Engaging vitality

An approach to more effective engagement with qi

By Dan Bensky and Charles Chace

The principle of qi lies at the heart of Traditional East Asian Medicine (TEAM). As practitioners of this medicine, most of us believe we take qi seriously and that it has an experiential reality. Yet if we critically examine our approach to qi, we often find that our engagement of qi has become so abstract as to be little more than a metaphysical concept.

FOR INSTANCE, OUR conceptualisation of the relationships between the *zangfu* and anatomical structures is often considered tenuous or irrelevant. We assure patients with Liver qi issues that this diagnosis has no relation to the anatomical liver. Despite its importance to Chinese medical theory, how many practitioners of TEAM have any interest in the location of the Gallbladder when seeing a patient who complains of insomnia?

There is, of course, a similar tendency to embrace the opposite extreme. From this perspective, qi is a primitive shorthand for blood circulation and the *chong* vessels are synonymous with the aorta. This approach is equally flawed and clinically limiting.

How do we take the principle of qi and its relationship to form and structure seriously? How do we engage qi in a concrete, expansive and clinically useful manner?

Over the course of our careers, we have utilised palpatory techniques and sensibilities from the Western osteopathic profession in response to this challenge. This has led us to new modes of thinking about what we are doing that we believe have helped us become more effective practitioners. As we will show below, an integration of osteopathic palpation into the practice of TEAM transforms how we conceive what we are doing. While in some ways a product of the contemporary Western clinic, this engagement with the vitality of

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the body and our traditions is an outgrowth of those traditions and the emphasis on context that permeates much of the East Asian world view.

We operate with the postulate that one should be able to feel the effects of any function that interacts with the structure of the body. Traditional East Asian forms of palpation, such as pulse diagnosis and abdominal exams, are extremely useful ways to get this information, but some osteopathic approaches, with their stronger emphasis on the intersection of structure and function, can be more concrete and easier to use. At the same time, the way that we have come to think about what acupuncture actually does is to see it as giving information to or engaging the body's self-healing mechanisms and mobilising them to improve the health of the patient and treat problems. Palpation that allows us to directly feel and engage the qi makes this work much easier.

It is worth noting here that while we have actively adapted a new and ostensibly "foreign" set of palpatory findings to the TEAM framework, what makes these findings so useful is that they are all clearly connected to the basic building blocks of the body in TEAM. For us, these palpatory findings *are* qi, yang, yin, the channels etc. In this, they do not really require translation, and there is nothing about them that requires therapies outside of the TEAM framework. For this reason, we refer to these palpatory findings in terms that are drawn from within the TEAM model whenever possible, while acknowledging their origins in osteopathy.

Multiple lenses on qi

Once we take seriously the premise that we are working with qi, we are immediately confronted with the question of how we can meaningfully evaluate that engagement. Radial pulse diagnosis has traditionally been regarded as the pinnacle of qi-assessment. Yet from the earliest extant texts on this medicine, it has been recognised that the pulse alone is not an entirely reliable arbiter of therapeutic change. Regardless of how good one is at pulse diagnosis, an improvement in how the pulse feels does not invariably reflect the full effect of a treatment nor does it necessarily signify a positive outcome.

TEAM practitioners often rely on useful and frequently conflicting information from the tongue and abdomen to complement our appreciation of qi. Confidence in our therapeutic effect is enhanced, though not guaranteed, when the pulse, tongue and abdomen all suggest an improvement in the regulation of the qi. As a general rule the more palpatory referents that we have for assessing our engagement of the qi, the more clearly and precisely we will be able to do so. On this basis, the mere fact that the osteopathic tradition gives us additional ways to do this is useful.

TEAM posits a wide range of distinct kinds of qi. These include, for instance, yin qi, yang qi, protective qi, nutritive qi, source qi, essence qi, blood, fluids and so on. Although we have clear definitions for these concepts, we have remarkably few palpatory referents for them in clinical practice. This is one way in which we have abstracted qi in modern TEAM to the point of ambiguity. Qi has become something to be conceptualised as opposed to something to be experienced. Using a range of palpatory techniques drawn from osteopathy we have found that we now have more immediate experiences of qi at play in the human body and are able to better verbalise those experiences.

Contextual therapeutic engagement

We have found that approaching our clinical work from this new perspective has helped us to make optimal use of the conceptual framework of TEAM. Not only does the theory of TEAM come alive under our hands, but it has led us to more effective treatments.

The palpatory information we receive in this way tells us a few important things. First, it provides a concrete sense of the location or locations where qi is disturbed or obstructed. Next, our palpatory findings can provide information regarding the nature of qi involved; for instance is it nutritive qi, fluids, or essence qi? Finally, these findings can help us to provide the optimal amount of stimuli for a given situation.

