charismatically qualified leader as such who is obeyed by virtue of personal trust in his revelation, his heroism or his exemplary qualities so far as they fall within the scope of the individual's belief in his charisma (Weber, 1978, pp. 215-216; 2003, pp. 311-312).

While American Chinese Medicine, with its focal point around acupuncture was not practiced until the 1970s, it fit with Weber's legal and charismatic authorities. Chinese medicine from the 1850s to the 1940s,

practiced by the Chinese diaspora, however, did not. The “scholar-doctors” and “heredity-doctors” could be classified as Weber’s “traditional authority,” but many Chinese medicine physicians of late-19th and early-20th century existed outside of Weber’s categorization. A great number of Chinese medicine physicians who immigrated to the United States neither came from a familial lineage nor were they trained in a formal setting such as the imperial court system.

The professionalization of biomedicine medicine in the United States was also complicated. It is best described as a process which occurred from the mid-19th century to the mid-20th century. From the 18th to early-20th century, the designation of “physician” or “doctor” was fluid and denoted an array of medical practitioners. Arguments on whether a medicine was “regular,” “irregular,” or “defective” did not arise until the mid-19th century. The term “irregular” medicine was simply used in contrast to those who practiced “regular” medicine. In contrast, “allopath” was used by the opposing homeopaths.

Allopaths, or regular doctors, were one of a number of medical sects vying for professional dominance throughout the nineteenth century. The term “allopath” was coined by Samuel Hahnemann, the founder of a competing medical sect known as homeopathy, to differentiate physicians who subscribed to a homeopathic philosophy from those who did not (Kaufman, 1971).

As of the early-19th century, “regular” medicine was known for the use of “heroic” treatments, which involved bloodletting, blistering, emetics, purgatives, opiates, surgery, and occasional use of lethal substances such as mercury. “Regular” physicians were known to “take action” and give less agency to the patients and more emphasis on their own discretion along with their heroic therapies (Klee, 1983, p. 187; Wharton, 2002, p. 7). This is opposed to “irregular” physicians, who treated with “natural healing” encompassed through the view of “*vis medicatrix naturae*” (“the healing power of nature”) and who entrusted nature to cure patients. With the French term *médecine douce* (“mild medicine”), “irregular” physicians utilized a range of treatment remedies from the extreme dilution of substances employed by the homeopaths to the use of herbs and roots in the form of elixirs and pastes used by the Thomsonians

(Wharton, 2002, p. 9). At the heart of “irregular” medicine was also the idea of vitalism. As James Wharton describes it,

Vitalism, or the belief that the human body is activated and directed by a life force that is unique to living organisms and the transcends the laws of physics and chemistry used to account for the phenomena of the inorganic world (Wharton, 2002, p. 10).

Vitalism was crucial for “irregular” physicians and was a counter to the rationalistic and theoretical approach of the orthodox “regular” doctors. “Irregular” doctors, therefore, felt “regular” doctors’ orthodox medicine lacked the crucial phenomenological skill attained from experience with patients. As Wharton further explains,

Listening to nature leaves room for intuitive discoveries of curative agencies, and irregular doctors have often claimed a special talent or knack for healing that comes from direct communion with nature and that could never be learned through science. That talent, they have maintained, is what makes one a true healer, instead of merely a technician, as most MDs are seen to be (Wharton, 2002, p. 11).

The convention of “regular” or “irregular” doctors did not have much of an impact on medicine until the latter part of the 19th century with the implementation of standards for medical curricula by state licensing boards as well as the creation of the American Medical Association (AMA). The terms “doctor” and “physician” were used loosely and had an array of connotations. In the Founding Era, physicians had a more civic role and were “influential figures in their community,” representing four of the fifty-six signers of the Declaration of Independence as well as twenty-six members of the Continental Congress (Starr, 1982, p. 83). Seventeen of the first hundred members of New Jersey’s Medical Society became members of Congress or held positions as state legislators (Starr, 1982, pp. 82-83). Historical perceptions of the practice of medicine were not as favorable as those of lawyers or clergymen. In an 1851 AMA study of 12,400 men from eight of the leading universities, roughly 26% of the students went to study law, while less than 8% went to pursue medicine. Through accounts from renowned physicians, medicine at the time was not a desirable profession to pursue. Surgeon J. Marion Sims was shunned by his father after telling him he wished to study medicine. The neurologist S. Weir

Mitchell's father, who was also a physician, pressured his son to pursue commerce and was disgusted by his son's decision to become a doctor (Starr, 1982, p. 82). The medical profession was starkly different in the 19th century from the rigorous standards which exist today. As Starr writes,

The nineteenth century could hardly offer a more vivid contrast. A professional career had no fixed pattern. Whether or not a physician went to medical school and if he did, for how long and with what general education, were all variable. Apprenticeships had no standard content. A medical education was neither as long nor as peer oriented; organized professional socialization was minimal. Few training positions were available in hospitals, and those were not awarded competitively; social connections weighed heavily in selecting candidates. Most young physicians had to strike out on their own, gradually building up a practice. At that early point in a professional career when doctors now spend sleepless nights as overworked interns and residents, their counterparts in the nineteenth century were waiting for their first patients to show up (Starr, 1982, p. 84).

With the initial path to pursue medicine in the early-19th century being varied and undesirable, a shift towards professionalization occurred later in the century. The consolidating of "regular" medicine began with the creation of the AMA in the mid 19th century. The validation of the AMA simultaneously produced the "legal authority" postulated by Weber, as well as a hegemonic force which alienated other forms of medicine, such as Chinese medicine, by determining legitimacy through its designation of "regular," "irregular," or "defective." Starr attributes the legitimacy of legal authority of physicians to institutionalization through the standardization of education and licensing.

Before the profession's authority was institutionalized in the late nineteenth and early twentieth centuries, physicians might win personal authority by dint of their character and intimate knowledge of their patients. But once it was institutionalized, standardized programs of education and licensing conferred authority upon all who passed through them (Starr, 1982, pp. 19-20).

Steps to institutionalize a "regular" medicine began in May 1846 in New York City when a conference was convened between all American medical societies to create a code of ethics and standards for medical formulas and education. Prior to 1846, the first national conference was convened in 1820 by

the physician Lyman Spalding (1755-1821) who wanted to create a “national consensus statement on pharmaceuticals.” This resulted in the *Pharmacopeia of the United States of America* (now *The United States Pharmacopeia*), which bears the inscription “published by the authority of Medical Society and Colleges.” Yet even as early as 1817 physicians in New York, who were a part of Medical Society of the County of New York (MSCNY) discovered formulas and vaccines for the treatment of small pox. The conference of 1846 was preceded by a few failed attempts at a national conference of “regular” medical societies. The first attempt was in 1835 at the behest of the Medical College of Georgia to the Medical Society of the State of New York (MSSNY) and other medical societies to discuss standards of education. Then another failure in 1839 at the request of the Utica, New York physician John McCall (1787-1867) (Baker, 2013, pp. 131-133).

Much of the success of the 1846 conference was almost accidental when one of the leading surgeons in New York, Alden March (1795-1869), sent out Nathan Smith Davis (1817-1904) to persuade delegates from MSSNY to convene in 1846 at University of the City of New York (now New York University) to discuss educational standards. Although 122 delegates responded to attend the event, the MSSNY had second thoughts and sent disinvitation letters to members they felt were not suitable for the conference. But, mail travelled slowly and these letters did not reach the delegates in time. When the disinvited delegates did arrive at the conference – unbeknownst of their rejection – the credential committee pragmatically accepted their credentials anyways with diplomas bearing the seal of the committee (Baker, 2013 p. 133). By 1846, without standards for medical education, schools competed with each other by shortening the duration of study and lowering tuition costs. With this in mind, two Philadelphia physicians, Isaac Hays (1796-1879) and John Bell (1796-1872), decided to conjoin educational standards with a national medical code of ethics to convene the following year.

In 1847, with the proposal of Isaac Hays and John Bell, a confederation was conceived which consisted of all medical societies and schools as well as hospitals, asylums, and other medical institutions. It became known as the American Medical Association (AMA). Similar to the conference a year before, there was an emphasis on standards of education. The 1847 conference

additionally constructed a code of medical ethics which differentiated “regular” practitioners from “irregular” practitioners; excluding membership to the latter (Baker, 2013, p. 16). The AMA’s medical code of ethics was influenced by Hays and Bell, who were also members of the secret fraternal society known as Kappa Lambda Society of Hippocrates. With Bell’s involvement with Kappa Lambda of Philadelphia, he translated the British physician Thomas Percival’s *Medical Ethics* to suit American physicians. The publication of *Extracts from Percival’s Medical Ethics*, served as a primary influence for the AMA’s medical code of ethics (Baker, 2013, pp. 138-140). Still, the AMA had little legitimacy in its beginning. As Starr explains,

Whatever the objectives of the AMA, it turned out to have little impact during its first half century. The "irregular" physicians accused it of attempting to monopolize medical practice and drive them from the field, and the AMA did have some success in keeping them out of the few medical positions in the federal government . . . The "irregulars" thrived. The efforts of the AMA at voluntary reform of medical education failed miserably, as the schools would not comply. The AMA had scant resources at its disposition. Its membership was small, it had no permanent organization, its treasury was bare. Its authority was questioned even within the profession. The association met once a year, and then for all practical purposes disappeared. It had an amorphous system of representation, at first drawing delegates from hospitals and medical schools as well as medical societies; once elected, delegates became permanent members, so long as they paid the dues... The association became so embroiled in political squabbles that the more scientifically minded members split off to form a separate learned society (Starr, 1982, p. 91).

It was not until 1906 when the AMA had a pivotal transition when its Council on Medical Education conducted an inspection of 160 medical schools in the United States and graded each school based on its students’ performance on the state’s licensing examination as well as its curriculum, facilities, faculty, and requirements for admissions. The AMA’s Council of Medical Education was initially created in 1904 and consisted of five medical professors from five of the major medical schools. Originally, the Council of Medical Education sought to determine an “ideal” minimum standard of education which culminated in a six-year curriculum after four years of high school. Out of the cumulative six years, five were spent at medical school with

one year devoted to the basic sciences and the sixth year devoted to a hospital internship. In its evaluation, the council fully approved only eighty-two schools with the "Class A," forty-six schools were graded "Class B" as imperfect but redeemable, and thirty-two were graded "Class C" as non-salvageable (Starr, 1982, pp. 117-118; Goodman and Musgrave, 1992, p. 143).

The unsettling results were presented at that year's AMA conference, but the AMA decided not to publicize their findings outside of the AMA. Instead, they chose to have a third party, which in this case was the Carnegie Foundation for the Advancement of Teaching, follow with a similar evaluation. In 1908, the Carnegie Foundation elected an inexperienced undergraduate named Abraham Flexner (1866-1959) to evaluate all the medical schools in the United States in his *Bulletin Number Four*, which is known commonly today as the "Flexner Report." Flexner had an undergraduate degree in arts and owned a for-profit preparatory school in Louisville, Kentucky. Because of Flexner's inexperience in the field, it is debated whether or not his methods of evaluation were sound. John Goodman and Gerald Musgrave found his approach negligent and claimed Flexner was known to evaluate a whole school in one afternoon. Flexner was accompanied by the secretary of the AMA's Council of Medical Education, N.P. Colwell (1870-1936), an unreliable witness, who was known to provide the results to the AMA's Council of Medical Education. Besides possible collusion with Colwell, Flexner also sought assistance from the AMA and spent a considerable amount of time at the AMA's headquarters in Chicago preparing his report (Goodman and Musgrave 1992, p. 143-144). Starr, on the contrary, argues though Flexner lacked experience, his expectations of the schools were too high whereby his criteria were even more rigid than the AMA's. During Flexner's tour of the medical schools, he most commonly found irregularities to what the schools advertised. As Starr remarks,

Repeatedly, with a deft use of detail and biting humor, he showed that the claims made by the weaker, mostly proprietary schools in their catalogues were patently false. Touted laboratories were nowhere to be found, or consisted of a few vagrant test tubes squirreled away in a cigar box; corpses reeked because of the failure to use disinfectant in the dissecting rooms. Libraries had no books; alleged faculty members were busily occupied in private practice. Purported requirements for admission were waived for anyone who would pay the fees. (Starr, 1982, p. 119)

Starr, as well as Goodman and Musgrave, would agree Flexner held Johns Hopkins' as the best and as the benchmark of medical school evaluations (Starr, 1982, p. 120; Goodman and Musgrave, 1992, p. 144). As a result, Flexner's report made scathing evaluations of "irregular" medical schools, comprised of eclectic, homeopathic, and osteopathic institutions (Burrow, 1977, p. 12; Shelton, 2013, p. 269). Debate remains as to whether Flexner's findings actually led to the closure of the many medical schools at the time. In 1906, United States reportedly had 162 medical schools. In 1910, the year the "Flexner Report" was published, the number of schools dropped to 131, and by 1915 there were only 95 schools nationwide (Starr, 1982, pp. 118, 120). Although Tamara Venit Shelton and James Burrow rightfully argued how Flexner's opinions were detrimental to "irregular" medicine, Shelton as well as Goodman and Musgrave, contend that Flexner's report also had a direct impact on the decline of a series of "regular" medical schools (Goodman and Musgrave, 1992, pp. 144; Shelton, 2013, p. 269). But, Starr claims differently and attributes the closures to a result of higher expectations from the state licensing boards. With the state licensing boards' request for more hours of training, tuitions costs increased. New requirements of the states' licensing boards pressured schools to either increase expenditure on laboratories, libraries, clinical facilities, and faculty or simply close (Starr, 1982, pp. 118, 120).

Starr claims state licensing boards had just as important a role in the trajectory of medicine as the schools. The history of the licensing boards started in the 18th century, medical licensing boards, schools, and societies seemed to have birthed around the same period. New York's licensing board was created in 1760, the first medical school in Philadelphia was founded in 1765, and the first provincial medical society was established in 1766 (Starr, 1982, p. 40). In the 18th and most of the 19th century enforcement of licensing was non-existent and it seemed unlicensed physicians were on the rise. It was not until 1877 Illinois made a ground-breaking decision to give its state medical board the authority to reject medical diplomas (Starr, 1982, p. 104). Physicians such as homeopaths, now seen as separate from allopathic biomedicine, defended their right to practice medicine all the way to the early-20th century.

In 1889, the Supreme Court unanimously ruled in favor of the State of West Virginia in the landmark case *Dent v. State of West Virginia*. An eclectic physician named Frank Dent, in practice for five years, had his license rejected and subsequently brought his case to court. West Virginia passed a statute in 1881 which required physicians to have graduated from “a reputable medical school” or to have passed the examination given by the State Board of Health. Dent, who graduated from the American Medical Eclectic College in Cincinnati, lost his case when he refused to take the examination given by West Virginia’s State Board of Health. The Court’s decision on Dent’s case was pivotal in the battle between “regular” and “irregular” medicine, finding the education at “irregular” institutions was no longer viable. At the turn of the century, the Supreme Court ruled in favor of the states, thereby upholding Michigan’s medical practice act to determine the qualifications of a practitioner and punish those operating in defiance of the act’s provisions. This set precedence for state medical boards to enforce their regulations (Hamowy, 1979, pp. 96-97). With the lack of schools and more rigid provisions against “irregular” physicians, the general public felt the shift. Though homeopaths still had political power, the rest of “irregular” medicine was losing favor.

In winning licensing privileges, the new sectarians were usually unable to win access to hospitals or the right to prescribe drugs. Unlike the homeopaths in the mid-nineteenth century, they did not represent a serious challenge to the profession. According to a survey of nine thousand families carried out over the years 1928 to 1931, all the non-M.D. practitioners combined – osteopaths, chiropractors, Christian Scientists and other faith healers, midwives, and chiropodists – took care of only 5.1 percent of all attended cases of illness (Starr, 1982, p. 127).

With ever more stringent state licensing requirements and the publication of the Flexner report, medical schools at the turn of the 20th century were on the decline to the growing influence of the AMA. The AMA’s alliance with the Association of American Medical Colleges (AAMC) helped shape medical education standards for the 20th century and continues to have an effect on the state licensing boards and the entirety of education standards today. The AAMC administers the Medical College Admission Test (MCAT), which is the standard examination for medical students in the United States.

The AMA, which is still a non-government agency, had little influence in terms of medicine for much of the 19th century. The Flexner report helped legitimize the AMA and formed a regular medicine orthodoxy.

Even though no legislative body ever set up either the Federation of State Medical Boards or the AMA Council on Medical Education, their decisions came to have the force of law.... Short of federal intervention, control seemed impossible. But the medical profession had carried its effort to every state, and its success was a measure of how far it had come since the mid-1800s (Starr, 1982, p. 121).

But at the time Chinese medicine began to take form in California, the definition of “regular” medicine was being debated.

2.9 Chinese Medicine’s Persecution

By the 1880s in California, “regular” medicine was still ill defined. In 1869, The San Francisco Medical Society made efforts to distinguish between “regular,” “irregular,” and “defective” medicine. At the time, “regular” physicians were perceived as having formally studied medicine and passed the proper examinations while “irregular” practitioners were those who were “champions of some exclusive idea” (Klee, 1982, p. 187). As late as 1870, “regular” physicians depended on heroic medical treatments, which were seen in some regards as equally if not less effective compared to “irregular” medicine. The primary attacks “regular” physicians made on “irregular” doctors at time were accusations of them as “quacks” or “charlatans.” It was not until the latter part of the 1880s when “regular” physicians adopted germ theory with the breakthrough of bacteriology; and not until the course of the 20th century did “regular” medicine discovered and adopted antibiotics, antiseptic surgery, and anesthesia in the United States (Klee, 1982, pp. 188-189). The advantage “regular” physicians in San Francisco did have was the law and the requirement for licensure.

“Regular” doctors had more disdain for Chinese medicine than they did for any other “irregular” medicine. Klee points out by 1880s in San Francisco, “Regular physicians had a special advantage while attacking Chinese

practitioners because Chinese were already regarded as ethnically and culturally aberrant in the community” (Klee, 1982, p. 189). As Shelton writes,

Descriptions of Chinese medicine drew on American Orientalist ideas and attitudes. American Orientalism was a popular discourse that developed in the context of trade and diplomatic relations between the United States and China... that linked unequal power relations between West and East to the presumed racial inferiority of Asian races. American perceptions of Asians as backwards and barbarous, decadent and effeminate, served as justification for exclusionary and discriminatory practices and policies. For white Americans who believed Chinese were racially inferior, it was no stretch to impose the same stereotypes onto Chinese herbal remedies. Attacks on Chinese medicine ridiculed the practice as anti-modern or unscientific and, at best, suited only to serve women’s medical problems (Shelton, 2013, p. 271).

With anti-Chinese sentiment further legitimized by the Chinese Exclusion Act, Chinese medicine had to endure “regular” medicine’s newly found power was enforced by law. Chinese physicians had three legal factors working against their practice of medicine in the United States, mostly but not mutually exclusive: access to a medical education approved by the state medical board, the ability to pass the state board’s examination, and, their status as “merchants.” By 1901, California created its medical licensing law, which required a mandatory diploma from a school approved by the medical board as well as for applicants to pass the medical board examination. Just as Trauner points out before, most, if not all, Chinese physicians were unlicensed because they simply did not attend an approved medical school. This was because schools in California did not allow any Chinese admittance (until 1908 at the University of California in San Francisco). The ramifications of the Chinese Exclusion Act did not allow any Chinese physician to claim themselves as “doctor” or “physician,” as they were still considered “merchants” by the law and were only permitted to provide merchant services. This meant throughout the early-20th century, the California medical licensing board could, and did, arrest any Chinese physicians caught practicing medicine (Trauner, 1978, p. 82; Hamowy, 1979, p. 113).

As stated before, Li Putai was one of the first practitioners in the United States during the late-19th century and was known to have legal troubles professionally and personally. In the print media, he was referred to as the

“quack high priest of charlatans,” yet thousands of patients reported being successfully treated by him. His harassment ended when he befriended Governor Leland Hopkins and Senator Mark Hopkins (Bowen, 1993, p. 50; Li, 1998, p. 185). Other physicians did not have government officials to help them, but only the support of their patients.

Removal of competition was one of the impetus which led to the arrest of unlicensed Chinese physicians. They were legally restricted from practicing medicine so it was relatively easy for a competing medical doctor to have a Chinese medicine physician arrested as the law did not favor any Chinese, regardless of class or profession. When Tan Fuyuan moved his practice to Los Angeles in 1915, he was arrested for practicing medicine without a license after an envious local doctor named C.A. Stoddard reported him (Liu, 1998, p. 185). Fong Wan’s legal issues began with a battle against California in 1925 when the California State Assembly proposed an anti-herb bill which specifically targeted Chinese physicians in California. The bill was struck down but Fong’s legal problems did not end there. In a pamphlet under the Herb Dealers’ Protective Association of California, Fong wrote,

The American Public has always been in favor of the herbs; persons who have been freed from pain and have felt their strength return have not been backward in expressing appreciation of the harmless herbs so wisely provided by Mother Nature... Nevertheless, the Chinese Herb Dealers have suffered incessant persecution at the hands of certain Special Agents and their Stool Pigeons... Years ago, the Christian Scientists and the Chiropractors had similar unhappy experiences because of the provisions of the Medical Laws. They stood their ground valiantly and the public stood loyally behind them. Now they have their own Examiners and are recognized as belonging to legitimate schools of healing. The Chinese Herb Dealers, being but few in number, are in a very difficult situation and undergo the greatest hardships at the hands of the Medical Examiners. All that the Herb Dealers ask for is fair play and the backing of all persons interested in herbs (as cited in Liu, 1998, p. 186).

From 1929-1932, Fong was arrested several times and won twenty of the judgements against him, even one by California’s Supreme Court. Oddly, it was not just envious “regular” physicians who were against him. Postmasters were known to have sent fraudulent orders to Chinese physicians to entrap them for practicing medicine without a license and would even search through

their mail looking for incriminating evidence (Liu, 1998, p. 184). Furthermore, during Fong's court hearings, "regular" doctors along with government agencies conspired to cease his ability to practice Chinese medicine.

Fong was repeatedly sued by Western doctors and government agencies and had to appear many times in both local and federal courts. They sued him for practicing medicine without a license, for using herbs that offered no cure, and for violating interstate commerce law when advertising outside of California (Liu 1998, 185).

In July 1931, Fong was indicted by federal court with sixteen counts on behalf of postmasters and various scientific professionals, ranging from physicians to chemists. The court found him innocent and he could continue practicing provided he did not advertise himself as a doctor.

Chang Yitang was never arrested but was harassed by the police because of complaints from local Los Angeles medical organizations. When questioned by the police, Yitang insisted he was only an herb seller and did not treat patients. Unlike Yitang, there were some Chinese physicians who wanted to fight for the title of "doctor." As discussed before, Tom Leung was one of the more prosperous Chinese physicians in California. Just as Li Putai and Fong Wan, he too was arrested several times, but unlike them, Leung was set on keeping the designation of "doctor," but would never win his case. Leung's daughter Louise Leung Larson later explained the police suppression,

Father did well as an herbalist, too well, in the opinion of the American Medical Association and the Board of Medical Examiners. He and the other Chinese herbalists in Los Angeles at that time were accused of practicing medicine without a license because they used the title "Doctor" and felt the pulse as one way of diagnosis. Papa was a special target and was arrested over 100 times on the misdemeanor charge... The police, at times, used stool pigeons – people pretending to be patients – and would arrest Papa after the usual consultation. Sometimes a whole squad of police would arrive in a patrol car and raid our home... He had set up a routine for these crises. As soon as the police came, the secretary phoned A. C. Way of the First National Bank to arrange for bail (as cited in Liu, 1998, pp. 186-187).

Communities outside of California had more luck in practicing Chinese medicine without much scrutiny. In 1905, Ing Hay was charged on behalf of the

local white doctors for practicing medicine without a license, but because of his popularity in John Day among his white clientele, no one in Grant County would convict him (Barlow and Richardson 1997, 60). Ah Fong was such a pivotal member in Boise, he would be an exception to the law. In all of the Chinese physicians from the late-19th and early-20th century, only Ah Fong was licensed as a “doctor,” but it did not come easily. Before Idaho joined the United States, its legislature passed their first medical licensing law in 1887. Though the law required doctors to graduate from a “regularly chartered medical school,” it also had a grandfather clause allowing anyone who was practicing medicine before the law the ability to continue practicing. Ah Fong, who was educated in China and graduated from the Kung Guh Medical College, had more than enough experience treating patients throughout the Washington Territory and Boise and, thus, decided to pay the annual licensing fee to continue to practice medicine.

In 1899, Idaho passed a more rigid law which required all physicians to be American citizens. After more than a decade of paying his dues, Ah Fong went to renew his license in 1899 but instead of receiving a new license, his license was rejected by a competing physician and medical board member George Collister. Ah Fong challenged the medical board on the grounds of discrimination, but lost his case at the district court. He then appealed the decision to Idaho’s Supreme Court, which reversed the district court’s decision allowing him a medical license. At first, the Idaho medical board did not comply, but after a few more submissions he was granted a medical license on February 1901 (Devitt, 2011, pp. 9-10).

2.10 Conclusion

It was not until 1943 when the Chinese Exclusion Act was repealed with the passing of the Magnuson Act (Chinese Exclusion Repeal Act of 1943), which enabled Chinese the right to naturalized citizenship. The repeal of the Chinese Exclusion Act allowed Chinese medicine physicians to own their own businesses and not hide under the classification of “merchant.” Anti-Chinese sentiment was evident from the latter part of the 19th century until the early-20th century, as a painful chapter in United States history. Although the policies are

a fragment of the county's history, the baggage of its shameful legacy still permeates American society and will exhibit itself through a new dimension of American Orientalism.

As I will show in the following chapters, Chinese medicine will not professionalize with its own licensure until the 1970s, where its legitimation would be determined by mostly white Americans. Unlike the pioneers of Chinese medicine from the mid-19th and early 20th century who were all Chinese, the pioneers of its professionalization, Americanized Chinese Medicine, are primarily white Americans from the counterculture of the 1960s and 1970s. As participants of the counterculture in America, they constructed a new form of orientalism which romanticized the East while simultaneously marginalizing Asian American practitioners of Chinese medicine, most notably with acupuncture, in the United States.

In the 1970s, Chinese medicine's professionalization would mimic the model of "regular" medicine's partnership with the AMA and its "legal authority" determined by the State and corporate governance. Unlike "regular" allopathic biomedicine, Chinese medicine not only differs in its epistemological framework, but is ontologically heterogeneous whereby consensus on diagnosis and treatment varies from one tradition to another.

Chapter 3.

Orientalized Biopower

Here I examine the period from 1960s to the early-1980s. It is marked by the rise of Chinese medicine's professionalized form, American Chinese Medicine. This chapter investigates a group of UCLA medical students whose infatuation with Chinese medicine led them to professionalize it through the State. This strategy for professionalization entails two unique components: orientalism and biopower. The orientalism reflected by this group was a specific romanticism of the East found in the counterculture of 1950s to the 1970s. I refer to this as counterculture orientalism. The pioneers of American Chinese Medicine mediate their experience of Chinese medicine through the lens of counterculture orientalism which was later enforced by the State's use of biopower. In its professionalized form, American Chinese Medicine literally 'orientalized' where the profession is labelled "Oriental Medicine" all the while exemplifying the colonialist tendencies which Edward Said characterized as orientalism. Along with the orientalizing process, the profession used the State to create regulatory bodies while the State adopted Chinese medicine as an extension of biopower. The implementation of orientalized biopower would result in the arrest of numerous Asian American practitioners along with the marginalization of their practices. With much discussion around orientalism, I question whether the counterculture engaged what is deemed as "cultural appropriation" or was it something else?

3.1 The Construction of American Chinese Medicine

In 1978, a few years after the death of Mao Zedong's (毛澤東 1893–1976), the People's Republic of China adopted the State capitalist model described as "Socialism with Chinese characteristics" (*zhong guo te se she hui zhu yi* 中国特色社会主义). As a play on this theme, I found the professionalized form of Chinese medicine established in the early-1970s could best be described as "Chinese medicine with American characteristics." To simplify this notion, I refer to it as American Chinese Medicine. This form was shaped by

the distinctly American concept “states’ rights,” which gives states a certain sovereignty over the federal government. In addition, it encompassed the privatization of regulatory bodies as an extension of State power, shown in the previous chapter with the creation of the American Medical Association (AMA). Two unique features of American Chinese Medicine were the regulation of acupuncture and the demographic shift to predominantly white Americans. The previous practice revolved around the use of herbs and consisted of Chinese practitioners.

As shown in the preceding chapter, acupuncture is rather simple in theory and practice, where even Benjamin Franklin’s grandson Franklin Bache, who had no formal training in acupuncture, was able to practice with success in late-19th century. With such simplicity, acupuncture does not require practitioners to speak nor understand basic Chinese. It is accessible and only requires acupuncture needles, a container for disposal,³⁹ and a place where a patient can lie or sit-down. The relative simplicity of the method allowed two distinct groups of the counterculture to form their own epistemologies. One group consisted of Ted Kaptchuk and Daniel Bensky who met in Macau. The other, more central group, comprised of various individuals who studied at UCLA. The two groups would later converge at one institution, New England School of Acupuncture (NESA),⁴⁰ the first nationally recognized Chinese medicine school in the United States⁴¹ (Cohn, 2010, p. 15; Fan and Faggert, 2015, p. 284; Fan, 2016, p. 10).

Ted Kaptchuk, known for his Chinese medicine book *The Web That Has No Weaver*, was a radical communist who was politically active in the 1960s. The nature of his exact political activity is unclear, but he allegedly evaded the Federal Bureau of Investigation (FBI) to testify before a grand jury, seeking refuge at a Chinese safe house (“Red House”) in California. There, he came upon a series of books on Chinese medicine and would later go on to study under Chang dan An⁴² of San Mateo, California. From California, Kaptchuk fled

³⁹ This assumes the acupuncturist wants to practice in a relatively safe way.

⁴⁰ Formerly the James Steven Acupuncture Center.

⁴¹ New England School of Acupuncture was accredited as a trade school (Barnes, 2003, p. 271).

⁴² Not to be confused with Chen Dan-An (1899-1957).

to Macau and evidently studied at the Macau Institute of Chinese Medicine.⁴³ It was in Macau where he met Daniel Bensky and together they studied Chinese medicine.⁴⁴ Kaptchuk stayed in Macau until 1976, when it was safe for him to return to the United States. Kaptchuk and Bensky would be instrumental creating the knowledge base found in contemporary Chinese Medicine schools in the United States. Kaptchuk taught around the world, but has noticeable influence at NESA, which was created by the second group of practitioners (Cohn, 2010, p. 13).

The other group (from now on UCLA cohort) was formed mostly by members of UCLA's psychology department. It consisted of Steven and Kathleen Rosenblatt, William Prensky, David Bresler, Elliot Greene, John Ottaviano, and Gene Bruno. The one non-white member of the group was their teacher James Tin Yau So. He joined the group on a special person's visa from Hong Kong to accompany the UCLA cohort in the creation of NESA. Tin Yau So and other Asian teachers were intermediary figures who provided legitimacy to the various white-led Chinese medicine groups.⁴⁵ The UCLA cohort, similar to Kaptchuk, were all members of the counterculture protesting the Viet Nam War. According to the law professor Sherman Cohn,

All [UCLA cohort] were involved in the anti-war movement, participating in marches and sit-ins in California and Washington, D.C. They occupied public land for the people, maintaining tent cities. They were leaders of the group that shut down UCLA. Bill Prensky was the chair of that Strike Committee. And they were arrested; Dave Bresler was arrested three times (Cohn, 2010, p. 13).

Steven Rosenblatt, David Bresler, and William Prensky met when they worked together researching serotonin in animals at UCLA's psychology department. They had a common interest in tai chi (*taiji quan* 太極拳) and thought about introducing it to the department. In 1969, they practiced tai chi at Sunset Park in Los Angeles with their teacher Marshall Ho'o (1910-1993). Ho'o

⁴³ Possibly as an informal school or a mistranslation, but little information available on the Macau Institute of Chinese Medicine.

⁴⁴ Bensky is known in the US for his publications on Chinese herbal medicine, specifically: *Chinese Herbal Medicine: Formulas & Strategies* and *Chinese Herbal Medicine: Materia Medica*.

⁴⁵ This phenomenon is not just unique to Chinese medicine but found in other health-related manifestations of counterculture orientalism such as yoga and meditation.

was a nationally renowned tai chi instructor who in his youth campaigned on behalf of trade unions and was later a professor at the California Institute of the Arts in Valencia (“Marshall Ho’o,” 1973; Boucher, 2013). Ho’o taught the UCLA cohort in a mall called The Crossroads of the World. The UCLA cohort would later rename their place of study, the Institute of Taoist Studies (Cohn, 2010, p. 14; Dunas, 2014; Fan and Faggert, 2015, pp. 281-282; Fan, 2016, pp. 5-6).

Tai chi and qigong (气功) are techniques considered to be “Daoist” cultivation practices. Anthropologist Adam Frank explains,

Taijiquan in its Daoist guise is a conduit for the fetishization of Chineseness. I would argue that the popularity of taijiquan in China as a symbol of Chinese history and culture is attached to what is more properly called a kind of “self-aware,” self-orientalizing process – even a point of pride. The growing popularity of the art in the United States has as much to do with Chinese awareness of and willingness to capitalize on the American tendency to orientalize as it does with the tendency itself (Frank, 2006, p. 36).

Tai chi and *qigong* were exotic in comparison to American exercise practiced at the time. When adopted by the counterculture in America, *tai chi* and *qigong* were used to fulfill Western ideas of fitness. Both practices became influential forces for American Chinese Medicine, where almost all of the Chinese medicine schools in the United States incorporated either one or both as a part of the Chinese medicine curriculum. In the case of the UCLA cohort, it was a gateway to acupuncture.

The exact details on how the UCLA cohort began are uncertain, but all revolve around Marshall Ho’o and the local acupuncturist Dr. Ju Gim Shek (赵金石), who the UCLA cohort referred to as “Dr. Kim.” One such account was in the late-1960s, Marshall Ho’o wanted to have a few of his non-Chinese practitioners perform *tai chi* for a Chinese New Year’s event in Los Angeles’ Chinatown and chose Steven Rosenblatt and William Prensky to perform. After the event, the local acupuncturist Ju Gim Shek invited them for tea, thus began their friendship. A little later, Ju Gim Shek would elect Rosenblatt to observe patients he was treating (Dunas, 2014). The other narrative was after training in *tai chi* with Marshall Ho’o for some time, one of the members of the group

suggested they should also learn acupuncture.⁴⁶ They asked Ho'o if he knew anyone who would teach them and Ho'o recommended Ju Gim Shek. Ju Gim Shek agreed to hold a weekly class for \$200 per session. Ju Gim Shek did not speak English and required Ho'o to act as the translator (Fan, 2016, p. 6). Despite conflicting narratives, by 1969, the UCLA cohort had established one of the first Chinese medicine institutions at the Institute of Taoist Studies in Los Angeles.⁴⁷ The recognition of the group, however, would come from an event which took place in China.

3.2 “In the Right Place at the Right Time” or Opportunism?

In July 1971, *New York Times* reporter James “Scotty” Reston accompanied President Nixon as his envoy to China. During the visit, Reston suffered an acute case of appendicitis and received an emergency appendectomy and was treated with acupuncture for the pain. On July 26, 1971, Reston published his experience with acupuncture and would thus familiarize the American public with Chinese medicine, particularly acupuncture (Reston, 1971). A week after Reston’s article came out, the media somehow “discovered” the UCLA cohort and conducted interviews. After a few days, the cohort decided to form a professional organization, the National Acupuncture Association (NAA), which served as a sister organization to the Institute of Taoist Studies (Yan, 2016, p. 7). Literally in a month’s time, the UCLA cohort became *the* source for Chinese medicine in California. With their affiliation at UCLA, the NAA deemed itself a research organization, and would use UCLA’s medical school to establish a clinic for treating pain with acupuncture (Dunas, 2014; Yan, 2015, p. 283).

During the beginnings of the NAA, Steven Rosenblatt had trained under Ju Gim Shek. When Ju Gim Shek felt Rosenblatt was ready for advanced training in Hong Kong, thus directing him to the former Christian missionary James Tin Yau So (from now on Tin Yau So). It is claimed Tin Yau So was a

⁴⁶ It is unclear who in the group made this suggestion.

⁴⁷ SAMRA (Sino-American Medical Rehabilitation Association) University was chartered in 1969 but it’s unclear when it actually encompassed acupuncture to its program.

seasoned acupuncturist and founder of the Hong Kong Acupuncture College.⁴⁸ Tin Yau So would teach Rosenblatt until 1972,⁴⁹ when the UCLA cohort asked for Tin Yau So to travel to the United States to teach permanently under a “distinguished person’s” visa (Dunas, 2014; Yan, 2015, p. 284).

The UCLA cohort were fortunate because of their connections with local power figures. By 1972, Steven Rosenblatt and William Prensky had allied with California legislator Gordon W. Duffy to establish AB1500, the first acupuncture bill in the United States. Steven Rosenblatt recounts how the professionalization of Chinese medicine occurred,

[Interviewer Keith Kirts] “So you, Bill Prensky, and David Bresler sat down one day and decided there had to be some laws?”

[Steven Rosenblatt] “Yes, we went to State Senator Gordon Duffy. Bill had a lawyer friend named Bob Cogan, who knew him. Senator Duffy was a member of the State Committee on Health and Welfare. We convinced him that it was important to have a new way of treating disease; one that could grow out of the Chinese community, which is politically powerful in some areas of California. This was right after President Nixon went to China, so acupuncture was in the news. And here we were in California, the most western state facing China, the perfect place to introduce Chinese medicine... Senator Duffy held a series of open hearings on acupuncture. Then he hammered out the first bill [AB1500], which said that acupuncture could be practiced in a medical school under MD supervision.”

AB1500 stated that the practice of acupuncture was limited to unlicensed persons under the supervision of a licensed physician or surgeon in an approved medical school for the sole purpose of scientific research.

The performance of acupuncture by an unlicensed person, alone or in conjunction with other forms of traditional Chinese medicine, when carried on in an approved medical school for the primary purpose of scientific investigation of acupuncture, shall not be in violation of this chapter, but such procedures shall be carried on only under the supervision of a licensed physician and surgeon (AB1500, 1972).

⁴⁸ Besides information relating to the UCLA cohort and James Tin Yau So, there is little to no information about Hong Kong Acupuncture College.

⁴⁹ Information about the extent of Rosenblatt’s training in Hong Kong is unclear.

The bill only benefited the UCLA cohort as they were the sole group aware of acupuncture who had resources and connections with a medical research facility. But, the UCLA cohort was only a small part of acupuncture's burgeoning popularity in California. As legal scholar Jean Harrison Ogrod writes, "Patients swamped newly opened clinics which charged as much as \$50 per treatment. Weekend seminars designed to train persons in acupuncture techniques proliferated" (Ogrod, 1974, pp. 385-386). This newly found interest in acupuncture also brought scrutiny from the California Medical Board of Examiners. As Ogrod points out,

The Executive Director of the California Board of Medical Examiners estimates that fewer than six complaints relating to the practice of acupuncture were filed with the Board prior to 1972. Since the Board investigates and refers cases to law enforcement officials only after it receives formal complaints, prior to 1972 the Board did not actively enforce § 2141 against nonphysician acupuncturists. In 1972 and 1973 the Board received complaints which led to approximately 32 legal actions related to acupuncture (Ogrod, 1974, p. 387).

This meant throughout the entirety of acupuncture's clandestine history, it only had a fifth of the medical complaints which would occur in the two years following the passage of AB1500. Unfortunately, much of the scrutiny would be diverted towards Asian American practitioners. Chinese American practitioners had always practiced on the fringes of the law. Chinese medicine has historically positioned them as outsiders for two reasons: The Chinese Exclusion Act and California's Business and Professional Code Section 2141. The latter defines the practice of medicine by unlicensed people:

Any person, who practices or attempts to practice, or who advertises or holds himself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition of any person, without having at the time of so doing a valid, unrevoked certificate as provided in this chapter, or without being authorized to perform such act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a misdemeanor (California's Business and Professional Code Section 2141).

Although Section 2141 was enacted in 1913 and meant for professions ranging from naturopathy to midwifery, it was never enforced against acupuncturists until after AB1500 was passed in 1972. But before exploring the coming prejudice of State power, it is important to understand the national influence of the UCLA cohort.

3.2.1 The Spread of the UCLA Cohort

By 1974 members of the UCLA cohort, Steven and Kathleen Rosenblatt, William Prensky, Gene Bruno, Kathy Ferick, and a nurse Karen Freede all left California to practice in Massachusetts (Fan, 2016, p. 284). The exact reasons some of the members of the UCLA cohort left California is unknown. Some members argue they feared Governor Ronald Reagan would veto AB1500 (Fan 2016, 9), others stated Massachusetts allowed non-allopathic physicians to practice acupuncture (Barnes, 2003, p. 271; Fan and Faggert, 2015), while another member said Rosenblatt and Tin Yau So were asked to practice in Massachusetts (Dunas, 2014, p. 284). Whatever the case may be, consensus was they left California for brighter prospects in Massachusetts.

In Massachusetts, they moved to Worcester then relocated to Kenmore Square in Boston where the group had private clinics. Rosenblatt found clinics were unsuccessful due to the presence of allopathic medical schools (Dunas, 2014), while Prensky found the clinics benefited from them because it brought interest from Tufts and Harvard universities (Fan, 2016, p. 9). The result was by 1975, they had paved the way to start a school based on Tin Yau So's teachings and called it the James and Steven Acupuncture Center.⁵⁰ In 1975, California Governor Jerry Brown changed the acupuncture laws and allowed non-allopathic physicians to practice acupuncture. As a result, Steven and Kathleen Rosenblatt along with Gene Bruno left Massachusetts to return to California and started the California Acupuncture College (CAC) while Tin Yau So stayed in Massachusetts. The James and Steven Acupuncture Center was renamed the New England School of

⁵⁰ Sometimes listed as "James and Steven Acupuncture School" (Fan, 2016) or "the James-Steven School" (Barnes, 2003, 271).

Acupuncture (NESA), it was the first accredited Chinese medicine school in the United States,⁵¹ with its first class to graduate two years later in 1977 (Barnes, 2003, p. 271).

After establishing NESA in Massachusetts, the UCLA cohort scattered throughout the United States to pursue professionalization. William Prensky moved to New York and began work on passing acupuncture laws. This was in opposition to the more revolutionary de-professionalized direction New York had headed with Lincoln Hospital. Prensky laid the foundations for “Oriental Medicine” to be taught at the first accredited institution at Mercy College and supported Pacific College of Oriental Medicine, which was at the time California Acupuncture College, to establish a satellite school in New York. He also had influence in New York’s professional organization, Acupuncture Society of New York, which would act as the primary lobbying body for acupuncturists in New York. It is unclear to what extent he and Rosenblatt had a role in the creation of the board in Nevada, but both claimed to have influenced the ruling which made Nevada the first state to license acupuncture (Dunas, 2014b; Fan, 2015; 2016). Gene Bruno would also have an impact in Oregon where he helped establish the Oregon licensing board (Fan and Faggert, 2015). Back in California, members of the UCLA cohort plus another counterculture acupuncturist from Maryland, Bob Duggan, had a direct impact on the nation’s curriculum and set precedence for a non-TCM route to study Chinese medicine.

Duggan established the first chartered acupuncture school in the United States with his wife at the time, Diane Connelly, and an allopathic physician named Haig Ignatius. All three were students of J.R. (Jack Reginald) Worsley at the College of Traditional Acupuncture in Lemington Spa, United Kingdom. The incorporated Maryland school was called College of Chinese Acupuncture, later renamed to Traditional Acupuncture Institute (TAI). TAI was established so Worsley could teach in America. Maryland’s law at the time allowed the practice of acupuncture under the supervision of a doctor who did not need to be on the premises (Cohn, 2011, p. 22). In addition to the creation of TAI,

⁵¹ Barnes claims it was accredited under the same status as trade schools (Barnes, 2003, p. 271).

Duggan would have direct influence on California's acupuncture curriculum as well as to help craft Maryland's acupuncture law.

Duggan had political power stemming from his connection with a United States Attorney in Maryland. Through mutual connections, the U.S. Attorney had influence with the Maryland governor at the time, giving TAI authorization to legally exist. Duggan was appointed as president of the governor's first advisory committee on acupuncture (Cohn, 2011, pp. 22-23; Fan, 2013, pp. 226-227). At this point, Maryland's acupuncturists were split into two groups: members of TAI and a group consisting mainly of Asian Americans from Washington, D.C. When discussing the terms of Maryland's acupuncture law, two things occurred. First, many of the Chinese-Americans wanted routes for licensure through an apprenticeship model. For many Asian practitioners – myself included – apprenticeship was the primary means for the continuation of a lineage and learning acupuncture. Apprenticeship was the route Yeh-chong (Y.C.) Chan (陈奕昌) urged the committee to adopt. But this was opposed by Duggan, as it would conflict with TAI and all who were invested in the school. This motion would be struck down (Fan, 2013, p. 226). Secondly, there was a compromise for those wanting the apprenticeship model, where practitioners would be licensed provided they graduated from an approved school. This piece of legislation would continue to benefit TAI and its students even with the school's transition to the Maryland University of Integrative Health (MUIH). Maryland's law would be a distinctive case in professionalization because unlike most states who worked with the NCCAOM's criteria to sit for the national board exams, Maryland does not require practitioners to take the exam. Maryland's regulations are covered in detail in the later chapters, but it was an example of how schools influenced on the regulations.

My impression through interviews and observations of the pioneers revealed a desire to professionalize and, in most cases, follow in the footsteps of the American Medical Association (AMA). The pioneers constructed a process which emulated the professionalization of allopathic biomedicine. Practitioners had to enroll in an accredited Chinese medicine school, pass either a state or national board examination,⁵² then apply for licensure in a

⁵² Except in Maryland.

particular state. The pioneers shared a specific framework in which they perceived and practiced the medicine. I refer to this as orientalized biopower. Orientalized biopower becomes the basis on which I analyze the structures of power embody American Chinese Medicine.

3.3 Orientalized Biopower

Orientalized biopower is best described as various views and techniques of controlling bodies and populations built on a Western essentialist romanticization of ideas and practices from the East. It is the synthesis of Edward Said's Orientalism and Michel Foucault's biopower. This segment traces the historical nature of orientalized biopower in the realm of Chinese medicine as it emerged from professionalization. Members of the counterculture established a unique relationship with various elements of State power. In the effort to professionalize, the pioneers strove for a standardized model of Chinese medicine, often at the expense and marginalization of Asian American practitioners.

Before I engage the topic of orientalized biopower, it is important to understand the context of the term "oriental" in America. In 2009, the State of New York banned the word 'oriental' from all state documents (Bill S.5048-a/A.7698 (Rep. G. Meng [D-NY-6] & Sen. C. Johnson, 2009). Seven years later, President Barack Obama signed into law a statute which passed unanimously through the U.S. Congress and erased both 'oriental' and 'negro' from all federal documents, replacing them with appropriate terms (H.R.4238 (Rep. G. Meng [D-NY-6], 2015). Despite these legislative actions, the word 'oriental' is still common in the designation of Chinese medicine. In fact, many Chinese medicine schools⁵³ and all national regulatory bodies⁵⁴ have the term as a part of their name. As I will discuss in future chapters, the profession uses the term 'oriental' to designate a higher degree of scholarship with added curriculum in

⁵³ After the passing of S.5048-a/A.7698, one of the largest schools, Pacific College of Oriental Medicine (PCOM), continues to have 'oriental' in the name of its New York City branch campus.

⁵⁴ Council of Colleges of Acupuncture and Oriental Medicine (CCAOM), Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM), and National Certification Commission for Acupuncture and Oriental Medicine

Chinese herbal medicine, opposed to acupuncture only,⁵⁵ which often does not require the study of herbs. In spite of the pejorative nature of the name, current members of the Chinese medicine profession in the United States, the preponderance white,⁵⁶ continue to adopt what Edward Said described as ‘orientalism’ and to identify the profession as “Oriental Medicine.”

In the previous chapter, I outlined how historian John Kuo Wei Tchen’s three categories of orientalism: patrician, commercial, and political, coincided with three major epochs in American history from the Founding Era of the 18th century all the way to Reconstruction of the late 19th century. Here, I argue that the pioneers of American Chinese Medicine encompass a form of orientalism in the mid-20th century, counterculture orientalism.

Counterculture orientalism is built on a contradiction. The culture and ideas of the East are romanticized while at the same time the diaspora members of those cultures in America are either tokenized or marginalized. The romanticism came from the counterculture’s search for identity after being in opposition to identities associated with the dominant culture. Many of the counterculture’s pioneers would venture East in search of identity. While looking East, the counterculture either carried the baggage from anti-Asian sentiment found in the previous era of political orientalism or were naïve to it. As a result, counterculture orientalism would shape the gaze and construction of American Chinese Medicine.

The concept of orientalism itself came from Edward Said’s magnum opus of the same name. In the Introduction of Said’s *Orientalism* he delineates the American and European perception of the Orient. He writes, “Americans will not feel quite the same about the Orient, which for them is much more likely to be associated very differently with the Far East (China and Japan, mainly)” (Said, 1978, p. 1). Unlike the ‘Far East,’ much of the orientalism in his work relates to the Middle East and Africa. For Said, Orientalism is an expression

⁵⁵ The NCCAOM is responsible for creating the national board examination where they have different designations according to the exams ‘candidates’ have passed. It has two primary designations: ‘Diplomat of Acupuncture,’ whereby the candidate has finished the three exams (‘Foundations of Oriental Medicine,’ ‘Biomedicine,’ and ‘Acupuncture’) and ‘Diplomat of Oriental Medicine,’ which is the candidate has to pass all of the ‘Diplomat of Acupuncture’ exams in addition to the Chinese Herbology exam.

⁵⁶ According to the NCCAOM, 77% white (NCCAOM, 2013, p. 10) and from my survey of 100 practitioners, 80% white.

and representation of colonial cultural and ideological discourse, which in America, he unfairly holds to be “less dense” (Said, 1978, p. 2).

Said categorized orientalism into three divisions: academic, a style of thought, and Western imposition of colonial power over the East. In the academic sense, Orientalism is the research of the East. Said further describes orientalism as a “style of thought based upon ontological and epistemological distinction made between “the orient” and “the occident”” (Said, 1978, p. 2). Orientalism refers to the perception and discursive methods as well as ways it is enacted.

Taking the late eighteenth century as a very roughly defined starting point Orientalism can be discussed and analyzed as the corporate institution for dealing with the Orient—dealing with it by making statements about it, authorizing views of it, describing it, by teaching it, settling it, ruling over it: in short, Orientalism as a Western style for dominating, restructuring, and having authority over the Orient (Said, 1978, p. 3).

How then does orientalism manifest itself ethnographically? While working in the field, I encountered numerous occurrences of orientalism. One specific instance stands out from the rest.

During a participant observation at one of the California schools, a white American self-identified ‘physician-scholar’ was giving a guest lecture to first-year students on Chinese medicine. The lecturer was aware of my presence and knew I was taking notes and recording most of the classes. He warned the class on several occasions not to trust academics, especially social scientists researching Chinese medicine.

