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The Healing Circle: An Ethnographic Research Study of Human Interaction Within a New Model of Integrative Medicine

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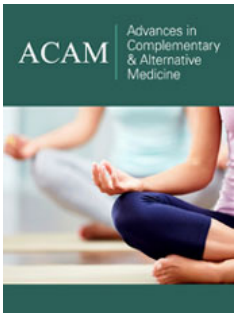

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Abstract

This ethnographic study explores an innovative experiment in integrative medicine known as the healing circle, as developed by a collaborative group of biomedical and alternative health practitioners in northern California. The original intent of the circle was to surmount the perceived shortcoming in many integrative clinics of subordinating and trivializing alternative healing practices as mere treatment options, under the auspices of biomedicine. The practitioners sought to create a more level playing field, in which an actual blending or harmonizing of disparate medical world views could be accomplished. The goal was to better serve patients with complex chronic disease by offering them an expanded array of healing options, a generous time for hearing their narratives, and the convenience of receiving viewpoints from practitioners of multiple modalities (e.g., ayurvedic, traditional Chinese medicine, herbalism, homeopathy) in one place, at one time. What emerged in this well-intentioned effort were escalating tensions and numerous interpersonal difficulties inherent in the attempt to negotiate understandings of widely opposing philosophies and epistemologies. Lack of skills and awareness in communicating, negotiating, and mediating among different disciplines derailed their best efforts. Half-way through this fieldwork, the circle's mission switched to a more cohesive facilitation of the meaning of someone's illness. The revised circle achieved a new solidarity among practitioners but met with an uneven response from clients.

Introduction

New forms and old styles of integrative medicine

This ethnographic study explores the interactions of a group of complementary, alternative and allopathic health practitioners and their patients in their attempts to assemble a new model for healing. Their goal was to partake in a structure that would be entirely different from the current reality of "integrative medicine," since they perceived the crux of the problem to be that true integration among disciplines does not occur; instead, subordination reigns, creating power struggles and discontent. With a new model to the rescue- one that placed the different disciplines in an egalitarian structure, a level playing field they called the multidisciplinary healing circle- the expectation was that practitioners would work together in harmonious ways. However, merely changing the structure proved to be just the initial hurdle to accomplish their intent. The truly formidable task rested in learning new ways of getting along for the good of all.

The practitioners' motivation to create a multidisciplinary healing circle was driven in part by frustration with trying to gain acceptance of alternative medicine healing approaches within conventional healthcare settings [1]. The practitioners also cited numerous chronically ill clients who were baffled by a rapidly changing health care system and a confounding array of alternative options. What better way to solve this, they thought, than to have practitioners of many complementary, alternative and allopathic medicine disciplines assembled together at one time for the patient in an educational format? The convenience of patients telling their stories at one time in one location, the time-efficiency of many disciplines represented at once, and the comfort of having several caring practitioners acknowledge the clients' difficulties were rationales for the circle's development.

Despite the fact that a broad range of complementary and alternative medicine (CAM) practices is available today, choosing among them can be confusing for people who have spent

considerable time and resources in seeking relief from chronic illness. In response to this predicament, conventional medicine practitioners have attempted to incorporate various forms of CAM techniques into their practices [2,3]. For example, primary care physicians get certified in acupuncture to assist in in pain relief for patient, or a family practice physician learns a point-counterpoint form of physical therapy to restore a traditional hands-on form of doctoring that allows great connection with her patients.

Another approach to integrative medicine is for a clinic to hire a variety of practitioners from various disciplines. For example, a full team would consist of an allopathic MD, a chiropractor, Traditional Chinese medicine practitioner (acupuncturist), and perhaps a massage therapist or clinical nutritionist.

"Integrative medicine" is the name given to this activity, which in the current turbulent climate of U.S. health care, is at once hailed as a way to develop potential areas of complementarity and interface with conventional medicine, and also criticized as an illegitimate co-opting of alternative methods by conventional medicine practitioners [4,5].

Whether various centers of integrative medicine represent true integration as an egalitarian enterprise or represent a subordinating process which places other healing disciplines under the aegis of conventional medicine (or at least the medical doctor in charge), is ripe for investigation. However, it is not the central issue of this ethnography, although it is a very thorny side issue providing the impetus for my study.

