Listening to the Channels: Preliminary Reflections on the Adaptation of one form of Osteopathic palpation to Acupuncture

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The goal of this brief article is to accomplish two simple things. First, introduce a type of palpation adapted from the osteopathic world to serve the practice of acupuncture. While simple and easy to practice, it does take some time to become proficient at this technique. After practicing it for over ten years, I believe I have achieved a modicum of proficiency; enough in any case to present it to the audience of the NAJOM which is well versed in various palpatory techniques. After a brief description of the background to this technique and going over how to practice it, I would like to both talk about some clinical ramifications and use some of my findings utilizing it to look at some of meridian therapy's basic assumptions from a slightly different perspective.

Brief Introduction to Osteopathic Medicine

Osteopathic medicine was developed in the American midwest during the latter part of the nineteenth century. It is based on a few basic principles:[i]

- A person is a unit made up of body, mind, and spirit
- The body is capable of regulating and healing itself
- Structure and function are interrelated at all levels of the human body

Given these principles, and the fact that the father of osteopathic medicine, Andrew Taylor Still, based his fame on his abilities with manipulation, it is not strange that osteopathic medicine has always emphasized palpation. The importance of finding areas of the body that do not move well (usually because of insufficient motion), manipulating them so that they move well, and then letting the organism take over the healing process is summed up in the popular osteopathic adage, "Find it, fix it, and leave it alone."

Over the last hundred years, numerous osteopathic practitioners in North America and Europe have made significant contributions to the study of palpation in general and the palpation of subtle body motions in particular. Two people are of particular relevance to this paper. While I will not be discussing cranial style palpation here, no discussion of osteopathically based palpation of subtle motions can avoid the name of William Garner Sutherland. While attending the first school of osteopathy at the turn of the twentieth century he became fascinated, perhaps even obsessed with the cranium. He carefully examined skulls and noticed that all of the joints of the cranium, known as sutures, were arranged in such a manner as to suggest that there was significant motion across them. Based on the above principles it was obvious to him that any structure that could move, *needed* to move. He worked on the anatomy and practical applications of this idea for about thirty years before going public with his ideas.[ii] The concepts that he came up with form the basis of most forms of cranial manipulation or craniosacral therapy currently being practiced. Working on the cranium and the motion that originates in it (which is perhaps one palpable manifestation of the yang qi) requires sensitivity to very subtle motions.

France has been very fertile soil for osteopathy since its main introduction there in the 1970's. French practitioners have pushed the boundaries of osteopathy in many ways, including the first integration of the inner organs into the structural vision of osteopathy. The technique known as listening which is the subject of this article was pioneered by a group of French osteopaths under the leadership of Jean-Pierre Barral. Simply, you put your hand on the patient and feel to which part of their body it is drawn.[iii] It is important to have a light touch and feel quickly while your mind is in a receptive state. For most people, it helps if the practitioner inhales while doing this technique.

Listening to the Channels

In the late 1980's I put one (listening is a quick method of checking the state of aspects of the body that move) and one (the channels are pathways of motion through the body) together. This lead to the technique of listening to the channels. The way I do this is to place the pad of a finger or a thumb on some important point of a channel (usually the source point) and pay close attention to what I *immediately* feel. With healthy channels, I usually feel a very smooth flow; there are a variety of feeling from disturbed channels, including a sense of blockage or a sense of insufficient flow.[iv] Usually it is easier to evaluate what you feel if you do this bilaterally simultaneously, that is both PC-7's, both LR-3's, etc.

This technique, like other forms of subtle palpation, requires the simultaneous presence of two mind states which are paradoxical if not contradictory. On the one hand to tune into the flow in the channels, you need to have a very, very clear picture of the anatomy of the channels in your head. This acts as a filter to screen out all the other motions that your hands are picking up. On the other hand, you need to be sure that you are working on being aware of what is there and not *looking* for anything. If you are actively looking for something, you will find it. This may make you feel good, but it is not very helpful for the patients.

It is for these reasons that Barral called this particular diagnostic technique "listening." To do it effectively requires an actively receptive and engaged state similar to that of a good listener. Just as good listeners are really interested in what they are hearing without trying to steer the conversation toward any particular topic, practitioners utilizing channel listening need to be aware of what is going on in the patient and not project their own desires or problems. I have found that the quicker I do the listening, that is the less time my fingers are touching the points, the easier it is to do.