Afterwards, a small group of students asked me to join them for lunch at a local Chinese restaurant near the school. The group consisted of a Chinese-American, Korean-American, and Latino-American. When we arrived at the restaurant, we noticed the guest lecturer in attendance but thought nothing of it and we were seated by the server not too far away from the lecturer. When seated, I started to ask the students why they decided to peruse Chinese medicine. Then, they asked me about my research and my education. I told them about my Masters education in researching Tibetan medicine (Tib. *Gso ba rig pa*), but before I could explain more I noticed a voice abruptly interrupting my conversation and the “physician-scholar” at the edge of the table.

“You research Tibetan medicine, huh? Well, tell me, are there any ‘internal’ pathologies in Tibetan medicine?” Before I could respond, he exclaimed, “No! There aren’t any internal diseases in Tibetan medicine.” It was quite a bold statement, then he directed a rhetorical question to the whole table. “What is the terms for ‘internal’ and ‘external’ in Chinese?”

The Chinese-American student hesitantly answered, but was suddenly interrupted by the lecturer, “I knew you were going to say that, but you are wrong.” Then he continued by saying, “It’s a shame. You clearly don’t know your own culture’s medicine.” The whole table was in shock.

It was unclear if he knew he insulted the Chinese-American student, but the student was visibly uncomfortable. The first thing which came out of my mouth was to ask him a simple question, “What is the name of Tibetan medicine in Tibetan?” He paused and stared at me.

As if I didn’t say anything, he began to lecture the table on the importance of Chinese medicine’s ‘authenticity’ and preservation. Then, he slowly walked away.

Everyone at the table looked at each other in awkward silence. Then, the Chinese-American student exclaimed, “Yo! I think we all just got ‘whitesplained.’”⁵⁷

“Yeah.” I replied. “It could also be described as “Orientalism” (Field notes, September, 2015).

The interaction with the physician-scholar was an example of posturing authority over a non-white group, while not being a part of the group. This is seen not only as an issue of authority, but also a style of dominating and restructuring, where the lecturer used his authority in an attempt to undermine the Chinese American student’s experience and understanding as well as demoralizes the student’s own position as a Chinese American. The scholar-physician attempted to make an example of the student and assert his authority. The student’s response of ‘whitesplaining’ was a reaction to the overt racism and ignorance which comes with orientalism. This is not an isolated event, but an example of a systemic issue of American orientalism and the racism inherent within.

Orientalism encompassed a range of disciplines and techniques to subjugate what colonialists thought were a homogeneous group of people and culture. As Said described it,

⁵⁷ A term used to describe a white person condescendingly explain something to someone who is not white, especially regarding race relations or minority behavior with the presumption the listener is unable to understand because of racial inferiority.

It [Orientalism] is rather a distribution of geopolitical awareness into aesthetic, scholarly, economic, sociological, historical, and philological texts; it is an elaboration not only of a basic geographical distinction (the world is made up of two unequal halves, Orient and Occident) but also of a whole series of "interests" which, by such means as scholarly discovery, philological reconstruction, psychological analysis, landscape and sociological description, it not only creates but also maintains....

The mechanism of power in orientalism is asymmetric. In its enactment, there prevails a dominant power, which results in the marginalization of the people of the East.

[I]t is, rather than expresses, a certain will or intention to understand, in some cases to control, manipulate, even to incorporate, what is a manifestly different (or alternative and novel) world; it is, above all, a discourse that is by no means in direct, corresponding relationship with political power in the raw, but rather is produced and exists in an uneven exchange with various kinds of power, shaped to a degree by the exchange with power political (as with a colonial or imperial establishment), power intellectual (as with reigning sciences like comparative linguistics or anatomy, or any of the modern policy sciences), power cultural (as with orthodoxies and canons of taste, texts, values), power moral (as with ideas about what "we" do and what "they" cannot do or understand as "we" do)" (Said, 1978, p. 12).

The interaction with the physician-scholar represents an American orientalism, whereby the dynamics relate to America and the Far East. In countering Said's argument of American orientalism being "less dense," I argue it is complex and I focus on a small component of orientalism found in mid-20th century America.

Through the historical climate as well as the various people involved in the 1960s and 1970s counterculture, America would produce a new culture of orientalism, counterculture orientalism, which would define the foundation and control of Chinese medicine. It is through the lens of counterculture orientalism the white pioneers would establish American Chinese Medicine.

3.3.1 *Counterculture Orientalism*

The term “counter-culture” was first coined by the sociologist Talcott Parsons to describe the subculture who held a “counter-ideology” which diverged from the “value system and ideology of the wider society” (Parsons, 1951, p. 239). Parsons further specified the term relative to revolutionary movements,

If, however, the culture of the deviant group, like that of the delinquent gang, remains merely a “counter-culture” it is difficult to find the bridges by which it can acquire influence over wider circles. This bridge is above all furnished by the third element, the development of an ideology—or set of religious beliefs—which can successfully put forward a claim to legitimacy in terms of at least some of the symbols of the main institutionalized ideology (Parsons, 1951, p. 350).

Later, J. Milton Yinger would expand on Parson’s definition of “counter-culture,” delineating it from the broad term “subculture.” Yinger’s counterculture or “contraculture”⁵⁸ contrasted with a subculture, its central theme was conflict.

To sharpen our analysis, I suggest the use of the term contraculture wherever the normative system of a group contains, as a primary element, a theme of conflict with the values of the total society where personality variables are directly involved in the development and maintenance of the group's values, and wherever its norms can be understood only by reference to the relationships of the group to a surrounding dominant culture... In a contraculture, however, the conflict element is central; many of the values, indeed, are specifically contradictions of the values of the dominant culture. Similarly, personality variables are involved in the development and maintenance of all cultures and subcultures, but usually the influence of personality is by way of variations around a theme that is part of the culture. In a contraculture, on the other hand, the theme itself expresses the tendencies of the persons who compose it (Yinger, 1960, p. 629).

In effect, Yinger felt the counterculture was a dialectical reaction to the dominant culture predominantly led by American white men. The counterculture would not change this arrangement of power, where the pioneers and figures,

⁵⁸ Favoring “contraculture” due of it Latin prefix, Yinger would later chose “counterculture” because its common usage in mainstream society which “the voice of the people has spoken” (Yinger, 1982, p. 3).

predominantly American white men. The counterculture, nevertheless, had an explicit reactionary tone towards the dominant culture.

Theodore Roszack who popularized the term “counter culture” from his work *The Making of a Counter Culture*, found the counterculture’s interpretation of old models of social analysis to be irrelevant and “it becomes a positive advantage to confront the novelty of daddy’s politics free of outmoded ideological preconceptions.” He continued by claiming the counterculture’s struggle was not just with the war in Viet Nam and racial injustice, but a dissatisfaction from something “far more formidable” and “less obvious” which he identified as “technocracy” (Roszack, 1969, p. 4).

By technocracy, I mean that social form in which an industrial society reaches the peak of its organizational integration. It is the ideal men usually have in mind when they speak of modernizing, up-dating, rationalizing, planning. Drawing upon such questionable imperatives as the demand for efficiency, for social security, for large-scale co-ordination of men and resources, for ever higher levels of affluence and ever more impressive manifestations of collective human power, the technocracy works to knit together the anachronistic gaps and fissures of the industrial society” (Roszack, 1969, p. 5).

In *Imagine Nation*, Peter Braunstein and M.W. Doyle considers “The counterculture, as one manifestation of the “Youthquake” (Braunstein and Doyle 2002, 10). The counterculture was not a movement but a reaction to post-World War II. It reflected a dissatisfaction with the various mechanisms of the dominant culture as well as the search for identity. Braunstein and Doyle continue by questioning the counterculture status as a movement along with a seeming identity crisis.

The term “counterculture” falsely reifies what should never properly be construed as a social movement. It was an inherently unstable collection of attitudes, tendencies, postures, gestures, “lifestyles,” ideals, visions, hedonistic pleasures, moralisms, negations, and affirmations. These roles were played by people who defined themselves first by what they were not, and then, only after having cleared that essential ground of identity, began to conceive anew what they were. What they were was what they might become – more a process than a product, and thus more a direction or a motion than a movement (Braunstein and Doyle, 2002, p. 10).

Braunstein and Doyle were critical of positioning the counterculture as a movement and instead called it a “motion.” They claimed the counterculture began with the Beatles. “Starting points may differ, but this phase took off roughly when the Beatles launched their first tour in 1964, reached its zenith of visibility in 1967-68” (Braunstein and Doyle, 2002, p. 11). I argue, however, that the counterculture and its associated orientalism started with the Beats instead of the Beatles.

The Beats were a profound inspiration for middle-class white Americans to experiment with different ideas and identities. Braunstein and Doyle considered the Beats pioneers of the counterculture,

In this initial phase, the counterculture contained many paradoxes, foremost among them its status as a youth-based movement whose primary spokesmen (Leary, Ginsberg, Snyder) were considerably older than its core constituency (Braunstein and Doyle, 2002, p. 11).

As the pioneers of the counterculture, the Beats went on to explore their identities through the different identities of the Other. Such an example of subsuming identities comes from Norman Mailer’s essay “The White Negro.” Mailer found that the “hipster,” who being synonymous with the Beats,⁵⁹ found his or her identity in emulating Black American culture by speaking their vernacular and listening to jazz. For the hipsters, the source of “Hip” derived from Black Americans who, at the time of the essay, were living through Segregation at the margins of society. Mailer writes, “So it is no accident that the source of Hip is the Negro for he has been living on the margin between totalitarianism and democracy for two centuries” (Mailer, 1957, p. 278).

This idealization of Black Americans in culture and literature resembles the notion of “romantic racialism.” Coined by George Fredrickson, romantic racialism was used during the 19th century for arguments against slavery “projected an image of the Negro that could be construed as flattering or laudatory in the context of some currently accepted ideals of human behavior and sensibility” (Fredrickson, 1971, p. 102). Similar to their infatuation with Blacks in America, the Beats would also romanticize the ideas of the East.

⁵⁹ Later to evolve as the Hippies.

It is from the initial exploration of the Beats where counterculture orientalism was conceived. Whereby members of the counterculture engaged in activities, ideologies, and processes which originated in the East, but were transformed by the imagination of those who transplanted and translated the various practices and forms of knowledge. While romanticizing the East, the counterculture also neglected, or as in later developments, actively enacted the marginalization and exploitation of Asian Americans in the United States. In the case of Chinese medicine, specifically with the professionalization of acupuncture, the pioneers would exemplify counterculture orientalism through the imagined expression of Daoism and adopted it to situate the philosophical foundation of their interpretation of Chinese medicine. With this practice, they later sanctioned the techniques and ideas encompassing Chinese medicine, using their power to create the dominant force and influence to contemporary practices.

Counterculture orientalism could be traced to Beat pioneers who converted to Buddhism such as Gary Snyder, Allen Ginsberg, Jack Kerouac, and Alan Watts. As the historian Michael Masatsugu writes, “Through informal conversations, correspondence, and published writings, convert Buddhists constructed a modified vision of Buddhism as an alternative to American religious traditions and Cold War society and culture” (Masatsugu, 2008, p. 437). Religious studies scholar David L. McMahan extends this critique and attributes much of the Beats influence to Daisetz Teitaro (D.T.) Suzuki (鈴木大拙 1870-1960) and Suzuki’s interpretation of Zen. McMahan writes,

Countercultural Buddhists and Buddhist enthusiasts latched onto a particular idea that had been presented in some of the most influential Buddhist books from the period: those written by D. T. Suzuki and his intellectual successors... Suzuki proffered an idea about Buddhism – and Zen in particular – that took on a life of its own in North America: that Zen has to do with spontaneity, and that this spontaneity is the font of creativity, art, and the emancipatory transcendence of stifling cultural norms... Such ideas come primarily through the modern interpretation of Zen and then are applied to all of Buddhism. That Zen involves an element of spontaneity and unpremeditated creativity is by no means a wholly modern invention, though as the description of the monastery scene above suggests, it does not reflect the way

Zen is typically practiced on the ground (McMahan, 2008, pp. 118-119).

As noted by McMahan, much of the spontaneous interpretation of Zen would transfer into contemporary discourse, most notably from the founder of mindfulness-based stress reduction (MBSR), Jon Kabat-Zinn. He felt “Buddhism is fundamentally about being in touch with your deepest nature and letting it flow out of you unimpeded” (Kabat-Zinn, 1994, p. 6). Suzuki was the intermediary charismatic authority helped launch the Beats’ spiritual-religious legitimacy. One catalyst for the Beats spiritual-religious endeavor, is Jack Kerouac’s semi-fictional *The Dharma Bums*, a pivotal work of countercultural orientalism which brought the philosophy of Zen Buddhism to countercultural America. In *The Dharma Bums*, one of the characters is Japhy Ryder who was based on Kerouac’s friend and American Beat poet Gary Snyder. Snyder’s pivotal inspiration for much of his work was attributed to the 9th century Chinese Chán Buddhist⁶⁰ poet Hanshan (寒山).⁶¹ Noticeably Buddhist, Hanshan’s poetry also contained elements of Daoism, which emphasized nature. Hanshan’s influence on Snyder brought the counterculture to the literary worlds of Buddhism and Daoism (Yunzhong, 1987; Clarke, 2000; Pohl, 2003; Yu, 2016).

Bringing the Eastern philosophical foundation to the Beats was the British thinker Alan Watts. Trained as an Anglican priest, Watts, like Snyder, was also influenced by Zen Buddhism and its Buddhist-Daoist hybridity. Most notably with the publication of *The Way of Zen*, Watts’ interpretation of Zen was used as a remedy for the dominant culture. In the book, Watts briefly introduces a condensed version of Buddhism and Daoism which denatured the religious aspects of both traditions by focusing only on the philosophies. Watts’ rendition of Zen, which has been criticized by D.T. Suzuki (Aitken, 1997, p. 30; Kapleau, 1967, pp.21-22) provided America the reductionist applications of Zen through *za-zen* (“sitting meditation”)⁶² and koan (Jp. 公案). Watts would codify his Zen

⁶⁰ Known in Japan as “Zen.”

⁶¹ Snyder originally translated Hanshan’s poems originally in the *Evergreen Review* and then again in *Riprap and Cold Mountain Poems* (Snyder, 1958, 1969).

⁶² Watts’ translation of “za-zen” (Jp. 座禪) to “sitting meditation” predates the term “zen” as a shortened form of the Chinese term “*chánna*” (禪那), which was the transliteration of the

approach with the publication of *Beat Zen Square Zen and Zen* where he differentiated between the rigid hierarchy of “square Zen” found in Japan and his adopted anarchic or, as he described, “underlying protestant lawlessness” of the “beat Zen.” Through Watts’ imagined Zen, Western Buddhist practitioners would formulate a counterculture orientalism placing themselves as the authority of ideas and practices which came from the East (Watts, 1954; 1959). Later in life, Watts’ would co-opt Daoism with a more secularized modern approach to the Chinese religion, which serve as the philosophical foundation for American Chinese Medicine.

Daoism’s first conversion to the West occurred during the early-20th century with seminal translations by the German missionary Richard Wilhelm. In 1911 and 1912, Wilhelm translated partial works of *Laozi* and *Zhuangzi* along with Martin Buber’s selection of *Zhuangzi*, brought on what would be described as “Dao fever” in Germany (Pohl, 2003, p. 473). Wilhelm’s work would be popularized by Carl Gustav (C.G.) Jung. Jung was influenced by Wilhelm’s translation of *Yijing (The Book of Changes 易經)*⁶³ and *The Secret of the Golden Flower (太乙金華宗旨)*, incorporating the former to his personal life and work with patients (Clarke, 2000, p. 48). After reading Wilhelm’s translation, Jung invited him to Zurich, Switzerland and thus began their friendship (Coward, 1996, p. 479).

Jung insisted the *Yijing* was not a source of divination, but had a practical purpose. In the realm of psychology. J.J. Clarke found Jung’s usage of the *Yijing* was applicable to the counterculture as opposition to a “prevailing mechanistic paradigm.”

He saw its [*Yijing*] central conception as virtually synonymous with his own idea of synchronicity, and believed that its focus on the chance connections between simultaneous events rather than on linear causality anticipated his speculations concerning meaningful coincidences between events which are not causally related. . . for he saw the idea of synchronicity as a key to breaking out of the mechanistic paradigm that had characterized Western thought from the time of the Scientific Revolution” (Clarke, 2000, p. 61).

Sanskrit term “*dhyāna*” or Pāli “*jhāna*,” contemporarily defined as “absorption” or “meditative absorption,” not broadly as “meditation” (Gombrich, 1990; Buswell and Lopez, 2014).

⁶³ Commonly referred to as “*I-Ching*.”

Jung's "synchronicity" was a relationship with the inner psychic realm and the external cosmos (Jung, 1950, p. xxiv). The *Yijing* provided a mechanism to obtain an equilibrium between the psychic and cosmic worlds through "wholeness." As Harold Coward explains,

Jung was convinced that the goal of the *I Ching*, namely a reestablishing of balance between the *yang* and *yin* in the *Tao*, and the goal of his psychotherapy, namely a balancing of the psychic opposites in the experience of the Self, were parallel processes (Coward, 1996, p. 479).

Jung's view of wholeness was influenced by Jan Smuts' idea of holism in *Holism and Evolution*. J.J. Clarke writes,

Wholeness is a key notion in Jung's thinking, and in general terms his way of looking at the human psyche could be described as 'holistic'. This now somewhat overworked term was first coined in 1926 by Jan Smuts, and was used by Jung in 1936 to characterise his approach to 'the systematic observation of the psyche as a whole' (CW6.966), and as early as 1913 he was using such terms as 'unity', 'totality', and 'wholeness' in relation to the psyche (CW4.556). He frequently spoke of the need to address the patient as a whole person rather than as a collection of acts or dreams, to 'turn our attention from the visible disease and direct it upon the man as a whole' (MM: 222). In terms of human praxis, wholeness is to be equated with mental health, and represents the goal of human activity, the fullest realisation of the human personality which alone, he believed, can give the individual a sense of true value and purpose in life. . . . [H]e [Jung] believed that all living things, through the interaction of opposing elements within themselves, have a natural tendency towards a state of harmonious balance, but with human beings this tendency becomes a deliberate process through which a conscious sense of meaning and purpose can be achieved (Clarke, 1994, pp. 72-73).

Volker Scheid also extends the critique of holism in its influence of Chinese medicine by claiming "The term holism is not originally Chinese and was applied to Chinese medicine from the 1950s onward" (Scheid, 2016, p. 66). He supports this argument by tracing the etymology of the term to two different yet interrelated German movements of the 18th century: the philosophical realms of "cultural, structural, and idealist, the other focused on science, process and material reality" (Scheid, 2016, p. 68).

Scheid traces the philosophical current of ‘cultural/structural holism’ to Johann Gottfried Herder and Alexander von Humboldt, backed by Kantian idealism where “cultures constitute integrated wholes which situated their members towards the world” and as “a scalable concept, such holism can equally be applied to persons, nations or indeed any bounded system in its relations to the outside world” (Scheid, 2016, p. 68). Scheid also argued Hegelians such as Friedrich Engels encompassed the idea of holism as a scientific critique of German idealism, where it is used to uncover laws grounded in history and proposes a ‘science of interconnections’ where it operates as a tool to understand a fundamentally inter-related and ‘emergently related’ world (Scheid, 2016, p. 68). Scheid contends it was Chinese who were inspired by German thinkers, which led to the notion of holism in Chinese medicine.

Influenced by Engels, Ai Siqi (艾思奇 1910-1966), was a Chinese Marxist philosopher and pioneer of dialectic materialism in China. Along with Mao Zedong, both were attributed by the *Comprehensive Chinese Word Dictionary (Hanyu dazidian)* 漢語大字典 for the use of the term ‘zhengti (整體). Zhengti, which is defined as ‘whole,’ is the first part of the word ‘zhengti guan’ (整體觀), a conventional term translated into English for the word ‘holism’ (Scheid, 2016, p. 69).

The formation of “holism” resulted from the exchange of Germans and Chinese ideas which presented a hybridized framework for Chinese medicine. An added approach to holism came from Beat writers Gary Snyder and Alan Watts, which was presented the idea of Daoist universalism.

Karl-Heinz Pohl argued Alan Watts’ “Dao” was seen as “a panacea for the allegedly materially over-saturated but spiritually emaciated Western civilization.” But he also found it was “A trivialized Dao, not so much oriented along Laozi and Zhuangzi⁶⁴ but rather along Yin-Yang thought (taken from the *Book of Changes*, which by then had achieved cult book status), which became the “core” philosophy of the New Age movement” (Pohl, 2003, p. 477).

⁶⁴ Laozi (老子) and Zhuangzi (莊子) were the pioneers of Daoism during the Warring States period.

Similar to Pohl, anthropologist Linda Barnes found the prevailing force fascinating white Americans with Chinese philosophies was the New Age. Like Pohl, Barnes found the New Age conflated different Chinese philosophical systems to encompass a homogenous “mystical” universalism. In addressing the issue of conversion or appropriation of Chinese ideas by the New Age, Barnes writes,

Chinese Daoist and Buddhist traditions were lumped under this heading, as was the divination text the *Yijing*. This process of invention entered the borderlands between conversion and appropriation, sometimes residing more on one side or the other, sometimes sitting awkwardly on the fence. Insofar as the invention was predicated on an assumption of universalism, it coincided with a core sense of entitlement on the part of European Americans to appropriate whatever appealed to them – a sense that overlooked its own roots in political and economic expansionism and domination (Barnes, 2005, p. 317).

This universalism was not entirely detrimental and positive outcomes did result from the approaches of Watts and Snyder. Clarke found despite what came from various interpretations of Chinese philosophical systems, both Gary Snyder and Alan Watts’ explorations of Daoism were instrumental in launching a new dimension of environmentalism. Clarke felt both Snyder and Watts “allied themselves with Zhuangzi and other Chinese thinkers to confront Western aggressiveness and destructive attitudes towards nature.” It was Watts’ and Snyder’s fascination with Daoism prompted awareness in ecology and environmentalism in the latter part of the 20th century. Clarke continues,

Such themes as these, in which Daoist and other Oriental philosophies were employed to administer to the diseased body of the modern West, became almost commonplace in both academic and popular writings concerning the environment from the 1960s onwards (Clarke, 2000, p. 82).

The disease body in regards to holism was reflected in the “microcosm” of an individual’s body to the “macrocosm” of a whole environment. A way to “balance” disharmony on the individual level was through physical practices such as *tai chi* and *qigong*.

Tai chi and to a lesser degree *qigong*, brought a unique secularization of Daoism for counterculture orientalism. Paralleled to the PRC’s stripping of

the religious context of Daoism, the counterculture conceptualized Daoism to their frame of reference by identifying it as “philosophical Daoism.” This entailed the removal of overtly religious rituals such as deity veneration or recitation of prayer where it became a strictly textual relationship. As Clarke explains,

The long historical disclosure of Daoism to Western gaze has until lately been marked by a concentration on a remarkably narrow range of sources, and more than any other Eastern religion Daoism has impinged on Western consciousness as a mainly textual object rather than as a living tradition (Clarke, 2000, p. 50).

Though I agree with Clarke’s analysis, I found *tai chi* and *qigong* were often described as “Daoist” practices by informants in the field. It is here where *tai chi* and *qigong*, which relates to the harmony of the “Dao” and the balance of yin-yang, are seen as ritual practices which supplement the more overtly religious activity such as the veneration to immortals and deities. As I point out later, my observations of concepts such as “*shen*” (神) and “possession” in Chinese medicine, blur the religious-spiritual confines of Daoism among American Chinese Medicine practitioners. The use of “philosophical Daoism” exemplified a secular framework compatible with TCM.

In the medicalization of Chinese healing practices, Linda Barnes argued its controlled form by the Chinese government was the “greatest influence in the United States.” Barnes also found certain aspects of it were incorporated to biomedicine, which is the case with “dry needling” and the Graston technique. She maintains it “involves the construction of Chinese healing within the “new science” by New Agers and their reactions to the biomedical scientizing of certain practices (Barnes, 2005, pp. 320-321). Evidence to support that the New Age had a role in American Chinese Medicine is limited. In the attempt to define New Age, Barnes identified Chinese medicine as one of its many disparate practices.

Rather, it [Chinese healing practices] functions as an umbrella category under which we find some NRMs [New Religious Movements], along with other practices as apparently unrelated as past life regression, crystal healing, naturopathy, and psychic healing. . . Chinese-based healing practices have often been positioned in the same framework [New Religious Movement],

even as they have contributed concepts and dispositions to the broader field of New Age healing (Barnes, 2005, p. 317).

The problem with “New Age” is a lack of a coherent definition. As Wouter Hanegraaff (1998) explains,

In spite of the popularity of the term, its actual content remains extremely vague. This is largely due to the fact that the New Age is not an organization, which could be unambiguously identified or defined on the basis of self-proclaimed leaders, official doctrines, standard religious practices, and the like. The initial fact about the “New Age” is that it concerns a label attached indiscriminately to whatever seems to fit it, on the basis of what are essentially pre-reflective intuitions. As a result, the New Age means very different things to different people (Hanegraaff, 1996, p. 1).

Because of the broad use of the term “New Age,” Barnes’ definition could refer to any non-allopathic healing practice. It is in this respect I found “New Age” to act as a ‘floating signifier,’ which is term without any substantial referent. Hanegraaff firmly delineates those who are considered “New Age” from members of the counterculture.

The early alternative movement was dominated by adolescents rebelling against the values of the older generation... While many people who were young in the 1960s have over the years developed into adherents of the New Age movement, others no longer wish to be identified with it because they feel it has betrayed the ideals of the counterculture (Hanegraaf, 1996, p. 11).

After the Beats, many of the ideas of the counterculture were rooted in Leftist politics reaction to the Vietnam War and the Civil Rights movement. The American Left had two major factors which influenced the sociopolitical climate: The Viet Nam War and the Civil Rights Movement. Unlike the Leftist movements in Europe, Americans had to deal with the direct effects of mandatory draft lotteries enforced by the US Government’s Selective Service System, which after the Military Selective Service Act of 1967, required all American men over the age of eighteen to enlist in the armed forces. This resulted in the involuntary deployment of many American soldiers to Viet Nam (Foley 2003; Lawrence 2008). In the 1960s, white middle-class university students organized in solidarity in support of the Civil Rights Movement in

America's southern states to end segregation and to demand equality for Black Americans. On the West Coast what is known as the Free Speech Movement started at the University of California Berkley and later swept throughout the nation, uniting with the Antiwar Movement (Rorabaugh, 1989; Cohen and Zelnik, 2002; Rosenfeld, 2012). By the late-1960s, with the escalating war in Viet Nam and the rise of national student protests, a new form of the counterculture was born and its members were known as hippies.

Sociologist John Robert Howard first heard the term "hippie" in the Fall of 1966 when attending a dance concert at the Fillmore Auditorium in San Francisco. Howard's opinion was the term 'hippie' derived from the Beats' term 'hipster,' who was an "individual whose attitude toward the square world (a steady job, material acquisitions, and the like) was one of contempt" (Howard, 1969, p. 44). Howard felt the hippie movement originated in San Francisco's Haight-Ashbury district. Others such as Micah Issitt found their East Coast presence in the bohemian Greenwich Village in New York. Issitt put hippies into one of two categories: leaders or followers. As Issitt explains,

It is perhaps easiest to view the hippie era as a phenomenon brought about by a small number of cultural leaders – philosophers, writers, musicians, activists, and politicians –and the thousands of young people, in America and across the world, who were inspired by them (Issitt, 2009, p. 14)

Howard has a more complex categorization of hippies: visionaries, freaks and heads, midnight hippies, and plastic hippies. The visionaries were the pioneers of the movement and were intent on challenging the status quo social system which was built on the idea "Success in this society is defined largely in terms of having money and a certain standard of living." The hippies felt "The work roles which yield the income and standard of living are, for the most part, either meaningless or intrinsically demeaning." Howard felt the hippies' approach was to invert the social system with an anti-intellectual attitude of 'dropping out' where a person could 'do his own thing,' encompassed various activities in opposition to the social system such as "making beads or sandals, or exploring various levels of consciousness, or working in the soil to raise the food that he eats" (Howard, 1969, p. 46). Intentional or not, Howard writes of hippies in reference to men, which reflects the patriarchal nature of

the then counterculture movement. Furthermore, the use of drugs was one of the focal points of the hippie counterculture and was how Howards defined one genre of hippie.

'Freaks and heads' were hippies who engaged in smoking marijuana, and using lysergic acid diethylamide (LSD) and methedrine (methamphetamine). Inspired by the ideas of controversial Harvard professor Timothy Leary, 'freaks and heads' used LSD to expand consciousness and investigate alternate realities. Howard identified two components of the 'LSD ideology': "LSD introduces the user to levels of reality which are ordinarily not perceived" and "LSD develops a certain sense of fusion with all living things" (Howard, 1969, pp. 48-49). Some followers were disillusioned with Leary, and explored the more dangerous drug methedrine.

The last two categories referred to different approaches to hippie culture. The plastic hippie was interested in the hippie style and aesthetic and had a superficial understanding of the countercultural movement. The midnight hippies were involved with the counterculture of the 1950s and early-1960s but also had 'straight occupations' such as engineering or banking. Howard saw them as a "link between straight society and the hippie world" (Howard, 1969, p. 51). In a more reductionist tone, *Time* magazine offered its take on the hippie code of ethics,

If there were a hippie code, it would include these exile guidelines:

- Do your own thing, wherever you have to do it and whenever you want.
- Drop out. Leave society as you have known it. Leave it utterly.
- Blow the mind of every straight person you can reach. Turn them on, if not to drugs, then to beauty, love, honesty, fun (*Time*, 1967).

The hippie identity emphasized an individual's break from convention and often led to followers exploring other forms of consciousness counter to the conventional social system. As the social scientist Paul Willis explains,

The hippies did not live in a world of personal certainty and had a far from certain grip on their own identities. Where in the 'straight' world this is a cause for concern, for the hippies it was a source of richness and the base for expanded awareness. In a crucial sense the hippies were operating with an abstraction of 'normality' strung out above the lidless eye of their own self-

consciousness. Consciousness, and awareness of consciousness capsized a belief in the everyday self. Fundamentally, they could never believe the world to be real, but they were in no sense *doomed* to this fate, they welcomed it as a profound insight. Instead of being *locked* in their inner selves, which is often the consequence of the conventional loss of reality, they *discovered* their own consciousness. In this sense, then, a state of ontological insecurity was welcomed as liberation, and not feared as disease: it set the mind free from that micro-dot of consciousness called 'normality' (Willis, 2014, p. 110).

The hippies brought a shift in reality, which either through drugs, or, in the case of Chinese medicine, ideas and practices, alternative reality. Whether the white pioneers identified as hippies or not, there is strong evidence they were seen as a part of the counterculture of society and medicine. As subversives against the State, it was odd to find them collaborating with the dominant power and using Chinese medicine to extend the grips of State control. Inadvertently, the counterculture became an accessory to biopower.

3.3.2 *Biopower*

With the counterculture's embracement of radical politics, it could be assumed they would approach Chinese medicine in a similar way. Unlike their confrontations with the State in protests against the war in Viet Nam, they chose to work with the State and push their agenda to establish a legitimate profession. With the tendency of professionalization to require some form of standardization, this led to a homogenization of something heterogeneous. Consequently, the homogenization of Chinese medicine also positioned it as a tool for biopower. Michel Foucault spoke of the term "biopower" in *Security, Territory, Population*.

By this I mean a number of phenomena that seem to me to be quite significant, namely, the set of mechanisms through which the basic biological features of the human species became the object of a political strategy, of a general strategy of power, or, in other words, how, starting from the eighteenth century, modern Western societies took on board the fundamental biological fact that human beings are a species" (Foucault, 2007, p. 1).

Foucault also found biopower as “an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations” (Foucault 1976, 140). Foucault felt by the 19th century, there was a shift in the control of human bodies, which he called the “power’s hold over life.” What Foucault meant was “the acquisition of power over man insofar as man is a living being, that the biological came under State control, that there was at least a certain tendency that leads to what might be termed State control of the biological” (Foucault, 1997, p. 240). This form of control Foucault described as “discipline.” Rabinow and Rose write, “At its most general, then, the concept of ‘biopower’ serves to bring into view a field comprised of more or less rationalized attempts to intervene upon the vital characteristics of human existence. The vital characteristics of human beings, as living creatures who are born, mature, inhabit a body that can be trained and augmented, and then sicken and die” (Rabinow and Rose, 2006, pp. 196-197).

Biopower is often complemented with the term “biopolitics.” Anthropologist Jonathan Inda explains:

[B]iopolitics attends to the biological processes of collective social body. It is concerned with regulating the phenomena that typify groups of living human being.... biopower centers not on the population per se but on the individual bodies that compose it (Inda, 2006, pp. 5-6).

Inda’s differentiation between “biopower” and “biopolitics” is subtle. Foucault’s work on biopower, however, is rather incomplete. When questioned about writing a genealogy of biopower, Foucault replied, “I have no time for that now, but it could be done. In fact, I have to do it (Foucault, 1984, p. 344). Foucault passed away before he could write further on biopower.

Though Foucault’s idea of biopower relates to government control of biology, the regulation and professionalization of Chinese medicine with acupuncture extends control to the vitalistic bodies such as *qi* (气) ‘vital force’ or *jing* (精) ‘essence’ / ‘semen.’ Chinese medicine and its theoretical framework becomes another technique for the State to subjugate bodies and control populations. William Prensky of the UCLA cohort clarified his intent in the interview below.

Our game plan was not to set up acupuncture in a small, isolated community away from medicine, much like the chiropractic profession had done.... Our plan was the opposite. We forced the Medical Board to recognize us, in fact we established ourselves right in the middle of the medical community at UCLA Medical School. If you run away and set up your own program, you get isolated...The Medical Board of California and the AMA isolated them. Chiropractors aren't allowed into hospitals. They can't get on staff at any medical schools. They aren't considered for research projects. The AMA won't even talk to them...We had a different political idea, which was to move into the middle of medicine and set up a tent. Then we'd force the Medical Board to license us (Rosenblatt and Kirts, 2016, p. 146).

The control of Chinese vitalistic bodies occurs in instances such as when the California Acupuncture Board, which is a part of the California government, determines the standards for ideas and techniques on how to diagnose and treat aberrant forms of *qi*. In effect, California defines the "correct" and "incorrect" way for Chinese medicine to interact with the body. California implements this unique form biopower on the state-level while the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) controls it at the national level. The NCCAOM and accompanying regulatory bodies⁶⁵ function on a corporate level,⁶⁶ shifting the discourse from discipline to control.

Gilles Deleuze traces Foucault's "disciplinary societies" with the advent of biopower which occurred from the 18th to the early-20th century through environments of "enclosure," specifically within the "factory." Deleuze saw a shift after World War II when "disciplinary societies" were replaced with "societies of control," represented by the corporation. Deleuze understood "the factory was a body that contained its internal forces at a level of equilibrium, the highest possible in terms of production, the lowest possible in terms of wages; but in a society of control, the corporation has replaced the factory" (Deleuze 1992, 4). Corporations are not mere entities of abstraction. As Michael Hardt and Antonio Negri explain in *Empire*,

⁶⁵ Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) and Council of Colleges of Acupuncture and Oriental Medicine (CCAOM).

⁶⁶ The NCCAOM, ACAOM, and CCAOM are all 501(c)(3) non-profit corporations.

The activities of corporations are no longer defined by the imposition of abstract command and the organization of simple theft and unequal exchange. Rather, they directly structure and articulate territories and populations. They tend to make nation-states merely instruments to record the flows of the commodities, monies, and populations that they set in motion (Hardt and Negri, 2000, p. 31).

With the regulation and professionalization of Chinese medicine through acupuncture, members of the counterculture such as the UCLA cohort and TAI, acted as instruments of State control. Instead of biological mechanisms of the body, they used Chinese medicine's vitalistic structures. They extended the reaches of biopower from the realm of biology to abstract concepts such as *qi* and *jing*. Another unique aspect in the creation of the profession is how they wanted to define it.

Some of the pioneers felt the term "acupuncture" was limited and did not encompass other healing modalities of Chinese medicine such as herbs, cupping, or *gua sha* (刮痧). As a result, some felt "Oriental medicine" was more inclusive. This title began to be used at the UCLA cohort's California Acupuncture College (CAC) where they designated their graduates "Oriental Medicine Doctor" (O.M.D.). Later it was adopted on a national-level by the entirety of the profession where it is used in all of the national regulatory bodies as well as in many of the schools. The use of "Oriental Medicine" continues to be a heated topic predominantly defended by white practitioners.

UCLA cohort member Gene Bruno, who also had influence in the State of Washington's acupuncture board, did not agree with the proposed change of "Oriental Medicine" to "East Asian Medicine." As he stated, "Personally I consider this a foolish and irresponsible attempt at only being politically correct, because it is not accurate" (Fan and Faggert, 2015, p. 287). Through internet forums⁶⁷ and interviews with various Chinese medicine practitioners, it was evident white American men felt the need to defend the use of the word. There was also a disregard for its social and cultural context, seen with a common argument "oriental" only meant "East." When juxtaposed with the use of the

⁶⁷ Though there are professional journals, internet groups such as "Acupuncturists on Facebook" and "Scholars of Chinese Medicine" are the primary modes of discourse within the American Chinese Medicine community.

word “negro,” many proponents of the word redirect their argument by stating an Asian colleague or friend in the profession had no qualms with the use of the word, thus somehow making it justifiable. These practitioners neglect to empathize with Asian American practitioners who are indeed uncomfortable with the term and disqualify any form of dissent, again, claiming authority from an Asian American friend or colleague who is indifferent with the term. This substantiates the orientalism conveyed by Edward Said where white Americans assumed the authority to decide how to refer to the people and culture of Asia. An even more apparent form of orientalized biopower was seen with the arrests of Asian American acupuncturists during the infancy of professionalization in the United States from 1972 to 1975.

The move to regulate acupuncture in the United States, as evident with California, was taken without consideration of the numerous Asian Americans who had already been practicing Chinese medicine years prior to the UCLA cohort. AB1500 legalized acupuncture for scientific research at an approved medical school under the supervision of a physician or surgeon. This excluded many Asian American practitioners who were then arrested for practicing medicine without a license. This was because AB1500 served as a safeguard for the UCLA cohort but did not protect anyone without the resources or ability to treat patients at a university for the purpose of clinical research. As stated before, since 1913, the Business and Professional Code Section 2141 broadly outlined the definition of medicine as well as expressed those who could or could not practice it. Section 2141 was not enforced for acupuncture until AB1500 was passed. The reason for its enforcement was because the California Medical Board of Examiners found a spike in the level of acupuncture related incidences after the passing of AB1500. Due to the cultural significance of acupuncture, the State would target Asian American practitioners. Out of the numerous arrests from 1972 to 1975, two specific arrests were important. Those of Tomson Liang and Miriam Lee.

Tomson Liang (1911-1997) was an electronics engineer for Hughes Aircraft in Oceanside, California and a part-time acupuncturist. He would treat his patients for free. During a 1972 interview with the *Virgin Island Daily News*, he joked, “I’d like to find a rich American... Someone who would put up enough money so I could set up a research institute to really study acupuncture” (Webb,

1972, p. 5). Liang was trained in Taiwan at the Chinese Acupuncture and Moxibustion Society, but then moved to the United States in the 1950s. The *Virgin Island Daily News* article states Liang was not a “black market acupuncturist” but “one of the handful of accredited acupuncturists in the nation.” In a deeper analysis of Tomson Liang, historian Michael Bowen examined several posts from the *San Diego Union*.⁶⁸ From 1972 to 1973, the paper published articles on Liang’s expertise ranging from teaching acupuncture to medical doctors at the University of California San Diego (UCSD) to his work on behalf of Veterans Affairs (VA). Despite his good reputation, Liang was arrested in 1974 for practicing medicine without a license and was sued by the California Board of Medical Examiners (Bowen, 1993, p. 109).

Liang’s arrest reflected the lack of respect the Board had for Chinese acupuncturists. The positive reception Liang received from the community and local media as well as his professional affiliation teaching at UCSD and at the San Diego’s VA did not matter. In fact, his arrest could have been because his involvement in the community made him a visible target. Another acupuncturist, factory worker Miriam Lee, was also arrested for practicing medicine without a license that same year. Miriam Lee (1926-2009), whose birth name was Li Chuan Zhen (李传真), was born in Shandong Province. She moved to Singapore at 27 and attended the Chinese Acupuncture Medicine General College (中国针灸医学总院). In 1969, Lee immigrated to the United States where she found work at a Hewlett-Packard factory in Palo Alto, California. Around 1973, Lee furthered her education in acupuncture by studying under the renowned Taiwanese acupuncturist Dong Jing Chang (董景昌), commonly known as “Master Tung” or “Dr. Tung” and his student Yang Wei Jie (杨维杰). She shared an office with allopathic medical doctor Harry Oxenhandler where Lee treated patients with acupuncture during Oxenhandler’s off-hours. In 1974, she was arrested for practicing without a license under Section 2141 and as a result, Oxenhandler’s license was temporarily suspended (Barnes, 2013; Fan, 2014).

⁶⁸ It is presently known as the *San Diego Union-Tribune* after it merged with San Diego’s other preeminent newspaper the *San Diego Tribune* in 1992.

In addition to Lee and Liang, there were other Asian American acupuncturists arrested for practicing medicine without a license. In San Francisco, Kung Fu instructor George Long was arrested in 1972 and in 1973 for practicing acupuncture without a license. He was fined \$600 and faced six months in prison. Both times his bail was set at \$500, which is unusually low and seen more as a harassment tactic (Elbasani, 2013; Staples, 1973, p. 61). A Japanese acupuncturist named Ted Hayashida was arrested three times by what he described as the “Western gestapo,” but continued to practice because as he stated, “I was breaking the law, but I was saving people” (Gorney, 1977).

The arrests were testaments to the prejudice Asian American acupuncturists had to endure at the beginning stages of California’s professionalization. During the time, known white acupuncturists were practicing without medical licenses, but were never arrested.

Barbra Bernie, a subject of anthropologist Mei Zhan’s (2009) *Other-Worldly*, was a student of Miriam Lee. She practiced acupuncture without medical license. Yet, Bernie never had any legal troubles (Skurko, n.d.). Other white acupuncturists who were known to practice acupuncture without a license in California were Harriet Beinfield and Efrem Korngold. They claimed to have started their practice in 1973, which was during the time of AB1500. Neither held a medical license nor practiced in an approved school at a research setting. Both would later be a part of the first group to be licensed in California (Beninfield and Korngold, n.d.). It is unclear whether Robert Felt, owner of the popular complementary medicine publication company Redwing Books, was active in California at the time. But in an interview with Linda Barnes, he did admit to practicing acupuncture without a license.

We were middle class kids, a lot of us. It was illegal as a practice, and we thought we would never make a living at it. I practiced out of a back room of the bookstore. It was something of an outlaw role. Having gone through our early adult years as outlaws with a feeling of rejection and of not belonging, we probably outlawed it more than it needed to be. But without outlaws, nothing new comes into the culture (Barnes, 2010, p. 270).

Felt’s sentiment reflected the white privilege many of the pioneers of American Chinese Medicine enjoyed at the time. In all actuality, it was various Asian American practitioners, and as I point out later in New York, members of

the Black Panther Party who practiced acupuncture, who were the real outlaws. Eventually, all charges against Asian American acupuncturists were dropped after the passing of Senate Bill 86 (SB86, 1975).

In July 1975, California's senate passed SB86, which allowed non-physician acupuncturists to practice acupuncture under the California Board of Medical Examiners and created a seven-member Acupuncture Advisory Committee. It also dismissed prosecution against acupuncturists who were practicing without a medical license (SB86, 1975). SB86 was a bill proposed by State Senator George Moscone, more notable for his role as San Francisco's mayor, and Alfred Song, who was the first Asian American California Legislator. The following year, Governor Jerry Brown authorized the complete licensure of acupuncture and in 1978 Brown deemed acupuncture a "primary healthcare profession" under AB1291 (Torres Bill) allowing acupuncturists to practice without referrals from physicians (California Acupuncture Board, 2001; 2016; California Little Hoover Commission, 2004). Though it is unclear whether Lee and Liang's trial had a direct effect on the change in regulation, it was apparent with SB86 and Governor Brown's decision, Asian Americans had the ability to practice as part of their culture. It is also important to understand the though the newly founded Acupuncture Advisory Committee worked with the California Board of Medical Examiners, SB86 was opposed by the Board. Also opposed to SB86 was a member of the UCLA cohort, David Bresler. In a memorandum to the governor, Bresler was listed as one of the oppositions to SB86 along with the Department of Health and the California Board of Medical Examiners (SB86 1975). The UCLA cohort, nonetheless, would maintain their dominance in acupuncture through the ownership of schools.

When Governor Brown changed the acupuncture licensing law, oversight on the practitioners, was to be through Chinese medicine schools. The California Board of Medical Examiners (Medical Regulatory Board) asked Bresler and Maryland's TAI founder Bob Duggan to testify on the content and duration of the curriculum. Instead of allowing Bresler and Duggan to convene an expert committee, the Board permitted the men to figure out curriculum standards over a lunch break. In a corner of a men's restroom, Bresler and Duggan, accompanied by Steven Rosenblatt, haphazardly scribbled notes on what they thought should constitute curriculum standards and duration of

acupuncture training. They settled on three years. After the break, the group handed the proposal to the Medical Regulatory Board and it was approved, making it the first Chinese medicine curriculum requirements for any state in the U.S (Cohn, 2010, p. 15). One of the requirements, mandated a practitioner attend an approved school. This would directly benefit members of the UCLA cohort and their school, the California Acupuncture College (CAC). As Gene Bruno notes,

Maybe in the first ten years (1975–1985), 70% to 80% of all students in (AOM) colleges within the U.S. were from the schools that Tin Yau So, Steven, Prensky and I had started. Probably 80% of practitioners can trace their lineage to our schools in this country (Fan and Faggert, 2015, p. 285).

With the help of the State, the UCLA cohort took advantage of the situation by using their position as architects of California’s mandatory Chinese medicine curriculum. The UCLA cohort’s Chinese medicine epistemology was built on the orientalism of its counterculture members and became an extension of the State’s control of bodies and populations; orientalized biopower.

The Chinese medicine adopted by the UCLA cohort and TAI, began as a romanticism of the East, then transitioned into a system of control. In academic circles, this progression could signal cultural appropriation.

3.4 Chinese Medicine as Cultural Appropriation?

It is easy to confuse counterculture orientalism with cultural appropriation but I argue the latter is more nebulous. While the counterculture was experimenting with cultures of the East, there was a collective amnesia toward the treatment of Asian Americans at home. Only a few decades earlier, until the Chinese Exclusion Repeal Act of 1943, Chinese were unable to obtain American citizenship. Japanese families were sent *en masse* to internment camps throughout the country. Meanwhile the counterculture adopted the ideas and practices of Asian culture by declaring themselves bearers of authority in regard to various traditional lineages. The counterculture orientalists have a pattern whereby they seek out more “authentic” ideas and practices by traveling abroad to the presumed country of origin then transplanting those ideas and

practices to the United States. This is often accompanied by a charismatic leader or at least the ideas and techniques of a certain leader. Contemporary academic discourse may argue the counterculture was engaging in cultural appropriation, but does this reflect what occurred with Chinese medicine in the United States?

To posit the notion of cultural appropriation, it is important to ask, “Who owns Chinese medicine?” Would it be the People’s Republic of China? Or maybe the Taiwanese? Could it be the Chinese Americans? The question overlooks the inherent heterogeneity of Chinese medicine. Suspending these questions, assume Chinese medicine is indeed homogeneous, the question then is who will collect, as legal scholar Susan Scafidi described, the identity tax?⁶⁹ Scafidi asks how will Chinese medicine “contribute to the national culture” (Scafidi, 2005, p. 7), but which national culture? Chinese medicine is not the first practice to undergo the question of ownership.

An attempt at ownership of a particular idea and practice in contemporary culture is best exemplified through yoga. In December 2014, the United Nations General Assembly (UNGA) declared June 21 would be the International Day of Yoga. The UNGA’s resolution was launched by Prime Minister Narendra Modi who appointed a Minister of Yoga, Shripad Yesso Naik, which is a part of the Ministry of AYUSH. This development was seen as Modi’s attempt to push for Hindu nationalist policies in an ethnically and religiously diverse country as well as a way to capitalize on yoga. Naik told the *Washington Post*, “There is little doubt about yoga being an Indian art form.... We’re trying to establish to the world that it’s ours.” Naik then went on to praise controversial yogi and Hindu nationalist Baba Ramdev (Ram Krishna Yadav) for the spread of yoga in India, “The saints and gurus practiced in the Himalayas but never took it to the general public.... Only Baba Ramdev knew how to take it to the people. Now it’s our turn to promote it more vigorously” (Gowen, 2014).

Albeit Ramdev is one of the most recognized yogis in India. He has also been a center of controversy for his position on homosexuality as a disease (Nelson 2009; HT Correspondent 2013) and for his battle with India’s Members

⁶⁹ Scafidi describes an ‘identity tax’ as a tax “payable to the public domain in the form of distinctive cultural products, including cuisine, dress, music, dance, folklore, handicrafts, healing arts, language, and image” (Scafidi, 2005, p. 7).

of Parliament over corruption (Dummett, 2011; *The Hindu*, 2013). Most notable is his stance on Hindu nationalism. In 2016 he was reported to advocate decapitation of Indians who refused to say, “*Bhārat Mātā Ki Jai*,” (भारत माता की जय) which translates to “Victory to Mother India” or “Long Live Mother India.” This is a familiar Hindu nationalist phrase from the Indian independence movements of the 19th and 20th century, but controversial to Indian Muslims because of its deification of India (Anand, 2016; Bhatia, 2016; Chisti, 2016). This has been seen as an example of a nation attempting to possess ownership of a practice, which then opens the discourse for cultural appropriation.

Cultural appropriation is defined by law professors Bruce Ziff and Pratima V. Rao as “taking – from a culture that is not one’s own – of intellectual property, cultural expressions or artifacts, history, and ways of knowledge” (Ziff and Rao, 1997, p. 1; Scafidi, 2005, p. 9). Ziff and Rao as well as Scafidi position cultural appropriation in terms of the law. Other complications with the idea of cultural appropriation relate to essentialist views of culture, a belief where culture has set characteristics which define a particular culture, discounting exchange, fluidity, and transformation. Further exploring the issue of cultural appropriation, media studies professor Richard A. Rogers defines it broadly as “the use of a culture’s symbols, artifacts, genres, rituals, or technologies by members of another culture” (Rogers, 2006, p. 474). Rogers situates cultural appropriation in four categories: cultural exchange, cultural dominance, cultural exploitation, and transculturation. Cultural exchange relates to the reciprocity between cultures who are roughly at equivalent levels of power. Cultural dominance accounts for an asymmetric dynamic characterized as “unidirectional imposition of elements of a dominant culture onto a subordinated (marginalized, colonized) culture.” Cultural exploitation, which is the common association used for describing cultural appropriation, is the nonreciprocal appropriation of the subordinate culture by the dominant culture without permission and/or compensation. Lastly, Rogers identifies transculturation, which can be the end product of globalization and transnational capitalism, as the construction of cultural elements from and/or by multiple cultures where it is unclear from where those elements originated (Rogers, 2006, p. 477).