The practitioners in the healing circle believed they were in retreat from systems of subordination. With an expressed desire to innovate an improved framework, the founding practitioners in this Northing California (USA) healing circle hastened to create a structure that would bypass the entrenched biomedical "red tape." They sought freedom from what they perceived as the dominant medical hierarchy, overblown bureaucracies, a lack of medical innovation, and a dispiriting and disempowering environment for non-allopathic practitioners. The vision was for the dominant medical groups in society would now be integrated with the subordinated healer groups in a healing circle that would somehow achieve neutral ground and blend the following disciplines, approaches or techniques:

A. Allopathic medicine
B. Ayurvedic medicine
C. Acupuncture
D. Biofeedback
E. Bodywork
F. Chiropractic
G. Qigong
H. Herbalism
I. Homeopathy
J. Clinical nutrition
K. Guided imagery
L. Meditation
M. Movement therapy
N. Naturopathic medicine
O. Chaplaincy/ prayer/faith
P. Psychotherapy
Q. Shamanism
R. Subtle energy (such as Reiki)

Traditional Chinese medicine

However, the circle proved to be a fertile breeding ground for the contested forms and interactions they had hoped to leave behind; unfortunately, they had towed along problems with communication, negotiation, and interpretation patterns that reflected difficult and unequal social relations. In many ways, the socialization and educational processes of the various disciplines had not prepared them for operating within this experimental model based upon more utopian ideals. At first glance, the hierarchy (structure) was flattened, but this ethnographic inquiry revealed that the behavior (process) was unaltered. The healing circle, for all its good intentions, had come full circle to witness the entrenched discord that lurked beneath the surface.

Experimental Model

The following problems emerged during the two-year experimental model:

Original intent derailed

At the onset of the circle's launch, the multidisciplinary healing circle was designed to be a convenient vehicle for a patient to learn about numerous healing modalities in a rich cross-dialogue among practitioners. This mission was to be accomplished by different types of practitioners sitting for two hours in circle with a patient (someone coping with a chronic disease), to provide a healing atmosphere for improving quality of life. Although some clients acknowledged the limitation of the healing circle as a single intervention, or "one-shot deal" as it was called, they insisted that the opportunity to receive the perspective of several practitioners in one place, at one time, held a potential benefit for chronically ill clients.

Poor inter-disciplinary communication skills emerged

At a half-way point in the two-year study, tensions and frustrations escalated dramatically among the various practitioners, and the circles were suspended for five months. This tension arose from the failure to negotiate a discourse of integration among opposing views of authoritative knowledge, medicine, treatment, the nature and meaning of illness, and even the social identity

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of patients and healers. Originally designed to be a convenient vehicle for learning about numerous healing modalities in a rich cross-dialogue among practitioners, the mission was deliberately redrafted into a more singular focus: the facilitation of clients in their search for the meaning of their illnesses within a healing circle. The healing circle would now be a framework for the client to ascertain a declared meaning for his or her illness. Just whose meaning or interpretation the client came upon was an arguable point.

Differences in ontology (nature of being) arose

How and why the practitioners came upon this switch is one of the most useful findings of this study. They were frustrated by the mounting tension that grew out of their lack of skill in mediating and negotiating the diverse, conflicting perspectives and voices. The tension they encountered was beyond the normal strain and pressure rampant in medical clinics today. This tension went to the core of deeply embedded, personal belief systems. The healing circle became an unusually candid and rich setting for bringing to light the conflicts of negotiated understandings that these various practitioners were experiencing with clients.

Epistemological chaos surfaced

In the beginning, the biomedical and alternative healers presented widely opposite views on healing, the nature of disease, the social meaning of illness, and the role of healers and suffering patients. They also had opposing views, on what makes people sick, and the necessary social contexts for regaining health. They even had opposing views on whether or not regaining health was a worthwhile endeavor, since some of the healers saw illness as a "gift," or "just what was needed right now." From the occasional head shake of disbelief, to harsh accusations of "No way! You can't say that!" practitioners, during the early period of the healing circles, were swept up in an epistemological chaos that was often disorienting and at cross-purposes, with only a few brief moments of creativity or unexpected insight. Most of the time, they found themselves in a "medical Tower of Babel," with conflicting philosophies, opposing etiologies, different nomenclatures, and no mediator in sight.

Over the two-year period in which my role as participant-observer followed a tumultuous course of inclusion, exclusion, and tenuous reconciliation, the mission was not the only aspect to change in the healing circle. At first, I thought my study would explore how the different epistemologies may run up against one another. After all, the timing was excellent for medical anthropology to bring its unique perspective to this burgeoning field of integrative medicine. The 1999 study by Harvard researchers Perlman et al. [6] on the public's usage of complementary and alternative medicine became the most quoted study in medical history.

Since1995, updates on the original CAM-usage profile continued to show explosive growth and interest from the public. The National Center for Complementary and Integrative Health Medicine (NCCIH), had tripled its congressional allocation, and installed new centers of research throughout the U.S. [7]. As more integrative medicine centers were established in which heretofore disparate entities were now clinical bedfellows, it made sense for the wares of medical anthropology to explore within them such factors as:

a) Traditions of healing as they articulate with each other and with conventional medicine;

b) Shifts in the meaning of illness and disease when attention is place on holism;

c) The difference between healing and curing;

d) The types of healing rituals that are enacted consciously and unconsciously;

e) The beliefs of both practitioners and clients who choose these centers, and their explanatory and cultural models; and

f) The roles of individual practitioners, how they interact, and the social markers of relationships.