Learning how to do these types of palpation effectively requires the cultivation of a beginner's mind, as we first appreciate our palpatory experience without any attempt at interpretation, and only after that do we consider what it might mean. In addition, they are a basis on which to build

an understanding of what is going on with the patient, but, like all other findings such as pulse, tongue, and abdomen, do not tell us specifically what to do. This encourages an openness and flexibility that we have found very helpful in the clinic, as all the various options that present themselves are grounded in immediate, concrete feedback. We may have a palpatory finding that feels a certain way. We may then, for instance, interpret that finding as an indicator that the yang qi needs to be more optimally mobilised. It is our responsibility to figure out how best to accomplish that goal given that particular presentation at that particular moment, and the therapeutic tools we as individual practitioners have at our disposal. Whatever we do, that finding should improve if we are to get a positive response to the treatment.

We have found that approaching TEAM in this manner is for many a radical divergence from their usual practices. The overwhelming majority of approaches to acupuncture are protocol driven. Given X set of symptoms or signs then one must needle Y. Having done Y, one must next do Z. Methodologies such as this are a fine place to start, but their rigidity makes them difficult to use as a foundation to gain experience.

The approach that we are advocating interjects a strong element of fluidity into one's clinical practice. At every step of the therapeutic encounter we need to check in and see what intervention is required. We use no fixed protocols in our own treatment approach but implement a moment to moment engagement of the qi. This methodology also allows for the coherent integration of a variety of treatment styles.

Many, if not most, acupuncturists practise more than one style. After many years it is not uncommon for practitioners to say that they practise their own style, meaning a synthesis of a variety of approaches. While this type of integration can be seen as a hallmark of maturity in clinical practice, it needs to be examined critically. Does one's approach represent a true integration of styles or simply a mixed bag of techniques, each of which is used to address a particular pattern or syndrome? Many young acupuncturists practice in this way, remembering that they saw Dr X use one technique to effectively treat a patient for one disorder, and Dr Y use another technique to treat another kind of problem. There is nothing inherently wrong with this sort of approach, as far as it goes, and it can produce good clinical results. In our experience, however, it does not create a true synthesis of styles and perhaps more importantly, it does not provide an avenue to learn from one's own patients and thereby gain experience. We believe that the contextual engagement of qi that we are advocating is a useful tool for growing a personal approach that takes advantage of the practitioner's own strengths and their own particular educational background. The resultant approach will be grounded in the concrete experience of qi in their hands.

Mindset

Traditional East Asian medicine has a deep understanding of a wide variety of processes and functions in the body. As noted above, we work under the postulate that if a process affects the structure of the body, there should be a way to feel the effects of that process. This idea of the intimate and irreducible relation between structure and function is the core of the osteopathic understanding of health and disease.

Another part of our background beliefs is that we all actually understand very little about human health and disease. This not only keeps us somewhat modest about what we can do, but makes us distrust all systems of understanding or practice that are rigidly applied or all-encompassing. These run the real risk of fitting the patient to some Procrustean bed that is harmful. We are convinced that more open-ended and flexible approaches are more consistently useful. This requires a comfort with uncertainty and an openness to possibilities that appear during a treatment session. This gives us the possibility of a more nuanced, accurate and helpful way of looking at a particular patient at a particular time. Being constrained by preconceived notions of such things as point combinations, the six types of insomnia etc. is not conducive to gaining experience.

If these new palpatory findings invariably confirmed our pulse and tongue findings then what good would they be? It is when they tell us something different, when they point us in an unexpected direction that they are truly of value. For this to happen,

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we must be comfortable with uncertainty and approach each patient with a clean slate. This means that we have to avoid having any agenda about what we think we should be feeling. We must remain open to whatever it is that we perceive, even if it initially appears to be contradictory information.

Listening to the qi in this way can be difficult as we are conditioned by the approaches we know and it is usually easier to make everyone fit into the patterns described by them. What if we feel something that is not intelligible in those contexts? We can no longer rest on the authority of an established perspective. This then forces us to take responsibility, to make sense of that finding, and to understand the relevance of that particular nuance of the qi in a given patient at a specific moment in time. These are not issues that can be found easily by looking in a textbook.

This discovery process has the side benefit of driving us to further study. On the one hand, the things that we feel push us to understand them better from a TEAM perspective, which requires further study of the classics and other important texts. On the other hand, the more we feel the structure, the more we want to clearly visualise it. This leads to work on modern anatomy and physiology. This engagement not only helps our patients, but helps us feel more connected both to our tradition and to the contemporary world.

Practicalities

Let us provide just one concrete example to illustrate these points. One of the palpatory techniques we utilise is feeling for one of the inherent motions of the body described by the 20th century osteopath William Garner Sutherland, the originator of most forms of "cranial" practised today. This is usually known in the osteopathic cranial world as the primary respiratory mechanism (PRM). Despite the presence of osteopathic jargon, we believe it is useful to list Sutherland's original formulation of what makes up the PRM:

1. Inherent mobility of brain and spinal cord
2. Fluctuating cerebrospinal fluid
3. Motility of the intracranial and spinal membranes
4. Mobility of the bones of the skull
5. Involuntary motion of the sacrum.