The most apparent issue with Rogers' definitions is his overt monopoly of the term 'cultural appropriation' to denote incompatible ideas. Rogers' definitions of cultural exchange and transculturation complicate matters, where both categories do not necessarily reflect appropriation, while appropriation is explicit to both cultural domination and cultural exploitation. Rogers' thoughts on transculturation actually discredit arguments of cultural appropriation whereby he critiques essentialist views on culture. In fact, Rogers states,

Transculturation, as conceived here, calls not only for an updating of the understanding of contemporary cultural dynamics but also for a radical reconceptualization of culture itself: as conjunctural, relational, or dialogic; as constituted by, not merely engaged in, appropriative relations; and as an ongoing process of absorption and transformation rather than static configurations of practices (Rogers, 2006, p. 495).

Transculturation is a response to the fixed notion of culture and supplements it as both fluid and hybridized. Further critiquing essentialist views on culture, Rogers argues,

The ongoing imposition of the essentialist view of culture embedded in the first three types of appropriation onto various others (marginalized and/or colonized peoples) may constitute the kind of "epistemic violence" critiqued by Spivak (Rogers, 2006, p. 495).

Just as in Rogers' critique and in the following chapters, Chinese medicine's heterogeneity is threatened through the process of professionalization, which manifests as Gayatri Spivak's "epistemic violence." This "epistemic violence" occurs when the counterculture adopts the various Asian traditions but presumes an essentialism whereby the ideas and practices they engage with are somehow ahistorical and stagnant. It is an essentialist presumption to view Chinese medicine as ahistorical and devoid of any social or cultural context. In reality, the counterculture's adoption of Chinese medicine is just another example of the continuity and evolution of practice. As I uncover throughout the thesis, the process of professionalization and the standardization it encompasses, continues to be changed and subverted because of Chinese medicine's innate heterogeneity as well as internal and external forces. In other words, Chinese medicine's professionalization is in

itself heterogeneous and shaped by its laws, cultures, and medical traditions. Further, not only is Chinese medicine heterogeneous but so are its techniques. Acupuncture is shared by various traditions such as Japan, Korea, and Viet Nam, and the vastly different practice of Tibetan medicine. Heterogeneities also extend to herbs, cupping, moxibustion and *gua sha*.

3.5 Conclusion

This chapter outlined the progression from the romanticism of Chinese medicine to the control of it. With members of the counterculture seated as the pioneers of Chinese medicine's professionalized form, American Chinese Medicine, they could have made a more radical approach to its professionalization. The trajectory of professionalization, however, took a route similar to biomedicine. As Braunstein and Doyle put it,

Unlike subcultures, a contraculture aspires to transform values and mores of its host culture. If it is successful . . . it *becomes* the dominant culture (Braunstein and Doyle, 2002, p. 7).

To exacerbate matters, there was an attached medical gaze derived from orientalist fantasies which became the dominant framework of Chinese medicine. This gaze utilized the State as a tool to help push the agenda of professionalization all while the State used Chinese medicine as another mechanism of control.

This orientalist sentiment is still prevalent. In 2016, one of the key members of the UCLA cohort/NAA, Steven Rosenblatt, wrote a book about his experience as a pioneer of acupuncture in America, *The Birth of Acupuncture in America: The White Crane's Gift*. The book details the history and theory of acupuncture in America. Journal entries from the cohort's teacher Ju Gim Shek, serve as an intimate look of what occurred at the time. A bit of deception is used in Rosenblatt's narrative. The journal entries were not actually written by Ju Gim Shek. As it states in the 'Introduction,'

Dr. Ju's Journal is a literary device which we [Rosenblatt and Kirts] developed to give a personal voice to his vision and ideas. It is formed of oral transmissions directly from Dr. Ju himself, as well as collected reflections from his colleagues such as Dr. So,

Tin Yau and Marshall Ho'o, from his daughters, and from his other Chinese students such as Howard Lee. These journal entries provide an insight into Dr. Ju's personal mission and his methods of transmitting this ancient knowledge (Rosenblatt and Kirts, 2016, pp. 9-10).

In other words, Rosenblatt took what he felt was the voice of his late teacher and used it to give credence to Rosenblatt's own narrative. This is an example of how orientalism still exists in American Chinese Medicine. This orientalized biopower may seem particular to Chinese medicine but other medical traditions and contemplative practices such as Āyurveda and Yoga are following the same trajectory.

As I explore in the following chapters, the role of white Americans and the institutions they construct will direct many of the Chinese medicine traditions. While conducting my ethnography, the profession's predominant figures, the majority of schools, and regulatory bodies would be led by white Americans. Their pursuit of authority over the medicine as well as the continued effort to professionalize it will prove to have repercussions in the bureaucratization of medicine, marginalization of traditions, practices, and people, as well as steering students to the route of financial debt from the required education. All of this is at the expense of students, practitioners, and most importantly, the safety of patients. As a result, what is presented as an organized profession trying to gain respect from the allopathic biomedicine community, would instead manifest as a self-serving profession which will provoke turf wars to maintain its place in American healthcare.

Chapter 4.

Professionalization

The last chapter highlighted the beginning stages of Chinese medicine's professionalization with the regulation of acupuncture. In the early 1980s, Chinese medicine began to legitimate its practice through the power of regulatory bodies in cooperation with state licensures and to establish more formal training. To understand this arrangement I concentrate on the history and structure of regulatory bodies since the early 1980s. In my analysis of the regulatory bodies key characteristics emerge which shape much of the profession today. I then focus on key state licensures to highlight the different routes to professionalization. Since it would be tedious and trivial to examine all forty-five states with acupuncture licensing laws, I examine three case studies: California, Nevada, and Maryland. These states expressed the variation of power structures and the heterogeneity of professionalized practices. Chinese medicine's innate heterogeneity continually unsettles the profession's attempt to standardize. As I discovered, no evidence proves one tradition is more effective than another. Despite this, TCM prevails as the standard tradition of the profession. The standard of knowledge is shaped by the regulatory bodies' authority and their acceptance of certain European written or translated Chinese medicine books.

4.1 Chinese Medicine as a Profession

A 'profession' is defined as "a paid occupation, especially one that involves prolonged training and a formal qualification" (Profession, n.d.). The professionalization of Chinese medicine, American Chinese Medicine, revolves around legislation on who can or cannot practice acupuncture. Though it was briefly mentioned in the last chapter, many Americans gravitated towards acupuncture because of its accessibility. The original pioneers of the 1970s and 1980s did not have a codified acupuncture system. In the 1980s, the World Health Organization (WHO) attempted to standardize acupuncture nomenclature. As the region director of WHO, S.T. Han wrote at the time,

Translations of the original Han (Chinese) texts and characters have proliferated. Numerous problems due to differences of spelling and pronunciation have arisen. Today, the same acupuncture points may have a wide variety of names because of these differences. Furthermore, to help those who do not read Han characters, a variety of alphanumeric codes have been given to meridian and acupuncture points. The need for standardization has become increasingly pressing (WHO, 1993, Foreword).

It was not until 1982 when the alphanumeric codes – the standard model of acupuncture point transmission – were first established by the WHO sponsored Working Group on the Standardization of Acupuncture Nomenclature in Manila, Philippines. From 1982 to 1987, there were three working group meetings held throughout Asia. In 1989, the Scientific Group to Adopt a Standard International Acupuncture Nomenclature agreed on 361 acupuncture points in Geneva, Switzerland. Based on the standardized perceptions of China, Japan, Republic of Korea, and Viet Nam, the points were ordered with the accompanying meridians (channels). The system was based on three components: “(1) alphanumeric code; (2) the Chinese phonetic alphabet (Pinyin) name; and (3) the Han (Chinese) characters of the meridian and the acupuncture point” (WHO, 1993, p. 2). The systematization made the points accessible in Chinese, English, French, Japanese, Korean, and Vietnamese (WHO, 1993). Though WHO brought one particular standardization of acupuncture nomenclature, it did not codify diagnosis and treatment. The issue with translating Chinese medicine from Chinese to English has been the focus for linguistic anthropologist and acupuncturist Sony Pritzker. Pritzker writes,

In light of the ever-growing popularity of Chinese medicine as a complementary and alternative medicine (CAM) in the English-speaking world, it would be beneficial to many practitioners and patients alike to have more English translations of Chinese medical texts. This need is amplified by the fact that only a few of the 50 schools of Chinese medicine in the United States that train students in acupuncture, Chinese herbal medicine, and massage require any Chinese language training. Most English-speaking practitioners in the United States must therefore depend on translated materials. Given this need for more high-quality translations, as well as the reality that many if not most United States practitioners must depend on such translations in order to further their education, it is crucial at this time that all stakeholders

in the translation of Chinese medicine, especially consumers, understand at least the basics regarding the scope and complexity of translation in this vast field (Pritzker, 2014b, p. 395).

Ignoring the complexity, regulatory bodies continue to push for standardization. The standardized tradition of the profession is a reworked version of China's state-sponsored TCM. State licensures use the standardized tradition as the primary model for the profession. The result is often marginalization of non-TCM Chinese medicine practitioners. This marginalization forces practitioners to practice outside of the law. To understand Chinese medicine's professionalization, it is important to first analyze regulatory bodies.

4.2 National Regulatory Bodies

To legally practice Chinese medicine in the United States, a practitioner will encounter at least three national regulatory bodies: Accreditation Commission for Acupuncture and Oriental Medicine (ACCAOM), National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), and Council of Colleges of Acupuncture and Oriental Medicine (CCAOM). Two designations are used to describe the profession: "acupuncturists" and "Oriental Medicine" practitioners. "Acupuncturists" typically designates the practice of acupuncture and its related techniques while "Oriental Medicine" represents the practice of acupuncture and herbs. This may seem straightforward but in some states such as California and Florida, "acupuncture" also encompasses herbs. In both routes, applicants must attend an educational institution designated as either "Accredited" or a "Candidate" school by ACCAOM. After meeting the required course hours, which is typically three years of coursework and roughly four hundred clinical hours,⁷⁰ the student is allowed to sit for the national board examination given by NCCAOM. The national board exam is not a single exam but three to four different exams.⁷¹

⁷⁰ According to the NCCAOM's 'Eligibility Requirements,' there's a minimum of 1600 course hours and 410 clinic hours for the Acupuncture modules and 2500 course hours and 410 clinic hours for the Oriental Medicine module (NCCAOM, 2014a).

⁷¹ Three exams for acupuncture only and an additional Chinese herbalism exam if the candidate wants to practice "Oriental Medicine."

The CCAOM serves as the guild for educational institutions. As a student, I thought the CCAOM's role was only to administer the "Clean Needle Technique" (CNT) course. I now understand they influenced the trajectory of schools and worked with policy relating to the profession. The American Association of Acupuncture and Oriental Medicine (AAAOM), was one of the first professional organizations. It was crucial in the formative years, but after internal issues and misallocation of funds, the organization's continued existence is questionable (Peterson, 2014; 2014a).

The creation of the AAAOM occurred in June 1981, when medical doctor Ralph Coan and professor Louis Gasper convened the first conference on the Chinese medicine profession at Los Angeles International University. Coan was known for his pioneering acupuncture research at one of the first legal acupuncture centers in Washington, D.C. called Acupuncture Center of Washington (Fan and Fan 2013, 43). Coan and Gasper organized the conference for medical doctors (MD) practicing acupuncture, non-MD acupuncturists, and people interested in acupuncture. Seventy-five people were in attendance and attendees elected the AAAOM's board. The board consisted of seven MDs and non-MD acupuncturists with medical doctor Lupo Carlota as the first president and Robert Sohn as the vice president (Cohn, 2011, p. 24).

A few months after the AAAOM meeting in Los Angeles, Bob Duggan, the founder of Traditional Acupuncture Institute (TAI) in Maryland, convened a conference at the Hyatt Regency Hotel in the historic Inner Harbor of Baltimore, Maryland under the Traditional Acupuncture Foundation, an affiliate of TAI. The conference focused on the content of Chinese medicine in the United States and was well received with an estimated four hundred people in attendance. During the conference, there was talk about creating a national organization of Chinese medicine schools. The conference was extended for an additional day to discuss the curriculum in the profession. Another meeting was set for February the following year (Cohn, 2011, p. 24). Bob Duggan described the Baltimore conference as a meeting of "future leaders for an American acupuncture – active, long-sighted people were brought together to discuss and plan for the future of the acupuncture profession in the United States" (NCCAOM, 2007, p. 7). American Chinese Medicine was on its way towards

professionalization and its central focus was the regulation of acupuncture. The next few years were pivotal for Chinese medicine.

In February 1982, the attendants who convened at the Baltimore conference to discuss matters of curriculum, met in Chicago. Invitations had been sent to Chinese medicine schools throughout the United States. Various schools replied sending their representatives. This resulted in the framework for the three national regulatory bodies: the council for schools known then as the National Council of Acupuncture Schools and Colleges (NCASC, now CCAOM),⁷² a commission to certify acupuncturists known at the time as the National Commission for the Certification of Acupuncturists (NCCA, now NCCAOM), and an accreditation organization for schools known as National Accreditation Commission for Schools and Colleges of Acupuncture and Oriental Medicine (NACSCAOM, now ACAOM), which was recognized by the United States Department of Education in 1988 (NCCAOM, 2007, p. 10; Cohn, 2011, p. 24).

The AAAOM met in San Diego the following month. The meeting partnered the AAAOM and NCASC to create the NCCA (now NCCAOM), which was responsible for the certification of practitioners. The creation of the NCCA created friction among the AAAOM board members with the appointment of an Asian American non-MD acupuncturist named Harry Ta as vice president. This meant the AAAOM's board consisted of a majority of six non-MD acupuncturists and five medical doctors. The newly formed NCCA consisted of nine members: four elected by the AAAOM and four elected by the NCASC, with the one member elected from the appointed eight members from both organizations. An issue within the AAAOM's ranks occurred over the debate between full-time non-MD acupuncturists versus medical doctors who practiced acupuncture on the side. Since the issue was unresolved, another meeting convened the following year at the Shoreham Hotel in Washington, D.C.⁷³

In May 1983, the AAAOM met in Washington, D.C. with an additional meeting held by TAI's affiliated Traditional Acupuncture Foundation two days

⁷² Sherman Cohn identified the organization's name as National Association of Schools of Acupuncture instead of National Council of Acupuncture Schools and Colleges (Cohn, 2011, p. 24).

⁷³ It is unclear whether Stuart Kutchins was the chair of the NCCA during the 1982 meeting in San Diego, appointed at the 1983 AAAOM meeting in Washington, or sometime in between.

prior. During the middle of the Traditional Acupuncture Foundation's conference, the AAAOM's president Lupo Carlota called for an emergency AAAOM board meeting. Since many of the non-MD acupuncturist members were not present, a protest erupted delaying the meeting for later in the day. The meeting convened again and the AAAOM elected four non-MD acupuncturists as members of the NCCA board. This meant the majority, if not all, members of the NCCA were non-MD acupuncturists. All but one of the medical doctor members, Ralph Coan, resigned. Coan was then elected as the new president of the AAAOM (NCCAOM, 2007, p. 10; Cohn, 2011, p. 25).

By 1983, Stuart Kutchins was elected Chair of the NCCA. His aim was for an impartial and inclusive commission would use third-parties such as the Professional Exam Services (PES) to help oversee testing standards. The inclusiveness was limited with the already disgruntled allopathic biomedical community. Partnership with PES was a way to encompass an impartial persona in shaping the future of the profession. The first task of PES was to establish a jobs task analysis to determine the 'domains of practice' for the profession.

In 1984, the NCCA made three decisions for the profession: introduce a Code of Ethics, develop safety measures in acupuncture known as the "Clean Needle Technique" (CNT), and establish a system for credentialing applicants. The NCCA decided there should be ethical standards for the profession and developed a Code of Ethics to maintain a degree of professionalism. The NCCA established the CNT because of previous incidences of Hepatitis and other infections which occurred because of unsafe acupuncture practices. 1984 also brought the NCCA's second meeting to Los Angeles where they discussed practitioners' certification criteria, and designed a point system for certification. The system was determined by: education, years of practice, apprenticeship, and professional achievements. This resulted in the creation of a credential documents review (CDR), which was one of the two ways to determine credentialing and the NCCA's first route for certification. The other route of credentialing was through a national examination. The first national examination was administered in March 1985 and taken by 300 applicants. The exam accommodated non-English speaking applicants who read in Chinese, Japanese, and Korean (NCCAOM, 2007, pp. 10-12).

In 1985, the Chinese medicine schools' accreditation commission known as the NACSCAOM came under scrutiny from the United States Department of Education. By law, any educational accrediting body must be "recognized" the Department of Education via the United States Secretary of Education. The core of the issue dealt with Title IV of Higher Education Act of 1965, which relates with student loans. (I cover this more in-depth in the following chapters.) The NACSCAOM's first application was rejected in 1984. Their rejection led to a meeting in May 1985 in Chicago by the NACSCAOM, NCAA, NCASC, and the AAAOM. The meeting was chaired by a Georgetown University law professor named Sherman Cohn. They discussed three main subjects related to all Chinese medicine schools: years of training, educational requirements, and degree-level once graduated. After a day of discussion, the groups came to the consensus, three academic years for students who wanted to only study acupuncture and four years if they wanted to learn both acupuncture and herbs. They also decided on a prerequisite of two years of post-secondary education and the degree awarded was a "Masters of Acupuncture" for those pursuing only acupuncture and a "Masters of Oriental Medicine" for students who studied both acupuncture and Chinese herbs.

The year before, Florida Congressman Claude Pepper wrote a book called *Quackery: A \$10 Billion Dollar Scandal*. A section in the book read in capital letters, "ACUPUNCTURE IS QUACKERY." To substantiate this claim, Congressman Pepper applied for a "Doctorate of AOM" (Acupuncture and Oriental Medicine) at a Chinese medicine school. At the Florida's State Legislature, Pepper showed the Congress a diploma he received from the school only required him to write six one-page book reviews and pay \$1000. With Congressman Pepper's controversy and lack of resources for research, the profession could not afford to have the doctorate degree designation. In 1988, the NACSAOM was recognized by the Secretary of Education as the accreditation agency for Chinese medicine schools (Cohn, 2011, p. 25).

Most of the focus for professionalization had been on acupuncture. In 1985, the NCCA proposed Chinese herbology as a distinct practice from acupuncture. This led to the consideration of a separate certification for practitioners who use Chinese herbs. Even though it was not until 1992 when the NCAA established the "Certification in Chinese Herbology," herbs played a

crucial role to complement Chinese medicine's use of acupuncture. By 1990, the NCAA established a non-profit organization called the NCCA Foundation for Acupuncture and Oriental Medicine Research and Education to research entry-level standards to practice Chinese herbology. The foundation launched its first hearing in 1991 during the AAAOM's annual conference. After a year of research, the NCCA's foundation created the "Certification of Chinese Herbology," which set the framework for Chinese herbal programs in schools (NCCAOM, 2007, p. 17). In 1995, the Chinese herb examination was administered in conjunction with the Comprehensive Written Examination (CWE). The tests were available in English, Chinese, and Japanese. Would a "Certification of Chinese Herbology" warrant the work the NCCA devoted to having a separate category?

Nationally, Chinese herbs or any herbs, are designated "dietary supplements" according to the United States Food and Drug Administration's (FDA) Dietary Supplement Health and Education Act of 1994. The Act was created in response to previous legislation such as the Nutrition Advertising Coordination Act of 1991, which gave more power to the federal government to control non-drug supplements. With a sizable public relation campaign, dietary supplement lobbyists managed to halt oversight of dietary supplements. Most notable was an advertisement where actor Mel Gibson's house was raided by armed federal agents to confiscate his Vitamin C supplements. The campaign was successful and launched the Dietary Supplement Health and Education Act of 1994. From then on, the FDA defined a 'dietary supplement' as,

[A] vitamin, a mineral, an herb or other botanical, an amino acid, a dietary substance for use by man to supplement the diet by increasing the total dietary intake, or a concentrate, metabolite, constituent, extract, or combination of any of the aforementioned ingredients.... [A] dietary supplement must be labeled as a dietary supplement and be intended for ingestion and must not be represented for use as conventional food or as a sole item of a meal or of the diet.... [A] dietary supplement cannot be approved or authorized for investigation as a new drug, antibiotic, or biologic, unless it was marketed as a food or a dietary supplement before such approval or authorization (Dept. of Health and Human Services, 2003, p. 4).

With the passage Dietary Supplement Health and Education Act of 1994, Chinese herbs are not under the jurisdiction of the federal government and considered a “dietary supplement.” This meant that unless the herb or supplement had numerous reports of adverse reactions or consists of an endangered specimen, the federal government cannot control the substance and holds the accountability of any wrongdoing on the manufacturer. If there was an adverse reaction to an herbal formula, either the practitioner or the distributor of the raw materials are held accountable.

The NCCAOM cannot enforce its standards on manufacturers, distributors, or even sales representatives who want to distribute or sell Chinese herbs outside of the profession, but only assures its diplomats uphold a level of safety. This is complicated in states such as Pennsylvania. If a Licensed Acupuncturists who did not take the NCCAOM’s Chinese Herbology examination sells herbs, they run the risk of losing their acupuncture license if they are reported to the state licensure. Any business owner outside of the Chinese medicine profession can legally sell herbs without any legal repercussion, unless there is serious injury. Throughout the United States the popularity of herbs had shifted the curriculum of many schools and change acupuncture regulations.

Many states did not include the use of Chinese herbs in their scope of practice at the time. This practice is changing. Today more and more states are including Chinese herbs in the scope of practice of acupuncture and are requiring the NCCAOM Chinese Herbology examination. Arkansas, Nevada, New Mexico, and Texas currently require the NCCAOM Chinese Herbology examination for licensure, in addition to the acupuncture examinations (NCCAOM, 2007, p. 18).

Another concern about herbs is the distributors restriction on non-licensed Chinese medicine practitioners. Licensed practitioners typically purchase herbs from reputable distributors or herbal companies who voluntarily maintain high quality standards. These herbal companies and distributors, however, are known to not sell herbal products to non-licensed practitioners. This results in the general public resorting to less-reputable brands who do not maintain a level of quality control. Besides the potential risk to the general

public, it forces patients to rely on practitioners and limits the ability for self-care.

The most apparent shift for the NCCAOM occurred in the 1990s and 2000s when they moved towards bureaucratization, through the use of computer-based examinations. The NCCAOM had complications with the Acupuncture with Point Location examination. Acupuncture point location is traditionally measured a few ways: a patient's structural landmarks, measurement based on the practitioner's anatomy, measurements based on the patient's anatomy, or an acupuncture ruler. Contention surrounds the "*cun*" (寸), translated as "thumb" or "inch," used as an objective length of measurement. The informal measurement is one *cun* is the size of a thumb's width, one and a half *cun* is the width of two fingers, and three *cun* is the width of four fingers. Some practitioners measure *cun* by the size of a patient's fingers while other practitioners used their own fingers. This subjectivity complicates any attempt for standardization.

In the late 1980s and 1990s, the NCCAOM tested the Acupuncture Point Location examination on live bodies through the Practical Examination for Point Location Practical Skills (PELPS) and enrolled people as subjects for the point location module of the exam. It lasted for almost a decade, but with the tedious task of recruitment of live bodies and a move to computer adaptive testing (CAT) which occurred in 2006, there was no need to continue the practical point location module.⁷⁴ The CAT or any computer-based exam provided a more objective format for point identification. *Cun* measurements were marked in relation to specific landmarks on the body and their location was written out (NCCAOM 2007, 23).

Historical analysis of the regulatory bodies serves to contextualize their contemporary framework. The proceeding segments deconstruct the regulatory bodies to understand their structure and function. Through my analysis, I discovered what ought to be the foundation of practice – patient safety – overshadowed by Chinese medicine theory.

⁷⁴ The NCCAOM phased out PELPS, but it is unclear what exactly was used in its place until 2006 when the NCCAOM moved to CAT. Peter Deadman et al *A Manual of Acupuncture* (1998) and Cheng Xinnong's *Chinese Acupuncture and Moxibustion* (1987) were already commonly used point location guides in preparation for the NCCAOM's point location module.

4.3 NCCAOM

To obtain a license to practice Chinese medicine in America, most states require candidates to take the NCCAOM’s national board exam. Depending on the state licensure, there are at least three exams for the Dipl.Ac. certification⁷⁵ and an additional Chinese Herbology exam for the Dipl.OM certification. Minimum required course (“didactic”) and clinical hours must be completed before a student can sit for the exam. Unless the state requirement stipulates otherwise, a candidate who only wants to practice acupuncture, must have at least 1600 combined didactic and clinical hours. If the candidate wants to encompass herbs, whether by choice or by the requirement of their state’s licensing regulations, they must complete 2500 combines didactic and clinical hours (as seen in Table 4.1) (NCCAOM, 2016a, p. 2; 2016b, p. 2).

Certification Type	Exam Modules	Minimum Didactic Hours	Minimum Clinical Hours	Total Hours Required
Acupuncture Certification (Dipl.Ac.)	I) Foundations of Oriental Medicine	1190	410	1600
	II) Biomedicine			
	III) Acupuncture w/ Point Location			
Oriental Medicine Certification (Dipl.OM.)	I) Foundations of Oriental Medicine	2090	410	2500
	II) Biomedicine			
	III) Acupuncture w/ Point Location			
	IV) Chinese Herbology			

Table 4.1 NCCAOM’s Pre-Graduation Hour Requirements for Taking Examinations (NCCAOM, 2016a, p. 2; 2016b, p. 2)

Once the candidate has reached their required didactic and clinical hours, they must choose the appropriate time and place to take the exam as well as the appropriate exam to take. The NCCAOM’s national board exam are distributed through Pearson VUE, who also handle other exams for various professions. To accommodate applicants, Pearson VUE’s exams are open one hundred days out of the year. This is in contrast to the biannual exams found in state licensures such as California. Each exam module has specific content.

⁷⁵ “Foundations of Oriental Medicine,” “Biomedicine,” and “Acupuncture with Point Location”

Table 4.2, outlines what percentage of a “domain” is covered in an exam module.

The content is based on a range of books recommended by the NCCAOM. Informants in the field list, *A Manual of Acupuncture* (Deadman, Al-Khafaji, Baker, 2007) and *The Foundations of Chinese Medicine* (Maciocia, 2005) as the two primary texts. As I cover in the next chapter, both Maciocia and Deadman came from the British-based International College of Oriental Medicine (ICOM) founded by the late Dick van Buren in East Grinstead, United Kingdom. This positions European translations as pivotal to the construction of American Chinese Medicine in its contemporary form. Unlike the national standards constructed by the NCCAOM, California has its own standard for textual sources.

Exam Module	Domains/ (% of Exam)	Certification Type
Foundations of Oriental Medicine (FOM)	A) Clinical Examination Methods (10%) B) Assessment, Analysis, and Differential Diagnosis Based Upon Traditional Chinese Medicine (TCM) Theory (45%) C) Treatment Principle (Zhi Ze) and Strategy (Zhi Fa) (45%)	Dipl.Ac. Dipl. OM.
Biomedicine (BIO)	A) Biomedical Model (90%) B) Office Safety and Professional Responsibilities (10%)	Dipl.Ac. Dipl. OM.
Acupuncture w/ Point Location (ACU)	A) Safety and Professional Responsibilities (10%) B) Treatment Plan (70%) C) Point Identification/Location (20%)	Dipl.Ac. Dipl. OM.
Chinese Herbs (CH)	A) Safety and Quality (10%) B) Treatment Plan: Develop a Comprehensive Treatment Plan Using Principles of Chinese Herbology Based Upon Patient's Presentation and Diagnosis (60%) C) Patient Management: Patient Education and Treatment Evaluation (30%)	Dipl. OM.

Table 4.2 NCCAOM's Content Outline⁷⁶

In Fig. 4.1, the NCCAOM consists of its Board of Commissioners who appoints the committees, taskforces, and panels. As of 2016, the NCCAOM has seven committees. The Council of Examination Development Committee is further broken into four subcategories of the Educational Development Committees (EDC), each respective to the four exam modules. Committees

⁷⁶ CAB (2016a, pp. 61-63, 70-73, 75-77) and NCCAOM (2016a, pp. 6-20; 2016b, 6-20, 27-32, 34-38).

“assist the Board by investigating, deliberating, and analyzing special issues on behalf of the Board.” Taskforces and panels are temporary operations where the former are created as ad hoc committees to deal with specific initiatives and the latter acts a special advisory committee assigned by the board. This has two taskforces: Integrative Care Practice Job Analysis and the Public and Professional Recognition Awareness. The NCCAOM also has one panel which focuses on Professional Development Activity (PDA), continuing education units most states require to maintain a license (NCCAOM, 2014b). Though it may seem tertiary, PDAs serve as a way for the preservation and the continuity of a tradition.

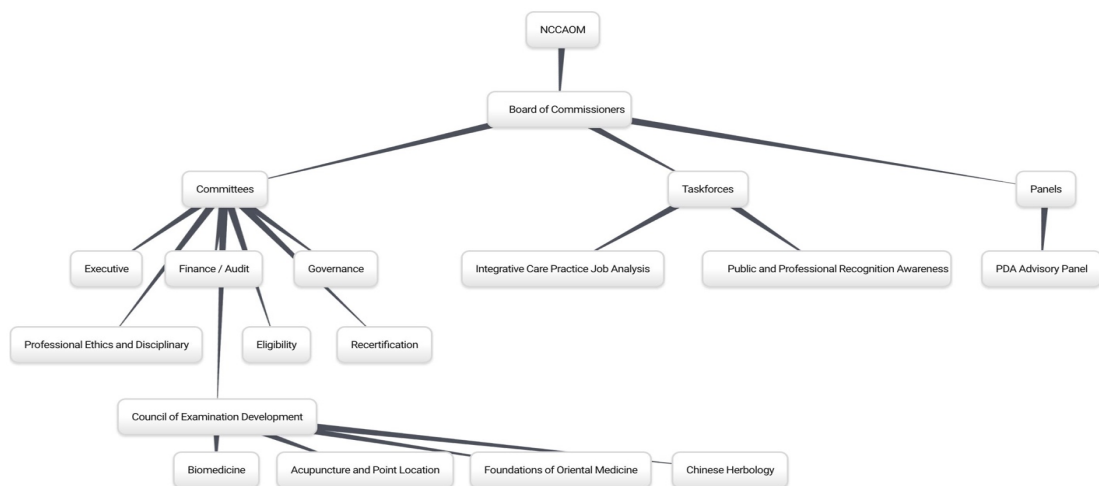


Fig. 4.1 NCCAOM's Governance (NCCAOM, 2014b)

The NCCAOM's examination content is based on the findings of six to eight “subject-matter experts” (SME). SMEs are primarily Chinese medicine practitioners the NCCAOM has asked to volunteer in composing an exam. Outline of SMEs criteria are:

- Must be an active NCCAOM Diplomate in the subject matter module on which they work.
- Must have significant practice experience and/or expertise in the subject matter.
- Prior experience serving as an item writer in the NCCAOM Item Writing Academy is essential.
- Ability to communicate in the English language is required.
- SMEs must be able to commit to attendance at all EDC meetings and workshops.
- May not be owners or presidents of schools of acupuncture and Oriental medicine.

- May be Senior Administrators or directors of schools of acupuncture and Oriental medicine.
- May be current members of state licensing Boards of acupuncture and Oriental medicine (NCCAOM, 2014b, p. 17).

The outline above has a few unclear issues. The most striking requirement comes from the first criteria that the SMEs “Must be an active NCCAOM Diplomate in the subject matter module on which they work.” This stipulation posits a potential bias and calls into question its impartiality. Since most states licensures do not require their licensed practitioners to be “active NCCAOM Diplomates,” this demonstrates the insularity of the NCCAOM. The other issue is the term “expert.” It is vague how the NCCAOM determines “significant practice experience/and or expertise.” Considering the limited research found within Chinese medicine in America, the measure would not be based on clinic research, but on individual practices. It is also hard to determine the extent of the practitioner’s experience or expertise through the treatment history of patients, when patients’ medical information is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Issues with the NCCAOM’s SME have been brought to my attention by a few practitioners who volunteered for the position. Volunteers have noted the trivial nature of the process where some SMEs simply inform NCCAOM what they commonly see in their clinic. Not to mention the methodological errors in this process, there exists a potential for bias based on the specialization of practitioners. It is also important to point out that the majority of the exam is grounded in Chinese medical theory, with only a small percentage based on patient safety.

In the NCCAOM’s ‘Code of Ethics,’ the second principle is to “Treat within my lawful scope of my practice and training and only if I am able to safely, competently and effectively do so.” Statistically, safety comprises only a fraction of the actual content of the NCCAOM’s examination. Through my analysis of the two exams’ content, 28.1% of the Dipl.Ac exam and 21.1% of the Dipl.OM exam is based on safety.

Shifting the emphasis of the exam to focus on safety in Chinese medicine would have three benefits: reinforce Chinese medicine heterogeneity, support the purpose of licensing boards, and add a reasonable focal point for

the profession which does not marginalize other traditions. Since Chinese medicine is heterogeneous with its countless traditions and manifestations, the attempt to situate a predominant tradition which overrides all others is destructive and hegemonic. No data supports the standardized TCM in America is more effective than any other tradition. In a 17,922-patient clinical study for chronic pain, there was no evidence that one particular acupuncture characteristic⁷⁷ had better treatment result than any other (McPherson et al., 2013). Secondly, most state licensing boards and their regulations of Chinese medicine – through acupuncture and herbs – are designed to protect the general public. With this common purpose, safety should be the utmost concern for the practitioner and schools. In the next chapter, however, schools are shown to be more preoccupied with Chinese medicine theory than with patient safety. Yet patient safety is translatable and does not require any esoteric transmission or orientalism.

It is important to understand that the NCCAOM works in unison with ACAOM to establish the educational credentials required for an applicant to practice in most states.

4.4 ACAOM

ACAOM is the only national accreditation organization for Chinese medicine schools. Originally known as National Accreditation Commission for Schools and Colleges of Acupuncture and Oriental Medicine (NACSCAOM), it transformed when it was recognized by the Department of Education in 1988 and was renamed Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) in 1997. ACAOM's responsibility is to accredit Chinese medicine programs throughout the United States and to create standards in curriculum.

ACAOM approves schools in two degree levels: Master's Degree/Master's Level⁷⁸ and Doctorate.⁷⁹ It grants three statuses for schools:

⁷⁷ Characteristics included style of acupuncture, point prescription, location of needles, use of electrical stimulation and moxibustion, number, frequency and duration of sessions, number of needles used and acupuncturist experience (McPherson et al., 2013).

⁷⁸ Also referred to as "Masters Diploma" and of "Master Level Diploma."

⁷⁹ Also referred to as "Postgraduate Doctoral Programs."

“Candidacy,” “Accreditation,” and “Unapproved.” ACAOM has specific criteria for schools to meet accordingly. Below in Table 4.3 is the “Standards” and “Criteria” it expects from the Master’s Level/Master’s Degree programs. Before I begin to explain ACAOM’s standards of curriculum, I need to clarify the differentiation with “Master’s Level” and “Master’s Degree.”

As a student of an acupuncture school in North Carolina, I noticed my academic qualification was a “Master’s Level Diploma.” Despite meeting the same standards as other Chinese medicine schools in the nation it granted a Master’s Degree of some designation.⁸⁰ My school, however, was limited to only grant the odd “Master’s Level Diploma.” This prompted me to research the legal context and understand why the school could not award a “Master Degree.” First, it is important to recognize that North Carolina is a unique state as it does not officially have a state Department of Higher Education, but instead grants power to the University of North Carolina. The University of North Carolina (UNC)⁸¹ – not be confused with the University of North Carolina at Chapel Hill – is an institution of accreditation in its own right. Article IX, Section 8 of North Carolina’s Constitution states,

The General Assembly shall maintain a public system of higher education, comprising The University of North Carolina and such other institutions of higher education as the General Assembly may deem wise. The General Assembly shall provide for the selection of trustees of The University of North Carolina and of the other institutions of higher education, in whom shall be vested all the privileges, rights, franchises, and endowments heretofore granted to or conferred upon the trustees of these institutions. The General Assembly may enact laws necessary and expedient for the maintenance and management of The University of North Carolina and the other public institutions of higher education (NC Const., Art. IX, § 8).

Though this does not explicitly claim that the UNC has authorization over higher education, the process actually took another two centuries to implement. In 1971, legislation gave the UNC control of sixteen of the major universities. The school I attended, Jung Tao School of Classical Chinese Medicine (from now on Jung Tao), would have to go through the UNC System to grant an

⁸⁰ The multitude of varying Masters degrees is covered in the next chapter on schools.

⁸¹ Known more commonly as the “University of North Carolina system” or “UNC system.”

official “Master’s Degree.” When I interviewed the former president of Jung Tao, Lora Moyle, she began to discuss the problem with the profession wanting to have an entry-doctorate roughly a decade earlier. Moyle mentioned the difficulty states such as North Carolina had to grant a “Master’s Degree.”

The problem is that in many states you have a Department of Higher Education. And you go to those groups [Dept. of Higher Education] and say, “I want to offer higher education degrees.” Then they [Dept. of Higher Education] grant it. North Carolina does not have that. We have a Department of Education, but that deals with K-12. We have community college [system], but that’s for two-year programs. On the higher education level, you are governed by the UNC Board of Governors. So that is a very unusual situation. And it took us many years for us to find who we [Jung Tao] had to go through. There were a lot of interpretations of our boards, guidelines where several attorneys said that the North Carolina Acupuncture Board [North Carolina Acupuncture Licensing Board] had the authority because they do accredit “programs” and that they had the ability. But our Board [Jung Tao] didn’t want that responsibility and helped determine that it was up to the UNC Board of Governors.

Moyle went on to say that the location did in fact matter and if the school moved roughly fifteen miles west to Tennessee, there would not be an issue.

If I were to move the school to Tennessee, fifteen miles away, I would apply to their Board of Higher Education and basically because I [Jung Tao] is accredited by the accrediting agency, recognized by the U.S. Department of Education, accredited at the Master’s-level, the Tennessee Board of Higher Education would allow Jung Tao to grant a “Master’s Degree. They [Tennessee Board of Higher Education] do a site visit, they may not, especially initially. But because the school is already accredited, they allow to grant the “Master’s Degree.” For UNC Board of Governors, you apply. Then you do a ‘self-study,’ very much like you do for ACAOM. And then they do a site visit at which time they [UNC] hire ACAOM people to come in and look at the program. So although I paid ACAOM and had my institution and program accredited, I’m going to turn around and pay the fees for yet more ACAOM people to come with UNC Board of Governors people to do it all over again. The cost of that is \$5,000 to apply. By the time you pay the honorarium, the travel expenses and etc. for the site visitors, you’re looking at probably \$10,000 to \$15,000. Then, there’s the ‘ongoing fee’ every year (Field recording, March, 2016).

Another school in North Carolina went through the process and as Moyle explained, it took them three years to achieve accreditation to reward a “Master’s Degree.” In theory, the jump from “Master’s Level” to “Master’s Degree” is a matter of state laws and bureaucracy. The outcome of obtaining a license is the same and the actual content is relatively similar where it abides by the criteria of ACAOM. The question then becomes what does the ACAOM require?

Standards	Criteria
1. Purpose	1.1: Content 1.2: Educational Objectives 1.3: Relationship 1.4: Review
2. Legal Organization	2.1: Off-Campus Control
3. Governance	3.1: Membership 3.2: Role 3.3: Bylaws 3.4: Meetings
4. Administration	4.1: Chief Administrator 4.2: Organization of Staff 4.3: Academic Leadership 4.4: Integrity
5. Records	5.1: Permanent Records 5.2: Clinical Records 5.3: Data
6. Admissions	6.1: Assessment of Prior Learning 6.2: Transfer Credit 6.3: Policy Publication 6.4: Policy Planning 6.5: Advanced Standing 6.6: Prerequisites 6.7: Recruitment 6.8: English Language Competency 6.9: Enrollment 6.10: Retention and Graduation Rates
7. Assessment	7.1: Programmatic Review 7.2: Measurement of Student Achievement 7.3: Assessment of Graduates Success 7.4: Standard Measurement
8. Program of Study	8.1(a): Program Length 8.1(b): Minimum/Maximum Time Frame 8.1(c): Clock to Credit Hour Conversion 8.2: Completion Designation 8.3: Consistent with Purpose 8.4: Appropriate Level of Instruction 8.5: Off-Campus Training 8.6: Syllabi 8.7: Clinical Training 8.8: Clinical Observation 8.9: Supervised Clinical Practice 8.10: Professional Competencies 8.11: Continuing Education 8.12: Licensure and Certification Exam Pass-Rates

9. Faculty	9.1: Faculty Size and Qualification 9.2: Faculty Background and Experience 9.3: Professional Development and Benefits 9.4: Policies and Procedures 9.5: Communication
10. Student Services and Activities	10.1: Support Fulfilment of Objectives 10.2: Published Fair Student Policies 10.3: Opportunity to be Hard 10.4: Grievances
11. Library and Learning Resources	11.1: Resources and Access
12. Physical Facilities and Equipment	12.1: Classroom Size and Equipment 12.2: Compliance and Standards 12.3: Upkeep 12.4: Staff and Faculty Space and Equipment 12.5: Clinic Space and Equipment
13. Financial Resources	13.1: Resources 13.2: Control 13.3: Expenditure 13.4: Budgetary Process 13.5: Management 13.6: Audit 13.7: Indebtness 13.8: Financial Aid Operation 13.9: Default Rate 13.10: Refund Policy
14. Publications and Advertising	14.1: Completeness and Accuracy 14.2: Accurate Disclosure 14.3 Representation of Opportunities 14.4: Status with ACAOM

Table 4.3 ACAOM's Master's Degree/Master's Level Programs (ACAOM, 2016, p. 16-51)

The Master's Degree/Master's Level programs must require prospective students to have completed 60 semester credits/90 quarter credits at the baccalaureate level from an accredited university or college by the U.S. Secretary of Education (ACAOM 2016, 21). Though this is the minimum, schools fluctuate on the entrance requirements, where some demand students finish undergraduate degree and expect them to complete a certain amount of credit hours devoted to the sciences.

Once a student is accepted to a Master's Program, the program itself must meet certain requirements. As Moyle mentioned in passing, schools seeking accreditation must go through a self-assessment of their schools along with mandatory 'site visits' conducted by ACAOM. Each time site visitors inspect and evaluate a school, it costs the school tens of thousands of dollars. Once an institution meets all of the criteria in Table 4.3, ACAOM will either label the school "Accredited," "Candidate," or reject a school. Though it seems straightforward, the next chapter shows discrepancies during site visits. The

most common complaint directed at ACAOM, was the issue of site visitors' partiality; where in some cases site visitors were asked by their colleagues to leave the sites because of their unprofessional behavior. All Master's programs are required to teach eleven of the twelve core curricula as follows:⁸²

ACAOM's Master's Degree/Master's Level Program Minimum Core Curriculum

1. History of Acupuncture and Oriental Medicine
2. Basic Theory
3. Acupuncture, Point Location and Channel (Meridian) Theory
4. Diagnostic Skills
5. Treatment Planning in Acupuncture and Oriental Medicine
6. Treatment Techniques
7. Equipment and Safety
8. Counseling and Communication Skills
9. Equipment and Safety
10. Equipment and Safety⁸³
11. Oriental Herbal Studies
12. Other Oriental Medicine Modalities (ACAOM, 2016, pp. 27-33)

The curriculum is the minimum standard each school has to comply with for accreditation. The curriculum requires practitioners to adhere to a standardized TCM. As I cover in the next few chapters, schools who do not fit within the dominant paradigm must find ways to navigate around these criteria. This is most apparent in schools who fit within the epistemology of "Five Elements," "Classical Chinese Medicine," and schools which encompass Taiwanese-based traditions which encompass "balance method" and/or "distal" techniques. These systems typically use points which do not correspond with the standardized point locations set by the World Health Organization. Outside of the context of Chinese acupuncture, there are also various forms of Korean, Japanese, and Vietnamese traditions, and most dissimilar, the practice of Tibetan medicine (Tib. *Gso ba rig pa*) through golden needle acupuncture (Tib. *Gser khab*).

ACAOM's criteria in sections 1 to 6 and 11 pertain to TCM theory while sections 7 to 10 relate to safety measures. The last criteria, "Other Oriental

⁸² There the optional twelfth is "Oriental Herbal Studies."

⁸³ "Equipment and Safety" is listed three times in their information, however, they have different criteria. Section 7 relates with safety of treatment equipment, Section 9 deals with patient information, and Section 10 concerns the basic knowledge of biomedicine and the reasons for referral (ACAOM, 2016, pp. 30-31).

Medicine Modalities” is rather ambiguous. It encompasses a subsection entitled ‘Exercise/breathing therapy,’ which sounds rather broad but as I encountered researching the schools, primarily encompasses either *tai chi (taijiquan)* or *qigong (chi kung)*. As a school administrator informed me, technically, ‘Exercise/breathing therapy’ could include practices such as yoga and meditation, but I did not encounter this at any of the sites I researched.

As seen in Table 4.4, ACAOM’s “Program Length” requires 705 hours (47 semester credits) of “Oriental medical theory” (Chinese medicine), 660 hours (22 semester credits) of “clinical training,” 450 hours (30 semester credits) of “biomedical clinical sciences,” and 90 hours (6 semesters credits) in “counseling, communication, ethics, and practice management” for its Master’s Degree/Master’s Level acupuncture programs. The Oriental medicine curriculum consists of 705 hours in “Oriental medical theory,” 450 hours (30 semester credits) in “Oriental herbal studies,” and another 870 hours (29 semester credits) in “integrated acupuncture and herbal clinical training, with 510 hours (34 semester credits) in “biomedical clinical sciences,” and 90 hours (6 semester credits) in “counseling, communication, ethics, and practice management” (ACAOM, 2016, p. 34).⁸⁴

Subject	Program Length Credit Hours/ Semester Credits	Program(s)
Oriental medical theory	705 hrs / 47 credits	Master’s Acupuncture Master’s Oriental Medicine
Biomedical clinical sciences (Acupuncture Program)	450 hrs / 30 credits	Master’s Acupuncture
Clinical training	660 hrs / 22 credits	Master’s Acupuncture
Biomedical clinical sciences (Oriental Medicine Program)	510 hrs / 34 credits	Master’s Oriental Medicine
Oriental herbal medical theory	450 hrs / 30 credits	Master’s Oriental Medicine
Integrated acupuncture and herbal clinical training	870 hrs / 29 credits	Master’s Oriental Medicine

Table 4.4 ACAOM’s Master’s Degree/Master’s Level Program Length (ACAOM, 2016, p. 34)

⁸⁴ Master of Acupuncture students and practitioners who want to add herbs, must complete a minimum of 450 hours of herbal coursework and 210 hours of herbal clinical training (ACAOM, 2016, p. 34).

ACAOM serves as the regulatory body which controls a program's curriculum and length of study. Another unique quality about ACAOM is its relationship with the NCCAOM. ACAOM's partnership with the AAAOM created the NCCAOM. ACAOM and the NCCAOM work in tandem where an applicant who wants to take the NCCAOM's national board exam must first attend an ACAOM "Accredited" or "Candidate" school. Table 4.1 shows the minimum didactic and clinical hours a student must meet for them to be eligible to sit for the national board examination. From my experience with the process, some students will try to take portions of the national board exam halfway during their clinical internship, while others choose to take the exam after they complete their clinical hours.

Beyond the Master's programs, ACAOM also began approving "Postgraduate Doctoral Programs" in 2002. As seen below in Table 4.5, ACAOM requires specific criteria and standards from the doctoral programs.

Standards	Criteria
1. Purpose	1.1: Relationship 1.2: Review 1.3: Educational Objectives
2. Legal Organization	-
3. Governance	3.1: Off-Campus Activities 3.2: Consortium
4. Administration	4.1: Organization of Staff 4.2: Academic Leadership
5. Records	5.1: Permanent Records 5.2: Clinical Records 5.3: Data
6. Admissions	6.1: Standard Admissions 6.2: Special Admissions 6.3: Transfer Credit 6.4: Policy Publication 6.5: Policy Planning 6.6: Recruitment 6.7: English Language Competency 6.8: Non-Matriculated Students 6.9: Retention and Graduation Rates
7. Assessment	7.1: Programmatic Review 7.2: Measurement of Student Achievement 7.3: Assessment of Graduates Success 7.4: Standard Measurement
8. Program of Study	8.1: Core Curriculum 8.2: Clinical Training/Specialties 8.3: Clinical Research Projects 8.4: Prerequisites 8.5: Program Length/Maximum Time Frame 8.6: Resident Program 8.7: Clock to Credit Hour Conversion

	8.8: Completion Designation 8.9: Syllabi 8.10: Challenge Examinations
9. Faculty	9.1: Faculty Credentials 9.2: Policies and Procedures 9.3: Professional Development and Benefits 9.4: Communication
10. Student Services and Activities	10.1: Support Fulfillment of Objectives 10.2: Published, Fair Student Policies 10.3: Student Input 10.4: Grievances
11. Library and Learning Resources	11.1: Resources and Access 11.2: Professional Librarian 11.3: Library Holdings 11.4: Computer Resources
12. Physical Facilities and Equipment	12.1: Compliance with Standards 12.2: Upkeep
13. Financial Resources	13.1 Financial Aid Operation 13.2: Default Rate 13.3: Refund Policy
14. Publications and Advertising	14.1: Catalog 14.2: Accurate Disclosure 14.3: Representation of Opportunities 14.4: Status with ACAOM

Table 4.5 ACAOM's Postgraduate Degree Programs (ACAOM, 2016, pp. 52-74)

Much of the debate surrounding doctoral programs is covered in chapter 6, but it is important to note Nevada is the only state which requires practitioners to enroll in a doctoral program for licensure. Doctoral programs are designed to elevate a practitioners' training, expand on their existing knowledge obtained in their master's education, medical specialization, collaboration in Integrative Health settings, situate them as faculty or researchers, and create "leaders" in the profession. Through my ethnographic research, I found a number of students enrolled in the doctoral program were also current faculty of the school. The reason for this is in ACAOM's Criteria 9 for the doctoral programs.

The majority of faculty must possess a doctoral degree, the terminal degree or its international equivalent, in the areas in which they teach within 10 years of the start of the doctoral program (ACAOM, 2016, p. 67).

Schools were encouraging their faculty to enroll in the doctoral program to meet the criteria expected by ACAOM. ACAOM expects the doctoral program to require students to satisfactorily complete a master's degree or master's-level program in acupuncture or Oriental medicine, however, it does not require the applicant to be licensed. In the field, I found many practitioners

enrolled in the doctoral program came straight from completing their master's program, which raises the issue of student debt. Applicants can also apply to ACAOM's doctoral programs based on experience. A reason for this could be practitioners who were 'grandfathered,' may want to enhance their skillset or want the designation of a "doctor" (ACAOM 2016, 57-58). Either way, the price for the additional education is in the tens of thousands of dollars, but no evidence to prove more education equates to higher incomes for practitioners.