It was this last factor- the interactions of the individual practitioners with each other and with clients- that upstaged the other potential study considerations with this experimental model of multidisciplinary work. Arising from the troubled landscape of an ailing health care system in the U.S., the practitioners saw themselves as innovators seeking to reform a deficient, outmoded practice based in hierarchical injustice and inefficiency. As stated earlier, the healing circle was to be a democratic and level playing field with no hierarchy. As the practitioners discussed the challenges of a particular client and examined options for treatment, each had a voice with equal merit, a vote with equal weight. The practitioners perceived their actions to be courageous and innovative. For at least a couple of hours every week, they abandoned the old system and experimented with a new working model.

Printed on the healing circle's brochure is the following purpose: "to bring information and insight, hope and meaning, and most of all, a new beginning for healing and wholeness" for their clients. Whether or not they accomplish this remains to be determined. It would be premature to assess the health outcomes of the clients in these healing circles since the circles are still in a formative state, changing roles and responsibilities, rewriting rules, and redrafting goals and mission statements.

After experiencing a year of circles, a core group grew disenchanted with the medical doctor who was a self-defined "recovering allopath," and deserted him in an undeclared revolution. Then they secretively re-formed elsewhere, dug in and drafted new codes of behavior, and wound up being just as tightly rule-bound as the system they had left.

Over the course of the two-year study, the compassionate atmosphere for listening to clients' narratives came to be ruled by a well-intended circle of practitioners who had coalesced into a new, dominant force. They had inadequate educational training and social communication skills to deal with the notable demands

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of their challenge. What was crucially needed was more awareness and enhanced skills of negotiation, mediation, and interaction in general. The practitioners came from a health care context that placed the search for solutions above listening to patient's narratives; they shared an educational mindset that cultivated an intolerance for ambiguity and uncertainty. Given the difficulty, and perhaps impossibility, of their task, they made some significant progress toward a discourse of blended modalities.

Occurrences of coercion, rejection, and ostracism made me realize that the darkness that exists within human hearts must be addressed before practitioners call themselves healers. Reinventing form has little merit if the same old power games persist. The circle practitioners believed they operated as an integrated consortium of health professionals, assembled to re-ignite what they saw as the original agreement between healers and patients: first, do no harm. In truth, another, perhaps older, covenant offered a prerequisite wisdom: physician, heal thyself.

The troubled milieu of health care delivery

To understand the compelling interest on the part of these practitioners in northern California to operate independently of the "old order" of health care delivery and to establish a "new order," namely, the healing circle, it is necessary to understand the protracted, troubled waters of the U.S. health care delivery system in the year 2015. Several decades contribute to the vastly complicated state of disarray and widespread malaise. Every facet- from the patients to the mainstream professionals and fringe practitioners- seems to have its gripe.

For instance, the medical doctors complain that they are hamstrung by insurance companies, health maintenance organizations (HMOs), and managed care organizations in their ability to practice medicine without untoward restraints placed on them [8-10]. Managed care is defined as a set of strategies aimed at containing expenses and controlling costs of health care services by curtailing utilization and establishing ceilings for insurance pay-outs per patient per month (i.e., capitation) [11]. Perceiving managed care as a threat that undermines their ability to deliver quality services, numerous biomedical practitioners have engaged in a discourse of discontent.

In the meantime, sensing that the grass is greener on the reimbursement side of the fence, the alternative practitioners complain of being ignored by managed care organizations and other types of third-party payors and insurance companies [12]. They also complain that they undergo continuous accusations of "quackery" from conventional medicine groups such as the National Council Against Health Fraud [13].

Even within the ranks of each particular modality, there is unrest and definitely a kind of "tribalism" or turf protection. For example, the naturopaths who are graduates of post-baccalaureate universities, want licensure and a separate class distinction from the older, less schooled naturopaths who received their training from mail order "certificate mills." The homeopaths want their studies and work legitimized and validated, but also insist that questionable scientific methodologies be accepted to appreciate the subtleties of their remedies. A host of non-licensed professionals, such as bodyworkers, massage therapists, music and art therapists, shamanic-based healers, intuitive healers, and herbalists, complain of being continually marginalized and rarely integrated into so-called integrative medicine centers. And most of all, the patients are mobilized into public interest groups, fighting for patients' bill of rights legislation, the ability to sue their HMOs, and greater access, more comprehensive care, and more choice within their insured programs. From a wider societal viewpoint, conditions do not fare much better. In the richest country in the world, there are growing numbers of uninsured individuals, a relatively high infant mortality, and a disconcerting rise in the incidence of chronic disease [14].

It is primarily the issue of chronic disease that the healing circles focus on, because of the acknowledged limitations within both the conventional health care system and modern medicine to successfully treat or manage chronic illness to the satisfaction of patients and their doctors. There is much discussion that complementary and alternative medicine (CAM) offers an optimal treatment by way of attending to the root causes of the chronic condition rather than by simply reducing the presenting complaint or symptom [15].