If we looked at these activities and structures from a TEAM perspective, what would we see? To us, these represent the main loci and functions of the yang qi, and the subsequent rhythm is a reflection of the activity of yang qi within the body. This understanding is bolstered by Sutherland's idea that this motion was related to the constant movement of the fluids that is necessary for the maintenance of normal physiology. This is why in our classes we refer to this rhythm as the "yang rhythm (YR)".

Once one has learned to feel the YR, it gives us information on the state of the yang qi of the entire body, the amount of yang qi activity in various parts of the body, the location of the problem area, the smoothness of the flow of qi (both in general and in particular areas of the body), when a needle has been inserted into the proper place, and when the body has had enough stimulation for the day, so that any more needling will lead to over-treatment. These are all very helpful, particularly in the practice of acupuncture.

Other tools from osteopathy or inspired by osteopathic techniques allow us to localise disorders in a variety of ways, directly sense problems with the channels, evaluate the state of the fluids, and so on. Once some facility is gained with these different forms of palpation, it is possible to engage the patient's body with as few preconceptions as possible and in this way gain a more accurate understanding of the pathophysiology involved in a particular case.

Clinical examples

These palpatory approaches can easily act as an alternative or supplement to traditional diagnostic methods. For example, the pulses of geriatric or deeply debilitated patients are commonly weak or even faint overall, especially in their proximal positions. Alternatively, it is also quite common for such individuals to have hard and bounding pulses indicative of a deep debilitation of kidney qi and essence. All of these pulses may improve somewhat with effective acupuncture treatment, though typically not in a particularly robust way. In such situations clinicians are frequently presented

with the question of how much stimulus is sufficient to initiate a therapeutic response without over-treating the patient.

By contrast, in our experience the yang rhythm in this patient population is often a more nuanced and clearer measure of therapeutic dosing and the likelihood of efficacy than the pulse, tongue or abdomen. In a similar manner, palpating the YR is very useful for checking patients on drugs such as Prednisolone that are well known to muddy the more common assessment tools of TEAM.

These palpatory approaches can also be used to pay attention to aspects of treatment that otherwise might remain opaque. The yang rhythm is an especially useful tool for assessing the immediate response to one's therapeutic input. This is palpable as a generalised response anywhere in the body. Once one becomes attuned to the yang rhythm, it is quite easy to feel the improvement in ease and amplitude indicating a therapeutic response in one's hands that occurs with needling.

The ability to feel these responses makes it much easier to needle precisely and get the maximum benefit from the fewest number of points.

Conversely, the yang rhythm immediately becomes sluggish and strained when the amount and intensity of needling exceeds the body's capacity to integrate it. This too is easily palpable and tells us that we should cease needling immediately. One need not wait until one is finished needling to check the pulse and assess one's result.

An old TEAM maxim criticises a poor practitioner by stating "they treat the head when the head hurts and the feet when the feet hurt". One useful way to determine where the problem area is (versus where the symptoms are) is to assess the amplitude of the YR. An area with a restricted or decreased YR amplitude is likely to be an area that treatment needs to be directed towards in order to get results, regardless of how close or far it is from the symptomatic area.

Combining this with an understanding of basic TEAM pathophysiology, we often are able to understand the genesis of the patient's problem and, in part by using the YR to see if point localisation and needling are effective, treat the problem successfully.

Conclusion

When we approach patients with a grounding in palpation and the immediate feedback that it can provide, it can allow us to meld together the background knowledge of the fundamentals of TEAM with the actual presentation of the patient. The general result is that we have come to an approach where we rarely can rely on any preconceived idea or received wisdom in treatment, but instead continually get feedback as we go through the diagnosis-treatment-recheck cycle to fine tune each aspect.

At each stage we have to combine what we are feeling with what we have learned and experienced in order to come up with what appears to be a good way of proceeding. We often end up with a diagnosis and plan of treatment that are very different from what we thought we would be doing. Similarly, there is no way to escape our responsibility to figure out a good way to proceed, nor rely on some external source as justification when treatments do not work. This has enabled us to continually improve our clinical skills and escape therapeutic stagnation.

The more comfortable we become with palpatory findings that do not directly tell us what to do, what the diagnosis is, or what point to needle, the more comfortable that we become with figuring out what to do for ourselves. This approach to palpation is a window into a larger perspective on clinical practice. We take greater responsibility for our treatment choices, and we become more comfortable with our unknowing. This allows us to really listen to and converse with the qi, hearing things what we would previously not have heard.

What we are advocating is not a style in itself, as it is a palpatory context for the mindful and coherent synthesis of any constellation of styles. We are presenting a means of moving fluidly between approaches, theories and techniques, in a manner that is grounded by the information we receive in our hands. It is our experience that both the technical and mental aspects of this approach to the work have definite clinical payoffs.

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