The doctoral curriculum is not as clear as it is for the master's programs but there are five competencies ACAOM requires:

1. Advanced patient assessment and diagnosis;
2. Advanced clinical intervention and treatment;
3. Consultation and collaboration;
4. Clinical supervision and practice management;
5. Clinical evaluation and research (ACAOM, 2016, p. 62).

The Doctor of Acupuncture and Oriental Medicine (DAOM) programs emphasizes clinical training and particularly specialization in various medical fields. This is shown through a more "integrative" approach to medicine but as I explain later, it is presented in a manner below the requirement of master's programs found in most universities and colleges. This is partly due to the limited capacity of their research output. The concerning aspect about the doctoral program criteria is the "Clinical Research Projects" or an actual publication and material contribution to further the field. Universities typically require students to complete a thesis or dissertation, but ACAOM's "clinical research project," which I found is referred commonly as a "capstone," does not list a word or page count and the process is mostly based on the standards of the schools. Programs are required to contain the following in their project:

- Theoretical analyses
- Surveys, analyses of archival data
- Outcomes of research
- Systematic, qualitative investigations
- Public policy issues
- Case studies
- Evaluative research
- Interpretive translation research
- Educational research – professional and patient (ACAOM, 2016, p. 64).

As a clinically oriented program, more than half (54%) of the curriculum is in “advanced clinical training” while only 46% is of actual didactic study. ACAOM requires students complete 1200 hours of study, which must be completed in four years (ACAOM 2016, 65). Once students have successfully completed their study, they are awarded the title Doctor of Acupuncture and Oriental Medicine (“DAOM”) (ACAOM, 2016, p. 66).

Though the ACAOM controls the curriculum of the schools, their decisions are mediated through the organization known as the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM).

4.5 CCAOM

As I stated before, the CCAOM was originally known as the National Council of Acupuncture Schools and Colleges (NCASC). Its mission is “to advance acupuncture and Oriental medicine by promoting educational excellence within the field” (CCAOM, n.d.). Just as with ACAOM, the CCAOM is involved with all of the states where Chinese medicine schools reside. It works in tandem with the ACAOM, only accepting member schools if they are approved by ACAOM. Along with their mission, the CCAOM also has a set of goals, which are as follows:

- to support the development and improvement of education programs in acupuncture and Oriental medicine;
- to develop recommended curricula for degree, diploma and other educational programs;
- to support and foster academic freedom and a diversity of educational approaches within the field;
- to encourage scientific research, innovative teaching methodology, and faculty development;
- to provide a forum for discussion of issues relevant to member colleges;
- to serve as an information resource for member colleges, other colleges and organizations, regulatory agencies, and the public;
- to encourage ethical business practices among member colleges;
- to work with accreditation, certification, licensing and regulatory agencies to develop appropriate educational standards and requirements;
- to promote increased public access to high quality health care provided by well-trained practitioners of acupuncture and Oriental medicine;

- and to take a leadership role in acupuncture safety through publication, education, and certification of a national standard for clean needle technique (CCAOM, n.d.)

Just as with any goals of an organization, they serve as the intended aspiration for the group. The actions tend to be incongruent with the intended objective. As in the case with the CCAOM and its partnership with the ACAOM, the goal “to support and foster academic freedom and a diversity of educational approaches within the field” manifests in a particular way which pushes a specific ideology. From the information I gathered, there were major differences between ‘big’ schools and ‘small’ schools. As one school director explained,

Unfortunately, the Council of Colleges [CCAOM] are verbally supportive of small schools and that would be it. They have attempted, I think, to maintain “fairness” but the larger schools are very vocal. And the larger schools tend to be run by non-acupuncturists. If you look across the country at small schools, they have a very strong influence of acupuncturists. The problem is that the Council of Colleges, in an attempt to be professional, has ‘bought into’ the educational jargon that is put out and the accreditation agency [ACAOM] ‘bought into’ it [as well]. There’s nothing wrong with it, but they’ve done it in spite of acupuncture. In spite of supporting acupuncture. It’s like ‘beating’ into acupuncturists, “you must do it this way, you must do it that way.” Instead of saying, “This is the art and science of acupuncture, how can we raise it to an educational level?” It’s been more of an approach of “You need to come on [board]! Forget whatever it is you do; you need to do it this way!” (Field recording, February, 2016).

This exemplifies an establishment mentality whereby a specific agenda is pushed by certain people in power and this becomes the norm for the profession. The people in power, many who are not directly related to the profession, see schools run by acupuncturists or Chinese medicine practitioners, not aligned with establishment mentality. This power structure was created because of an abundance of resources ‘big’ schools possess and the ‘small’ schools lacked. As one director explains,

First of all, you need a Dean. You can have a Dean for 60 students or you can have a Dean for 200 students, I have 60-80 students. So we both have to do the same thing. But we bring in so much less [money] that you have people ‘wearing multiple hats.’ It’s harder to grow in different areas because you don’t have

the resources. Not just the financial but also people resources. We can't afford many people. So I have one person doing multiple things. I'm registrar and I am also painting the walls. It's very humbling and maybe somewhat Daoist (Field recording, February, 2016).

As the director mentioned, the lack of resources directly affects the power structure within school's administration. If a school had the resources available to them, they could afford grant writers for research projects, regional accreditation, and employ administrators to perform the more specialized bureaucratic tasks. In the larger context of the profession, more resources also allow for more power. As the director continued,

To meet the requirement of the "Western World" of accreditation or of higher education takes money. And that's what smaller schools have difficulty with. The demands that are put on it, the requirements of people. There was time when your Dean wasn't looked at so closely. Deans now need to have degrees in higher education or experience in higher education. That's a more costly person. Financial is not for the weak, it's not something that you put a secretary to do. So it's requiring outside things are requiring higher level people, and that's more expensive (Field recording, February, 2016).

'Small' schools who are also are nonprofit institutions rely on government subsidies, donations, student tuition, and patients to support the school. 'Big' schools who are also for-profit institutions, rely on all of the same sources a nonprofit does, but also depend on their shareholders and other investments. The additional assistance of shareholders and investors, allows for added monetary support to be allocated for provisions such as regional accreditation. This offers schools a chance to elevate their reputation in higher education.

The CCAOM, NCCAOM, and ACAOM are the official national regulatory bodies in the United States. They are interconnected systems which determine much of the future of the profession and are slowly changing the culture of American Chinese Medicine. Some states have refused to accept the authority of the national regulatory bodies, but those states are already shifting their political power to the three organizations. In particular, California, Maryland, and Nevada.

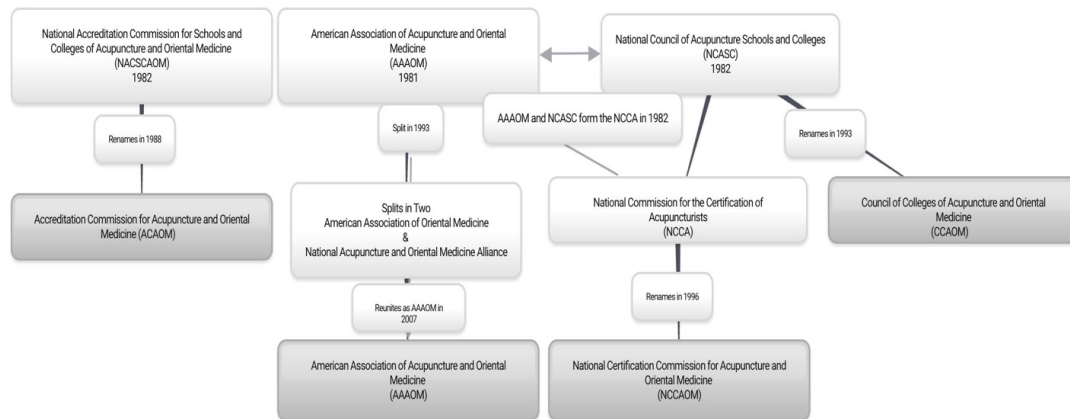


Fig. 4.2 The Evolution of Regulatory Bodies

4.6 California

The previous chapter left off with the influence of the UCLA cohort on California and Massachusetts acupuncture licensure. California is a unique state for acupuncture laws and with its history as one of the forerunners in the industry, it will continue to influence contemporary practices of Chinese medicine in the United States. Recently, California adopted a more exclusive policy which situated the California Acupuncture Board as an entity in its own right. Instead of abiding by the national regulatory bodies, the state set precedence in the profession with its accreditation of specific degree programs and required a higher standard of curriculum as well as additional hours of coursework. It is still unknown whether more curriculum hours contribute to better practitioners. Because of its high expectations for practitioners, the licensing board has set a specific tone for the rest of the profession.

Governor Jerry Brown's 1976 ruling allowed acupuncturists to practice as an independent profession through the licensing of acupuncturists. In 1978, acupuncture was labelled as a "primary health care profession," which liberated acupuncturists from required patient referrals from licensed physicians, chiropractor, or dentist. Under the Assembly Bill 2424 of the same year, acupuncture treatments were authorized by Medi-Cal and practitioners were able to receive reimbursement payments⁸⁵ (CAB, 2016, p.1). In 1980, under the authority of the Division of Allied Health Professions, the Acupuncture

⁸⁵ Medi-Cal is California's Medicaid program which serves low-income individuals, including: families, seniors, persons with disabilities, children in foster care, pregnant women, and childless adults with incomes below 138% of federal poverty level.

Advisory Committee transitioned to the Acupuncture Examining Committee and widened the scope of practice which included electroacupuncture, cupping, moxibustion as well as Asian massage, exercise, and herbs. Two years later in 1982, the Acupuncture Examining Committee became an autonomous body. The transition was not smooth, California's Acupuncture Examining Committee was rocked by a scandal which almost obliterated the profession.

Labelled "one of the biggest corruption scandals in California history" by the *Sacramento Bee*, the California Acupuncture Examining Committee was caught in a bribery controversy. In 1989, Korean-born acupuncturist Chae Woo Lew, who since 1981 had been a committee member of the California Acupuncture Examining Committee, was arrested with forty-seven other acupuncturists. Lew was caught accepting \$500,000 in bribes in exchange for answers to the California Acupuncture Examining Committee's exam. Bribes ranged from \$5,000 to \$20,000 and at least eighty cases were investigated by the Los Angeles District Attorney Ira Reiner, who speculated the total bribes to be in the "mega-millions." The Los Angeles District Attorney believed more than one hundred and fifty acupuncturists, including other members of examination committee, were involved. Evidently, the District Attorney's office was reluctant to turn in any evidence to the Attorney General's office because the Attorney General's office represented the examination committee. The stipulation for prosecution was that an administrative judge had to first rule on the cases. Since then, no one has ever had any prosecution against them relating to the bribery case. Four years later, nearly all of the acupuncturists who paid bribes to cheat on the exam, continued to practice.

Besides Lew, only six members had their license revoked, oddly, after their probation required them to retake their exam, they failed. All of the members of the committee at the time, immediately resigned and the exam is now handled by a third party. The result was at least 150 licensed acupuncturists in California are known to have bribed their way into obtaining their license and most likely continue to practice (Magagnini, 1993; Rothberg, 2014). As for the profession, a few of the California practitioners I interviewed who were around during the period, claimed the case was detrimental to the profession. Schools abandoned the move towards an entry-level doctorate and California did not take the acupuncture board seriously. It also jeopardized the

possibility of the state treating acupuncturists as physicians. It was also believed to be the reason why a few schools dropped the “doctor” title from their degree. It was unclear why California Acupuncture College dropped the “Oriental Medicine Doctor” (O.M.D.) designation, but those letters are no longer in use and have become markers for those who graduated from the CAC in the 1970s or 1980s.

By 1998, the Acupuncture Examining Committee was no longer under the Medical Board of California (SB 1981, Chapter 736, Statutes of 1998) and the next year, changed its name to the California Acupuncture Board (CAB) (SB 1980, Chapter 991, Statutes of 1998). The most distinctive characteristic of CAB is in the number of required hours for training. In 2002, AB 1943 raised the hours of training to 3,000 hours with 2,050 hours of didactic training and 950 hours of clinic training (AB 1943, 2002) (CAB, 2016, p. 1-2). This is nearly 400 more hours than the requirement set by ACAOM’s Dipl.OM.

To understand some of CAB’s processes, I sat in a public meeting. With their reputation for being a strict institution, I was expecting a lot from the board, but I would witness something different.

While researching California in 2015, I managed to conduct a participant observation of a CAB meeting. It consisted of members from the northern, central, and southern parts of the state. A few of the past and present board members stressed how CAB was the only board in California which required members to not only be from different parts of the state but to also include different ethnicities. I was told that the board required at least a Chinese American, a non-Chinese Asian American, and at least one non-Asian American. The board meeting itself was comprised of a conference call where most of the other members were located in Sacramento. Prior to the conference call, a memo which was sent out to all of the board members, which discussed the primary topic of their meeting. In this case, the main topic was the issue if ACAOM would take all responsibility of CAB’s ability to approve Chinese medicine schools in the state. This was a contentious issue where CAB took great pride by setting standards and allotting resources such as ‘site visits’ to approve schools. Put simply, it was a particular standard set by the board also provided sources of revenue for professionals in the state.

The meeting did not start well. There were issues with communication where the phone receiver was not delivering a clear correspondence to the other parties. There were non-board members present, including myself, which is allowed. What was

striking about the meeting was nearly half of the participants who were not board members were also not even acupuncturists. Oddly they seemed to have great influence in the conversation, to such an extent they were directing a new member of the board on what to say. It seemed natural for this to occur and no one in the room felt uneasy by this direction. It was as if it was how all the meetings functioned.

Attempting to tackle the issue in the memo, members in the room I was observing were trying to discuss ACAOM's prospects of taking over CAB's school accreditation responsibility. It was either the other parties could not hear or they did not care about the issue, but they immediately went to another topic relating to handling students who received training in Asia. Their issue was how the board would review students who received acupuncture and herbal training in countries like China or Korea. The members in the room erupted with frustration. Nearly shouting at the phone receiver, people in the room were demanding the board discuss ACAOM's takeover. After an hour of trying to get the other parties' attention, the board ended their meeting and everyone in the room was in dismay (Field notes, Summer, 2015).

According to a 2004 evaluation from the Little Hoover Commission (LHC)⁸⁶ which compared the California Bureau for Private Postsecondary Education (BPPE), ACAOM, and CAB's approval standards,⁸⁷ it found "ACAOM appeared to be superior to the school approval process used by the Board [CAB] and could be used by the state to ensure the quality of education for potential licensees" (CAB, 2016, p. 51). The Department of Consumer Affairs (DCA), which oversees the California Acupuncture Board, held hearings called the Joint Sunset Review Oversight Hearings (*Sunset Review*) consisted of the Assembly Business and Professions Committee and the Senate Business, Professions and Economic Development Committee reviewing the various boards under the DCA.

⁸⁶ The Little Hoover Commission (Milton Marks "Little Hoover" Commission on California State Government Organization and Economy) is an independent California state oversight agency which modelled the 1947 "Hoover Commission" (Commission on Organization of the Executive Branch of the Government) appointed by President Harry Truman and was chaired by former President Herbert Hoover. The purpose of the Little Hoover Commission is to independently oversee state government operations.

⁸⁷ California Bureau for Private Postsecondary Education (BPPE) was formed in 2010 and is a part of California's Department of Consumer Affairs. Its primary purpose is to regulate private postsecondary educational and prevent so-called 'diploma mills,' which are education institutions which awards academic degrees not substantiated by any official accreditation body or qualified government agency.

In the 2016 *Sunset Review* of CAB, the commission passed SB 1246 which relinquished CAB's ability to "approve" schools to ACAOM. The *Sunset Review* commission found that since ACAOM is the only national accreditation organization recognized by the Department of Education to accredit Chinese medicine schools, it has shown to be more effective than CAB. The *Sunset Review* found it in the best interest of the profession for CAB to recognize ACAOM as the accreditation body for all of California's acupuncture schools. The commission also found issues with CAB not properly serving students who have partially finished an ACAOM approved institution and wish for reciprocity to complete their education at a CAB approved institution. By 2017, CAB is expected to relinquish its authorization to "approve" schools to the authority of ACAOM and BPPE (CAB, 2016, pp.51-53).

SB 1246, the Board's last Sunset Review bill, changed this process [CAB approving schools] beginning January 1, 2017. SB 1246 expands the definition of approved training program to require schools be accredited, approved by BPPE and curriculum approved by the Board [CAB]. Upon receiving ACAOM/BPPE accreditation, the school should then submit a request to the Board to determine whether it meets applicable curriculum standards. The Board has 30 days in which to respond (CAB, 2016, p. 21).

CAB's decision to surrender power to ACAOM is an example of shifting structural changes. It is not only the approval of schools at stake but also the potential change in the examination may serve as CAB's last stand.

The California Acupuncture Licensing Examination (CALE) is the examination every prospective licensed acupuncturist has to pass to practice acupuncture and herbs legally in California. The exam occurs biannually and is held at a specific site of CAB's choosing. Since the examination is held biannually, CAB found it necessary to continually update the content based on their SME chosen by the Department of Consumer Affairs's Office of Professional Examination Services (OPES). Although it may be a 'good practice' to continually change the content of the exam based on the SMEs, especially with CAB's infamous history in its applicants cheating on the exam, it could potentially confuse applicants on what actual material to study. This was apparent when I researched multiple California schools in the summer of

2015 where students were frustrated because one of the textbooks, Giovanni Maciocia's *The Foundations of Chinese Medicine*, was recently updated to its third edition after a decade. The updated version included augmentations of acupuncture prescriptions, without any particular reason for the changes. This caused students to question if the exam will test the second or third edition of the textbook.⁸⁸ CALE tests on five content areas, each consisting of a specific percentage of the total exam as seen in Table 4.6.

Year	Patient Assessment %	Diagnostic Impression & Treatment Plan %	Providing Acupuncture Treatment %	Herbal Therapy %	Regulations for Public Health and Safety %	Total %
2015	31	10.5	35	10.5	13	100
2017	33	17	32	11	7	100

Table 4.6 Comparison of CALE Content Percentage (CAB, 2015, p. iii; CAB, 2017)

A striking aspect about Table 4.6 only 10-11% of the CALE is based on herbs. The de-emphasis on herbs in California is another unique phenomenon. With the NCCAOM's separate Chinese Herbology exam and added Chinese herb programs in the East Coast, there is indication of a growing interest in Chinese herbs elsewhere. I asked a few members of CAB and administrators at California schools about the decrease of herbs in California. Everyone I interviewed attributed the decline to safety concerns. Safety is evidently the primary reason for CAB and most of the licensures throughout the country.

The primary responsibility of the Board is to protect California consumers from incompetent, and/or fraudulent practice through the enforcement of the Acupuncture Licensure Act and the Board's regulations. The Board promotes safe practice through improvement of education training standards, continuing education, enforcement of the BPC and public outreach (CAB, 2016, p. 4).

If the primary responsibility of the Board is to "protect California consumers," then why is there a de-emphasis on safety on CALE? The

⁸⁸ When interviewing Maciocia, I would find that he has no actual input on the CALE – he is not even licensed in California – but it is actually CAB who determines the content of the exam and Maciocia only produces books independently of CAB.

“Regulations for Public Health and Safety” content is as little as 7% of the total exam.

Though no bill has passed, there has been a thorough evaluation by the OPES for the NCCAOM to take over CAB’s examination responsibility of providing an examination for licensure. In September 2015, OPES convened a three-day meeting to compare the NCCAOM’s national board exam to CALE. The OPES recruited nine California licensed acupuncturists as SME based on their experience, specialization, and geographical location, which entailed “experts” coming from northern and southern parts of the state along with acupuncturists from both rural and urban communities (CAB 2016a, pp. i, 27). It was concluded,

The procedures used to establish and support the validity and defensibility of the NCCAOM examinations (i.e., practice analysis, examination development, passing scores, test administration, examination performance, and test security) were found to meet professional guidelines and technical standards outlined in the Standards for Educational and Psychological Testing and Business & Professions Code section 139 (CAB, 2016a, p. 52).

The NCCAOM’s national board examination is seen as a viable replacement for CALE. More research is required, however, it seems the next step for CAB is to accept the national standards of the NCCAOM. This means CAB may feel their standards will be lowered with the acceptance of the NCCAOM’s national board examination, but little supports the claim of more hours equating to better practitioners.

California is distinct because it has more acupuncturists than any other state in the nation. As of 2016, the California Acupuncture Board regulates roughly 17,801 acupuncturists with 11,644 being active (CAB, 2016, p. 2). It was tough to get an accurate number of acupuncturists in the United States, considering it was only in 2016 the U.S. Bureau of Labor Statistics provided a code for the profession (“Acupuncturist”), but the number of practitioners range from roughly 18,000 (Acupuncture.com, n.d.) to approximately 22,671 in 2004 (NAF, 2007) to 29,970 in 2014 (Chapman, 2014). This means California accounts for more than half of the total number of acupuncturists nationally.

It may be understandable then for California to push their own regulations because of the sheer number of acupuncturists and schools, but the movement for them to join the national regulatory bodies seems inevitable. Nevada, on the other hand, has the opposite predicament. As the oldest state licensure, it has the fewest number of practitioners and no Chinese medicine schools, reflecting a unique case study in the world of professionalization.

4.7 Nevada

As seen in the last chapter, Nevada was one of the first states to have a licensing board. Nevada's licensing board has had an interesting history, seen today as an exclusive organization, with little information on the actual board.

Nevada's acupuncture licensing board began with four individuals: Arthur Steinberg, Yee Kung Lok (original name 陆易公 Yigong Lu), Jim Joyce and the UCLA cohort's Steven Rosenblatt. Arthur Steinberg was a semi-retired lawyer and real estate developer. Mostly known for his real estate development, Steinberg and his brother invested in unused parcels of land in Las Vegas during the 1950s. One of the plots would house The Mint casino, one of the largest casinos of its time. Steinberg was an acupuncture enthusiast who would fly back and forth from New York City to Las Vegas to receive acupuncture (Devitt, 2013, p.12; Fan, 2015, p. 73). In the summer of 1972, Steinberg and his Chinese wife Shirley Bia flew to Hong Kong and sought acupuncture treatment from Yee Kung Lok, who as Arthur Yin Fan notes, was the president of Hong Kong College of Acupuncture.⁸⁹ Impressed with Lok's treatments, Steinberg made a two-hour documentary on Lok's acupuncture and his clinic in Hong Kong. More importantly, Steinberg wanted acupuncture to be legally practiced in Nevada, which at the time was illegal.

According to the accounts of the Nevada's acupuncture licensing laws, Nevada's state legislature was unique in only meeting once every two years. With such a narrow timeframe, Arthur Steinberg decided to hire a public relations agency called May Advertising in an effort to persuade the legislature

⁸⁹ As stated before, there is little information of Hong Kong Acupuncture College and besides Arthur Yin Fan's seemingly uncritical examination of it, there is also limited sources on the school outside of the UCLA cohort and Fan.

to vote in favor of legalizing acupuncture. One of the ways Steinberg thought he could persuade the Nevada legislature was by having Lok perform a demonstration for them. On December 1972, the legislature rejected the first request for Lok to perform acupuncture. The May Advertising agency led a public relations campaign with Steinberg's two-hour documentary, cut down to thirty-minutes, telecasting it throughout Nevada in cities such as Las Vegas, Reno, and Carson City. Then, a few months later in March 1973, Steinberg sent a letter to the Nevada legislatures requesting them to allow Lok to perform a demonstration of acupuncture. After Steinberg's letter and a call from the May Advertising, an "emergency bill" was declared by the Committee on Health, Welfare and State Institution, which was then to the Nevada State Assembly. On March 13, 1973, SB420 was signed, allowing for Lok to perform a demonstration and two days later, SB448 was introduced and would allow the practice of Chinese medicine as long as it was under the supervision of the State Board of Acupuncture.

The telecast May Advertising produced created overwhelming interest in acupuncture throughout Nevada. From March 19 to April 6, 1973, Lok performed acupuncture on people at the casino hotel across the street from Nevada's Legislative Building, Ormsby House. Hundreds of people were treated, including legislators, with a great number claiming improvement. Also during this time, Steven Rosenblatt from the UCLA cohort has claimed to have had influence in the creation of Nevada's law. In a passage from his memoir *Acupuncture in America*, Rosenblatt states,

We had interviews with the Governor of Nevada. [William] Prentiss, Dr. Ju [Gim Shek] and I were introduced on the floor of the Nevada State Senate. That's a big honor. We were a major force behind the licensing in Nevada (Rosenblatt and Kirts, 2016, p. 150).

Although it was unclear the extent of Rosenblatt's involvement with the creation of Nevada's acupuncture regulation, Ju Gim Shek was in fact a colleague of Lok and testified on his behalf with Rosenblatt as the 'interpreter'.⁹⁰ Later, Rosenblatt gave his testimony during the Nevada Assembly hearing (Fan

⁹⁰ I use 'interpreter' instead of translator because at the time, Steven Rosenblatt did not know how to speak Cantonese, but had a rough idea how to interpret Ju Gim Shek's English.

2015, 76). On April 20, 1973, Governor Mile O'Callaghan signed SB 448 into law, making acupuncture legal to practice under the State Board of Chinese Medicine (Edwards, Jr., 1974, pp. 507-508; Devitt, 2013, pp. 17-19; Fan, 2015, pp. 74, 77).

The State Board of Chinese Medicine initially consisted of five members, none of who were acupuncturists⁹¹ and its regulations were not clear on the extent of a physician's oversight of acupuncture (Fan, 2015, p. 78). The board required applicants to show at least three-years of formal training with at least ten-years of active practice. The most striking aspect about the Nevada board was and continues to be its examination and criteria for curriculum. As Michael Devitt explains:

In addition, applicants had to list a history of years in practice, provide affidavits testifying to their "professional and moral character," and consent to an extensive background check that included submitting a set of fingerprints to the Federal Bureau of Investigation . . . The advisory committee took responsibility for testing applicants. To make sure that only the most qualified applicants could practice acupuncture, the committee created a lengthy, three-day examination, characterized by Dr. William Edwards, the Board's secretary, as "a blockbuster of a test..." The exam consisted of written, oral, and practical sections in basic medical sciences (e.g., anatomy, physiology, chemistry, bacteriology and pathology), herbology, acupuncture, and traditional Chinese medicine. Applicants also had to demonstrate fluency in English as a part of the oral portion of the exam (Devitt, 2013, p. 19).

In comparison to California and the national requirements, Nevada required much more, applicants were required to have an extensive background screening to assess their character and aptitude. Nevada also required an unorthodox approach by having applicants subjected to an oral English examination.

The structure of the board made a transition to its majority being members of the profession and in 1975 changed its name to the 'Nevada State Board of Oriental Medicine,' which used as a more encompassing label, it

⁹¹ Neil Galatz (attorney), William M. Edwards, MD, (Chief of the Bureau of Community Health Services of Nevada State Health Division in Carson City), Barbara Greenspun (wife of the editor-publisher of the Las Vegas Sun newspaper), Robert McQueen, PhD (professor of psychology, University of Nevada in Reno), and John Holmes, MD (Edwards, Jr. 1974, 509).

“covers the broader spectrum of traditional, natural medicine in eastern Asian countries” (Fan, 2015, p. 78). Despite the changes, Nevada still has a reputation for having some of the most stringent and nebulous regulations in the nation with an odd vetting process.

According to a 2001 article from the *Las Vegas Sun*, Nevada only had twenty-seven licensed practitioners in the whole state. Board member Sae Eun Lee stated, “We need experienced doctors to protect the patients.... Why should we go from good standards here to lower standards like other states? But it's up to the (Nevada) Legislature to change the law, not us.” Adding to Lee’s response, another board member Hak Eun Rhee felt, “How can you be a doctor if you have only three or four years of education?.... The people who want to eliminate the six-year requirement want to eliminate 'doctor' as well” (*Las Vegas Sun*, 2001). This requirement surpasses any other state criteria who identifies its Chinese medicine practitioners as “doctors”.⁹² On top of the three-year education requirement found in most states, Nevada required an additional six, originally ten, years of post-graduate experience.

Since Nevada’s practitioner are known as ‘Oriental Medicine Doctors’ (O.M.D.), the board seemingly expects applicants to meet ‘doctoral’ standards. In May 2015, Section 2. Chapter NAC 634A .080 of the Regulation of the State Board of Oriental Medicine, which required 3,000 curriculum hours – 2,500 of which are didactic hours – was redacted to require an additional 1,000 hours, making the standard to be at 4,000 hours.

Requires a degree of Doctor of Oriental medicine (O.M.D. or D.O.M.) or Doctor of Acupuncture and Oriental Medicine (D.A.O.M) attained from any school or college accredited by the government of his or her state, county, or Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) and the completion of at least 4,000 hours of instruction including not less than 2,700 didactic hours except for Continuing Education Units (CEU) for a student who has graduated on or after November 25, 2017 (SNBOM, 2015, p. 18).

⁹² The use of the title “Doctor” or “Dr.” as the standard designation for licensed Chinese medicine practitioners are only found in two other states, New Mexico and Rhode Island. Unlike Nevada, New Mexico and Rhode Island only require 2,500 hours of training without any additional post-graduate experience (NMBAOM 2003; SRIPP 2007).

In other words, the Nevada board only accepted applicants who have graduated from an ACAOM approved doctoral program. This surpasses any other states' curriculum requirement and is not based on any solid evidence for competency. Nevada is seen as the most exclusive state with only fifty-seven 'good standing' practitioners in the whole state (SNBAOM, 2017). Evidence points to other socio-cultural motives.

The *Las Vegas Sun* article notes something interesting about its licensed members,

When Nevada began licensing Oriental-medicine practitioners in 1973, there weren't any accredited schools or standardized tests. The licensing requirements adopted by Nevada were taken mostly from Asia, where aspiring practitioners often complete the same amount of education and residency required of physicians who practice Western medicine. That's why Rhee and Lee said some post-graduate experience should remain in Nevada's law... It so happens that all licensed practitioners in Nevada have either Chinese or Korean surnames, and most were educated in Asia (*Las Vegas Sun*, 2001).

In other words, Nevada has overwhelmingly high percentage of Asian practitioners. Though the requirements are quite strict for its curriculum there seemed to be a loophole which "allows individuals with at least 4,000 hours of apprenticeship but no college background to take that test" (*Las Vegas Sun*, 2001). It is questionable whether there is an actual vetting process for the apprenticeship route or is it nepotism hidden as bureaucracy?

Though it is changing, apprenticeship serve as one of the last attempts to maintain the transmission of Chinese medicine for specific lineages. Another route, which as I examine in the last chapter, was established in Maryland in opposition to apprenticeship but served as a way to maintain a Chinese medicine tradition without adhering to the national standards.

4.8 Maryland

Bob Duggan and Dianne Connelly's Traditional Acupuncture Institute (TAI) (now Maryland University of Integrative Medicine) had an enormous influence on Acupuncture in Maryland. Not only was TAI one of the first schools in the nation, it was also the first school to transmit the lineage of British

acupuncturist J.R. Worsley. As seen in the last chapter, Duggan and the TAI cohort had influence on Maryland's regulations. Though they left out the possibility for apprenticeship, thus potentially marginalizing Asian American practitioners, it maintained a lineage without compromising to fit the predominately TCM standards. Maryland's acupuncture regulations in Title 10 Department of Health and Mental Hygiene, Subtitle 26. In Section 3 'Application for License' it reads,

D. The applicant shall provide documentary evidence of having met *one*⁹³ of the following standards for education, training, or demonstrated experience:

(1) Graduation from a course of training of at least 1,800 hours in acupuncture, including 300 clinical hours, that is:

(a) Approved by the Maryland Higher Education Commission,

(b) Accredited by the ACAOM; or

(c) Found by the Board to be equivalent to a course approved by the ACAOM;

(2) Achievement of a:

(a) Diplomate in Acupuncture from the NCCAOM; or

(b) Passing score on an examination that is determined by the Board to be equivalent to the examination given by the NCCAOM; or

(3) Existing license, certification, or registration in acupuncture in another state that has a reciprocity agreement with Maryland and has education, practice, or examination requirements equal to or greater than those established in this State (MDHMH, 2017).

To practice acupuncture in Maryland, applicants are not required to take the NCCAOM's national board exam. The Maryland Acupuncture Board found graduation from an ACAOM approved school was valid enough to practice. In 2002, some members of the Maryland Acupuncture Board attempted to require the NCCAOM board exam for licensure. It was struck down from the practitioners who studied and practiced Five Elements acupuncture. In 2012, Maryland's *Sunset Review* wrote,

Maryland is one of only three states that regulate acupuncture (and the only health occupations board in Maryland) that *does not* require an examination as a condition of licensure. During the 2002 preliminary evaluation, the board expressed plans to

⁹³ I intentionally italicized 'one' to emphasize the discrepancy in the regulation.

introduce legislation to mandate passage of the NCCAOM examination as a licensure requirement. However, the board ultimately decided not require the examination based on objections from MAS [Maryland Acupuncture Society] that the NCCAOM examination, which is designed to test TCM, is “strongly biased” against the 5-element approach. Due to the large number of 5-element acupuncturists in Maryland, the board concluded that the examination requirement would be inappropriate. Unfortunately, no other national acupuncture examination is currently available. Given that preparation and administration of a State examination would be a time-consuming and costly process (and one that states such as California have found difficult and fraught with legal issues), the board continues to not require an examination as a condition of licensure (MDLS, 2012, p. 8).

Maryland’s internal struggle between TCM and Five Elements relates to what Linda Barnes referred to as the “acupuncture wars” (Barnes, 2003). Maryland is one of the few states to overtly resist the national standards which marginalize other Chinese medicine traditions. As a case study, no proof suggests Maryland’s practitioners are ill-equipped or less competent to practice Chinese medicine than any other practitioner in the United States who has taken any exam. Though legitimated through the authority of the school’s relationship with the Maryland Acupuncture Board, which could be seen a potential monopoly of a Chinese medicine tradition in the state, Maryland has shown it is possible to maintain the transmission of Chinese medicine without compromising its tradition or the safety of patients. Recently, after TAI was sold to MUIH – which now encompasses a fusion of Five Elements and TCM – there has been talk of reinstating the requirement for licensing applicants to take the NCCAOM’s national board exam.

4.9 Conclusion

Undoubtedly, the regulation and professionalization of Chinese medicine – primarily though acupuncture – relates to the distinctly American issue of “states’ rights.” Throughout this chapter, I outlined the practices and criteria of the national regulatory bodies, but inevitably, the decision to conform to the national regulatory bodies is solely the decision of each individual state. With states such as California and Nevada, the issue of reciprocity is

complicated because of the standards set by each state. As I cover in the next chapter, along with states' rights, the simple issue of a definition for "acupuncture" and "scope of practice" varies from state-to-state. This can cause confusion for the general public, but I question whether it actually matters. Since the level of competency for the majority of states in the country is only a master's-level education, I question the value of a doctoral education.

Though American Chinese Medicine is the professionalized form of Chinese medicine in America, it maintains a level of heterogeneity. A topic I stress again is the questionable process of standardization, which continues to marginalize practitioners and traditions. By offering the national board examination in limited language choices, English, Mandarin, and Korean, there is the risk of alienating practitioners and their traditions. Stuart Kutchins, the first Chair of the NCCAOM (formerly NCCA), wanted the NCCA to be known for its non-partiality as well as its commitment to the respect of different ethnic groups and traditions.

We [NCCA] pulled together many practitioners from all over the country, representing different ethnic groups and styles of practice. We wanted to be as inclusive as possible. With the expert help of Professional Examination Services (PES), we were able to articulate a national consensus on what acupuncturists do, what they needed to know to do it, and what a fair measurement of entry-level competence could look like. We were careful not to impose our own standards, but to facilitate the expression of our profession as a whole. We did our best to include all the voices. While the mission of the organization is necessarily to protect the public, our motivation to undertake all this was to serve the profession (NCCAOM, 1997, p. 9-10).

Current exams are conducted in English, Mandarin, and Korean (NCCAOM 2014; CAB 2017a), however, the NCCAOM and the CALE still does not accommodate Cantonese, Vietnamese, and/or Japanese speaking applicants. Beyond language requirements, the epistemological standard of TCM constructed from European and American sources, who in some cases, are unable themselves to practice legally in the U.S., alienates other non-TCM traditions. These sources, which are subjected to change based on the updating editions of texts, are grounded in translation of Chinese medicine sources and primarily substantiated through their private clinical practice. But I

question the legitimation of the standardized epistemology adopted by the regulatory bodies at the exclusion of other Chinese medicine traditions. The scientific evidence demonstrates acupuncture characteristics/traditions made no difference in treatment outcome, therefore, the standardized epistemology of TCM adopted by the national regulatory bodies or by CAB has no more weight than any other epistemology of acupuncture. The standardized epistemology of TCM adopted by the national regulatory bodies further marginalizes non-TCM traditions, giving practitioners little choice but to practice outside of the law. This raises the question about acupuncturists who practice an entirely different system?

An even more conflicting position is for physicians of Tibetan medicine (Tib. *Smen pa, Drung 'tsho, Am chi*) who use a form of acupuncture known as “golden needle” (Tib. *Gser khab*). Their approach to the body is significantly different where the medicine itself has an array of varying medical epistemologies. Yet, the constraints of acupuncture laws throughout the United States completely inhibit Tibetan physicians from practicing any form of acupuncture unless they adhere to the study of the People’s Republic of China’s TCM adopted by the United States. It is something unsavory for Tibetan medicine physicians who already endure Chinese hegemony. All these issues can be potentially resolved through the medium of safety.

Though issues remain on the consensus of what safety entails, it is an overarching subject translatable to any language and does not require extensive training. In fact, the acupuncture licensing boards throughout the United States were not established to maintain a profession, but instead, to protect the welfare of the consumers. If indeed the basis of licensing was on patient safety, the evidence I provide has shown the majority of the curriculum is arbitrary since it is mostly rooted in Chinese medicine theory. A counter-example to the U.S. in terms of acupuncture regulations is the United Kingdom.

Acupuncture has been practiced in the United Kingdom (UK) since the 19th century and similar to America, reemerged in the 1960s and 1970s with the British counterculture (Bivins, 2000, p. 186-187). Unlike the United States, the UK has no national regulations for the practice of acupuncture. Previously, members of Britain’s Chinese medicine community had attempted to seek parliamentary oversight by creating the Acupuncture Regulatory Working

Group (ARWG), which in 2003 launched “The Statutory Regulation of the Acupuncture Profession” and the following year the Department of Health framed their proposal entitled “Regulation of Herbal Medicine and Acupuncture: Proposals for Statutory Regulation,” but to this day, there is no government oversight on Chinese medicine. Instead, the UK has self-regulating bodies known as the British Acupuncture Council (BAC) and European Herbal & Traditional Medicine Practitioners Association (EHTPA), but no parliamentary mandate requires membership to the either organizations (EHTPA, n.d.). Ironically, despite the lack of regulations on Chinese medicine in the UK, far more resources are invested in clinical efficacy of Chinese medicine at British universities than in the United States. Institutions include the Department of Health Sciences at the University of York headed by Hugh McPherson, University of Southampton’s Health Research in the Medicine Department led by George Lewith, Volker Scheid’s EASTMedicine Research Group at the University of Westminster, and University College London with Vivienne Lo’s China Centre for Health and Humanity.

The United Kingdom is a good comparison to the United State because of the similarity of practice and tradition. In the next chapter, I identify how this similarity is reflected through the traditions. American Chinese Medicine, especially its standardized model, reflects the continuity of British and European tradition but with American characteristics.

Chapter 5.

Traditions

In the previous chapter, I discussed the professionalization of Chinese medicine in the United States and the bodies of authority which oversee the profession. This chapter focuses on pre-existing Chinese traditions because they serve as the foundation for schools which, in almost all cases, practitioners must enroll in and graduate from to legally practice Chinese medicine. In particular, this chapter investigates the three prevailing epistemologies of American Chinese Medicine: Traditional Chinese Medicine, Five Elements, and Classical Chinese Medicine. The latter two are distinctly different from the former as mostly oral traditions.⁹⁴ The category of “Classical Chinese Medicine” is not a single epistemology but a group of various knowledge-bases rooted in the “Classics,” which are a range of pre-modern Chinese texts. Although their foundation is found in textual sources, much of the transmission of the “Classics” does not consist of reading and translating the Chinese sources. Instead, the transmission is passed through charismatic figures who orally teach the material either through a school solely devoted to the system or a few courses which constitute a portion of a curriculum. Furthermore, the traditions themselves are not fully divorced from the regulatory bodies. I examine how some epistemologies are changed and created anew because of the intervention. This chapter is informed by interviews, observations, and textual sources of Chinese medicine pedagogy and traditions.

5.1 Traditional Chinese Medicine (TCM)

As stated throughout the dissertation, the standard epistemology of American Chinese Medicine is TCM, a reworked version of the People’s Republic of China’s state-sponsored Chinese medicine. The most distinctive feature of TCM in the United States is the use of *bianzheng lunzhi*. Besides Five Elements and some CCM schools, I found the majority of schools and

⁹⁴ I have also left out Joseph Helms’ “medical acupuncture” tradition because it is geared solely to the allopathic medical community who do not require the same amount of education as non-physician acupuncturists nor has assembled a profession solely around the tradition.

practitioners in the United States used a translated version *bianzheng lunzhi* as the primary lens to view the body or use the nomenclature to communicate with other practitioners in the profession. Historically, *bianzheng lunzhi* is rather recent: contemporary Chinese medicine scholars argue it was a construction of the People's Republic of China in the 1950s (Scheid, 2002; 2002a; Karchmer 2010; Lei, 2014; Chang, 2015). As Scheid explains,

Prior to the 1950s *bianzheng lunzhi* did not exist. By this I do not mean that physicians did not know the concept or that they did not engage in the practices that resemble what their contemporary colleagues would call *bianzheng lunzhi*. Rather, the place accorded to the concept in contemporary discourse, its conceptual coherence, and its naturalized history are the results of specific concerns faced by physicians from the 1950s onward (Scheid, 2002, p. 203).

Sean Hsiang-lin Lei (2014) attributed the status of 'architect' of *bianzheng lunzhi* to Shi Jinmo (施今墨 1881-1969) (Lei, 2014, p. 337). By the 1930s, Shi was the vice president of the Central Institute of National Medicine in Beijing. He was a notable figure because of his controversial plan to "unify [Chinese] nosological nomenclature" (统一病名), which had been proposed by the Central Institute of National Medicine. As Lei pointed out, Chinese medicine practitioners in the 1930s were in a difficult position when it came to diagnosing and treating infectious diseases.

If practitioners used the conventional way of diagnosis in Chinese medicine, which was based on manifested symptoms, they would run the risk of breaking the law, as the union clearly described. On the other hand, if a practitioner of Chinese medicine tried to obey the law and reported a case as a type of infectious disease on the basis of traditional Chinese diagnostic methods, he or she would then be at risk of a malpractice suit later if the bacterial test turned out negative (Lei, 2014, p. 171-172).

Shi held a hardline position where he not only proposed a national nomenclature, but also believed if people did not adhere to the nomenclature, they should be banished from practicing medicine. As Lei personified Shi's aggressive approach,

Once the disease names have been settled, the institute will promulgate the regulation, inform practitioners all over the country, and demand that they use this set of standardized [disease] names within a designated time. Those who disobey the regulation will be properly punished. If they again disobey the regulation after being punished, they will be prohibited from practicing medicine (Lei, 2014, p. 172).

Chinese medicine in particular had to meet the criteria of the burgeoning ideas of biomedicine, which shifted the discourse on how Chinese medicine practitioners could understand and talk about the body. Not only did they have to resolve tensions with biomedicine, there were also internal issues within Chinese medicine, especially in context of the dominant epistemologies.

Shi discovered the two predominant Chinese medicine epistemologies, Cold Damage (*shang han* 伤寒)⁹⁵ and Warm Disease (*wen bing* 温病), were contradictory in how they approached the body. Historically, the school of Cold Damage derived from the Late-Han Dynasty text called the *Discussion of Cold Damage and Various Disorders* (*shang han za bing lun* 伤寒杂病论) while the Warm Disease school came out of the Cold Damage schools during the second half of the 17th century and 19th century (Hanson, 2011, p. 2; Lei, 2014, p. 174). Shi felt it was appropriate to see the epistemologies in the context of seasons. As Lei summarizes Shi's approach of the schools,

First, all forms of fever should be called Cold Damage because they were caused by cold in winter. Depending on the specific season in which the illness manifested, these fevers were given specific names. If the disease manifested right away in the winter, it was called Cold Damage. If it did not manifest until the spring, it was called Warm Disease. The second method of differentiation was based on the patients' subjective sensations: patients with a fear of cold suffered from Cold Damage, while patients with a fear of heat suffered from Warm Disease. As a third alternative, the two kinds of disorders could be differentiated on the basis of their etiology, that is, the fact that they were caused by different unseasonal *qi* (Lei, 2014, p. 174).

Despite positioning the epistemologies within a logical framework, Shi's effort for a "unifying nosological nomenclature" fell out of favor but was a

⁹⁵ It was also the Chinese term for typhoid (Lei, 2014, p. 176).

starting point to unite the two ideas. Around the same time, a Chinese nationalist intellectual by the name of Zhang Taiyan (章太炎 1869-1936) shifted the framework in Chinese medicine from the focus on disease (*bing* 病) to patterns (*zheng* 证). This served a practical function as Chinese medicine is heterogeneous in the etiology of disease. Zhang proposed to identify the patterns of disease, thus making it accessible to the biomedical sciences. Again, Lei continues,

While he refused to accept the modernist remapping proposed by other modernizers like Shi Jingmo, he also did not want Chinese medicine to keep fighting against the germ theory in the latter's favored battlefield. Zhang was willing to give up that battle and concede that Chinese medicine did not know the cause of disease, because... he wanted to emphasize that the real objective for medicine, and also the real strength of Chinese medicine, lay in its therapeutics. Although its theories might be incorrect in certain aspects, Chinese medicine was nevertheless effective in treating many diseases, including many life-threatening infectious diseases. The point was not which medical theory could identify the real cause of diseases, but which medicine could provide effective treatments, regardless of how it conceptualized health problems. Therefore he advocated that the value of any conception of disease should be judged in terms of its clinical function or, in other words, its efficacy in treating disease (Lei, 2014 p. 185).

Taking the idea of approaching disease from the lens of patterns helped pave the way for *bianzheng lunzhi*. This shift was finally implemented in 1958 with the first state-sponsored textbook, *Outline of Chinese Medicine* (*Zhong yi xue gai lun* 中医学概论), sponsored by the Ministry of Health and compiled at the Nanjing College of Chinese Medicine (南京中医学院) (Scheid, 2002, pp. 73, 179). *Outline of Chinese Medicine* systematized *bianzheng lunzhi* in a dialectically sound manner and which paired well with the PRC's emphasis on dialectical materialism. As Scheid points out,

Pattern differentiation [*bianzheng*] was employed as a prime example demonstrating how Chinese medicine approached the treatment of illness "dialectically." Rather than focusing on defined diseases, Chinese medicine understood illness as a process of emerging contradictions. The purpose of treatment was to resolve these contradictions flexibly and practically by treating changing symptom complexes. Chinese medicine thus

became an expression of dialectics based on naive materialism, open to improvement under the guidance of the party and with the help of Western science (Scheid, 2002, p. 217).

Scheid also conveys *Outline of Chinese Medicine* resolved the centuries-old epistemological division between the Cold Damage and Warm Disease schools.

Its [*Outline of Chinese Medicine*] authors employed a twofold strategy. On the one hand, they outlined a number of different systems in Chinese medicine by which the now clearly defined symptoms and signs could be organized into patterns. On the other, they designated the “eight rubrics” (*ba gang* 八纲), a system made up of the four opposing pairs *yin/yang*, exterior/interior (*biao li* 表里), cold/heat (*han re* 寒热), and depletion/repletion (*xu shi* 虚实), as the basic matrix of Chinese medical diagnostics (Scheid, 2002, p. 220).

The “Eight Rubrics” (*ba gang* 八纲), which in the United States is often translated as the “Eight Principles,” served as the basis for curriculum and content of the national board exams in America. It consists of eight foundational characteristics of disease: *yin/yang* (阴/阳), external/internal (*biao/li*), cold/hot (*han/re* 寒/热), and depletion (deficiency)/repletion (excess) (*xu /shi* 虚/实). In addition to the “Eight Principles,” there are “dryness/humidity” (*zao* 燥/*shi* 湿),⁹⁶ “wind” (*feng* 風), “qi” (气), and “stagnation” (*yu jie* 郁结 or *yu zhi* 郁滞). Scheid’s diagram (Fig. 5.1) which summarizes the content of *Outlines of Chinese Medicine*, the original textbook for the State-sponsored Chinese medicine from mainland China (Scheid 2002, p. 278; NCCAOM 2016a pp. 10-14; 2016b, p. 10-14) corresponds with roughly 90% of the National Certification Commission for Acupuncture and Oriental Medicine’s (NCCAOM) “Foundation of Oriental Medicine” module on the national board examination, the accepted test for licensure in more than forty states.

⁹⁶ “Dryness” is also written as (*ye kui* 液虧) in Traditional Chinese.

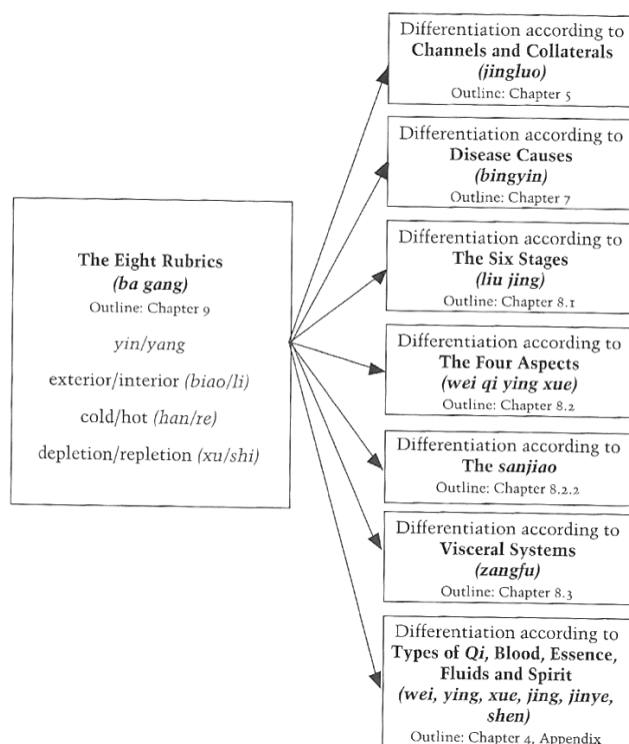


Fig. 5.1 “Pattern differentiation” (*bianzheng*) according to the *Outline of Chinese Medicine* (Scheid, 2002, p. 278)

Chapter 8.3 of *Outline of Chinese Medicine*, which relates to the *zangfu* commonly referred to in America as “organ-bowel,” serves as the basis for the nomenclature and patterns of diagnosis used among practitioners to describe disease. Below in Table 5.1 are the twelve *zangfu* along with the acupuncture abbreviation [Acu. Abbr.], which are matched with five phases (*wu xing* 五行) or often referred to in the United States as “five elements.”