Challenges of the chronically Ill

Whether or not CAM practices actually reduce the morbidity or mortality of chronic disease, it is apparent that these practitioners seem to be filling a desire among the public for care that is considered more compassionate or better attuned to the needs of the chronically ill. One of those pressing needs is to address the fact that the chronically ill are the least able to shoulder the burden of seeking out a variety of treatment options. They often cope with refusals for insurance coverage, or easily exceed their limits on reimbursement. In addition, the types of treatments that may be helpful to them are often not covered. The very nature of chronic illness which is physically and financially depleting and beset with unexpected exacerbations tends to extinguish hope and optimism and confront its sufferers with a flood of hardships [16].

The clients in these healing circles carry their own significant weight as savvy, weary, and slightly fried "consumers" of the health care industry. Shackled with at least a decade of coping with chronic ailments, they have usually been through the trenches of biomedicine, with multiple tests, examinations by dozens of physicians, blood work, and sometimes surgeries or invasive treatments.

The chronically ill subjects in this study were aware that conventional medicine had its limitations in helping them with their chronic disease, but they also knew that some unconventional methods did not necessarily work much better. The fact that they have greater choice in health care than ever before was only mildly liberating, since they worried about their lack of energy, the time spent, and money paid for non-reimbursable health care services.

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Having relied heavily on conventional medicine most of their lives, they were now ready to entertain a few different methods of alternative and natural healing, but they were concerned about safety, efficacy, herb-drug interactions, and also worried about going behind their doctors' backs. They often showed up in the circle wondering, "Which method should I try now?" and "Will these methods be any good for me?" They also wanted to know how they could benefit from a blending of modalities, and if any approaches presented drawbacks or side effects if combined with other therapies.

In short, the clients provided the opportunity for change by asking the exact types of questions that are driving the field of biomedicine to transform. They also alerted the healers to the very sobering tasks of healing themselves, and redirected attention from a philosophical debate onto the immediacy of providing relief for the suffering person in front of them.

Dynamics of crossfire interaction

Even though the direct impact on a patient's health status is indeterminable, I have been able to witness in over 40 circles in the course of two years the shifting dynamics of human interaction, as practitioners and clients attempted to create a unique and unprecedented framework to assist healing. It is in this setting that an unanticipated and highly significant development occurred. The circle gave these practitioners a chance to cross a conceptual divide, sit elbow to elbow, and actually hear in a lively sort of "grand rounds" what the "other side" would do for this client. Sometimes the "other" was a practitioner representing the other side of the world, and the differences between conventional medicine and traditional Chinese medicine, for example, became glaringly apparent in the circle. If the "other" practiced herbalism or bodywork or hypnosis, and alarms of invalidity would go off.

As an example, in one circle, a kahuna (a respected teacher of Hawaiian folk medicine) suggested chanting for a client who was extremely stressed. The psychiatrist, a professor of medicine at a major university, told the kahuna, "I doubt seriously if chanting would bring inner peace." The rest of the circle first reacted with stunned silence. Then, one by one, practitioners told the psychiatrist, in front of the client, that they wondered how such a learned man could dismiss thousands of years of chanting and its value as a technique for inner peace. They informed him of the chanting practices of monastic orders from the Benedictines in Spain to Tibetan Buddhists, and of the healing chants of shamans. Yet the psychiatrist would not shift his view: chanting had no business in the world of psychotherapy.

Subjecting the patient to divisional strife

Some obvious questions the reader might have about now are: What is the value in holding such a divided discussion in front of a patient, who is seeking relief from chronic illness and a means for reducing its stressful toll? Why subject the patient to a fairly cantankerous cross-dialogue among health practitioners of such vastly different persuasions? Would it not be a more healing and therapeutic environment if health professionals would at least get their act together, sing from the same sheet of music, and find some consensus of treatment options, instead of expecting a patient to withstand their divisional strife?

Divisional strife, lack of consensus, and the thunderous friction of competing paradigms comprise the milieu of medicine these days. One may argue that it has always been rife with competing arguments. As long as there have been different schools of thought on healing, there have been diehard convictions about right and wrong ways to treat the ill. However, the contemporary and radical shift in this contentious field is the inclusion of patients in these dialogues. The political movement for a Patient's Bill of Rights in the U.S., along with legal and social arguments for the right to sue one's HMO, are testament to a time of unrest with the present health care system. Editorials about patient empowerment, patient-centered care, and popular advice in the media on how to "arm yourselves with questions for the doctor's office," attest to the sense that somehow the public can be a deciding force for change.

The U.S. health care system has been criticized in the past four decades as neither healthy nor particularly caring. Politicians argue about rescuing Medicare, while state medical societies issue warnings about record numbers of medical group bankruptcies, and hospital mergers prove a fatal prescription for two ailing systems. In addition to the growing complaints of rationed services and limited access, is one of increasing confusion over which healing options are safe and effective.