Findings

Listening to the channels has been a challenging experience for me. First, while simple I

have found it far from easy to learn. It took quite a few years of practice before I usually felt confident in what I felt. Secondly, what I felt using this technique was often surprising to me. Let me summarize just a few of the more interesting findings:

• Channel flow is almost always experienced as being centripedal, that is going from the extremities towards the trunk. While this does not agree with the channel flow as described in some parts of the classics,[v] it does go along with the description in chapter 23 of the *Classic of Difficulties.* This has some ramifications for direction of needling in support of tonifying or draining.

• There is a degree of normal variation in the pathways of the channels. They do not follow exactly the same paths in everyone. This should not be surprising as normal variation is true for the pathways of veins, the location and shape of the stomach, length and width of fingers, and so on. This idea shifts the discussion from the sterile and clinically irrelevant region of where the channels are to the more pertinent, where are the channels in this person now. I have found all of the variants in point location that I have been taught to be easily accounted for by this.

• Points can be seen as handles by which one can access the pathways of the channels. For example, when there is a dysfunction of the penetrating *(chong)* vessel, one will get a very different feeling from touching SP-4 than from touching other points along the Spleen channel. This comes in very useful when deciding whether or not to use ion pumping cords and whether the cords should cross or not.

• Channel findings do not always match pulse findings. Often the channels felt to be dysfunctional are different from those one would expect based on pulse diagnosis. There are many possible reasons for this. One that appears to be true to me based on my experiences is that the pulse positions reflect the state of the organs and not the channels. For example, if someone has done some damage to the medial aspect of their

knee it is unlikely to show up as a disruption of their Kidney, Liver, or Spleen pulse (unless an underlying problem with one or more of those organs made the area vulnerable). However, there will always be a palpable blockage of the involved channels based on channel listening. In fact, this can be a very useful tool to determine which distal points will have the best effect.

Assumptions

Part of the problem is that we work on assumptions that make us feel good about our work and ourselves, but do not necessarily help us treat patients more effectively. I would like to briefly address one of these assumptions. My goal is more to raise questions than to give any definitive answers as the recognition of problems is the first step to dealing with them.

One of the most basic assumptions in most of the classically oriented styles of acupuncture is that palpation is a primary avenue for accessing the body's knowledge. This has both diagnostic aspects (pulse diagnosis, feeling for the active point, etc.) and also prognostic aspects. The latter usually takes the form that some feedback, which is conceived as happening very quickly if not instantaneously. This is supposed to occur in both the pulse and the hara. If the points chosen are deemed to be correct, then the pulse and hara will "normalize." In fact, we usually use palpation as a means to see through or get past the symptoms to what is the basic dysfunction or problem.

As I understand it this assumption is based on the following premises:

1) Acupuncture is a means by with we interact with the body's healing mechanisms
2) Through needling we provide some information to the body (and, in some styles, we provide some of our own qi to the body)
3) In response to this, the body responds:
    a) if the acupuncture is done correctly the response is positive
    b) if the acupuncture is done less than correctly , there is no response
    c) if the acupuncture is done incorrectly the response can be negative

4) This response is quick and involves a renormalization of whatever is being felt
5) We can check whether the response is positive or not by checking the markers we used to make the diagnosis (primarily the pulse and hara)

All of these premises should be open to question. In addition, they have become so much of the way that many of us view our work that instead of being means towards an end, that is a way in which to tell if we are helping people, they have become an end in themselves. What can happen is that whether or not a treatment "works" in our minds is determined by whether or not the patients pulse and hara improve right after the treatment. In extreme cases, we can work to invalidate the experiences of the patient and make them dependent on us. In conventional medicine they have the example of "the surgery was a success, but the patient died." In our line of work we have the equally mistaken, although much less serious, circumstance of "your pulse and hara continue to improve every week, but you still have the problem that you came with."

For the purpose of this article, I want to just focus on the fourth one as an example and integrate it with using the channel listening. For our purposes here, I will allow that premises number 1 and 2 delineate our basic understanding of acupuncture and that we could not work the way we do if we did not take them as statements of fact. All the work that we do honing our skills of point selection and needle manipulation are predicated on number 3 being true; otherwise acupuncture would just be sticking needles in people. Similarly, for us to practice for years to improve our palpatory skills, we have to believe that number 5 is correct.