Phase/Element	Organ/Viscera [Acu. Abbr.] (<i>zang</i> 脏)	Bowel/Internal Organs [Acu. Abbr.] (<i>fu</i> 腑)
Wood (<i>mu</i> 木)	Liver [LV] (<i>gan</i> 肝)	Gallbladder [GB] (<i>dan</i> 胆)
Fire (<i>huo</i> 火)	Heart [HT] (<i>xin</i> 心)	Small Intestine [SI] (<i>xiao chang</i> 小肠)
Fire (<i>huo</i> 火)	Xin Bao [XB]/Pericardium [PC](心包)	San Jiao [SJ]/Triple Burner [TB] (三焦)
Earth (<i>tu</i> 土)	Spleen [SP] (<i>pi</i> 脾)	Stomach [ST] (<i>wei</i> 胃)
Metal (<i>jin</i> 金)	Lungs [LU] (<i>fei</i> 肺)	Large Intestine [LI] (<i>da chang</i> 大腸)
Water (<i>shui</i> 水)	Kidney [KD] (<i>shen</i> 腎)	Urinary Bladder [UB] (<i>pang guang</i> 膀胱)

Table 5.1 *Zangfu* matched with the Corresponding Phases

The combination of the “Eight Rubrics”⁹⁷ and the twelve *zangfu* serve as the basis for diagnosis and treatment. Before coming to the treatment, a practitioner generally has the four diagnostic techniques: observation (*wang zhen* 望診), listen and smell (*wen shen* 聞診), interview/interrogation (*wen zhen* 問診), and palpation (切診). These techniques include tongue diagnosis (*she zhen* 舌診), which is a part of the observation component of diagnosis and pulse diagnosis (*mai zhen* 脉診), a predominant focus in palpation. The tongue is diagnosed based on the following characteristics: body, shape, color, and coat. Any of these characteristics are mapped onto one, a combination, or all six sections of the tongue. Each of the characteristics of the tongue correspond to the “Eight Rubrics” and depending on the location, can assist a practitioner on where to locate disease in the *zangfu*.

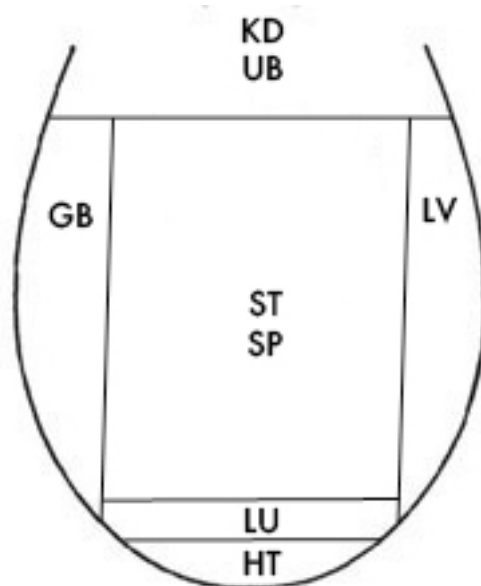


Fig. 5.2 Six Sections of the Tongue⁹⁸

Unlike tongue diagnosis, pulse diagnosis has a more specified criterion where the position and qualities denote a particular pattern. From the patient’s most distal area where the practitioner rests their index finger on the crease of the wrist to the most proximal area where the practitioner places their ring finger, the three pulse positions are: “inch” *cun*, “bar” *guan*, and “cubit” *chi* (寸, 关, 尺),

⁹⁷ Besides for Scheid’s work on the “Eight Rubrics,” further research is necessary on the history of the system.

⁹⁸ Refer to Table 5.1 for the list of acronyms.

关, 尺). Each position corresponds to a particular phase with an accompanying *zangfu*, with the yin-organ being at the deepest and the yang-bowel at the most superficial.

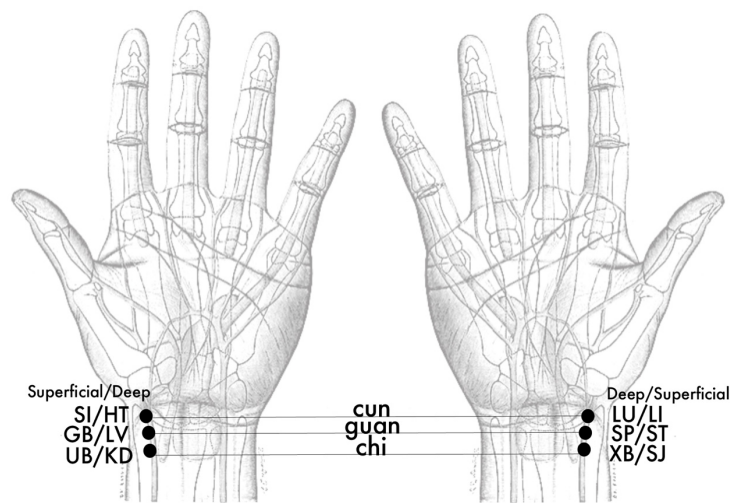


Fig. 5.3 Pulse Positions

In addition to the positions, pulses also have distinct qualities which determine – primarily based on the “Eight Rubrics” – the specific type of disease a patient exhibits. For example, if the pulse quality feels fast, it typically indicates to the practitioner the patient is exhibiting more of a “yang” disease opposed to a slow pulse, which would generally represent a more “yin” pattern. Pulses cannot be held in exclusion and are based relative to the patient’s circumstances. Specifically, a patient’s pulses are generally faster if they were in a hurry to their appointment or if they just recently exercised. Pulses are more systematized than the tongue as particular qualities personify a specific type of disease.

The heterogeneity of TCM in United States is clearly manifested in the systematization of pulse qualities. With the two primary regulatory bodies, NCCAOM and CAB, both expect its candidates to know a certain set of pulse qualities. Albeit an important distinction relative to the regulatory bodies, I have found as an acupuncturist and through my ethnographic research pulse diagnosis a rather subjective diagnostic tool which varies in form from practitioner to practitioner. Table 5.2 shows different characteristics set by the California Acupuncture Board in the CALE with twelve less than what is expected from the NCCAOM’s national board exam.

Characteristic	Pinyin	Chinese	Yin/Yang	NCCAOM/CALE
1. Floating	<i>Fu</i>	浮	Yang	NCCAOM/CALE
2. Deep	<i>Chen</i>	沉	Yin	NCCAOM/CALE
3. Slow	<i>Chi</i>	遲	Yin	NCCAOM/CALE
4. Rapid	<i>Shu</i>	數	Yang	NCCAOM/CALE
5. Empty	<i>Xu</i>	虛	Yin	NCCAOM/CALE
6. Full	<i>Shi</i>	實	Yang	NCCAOM/CALE
7. Overflowing	<i>Hong</i>	洪	Yin Within Yang	NCCAOM/CALE
8. Fine/Thin	<i>Xi</i>	細	Yin	NCCAOM/CALE
9. Slippery	<i>Hua</i>	滑	Yang Within Yin	NCCAOM/CALE
10. Choppy	<i>Se</i>	澀	Yin	NCCAOM/CALE
11. Wiry	<i>Xuan</i>	弦	Yang	NCCAOM/CALE
12. Tight	<i>Jin</i>	緊	Yang Within Yin	NCCAOM/CALE
13. Soggy (Weak-Floating)	<i>Ru</i>	濡	Yin	NCCAOM/CALE
14. Weak	<i>Ruo</i>	弱	Yin	NCCAOM/CALE
15. Hasty	<i>Cu</i>	促	Yang	NCCAOM/CALE
16. Knotted	<i>Jie</i>	結	Yin	NCCAOM/CALE
17. Intermittent	<i>Dai</i>	代	Yin	NCCAOM/CALE
18. Long	<i>Chang</i>	長	Yang	NCCAOM
19. Short	<i>Duan</i>	短	Yin	NCCAOM
20. Minute	<i>Wei</i>	微	Yin	NCCAOM
21. Slow-Down	<i>Huan</i>	緩	Yin	NCCAOM
22. Hollow	<i>Kou</i>	朮	Yin	NCCAOM
23. Leather	<i>Ge</i>	革	Yin	NCCAOM
24. Firm	<i>Lao</i>	牢	Yang Within Yin	NCCAOM
25. Scattered	<i>San</i>	散	Yin	NCCAOM
26. Hidden	<i>Fu</i>	伏	Yin	NCCAOM
27. Moving	<i>Dong</i>	動	Yang	NCCAOM
28. Hurried	<i>Ji</i>	急	Yang	NCCAOM
29. Big	<i>Da</i>	大	Yang	NCCAOM

Table 5.2 Pulse Qualities (Maciocia 2005, 361-367; Kim 2014, 57).

The most seemingly objective diagnostic tool found in TCM is the interview/interrogation. In the 17th century, Chinese physician Zhang Jing Yue (1563-1640) outlined the traditional “Ten Questions” (*shi wen* 十問); however, since then, there has been four or six questions added, which include pain,⁹⁹

⁹⁹ Pain is in Maciocia’s original “Ten Questions,” but is replaced “Eyes and Ears” (Maciocia, 2005, p. 321; Kim, 2014, pp. 45,51).

emotions, energy level, and sexual symptoms (Maciocia, 2005, pp. 320-323; Kim, 2014, pp. 45-50).

Chinese	Pinyin	Question Content
寒热	<i>Han re</i>	Feelings of Cold and Heat
汗	<i>Han</i>	Sweating
頭身	<i>Tou shen</i>	Head and Body
胸腹	<i>Xiong fu</i>	Chest and Abdomen
耳目	<i>Er mu</i>	Ears and Eyes
飲食	<i>Yin shi</i>	Food and Drink (Diet)
睡眠	<i>Shui mian</i>	Sleep
便溺	<i>Bian niao</i>	Urine and Stools
婦女	<i>Fu nu</i>	Women's Symptoms
小兒	<i>Xiao er</i>	Children's Symptoms

Table 5.3 Ten Interview Questions (Maciocia, 2005, pp. 320-323; Kim, 2014, pp. 45-50).

Yet, the epistemological framework from textual sources is a continuity of TCM, where the current sources came from an evolution of Chinese medicine texts. Below in Table 5.4 is a list of texts used from the 1980s to the 1990s for the purpose of the national and California examinations as well as for the basis of various schools' curriculum.

Text	Author	Year First Published
<i>An Outline of Chinese Acupuncture</i>	Academy of Traditional Chinese Medicine	1975
<i>Acupuncture: A Comprehensive Text</i>	Shanghai College of Traditional Chinese Medicine, Dan Bensky (Ed. and Tr.), and John O'Connor (Ed. and Tr.)	1981
<i>Acupuncture and Chinese Medicine</i>	Homer Cheng	1976
<i>Acupuncture and Medical Rehabilitation</i>	Sino-American Rehabilitation Center and Homer Cheng	1976
<i>Essentials of Chinese Acupuncture</i>	Beijing College of Traditional Chinese Medicine, Shanghai College of Traditional Chinese Medicine, Nanjing College of Traditional Chinese Medicine, The Acupuncture Institute of the Academy of Traditional Chinese Medicine	1980
<i>The Book of Acupuncture Points</i>	Dr. Tin Yau So	1989
<i>The Web That Has No Weaver: Understanding Chinese Medicine</i>	Ted Kaptchuk	1983

Table 5.4 Commonly Used Texts for Exams and Curriculum from 1980s-1990s

In particular, *An Outline of Chinese Acupuncture* and *Essentials of Chinese Acupuncture*, were modifications of the PRC-sponsored *Outline of Chinese Medicine*. *Essentials of Chinese Acupuncture* was a widely used textbook throughout the United States from the 1980s to the 1990s. It was compiled by the four major Chinese medicine universities in the PRC: Beijing College of Traditional Chinese Medicine, Shanghai College of Traditional Chinese Medicine, Nanjing College of Traditional Chinese Medicine, and the Acupuncture Institute of the Academy of Traditional Chinese Medicine. It outlined the major *bianzheng* of the *zangfu*, which is TCM's most distinguishing characteristic.

To treat a patient, the practitioner must determine the pattern and then treat accordingly. For the most part, TCM is somewhat cohesive. Even this seemingly homogenous form of Chinese medicine has a different set of protocols based on the sources required by the regulatory bodies. The two primary sources are Giovanni Maciocia's *Foundations of Chinese Medicine* (FCM) and Xinnong Chen's *Chinese Acupuncture and Moxibustion* (CAM). The former is the primary text for the NCCAOM's national board and the latter the basis for the CALE.

Ideally, the patient's symptom configuration gives an approximation on what specific pattern to treat. Thus, identifying the correct pattern is crucial in TCM because it determines the route of treatment. TCM has more than a hundred treatment protocols determined by the pattern. Table 5.5 lists possible patterns and their associated treatments.

FCM Pattern	Herbal Formula	Acupuncture (FCM)	Organ/Bowel
LV Qi Stagnation	<i>Yue ju wan</i> (越鞠丸) <i>Xiao yao san</i> (逍遙散)	GB34, LV3, LV13, LV14, SJ6, PC6	Liver (LV)
LV Qi Stagnation turning into Heat	<i>Dan zhi xiao yao san</i> (丹梔逍遙散)	GB34, LV3, LV13, LV14, SJ6, PC6, LV2	Liver (LV)
Rebellious LV Qi	<i>Chai hu shu gan tang</i> (柴胡疏肝丸)	LV14, PC6, GB34, LV3, SJ6, LI4, ST21, ST19	Liver (LV)
LV Blood Stasis	<i>Ge xia zhu yu tang</i> (膈下逐瘀湯) <i>Shi xiao san</i> (失笑散) <i>Yan hu suo tang</i> (延胡索湯)	GB34, LV3, UB18, UB17, SP10, RN6, SP4, PC6, ST29, KD14, LV5, LV6	Liver (LV)
LV Fire Blazing	<i>Long dan xie gan tang</i> (龍胆瀉肝湯) <i>Dang gui long hui tang</i> (當歸龍薈湯)	LV2, LV3, GB20, GB13, LI11, GB1, GB9, GB8, GB6, SP6, LV1	Liver (LV)
LV Damp Heat	<i>Long dan xie gan tang</i> (龍胆瀉肝湯)	LV14, GB34, UB18, RN12, SP9, SP6, LI11, LV2	Liver (LV)
Cold Stagnation in LV Channel	<i>Nuan gan jiang</i> (暖肝煎)	RN3, LV5, LV1, LV3	Liver (LV)
LV Blood Deficiency	<i>Bu gan tang</i> (補肝散)	LV8, SP6, ST36, RN4, UB18, UB20, UB23, UB17, <i>Yuyao</i>	Liver (LV)
LV Yin Deficiency	<i>Yi guan jian</i> (一貫煎)	LV8, SP6, ST36, RN4, KD3, KD6, LV2	Liver (LV)
LV Yang Deficiency	<i>Bu gan tang</i> (補肝散)	N/A	Liver (LV)
LV Yang Rising	<i>Tian ma gou teng yin</i> (天麻苟藤飲) <i>Ling jiao gou teng tang</i> (羚羊苟藤湯)	LV3, SJ5, PC6, LI4, GB43, GB38, GB20, UB2, Taiyang, GB9, GB8, GB6 (If LV Blood/Yin Deficiency: Add SP6, LV8, ST36, KD3, KD6)	Liver (LV)
Extreme-Heat Causing Wind	<i>Ling jiao gou teng tang</i> (羚羊苟藤湯) <i>Da ding feng zhu</i> (大定風珠)	LV3, Shixuan, DU20, DU16, GB20, DU8, DU14	Liver (LV)
LV Yang Rising Causing LV Yin Deficiency	<i>San jia fu mai tang</i> (三甲復脈湯)	LV3, GB20, LI4, SJ5, DU19, SP6, LV8, KD3	Liver (LV)
LV Yang Rising Causing LV/KD Yin Deficiency	<i>Zhen gan xi feng tang</i> (鎮肝熄風湯)	LV3, GB20, LI4, SJ5, DU19, SP6, LV8, KD3, KD6, RN4	Liver (LV)/Kidney (KD)
LV Yang Rising Causing LV Blood Deficiency	<i>E jiao ji zi huang tang</i> (阿膠雞子黃湯)	LV3, GB20, LI4, SJ5, DU19, SP6, LV8, KD3, UB17, RN4	Liver (LV)

LV Blood Deficiency Causing Wind	<i>E jiao ji zi huang tang</i> (阿膠雞子黃湯)	LV3, GB20, LI4, SJ5, DU19, SP6, LV8, KD3, UB17, RN4	Liver (LV)
LV Fire Causing Wind	<i>Ling jiao gou teng tang</i> (羚羊苟藤湯)	LV2, LV3, GB20, LI11, GB1, SP6, LV1, DU8	Liver (LV)
LV Qi Invading SP	<i>Xiao yao san</i> (逍遙散)	LV13, LV14, LV3, GB34, RN6, SJ6, PC6, ST25, SP15, RN12, ST 36, SP6, SP4, PC6	Liver (LV)/Spleen (SP)
LV Qi Invading ST	<i>Si mo tang</i> (四磨湯) <i>Xuan fu dai zhe tang</i> (旋覆代赭湯) <i>Ju pi zhu ru tang</i> (橘皮竹茹湯) <i>Ding xiang shi di tang</i> (丁香柿蒂湯) <i>Ban xia hou po tang</i> (半夏厚朴丸)	LV14, GB34, RN13, RN10, ST21, ST19, ST36, ST34, UB21	Liver (LV)/Stomach (ST)
LV Fire Insulting LU	<i>Long dan xie gan tang</i> (龍胆瀉肝湯)	LV2, LV14, LV14, RN17, RN22, PC6, LU7, LI11	Liver (LV)/ Lungs (LU)
HT and LV Blood Deficiency	<i>Gui pi tang</i> (歸脾湯) <i>Sheng yu tang</i> (聖愈湯) <i>Bu gan tang</i> (補肝湯) <i>Dang gui ji xue teng tang</i> (當歸雞血藤湯)	HT7, PC6, RN14, RN15, RN4, UB17, UB20, LV8, SP6, ST36, UB18, UB23	Liver (LV)/Heart (HT)
GB Damp	<i>San ren tang</i> (三仁湯) <i>Yin chen hao tang</i> (茵陳蒿湯)	GB24, LV14, RN12, GB34, <i>Dannangxue</i> , DU9, UC19, UB20, LI11, SJ6, ST19	Gallbladder (GB)
GB Damp-Heat	<i>Yin chen hao tang</i> (茵陳蒿湯)	GB24, LV14, RN12, GB34, <i>Dannangxue</i> , DU9, UC19, UB20, LI11, SJ6, ST19	Gallbladder (GB)
GB Deficiency	<i>Wen dan tang</i> (溫膽湯)	GB40, LV8, ST36, SP6, RN4, UB18, UB47	Gallbladder (GB)
LV/GB Damp-Heat	<i>Long dan xie gan tang</i> (龍胆瀉肝湯)	GB24, LV14, UB18, RN12, GB34, <i>Dannangxue</i> , DU9, UB19, UB20, LI11, SJ6, ST19, LV3, LV5	Liver (LV)/Gallbladder (GB)
HT Qi Deficiency	<i>Bao yuan tang</i> (保元湯)	HT5, PC6, UB15, RN17, RN6, DU14	Heart (HT)
HT Yang Deficiency	<i>Rou fu bao yuan tang</i> (肉附保元湯)	HT5, PC6, UB15, RN17, RN6, DU14	Heart (HT)
HT Yang Collapse	<i>Shen fu tang</i> (參附湯)	RN6, RN4, RN8, DU4, ST36, PC6, UB23, DU20, DU14, UB15	Heart (HT)
HT Blood Deficiency	<i>Shen qi si wu tang</i> (參芪四物湯)	HT7, PC6, RN14, RN15, RN4, UB17, UB20,	Heart (HT)

HT Yin Deficiency	<i>Tian wang bu xin dan</i> (天王補心丹)	HT7, PC6, RN14, RN15, RN4, HT6, SP6, KD7	Heart (HT)
HT-Fire Blazing	<i>Xie xin tang</i> (瀉心湯)	HT9 HT8, HT7, RN15, SP6, KD6, LI11, DU24, DU19	Heart (HT)
Phlegm-Fire Harassing the HT	<i>Wen dan tang</i> (溫胆湯)	PC5, HT7, HT8, HT9, PC7, RN15, UB15, RN12, ST40, SP6, UB20, DU20, LV2, GB13, GB17, DU24	Heart (HT)
Phlem Misting the Mind	<i>Gun tan wan</i> (滾痰丸)	PC5, HT9, UB15, ST40, DU26, RN12, UB20, DU14	Heart (HT)
HT-Qi Stagnation	<i>Mu xiang liu qi yin</i> (木香流氣飲) <i>Ban xia hou po tang</i> (半夏厚朴湯)	PC5, HT5, HT7, RN15, RN17, LU7, ST40, LI4	Heart (HT)
HT Vessel Obstructed	<i>Zhi shi gua lou gui zhi tang</i> (枳實瓜蒌桂枝湯) + <i>Dan shen</i> (丹參)	PC5, HT5, HT7, RN15, RN17, LU7, ST40, LI4, UB15, UB17, RN12	Heart (HT)
HT Blood Stasis	<i>Xue fu zhu yu tang</i> (血府逐瘀湯)	PC5, HT5, HT7, RN15, RN17, UB14, UB17, SP10, KD25	Heart (HT)
SI Full Heat	<i>Dao chi san</i> (導赤散) <i>Dao chi qing xin tang</i> (導赤清心湯)	SI2, SI5, HT5, HT8, ST39	Small Intestine (SI)
SI Qi Pain	<i>Chai hu shu gan tang</i> (柴胡疏肝丸)	RN6, GB34, LV13, ST27, ST29, SP6, LV3, ST39	Small Intestine (SI)
SI Qi Tied	<i>Zhi shi dao (zhi) wan</i> (枳實導滯丸) <i>Tian tai wu yao san</i> (天臺烏藥散)	ST39, Lanweixue, RN6, GB34, ST25, SP6, LV3	Small Intestine (SI)
SI Worm Infestation	<i>Li zhong an hui tang</i> (理中安蛔湯) <i>Lian mei an hui tang</i> (連梅安蛔湯) <i>Hua chong wan</i> (化蟲丸) <i>Qu tiao tang</i> (驅條湯)	N/A	Small Intestine (SI)
SI Deficiency and Cold	<i>Xiao jian zhong tang</i> (小建中湯) <i>Shen ling bai zhu san</i> (參苓白術散)	RN6, ST25, ST39, UB20, UB27	Small Intestine (SI)
PC Heat	<i>Qing ying tang</i> (清營湯)	PC9, PC8, HT9, KD6	Xin Bao/Paracardium (XB/PC)
PC Fire	<i>Xie xin tang</i> (瀉心湯)	PC8, HT8, UB14, RN15, RN14, RN17, LI11, DU24, DU19, SP6, LV2	Xin Bao/Paracardium (XB/PC)
Phlegm-Fire Harassing the PC	<i>Wen dan tang</i> (溫胆湯)	PC5, HT7, HT8, HT9, PC7, RN15, UB15, UB14, RN17, RN12, ST40, SP6,	Xin Bao/Paracardium (XB/PC)

		UB20, DU20, LV2, GB13, GB17, DU24	
PC Qi Stagnation	<i>Mu xiang liu qi yin</i> (木香流气饮) <i>Ban xia hou po tang</i> (半夏厚朴汤)	PC6, HT5, HT7, RN14, RN15, RN17, UB14, LU7, ST40, LI4	Xin Bao/Paracardium (XB/PC)
PC Blood Stasis	<i>Xue fu zhu yu tang</i> (血府逐瘀汤)	PC6, PC4, HT7, RN14, RN17, UB14, UB17, SP10	Xin Bao/Paracardium (XB/PC)
PC Blood Deficiency	<i>Shen qi si wu tang</i> (参芪四物汤)	PC6, HT7, RN14, RN15, RN4, UB17, UB20, UB14, RN17, PC6, SP4	Xin Bao/Paracardium (XB/PC)
SP Qi Deficiency	<i>Si jun zi tang</i> (四君子汤) <i>Liu jun zi tang</i> (六君子汤)	RN12, ST36, SP3, SP6, UB20, UB21	Spleen (SP)
SP Yang Deficiency	<i>Li zhong wan</i> (李中堂)	RN12, ST36, SP3, SP6, UB20, UB21, SP9, RN9, ST28, UB22	Spleen (SP)
SP Qi Sinking	<i>Bu zhong yi qi tang</i> (补中益气汤)	RN12, ST36, SP3, SP6, UB20, UB21, DU20, RN6, ST21, DU1	Spleen (SP)
SP Not Controlling Blood	<i>Gui pi tang</i> (归脾汤)	RN12, ST36, SP3, SP6, UB20, UB21, SP10, UB17, SP1, SP4	Spleen (SP)
SP Blood Deficiency	<i>Gui pi tang</i> (归脾汤)	RN12, ST36, SP3, SP6, UB20, UB21, RN4, UB17	Spleen (SP)
Cold-Damp Invading SP	<i>Ping wei san</i> (平胃散)	SP9, SP6, RN12, SP3, ST8, UB22, UB20, RN9, RN11, ST22, ST28	Spleen (SP)
Damp-Heat Invading SP	<i>Lian po yin</i> (莲朴饮)	SP9, SP6, DU9, LI11, UB20, RN9, RN11, ST22, ST28, UB22	Spleen (SP)
SP Qi and HT Blood Deficiency	<i>Gui pi tang</i> (归脾汤)	HT7, PC6, RN14, RN15, RN4, UB17, UB20, RN12, ST36, SP6	Spleen (SP)/Heart (HT)
SP and LU Qi Deficiency	<i>Si jun zi tang</i> (四君子汤) <i>Liu jun zi tang</i> (六君子汤)	LU9, LU7, RN6, UB13, DU12, ST36, RN12, SP3, SP6, UB20, UB21	Spleen (SP)/Lungs (LU)
SP and LV Blood Deficiency	<i>Gui pi tang</i> (归脾汤)	LV8, SP6, RN4, UB18, UB23, RN12, ST36, SP3, UB20, UB21, UB17	Spleen (SP)/Liver (LV)
SP Damp + LV Qi Stagnation	<i>Ping wei san</i> (平胃散) + <i>Mu xiang</i> 木香 + <i>Xiang fu</i> (香附) <i>Huo xiang zheng qi san</i> (藿香正气散) + <i>Mu xiang</i> (木香) + <i>Xiang fu</i> (香附) <i>Yi jia jian zheng qi san</i> (加减正气散)	RN12, SP6, SP3, SP9, UB20, LV13, LV14, GB24, GB34, LV3, ST19	Spleen (SP)/Liver (LV)

ST Qi Deficiency	<i>Si jun zi tang</i> (四君子汤)	ST36, RN12, UB21, RN6	Stomach (ST)
ST Deficiency and Cold	<i>Huang qi jian zhong tang</i> (黄耆建中汤) <i>Xiao jian zhong tang</i> (小建中汤)	ST36, RN12, UB20, UB21, RN6	Stomach (ST)
ST Yin Deficiency	<i>Sha shen mai dong tang</i> (沙参麦冬汤) <i>Shen ling bai zhu san</i> (参苓白术散) <i>Yi wei tang</i> (益胃汤)	RN12, ST36, SP6, SP3	Stomach (ST)
ST Qi Stagnation	<i>Chen xiang jiang qi san</i> (沉香降气散) <i>Yi wei tang</i> (益胃汤) <i>Ban xia hou po tang</i> (半夏厚朴汤) <i>Zou jin wan</i> (左金丸)	ST34, ST21, ST19, KD21, SJ6, PC6, SP4, PC6, GB34, RN12, ST40	Stomach (ST)
ST Fire (or Phlegm-Fire) [*Stomach Fire Blazing]	<i>Tiao wei cheng qi tang</i> (调胃承气汤) <i>Qing wei san</i> (清胃散) <i>Liang ge san</i> (凉膈散)	ST44, ST34, ST21, RN12, RN13, LI11, LI4, RN11, SP15	Stomach (ST)
Cold Invading ST [*Pathogenic Cold Insulting Stomach]	<i>Liang fu wan</i> (良附丸)	ST21, SP4, RN13, ST34	Stomach (ST)
ST Qi Rebellling Upwards	<i>Ding xiang shi di tang</i> (丁香柿蒂汤) <i>Huo xiang zheng qi san</i> (藿香正气散) <i>Ban xia hou po tang</i> (半夏厚朴汤)	RN13, RN10, PC6, SP4, ST21, ST19	Stomach (ST)
ST Damp-Heat	<i>Lian po yin</i> (莲朴饮)	ST44, ST34, ST21, RN12, RN13, LI11, LI4, RN11, ST25, ST40, SP9, RN9	Stomach (ST)
Food Retention in the ST	<i>Bao he wan</i> (保和丸) <i>Zhi shi dao zhi wan</i> (枳实导滞丸)	RN13, RN10, ST21, ST44, ST45, SP4, PC6, ST40, ST19, KD21, RN12	Stomach (ST)
ST Blood Stasis	<i>Shi xiao san</i> (失笑散) <i>Dan shen yin</i> (丹参饮) <i>Ge xia zhu yu tang</i> (膈下逐瘀汤)	ST34, ST21, ST19, KD21, SJ6, PC6, SP4, GB34, RN12, ST40, UB17, SP10, LI4, RN11	Stomach (ST)
ST and SP Qi Deficiency	<i>Si jun zi tang</i> (四君子汤) <i>Shen Ling Bai Zhu San</i> (参苓白术散)	RN12, ST36, SP3, SP6, UB20, UB21, RN6	Stomach (ST)/Spleen (SP)
LU Qi Deficiency	<i>Ren shen bu fei tang</i> (人参补肺汤)	LU9, LU7, RN6, UB13, DU12, ST36, RN12	Lungs (LU)
LU Yin Deficiency	<i>Yang yin qing fei tang</i> (养阴清肺汤)	LU9, RN17, UB43, UB13, DU12, RN4, KD6, RN12, SP6, LU10, LI11	Lungs (LU)

LU Dryness	<i>Bai he gu jin tang</i> (百合固金湯)	LU9, RN4, KD6, SP6, RN12, ST36	Lungs (LU)
LU Wind-Cold	<i>Ma huang tang</i> (麻黃湯)	LU7, UB12, DU16	Lungs (LU)
LU Wind-Heat	<i>Sang ju yin</i> (桑菊飲)	LU7, LI4, LI11, LU11, DU14, UB12, DU16, GB20, SJ5	Lungs (LU)
LU Wind-Water	<i>Xiao qing long tang</i> (小青龍湯)	LU7, LI6, LI7, LI4, UB12, RN9, UB13, DU26	Lungs (LU)
LU Heat [*Pathogenic Heat Obstructing LU]	<i>Ma xing shi gan tang</i> (麻杏石甘湯)	LU5, LU10, LU7, LI11, LU1, UB13	Lungs (LU)
LU Damp-Phlegm [*Phlegm-Damp Obstructing LU]	<i>Er chen tang</i> (二陳湯)	LU5, LU7, LU1, RN17, ST40, PC6, RN22, RN12, RN9, UB20, UB13	Lungs (LU)
LU Cold-Phlegm	<i>She gan ma huang tang</i> (射干麻黃湯) <i>Ling gui zhu gan tang</i> (苓桂朮甘湯) <i>Liang gan wu wei jiang xin tang</i> (苓甘五味薑辛湯) <i>San zi yang qin tang</i> (三子養親湯)	LU5, LU7, LU1, RN17, ST40, PC6, RN22, RN12, RN9, UB20, UB13, UB23	Lungs (LU)
LU Phlegm-Heat [*Phlegm-Heat Accumulation Causing an Obstruction]	<i>Wen dan tang</i> (溫膽湯) <i>Qing qi hua tan wan</i> (清氣化痰湯) <i>San zi yang San zi yang qin tang</i> (三子養親湯)	LU5, LU7, LU10, LI11, UB13, RN12, ST40	Lungs (LU)
LU Dry-Phlegm	<i>Bei mu gua lou san</i> (貝母瓜蒌散)	LU9, LU7, KD6, RN12, ST36, SP6, ST40, UB13, RN17	Lungs (LU)
Phlegm-Fluid Obstructing LU	<i>Liang gan wu wei jiang xin tang</i> (苓甘五味薑辛湯)	LU5, LU9, RN17, UB13, ST40, UB43, RN12, ST36, RN9, SP9, UB20, UB23	Lungs (LU)
LU and HT Qi Deficiency	<i>Si jun zi tang</i> (四君子湯) + <i>Huang qi</i> (黃耆) <i>Bao yuan tang</i> (保元湯) <i>Bu fei tang</i> (補肺湯) <i>Sheng mai san</i> (生脈散)	LU9, LU7, RN6, UB13, DU12, ST36, RN12, HT5, PC6, UB15, RN17	Lungs (LU)/Heart (HT)
LI Damp-Heat	<i>Ge gen qin lian tang</i> (葛根芩連湯) <i>Bai tou weng tang</i> (白頭翁湯) <i>Shao yao tang</i> (芍藥湯)	SP9, SP6, RN3, UB22, ST25, ST27, RN6, UB25, LI11, RN12, ST37, UB20, SP10	Large Intestines (LI)
LI Heat	<i>Ma zi ren wan</i> (麻子仁丸)	ST25, UB25, LI11, ST37, ST44, LI2, SP6, KD6, RN12	Large Intestines (LI)
LI Heat Obstruction	<i>Tiao wei cheng qi tang</i> (調胃承氣湯)	LI11, LI4, SP15, SJ6, SP6, LI2, ST44, ST25, UB25	Large Intestines (LI)

Cold Invading LI	<i>Liang fu wan</i> (良附丸) + <i>Zheng qi tian xiang san</i> (正气天香散)	ST37, ST25, ST36, SP6, LV3, ST27	Large Intestines (LI)
LI Qi Stagnation	<i>Chai hu shu gan tang</i> (柴胡疏肝湯)	RN6, GB34, ST25, SP15, ST37, SP6, UB25	Large Intestines (LI)
LI Dry	<i>Zeng ye tang</i> (增液湯) <i>Qing zao run chang tang</i> (清燥潤腸湯) <i>Wu ren wan</i> (五仁丸) <i>Si wu ma zi ren wan</i> (四物麻子仁丸) <i>Ma zi ren wan</i> (麻子仁丸)	ST36, SP6, RN4, KD6, ST25, SP15	Large Intestines (LI)
LI Cold	<i>Liang fu wan</i> (良附丸)	ST25, RN6, ST36, ST37, UB25, UB20	Large Intestines (LI)
LI Collapse	<i>Bu zhong yi qi tang</i> (补中益气湯)	RN6, ST25, ST36, SP3, UB20, UB21, DU20	Large Intestines (LI)
KD Yang Deficiency	<i>You gui wan</i> (右歸丸) <i>Jin gui shen qi wan</i> (金匱腎氣丸)	UB23, DU4, RN4, RN6, KD3, KD7, UB52, <i>Jinggong</i>	Kidney (KD)
KD Yin Deficiency	<i>Zuo gui wan</i> (左歸丸) <i>Liu wei di huang wan</i> (六味地黄丸)	RN4, KD3, KD6, KD10, KD9, SP6, RN7, LU7	Kidney (KD)
KD Qi Not Firm	<i>You gui wan</i> (右歸丸) + <i>Huang Qi</i> (黃耆) + <i>Qian shi</i> (芡實) <i>Jin suo gu jing wan</i> (金鎖固精丸) <i>Fu tu dan</i> (茯菟丹)	UB23, DU4, RN4, RN6, KD3, KD7, UB52, <i>Jinggong</i> , DU20, KD13, UB32	Kidney (KD)
KD Failing to Receive Qi	<i>You gui wan</i> (右歸丸) + <i>Dong chong xia cao</i> (冬虫夏草) + <i>Wu wei zi</i> (五味子) <i>Shen ge san Ren</i> (參蛤散)	KD7, KD3, LU7, KD6, ST36, UB23, DU4, RN6, RN17, KD25, DU12, UB13, RN4, KD13	Kidney (KD)
KD Essence Deficiency	<i>Zuo gui wan</i> (左歸丸),	KD3, KD6, RN4, KD13, UB23, DU4, GB39, DU20, DU14, UB15, UB11, DU17, DU16	Kidney (KD)
KD Yang Deficiency + Water Excess	<i>Jin gui shen qi wan</i> (金匱腎氣丸) <i>Wu ling san</i> (五苓散)	DU4, UB23, UB22, UB20, RN9, ST28, SP9, SP6, KD6, (Water -> HT: DU14, UB15, Water -> LU: LU7, UB13, DU12)	Kidney (KD)
KD Yin Deficiency + Empty Heat Excess	<i>Liu wei di huang wan</i> (六味地黄丸) + <i>Di gu pi</i> (地骨皮) + <i>Zhi mu</i> (知母)	KD3, KD6, KD10, KD9, RN4, KD2, SP6, HT5, LU7, LU10, HT6, DU24, LI11	Kidney (KD)
KD and LV Yin Deficiency	<i>Zuo gui wan</i> (左歸丸) <i>Qi ju di huang wan</i> (杞菊地黄丸)	KD3, KD6, LV8, RN4, UB23, KD13, SP6, UB10	Kidney (KD)/Liver (LV)

KD and HT Not Harmonized	<i>Tian wang bu xin dan</i> (天王補心丹) <i>Liu wei di huang wan</i> (六味地黃丸) + <i>Jiao tai wan</i> (交泰丸)	HT7, HT6, HT5, <i>Yintang</i> , UB15, RN15, DU24, KD3, KD6, KD10, KD9, RN4, SP6	Kidney (KD)/Heart (HT)
KD and LU Yin Deficiency	<i>Ba xian chang shou wan</i> (八仙長壽丸)	KD3, KD6, LU7, RN4, KD13, LU9, LU1, SP6, UB43	Kidney (KD)/Lungs (LU)
KD and SP Yang Deficiency	<i>Li zhong wan</i> (李中堂) + <i>Jin gui shen qi wan</i> (金匱腎氣丸)	UB23, DU4, RN4, RN6, KD3, KD7, UB52, <i>Jingong</i> , rn12, st36, sp3, ub20, ub21, rn9, st37, st25, ub25	Kidney (KD)/Spleen (SP)
UB Damp- Heat	<i>Ba zheng san</i> (八正散)	SP9, SP6, UB22, UB28, RN3, UB63, UB66, ST28	Urinary Bladder (UB)
UB Damp- Cold	<i>Ba zheng san</i> (八正散) <i>Si wu san</i> (四物散)	SP9, SP6, UB22, RN3, ST28, RN9, UB28	Urinary Bladder (UB)
UB Deficient and Cold	<i>Suo quan wan</i> (縮泉丸) <i>Sang piao xiao wan</i> (桑螵蛸丸) <i>Tu si zi wan</i> (菟絲子丸)	UB23, DU4, UB28, RN4, RN3, RN6, DU20	Urinary Bladder (UB)

Table 5.5 *Zangfu* Pattern Differentiations with Acupuncture & Herbal Treatment (Maciocia, 2005, pp. 463-704; Kim, 2014, pp. 80-84).

The enactment of a standardized model of Chinese medicine through the modified version of TCM, unravels a logical synthesis of diagnosis and treatment. In fact, much of what I encountered at the various TCM schools was instilling in students a specific dialectical approach in understanding the medicine; a specific logic. As one teacher explained at a California school.

Listen class, your objective in studying for the exam (CALE) is not actually to memorize the material. Anyone can memorize the material. My goal here is for you to understand the *logic* of the exam. For instance, when you see “pain in hypochondrium,” think of Liver. If you see anything relating to “appetite,” think of Spleen. When you see “palpations with shortness of breath,” think Heart. There are key terms they use that fit a logical process for you to identify what they’re looking for. Don’t forget! Their objective is to also throw you off. Pay close attention to the timeframe when the symptoms occur. If the symptoms don’t currently exist in their case studies, forget it, and focus on the symptoms that are occurring in the present moment (Field notes, July, 2015).

The process is straightforward: identify the symptoms which closely match the associated pattern, then use the treatment protocol given in the form of acupuncture and herbs. In the United States, acupuncture or acupuncture and herbal formulas are the primary routes of treatment for a typical TCM-based treatment. Additional adjunct techniques such as cupping (*ba guan* 拔罐), *gua sha* (刮痧) and moxibustion (*jiu* 灸), are commonly used in conjunction with acupuncture. Practitioners may also advise their patients on lifestyle advice, dietary recommendations, and possibly recommend exercises such as *tai chi* or *qigong* (气功).

5.1.1 Herbs

Chinese herbal formulas rarely comprise a single herb, but are rather made up of a combination of raw materials. Herbal formulas come as either patented formulas, which are either factory-made formulas or loose raw materials patients have to boil in water at least twice to create a tea decoction. Patented herbal formulas come in the form of black circular pellets called *wan* (丸), as powders (*san* 散)/ *dan* (丹), or as brownish-green circular tablets called *pian* (片). Herbal formulas are structured in a way where the name has

two parts. The first part comprises either the main ingredient(s) or its action in relation to the disease intended to be treated. The latter aspect usually denotes a decoction (*tang* 湯) or the formula's dispensed form (e.g. *wan*, *san/dan*, or *pian*).¹⁰⁰

The assemblage of an herbal formula has a specific hierarchy for its ingredients. From most important to least important: Monarch (*jun* 君), Deputy (*chen* 臣), Assistant (*zuo* 佐), and Envoy (*shi* 使). The Monarch is the primary ingredient and determines the action in treatment of the pattern or disease. In essence, the Monarch is indispensable to the formula. The purpose of the Deputy is to assist the Monarch in treating the pattern or disease as well as treat tertiary patterns the patient is expressing. The Assistant can help the Monarch and Deputy by neutralizing harsh properties from the Monarch or Deputy, as well as serving as an antagonist to the Monarch. Lastly, the Envoy directs the formula to specific channels of the body and harmonizes all of the ingredients of the formula together (Bensky and Barolet, 1990, pp. 14-15).

Herbal formulas are typically grouped by their actions/strategies (*fa* 法). The actions/strategies are usually to counteract the pattern presented by the patient. Eight specific actions/strategies are listed below in Table 5.9:

Action/Strategy (法)	Chinese	Pinyin
Sweat	汗法	<i>han fa</i>
Vomit	吐法	<i>tu fa</i>
Descend	下法	<i>xia fu</i>
Harmonize	和法	<i>he fu</i>
Warm	温法	<i>wen fu</i>
Clear	清法	<i>qing fu</i>
Disperse/Reduce	消法	<i>xiao fu</i>
Tonify/Supplement	补法	<i>bu fu</i>

Table 5.6 Herbal Actions/Strategies (Bensky and Barolet, 1990, pp. 9-11; Wiseman and Ye, 2002, pp. 182-183)

In addition to the eight strategies, regulatory bodies require students to know more nuanced actions. As I observed and researched the curriculum for Chinese herbs, I came to understand the formulas are organized in more

¹⁰⁰ There are also syrups (*tang jiang* 糖浆), wines (*yao jiu* 药酒), tinctures (*ding ji* 酏剂), and injections (*zhen ji* 针剂) but they are not as commonly used (Bensky and Barolet, 1990, pp. 19-20).

nanced actions within a matrix. Below in Table 5.7 are the sixteen matrices used in CALE.

Formula Classifications	Chinese	Pinyin
Formulas that Release the Exterior	解表劑	<i>Jie Biao Ji</i>
Formulas that Clear Heat	清熱劑	<i>Qing Re Ji</i>
Formulas that Drain Downward	瀉下劑	<i>Xie Xia Ji</i>
Formulas that Harmonize	和解劑	<i>He Jie Ji</i>
Formulas that Expel Dampness	祛濕劑	<i>Qu Shi Ji</i>
Formulas that Treat Dryness	治燥劑	<i>Zhi Zhao Ji</i>
Formulas that Warm Interior Cold	溫裏劑	<i>Wen Li Ji</i>
Formulas that Tonify	補益劑	<i>Bu Yi Ji</i>
Formulas that Treat Phlegm	祛痰劑	<i>Qu Tan Ji</i>
Formulas that Regulate the Qi	理氣劑	<i>Li Qi Ji</i>
Formulas that Invigorate the Blood	活血劑	<i>Huo Xue Ji</i>
Formulas that Stop Bleeding	止血方	<i>Zhi Xue Fang</i>
Formulas that Calm the Spirit	安神劑	<i>An Shen Ji</i>
Formulas that Expel Wind	治風劑	<i>Zhi Feng Ji</i>
Formulas that Reduce Food Stagnation	消導劑	<i>Xiao Dao Ji</i>
Formulas that Stabilize and Bind	固澀劑	<i>Gu Se Ji</i>

Table 5.7 Formula Strategies of CALE (CALE, n.d.)

According to the CAB, eighty-four formulas are to be memorized for the CALE and the NCCAOM requires candidates to memorize one hundred and forty-eight formulas (CALE, n.d.; NCCAOM, 2016b, pp. 38-43).¹⁰¹ Typically, in the United States, herbal formulas are used in conjunction with acupuncture treatment. They serve either as a supplement to an acupuncture treatment and/or a form of treatment used in between sessions to sustain the therapeutic value chosen by the practitioner.

While observing nine schools and attending more than twenty lectures from Chinese herbal courses, I noticed a consistent approach to how the information was disseminated. The lecturer presents the information by either stating the formula or raw material, describes its actions, and lists the ingredients and the roles each ingredient has in regard to the formula. Mostly in California, lecturers would provide the information about the formula or raw material but then stress whether it would be on NCCAOM's national board

¹⁰¹ Please refer to the Appendix for the complete list of herbal formulas required by the NCCAOM and CAB.

exam or CALE. The only variance in this approach was at a Chinese medicine school in Portland, Oregon which described its application of the formulas as found in the *Shanghan zabing lun* (傷寒雜病論) written by the 1st and 2nd century Chinese physician Zhang Zhongjing (張仲景; 150—219). Out of all subjects taught at the Chinese medicine schools, I found the herbal education was primarily taught by Asian Americans, which was in stark contrast to the mostly white lecturers I found throughout my observation of schools. Again, as stated in the previous chapter, there was a de-emphasis on herbs in California compared to the East Coast schools who have either added herbal education to their curriculum or have expanded the curriculum. Either way, herbs is a crucial component to the treatment but still tertiary to acupuncture.

5.1.2 Acupuncture

In TCM, acupuncture treatment protocols are based on *bianzheng lunzhi*. With more than a hundred patterns as listed in Table 5.5, the acupuncture treatment protocol coincides with the paradigm of the pattern as well as with the herbal formulas prescribed. The World Health Organization (WHO), lists three-hundred and sixty-one acupuncture points which reside on the twelve channels or meridians of the body and forty-eight extra points, which is a total of four-hundred and nine acupuncture points collectively (WHO, 1999, p. 13). The twelve channels correspond with the twelve *zangfu*.

It is rare for acupuncturists to needle all four-hundred and nine points, but generally – as shown by WHO – there are at least two-hundred and one commonly used points. Both in California and on the national-level, practitioners refer to Peter Deadman, Mazin Al-Khafaji, and Kevin Baker's 1998 text *A Manual for Acupuncture*. *A Manual for Acupuncture* was one of the few books in America which was not based on the TCM *bianzheng lunzhi*, but was explicitly a channel-based compendium of acupuncture channels and points. As Deadman explains,

I think the book is an interesting blend of classical and modern usage, of theory and empirical practice, of the so-called (and in my opinion misunderstood and mis-named) 'herbalisation' of

acupuncture and deeply acupunctural channel-based practice (P. Deadman, Personal communication, August 1, 2016).

The “herbalisation” Deadman referred to was in reference to the *bianzheng lunzhi* orientation of TCM where the patterns were matched with the herbal prescription and vice versa. Instead, *A Manual of Acupuncture* revolves around a historical analysis of acupuncture points and how they were applied based on various classical and pre-modern texts. Not only was *A Manual of Acupuncture* a historical analysis of points, but it was practical. It was categorized in the classical order-circulation of the *zangfu* as well as two of the Eight Extraordinary/Curious Vessels (*qi jing ba mai* 奇經八脈), Conception Vessel/Ren Mai (任脈) and Governor Vessel/Du Mai (督脈).

Channel	Abbreviation	Phase	Number of Points
Lungs	LU	Metal	11
Large Intestines	LI	Metal	20
Stomach	ST	Earth	45
Spleen	SP	Earth	21
Heart	HT	Fire	9
Small Intestine	SI	Fire	19
Urinary Bladder	UB	Water	67
Kidney	KD	Water	27
Pericardium/Xin Bao	PC/XB	Fire	9
Triple Burner/San Jiao	TB/SJ	Fire	23
Gallbladder	GB	Wood	44
Liver	LV	Wood	14
Conception Vessel/Ren Mai	CV/RN	N/A	28
Governor Vessel/Du Mai	GV/DU	N/A	24

Table 5.8 Classical Order-Circulation, Phase, and Number of Points on Each Meridian

Each point has its written anatomical location measured by a Chinese measurement system. It used anatomical landmarks of the body along with a picture to show: approximate location, depth of needle insertion, actions, indications from classical and pre-modern texts, as well as contraindications where needed, commentary, and combinations. Practitioners in the profession have complimented its accessibility compared to the archaic texts, such as *An Outline of Chinese Acupuncture*, *Essentials of Chinese Acupuncture*, or even

the 1966 version of Felix Mann's *Atlas of Acupuncture*. An epistemology of Chinese medicine in the United States was constructed by *A Manual of Acupuncture*.

With the acceptance and adoption of *A Manual of Acupuncture* into schools and regulatory bodies, Deadman, Al-Khafaji, and Baker unintentionally were responsible for the construction of an epistemology which was additional to the standardized model, but could also serve as an alternative to the pattern-based *bianzheng lunzhi* of TCM. In theory, Chinese medicine schools – especially those with acupuncture studies – could apply *A Manual of Acupuncture* as the basis for their curriculum. Since *A Manual of Acupuncture* is channel-based, it adds a layer to the classification of diseases and symptoms found in channels and vessels (*jing luo* 经络). This layer consists of a network of channels (*jing mai* 经脉) and connecting vessels (*luo mai* 絡脈) throughout the body. The term *jing luo* often refers to the twelve channels usually found on acupuncture mannequins, but *A Manual of Acupuncture* introduces it in addition to the twelve primary channels, the twelve corresponding Divergent (*jing bie* 经别) and Sinew channels (*jing jian* 腱别) as well as the Eight Extraordinary/Curious Vessels. It also has a vast array of information on the multitudinous network of vessels.

Though *A Manual of Acupuncture* was a practical guide to acupuncture, it served as an immense compendium of knowledge. Readers have also simplified its primary content to create the “Big Picture.” In most schools, even the non-TCM schools, the “Big Picture” consolidates the most pertinent theoretical information on acupuncture in an accessible format. “Big Picture” highlights all the essential categories of points needed to treat someone. These categories primarily consist of the Five Antique Points (*wu shu xue* 五输穴), twelve Source Points (*yuan xue* 源穴), twelve Front-Gathering and twelve Back-Transporting Points (*mu xue* 募穴 and *shu xue* 俞穴), as well as more esoteric points such as the 7th century physician Sun Simiao's (孙思邈) “Thirteen Ghost Points” (*shi san gui xue* 十三鬼穴) and “Window of Heaven/Sky Points” (*tian you xue* 天牖穴), both used for psychological illnesses. They can be found in the second chapter of the *Divine Pivot* (*Lingshujing* 灵枢经), which is the

acupuncture portion of the *Inner Cannon Yellow Emperor (Huangdi Neijing 黄帝内经)*.