The conventional biomedical voices urge the public to avoid venturing blindly into alternative practices, and to always "check with your doctor first." Yet, beleaguered physicians and the growing lack of responsiveness within systems seem to be driving the public to alternative healing choices. It is this confusion that is the driving impetus behind integrative medicine. In an attempt to usher in the best of complementary and alternative health practices under the aegis of conventional medical care, integrative medicine is showing up in a variety of modes throughout North America. Some of the more successful clinics are presented at an annual conference dedicated to bringing integrative medicine to diverse populations who cannot afford the out-of-pocket expenses. These clinics are featured at the IM4US annual conference. (See www.im4us.org) [17].

Co-opting of traditional approaches by non-natives

As an experimental model of integrative medicine, the healing circle embodies a unique feature: it is a completely unsanctioned renegade. I could find no similar types of healing circles in the United States. As stated earlier, instead of operating under the bastion of conventional modern medicine, it is a true maverick, carving out new territory in uncharted land. Not operating under any hospital, clinic, medical authority, or under the rubric of one particular authority, the circle practitioners take a risk in today's litigious climate. And the fact that they do so without compensation or peer recognition is a significant factor.

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In the best of healing circles, there was a willingness to learn and explore with each other. In the worst, there were moments of professional bashing, cutthroat competition, chaos, and lack of direction; but most of all, standoffish arguments appeared to place the whole thing on the verge of collapse. At times, comments exposing the practitioners' differences erupted so vehemently that it seemed as though healing was the last thing that would be accomplished in the circle.

The circle noted above, in which the psychiatrist's comment seemed to reveal a major rift between his point of view and that of the other practitioners, was typical of many in the past two years. In another circle, the massage therapist argued with the neurologist about the possible brachial nerve damage in the volunteer patient, and the neurologist became outraged that his expertise knowledge would be questioned by the massage therapist, and threatened to stormed out of the circle, saying this whole enterprise is a "sham operation." The patient, however, sided with the massage therapist, saying the neurologist had mistakenly confused his medical record with other patients at the hospital- that he himself did not have any brachial nerve impairment. But that his chronic shoulder pain was relieved by the massage therapist. Telling that in the circle further angered the neurologist who insisted that brachial nerve damage was not going to be "repaired with massage!".

Conflicts and disagreements were not always resolved. Within the circle, the various practitioners sometimes had little real understanding of or empathy toward each other's disciplines, or rather, the hybrids of healing methods that result when practitioners reorganize some of the principles of traditional systems such as Ayurvedic medicine into their own understanding and practice.

The practitioners were all residents of northern California cities, and enjoyed the diversity of religious, ethnic, and cultural conditions that exist in the area. They did not think of themselves as having appropriated or co-opted healing disciplines from around the world, lifting them out of their cultural contexts. Instead, like many Californians right now, they regarded the diversity from which they freely drew fresh ideas and saw new possibilities as the fruitful ground for innovation.

For instance, the young man who teaches Native American healing methods is not Native American, but he says he was "adopted" by a Toltec tradition. The woman who teaches Hawaiian ancient healing arts is not Polynesian or Hawaiian; she is a white woman, from European background, a public relations worker who awakened one day with a dream that she was supposed to learn Hawaiian chants to heal an illness. The man in the circle who practices traditional Chinese medicine is a former engineer of Irish-English descent, who was fascinated by acupuncture and Taoist philosophy. The one man of Asian descent was trained in strictly conventional types of scientific thinking, is a board-certified internal medicine physician who just recently came to appreciate the workings of mind-body medicine, and "looked beyond the West" for an understanding of his own illness.

They all sat in a circle in which the differences that formerly qualified for making distinctions no longer seemed to be applicable. The distinct categories of healing traditions started to fade in importance as the healing circle became its own predominant system for change and discovering the meaning of illness.

Overcoming medical ascendancy

The practitioners and the clients tended to regard each other through the veils of their respective roles. That "gaze," as Foucault [18] warned, was laced with inherited assumptions and unexamined stereotypes about how the various health disciplines "should" operate, and how they are viewed within the pecking order of medical ascendancy.

What has kept these disciplines divided no longer seemed as compelling to these healers as what was now pulling them together every week. Whether or not they always agreed was not important for their continued motivation to gather and work out the rough edges of their differences. It is this serendipitous dynamic that had me intrigued, had the practitioners ablaze, and seemed to give this circle a sustaining life of its own.

At the end of the two years of observation, the practitioners wanted to move forward because they sensed new possibilities and emergent directions as they broke through old forms. Despite the many false starts and difficult moments in attempting to create a new model, they constituted, on the whole, a well-intentioned group of medical and health professionals, who took huge risks by joining with non-credentialed modalities with the intention of healing chronically ill clients. They pursued this radical action for no money, operating on the fringes of a medical paradigm that presented considerable barriers to their continued efforts.