Kidney deficiency

One of the best examples of the how we need to be flexible in using these concepts can be found in the Kidney deficiency presentation.[vi] I have found that patients with the pulse and hara of Kidney deficiency ala meridian therapy can be divided into two groups. One group, with what I will call "comprehensive Kidney deficiency," also has

something from the gamut of Kidney deficiency symptomatolgy as noted in in the Chinese medical literature. These are well known and include deficient type lower back pain, weakness, sexual dysfunction, severe fatigue, and/or urinary dysfunction. That is, there are people who would be diagnosed as having Kidney deficiency even by practitioners who do not have access to the tools of meridian therapy. The other group, with what I will call "partial Kidney deficiency" have none of those symptoms.

When I have treated people with comprehensive Kidney deficiency utilizing meridian therapy protocols, if I get an immediate positive effect on the pulse the long-term effects of the treatment are minimal. That is, they may or may not feel better for a short time after the treatment, but there is no long lasting effect on how they feel and when they return to the office a couple of weeks later there is no noticeable improvement in their condition.[vii] As such, even though the pulse "improved" significantly at the time of the treatment, this was not a good marker for the efficacy of the treatment.

Over the years I have noticed that if I am just a little more careful with my point location, angle of needling, and depth of needling so that I engage the qi in the channel rather than adhering to some rigid protocol, I can treat people so that when they come back in two or three weeks they both feel better themselves and feel better to me. When this happens, after the needles go in the pulse in the left proximal position will become totally imperceptible and stay that way for a length of time. Not only that, but the entire pulse will become thinner and deeper.

If one adhered to the doctrine that the goal of acupuncture is to balance the pulse at the time of treatment, you would have to say that these treatments were disastrous. To me this is too narrow minded and short sighted. Taking the view that it is the patient's long term response to the needling that is the treatment, I maintain that this is just another example of how trying to fit patient's response to treatment into some preordained box does the patients and acupuncture a disservice.

What about those with partial Kidney deficiency presentations? In my experience, with needling based on meridian therapy protocols one of two things happens. One is that the patient's pulse and the patient themselves responds in a positive manner just as is supposed to happen. Other times, nothing happens. In these latter patients I have often found that when listening it is their Stomach channels that are dysfunctional. In those cases, needling ST-36 improves both the pulse and their long term response to treatment. There are a few obvious reasons why this could occur. Of course, any patient with Stomach problems requires a degree of counseling about how they eat to maintain a good response to treatment.

Final Thoughts

In this article I have introduced how one osteopathic palpatory skill may be adapted to the practice of acupuncture. Some of the issues that the findings from this type of palpation have also been noted. In addition, I have given one example of how I utilize this particular technique to help me be of service to my patients.

I am fully aware that one possible explanation of the above is that my skills in meridian therapy style acupuncture are lacking in some regards. While that certainly is the case, I hope that my relatively mediocre skills do not invalidate the points I have raised. I hope that those of you with more highly developed skills will be motivated to explore these issues for yourselves.

[i] M.A. Seffinger, M.A. "Development of Osteopathic Philosophy" in R. Ward, et. al., *Foundations for Osteopathic Medicine.* Baltimore: Williams & Wilkins, 1997, 3-7.

[ii] W.G. Sutherland, edited by Anne Wales. *Teachings in the Science of Osteopathy.* Fort Worth, TX: Sutherland Cranial Teaching Foundation, 1990.

[iii] J-P. Barral, *Visceral Manipulation II.* Seattle: Eastland Press, 1987, 8-14.

[iv] I briefly went over this technique in "An Achilles Heel" from *Acupuncture Case Histories from the West*, edited by Hugh MacPhearson. Edinburgh: Churchill Livingstone, 1997, 337-345.

[v] For example *Spiritual Pivot* 10 &38.

[vi] Shudo Denmei. *Japanese Classical Acupuncture: Introduction to Meridian Therapy,* translated by Stephen

Brown. Seattle: Eastland Press, 1990.

[vii] I realize that for those practitioners who see patients more frequently than every two or three weeks, some of this discussion will be irrelevant.