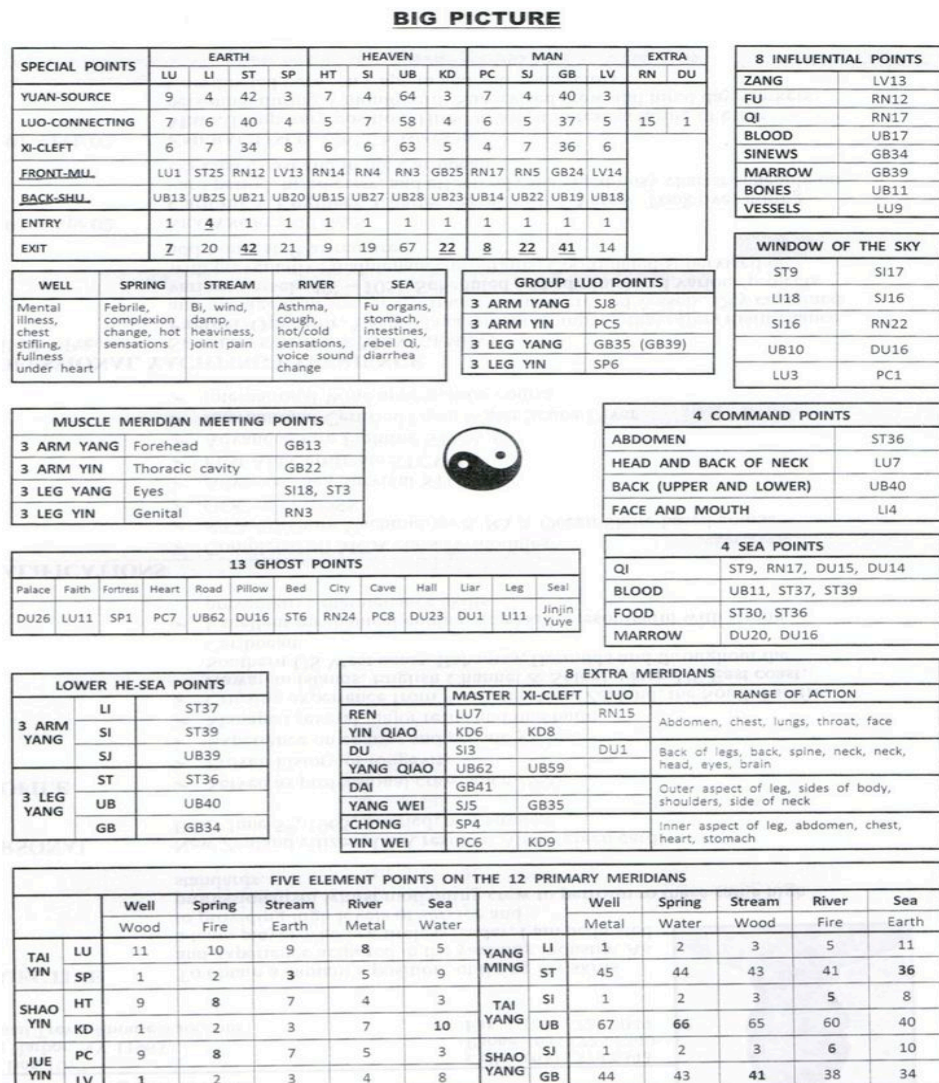


Fig. 5.4 "Big Picture" (Kim, 2014, p. 140).

In theory, with the combined sources along with the curriculum at a Chinese medicine school, students should be able to diagnose and treat a patient. The common pedagogical approach I encountered in TCM schools was a medical praxis based on primary sources and informed by the lecturers' personal experiences in the clinic.

In Fig. 5.5, the progression of a practitioner to diagnose and treat a patient at a clinic is outlined.

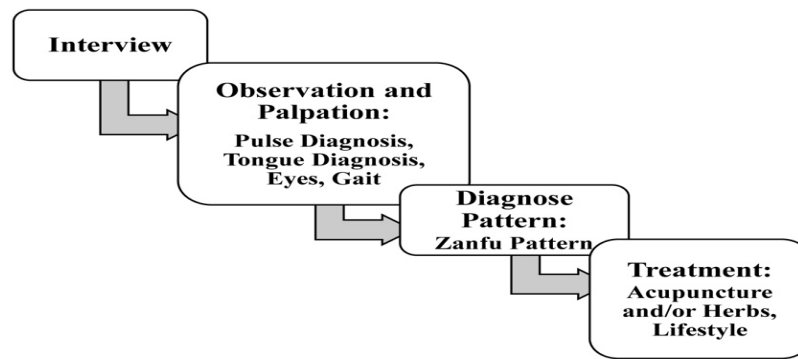


Fig. 5.5 Steps of a Practitioner for Diagnosis and Treatment

I had the opportunity to receive treatment at a few of the TCM schools throughout the United States. Similar to their systematized epistemology, their procedures for diagnosis and treatment were mostly consistent. Below is my experience receiving treatment at a TCM school's student clinic in Southern California.

California Chinese medicine schools are noticeably more ethnically diverse than those of other states. This student clinic had an array of orientalist motifs on the walls and Chinese scripts and scrolls with quotes from various passages of Daoist and Chinese medical texts. This was common for many of the clinics I visited, but this clinic had more of an emphasis on the founders of the school. An interesting component about this clinic was when I was filling out the intake forms, which vary from school-to-school, I noticed quite a few of the patients used crutches and others were clearly in pain. I assume they were seeking treatment to alleviate their pain.

The student clinic was aware I was an anthropologist and a licensed acupuncturist who was researching their school. Given this information, the student clinician was aware of my knowledge of techniques and points which were performed on me. This put an interesting twist to my research because it allowed for the institution to choose a fitting student clinician and quite possibly change the way the student clinician interacted with me.

A common trait I noticed with TCM practitioners is the use of white coats. This was certainly the case in student clinics. Interestingly, white coats are falling out of favor by biomedical physicians in the United States and United Kingdom. In every interaction I had with medical doctors in the United States and in the United Kingdom, none wore white coats.

Just as in all of my interactions seeking acupuncture treatment, the student clinician asked me a series of questions; some relating to my chief complaint while others seemingly unrelated,

but in all reality a part of the *zangfu* pattern differentiation they are trying to assign me into. After an interview of about twenty-minutes the student clinician began to ask me about my diet. I told him I was vegan; he was not pleased.

I decided to become vegan after I received the results from a blood test administered by my allopathic biomedical doctor who diagnosed me with non-alcoholic fatty liver disease (NAFLD) with elevated triglycerides levels. Her and I both agreed adopting a vegan diet was a suitable route given my circumstance. I told the clinician this, but he did not seem to have listened and began to lecture me on how, according to Chinese medicine, it was unsuitable for someone to follow a vegan diet. He went on to claim that he strongly advised all of his patients, who I assume were limited considering it was his only year as a student clinician, to eschew a vegan diet.

This put me in an awkward position because I was well aware of the mixed claims in Chinese medicine both in support of and against eating meat. I had more than fifteen years of experience working with and treating people in Viet Nam, Bhutan, the United Kingdom, and the United States and never told anyone so adamantly to stop their dietary choices. Either way, I just let him carry on with his tirade against my vegan diet choice.

After he finished his lecture, he began to take my pulses by examining both my left and right pulses simultaneously for roughly three minutes. Then, he briefly examined my tongue. Soon after, he informed me he had to leave and find the clinic supervisor to examine my pulses and tongue. When he came back, he was accompanied with one of the clinic supervisors, who was also wearing a white coat. The supervisor was an African American acupuncturist who evidently had been practicing for a few decades. He did not say much and began to palpate both of my pulses on my left and right wrist simultaneously for more than five minutes. He examined my tongue for a bit longer than the student clinician had. He said "Thank you." Afterwards, the supervisor turned to chat with the student clinician in an inaudible mumble. Nodding his head in agreement, the student clinician looked at me and told me to undress to my underwear and put on the medical gown they provided.

The student stepped out for a few minutes then returned with a marker. He said he had to mark all of the points he is going to needled before he actually needles me and retrieve the clinic supervisor to approve the markings. He marked the points and left for what seemed like fifteen minutes to find the clinic supervisor. When they arrived back, the clinic supervisor checked all of the points and approved the student to needle me. The student clinician swabbed all of the points with alcohol and

proceeded to open his pack of needles. I noticed something intriguing: he was not using a guide tube, which is a tube used to lessens pain associated with insertion of needles. When an acupuncturist does not use guide tubes, it is called “freehand.” From my experience, the freehand technique hurts a little bit more than using a guide tube. This student had an impressive needling skill where I did not feel any pain when he inserted a needle. I could not believe it, so I told him to needle me while I look and sure enough, it was painless.

Once he finished needling me, the student allowed me to rest for roughly an hour. In an hour, I experienced a heaviness throughout my body and then uncontrollable twitching in my right *vastus medialis* muscle. It was not painful or uncomfortable but it was noticeable. After an hour, the student clinician came back in and took out my needles and said good-bye.

I did not receive any relief for my chief complaint, but I did feel a little more relaxed. I walked out of the student clinic and saw in the window of the student store a copy of Cheng’s *Chinese Acupuncture* and Maciocia’s *Foundation of Chinese Medicine* with advertisements for *A Manual of Acupuncture*’s new application was recently launched for “smart devices” (Field notes, August, 2015).

My experience receiving treatment at a TCM clinic highlighted the potential authority practitioners may potentially assume. Maybe it was their sense of legitimacy wearing white coats or maybe it is the whole notion of seeking medical treatment from them; there was certainly this position of authority the student clinician tried to assert, despite his limited training. It seemed there was a lack of agency the clinician set up for the patient. I had to question, if I was not a practitioner or knew nothing about Chinese medicine, what choices would I actually have in my own care?

When I was at the school in Southern California, I realized the information in *Foundations of Chinese Medicine* and *Chinese Acupuncture and Moxibustion* were quite similar but *A Manual of Acupuncture* is rather incompatible with the former two texts. The reason for this was it was not until systematization of TCM in the 1950s when acupuncture and herbs were combined, especially through the construction of *Outlines of Chinese Medicine* (Scheid, 2002, p. 217). Giovanni Maciocia also explains,

One thing I would say is the fact that acupuncturists [in California] have to study herbal medicine and as you know in China, you

don't have to. You don't have to and there is no reason whatsoever why as an acupuncturist. And of course every acupuncturist knows the main picked remedies. They would know . . . But you don't need to know a detailed study of herbal medicine if you want to be an acupuncturist (G. Maciocia, Personal communication, July 15, 2015).

This discrepancy was something many students had to navigate and they managed to do it in a few ways. The first was to use *A Manual of Acupuncture* primarily as the reference for the "Acupuncture and Point Location" module of the NCCAOM's national boards and as a reference for point location in the CALE. In addition to its practical application, which at the time of my research had just transitioned as a smart device application (app), it was used in almost every student clinic and was a reliable companion for point location. *A Manual of Acupuncture* was also the basis for much of the theoretical framework used to describe the actions and purposes of points as well as for diagnosing complicated diseases found in the student clinic. While *Foundations of Chinese Medicine* served as the primary theoretical text at the national level. *Chinese Acupuncture and Moxibustion* provided the knowledge base in California. In fact, coming from the East Coast, I was surprised to see many of the California students more concerned with memorizing the patterns in *Chinese Acupuncture and Moxibustion*, than with studying *Foundations of Chinese Medicine*. Regardless of the text, there have been tools to help students pass the exams and more importantly, understand the logic of the exams.

Starting in 2003, Richard A. Feely and Sebastian Palmigiani have created a resource for students who are about to take CALE or NCCAOM's national board exams called TCMTests.com. TCMTests.com is a subscription-based online platform which provides sample exam questions which resemble those on either one of the exams. Two separate subscriptions are available for either taking NCCAOM national boards and/or for CALE. Students throughout the United States have used TCMTests.com as a primary platform outside of the textual sources, to help them pass either one or both of the exams.

A unique aspect was two of the three sources are of British origin but given the acupuncture regulations in the United States, none of the authors were legally able to practice there. Put simply, the ones who constructed the

majority of the knowledge-base of Chinese medicine in the United States could not legally practice acupuncture in the country. Maciocia and Deadman were also colleagues in the United Kingdom.

Besides their paired texts for NCCAOM's national board examination, Giovanni Maciocia and Peter Deadman attended the same acupuncture school in the United Kingdom, the International College of Oriental Medicine (ICOM) during the early-1970s. ICOM was founded by the late Richard van Buren, a student of the French acupuncturist and Sinologist Jacques Lavier (Barnes, 2013, p. 292). Jacques Lavier was known for translating Wu Wei-Ping's *Chinese Acupuncture*, gave lectures on acupuncture throughout England during the 1960s, and was mostly responsible for the introduction of Five Elements acupuncture in the United Kingdom (Eckman 1996, 145). Besides his education with Lavier, it is unclear where van Buren received his Chinese medicine education. The issue of lineage and legitimacy would surface again with his colleague J.R. Worsley, but in both cases, the extent of their education and their lines of transmission would remain an enigma. But van Buren and Worsley had cult-like charismatic personas and attracted orientalists and members of Britain's counterculture. As Peter Deadman mentions,

In fact, the schools – especially van Buren's and Worsley's (Five Element) - had very mystical and cultish aspects. I found it deeply confusing and depressing, especially when ignorance was masked as mystery, a trick van Buren was especially fond of. I felt very isolated and frustrated because it all seemed very transparent to me (the ignorance, obfuscation and cultishness) and yet many students and patients seemed to fall for it. By that age (I was 30 when I qualified) I'd seen more than my fair share of cults (P. Deadman, Personal communication, August 1, 2016).

Deadman was not alone in his disenchantment. Others at ICOM discovered behind van Buren's charismatic authority, much of curriculum was empty. Limited by the curriculum at ICOM, Maciocia led a group of three other British acupuncturists, referred by Maciocia himself as the "Gang of Four." They included Deadman, Julian Scott, and Vivienne Brown who were all to take part in an intensive training course in mainland China for three and a half months (G. Maciocia, personal communication, July 15, 2015). It occurred to the four the education they received in China was immensely superior than the

education they received at ICOM, even if it was only for a few months. With the stark difference in curriculum, members of the “Gang of Four” decided to teach what they received in mainland China and disseminate it to British acupuncturists as ‘post-graduate’ courses. Deadman explains,

Although it was only three and a half months, it was a period of intense learning for me, since by that time I had been practicing for a couple of years and was very aware of all the things I didn't know. When we returned to the UK four of us were so energized and excited, we decided to start running one year 'post-graduate' courses for European practitioners who for one reason or another hadn't had any grounding in Chinese medicine. In practice these were mostly people who had qualified from Worsley's five element school. Four of us worked as a fun and effective team – Giovanni, Julian Scott, Vivienne Brown and myself. Over the years we taught a great number of practitioners (P. Deadman, Personal communication, August 1, 2016).

Besides an author of *A Manual of Acupuncture*, Deadman was also one of the founders of the first natural food cooperative in Brighton called Infinity Foods. It is still one of the largest suppliers of organic bulk food products in the United Kingdom. In 1979, Deadman also established the renowned *Journal of Chinese Medicine*, which is still in circulation. Maciocia furthered his education in Chinese medicine by embedding himself within the Nanjing University of Chinese Medicine (*Nanjing Zhongyi Yiyao Daxue* 南京中医药大学) throughout the 1980s. As described by Maciocia, Nanjing University of Chinese Medicine was known for its “warm disease” (*wen bing* 温病) studies. After ICOM, Maciocia's first experience with Chinese herbal medicine was with the American counterculture pioneer Ted Kaptchuk. Maciocia brought Kaptchuk to speak in the United Kingdom almost on a monthly basis from 1986 to 1987. Soon after, Maciocia would expand his Chinese herbal studies at Nanjing (G. Maciocia, Personal communication, July 15, 2015).

The NCCAOM's “Chinese Herbology” module is a mixture of Dan Bensky and Andrew Gamble's *Chinese Herbal Medicine: Materia Medica* and Bensky's work with Volker Scheid, Andrew Ellis, and Randall Barolet in *Chinese Herbal Medicine: Formulas and Strategies*. Elements of Maciocia's *Foundations of Chinese Medicine* and Cheng's *Chinese Acupuncture and Moxibustion* can also be seen on the exam. Students reported finding a lot of

content in the “Chinese Herbology” module from John and Tina Chen’s *Chinese Medical Herbology and Pharmacology*. The exam had fragments of Xinnong Cheng’s *Chinese Acupuncture and Moxibustion* and Ted Kaptchuk’s *Web That Has No Weaver* but again, *Chinese Acupuncture and Moxibustion* is the primary source for CALE.

With the overwhelming majority of schools in the United States driven by the epistemology of TCM, there is a burgeoning interest in Five Elements and Classical Chinese Medicine schools. Though many of the Classical Chinese Medicine schools have started in the past twenty years, the Five Elements epistemology has been in the United States since Chinese medicine began professionalization in the 1970s with Bod Duggan and Dianne Connelly’s Traditional Acupuncture Institute (TAI) in Maryland.

5.2 J.R. Worsley’s Five Elements

Five Elements or Five Element Acupuncture is the second most predominant epistemology in the United States. As of 2017, there were two explicit Five Element schools, Academy for Five Element Acupuncture (AFEA) and Institute of Taoist Education and Acupuncture (ITEA). Since Bob Duggan and Diane Connelly sold most of TAI/Tai Sophia to Maryland University of Integrative Health, the Five Element roots have been slowly de-emphasized and focus put towards adopting more of the standardized model of Traditional Chinese Medicine.

Five Elements was created by the British acupuncturist Jack Reginald (J.R.) Worsley (1923-2003). Worsley was from a working-class family in Coventry, United Kingdom. Little is known about his formal education in medicine, but anthropologist Linda Barnes wrote he studied physiotherapy, osteopathy, and naturopathy while serving in the British Army as an education officer (Barnes 2013, 302). In the 1950s, Worsley went to study acupuncture throughout Asia with various Asian acupuncturists coming from Japan, Taiwan, Singapore, and Korea. Then, in 1959, Worsley established the College of Traditional Acupuncture in Leamington Spa, UK, near Coventry. Similar to Deadman’s experience with Richard van Buren, historian Vivienne Lo, a

student of Worsley in the 1970s and 1980s, shared a similar sentiment concerning Worsley,

In a creative mix designed to appeal to those who were seeking alternative lifestyles (aligned with the environmentalism of the time, with women's 'our bodies ourselves' kind of culture, yoga, taiji etc), JW's acupuncture incorporated many therapeutic concepts and treatment modalities that borrowed from psychotherapy, homeopathy, osteopathy. He was himself a Christian, and talked a lot about the healing power of love. All of this was fused with his interpretation of the 'Five Elements' as a correspondence medicine with a strong emphasis on the emotional correspondences as causative of disease. Thus we were taught to look for the 'Casuative Factor' as emotional trauma and/or emotional 'types'. This involved in-depth interviews about the patients' lives and life experiences. He also emphasized complexion diagnosis, and body odor, as well as the importance of pulse reading. We did not do tongue diagnosis, as was growing on the mainland at that time. Other techniques that testify to JW's eclectic training and exposure to a variety of traditions included the 'Japanese akabane' diagnosis, and various forms of abdominal diagnosis that likely had some relationship with Japanese medicine. We used a lot of moxibustion. We also treated people for many weeks, once a week, or more. This is very different from what I know from mainland Chinese institutional work now (V. Lo, Personal communication, March 13, 2017).

Many of the theoretical concepts Lo mentioned are soon covered, but put simply, Worsley and van Buren were charismatic figures who encompassed a European orientalism built on the angst and curiosity of the British counterculture along with their own European twist to Chinese medicine. Just as Lo mentioned, Worsley's "eclectic training" was indeed a hodgepodge of various Asian traditions of acupuncture. Although he attributed most of his knowledge to a Japanese acupuncturist named Bunkei Ono, and presumably, a prominent Taiwanese acupuncturist by the name of Hsui Yang-chai, the extent of his education with the acupuncturists remains in question (Eckman 1996, 97-98, 166, 170). Medical doctor and acupuncturist Peter Eckman discovered, even though Worsley never attributed his knowledge directly to Japanese acupuncturists such as Honma Shohaku (1904-1962) and Madame Hashimoto Masae (1899-1981), there was strong evidence which points to their influence. Fig. 5.6 illustrates the similar ontology Worsley adopted from his

Japanese predecessor Honma Shohaku, who had his chart (on the left) distributed throughout Europe. Ideas such as “body, mind, and spirit” were brought up in previous contexts in relation to acupuncture prior to Worsley’s teachings by the founder of macrobiotics Georges Ohsawa and even the Canadian Protestant missionary W.R. Morse (Ohsawa, 1969; Eckman, 1996, p. 210-211).

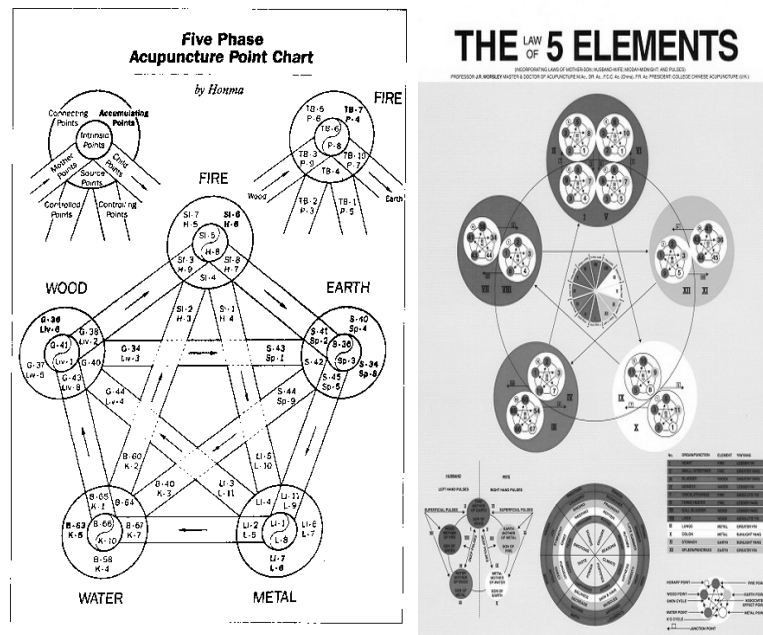


Fig 5.6 Comparison Between Honma Shohaku’s Five Element Chart (Left) and J.R. Worsley’s Five Element Chart (Right) (Eckman 1996, 114, 121).

Two components are emphasized in the Five Elements epistemology: the Spirit (*shen* 神) and the Five Elements (*wu xing* 五行).¹⁰² The Spirit, which is commonly referred to by its Chinese name *shen*, is best described in one Five Element textbook, *Five Element Constitutional Acupuncture* as “the animating or vital principle of man,” which encompasses translations of Chinese medicine scholars to mean “mind,” “spirit,” or “spirits” and “includes the mental and spiritual aspects of all the Organs” (Hicks, Hicks, and Mole, 2011, pp. 14-15). The Five Elements are usually represented by a pentagram consisting of Fire, Earth, Metal, Water, and Wood as seen in Fig. 5.7. Without getting too detailed, Five Element acupuncture theory has five primary *shen* ascribed to

¹⁰²J.R. Worsley translated 五行 as “Five Elements” rather than “Five Phases” or “Five Movements.”

the Five Elements, namely Fire-*Shen* (*shen* 神), Earth-*Yi* (*yi* 意), Metal-*Po* (*po* 魄), Water-*Zhi* (*zhi* 志), and Wood-*Hun* (*hun* 魂).

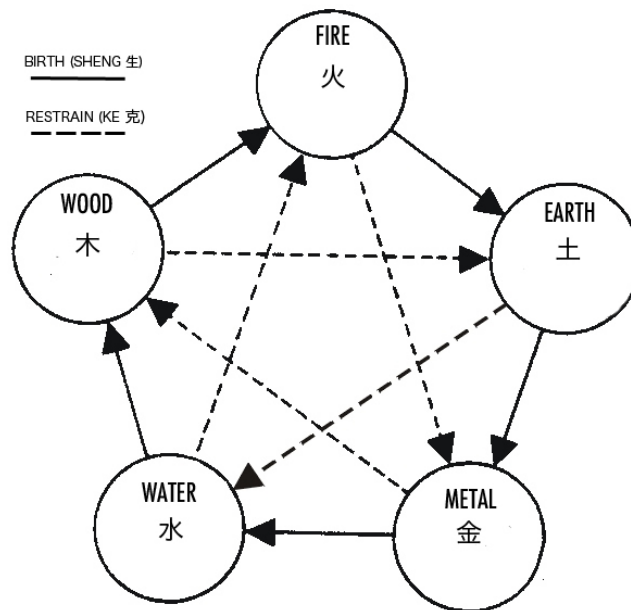


Fig. 5.7 Basic Model of Five Elements from Five Element Tradition

Just as in traditional *wu xing* configuration, the same *zangfu* are associated with each element; however, for Five Element adherents, they refer to the *zangfu* as “Officials.” In addition, Worsley assigned all “Officials” to have a corresponding numeric as seen in Table 5.9.

Numeric	Officials/Organs	Element
I	Heart	Fire
II	Small Intestines	Fire
III	Bladder	Water
IV	Kidney	Water
V	Circulation/Sex	Fire
VI	Three Heater	Fire
VII	Gall Bladder	Wood
VIII	Liver	Wood
IX	Lungs	Metal
X	Colon	Metal
XI	Stomach	Earth
XII	Spleen/Pancrease	Earth

Table 5.9 Worsley’s Numeric Organization of the Officials (*Zangfu*) (Eckman, 1996, p.114).

Before I began my research, I discovered the numeric system was quite an enigma, but then I realized it had a practical purpose. The Executive Director of a Five Element school explains,

We have a lot of jargon. We are jargon full at Five Elements. Even the nomenclature for the channels was out of benevolence from protecting the patient from undue stress. We'll say "We're going to work on I - II today." As oppose to "Heart and Small Intestine," where patients would ask, "What's wrong with my heart?" How patients can latch onto that (Personal communication, January 25, 2016).

Much of the theoretical structure is based on the birth (*sheng* 生) and restrain/overcoming (*ke* 克) cycles. The tonification/supplementation (*bu xue* 补穴) and dispersion/reduction (*xiao xue* 消穴) points are crucial in the treatment. Just as important are the Five Antique Points (*wu shu xue* 五输穴). In the most basic acupuncture theory and in Worsley's Five Elements, the Five Antique Points correspond with the Five Elements. The Zang-Organ Channels' Well Points begin with Wood while the Fu-Bowel Channels Well Points begin with Metal as seen in Table 5.10.

	Well	Spring	Stream	River	Sea
Zang-Organs	Wood	Fire	Earth	Metal	Water
Fu-Bowels	Metal	Water	Wood	Fire	Earth

Table 5.10 Five Antique Element/Phase Correspondence

The Five Antique Points are important in Five Element acupuncture treatment because they provide the foundation to understand the familial archetype used in understanding disease, which in the Worsley's Five Element chart seen on the left in Fig. 5.8 is referred to as "Incorporating Laws of Mother-Son; Husband-Wife; Mid-Day-Midnight; and Pulses." The Mother-Son relationship is the relationship between the chosen element and the following clockwise element. For example, when Fire is the Mother, Earth is its Son or if Earth is the Mother then Metal is the Son, etc. Fig. 5.8 shows each element contains a *wu xing* pentagram which has the acupuncture point number in the associated element based on the Five Antique Points according to the Zang-Organ and Fu-Bowel. For example, in the lower left portion of Fig. 5.8 the Roman numeral III represents Urinary Bladder and a *wu xing* pentagram

Receiving acupuncture treatments at a Five Element school was unique where the most apparent characteristic was the intimate relationship clinicians try to provide for their patients. This was expressed through clinicians embracing (hugging) all of their patients. Personally, I found it a bit invasive and when the clinician went to hug me at first, it caught me off guard. It also seemed the clinicians were subtly forced to hug, which resulted in what I can only refer to as awkward.

The second most apparent characteristic of a Five Element treatment is its length. At the TCM schools, my session's initial intake and treatment was a total of one hour and a half, sometimes extending to two hours. At the Five Element school the session lasted three and a half hours. Just to check if this was the norm, I made an appointment at another Five Element school and the receptionist told me that I would need at least four hours for an initial treatment.

The treatment began with a series of questions; some had relevance to the issue I was seeking treatment for and others did not. There were a few questions relating to my physical pain but a considerable bulk of them pertained to my emotional state and how I reacted to certain emotional stresses. In all honesty, it felt as if I were in a psychotherapy session.

Then, after an hour intake, I had my pulses read. Their technique was to read the pulses on each wrist at separate intervals. This was done by positioning my hands in a manner as if I was shaking the clinician's hand, then they would palpate my pulses with their other hand. The clinicians paid a considerable amount of attention to my pulses and after five to ten minutes went on to palpate my other hand's pulse. After taking my pulses, the clinician briefly examined my tongue and told me she was going to speak with the clinic supervisors which, with my experience at other Chinese medicine school's student clinics, was the norm. Then, the clinic supervisor accompanied the student clinician to check my pulses and observe my tongue, and asked me a few additional questions while conversing with the student clinician on their observations. The supervisor advised the student to perform an "AE" treatment, which required me to remove my shirt and the student clinician would superficially needle certain points on my back. These were roughly 0.5" lateral on both sides of my spinous process on the Back-Transporting Point, which they referred to as the "Associated Effect Point." From my understanding, if they find an erythema around the needle, it signifies Aggressive Energy and they would needle me accordingly and if not, they would need to figure out another treatment plan. After they placed the needles on my back, they were surprised to find no erythema. In other words, no AE so they begin to remove the needles. Once the needles were removed from my back, they asked me to

remove my trousers and socks and put on a medical gown. They both left, but before their departure, the clinic supervisor said the student clinician would return with a treatment plan.

Devising a treatment plan usually takes a half hour. When the student clinician returned, she marked the acupuncture points she planned to needle and went to find the clinic supervisor to confirm all the points were in the correct position. Oddly, finding the clinic supervisor for the approval to needle took a long time. Upon his return, the supervisor examined the markings and made a few comments about their position, then gave the student approval to needle. The student clinician wiped an alcohol swab in the areas of needle insertion and began to pin my body. She placed all of the needles in my body and left me to rest for roughly forty-five minutes.

I noticed slight sporadic muscle twitches in my left lower *latissimus dorsi* muscle sporadically throughout my rest and manage to slip into a deep sleep. When the student clinician returned she seemed in a bit of a rush and quickly removed my needles. I dressed and made my way out of the clinic when she stopped me and gave me another awkward hug. After the treatment, I realized the whole interaction seemed empty and I did not know what to expect. In the following days, I did not find any substantial relief to my initial complaint (Field notes, January, 2016).

Coincidentally, during my visit at a Five Element school, I was diagnosed with another unique diagnosis Five Element practitioners have called “Possession.” In *Five Element Constitutional Acupuncture*, borrowed from its ancient usage,

Possession described someone from being fully or partially taken over by an entity of some kind. This caused people to no longer be fully in control of a part of themselves... The use of the term ‘possession’ by a Five Element Constitutional Acupuncturist has been broadened. It is used to include many other ways that a person may be out of control of their mind and spirit. Signs and symptoms can manifest along a spectrum from obsessive thoughts or behaviour to the kind of possession by spirits described above (Hicks, Hicks, and Mole, 2011, pp. 244-245).

To get more of an idea on “Spirit” and “Possession” from a Five Element perspective, I asked an Executive Director of a Five Element school, who was also an alumnus of the school, what the words “Spirit” and “Possession” meant to her. She cited a passage from the *Suwen*,

Because of the system of medicine we practice can be taken back to the *Neijing*, especially in *Suwen* – some in the *Linshu* – but particularly in the *Suwen*. There is a phrase used “In order for acupuncture to be thorough and effective, one must first cure the spirits...” Working at the level of spirit underpins almost of all of Chinese medicine if you go back to the classics. And that’s one of the huge difference between classical acupuncture treatments and post-Communist Traditional Chinese Medicine (TCM) tradition... Spirit is something that comes to us. It’s from the heavens, divine in nature. We get what’s called a “Heavenly Mandate” and the work of the spirits that move through us. There is a spirit that resides in the Yin-Organs that is a flavor or an aspect of a universal, *shen* or spirits or consciousness. It is those flavor of those spirits that give rise to the title in charge for each of the Officials, that give rise to the flavor of that element. So that ties in very nicely with the concept of Causative Factor or Constitutional Factor as I have chosen to look at it. Somebody comes into this existence with one of those elements as being ‘front and center.’ It is lens that they see the world. Why would that be? Because each of the spirits have little bit of work to do. And so you’re coming in and your lens is green, your element is Wood, then we’re talking about the *hun*. How the *hun* works in terms of ‘new birth,’ ‘new beginnings,’ creativity, vision, planning, strategizing. It flavors the entire element (Personal communication January 25, 2016).

What I gathered from the director was the Five Element interpretation of “Spirits” is a blend of both Daoist and Confucian concepts put into practice. More than just the *zangfu*, Five Elements formulate a heterodoxy to TCM blurs Chinese religious and philosophical systems to understand the body. Seen with Classical Chinese Medicine traditions, the *Neijing* (short for *Huangdi Neijing* (黄帝内经)) and in this case the “Mandate of Heaven” (*tian ming* 天命), serves as doctrinal authority which legitimizes beliefs and practices. Whether a direct transmission from Worsley or not, both religious and philosophical systems also validate a central theme of Five Element, which is Constitutional Factor, commonly referred to as “CF.”

As a hallmark to the Five Element tradition and as Lo mentioned before, “CF” is often the “root” of disease in patients. *Five Element Constitutional Acupuncture* has noted Worsley referred to it as “Causative Factor” “because, as it is the primary imbalance, it ‘causes’ other Elements to become

imbalanced” (Hicks, Hicks, and Mole, 2011, p. 18). “CF” is also explained by senior practitioner Neil Gumenick:

The causative factor does not change from one element to another, regardless of how symptoms change with time. Therefore, the thrust of our treatment is to help, support and restore the balance of the causative factor in the exact way needed by each unique and individual patient. In this way, symptoms (which are only the expression of the underlying imbalance) resolve naturally. No two patients are ever treated the same, even those presenting identical symptoms or having the same causative factor. Treatments are rarely, if ever, repeated on the same patient. If a treatment is successful in moving a patient from step A to step B, there is no need to retrace those steps. We need to move to step C and so on as the journey toward health continues (Gumenick, 2001).

It does not seem Worsley was the originator of “CF.” Instead, much of Worsley’s notions such as “CF” and the “Officials” arose from the early-20th century Canadian Protestant missionary William Reginal (W.R.) Morse (1874-1939), who published several books on Chinese medicine. As Eckman pointed out,

He [W.R. Morse] is of interest because in addition to focusing on the moral force of Christianity in healing, he specifically mentions the terms “body, mind, and spirit,” “causative factor of disease,” and the “Officials,” all of which are “technical terms” used in LA [Five Elements] (Eckman, 1996, p. 176).

The adoption of ideas and practices by Worsley is not necessarily wrong, but it calls into question to what extent are the ideas actually his own. Moreover, it substantiates the orientalism which had been a part of acupuncture’s professionalization in the United States, where he took various ideas of Asia and then placed himself as the authority of a specific tradition. Through Five Elements, a tangible lens to view health and disease is unraveled by its adherents. With each element having essential “flavors” to its Spirit, the Five Elements tradition’s “Spirit” has a spectrum from virtue to pathology. The director continued,

The way that I hold that and many of us at the school hold that, everybody in their element and in their spirit is in a spectrum between pathology and virtue. Your element is expressing itself,

sometimes pathologically, getting angry and frustrated at everything versus when you encounter an obstacle, being able to flow around that obstacle in order to generate benevolence. The virtue of the element Wood is benevolence, the emotion is healthy assertion when it's there and anger and frustration when it's 'out of whack.' So the idea to being able to see somebody as a complete being: body, mind, and spirit; recognizing a lot of problems in the body, in the mind, come from imbalances in the Spirit. The inability to access it or to move freely through you, that sets us up to work at that level. I know you heard about [acupuncture] points. We talk about points in terms of their function but also about their essence or their spirit... So we can use points to talk about that [spirit] and touch people in that way. Bring an element in balance so their working more from virtue than pathology. What we all find and part of the reason what makes this medicine seem like magic that by working at that level, bringing an element into balance, allowing the spirits to move freely; then their physical pathology evaporates. We don't need to chase after symptoms because we're working perhaps at a deeper level that will be more impactful for them... (Personal communication January 25, 2016).

Though the bulk of what she described seemed to come from a more abstract and theoretical level, she assured me the school was indeed addressing the physical realm of disease. The director continued,

. . . The other piece that I'm really working toward and also with the help of these faculty that are helping us with the development of our curriculum is what happens if it is a purely physical thing? I think Five Element has had a reputation of being elitist, only working at the level of the Spirit and not really caring about the body, well that's just not true. So our goal is to help students correctly identify what level they need to be working and know how to do that (Personal communication January 25, 2016).

Although the Five Element school is aware of its reputation for being from the more abstractly esoteric traditions of Chinese medicine, it resolves this issue by assisting students in identifying and working with the three levels of body, mind, and spirit. In a way, the term "spirit" in reference to "mind, body, spirit," reflects more of the "spiritual, but not religious" sentiment and places the Spirit as an extension of a holistic body, much of which TCM has lost. Yet, because of Five Element's esotericism, I found its relationship with the physical body was quite profound. From the onset, Five Element practitioners are taught a phenomenological awareness through the acronym CSOE, which stand for:

color, sound, odor, and emotion. Practitioners are taught to identify illness and disease from how the patient presents these four aspects in correspondence to the Five Elements. This is in stark contrast to TCM schools which, unless it was a class on *shen* or the Spirit, mostly dealt with the memorization of *bianzheng lunzhi*. Reverting back to my conversation with the director of the Five Element school, Five Elements, especially in relation with the Spirit, deals with the different levels of the body. It is especially intriguing when it comes to Five Element's thoughts on "possession."

In terms of possession, I have not read it in the Classics so much. I am very curious on where it came from. It's something I learned in the Worsley tradition... So, when you say "Working at the level of Spirit is your number one priority." Yes, we'll deal with your body. Yes, we'll deal with your mind. But we want make sure that everything is good at the level of the Spirit. There is this phenomenon that could occur where there is either another energy body present or what I've read – especially in places like Lonny Jarrett's book *Nourishing Destiny* – is that strong emotions can then become a possession. It's when the emotions, as in the internal and external causes of disease, not the Five Element emotions but the shock or rage or trauma... something that can up from inside of you that blocks your access to your own Spirit. When we diagnose it through a number of things but primarily we look at someone's eyes and if *shen* is present in their eyes. Just because *shen* isn't present, doesn't mean they're possessed but often you'll see that there's a veil between you and that person or their eyes are kind of glossy or their behavior is erratic or bizarre. Their stories are not consistent... So there's a lot of things we look for, so there's usually a lot of distress. When someone has a possession, their ease of being is not there. So we learn these tools for diagnosing it and they literally mean possessed, either by an entity or by a strong emotion, maybe even also by a climate. I know I've treated possession on someone who was struck by lightning. I've treated possession on someone as a child and was resuscitated. There's a lot of ways it can come about. But if you do not clear possession first, you don't have access to the person's spirit. The person doesn't have access to their own spirit, so no treatment can be effective. And that's one of things we found that if you miss it and go through treatment; nothing sticks, nothing changes, the pulses may change momentarily but they revert. So we always want to back and look for presence of that. And there are two different treatment protocols to help clear out the possession and reestablish the person on their 'seat of their throne' in their Heart, the *shen* residing in the Heart, most predominately. One of the treatments is called "ID" for releasing the "Inner Dragons" and one is called "ED" for releasing the

“External Dragons.” There are seven points on each protocol and those points are said to “unlock the Seven Dragons that chase out possession.” It’s all very poetic. And I love to know where it came from! And I love to know why those points in particular. So I know enough to use it and have lots of question. So far in my exploration there hasn’t been anybody to answer those questions. As far as I can tell, that it is particular to the Five Element tradition. Although, I feel like I came close to learning more about it through Heiner Fruehauf and *gu* syndrome. He calls *gu* “possession.” He uses herbs to clear that out, where we have points to clear it out. We don’t ever say those terms to patients, unless the patient also happens to be a student but even in treatment room we don’t say that. We describe some of the initial treatments as “clearing treatments,” setting the stage to “wiping the slate clean.” For people who have it we start with those until we can connect with their *shen* from their eyes and they are present in themselves and then we move on to other clearing treatments (Personal communication, January 25, 2016).

The esoteric nature of Five Elements serves as an alternative to the pattern-based dialectical nature of TCM. Technically, the term “dialectics” (*bian zheng* 辯證) is the same term which translates to “pattern differentiation” (Scheid, 2016, pp. 69-70). It is no surprise Five Elements affirms its system of difference, especially when the standardized model is devoid of religiosity, a component which has been an inherently part of Chinese medicine. In fact, divination practices were one of the most prominent methods of healing in pre-Shang Dynasty. Historians Constance Cook and Donald Harper have found evidence one of the oldest Chinese medical texts called the Day Book (*ri shu* 日書), dating back to the 3rd century B.C.E., tells of potions which consisted of anything from feces, hair, to worms and were mixed with alcohol were ingested, thrown on bodies, or used against visualized demons (Harper, 1985; 1999; 2001; Cook, 2013, p. 25). The continuity of divination practices persists through exorcist techniques in acupuncture. Coincidentally, I had the privilege to be diagnosed as “possessed” at a Five Element student clinic. Here is an excerpt from my notes.

After receiving my treatment for the first time at a Five Element clinic, I routinely ask the student clinicians for my diagnosis and treatment. Since the student clinician seemed like she was in a rush, she did not hand me my diagnosis. Instead, I asked her to send me the diagnosis via email. She wrote,

“We diagnosed you as a Fire CF, specifically a Small Intestine CF. The treatment Francine [anonymized name] and I gave you yesterday was the Song of the 7 Internal Dragons a/k/a IDs - it is a treatment for possession and is one of the major blocks to treatment, which is why it is often included in the initial "clearing" treatments some patients need. I'd be happy to talk to you more about possession and the songs of the internal and external dragons if you'd like. Additionally, we tonified the source points on your CF and sister meridian to ground the treatment: I-7 Spirit Gate (HT-4) and II-4 Wrist Bone (SI-4).”

When I met her for the next treatment, the student clinician evaded my question as to what a possession meant. She went through the process of seeing how I felt after the last treatment and checking my pulses and tongue. There was a large part of me which felt guilty for asking her what she meant by possession. Then I realized, as a patient I should at least try to understand why she diagnosed me in such a way. It is my body and/or Spirit we are talking about.

Throughout the treatment, the only actual definition she gave me was towards the end after they removing my needles. She told me possession was manifested by feelings like “you’re not yourself.” I asked her, “What if you don’t believe in a “self” or a “soul” or a “spirit”? She then quickly handed my inquiry to a student observer who was in their 40s. They [anonymizing gender] informed me the “self” relates to the oneness of the Dao and to feel like one’s self is to be in harmony with the Dao.

I paused to process what the student observer said and asked, “What if you’re not Daoist or believe in the “Dao”?”

The student observer replied somewhat shaken, “You don’t believe in a soul or Dao but you’re an acupuncturist?! The soul and self are both Buddhist concepts as well!” Although Buddhism is explicitly an *anātman* (“no self”) movement in India, I just remained silent. I felt as if I committed some reprehensible act. There was a palpable silence in the room and they had me get dressed.

I left the treatment feeling kind of upset about the whole encounter and at the end, I was bid farewell with the same awkward hug I was welcomed with. The whole experience felt automated and I did not feel any relief from the issues which I was seeking care (Field notes, January, 2016).

From my own experience I understood the fragility of the term “possession” which the director of the school referred to. However, it was a characteristic unique to the Five Element tradition. Just as with most of Worsley

ideas, one needs to question the exact tradition he adopted to arrive at the idea of possession and its treatment with acupuncture. Again, Eckman points out Worsley seemed to have borrowed the notion of possession from another missionary by the name of Edward E. Hume, known for his work with Yale-in-China during the turn of the 20th century. In Hume's *The Chinese Way in Medicine*, he writes,

The physician now has all the diagnostic material in hand, and proceeds to ask himself three questions: (1) Is this illness due to a loss of balance between Yin and the Yang, those primal forces that represent the opposing elements in the universe? (2) Are there evil spirits present whose hostility has resulted in disease? (3) Are there organic disturbances due to heat or cold, to dry conditions or damp, or to other influences in the environment that known to be capable of producing disease? (Hume, 1940, p. 121; Eckman, 1996, p. 178)

The Seven Dragons treatment of Five Element is a subtle hint at the religiosity present. In theory, the Seven Dragons are as follows, External Dragons: DU20, UB11, UB23, UB61 and Internal Dragons: RN14 to RN15, ST25, ST32, ST41 (Eckman, 1996, p. 213). If perceived as a form of shamanism, the Seven Dragons technique can be seen as an exorcism. According to the *Oxford English Dictionary*, the term "exorcism" refers to "The expulsion or attempted expulsion of a supposed evil spirit from a person or place" (Exorcism, n.d.). If an acupuncturist "unlocks the Seven Dragons that chase out possession," by definition, does this not mean the acupuncturist is performing an exorcism? From my encounters with Five Element, I had the impression it was a blend of acupuncture and shamanism, and I am not alone. Eckman comments on Ted Kaptchuk's experience with J.R. Worsley,

Ted Kaptchuk mentioned to me, after watching Worsley at work, that he thought Worsley was the greatest shamanic healer he had ever seen. I think this is an aspect about our profession that needs to be brought out into the open, and Worsley has constantly stressed that developing the deepest possible rapport with patients, and then allowing yourself become an instrument for forces beyond your own personal power, is what we should be striving for (Eckman, 1996, p. 173).

As Eckman mentions, Five Element provides practitioners a unique ability for patient care. Albeit sometimes adverse, as in my situation, it

encourages practitioners to listen to patients and develop a more patient-centered approach to healing. I found the *shen*-centered approach encourages practitioners to search for more than the physicality of patients and explore the more psychosomatic aspects of health and disease. At all the Chinese medicine schools I have observed, I noticed a considerable number of students were interested in the courses on the *shen* or Spirit and it seems to be the most unique component to Five Element tradition. As Vivienne Lo remarks,

JW spoke a lot about establishing empathy with patients. This was a very interesting training, and a transferable skill that I've found useful throughout my life. The training also prepared us to deal with the expectations of the kind of clientele that would search out Five Element acupuncture at the time. There is no doubt that many patients gained a lot both from the time we took, and from the variety of therapies administered along with the acupuncture and moxibustion. I grew to appreciate the personalized style, and how that did provide insights into a patient's unique illness and health experience. The treatments were often very powerful, and successful when measured against the patient's expectations (V. Lo, Personal communication, March 13, 2017).

This approach to patient-centered care continues to be a signature characteristic of Five Elements and is a distinctive feature of the tradition. As Lo mentioned before, Worsley also encompassed modalities such as homeopathy as a part of the tradition. Despite this, Worsley was an outspoken opponent of herbs. This was especially evident in all of my interviews with Five Element practitioners. But, pressures from regulatory bodies would challenge the ability of Five Element schools in the United States to maintain the fundamental principles of Worsley's teachings.

Investigating Five Element through schools and practitioners in the United States, I found two of the three schools were adopting herbal programs. The administrator clarified for me why the break in the acupuncture-only curriculum occurred.

The really big difference between us and the other [Five Element] school – that I know for sure – is that we have a Chinese herbal studies program. I think it was probably around 1999 that the State of Florida said, "You must have herbs in your transcript to be licensed in Florida." And because we're a Florida school granting a Master's degree, they said let's put together an herbal

studies program. And that was huge and tumultuous for the academy. A lot of the faculty that were “pure Worsleyian” were like, “Nope, I don’t want to be associated anymore. This flies in the face of what Worsley taught.” I don’t know if that’s true or not but what I understand and what other people has said was that Worsley said, “You can’t be a master of two things. So you should pick one and stick with it.” But what I also know is that a lot of “pure Worsleyian” practitioners practice homeopathy. There’s a real hand-in-hand relationship, many of the older 5E people also practice and use homeopathy in their practices. So I’m like, “Well what’s *really* the difference, ultimately?” And so we have our herbal studies program. Personally, I’m biased, I’m a 5E practitioner and I practice Chinese herbal medicine. I think it’s really powerful. Some of the things that are really stubborn like “clearing phlegm” or “moving blood stasis.” I think it’ll be really challenging to do that... Even building qi in the long run. Doing that without the herbs would be really challenging (Personal communication, January 25, 2016).

Specifically, because of the location of the school and the criteria set by the state’s regulatory body, the school had to change its curriculum to accommodate this standard. As a result, this process alters the epistemology of Five Element and creates a new knowledge-base which some find antithetical to Worsley’s original teaching. As the administrative informant mentions, considering the “pure Worsleyian” practitioners were also practitioners of homeopathy, the use of Chinese herbs is not far removed. Instead, it opens a world of possibilities for practitioners and resolves difficult situations where practitioners might feel limited with an acupuncture-only approach. The adoption of herbs at schools such as AFEA and MUIH have been situated in a Five Element epistemology which does not conflict with the theoretical foundation of Worsley, but expands on it. Despite the adverse characteristics of regulatory bodies, they do require a form of structure for training in schools. Asked about the training she received at Leamington Spa with Worsley, Lo remarked,

The training? No, insufficient. It was powerful, of its time, but totally inadequate. And that’s why ten years later I embarked on a lifetime of Chinese medical history to track what it was they didn’t tell us, and to find out what they didn’t know. History has been important to me, but it isn’t really necessary for good practice. At least I think history should be taught in practice, but students don’t need to be historians. They should be absorbed in the philosophy and culture of the medicine. There was much

missing in the training in the 70s and 80s that has been supplemented now in most schools: techniques, concepts of illness, etc. Mainly a longer term clinical training (it was part time), more apprenticeship work, so as to develop one's own individual style (V. Lo, Personal communication, March 13, 2017).

Whether it is the use of herbs or the training itself, authenticity comes into question. As seen through the analysis of Five Elements, the authentic experience of the 1970s and 1980s, actually working with Worsley was not sufficient for practitioners. Though presently the majority of Worsley schools incorporate Chinese herbs, at least their training has to meet certain criteria established by the regulatory bodies. Another unique component of Worsley Five Elements is many of its students have entered academic and leadership positions. In the United Kingdom, Vivienne Lo and Volker Scheid both hold associate professorships, respectively at University College London and University of Westminster. Author Lonny Jarret, who has influenced a range of acupuncturists throughout the United States with his book *Nourishing Destiny* and the influential teacher Thea Elijah, were both students at Bob Duggan and Diane Connelly's Traditional Acupuncture Institute, which was devoted to Worsley's teachings.