Bridging radical differences in thinking/problem-solving

An obvious challenge to studying such a multidisciplinary entity is the inherent differences in epistemological frameworks of each method of health care. How each discipline comes to know what it knows is a hard-won alchemy of medicine and faith. Clearly, traditional Chinese medicine, with its foundations of health based in the Tao, the flow of chi, and the five elements, stands worlds apart from the material-based structure and function of allopathy. Radical differences exist in how the two systems view energy, metabolism, diagnosis, proper technique, and physiologic interpretations. But they are both empirical, having a reliance on some organized system of trial-and-error experimentation, and they are both faithful to their practices, with codes for conduct and loyalty to favorite therapies.

Modern conventional medicine may seem an unlikely bedfellow to such intangibles as metaphysics, the invisible, unproven, or immaterial, but its rigid adherence to its practices carries much of the fervor of a faith system. For example, biomedicine practitioners have fervently held onto beliefs that a certain practice or ongoing research project will eventually yield positive results, even after a decade of not one single documented cure.

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Gene therapy- the replacing of a "broken" gene with a new gene- is undergoing vigorous experimentation in labs, but not yet by that gold standard of biomedical research, the randomized, double-blind clinical trial. Critics of gene therapy insist that replacement of genes is not the problem, since a gene will not express itself correctly in a faulty environment (e.g., impaired messengers, bad enzymes, deficient nutrients, deleterious epigenome). But that did not stop scientists from talking a family into receiving gene therapy for their son, who died from the risky procedure. Paul Gelsinger, the boy's father, told Congress that his family was misled by scientists who hyped the cure and hid the dangers. One has to hold a rather staggering belief in something that has never been proven effective [19].

That blind adherence to beliefs has also been known to convince some scientists that tainting research data is justifiable. Researcher Werner Bezwoda admitted faking data on high-dose chemotherapy followed by bone-marrow transplantation, a therapy in which previous trials found no benefit. Bezwoda believed so much in the procedure, he did not want to stack the deck against it. Despite evidence to its non-effectiveness, women continue to receive these levels of chemotherapy and bone marrow transplants for breast cancer that have been proven ineffective and controversial since doctors began using the method in the late 1980s [19].

Again, as biomedical science declares itself to be the final arbiter of what is valid and what is not, an entire universe of discovery can be overlooked or dismissed. The most blatant example of this blind spot occurred when the Journal of the American Medical Association (JAMA) decided to publish the flawed study of a 12-year-old girl whose mother, Linda Rose, was a rabid denouncer of Therapeutic Touch (TT), a method of energetic healing practiced by nurses and developed by Dolores Krieger [20]. The 12-year-old's faulty conclusion that Therapeutic Touch was worthless was built on the premise that the technique was invalid because the mechanism of action could not be proven.

However, there are many dozens of medical practices done on millions of people in which the mechanism of action is not understood, but the therapeutic effect is so evident it would be unwise to discontinue its practice. The editors of NEJM announced that further use of TT was "unjustified," and as good enforcers of the sanctioned science, that we should all just go back to our usual business and forget this human energy field [20]. Over 200 studies on TT's effectiveness have been conducted; none has been accepted for publication in NEJM. The inflexibility of a fixed position begins to impose like the belief systems of a tyrant.

In that same issue, an editorial decried alternative therapy as completely unproven, completely ignoring years of clinical trials by the Office of Complementary and Alternative Medicine [21]. Playing the role of quackery police is not easy; you have to snuff out the sparks of possible cures and paradigm threats all about you. Skepticism becomes its own religion, and the eye is blinded by firmly held preconceptions. Beliefs in one particular worldview can diminish unbiased critical inquiry into novel experiences.

Breaking the isolation of narrow disciplines

To return to the healing circle that stunned its participants with a cacophony of tongues, there was a moment in which we searched each other's eyes with "What now?" Was it worth it to put a client through this kind of confusion? No one knew, but no one wanted to give up. Although the session had all the hallmarks of a medical Tower of Babel, the commitment to hang in there and plod through the mire of separateness was overwhelming on everyone's part- client and practitioner alike. This was confirmed in the practitioners' willingness to donate their time, free of charge. Not knowing the effectiveness of the circle, or being able to guarantee an improved health outcome, all practitioners believed that they should not charge for the service, since it was primarily a learning experience for everyone involved. (There was a nominal fee for the administrative set-up, but no practitioners received compensation.)

We may get dizzy from the efforts, but we would rather take our chances together than retreat to that lesser world of isolated practice. And several clients and clients-in-waiting informed us that the they would rather ride the rollercoaster of an "unproven" healing circle than be on the solo trek of seeking relief from the confusing array of alternative health treatments.