Through the analysis of Five Elements, it is debatable what constitutes an "authentic practice" and if those practices found in their "authentic" state of the 1970s and 1980s are adequate by today's standards. Five Elements, however, opened a pathway for many prominent acupuncturists to discover other realms of Chinese medicine, whether through disenchantment or furthering curiosity. Besides the Five Elements, the pursuit of authenticity becomes a driving force for the milieu known as Classical Chinese Medicine, which bases its authority and legitimation through the "classics."

5.3 Classical Chinese Medicine (CCM)

In the field, I found a faction of Chinese medicine practitioners who attempted to resurrect classical systems of Chinese medicine. This element could be found in a range of places, from an entire Chinese medicine school to a department within a school. The most notable epistemologies arose out of the teachings of Nguyen Van Nghi, Heiner Fruehauf, and Jeffrey Yuen. Though

Ngyuen Van Nghi has since passed, Jeffrey Yuen and Heiner Fruehauf are still active teachers in schools and professional development settings. Medical doctor Leon Hammer has taught extensively on pulse diagnosis and been an influential figure in the United States, however, due to time constraints and limited access to his school and students, I will not focus on him. The common thread between the three teachers is they all teach elements which come from specific “classical texts,” namely, the *Basic Questions* (*Suwen* 素問) and *Divine Pivot* (*Ling shu jing* 靈樞經) of the *Yellow Emperor’s Inner Cannon* (*Huangdi neijing* 黃帝內經), and *Treatise on Cold Damage* (*Shang han lun* 傷寒論). All of the texts have a trove of heterogeneous information, at times contradictory, but the teachers have managed to situate the passages to fit their instructions.

5.3.1 Nguyễn Văn Nghi and Sean Marshall

I have a personal connection to Classical Chinese Medicine (CCM), as the school I attended for my acupuncture training in the United States, Jung Tao School of Classical Chinese Medicine (from now on Jung Tao), was one of the few accredited programs in the country. Jung Tao is located in the middle of the Blue Ridge Mountains in a town called Sugar Gove, North Carolina. The school’s approach to Chinese medicine is based on the teachings of the French-Vietnamese Nguyễn Văn Nghi. I chose Jung Tao because it, in theory, was the school which closely resembled my acupuncture training in Viet Nam. The school was founded in 1998 by a half Native American and half Irish-American named Sean Marshall (1946-2011).

Marshall to me was an enigma. Originally born as Jack Stanley Jones, he once spent a part of his life working in a carnival and later changed his name to “Sean Jones” when he joined the garage rock band called The Litter during the 1960s and 1970s. It is unclear when he began learning Chinese medicine. One source claims he began his studies of Chinese medicine when he was traveling with his band in Europe during the 1970s (Mitchell 2011) and he claims to have discovered the medicine through his interest in tai chi with Fred Lehrman and his teacher, taijiquan pioneer Cheng Man-Ching (Marshall 2008, 3). Sometime in the 1970s and 1980s, he attended two schools, the Occidental

Institute of Chinese Studies in Toronto, Canada, which was partially a correspondence school based on the teachings of Nguyễn Văn Nghi and the British College of Acupuncture, a school founded by the former president of the British Acupuncture Association, Royston Low. It is unclear when Marshall finished his training at OICS, but after graduation, he began working with the president Walter Sturm and the team at OICS translating the *Suwen*, *Lingshu*, and *Nanjing*.

In 1988, Marshall received a Doctor of Acupuncture degree from the British College of Acupuncture. He was then hired by the Northwestern College of Chiropractic (now Northwestern Health Sciences University) in Bloomington, Minnesota to teach the acupuncture program. While at Northwestern College of Acupuncture, he invited Nguyễn Văn Nghi and Trần Việt Dzung to teach in Minnesota. This began the connection between Marshall and Nguyễn Văn Nghi, which by 1997, had enough of a following to create a semi-structured group, centered around Nguyen's teachings. The later became the school known as Jung Tao or "Middle Way" (*zhong dao* 中道) located in Sugar Grove, North Carolina. As Marshall described it, "Rather than a school looking for dedicated students, it was dedicated students creating a school" (Marshall, 2008, p. 4). Although Marshall was one of the acupuncture pioneers in North Carolina, he was never licensed and was harassed by competing acupuncturists at the time.

Nguyễn Văn Nghi (1909-1999) was one of the leading acupuncturists in France. Born in Hanoi, Viet Nam, he was a medical doctor who received his degree from the University of Montpellier (*Université de Montpellier*). In 1954, he began to translate the *Yellow Emperor's Inner Canon*, however, there is controversy surrounding his version. Different from other translations, Nguyễn's texts had added commentaries from two unknown authors, "Zhang Shi" and "Ma Shi." The added commentary reinforced his unconventional theories on Chinese medicine. This technique resembles the Tibetan Buddhist school of the Nyingmapa (Tib. *Rnying ma pa*) who legitimized their often-polemical arguments against opposing schools through the use of *terma* (Tib. *Gter ma*) or "hidden treasures." *Terma* were allegedly secret texts concealed throughout the Himalayas by the adept Padmasambhava. They were "miraculously"

discovered and used by the Nyingmapa to counter debates between opposing schools.

Marshall's instruction was unorthodox and disorganized. Though he was president and primary teacher, however, sometimes he would appear hours late to teach and sometimes was completely absent from the classroom. There was a collective stress in my class, particularly because the school was not accredited by the ACAOM, and we were enrolled when it was in a candidacy status, preparing to be accredited. Marshall taught a tradition based on the *Lingshu*, in particular the role of San Jiao (三焦) as an ontology of the body, which he called "San Jiao Energetics." The energetics is based on the three metabolic systems (*jiao* 焦) of the upper, middle, and lower and how they produced and circulate *ying qi* (英氣), *wei qi* (衛氣), and *yuan* (元氣) as well as the different forms of *jing* (精), which was divided in anatomical, sensorial, and mental (精神).

This system continues to be taught at Jung Tao and is also transmitted through the Vietnamese-French acupuncturist and successor to Nguyễn Văn Nghi, Trần Việt Dzung who teaches throughout Europe under the different chapters of the Institute of Van Nghi. In hindsight, it was peculiar to have an extremely nuanced and esoteric tradition of Chinese medicine found in the rural encampments of the Blue Ridge Mountains.

Besides the "San Jiao Energetics," which was the bulk of diagnosis, there was a different interpretation of the "Six Stages" (*liu jing* 六經), which at Jung Tao was translated as the *liu qi* (六氣) an augmentation of the "Six Stages" from the *Shang han lun*¹⁰³ by switching Faint Yin (*jue yin* 厥陰) and Lesser Yin (*shao yin* 少陰), making Lesser Yin the deepest level, which seemed to be influenced from Vietnamese traditions. A host of other theoretical discrepancies existed, which were a combination of Marshall and Nguyễn's interpretations.

The frustration students and faculty had with Jung Tao was its oral pedagogical structure. Until recently, there were no textbooks at Jung Tao.

¹⁰³ Six Stages: Greater Yang (*tai yang* 太陽), Lesser Yang (*shao yang* 少陽), Yang Bright (*yang ming* 陽明), Greater Yin (*tai yin* 太陰), Lesser Yin (*shao yin* 少陰) and Faint Yin (*jue yin* 厥陰).

When I was a student, the first class sessions consisted of Marshall teaching the esoteric foundational theories in the first few days. The proceeding years were essentially expansions of the foundations. Because of Marshall's frequent unexplained absences, classes were mostly taught by previous students of the school. Students who were frustrated began to investigate TCM material because of its relatively simplistic organization of *bianzheng lunzhi*. While researching Jung Tao ethnographically, I realized the content had changed.

Jung Tao is segmented into cohorts based on the year of attendance. Classes are only five consecutive days a month but are all day long. This is convenient for individuals who work full-time and many people chose Jung Tao because of this factor. The particular class I observed is the third and last year of didactic training. Specifically, I was observing what is known as "grand rounds," which is where a patient is presented in front of class, who tells the students a list of their symptoms and is seeking an acupuncture treatment for help.

After a lengthy forty-five-minute discussion, I noticed the students talking amongst themselves on what they thought was the diagnosis of a patient. It was apparent to me the patient had a "*Taiyin* Disharmony," which related to the Lungs and the Spleen not working mutually. I mentioned this diagnosis after a few students asked me my thoughts on her case. Then, a white male student in his late-20s, early-30s abruptly corrected me, "No, it's absolutely a Kidney Yang Deficiency!" I was surprised.

Two things caught me off-guard. First, he was using a TCM pattern differentiation. Secondly, there was not much discussion but an abrupt need for me to be corrected. Out of my experiences traveling and engaging with over a dozen Chinese medicine schools, I never found anyone to be so sure of their diagnosis and shut down any discourse.

I responded, "What do you mean by Kidney Yang and how did you come to the diagnosis?"

He responded, "All of the symptoms they¹⁰⁴ [anonymized gender] exhibited were exactly how Kidney Yang Deficiency is described." He begins to list all of symptoms which fit the Kidney Yang Deficiency pattern and concluded by saying, "They fit the pattern precisely to what is described as Kidney Yang Deficiency."

¹⁰⁴ Because of HIPAA, I will not describe the symptom of the patient but I will describe the differential diagnosis of what the students arrive at.

From my experience Sean Marshall despised TCM and did not approve of patterns. This was hard for a lot of students because they wanted a formalized diagnosis and treatment. I recollect Marshall continually stressed he was not necessarily teaching us students Chinese medicine, but instead, “teaching us *how* to learn Chinese medicine.” Nevertheless, at times he would concede and label a certain phenomenon of disease in the terms of *bianzheng lunzhi*, but as I understood it, it was more of a compromise. “Kidney Yang” was never a pattern but a network of various systems. In other words, it could not be held in exclusion as it interacts with a series of other systems, unless of course it is positioned and seen as pattern differentiation. The idea of “deficiency” or “excess” is a distinctive diagnostic marker found in TCM’s *bianzheng lunzhi*. Mostly Marshall taught diagnosis through the terms of the Six Stages. In fact, the most important lesson Marshall gave to me was the day he had congestive heart failure.

I was helping him move equipment on his farm. It was wet and cold and he looked ill. He was out working a bit with me but then retired back to his house. Later that evening, I received a call from him and said to me, “Tyler, my *shaoyin* has collapsed. I cannot work tomorrow.” I thought he was joking because this meant his Heart and Kidneys have failed. I told him he’d be alright and I’ll help him in a few days. Hours later, I received a mass email which read he was rushed to the emergency room because he had congestive heart failure (Field notes, March, 2016).

After Marshall died in 2011, the school was in disarray. There was uncertainty on the future of the school and for the lines of transmission. Trần Việt Dzung quit teaching in the United States after 2014. When I returned to Jung Tao for my fieldwork, the school was more organized than when I attended school and the legacy of Nguyen and Marshall survives with its teachers. Trần Việt Dzung continues to teach throughout Europe, catering towards medical doctors.

CCM is mostly an oral tradition. The legitimation of its leaders came from various routes. Marshall’s role in transmitting a tradition originated with his work as a liaison to Nguyễn Văn Nghi. Other teachers such as Heiner Fruehauf, acquired their position from academic experience.

5.3.2 Heiner Fruehauf

Fruehauf came from a family of doctors interested in natural healing. His grandfather studied under one of the forefathers of the hydrotherapy

movement, Sebastian Kneipp. In 1990, Freuhauf received his Ph.D. from the University of Chicago in the Department of East Asian Languages & Civilizations where his dissertation was the “Urban Exoticism in Modern Chinese and Japanese Literature.” He was appointed assistant professor in 1992 at the National College of Natural Medicine (NCNM, now National University of Natural Medicine) in Portland and then promoted to associate professor and chair of Classical Chinese Medicine at NCNM. By 2006 he became the founding professor of the School of Classical Chinese Medicine which created the reputation as one of the foremost prominent schools of Classical Chinese Medicine in the United States.

Fruehauf has studied with an array of Chinese medicine practitioners. During his post-doctoral education at Chengdu University of Traditional Chinese Medicine (*Chengdu zhong yiyao daxue* 成都中医药大学), he studied Chinese herbal medicine under Deng Zhongjia and Zeng Rongxiu as well as qigong (氣功) with Wang Qingyu, who was the successor of the Jinjing Qigong lineage of Li Yunhong. In 2005, he began studying a form of Chinese psychology from Liu Yousheng and Wang Yuanwu (Wang Fengyi lineage) called *xing li liao bing* (性理療病), which translates to “treating disease through inner nature principles” (Fruehauf, n.d.)

Recently and somewhat controversially, Fruehauf began teaching at a doctoral program at one of the most renowned Chinese medicine schools in the United States, and a seeming rival to his NCNM in Portland, Oregon College of Oriental Medicine (OCOM).

Fruehauf is known in the United States for the treatment and teaching of *Gu* Syndrome (*gu zheng* 蠱症). *Gu* syndrome was commonly associated with witchcraft or possessions, but Fruehauf situates the syndrome to represent “systematic funguses, parasites, viruses and other hidden pathogens” (Fruehauf 1998, 10). Throughout the country, patients notably seek treatment from Fruehauf with issues in relation to Lyme’s disease and use his line of herbal patents known as Classical Pearls Formula.

The arrangement of NCNM is unique because it is one of the few naturopathic schools in the United States. The blend of naturopathic students and Chinese medicine created an interesting environment. At least a half dozen

people I interviewed joked that many people in the naturopathic program who find the program too difficult end up enrolling in the Classical Chinese Medicine program.

The Classical Chinese Medicine coursework at NCNM was a blend of the esoteric phenomenological skills found within the Five Element traditions, but also something quite rare, Chinese language courses and Chinese medical translation courses taught by scholar Sabine Wilms. Most of the Chinese theory courses were rooted in either the *Yellow Emperor's Inner Canon* and/or the *Treatise on Cold Damage*. Similar to the manner in which Sean Marshall taught the categories of diagnosis based on what he called the *liu qi*, most of the students at NCNM were taught to see disease in a similar way. I found a few faculty members of the Five Element tradition and at least one faculty member who was an adherent of Leon Hammer's tradition. Since the students were studying CCM in a world of TCM, I found the students to possess an interesting confidence.

NCNM is one of three Chinese medicine schools in Portland, Oregon. The school itself is a mix of naturopathic students and Chinese medicine students in a two-story building which resembles an old secondary school. At one of the classes, the topic taught was needle technique. The class was instructed by a Chinese practitioner who demonstrated the various names and techniques for needling.

Throughout the class there was talk about whether or not to use guide tubes. The teacher was not a proponent of guide tubes and taught the students "freehand" techniques. Each of the techniques had characteristics of either tonification or dispersion. Then, students had to practice the technique on each other under the supervision of the instructor.

During my observation, some of the students in class knew I was an anthropologist and acupuncturist. After class, a white student came up to me and asked if I practiced acupuncture and for how long. After I responded, she commented, "Well, I'm sure you "freehand" when needling."

I responded, "No, I don't "freehand." At least not while I'm in America. Since guide tubes are available here and patients tend to prefer guide tubes over freehand, I find it convenient to use them."

The student brashly responded, “It doesn’t say anything in the Classics about using guide tubes.”

“So does it mean you can’t use them? I’m a little confused.” I reply, perplexed by what she is asserting.

“We’re taught here [NCNM] that guide tubes are a barrier to your patients and prevents you from feeling the what’s going on with the patients. It’s a little odd for a practitioner like yourself who has practiced in the Viet Nam to use guide tubes.”

“In Viet Nam I don’t use guide tubes because Vietnamese don’t use them. But in America I do because they exist and it makes needling easier for me and a tad bit less painful for the patient. It’s a practical and personal preference.”

The student looked at me as if I committed an unspeakable sin. I felt I offended her by my choices in needling technique (Field notes, November, 2015).

It was apparent my use of a guide tube was seen as somehow unauthentic. With the different choices of Chinese medicine schools in Portland, students who chose NCNM for its curriculum were certainly looking for an authentic experience of Chinese medicine. Removed from TCM, but also different from the explicitly Five Element tradition, NCNM is a school which may have inadvertently manufactured a quasi-CCM orthodoxy due to its greater emphasis on a classical approach. The students were indeed obtaining a rare curriculum, but this sometimes led them to feel superior to students from other schools and traditions, or at least indifferent to other ideas and practices. NCNM seemed a forerunner in the preservation of the tradition of CCM and an alternative to the TCM orthodoxy.

Both Sean Marshall and Heiner Fruehauf are examples of how CCM is transmitted through the medium of a school. In the case of Jeffrey Yuen, it is a school which is transmitted through the medium of a person.

5.3.3 Jeffrey Yuen and Jade Purity

Jeffrey Yuen is a New York-born 88th generation Daoist priest from the Jade Purity Yellow Emperor Lao Zi School (*yu qing haung lao pai* 玉清黃老派). My focus is on Yuen’s contributions to CCM as one of the few visible teachers

in the United States teaching Chinese medicine's *Yellow Emperor's Inner Cannon* from the perspective of his own lineage. He is also singular as a Chinese medicine practitioner linked with religious Daoism in the United States.

In addition to the Jade Purity school, Yuen has studied under Hsien Yuen who was the director of the American Taoist and Buddhist Association in New York's Chinatown. Hsien Yuen was originally born in mainland China then emigrated to Taiwan and made his way to the United States. In America, Hsien Yuen is known for a meditation technique called *dan ding chan zuo* (丹鼎禪坐) and he is one of the few Daoist priests who claim to speak with Daoist deities and immortals (Komjathy 2004,15).

Jeffrey Yuen has been teaching across the United States for a few decades but came into prominence when he served as the dean for academic affairs at a school called the Swedish Institute in Manhattan. Since then, he has taught on a semi-regular basis in places such as New York, Los Angeles, and Asheville, North Carolina, but does not have a specific school devoted solely to his teachings.

Yuen has never officially published any material on his teachings. But one of his senior students, Ann Cecil-Sterman, has published a textbook called *Advanced Acupuncture: A Clinic Manual*. As she discussed with me, the manual is a composite of Yuen's core ideas on acupuncture theory, gleaned from working with him in New York and accompanying him around the world (A. Cecil-Sterman, Personal communication, April 2, 2016).

The bulk of the material in the text relates to the diagnosis and treatment of channels and vessels. It covers the nuances in the sinew (*jian* 腱), *luo* (絡), divergent (*bie* 別), and extraordinary channels (*qi jing ba mai* 奇經八脈). Cecil-Sterman presents the idea of needling at three levels: superficial-*wei* (衛), middle-*ying* (英), and deep-*yuan* (元). She has two primary techniques, "superficial-deep-superficial" (SDS) and "deep-superficial-deep" (DSD). SDS is used when pathology is trapped by *wei qi*. The technique is to first stimulate the needle at the level of *wei* and then insert it deeper to the *yuan* level, and lastly bring the needle back up to the *wei* level. She describes how in needling the DSD, "the aim is to move the pathology to the densest, most Yin region of the body; the joints" where the needle is first inserted at the deepest level to activate

the *yuan*, then the pathogenic factor (PF) is lassoed at the level of *wei* and brought back down again to the *yuan* level where “Wei Qi returns to its origin of Yang Qi” (Cecil-Sterman, 2012, pp. 134-135).

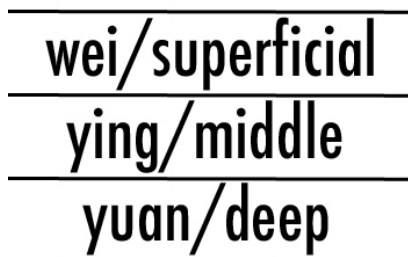


Fig. 5.9 Three Levels of the Body

In researching Jeffrey Yuen and his lineage, I could not find any evidence of him holding a license either in New York or California. Technically, this would pose a potential issue for students except he primarily teaches essential oils and herbs. When he does teach acupuncture, I have been told he usually has licensed acupuncturist students needle patients at demonstrations. Either way, this posits the question of agency and legitimation in the practice of acupuncture.

Of the CCM pioneers, Heiner Fruehauf was the only licensed acupuncturist. Despite the pivotal role J.R. Worsley played in the United States, he did not receive his acupuncture license in Florida until after a decade from the first issued license in the state.¹⁰⁵ None of the authors whose books are primary sources of standardized Chinese medicine in the United States have licenses to practice in any of the states. Even Giovanni Maciocia, who lived in Santa Barbara, California, is unable to legally practice acupuncture in the state. Put simply, those who contributed to the contemporary practice of Chinese medicine in America are not in any capacity able to legally practice. This is an example of the disjunction between the people in power and modes of knowledge production.

¹⁰⁵ Although J.R. Worsley received his California acupuncture license in 1978 (#658), his address was listed in Florida. His acupuncture license was issued on April 15, 1992 (license # AP393), a decade after the first Florida acupuncture licenses that were issued on February 9, 1982 (FDOH, n.d.).

5.4 Conclusion

Through my analysis of the primary traditions in the United States, I outlined the prominent features of each tradition and the methods of transmission. TCM, the standardized model of Chinese medicine in the United States, has a logical structure based on patterns. There was a tendency for practitioners to be limited by *bianzheng lunzhi* and only view patients within that paradigm. I found Five Element practitioners focused on their phenomenological refinement to assist in patient-centered care. It is questionable on the actual source of Worsley's education and the tradition borders religious practice. In the search for authenticity, CCM provides a multitude of approaches which place the theory and practice of Chinese medicine into a historically-oriented frame of reference. It is uncertain whether or not it is more effective than any other tradition.

I have left out several other traditions who had a tremendous impact on Chinese medicine, but the resulting standardization by regulatory authorities did not allow for these traditions to be taught.

I leave this chapter with a hypothetical question as a critique of the mechanism of power in American Chinese Medicine. If the bulk of what is expected from regulatory bodies relates to theory, then why are Maciocia and Deadman unable to practice legally in the United States? Their knowledge was used to construct the standard epistemology of American Chinese Medicine. Both practitioners, however, would have to attend an ACAOM approved school for three to ten years and pass the NCCAOM's national board exam and/or CALE before they could practice acupuncture legally. The breadth of their knowledge does not determine legitimation as practitioners, but compliance with the profession's bureaucracy sanction their legal practice. This power structure is substantiated by regulatory bodies and the State.

The next chapter is devoted to the arbitrary mechanisms which authorize the profession. What is presented as a unified medicine, in reality acts as disharmonious system of control.

Chapter 6.

Decoding Chinese Medicine (Conclusion)

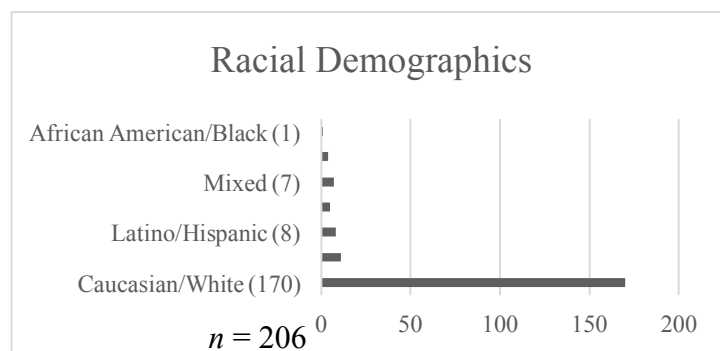
The previous chapters outlined the progression of Chinese medicine's unregulated practice among the Chinese diaspora to a standardized profession through the regulation of acupuncture and Chinese herbs as influenced by the American counterculture. Chinese medicine's professionalization in contemporary practice is sustained through student enrollment, accreditation, and membership fees paid by schools and practitioners, as well as the existence of regulatory bodies. The profession is a self-perpetuating bureaucracy which relies on the mechanisms it has established. This chapter highlights the actual factors which shape American Chinese Medicine. A "house of cards," the profession is built on the debt of students, a nameless profession, and a war with physiotherapists and chiropractors who challenge American Chinese Medicine to define itself.

This chapter aims to decipher American Chinese Medicine. I first examine who actually studies and practices it. I then assess what model of education it expects from its schools. If standardization of traditions was not enough, the profession also attempts to homogenize its schools with entry-level degrees built on unattainable accreditation standards. With the appearance of an established medicine, the profession – in all actuality – is plagued with an identity crisis, where it has at least thirty different titles for its practitioners and almost a dozen names to call itself. This confusion is mounted with inconsistent scopes of practice which vary from state-to-state. As a way to define itself, the profession begins to wage war against physiotherapists in their practice of "dry needling." Despite uncertainties, there are signs of redemption from unlikely sources. What are perceived as subversives and revolutionaries of the profession, took alternative approaches to re-professionalize and change the face of Chinese medicine in America.

6.1 Who Practices American Chinese Medicine?

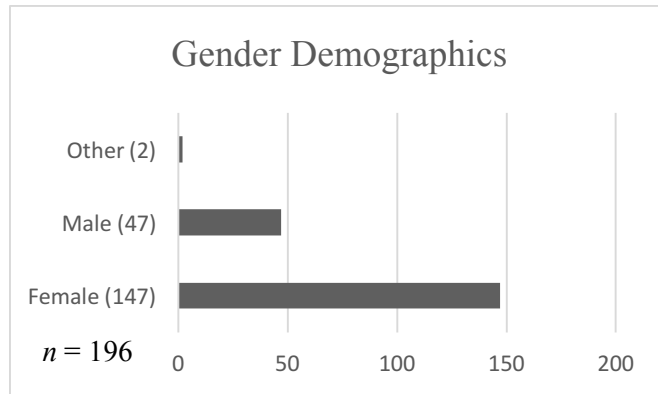
Chinese medicine has made substantial changes from its inception in America in the late-19th century to its current practice. Demographically and as

a formal profession, Chinese medicine is primarily practiced by white female Americans. In a field survey I conducted, white Americans accounted for more than three-quarters of the total demographic at 82.52%, Asian/Pacific Islanders 5.33%, Latino/Hispanic 3.88%, Native American/Alaskan Native 2.42%, Mixed 3.33%, Other 1.94%, and African American/Black 0.4%. In the data collection process, non-white participants marked themselves in multiple categories, skewing the total sample. For instance, a self-categorized “Arab” participant labelled both “Other” and “Caucasian/white.” One participant marked both “Native American/Alaskan Native” as well as Latino/Hispanic. Two participants who identified of “Jewish” ancestry, also listed themselves also as “Other,” with one of the two identified as “Other” and “Caucasian/white.”

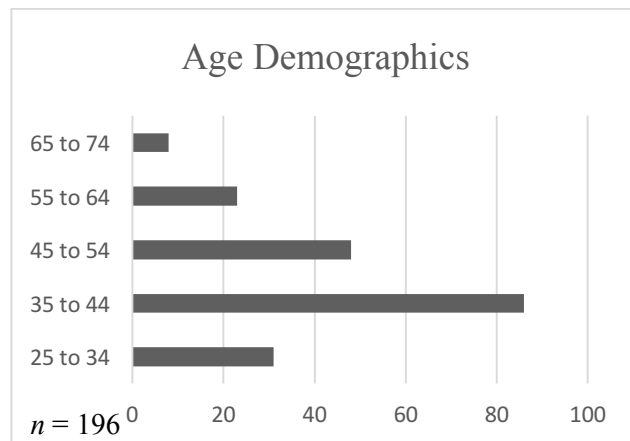


Graph 6.1 Racial Demographic for Chinese Medicine Practitioners in the United States

Women account for the majority of the practitioners in the field at 75% of the total demographic while 23.9% were men, and 1% identified as “other.” The age range for practitioners was mostly 35-44 years-old accounting for 43.36% of practitioners followed by those who were 45-54 years-old at 24.48%. In other words, if a patient is seeking acupuncture, they will most likely will encounter a white woman from the age of 35 to 44 years old as their practitioner.



Graph 6.2 Gender Demographic for Chinese Medicine Practitioners in the United States



Graph 6.3 Age Demographic for Chinese Medicine Practitioners in the United States

In my recorded observation of at least thirty-nine class sessions (seen in Graph 6.3),¹⁰⁶ which did not include several of the herbal classes I observed,¹⁰⁷ the average class size was 15.3 students per teacher and with women accounting for 76.24% of the classroom. A survey I conducted consisting of 114 student participants, women ($n=84$) accounted for 73.68% of the classroom while men ($n=28$) were a minority at 24.56% and “Other” ($n=2$) consisted of 1.75%. Matched in comparison, the recorded demographics of the classrooms and survey were commensurate with each other with a few points of margin.

In a typical Chinese medicine classroom, women account for the majority. During an observation of one class session in California, I noticed all of the students and the lecturer, were women. Something I had not noticed at other schools was the clicking of high heels. As I looked down, I realized an overwhelmingly high percentage of women wore high heels. In all, I accounted

¹⁰⁶ Class durations fluctuated from 1.5 hours to a whole day.

¹⁰⁷ Since most of the herbal classes were repetitive, I did not take many field notes.

for nine of the twelve students wore high heels to the particular class. Only at the school I attended, Jung Tao School of Classical Chinese Medicine, was a classroom with a male majority.

Class lecturers varied in race and gender depending on the geographic location. California lecturers were mix of white and Asian as well as women and men. This diversity was in stark contrast to the racial makeup in non-California schools, where in the West Coast, specifically in Portland, Oregon, most were white rather than Asian. In the East Coast, not one class I observed was taught by a non-white lecturer. Most of the students on the East Coast were also predominantly white followed by Asian Americans at far lower percentage.

Date	Class	Female	Male	Total
6/17/15	Shen	4	0	4
6/28/15	Diagnostics of TCM	6	2	8
6/23/15	Princ. & Theories III	6	3	9
6/23/15	Acu. Anat. Ener. III	7	5	12
6/23/15	Zang Fu II	10	1	11
7/1/15	Basic Nutrition	12	3	15
7/1/15	Ethics and Jurisprudence	12	0	12
7/2/15	Princ. & Theories II	9	3	12
7/7/15	Internal Medicine	2	2	4
7/8/15	TCM Specialties	4	1	5
7/10/15	DAOM: Brain and Nervous System	10	5	15
7/22/15	Foundations of CM	14	2	16
7/27/15	Dx and Tx of Disease	15	3	18
7/29/15	Intro of Clinical Techniques	15	5	20
9/15/15	History of Med.	15	5	20
9/15/15	Herbology 3	15	6	21
10/8/15	Cosmology and Imagery	12	4	16
10/9/15	Palpation and Perception	16	3	19
10/14/15	Chinese History and Culture I	15	5	20
10/22/15	Business Seminar	13	4	17
10/26/15	Imagery and Experiential	2	2	4
10/28/15	Chemical Dependency	21	9	30
10/28/15	Classical Texts - Neijing	3	2	5
11/2/15	Point Indication	20	4	24
11/2/15	Acu-Moxa Techniques IV	13	2	15
11/3/15	TCM Theory I	24	3	27
11/3/15	Chinese Medicine Business	13	5	18
11/4/15	Medical History East & West	20	5	25
11/6/15	TCM Pathology IV	19	9	28
1/11/16	Professionalization	4	3	7
1/11/16	Acupuncture Methods?	4	5	9
1/27/16	Class 1: Basics 101	5	2	7
1/28/16	Class 1: Constitutional Acupuncture	5	2	7
2/1/16	Intensive 5: Tx Planning	14	1	15
2/3/16	Clinical Training	15	1	16
2/4/16	Clinical Training	13	1	14
2/20/16	Year 3: Energetics	15	2	17
3/2/16	Year 1: Energetics	2	9	11
3/10/16	Year 2: Energetics	6	5	11

Table 6.1 Class Demographics of Chinese Medicine Schools

Through my observation and data, I discovered much of the depiction of Chinese medicine in popular culture were inconsistent with the numbers. Besides herbal storefronts, which as I covered in the chapter on professionalization do not require an acupuncture license to sell herbs, the vast majority of practitioners in the United States are white women. I have not accounted for practitioners who practice without a license. During the course of my research I found three Vietnamese American practitioners who were unable to attend Chinese medicine schools or pass either the CALE or NCCAOM's national board examination because of language restrictions. Their illegality exposed the power regulatory bodies have over practitioners. The next component addresses tensions found between the schools, regulatory bodies, students, and practitioners.

6.2 Standardize a School's Legitimation

The criteria for being a licensed acupuncturist, except in Nevada, is for a practitioner to graduate from an accredited master's-level program; though there have been attempts to change this. Schools in the United States have three statuses, all determined by their accreditation either at the region and/or national level: Masters-level, Doctor of Acupuncture and Oriental Medicine (DAOM), and First-Professional Doctorate (FPD).¹⁰⁸ In my research of schools, I found not only was there an attempt by the people in power to standardize the traditions, but also to standardize the education.

As I discussed in Chapter 5 of Professionalization, all schools which provide students the eligibility to sit for the NCCAOM's national board exam or for California Acupuncture Board's CALE to be licensed, must be approved by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM). ACAOM's approval process can be quite costly for the schools. In 2014, ACAOM claimed \$982,738 in revenue for the fiscal year, with \$978,330 coming from fees they receive from schools (IRS, 2014). Below in Table 6.2 is the amount ACAOM charges both Master's-level and Doctoral Programs.

¹⁰⁸ Also known as "entry-level doctorate."

Fees/Dues	Masters-Level	Doctoral
Orientation Visit Fee	1300	1300
Eligibility Report Review Fee	4000	4000
Eligibility Site Visit Fee	7600	7600
Pre-Accreditation Acceptance Fee	6600	3300
Annual Sustaining Pre-Accreditation Dues	6600	3300
Accreditation Site Visit Fee	7600	7600
Self-Study Report Review Fee	4000	4000
Accreditation Acceptance Fee	0	0
Annual Sustaining Accreditation Dues – Main Campus ¹⁰⁹	6600	3300
Total	\$44,300	\$34,400

Table 6.2 ACAOM's Fees for Accreditation (ACAOM 2016b)

Besides the obvious financial issue with ACAOM, schools found the process of accreditation by ACAOM tedious and in several circumstances, site visitors did not treat schools well. This was apparent when it came to epistemological standards. One of the CCM schools explained to me,

If you look at ACAOM's standards, there is a homogeny. So they require that, "You must teach all of these things." When I first started here, one of my first jobs was to make sure all of those things [ACAOM curriculum] were in classes and made objectives for them. There are things that are not in our tradition, but we're regulated to teach it... Just on the standards for the curriculum part, immediately create a homogeny... I did have a bad experience with the last site visit in that one of visitors came in and you have an introductory meeting. So you know, we identify ourselves as a Classical Chinese Medicine school, and a site visitor asked, "Why do you call yourselves that? And what grounds to you consider yourself as "Classical Chinese Medicine?"

Now if you look at their standards, there is nothing about that. And then argued with me why we weren't that. He brought it up several times and even after the exit interview, cornered our Vice President and continued to discuss it. So that was an example of someone not being respectful of our tradition (Anonymous, Personal communication, March, 2016).

At the Master's-level, the school's legitimation is solely based on the criteria and acceptance of ACAOM. As a result, the site visit is the primary determinant on whether or not a school is accredited, which is why the site visit is crucial. From interviews, two other schools had issues with the ACAOM in

¹⁰⁹ Plus \$30 per student for a 12-month period of pro rata if > 12 months with a cap of \$20,000 (ACAOM, 2016b, pp. 3).

relation to documentation, one dealt with the receipt of documents, where ACAOM attempted to discipline a school for not sending a document through fax and stalled the whole process of accreditation when in fact it was ACAOM who had lost the document. Another issue arose when a site visitor requested an IRS W-9 document for one of the school's workers. The site visitor docked the school for not having the document present at the time of visit. This is not the only issue schools had with the ACAOM.

6.2.1 First-Professional Doctorate (FPD)

In the past decade, there has been recommendation from the larger acupuncture schools, who are mostly regionally accredited, to push for an entry-level degree known as the "First-Professional Doctorate" (from now FPD), which increases the entry standards from Master's to a Doctorate.

The FPD was first considered by ACAOM and CCAOM in 2002. By 2013, ACAOM created the standards for the FPD with twenty-eight added doctoral competencies from the master's program which consist of: "evidence-informed practice, advanced integrative diagnosis, integrative case management, current healthcare systems, inter-professional communication, and practice-based learning" (Miller, 2017). Most of the added competency criteria are designed for more "integrative" medical approaches, which emphasize the need to prepare students for research and/or hospital settings. Though this may be seen as a valiant effort, the profession is mostly private practice. The majority of practitioners are either sole proprietors who own their own practice or share a practice with other acupuncturists. In the NCCAOM's 2013 Job Task Analysis ($n = 1492$), only 2.9% of practitioners in the United States practice in a hospital setting (NCCAOM, 2013, p. 15) and there has been no evidence of this to increasing. When asked about hospital privileges and the degree level of a student, a licensed acupuncturist who works for a California hospital commented,

Hospital privileges are not determined by the degree an acupuncturist holds. In fact, I had to work my way to obtain hospital privileges when I was a L.Ac. (licensed acupuncturist) ... The administrators at hospitals honestly don't know or care about

the differences between a “DAOM” or a LA.c.” Instead, what they’re looking for is experience and prior engagement with the hospital (Anonymous, Personal communication, June, 2015).

Other issues which might warrant the need for an FPD are funding for clinical research or signs of an increased need for more inter-professional models of communication. Interestingly, none of the schools I researched had the capacity to fund substantial clinical research such as a randomized control trial. No research has shown a substantial need for inter-professional communication between allopathic biomedicine physicians and Chinese medicine practitioners. If the profession does require the FPD as an entry-level degree, it would pose a series of issues which would marginalize the majority of schools who only have a master-level program. This would potentially raise the accreditation expectancy to regional accreditation, and force non-regionally accredited schools to close. Tuition costs would rise and thus drive students further in debt. As far as the general public is aware, there is no difference between a practitioner who graduated from a Master’s program, postgraduate doctoral program (DAOM), or an entry-level doctoral program (FPD).

Accreditation is a voluntary process which provides respectability for a higher education institution. The issue with accreditation of Chinese medicine schools, especially in terms with the FPD, is around the differences in regional accreditation and national accreditation. The former has been seen as one of the primary methods of accreditation for public non-profit universities and college in the United States while national accreditation is mostly associated with for-profit universities and/or vocational higher education institutions, such as the ACAOM (Blumenstyk, 2014, pp. 116-117). In theory, regionally accredited degrees and credits are transferable with other regionally accredited schools but there is reluctance for regionally accredited schools to accept credentials from nationally accredited institutions. Regionally accredited schools also have access to federally funded grants and loans while nationally accredited institutions are primarily entitled to loans under Title IV of the Higher Education Act of 1965. The cost and criteria of regional accreditation is considerably higher. As one of the administrators at a renowned West Coast school, which was rejected for regional accreditation explained.

Regional accreditation does not only involve the curriculum, but the actual infrastructure to a school. In addition to the thousands of dollars we spent for the application, our self-assessment, and to have the regional accreditation agency send site visitors to evaluate the school, we also spent hundreds of thousands, if not millions of dollars, in changes to have our actual physical infrastructure to meet the regional accreditor's criteria. Throughout the process, we were reassured that our school was going to receive accreditation and that we have met all of the criteria, but when we received our evaluation, we were rejected for regional accreditation (Field notes, October, 2015).

Since its approval from the U.S Department of Education in 1988, ACAOM remains the only national accreditation agency for Chinese medicine schools in the United States. It is only within the past decade Chinese medicine schools have had the resources to apply for regional accreditation. Some of the schools created a non-DAOM doctorate program which was outside ACAOM's jurisdiction. These non-DAOM doctoral programs were advertised as entry-level FPDs.¹¹⁰

To confuse issues further, and this has recently changed, one of the programs which offered the entry-level doctorate or FPD, called their program "DAOM." The school simultaneously offered a post-graduate doctoral program accredited by ACAOM of the same name, also called "DAOM." This displeased the students of the post-graduate DAOM program because they essentially worked an extra two years after their masters to receive the same doctoral status as a program which at most, was only a year more curriculum to obtain a masters.

Another unique component was schools who had non-DAOM doctoral programs were regionally accredited, but were not "accredited" by ACAOM. Although some schools such as ACTCM have claimed ACAOM "approved" their FPD program,¹¹¹ there was no indication the programs were actually "accredited" by ACAOM nor are they listed on ACAOM's website as "accredited" FPDs. This may seem nuanced, but it actually unravels a serious issue within ACAOM; they have not officially "accredited" any FPD programs.

¹¹⁰ AOMA, ACTCM, and PCOM openly deemed their degrees as "First Professional Doctorate."

¹¹¹ "We are proud to be the first institution in the United States to offer a first professional doctorate degree approved by a national accreditor (ACAOM) and a regional accreditor (WSCUC)" (ACTCM, n.d.).

Since 2015, ACAOM has been asking experts in the field and the CCAOM for input on “AOM degree titles,” which would potentially clarify the FPD. Methodologically, ACAOM determined they would employ the Delphi method to figure out the opinions in the field about the degrees. The Delphi method relies on a series of intensive questionnaires along with controlled-opinion feedback. The method was developed in the 1950s by two scientists from The Rand Corporation (RAND), Olaf Helmer and Norman Dalkey, to determine probable bombing targets Russians would attack in the case of war (Custer, Scarcella, and Stewart, 1999).

Through interviews in the field from 2015 to 2016, it seemed many of the school administrators were mostly positive about the process and the profession would have some clarity on the new possible degrees. In 2017, the CCAOM abandoned their involvement with the process. As the CCAOM explained:

In the past year, the Council participated in three rounds of ACAOM’s Delphi process for naming degree titles. The EC [Executive Committee] wishes to express gratitude to ACAOM for taking the lead with this process. The Council’s involvement in the process has highlighted key areas where more work is needed. During the fourth survey round, the Executive Committee voted to withdraw from ACAOM’s Delphi process and has plans to create a process in 2017 for the Council to move toward greater clarity and consensus. The Council will share the results of our process with ACAOM (CCAOM, 2017, p. 3).

The CCAOM’s decision revealed a rather substantial rift between the regulatory bodies. Though the future of non-DAOM doctoral programs as well as consensus on the FPD remains uncertain among the people in power, the schools present themselves differently to prospective students. Since all of the self-identified “First Professional Doctorate” programs are regionally accredited, they seem to disregard ACAOM’s accreditation and advertise their programs in a manner which appeals to prospective students. These schools have marketed as “Transitional Doctorate,” where graduates of ACAOM’s accredited master’s programs are allowed to attend the FPD programs to further their education in “integrative medicine.” The impression of my informants was “Transitional Doctorates” were available to elevate their status as practitioners. Put simply, it was a route for practitioners to be called “doctor.”

The assumption doctoral graduates earn more money or provide better results in patient care than students with only a master's degree is not grounded in any substantial evidence. The status of being a "doctor," however, may provide practitioners a level of authority and comfort in practicing Chinese medicine. As a school admin explained to me,

The issue comes down to status. Some acupuncturists just want to be called "doctors." It's a power thing... But let me ask you this. When you go receive a chiropractic adjustment, do you say, "I am going to see my Chiropractic doctor?" or do you say "I am going to see my Chiropractor?" Look at the state we're in now. When someone is looking for an acupuncturist, do they ask, "Do you know of a Doctor of Acupuncture and Oriental Medicine?" or something along those lines... Or do they ask you, "Do you know of an Acupuncturist?" My point is that in our situation, the "doctoral" standard is simply to please the practitioner and the patient could care less (Anonymous, Personal communication, March, 2016).

It is safe to assume the majority of the general public is not concerned with these differences, but it matters to the students and is a potential income generator for regulatory bodies and schools. Besides the disputed results from the proposed programs, cost is also an issue.

The DAOM programs range from \$29,000 to \$32,500 in addition to the cost of Master's programs which range from roughly \$23,000¹¹² to upward to \$84,000, none of which include the cost of living. The DAOM route for practitioners would cost at the minimum, tuition-only, \$52,000. Relatively speaking, the "transitional doctorate" programs are not too expensive, ranging from \$6,525 to \$9,996 (ACTCM, n.d.; PCOM, n.d.), but if the student does not reside near the programs – all located in California – the costs of attendance significantly rises taking into account the cost of living. I have found roughly a dozen students who were interested in the programs but all of them lived in the East Coast, which would require rather expensive commutes and/or relocation to either the Bay Area or Southern California. The FPD programs in

¹¹² The most affordable school I found with ACAOM "candidacy" was POCA Tech, who intentionally lowered the costs of school but have criteria for applicants. I cover POCA Tech in more detail at the end of the chapter.

themselves, beginning straight out of an undergraduate education, range from \$65,259 to \$91,392, not including the cost of living.

To understand the doctoral programs, Table 6.3 lists all of the schools which provide Chinese medicine doctoral programs in the United States. Roughly a third of the schools are for-profit colleges, which may allow them access to additional funding from stock holders and investors; a component I found in the field to be a useful gauge for regional accreditation costs.

Schools	Regional Accreditation	DAOM Program	Non-DAOM Doctoral Program	FPD "Approved" by ACAOM	Master's Program	Transitional Doctorate	Non-profit or For-profit
Academy of Chinese Culture and Health Sciences (ACCHS)	No	Yes	No	No	Yes	No	Non-profit
Academy of Oriental Medicine at Austin (AOMA)	Yes	Yes	Yes	No	Yes	No	For-profit
American Academy of Acupuncture & Oriental Medicine (AAAOM)	No	Yes*	No	No	Yes	No	For-profit
American College of Acupuncture and Oriental Medicine (ACAOM)	Yes	Yes	No	No	Yes	No	For-profit
American College of Traditional Chinese Medicine (ACTCM)	Yes	Yes	Yes	Yes	Yes	Yes	Non-profit
Atlantic Institute of Oriental Medicine	No	Yes	No	No	Yes	No	Non-profit
Bastyr	Yes	Yes	Yes	No	No	No	Non-profit
Emperor's College	No	Yes	No	No	Yes	No	For-profit
Five Branches	No	Yes	Yes	No	Yes	No	Non-profit
Maryland University of Integrative Health (MUIH)	Yes	No	Yes	No	Yes	No	Non-profit
National University of Natural Medicine (NUNM)	Yes	No	Yes	No	Yes	No	Non-profit
Oregon College of Oriental Medicine (OCOM)	No	Yes	No	No	Yes	No	Non-profit
Pacific College of Oriental Medicine	Yes	Yes	Yes	No	Yes	Yes	For-profit
South Baylo	No	Yes	No	No	Yes	No	Non-profit
Southern California University of Health Science (SCUHS)	Yes	No	Yes	No	Yes	No	Non-profit
University East-West Medicine	No	Yes	No	No	Yes	No	For-profit
Yo San	No	Yes	No	No	Yes	No	Non-profit

Table 6.3 Doctoral-level Schools in the United States

ACAOM had procedures to “approve” FPD programs, but it had no accreditation criteria were made public. This was confusing for schools, some

of which applied to have their FPD programs accredited by ACAOM, but were inevitably rejected for numerous reasons. It led schools with FPD programs, who had financial and material resources, to pursue regional accreditation while they waited for accreditation from ACAOM. As a result, the ACAOM still has not “accredited” any of the FPD programs, but a number of Chinese medicine programs are now regionally accredited. Not surprising, the schools who received regional accreditation, now feel that schools should be held to the same standards. Because of the reluctance or failure to accredit the FPD programs as well as the severed relationship with the CCAOM, it was clear ACAOM’s role as a predominant accreditor of schools was slowly shifting. What does this mean for the practitioners?

6.3 Titles in a Profession

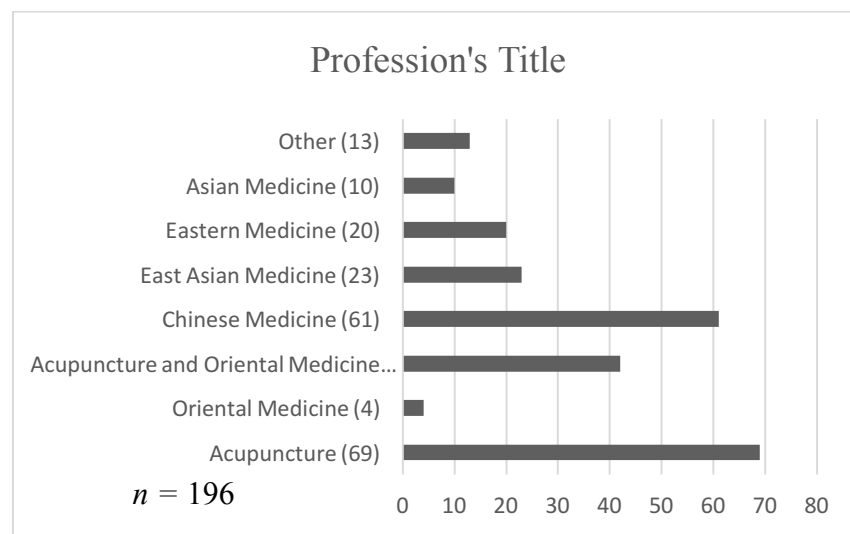
Most American medical professions’ titles are consistent. Allopathic biomedical physicians are known as “M.D.” (Lt. *Medicinae Doctor*), doctors of osteopathic medicine are “D.O.,” and Chiropractors are called “D.C.” Chinese medicine practitioners vary by state, accreditor, and school that a practitioner graduated from. In total I have counted thirty different titles for Chinese medicine practitioners in the United States. This is rather confusing for practitioners, let alone to the general public. Below in Table 6.4 is a list of common titles used by state licensure or school that uses the abbreviations for its practitioners. It is no way complete.

Title Abbreviation	State or Organization
AP	Florida
DAC	PCOM
DACM	ACTCM, PCOM
D.Acu	Rhode Island
DACoM	AOMA
DAHM	Daoist Traditions
DAOM	Designated Post-graduate degree
Dipl.Ac.	NCCAOM
Dipl.CH.	NCCAOM
Dipl.O.M.	NCCAOM
D.O.M.	MUIH
DSOM	NUNM
DTCM	Five Branches
EAMP	Washington State
L.Ac.	Common designation for License Acupuncturist
Mac	Five Branches, MUIH, NES/MCPHS, SIOM
MacOM	AOMA, OCOM, SIOM
MAOM	NESA/MCPHS
MATCM	Yo San
MOM	MUIH
MSA	Finger Lakes
MSAc	TSCA
MSAOM	South Baylo, Finger Lakes
MSOM	TSCA, NUNM
MSTCM	ACTCM, UEWM
MSTOM	PCOM
MTCM	Five Branches
MTOM	Emperor's
OMD	Original California designation
RAc.	Colorado, Canada

Table 6.4 Common Title Abbreviations of Chinese Medicine Practitioners

Consistency in titles and agreement on them is important in terms of legitimation for a profession. Throughout my thesis I have called it Chinese medicine, but many in the profession would disagree with this designation. With the variances of titles, data collection for Chinese medicine is rather complicated. Until 2016, the profession could not agree on what the profession should be called because the Bureau of Labor Statistics (BLS) had no Standard Occupational Code (SOC) for the profession. It was in fact NCCAOM who proposed the designation, “Acupuncturists,” which was at the dismay of several practitioners in the profession. Still no consensus has been met on the appropriate title for practitioners and profession. To better understand the sentiment of what the profession/ “medicine” should be called, I sent out a survey to practitioners in the field. The survey itself presented several methodological issues in that many of the participants chose several titles they

found fit for the profession. As a result, Graph 6.4 charts the sentiment of the various titles.

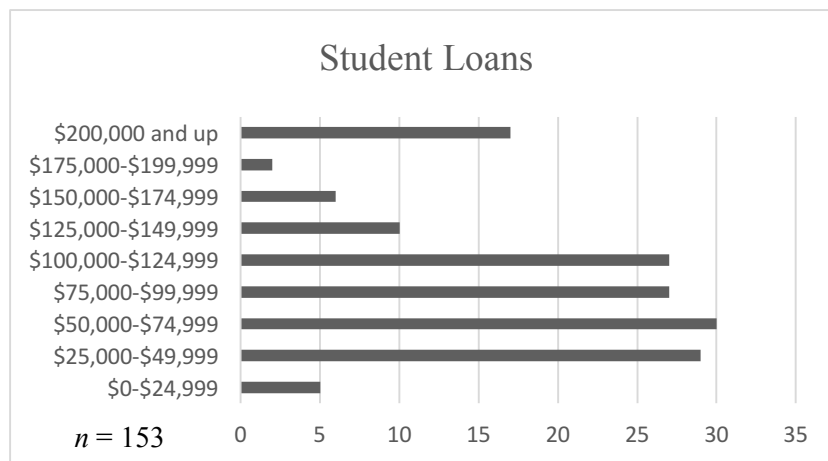


Graph 6.4 Profession's Title

The most favorable designation for the profession was “Acupuncture” (*n*=69) at 35.2%, which is commensurate with the NCCAOM’s recommendation to the BLS, but “Chinese medicine” (*n*=61) came rather close at 31.1%. The term “Acupuncture and Oriental Medicine” (*n*=42) was the third most acceptable term but this is complicated to analyze because it is commonly used by the regulatory bodies and schools as the norm to describe the profession. There was fierce opposition to the term “Oriental,” which matched the data. In the comments, the voiced opposition to the term “Oriental” ranged from a person who commented, “Would be supportive dropping the "Oriental" if that is offensive to east Asian groups.” Another person wrote, “oriental = carpets. acupuncture = leaves out herbs.” The issue of the designation of the profession will occur again, but later it would haunt the profession in the battle against other medical professions. Besides the ambiguity on what to be called, Chinese medicine in the United State acts as a ‘house of cards,’ with the appearance of an organized profession, but in reality a profession that is on the brink of failure. This is especially apparent when it comes to debt.

6.4 Debt and Gainful Employment

The prevailing challenges that practitioners encounter is debt. Practitioners have spent upwards of one hundred thousand dollars in student loan debt for Chinese medicine school. Out of 196 practitioners, 153 (78.06%) took out loans. Of the 153 practitioners who were paying off their debt, the slight majority of students took out respectively \$50,000-\$74,999 (19.6%) and \$25,000-\$49,000 (18.95%) in student loans, but just right behind were students who took out \$75,000-\$99,999 (17.64%) and \$100,000-\$149,000 (17.64%). In other words, 77.77% of graduates who took out loans have paid or a still paying off more than \$50,000 in student loans.

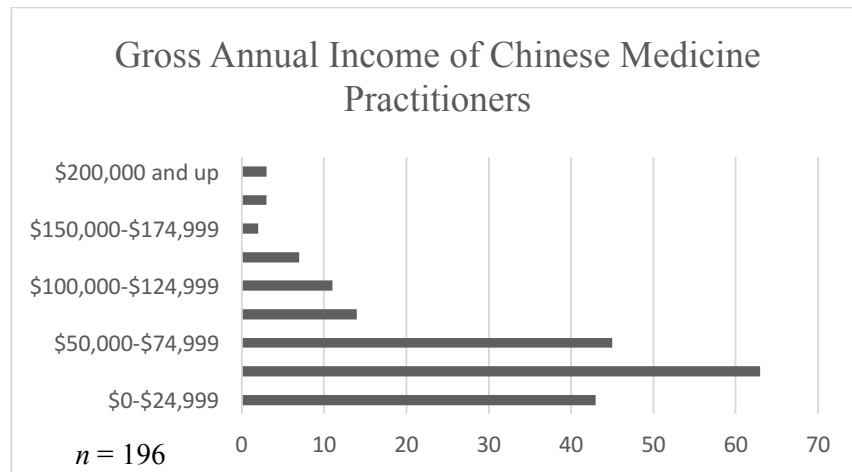


Graph 6.5 Student Loan Debt Among Graduates

The common scapegoat I heard from administrators is that student debt is pandemic within higher education. Although this is valid, Chinese medicine is a specialized field with skills that are not transferrable outside of the profession. This complicates matters for students who have spent more than four years and have thousands of dollars in debt. Besides the mostly theoretical training of Chinese medicine, schools were ill equipped to educate practitioners on how to build their own business.

A common theme I gleaned from interviews and internet forums such as “Acupuncturists on Facebook” is the claim of a six-figure salary. The data I have collected, as well as data from Job’s Task Analysis, shows the contrary. The NCCAOM’s 2013 Job’s Task Analysis (*n* = 1112) indicates that 62.2% (*n*=692) of its practitioners made less than \$65,000 gross before taxes and the

California Acupuncture Board's Occupation Analysis ($n = 485$) found that 59% ($n=286$) made less than \$59,999 gross before taxes (NCCAOM 2013, 30; CAB 2015, 19). Similarly, in a survey Graph 6.6 I conducted ($n = 196$), 79.05% (151) of the profession made less than \$50,000 annually.



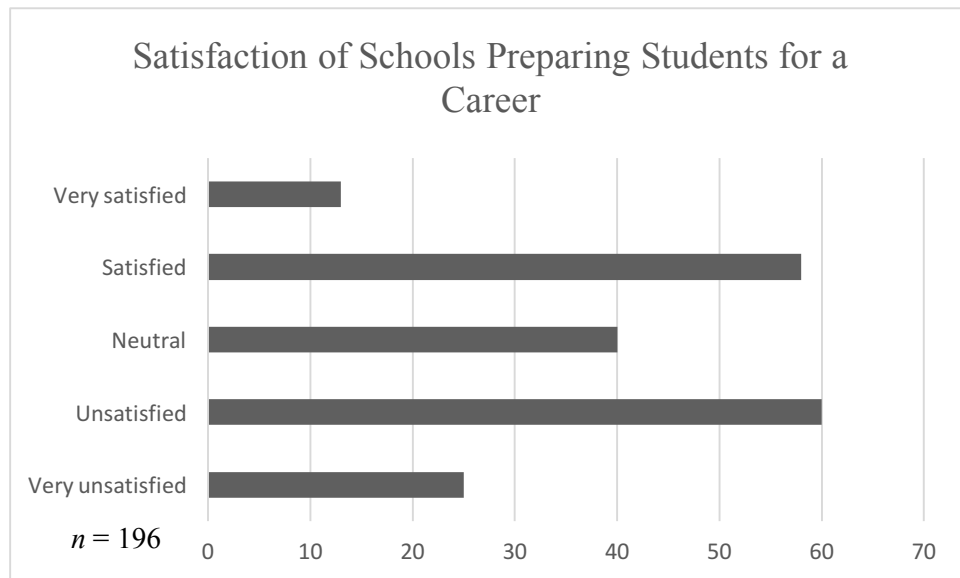
Graph 6.6 Gross Annual Income¹¹³

With the majority of practitioners earning less than \$65,000 annually, along with the debt that they have to pay in student loans, many schools have not addressed the issue properly. Since the majority of practitioners are in private practice, I was surprised to see many of the schools did not teach their students business skills. Out of the twelve sites I researched, only a third of schools actually taught their students skills relating to business. While in the field, I was approached on two separate occasions by school administrators for advice I could give their schools in teaching a business component. In both cases, I referred them to their nearest local universities who had small business development centers who helped small business owners start their own business. With the mounting debt students were accruing, it struck me as odd that the schools did not have resources for students to start their own business.

I asked graduates ($n = 196$) of Chinese medicine schools their feelings on how their school prepared them for a career (“How satisfied are you with your AOM/Chinese medicine school in preparing you for a career?”). On a five-point Likert scale, I found that 43.36% (85) of students were either “Unsatisfied” or “Very unsatisfied” with how the school prepared them for a career and 20.4% (40) were neutral. In other words, the majority of graduates felt that their school

¹¹³ Four participants did not want to divulge their financial information.

did not prepare them well for a career. Under the Obama administration, the Department of Education had taken measures to address the issue with their criteria of “gainful employment.”



Graph 6.7 Satisfaction of Chinese Medicine School Preparing Students for a Career

According to Black’s Law Dictionary, gainful employment is the “Condition of the employee receiving consistent work and payment from the employer. What a worker or college graduate seeks to provide consistent, continual income for self and family. Used in ranking colleges or universities as an attribute of the training and education received” (Gainful employment, n.d.). Gainful employment guidelines were proposed by Barak Obama in 2010 to prevent predatory business practices by for-profit universities and colleges in the United States where it ranked institutions as either “Fully eligible,” “Restricted,” or “Ineligible” (U.S. Department, of Education, 2010). Just recently, the U.S. Department of Education release its statistics on the for-profit institutions that have been failing the gainful employment criteria. In Table 6.5, it lists fourteen Chinese medicine schools that have been listed as “fail” for schools who have not met “Debt-to-Earning” (D/E) criteria.

School	Location
Acupuncture and Massage College	Miami, FL
American Academy of Traditional Chinese Medicine	Roseville, MN
American College of Acupuncture & Oriental Medicine	Houston, TX
AOMA Graduate School of Integrative Medicine	Austin, TX
Colorado School of Traditional Chinese Medicine	Denver, CO
East West College of Natural Medicine	Sarasota, FL
Emperor's College of Traditional Oriental Medicine	Santa Monica, CA
Florida College of Integrative Medicine	Orlando, FL
Midwest College of Oriental Medicine	Racine, WI
Pacific College of Oriental Medicine	San Diego, CA
Phoenix Institute of Herbal Medicine and Acupuncture	Phoenix, AZ
Seattle Institute of Oriental Medicine	Seattle, WA
Southwest Acupuncture College	Santa Fe, NM
Texas Health and Science University	Austin, TX

Table 6.5 Chinese Medicine Schools Listed as “Fail” but the U.S. Department of Education “Debt-to-Earnings” Criteria (U.S. Department of Education, 2016).

Fourteen schools are nearly a quarter of Chinese medicine schools in the United States and the list does not mention any of the non-profit schools. Four of the schools listed have doctoral programs. Chinese medicine schools, however, have taken a peculiar approach to the issue of gainful employment. As one president explained to me,

My biggest concern at this point is gainful employment. Our students, on the average, have \$95,000 in debt when they get out and some have more. We did look into turning into a non-profit, but the board didn't seem to want to go that way... There's no way we can meet those gainful employment requirements, we just can't. They're going to do the statistics and it's not just going to be on our students... The first time gainful employment thing came around – I wish that it has passed – because there was one way that they [Department of Education] had where we would have made it. The second time, they took that out. The first time was that if you [schools] had less than 35% of your students not in repayment, then you met the qualifications. Now repayment is not the same as default because we always had low default rates; most of the times zero. But students had to be in “repayment process.” A lot of students will be in deferment from hardship or other reasons going back to school. Those students would be considered a part of that 35%. Nonetheless, we would still be able to make it. Now they've taken that out. So it's not based on default or repayment. It's all based on debt-to-income ratio. They're not only going to be looking at our student's debt-to-income ratio, they're doing an average... There's no way we'll make it. So, I'm hoping that we get a Republican in because they're against it. You know? They're against it (Anonymous, Personal communication, December, 2015).

Sure enough, the Republican candidate who was elected president was Donald Trump. Not only was Donald Trump a Republican, he also ran a for-profit university, Trump University, that had to settle \$25 million on a series of fraud cases against him and the university (Eder 2016; Helderman 2016). Trump also chose Betsy DeVos as the Secretary of Education. DeVos and her husband had financial holdings through their Michigan-based private equity firm RDV Corporation. Recently, it has been uncovered that RDV Corp. had formed an investment fund known as Ottawa Avenue Private Capital which is the listed agent for LMF WF Portfolio, one of the companies who brokered a \$147 million loan to a debt collection agency for the Department of Education called Performant Financial Corporation. As *Washington Post's* Danielle Douglas-Gabriel writes,

If confirmed as secretary, DeVos would be in a position to influence the award of debt collection, servicing and recovery contracts, in addition to the oversight and monitoring of the contracts. She would also have the authority to revise payments and fees to contractors for rehabilitating past-due debt — all of which has Senate Democrats concerned (Douglas-Gabriel, 2017).

With a president who has profited from a for-profit university and an education secretary who has ties with student loan debt collectors, Chinese medicine schools, especially for-profit schools, seemed to have allies within the government to benefit their cause. In an odd turn of events, almost a month after Donald Trump was sworn in as the President of the United States and less than twenty days after DeVos assumed office, twelve of the fourteen Chinese medicine schools in Table 6.5 filed an injunction in an Arizona District Court against Betsy DeVos because the Department of Education had listed the schools as “failing” under the gainful employment regulations of the Obama administration (PIHMA Health & Education Network et al v. Betsy DeVos, 2017).

With evidence of Chinese medicine schools failing and practitioners in debt, it would be safe to assume that the profession would focus on the issues of education. Instead, the schools, regulatory bodies, and practitioners have spent most of their attention on the issue of “dry needling,” a technique employed by various biomedical professions which involve the insertion of

needles for the treatment of pain, mostly practiced by physiotherapists and chiropractors.

6.5 Is Dry Needling Acupuncture?

The issue of dry needling can be broken into two parts, scope of practice and safety. Dry needling, also known as “myofascial trigger point dry needling” is a technique employed by physiotherapists and chiropractors that is defined as “insertion of thin monofilament needles, as used in the practice of acupuncture, without the use of injectate” (Dunning et al., 2014, p. 253). Though the definition of dry needling is defined, its use varies. In the same review, James Dunning *et al* explains,

Given the broad base of international literature presently available on the technique, it is particularly concerning that the primary US-based, National Physical Therapy Association and several State Boards of Physical Therapy have recently narrowed their definition of dry needling to an ‘intramuscular’ procedure, i.e. the insertion of needles into nodules within taut bands of muscle, more commonly referred to as ‘trigger points’ (TrPs) or ‘myofascial trigger points’ (MTrPs). More specifically, these professional organizations have equated the procedure of dry needling with the term ‘intramuscular manual therapy’ (IMT) or ‘trigger point dry needling’ (TDN). Certainly, IMT, or the insertion of needles into TrPs within muscle bellies, is one aspect of dry needling; however, IMT or TDN should not be used synonymously with the term dry needling (Dunning et al., 2014, p. 253).

Debate over the origins of dry needling revolves around occidentalization, with a de-emphasis of its Eastern origins. Injections to MTrPs were first proposed by Janet Travell and David Siomons in *Myofascial Pain and Dysfunction: Trigger Point Manual*, but Travell introduced the idea of MTrPs or “trigger points” back in 1942 with her article in *JAMA* called “Pain and disability of the shoulder and arm: treatment by intramuscular infiltration with procaine hydrochloride.” In 1979, Karel Lewitt proposed the idea that mechanical stimulation of MTrP can relieve pain (Lewitt 1979; Kalichman and Vulfsons 2010, 641). In Canada, Chan Gunn developed the idea of Intramuscular Stimulation (IMS), which was more explicitly rooted in Chinese medicine and

was used in randomized controlled trials beginning in the 1970s. Gunn began studying Chinese medicine in 1974, but instead of meridians and channels, he believed that the acupuncture points corresponded with “neuroanatomic entities” that consisted of muscle motor points or musculotendinous junctions. As Gunn differentiates dry needling from acupuncture,

We tested dry needling in a randomized clinical trial but, unlike traditional Chinese acupuncture, in our approach (which was the beginning of IMS) patients were needled at muscle motor points. The group that had been treated with needling was found to be significantly better than the control group (Gunn and Wall, 1996, p. xvi).

In the Foreword of Gunn’s textbook, *The Gunn Approach to the Treatment of Chronic Pain*, physician Patrick D. Wall firmly details Gunn’s method.

[T]he fact that he [Chan Gunn] uses needles does not mean that he does so for the mystical unproven reasons on which Chinese acupuncture is based. After all, it was Janet Travell MD who introduced the phrase he uses, “dry needling”, when she discovered in the course of injecting local anaesthetic into tender points that it was not necessary to inject the local anaesthetic, since it was the insertion of the needle which produced the effect... It is true that he is of Chinese-Malaysian origin and is therefore familiar with the great tradition of Chinese medicine. However, his own educational background could not be more Western and traditional with his medical degree from Cambridge, his residency training in medicine and surgery, and his extensive clinical experience in family medicine and in industrial medicine (Gunn and Wall, 1996, Foreward).

Instead of the orientalism used for the professionalization of Chinese medicine in the United States, proponents of dry needling were attempting to occidentalize the medicine by deemphasizing any non-Western roots. Arguments that dismiss channel or meridians as well as *qi* or any other Chinese medicine nomenclature, serve as rhetorical devices used against the case which claims dry needling is acupuncture. The American Physical Therapy Association has issued guidelines and definitions for dry needling.

Dry needling is a skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the

management of neuromusculoskeletal pain and movement impairments. Dry needling (DN) is a technique used to treat dysfunctions in skeletal muscle, fascia, and connective tissue, and, diminish persistent peripheral nociceptive input, and reduce or restore impairments of body structure and function leading to improved activity and participation (APTA, 2013, p. 2).

Though the definitions of dry needling vary slightly, there is less consensus on the definition of acupuncture. Along with the thirty different titles of Chinese medicine practitioners as well as the various names for the profession, the definition of acupuncture varies from state-to-state. Here are a few,

“Profession of acupuncture” is the treating, by means of mechanical, thermal or electrical stimulation effected by the insertion of needles or by the application of heat, pressure or electrical stimulation at a point or combination of points on the surface of the body predetermined on the basis of the theory of the physiological interrelationship of body organs with an associated point or combination of points for diseases, disorders and dysfunctions of the body for the purpose of achieving a therapeutic or prophylactic effect. The profession of acupuncture includes recommendation of dietary supplements and natural products including, but not limited to, the recommendation of diet, herbs and other natural products, and their preparation in accordance with traditional and modern practices of East Asian (Chinese, Korean or Japanese) medical theory (NYSED, 2016)

“Acupuncture” is defined as the “stimulation of a certain point or points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body and includes the techniques of electroacupuncture, cupping, and moxibustion (CAB 2004, 10; B&P § 4927).

"Acupuncture" means a form of primary health care, based on traditional Chinese medical concepts and modern oriental medical techniques, that employs acupuncture diagnosis and treatment, as well as adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease. Acupuncture shall include, but not be limited to, the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body and the use of electroacupuncture, Qi Gong, oriental massage, herbal therapy, dietary guidelines, and other adjunctive therapies, as defined by board rule. (Florida Legislature, 2011, Chapter 457.102).

Acupuncture then is defined as either a treatment or a therapy. It can encompass the use of points or be a complex set of concepts and techniques. Embedded in each of the definitions are also its scope of practice. In some cases, such as Florida's acupuncture is not only the insertion of a needle but is also includes of oriental massage and herbs. It is uncertain if Florida acupuncturists have a monopoly on all herbs in the state as well as on the definition of "herbal therapy." The need for a national definition of acupuncture is important in the dry needling battle since common rhetoric used against physiotherapists and chiropractors by the acupuncturists is that "Dry needling is acupuncture." Since the definition of acupuncture fluctuates from state-to-state, this argument is complicated to justify. Besides the issue of professional definitions and scope of practice, the debate also relates with safety.

Dry needling is a rather aggressive and invasive technique. In California, a state which prohibits non-acupuncturists to practice acupuncture, I witnessed firsthand the technique used on a patient at a student clinic. Here is how I described the practice,

The course was taught by a senior practitioner in California who was said to be one of the pioneers of dry needling. He expressed to the class the legal aspects of dry needling and how California was one of the few states where chiropractors and physiotherapists could not practice it. After roughly an hour of explaining the theory behind the technique, the lecturer decided to perform it on one of the students. Fortunately for the lecturer, a middle-aged male student, agreed to having the technique performed on him.

The student-patient complained of a pain in his right hip. He told the lecturer and class that is was often uncomfortable for him to walk. After a five minute consultation on the duration and pain level of the student-patient's hip, the lecturer asked the student to lower his trouser and underwear so that his right gluteus was exposed. Then, the lecturer asked the student-patient where was the area of pain. The student-patient reached behind and touched the area on his right gluteus and directed the lecturer to palpate in the area. After roughly ten seconds of palpation, the student-patient screamed in discomfort. Immediately, the lecturer rubbed alcohol on the area, pressed the location that caused discomfort, placed a 6 inch needle (15.24 cm) that was in a guide tube on the specific region, tapped the needle in and vigorously needled the patient, thrusting the needle up and down.

The student-patient was clearly in agony and began to scream loudly, but the lecturer did not stop. Instead, the lecturer explained to the student-patient that it was supposed to be painful. As the student-patient began to scream even louder, the classroom was visibly shocked; the lecturer continued thrusting the needle. After almost a minute of manipulating the needle, the lecturer left it in the student-patient and continued with the lecture.

After twenty minutes, the lecturer went to see how the student-patient was feeling. The student-patient responded that the pain is worse. The lecturer began to affirm to the class that it was a natural reaction. Roughly an hour after the initial insertion, the lecturer removed the needles. Yet, instead of a cathartic relief that the class was expecting, the student-patient could barely walk.

I saw the student-patient in class a few days later and I noticed something that I did not notice before, he was limping. It seemed that the student did not receive the intended result, but he continued to attend class a few days after the “treatment” (Field notes, September 15, 2015).

The noticeable difference with dry needling compared to other techniques is how deep the practitioners insert the needles and how aggressively they manipulate it. The only other time I have seen acupuncture needles inserted as deeply was in Viet Nam with practitioners such as the renowned Nguyễn Tài Thu and Nghiêm Hữu Thành. The depth and aggressive insertion raises the issues of safety, not only for physiotherapists but also for acupuncturists.

In 2014, during a public demonstration of dry needling at a central London hospital, a video recorded an American allopathic medical doctor Dr. Robert Gerwin, perform the technique on a fifty-five-year-old male patient a weekend course. The video, it shows a doctor needling the patient’s left iliocostalis but at a perpendicular angle to the back and inserted the needle roughly 50 mm (roughly 2 inches) in the patient’s back. In most Chinese medicine schools I have observed, needling the back at that angle and depth would be forbidden. The following day, the patient went back to the clinic where he complained of a dry cough and a “sense of breathlessness on the left side,” which was where he was needled. The British medical acupuncturist had the patient x-rayed and found the patient had a 20% pneumothorax to his left-lung (Cummings, Ross-Marrs, and Gerwin, 2014).

This case presents a few issues in regard to both acupuncture and dry needling safety. Firstly, the technique was demonstrated by an American medical doctor who was evidently trained in dry needling. Secondly, the United Kingdom has no acupuncture regulations. The incident occurred under the supervision of British medical acupuncturists, who were licensed medical doctors practicing acupuncture. Lastly, they reported the incident in a letter to the journal *Acupuncture in Medicine*, a journal of the *British Medical Journal*.

Besides the apparent Adverse Event related to the demonstration, the doctors at least had procedures to record the event. Even in a country that does not have regulations for acupuncture, the United Kingdom's acupuncturists have managed to record Adverse Events whether mild or severe (White, et al. 2001; MacPherson et al., 2004). The World Health Organization has also recorded an extensive list of Adverse Events relating to acupuncture found in Chinese literature (Zhang et al., 2010). In the surveys listed, more severe Adverse Events such as pneumothorax and haemothorax as well as mild Adverse Events do occur in acupuncture and are recorded. I found arguments against dry needling in numerous Chinese medicine social media groups concerning the angle of safety. The acupuncturists used Adverse Events records physiotherapists and chiropractors voluntarily reported to various academic journals. A most striking observation about Chinese medicine practitioners in the United States is that either they do not know how to record Adverse Events or simply do not want to record Adverse Events. I experienced this firsthand when I was in the field.

As a part of my research, I received numerous acupuncture and herbal treatments at various schools throughout the United States. At one school I received both. It seemed the school dispensed mostly individualized herbal formulas that the student clinicians concocted based on my symptoms. Below in Table 6.6 is a list of herbs that I was prescribed.

Pinyin	Latin	Dosage (grams)
<i>Gau lou</i>	<i>Fructus Trichosanthis</i>	18
<i>Hou po</i>	<i>Cortex Magnoliae Officinalis</i>	12
<i>Zhi shi</i>	<i>Fructus Aurantii Immaturus</i>	12
<i>Zhi zi</i>	<i>Fructus Gardeniae</i>	9
<i>San bai pi</i>	<i>Cortex Mori</i>	9
<i>Fu ling</i>	<i>Sclerotium Poriae Cocos</i>	9
<i>Ban xia</i>	<i>Rhizoma Pinelliae</i>	9
<i>Chen pi</i>	<i>Pericarpium Citri Reticulatae</i>	9
<i>Gan cao</i>	<i>Radix Glycyrrhizae</i>	3

Table 6.6 Herbal Formula Prescribed

After the acupuncture treatment, it took almost an hour for me to receive the actual herbal formula. As a Vietnamese-American, I was accustomed to herbal tea formulas and had utilized them since I was a child, occasionally taking them if I was ill. Until this experience, I had been taking various herbal formulas recommended in my fieldwork and I never ran into any issues. On this occasion, I was instructed to, “Boil one bag [of herbs] in six cups of water down to four cups. Strain the decoction. Boil again four cups of water down to two cups.” The quantity was slightly different from other formula teas that I have tried or concocted, but not all too different.

I prepared the concoction as directed and drank roughly half a cup of the herbal tea. About forty-five minutes I noticed my heart racing with apparent palpitation and my right hand shaking uncontrollably. I thought it would disappear after a few minutes but approximately an hour later, the shaking got worse. My heart palpitations were still noticeable but did not improve or get worse. Coincidentally, I knew some of the clinicians in the clinic and contacted them as well as the school.

I thought the clinicians would be receptive to my adverse reaction to the formula, but instead, they started to blame me and not the formula. One clinician went on to say, “I don’t know how this could possibly happen. There’s no way the formula caused this issue.”

Frustrated and without any comfort from the clinicians, I decided to post my symptoms on a social media forum for licensed acupuncturists. It was common for practitioners to post adverse symptoms or complicated case studies on the forum where other

acupuncturists could find solutions. Reluctant at first, I decided to give it a try and hopefully I would receive positive feedback.

Most of the responses were positive, however, a few comments were outright abhorrent. One senior acupuncturist took on an accusatory tone and said, “WOOW You are an acupuncturist? Students prescribe a formula and you did not check if it was appropriate for you?”

I did in fact check the ingredients, and though I have not used them in combination, I never had adverse effect to them. Then, the same person decided to personally attacked me by posting my webpage to the forum and made a slanderous claim that I was a “student on the herb program,” which is incorrect. I never received any herbal education in the United States, nor was I a part of any herbal program.

I did not know what to do, so I decided to report the incident to both the school’s clinic and the state regulatory organization. I received a refund for the herbs I bought, but I wanted some proof that they filed the Adverse Event report or some indication that my case went on record. I never received anything. In fact, neither the school nor the state regulatory body did anything in the way of policy and procedures to resolve the issue or enacted any policy in the event of an Adverse Event (Field notes, March 28, 2016).

What I discovered from my own experience with an Adverse Event was that none of the Chinese medicine practitioners involved had any procedures in place for patients with adverse reactions to herbs and/or acupuncture. The insensitivity of practitioners and the public embarrassment that I endured displayed a lack of compassion and professionalism even amongst the senior acupuncturists. My situation revealed a ‘house of cards,’ in which the system of American Chinese Medicine clearly a dysfunctional system. I did find one group of acupuncturists who were actively trying to change the profession, Liberation Acupuncture.

6.6 Community Acupuncture and Liberation

With mounting student debt and the “turf wars” over the scope of practice, there was one group in Chinese medicine which had defiantly resisted the more capitalistic motives of the profession. They are commonly known as

Community Acupuncture (CA), but their struggle is termed Liberation Acupuncture.

In 2000, disgruntled by the American Chinese Medicine establishment, an Oregon acupuncturist named Lisa Rohleder opened the first Community Acupuncture clinic: Working Class Acupuncture (WCA). WCA provided and still provides today, acupuncture treatments on a sliding-scale where patients pay from \$15-45 per treatment. Because of its affordability, patients from almost every economic stratum can afford acupuncture. The average cost of an acupuncture treatment at the time was around \$55. WCA became quite successful and inadvertently turned into a social enterprise. With the success of WCA, Rohleder decided to reach out to the rest of the Chinese medicine community in the United States and created Community Acupuncture Network (CAN), which by 2011 incorporated as a cooperative called the People's Organization of Community Acupuncture (POCA, n.d.). Along with the help of her partner Skip van Meter, Rohleder taught a model that was not only revolutionary in its message but also in its approach.

Different from conventional Chinese medicine clinics in the United States, CA offered a unique experience that has since been repeated in dozens of clinics. Instead of the typical massage tables that acupuncturists use, CA used either home recliners with bed sheets on top or zero-gravity chairs that resemble a sturdier lawn chair. Patients sat in an open-room opposed to partitioned treatment rooms as in doctors' offices. For some Americans, this may seem foreign, but after receiving treatments from multiple CA clinics and running a CA clinic in Pittsburgh, I can attest that patients could not hear other patients due to either the distance from others and/or that the music drowned out any talking.

From my experience conducting fieldwork in Viet Nam and Bhutan, CA resembles the more "authentic" experiences of traditional medicine in both approach and layout. Vietnamese acupuncture clinics are meant for the poor and are often crowded with people receiving treatment in an open room. Similarly, the traditional medicine in Bhutan is government subsidized. Their hospital often treats poor patients from remote rural regions of the county. In the United States, without a national healthcare system that provides free acupuncture, CA is the closest model in Chinese medicine that offers

accessible and affordable treatments to accommodate poor and working-class Americans. CA is not an entirely original idea, but a continuity of revolutionary motivations within Chinese medicine in the United States.

Although CA and members of POCA reflect the more common traditional medical practices in Asia, they are perceived by the establishment as subversives. Instead of allowing the status quo to alienate them, POCA has embraced their differences by label for themselves as “acupunks” or simply “punks.”

Genuinely successful community acupuncturists have to refuse to act like acupuncturists, think like acupuncturists – even think of themselves as acupuncturists. The movement has come up with a useful shorthand: we call ourselves acupunks, or often just punks. Upstanding representatives of conventional acupuncture culture in the US are more than happy to agree with us about that: we are the troublemakers of the acupuncture world... Community acupuncture has a vision of what acupuncture would look like if it were truly grounded in the West, and we are fixated on the rooting process. ‘Root’ in Latin is radix. Not only are we punks, we are radicals. If conventional acupuncture in the West is an orchid – a delicate and exotic epiphyte – we are dandelions: not much to look at, but tenacious, nutritious and challenging (Rohleder, 2012, pp. 22-23).

A year later, Rohleder once again defended the labels of “acupunk” or “punk” after inappropriate accusations were made against POCA. Rohleder responded appropriately,

And so we have opted for irreverence, self-help and a spirit of mutualism. Instead of waiting for anyone important to recognize our ability to provide a valuable service and make life easier for us, we’ve embraced DIY (do it yourself) and DIT (do it together) to build our own structures. We’re approaching the practice of acupuncture the way that punk rock approaches music. We’re stripped down, technically accessible, populist and committed to doing it ourselves, so we feel it’s both responsible and transparent to identify ourselves as acupunks. And on a purely practical level, “acupunk” or just “punk” is a shorter and more efficient term than “acupuncturist” -- and we need to be efficient because, unlike some of our more reverent colleagues, we’re really busy treating people (Rohleder, 2013).

As radicals, PCOA borrowed ideas from revolutionary political movements as well as in Chinese medicine. Two specific movements that

influenced the bulk of POCA's acupuncture framework are Lincoln Detox Center and Taiwanese practitioners of Chinese medicine.

6.6.1 Lincoln Detox Center

On July 14, 1970, Bronx's condemned Lincoln Hospital was seized by the Puerto Rican nationalist group from New York called the Young Lords who had "the goal of improved health care and working conditions (Wanzer-Serrano 2015, 59). The Young Lords were a part of the self-described "Third World radical organizations" who shared a common struggle with groups such as the Black Panther Party (from here on Black Panthers), I Wor Kuen, and the Brown Berets who sought a "revolutionary nationalist agenda," which was to "address the material, political, and psychological needs of the community" (Wanzer-Serrano, 2015, pp. 1-2). During the occupation of Lincoln Hospital, a cadre of health professionals ranging from medical doctors to acupuncturists, created the Lincoln Detox program, which was initiated to combat the crack cocaine epidemic destroying African American and Latino communities in New York. As one of the prominent figures, Mutulu Shakur of Lincoln Detox explained,

The goals of Lincoln Detox were to provide the community with a healing, non-chemical solution to the detoxification of addicts (acupuncture and natural healing), train community people in the theory and use of acupuncture, and provide political education about the drug plague, who controls the drug empire and how to resist (Shakur, 1985).

Mutulu Shakur, who was the adopted father of the late-rapper Tupac Shakur, began his revolutionary activity by joining the Black Panthers in the 1960s. Shakur and others joined Lincoln Hospital in the early-1970s because they were unsatisfied with the government's response to the crack cocaine epidemic, which was by prescribing addicts the opioid drug methadone. Along with others at Lincoln Detox, Shakur went to Canada to learn acupuncture from doctors Oscar and Mario Wexu. The Wexus, who were influenced by the teachings of Nguyễn Văn Nghi, established the International Society of Acupuncture in Quebec, which by 1972, became Institut de Médecine Traditionnelle Chinoise du Montréal (Institute of Traditional Chinese Medicine of Montreal) (Barnes, 2013, p. 296).

Before 1975, New York had no acupuncture laws and most of the patients at Lincoln Hospital were signed-off by medical doctors. Shakur worked with medical doctors such as Frank Atfeld, Richard Taft, who was the grandson of twenty-seventh president William Howard Taft, and Michael O. Smith, who was known for a five-needle technique called the “NADA protocol.” In the late-1970s, Shakur flew to China with Mario Wexu then toured Europe to further acupuncture education. By 1978, Lincoln Hospital was closed by the New York Police Department (NYPD) (Shakur, 1992). After the closure of Lincoln Hospital, Shakur created Black Acupuncture Association of North America (BAANA)¹¹⁴ in Harlem, which taught African Americans acupuncture and provided free acupuncture for the community.

In the late-1970s, the Black Panthers had almost entirely dissolved. With the Federal Bureau of Investigation’s (FBI) Counter Intelligence Program (COINTELPRO) and internal fighting, often as a result from COINTELPRO, many Black Panthers such as Shakur either abandoned the organization, went “underground” in hiding, or were killed. Especially displeased with the Black Panther’s treatment of women, Shakur left the Black Panthers and joined, with other members, the Black Liberation Army (BLA). The BLA were known to be more militant than the Black Panthers, but also had an explicit anti-sexist position. Their three-point platform was,

1. That we are anti-capitalist, anti-imperialist, anti-racist, and anti-sexist.
2. That we must of necessity strive for the abolishment of these systems and for the institution of Socialistic relationships in which Black people have total and absolute control over their own destiny as a people.
3. That in order to abolish our systems of oppression, we must utilize the science of class struggle, develop this science as it relates to our unique national condition (BLA, 1976, p. ii).

Shakur’s affiliation with the BLA would result in his indictment on a Racketeer Influenced and Corrupt Organizations (RICO) charge where the federal government alleged BAAANA was funded by money stolen from armed robberies conducted by the Black Liberation Army.

¹¹⁴ Also known as the Black Acupuncture Advisory Association of North America (BAAANA).

BAAANA became a target in a RICO conspiracy. What they allege is that because BAAANA was providing this kind of healthcare and the insurance companies were not giving money to BAAANA because they were a part of another counter-intelligence strategy to try to close us down by refusing to pay rightfully due insurance bills to the clinic, they alleged that the clinic was being kept alive by the Black Liberation Army. And they alleged that the Black Liberation Army was robbing armored trucks in order to keep the acupuncture clinic alive as well as other organizations and facilities in the black nation. And so I became a target of an investigation, March 20th, 1982 I was indicted for the liberation of Assata Shakur because I was her legal assistant on many of her cases during the '70s. They target me with her liberation, I was targeted as part of the liberation of freedom fighters as well as the expropriation of 9 or 10 armored trucks during the course of '76 to '81 (Jess, 1992).

Since 1982, Mutulu Shakur has been serving a life sentence while Assata Shakur has been a fugitive of the United States and exiled in Cuba. Shakur and members of Lincoln Hospital provided something unique and revolutionary. Unlike most of the white pioneers of Chinese medicine in the United States who used acupuncture as an asset to the State with an orientalist gaze, the New York acupuncturists at Lincoln Hospital practiced acupuncture to assist the poor and to combat the addiction epidemic. It was used as tool and alternative to the proposed treatments by the government. As Mutulu Shakur explained,

So the Lincoln Detox became not only recognized by the community as a political formation but its work in developing and saving men and women of the third world inside of the oppressed communities, resuscitating these brothers and sisters and putting them into some form of healing process within the community we became a threat to the city of New York and consequently with the development of the barefoot doctor acupuncture cadre, we began to move around the country and educate various other communities instead of schools and orientations around acupuncture drug withdrawal and the strategy of methadone and the teaching the brothers and sisters the fundamentals of acupuncture to serious acupuncture, how it was used in the revolutionary context in China and in Vietnam and how we were able to use it in the South Bronx and our success. Primarily because we had a love for our people and we had a commitment to our people, we started very rudimentary (Jess, 1992).

Although Lincoln Hospital and BAAANA have been closed for more than thirty years, their legacy prevails through the treatment of addiction with acupuncture and community acupuncture. From the experience at Lincoln Hospital, medical doctor Michael Smith helped create the five-needle auricular procedure known as the “NADA protocol,” which serves as the primary protocol for treating addiction. The NADA protocol was created in the most unorthodox circumstances, where Smith informed me that in its experimental stages, the acupuncturists at Lincoln Hospital just randomly placed needles on patients’ bodies. Smith eventually decided to create a protocol that would be used to treat patients with substance addiction (M. Smith, Personal communication, April, 2016).

In a conversation with him about the creation of the five-needle protocol, he bluntly stated, “I made it up.” Surprised by his response, I asked him again and he reiterated how the protocol was simply constructed through the experimenting at Lincoln Hospital. The protocol has been widely used all over the world including communities who were affected by Hurricane Katrina in Louisiana and British prisons where prison officers have been trained in the protocol under the UK SMART Recovery (because of its success in lowering violent incidents by 80%). Northern Europe has implemented the protocol for psychiatric care, Thailand’s DARE program used it in Burmese refugee camps, and the Real Medicine Foundation practiced the technique in East Africa. Out of the fifty states, only twenty states allow non-acupuncturists to practice the technique without being licensed acupuncturists.

When I approached Michael Smith about the issue of NADA’s restrictions, he was rather disappointed that most states did not allow non-acupuncturists to practice it and that most of the resistance came from the acupuncturists. Another unique aspect about NADA is its accessibility. NADA is not weighted down with all of the medical restrictions because there is no diagnosis and can be taught to and by anyone. Smith discussed with me how he wanted acupuncture to be freely practiced just as it was at Lincoln Hospital and that he was one of the few practitioners in New York who resisted regulations. The NADA protocol is an example of an effort to bring acupuncture to the community. It is a form of resistance, not only as an alternative to proposals from the government, but also a way to spread Chinese medicine to

the community. Its removal of diagnosis and treatment was essentially a revolutionary shift which simplified the practice without the medical complications that groups such as the UCLA cohort complicated themselves with. Along with Lincoln Hospital, Taiwanese traditions have deeply impacted Liberation Acupuncture.

6.6.2 Taiwanese Traditions

With the political legacy of Lincoln Hospital and NADA, Community Acupuncture's praxis is borrowed from Taiwanese schools of Chinese medicine. In particular, Rohleder has mentioned on numerous occasions how Miriam Lee is one of her pivotal influences. From Lee's struggle to practice acupuncture in California to her relentless work to help people, Rohleder has found inspiration in Lee's legacy (Rohleder, 2009, p. 35; 2017, pp. 27-28; n.d.). Lee has attributed her influence to Master Tung Ching Chang (Dong Jing-Chang 東景昌 1915-1975), who is known for his "magical points" (*qi xue* 奇穴). Tung was from Shangdong (山東) and reported to be from a three-hundred-year-old acupuncture tradition. Following World War II, he fled mainland China and moved to Taiwan. There, he amassed a sizable following and was known for a particular classification of acupuncture that used a Roman numeric similar to the World Health Organization's but was completely different in its configuration (Flaws 2002, vii-viii). Many practitioners in the field, especially community acupuncturists, used Tung's hand points, which mirror the entire system of the body. Another student who claimed to have learned under Tung was Richard Tan.

Richard Tan (Teh-Fu Tan 譚特夫 ?-2015) was one of the most influential teachers of American acupuncture during the late-20th and early-21st centuries. He advertised seminars on his as the "Dr. Tan Show." I had the opportunity to attend his last seminar in the United States right before he passed in 2015. Tan was a charismatic figure who had a low raspy voice. He carried a microphone set that had a speaker system attached to his belt and was known for his casual use of profanity and un-politically correct views. He was most notably known

for his dismay with the American acupuncture establishment, especially TCM. In the preface to *Master Tung's Acupuncture*, Tan explains,

After coming to the U.S. some 20 years ago I was astounded at the relatively low level of clinical efficacy accepted as normal by the American TCM trained acupuncture community. The highly standardized TCM format adopted for curriculum purposes by U.S. acupuncture colleges does make it possible to educate and test large numbers of practitioners in a consistent way. Establishing a baseline level of competency is an important service, and the schools do this job well. However, standardization causes TCM acupuncture to suffer from the serious side effect of oversimplification. In terms of the rich and diverse tradition of theory and practice... what is taught in the U.S. as TCM represents only a conceptual skeleton and one with a few bones missing at that. As a result, acupuncturists in this country are often at a disadvantage when it comes to obtaining a consistently high level of clinical results (Tan, 2002, p. iii).

Tan's critique of the standardization of TCM reflected several other traditions who have been pushed to the margins. Just as Tan mentioned, the potential for oversimplification strips the rich diversity that Chinese medicine has to offer in its heterogeneity. Unlike Tan, many practitioners continue to practice in secret.

Tan's approach was surprisingly logical, accessible, and taught in a matter of a five days. There was no pulse or tongue diagnosis. Instead, he had an easy three-step assessment and treatment protocol based on the meridians/channels and the only real knowledge needed prior to attending the seminar was the trajectory of channels and the "Six Stages" (*liu jing* 六經).

Step 1: Diagnose the Sick Meridian

Step 2: Determine the Treating Meridians based on the Five Systems of the Balance Method

Step 3: Point Selection base on Step Two (Tan, 2007, p. viii).

His method emphasized distal points where practitioners never needle the site of injury or pain, but mirror the system of the body. Without going into too much in detail, one technique involves the hand gesture of a swan in shadow art; the back of the wrist would be the neck, front of the wrist for the neck, the crease between the index finger and thumb resembles a mouth, and knuckles looks like eyes. The acupuncturist would palpate the areas that mirror

the area of pain and place a needle in the tender area such as a pin the back of the wrist if the patient had neck pain, front of the wrist for throat pain, crease of index finger and thumb for mouth issues, and knuckles for eyes. In many ways, it was the opposite of dry needling where the needle was placed in the direct area of pain. In all of his demonstrations, he immediately had attendants practice and results were almost immediate.

Tan's motto was "Stand a pole under the sun, and you should immediately see its shadow" (*li gan jian ying* 立竿见影), which meant "the acupuncturist should have no doubt about the effectiveness of his treatment because the results are instantaneous" (Tan 2007, vii). Two noticeable aspects of his seminars were the diversity of attendants and the amount of knowledge people obtain in such a limited time. On numerous occasions, practitioners claimed to have learned more in the few days of the seminar than the combined four-years of Chinese medicine school. Because Tan's method is practical and effective, community acupuncturists have adopted the method and it is now taught at the community acupuncture school POCA Tech.

6.6.3 *Combating the Financial Bubble*

POCA was the only organization I encountered which provided practitioners strategies to pay off their student debt. During their semi-annual conference called "POCA Fest," workshops included ways to setup a clinic as tax exempt non-profit corporation. In 2007 the then President of the United States, George W. Bush proposed the Public Service Loan Forgiveness (PSLF) program whereby applicants who were approved by the program and worked for a non-profit organization, would have their student debt erased after ten years as long as they made the expected monthly payments. The workshop was tedious and quite involved but the presenters, all of whom setup their clinics as tax exempt non-profits, had the appropriate forms listed on POCA's website and even posted a video of the workshop. The non-profit clinics answered any questions people had about the nuances of either program or the bureaucratic hurdles that entailed being a non-profit.

POCA also sought to change the initial cause of financial burden, student tuition. In 2014, POCA opened a school in Portland to train community acupuncturist and offer an alternative to the standard model of Chinese medicine schools. Unlike most schools costing upwards to \$84,000, POCA Tech's entire program was nearly a third of the price at \$23,000. POCA Tech, however, does not accept everyone who applies and actually encourages applicants not to.

- 1) Practitioners of Liberation Acupuncture don't make a lot of money or have a lot of material security. If those things are important to you, you'll be miserable here. Do your homework about what community acupuncturists earn.
- 2) POCA Tech is no place for consumers, and we've all been socialized to be consumers. POCA Tech is a project of the POCA Cooperative, and it reflects a cooperative mindset, which can be a real shock to your system. Another way of saying this is that being in the POCAverse will mess with your head (and possibly with your relationship to other parts of our consumer society). Down the rabbit hole, through the looking glass, out of the matrix -- however people describe it, it's radically different here. Some people love that about the POCAverse, some people hate it (POAC Tech, n.d.)

As an assurance, the school requires all of its incoming students to sign an agreement before attending. The first paragraphs read.

I recognize that the only purpose of POCA Tech is train punks for the POCA Cooperative, and that POCA Tech would not exist without the personal sacrifices of many Co-op members.

I understand that part of POCA Tech's role as an acupuncture school is to be a gatekeeper for people entering the acupuncture profession: to prepare graduates to be independent healthcare practitioners. Clinical supervisors are obligated to address situations in which they feel an intern's judgment, maturity, emotional stability, temperament, and/or attitudes may make punking a poor fit as a career. Clinical supervisors may create plans for improvement for students (subject to approval by the Clinic Circle) to follow as a result of identifying these situations. Interns are obligated to fulfil these plans for improvement; failure to do so will result in failing clinic evaluations (POCA Tech, n.d.-a).

POCA and POCA Tech are the only Chinese medicine organizations that addresses the issue of capitalism within the school system. As another way

to dissuade people away from the school only because of its affordability, they write,

Being an acupuncturist will bring you face to face with all the problems of our society: unequal access to healthcare, the physical and mental effects of oppression, the structural violence of capitalism, your own relative privilege. (If you're thinking of going to acupuncture school, by definition you have more privilege than a lot of community acupuncture patients do.) POCA Tech won't romanticize any of that. If you're looking for an escape, this isn't it. On the other hand, if you really can't be happy without engaging those kinds of problems, this might be the right place for you (POCA Tech, n.d.)

Though POCA is not for everyone, it does present an alternative to the profession. Throughout POCA's website, it stresses that acupuncture is a vocation. Their strategy to reprofessionalize is another plan that POCA has to combat the issue to financial debt. Instead of the impetus for the profession to raise standards to the entry-level doctorate, POCA reengineered this idea by labelling acupuncture a vocation, which has the potential to be an undergraduate education. This would save students money and pave the way for education to be taught at a university level, which reflects the British education system.

6.7 Solutions from Britain?

As an anthropologist at a British university and as an acupuncturist, it is difficult not to draw comparisons between the two countries, especially when much of contemporary American Chinese Medicine traditions were influenced by British Chinese medicine practitioners. The most obvious difference is the lack of licensure or government regulations of acupuncture in Britain. Membership is not compulsory in the United Kingdom's professional organization, the British Acupuncture Council. Attempts have been made for government regulation, but no sign of Parliament actively proposing any legislation. Despite the lack of regulations, a considerable amount of research at various universities across the country has been invested in Chinese medicine for both acupuncture and pharmacology. Many of these institutions

have protocols in place for Adverse Events recording and the Medicines and Healthcare products Regulatory Agency (MHRA) have the Yellow Card Scheme for the general population and healthcare providers to report adverse side effects of herbal formulas as well adverse incidents related to medical devices. This is simply not the case in the United States.

Despite the required education and stringent regulations in America, there has been a lack of clinical research produced from Chinese medicine schools and/or universities. With the education predominantly comprised of abstract Chinese medicine theory, constructed from British Chinese medicine practitioners, a fraction of the curriculum actually relates to patient safety. As a result, practitioners are not taught how to record complications that arise from treatment or ways the profession can prevent future incidences from occurring. No formal procedures are in place to report adverse events in American Chinese Medicine. Members of the profession and the profession itself hide behind the veil of its presumed benign methods of treatment. This also has adverse outcomes for the general public in terms of herbs.

Since there are no regulations or curriculum requirements for acupuncturists in the United Kingdom, British acupuncturists do not have as much of a financial burden as Americans. A common response from school administrators and members of regulatory bodies is that student debt is a national issue, not only specific to Chinese medicine. While student debt is a national issue, Chinese medicine is a specialized field where its skills are mostly non-transferable to other professions. If graduates in the profession are unsuccessful, their options are limited. Those who actually benefit from professionalization are members of regulatory bodies and charismatic figures who create or borrow techniques. From the gainful employment statistics, not even the top schools are fulfilling the government's standards.

Sometimes labelled an "alternative medicine," Chinese medicine was meant to create an alternative or an adjunctive complement to the system of allopathic biomedicine, both in structures of care and actual treatment. Maybe it is time for the American profession of Chinese medicine to approach these issues from a similar approach.

6.8 Final Thoughts

The original purpose of my thesis was to determine the power structures of American Chinese Medicine. I have laid some of the groundwork to outline the basic structures of domination and the triviality of its focus for control. As an anthropologist and Chinese medicine practitioner, it is my obligation to synthesize the data from the field to inform social scientists and practitioners alike on ways to approach the crucial issues of professionalization and social inequity. Throughout my research and ethnographic experience of American Chinese Medicine, there are several potential routes to further investigate. Some regulatory bodies have addressed the issue of gainful employment but little has been done to resolve the issue. Schools continue to market more advanced degrees or specializations while students continue to struggle to pay off their debt. Professionally, acupuncturists lead a crusade against physiotherapists to maintain their territory, however, both sides have not considered mediation strategies to find common ground. The energy devoted to court battles and lobbying should be directed at finding ways to ensure patient safety and wellbeing. Anthropologists are needed in all of these areas. We have the expertise to work as “cultural brokers” and create positive change for the medicine and the people involved.

One of my contributions to both fields is to address the problems Chinese medicine faces in America so it does not happen again to other professions and traditions. Chinese medicine has a tenet to observe phenomena as “microcosm of the macrocosm.” The difficulties Chinese medicine confronted with professionalization reflect a series of issues other Integrative Medicine professions such as yoga, Āyurveda, and various meditation techniques are beginning to encounter. If there was a lesson to be learned from my research, it is to embrace difference. Heterogeneities keep medical traditions like Chinese medicine “alive,” adapting to the needs of patients and practitioners.

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