Seeking common ground

As stated earlier, major differences are evident among most of the disciplines represented in these healing circles. The allopath is convinced that a certain chemotherapy is the treatment of choice for a leukemic patient. But the naturopath is insistent that the person needs to be cleansed of toxic metals so the immune system can vanquish the cancerous cells without need of chemotherapy. When both of these views offer convincing arguments within the circle, how does reconciliation occur? Can there ever be a common ground? What are the ethical implications of dragging a client through this bumpy landscape? Isn't it only fair to the client to reach some consensus for a recommended course of action? In my role as participant-observer, I was not only caught up in these ambiguities and complexities along with the other practitioners, but I began to suspect there was no need to reconcile the differences. I also observed that many of the clients had the same tolerance for ambiguity. Often, they listened to the disagreement among practitioners and saw how the field was split, they understood the lack of consensus much better. One elder client stated, "Now I see why I was confused about what to do - you folks can't agree on much yourselves!".

Additionally, there is no common language or nomenclature among these disciplines. In one circle, the ayurvedic physician looked at the client and said, "It seems the imbalance in your doshas centers on your pitta and vatta being overwhelmed by the kapha dosha." The acupuncturist chimed in with, "and your splenic flow is obviously at low ebb." A brief, awkward silence ensued. "Now what?" seemed etched on everyone's brow. Suddenly, the ayurvedic practitioner and the acupuncturist looked at each other, wondering if they said anything remotely similar. Everyone was stunned into realizing how we were perhaps attempting the impossible, trying to

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cross chasms that might as well have come from different planets. The silence was broken by the client's good-natured remark, "I'm glad I'm not the only one who doesn't get this stuff. Imagine what it's like alone with each of you."

That moment was pregnant with realizations: How each healing modality, through centuries of isolated practice, delved unhindered into distinction and specialization; how the trial-and-error origins of each tradition progressed to an unquestioned dogma about how the body works, heals, and responds; how healers, no matter what the culture or discipline, can speak above the heads of their clients and mystify basic body knowledge; and how we have a chance to carve out a new Rosetta stone of medical-talk, and look for golden threads of commonality among traditions.

Addressing the lack of diversity

Any attempt at multidisciplinary healing work needs to articulate a plan for addressing the diversity of clients. No discussions were held about the ways in which to work with clients of various ethnicity, background, age, or gender. From an anthropological viewpoint, this oversight in the current study's healing circle was highly problematic. For example, Sylvia (a pseudonym) was a Spanish-speaking childcare provider from South America, who worked for an affluent white couple, and whose healing circle was arranged, sponsored, and attended by her employers. Most circle practitioners were convinced her stress-related illnesses, such as insomnia and intestinal ailments, were due to her "control numbers." They perceived her as not asking for help and therefore, unwilling to relinquish control in favor of receiving support.

From Sylvia's viewpoint, she had the enormous financial and moral responsibility of caring for her own family of six, with an unemployable, alcoholic husband. Sylvia was managing her family in the most responsible way she knew, and the phrase "control numbers" was not part of her world. The cultural incongruity between feeling like she was not being a responsible mother and talk of "control numbers" was starkly apparent. According to social construction theory, Sylvia's moral calling operated along traditional, duty-bound conceptualizations, rather than individual-based or "rights-based" conceptualization of the northern California practitioners (19). To the two different parties, there was a "natural order" to these roles that "the other" was simply blind to, heightening the level of frustration in the circle.

Sylvia's very significant needs and complex family life required the attention of friends and relatives with whom she had no language barriers and could trust. The face-to-face interactions with a roomful of professionals, all strangers, seemed to add more to her confusion and sense of isolation. There was also the stigma that she associated with one admission revealed in the circle: She had moved to the U.S. to leave her husband behind. After a seven-year search, he had found her and moved into her small apartment. However, because she did not feel it was acceptable for her to kick him out, she managed the situation by earning more money to support them all.

All suggestions by circle practitioners aimed at having Sylvia "do less" were not addressing the broader financial, social, religious, and cultural difficulties she faced. In closing, I do not believe the circle knew how to elicit the subjective experience of someone like Sylvia, let alone understand how she conceived of her duty, illness, her right to good health, and even the meaning of family and responsibility. The dialogue of "optimizing your health," "self-actualizing your desires," and even "what would you want, apart from your family?" had no relevance or much meaning for her, since her responses, even after extensive translation, were always, "I don't know. . . ." It was not an admission of ignorance as much as a dismissal of our suggestions, based upon the "you've got to be kidding" look on her face as she whispered in Spanish to her employer, and rolled her eyes with a head shake and giggle. Judging from her lack of follow-up of any of the suggestions (written in Spanish), her sponsors determined that Sylvia was ambivalent or skeptical toward the circle's "medicine," and did not understand our assessment of what ailed her.

The healing circle, with all its talk of "transformative journeys," and "the meaning of your illness" was created by educated, economically comfortable, white people for dis-ease and disturbances recognized and shared by the same. Despite our attachment to a notion that the healing circle west a multi-cultural undertaking, it was clearly the product of the combined experiences of a more culturally homogenous, small group of people born, raised, and responding to the educational, social, and economic conditions of the current health care system in the United States, and, more specifically, the managed care climate of northern California. The desire opportunity for a wider cultural representation in practitioners diminished over the two years, while they focused on refining the process and narrowing its purpose. Once more open, its boundaries became now static, and the inclusion of other healing or knowledge systems was diluted, if not barred.

The rare gift of free health care

The possibility also exists that there was a placebo effect from clients simply being surprised and grateful to have so many practitioners (who could make hundreds of dollars for their time) waive their fees in order to be present with them. The charitable act of non-compensation by the practitioners most likely contributed to the healing atmosphere of the circle. I have witnessed clients be visibly moved that this rarity occurred in today's cost-obsessed health care market. Non-compensation particularly affects the chronic disease patient who often is depleted of financial resources in seeking medical assistance. But just the time factor alone seems luxurious to clients. One physician in the healing circle noted that her HMO had a goal of three-minute clinical office visits, although one hour of waiting time was not unusual.

What the clients appreciated, the practitioners struggled with more and more as time went on. For those practitioners who had busy practices, and high status and salaries, the spirit

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of volunteerism was considered a noble endeavor. The allopathic physician of the circle wrote in one of his office newsletters:

The deepest aspects of medical freedom issues are not specific to our health care profession; they are deeply rooted in our culture. Until we become oriented to honor service before materialism, there will be ongoing turf wars that compete for market share control as a profit-motivated endeavor. While it is easy to appreciate that there will always be important economic issues to solve, if we work together with the highest goal being to provide service, medical reform will evolve naturally and appropriately.

For the practitioners who had no license or recognized credential in the health care field, and thus struggled to make a living, the uncompensated factor should only be temporary. Avenues to correct this shortcoming should be vigorously pursued. They kept encouraging those with formal ties to hospitals and clinics to secure research grants, insurance reimbursement, or other form of compensation. The Native American shaman, Pierre, said, "When I invite guest speakers, I ask for a respectful donation. I didn't think it was respectful for the Institute to ask practitioners to give their services away without any compensation. I believe in honoring people for their contribution."

Communities of care

Since this study on multidisciplinary interaction, new professionals have appeared in the multidisciplinary landscape: national board-certified health and wellness coaches in the U.S. They comprise about 1500 (at the time of this writing) individuals from diverse backgrounds, who have completed an approved curriculum that addresses key competencies based on published national standards [22,23], and successfully passed a proctored examination administered by the National Board of Health and Wellness Coaches in conjunction with the National Board of Medical Examiners his emerging body of health advocates is charged with stemming the rising tide of lifestyle-related chronic disease in the U.S. and other nations, primarily through a facilitated coaching dialogue that supports intrinsic motivation and goal-directed behavior change [24].

Staying well: The call-to-action for integrative health-care

More than ever, the public needs a system of integrative health care that helps people stay well in the first place. As our national health care bill exceeds one trillion dollars, we simply cannot afford high-tech, costly solutions to premature aging and chronic degenerative diseases. As the population ages, the need for natural healing sources as direct substitutes for conventional drugs will be most pressing.

Part of the problem of U.S. health care is that there are too many specialists. From 1950 to 2010, specialists went from about 30% of the medical work force to a staggering 80%. As mainstream medicine begins to incorporate alternative practitioners within its ranks, there is a danger that these holistic professionals will also become overly specialized. That would leave patients with the need to pursue several roads with equally unsatisfying results, since what the psyche and body are craving the holistic viewpoint are often neglected.

Also, as more people seek alternative therapies, it is time to deconstruct many of the aspects of clinical practice in that field. Examining how these methods can advance public health has enormous social benefit. Finding ways to safeguard the distinctive positive attributes of these traditions while they become integrated into mainstream medicine is notable, as well. Alternative therapies are recognized as accessible and affordable; however, that could change if they become fully co-opted by this country's health care delivery system.

The field of complementary and alternative medicine is also plagued by charlatan activities and quackery that prey on the desperation of the terminally ill. This ethnography could be an early mapping system that leads to more studies on safety, efficacy, interactions, and quality data to help practitioners sift fact from fiction and forge new integrative realities.

Efforts should be made worldwide to ease a false polemic that distinguishes between "Western" and "non-Western" medicine. Almost every medical anthropology text describes medical systems according to this contrived dichotomy. I can understand how the polarizing terms offer a quick shorthand, but the consequences of their continued use present a harmful stumbling block toward harmonious integration, improving relations between disparate disciplines, and eventual enhanced patient care. So far, I have seen how it is inaccurate to describe illness in either strictly biological or cultural terms. Likewise, it is inaccurate to freeze characteristics under a geographical label. The terms Western and non-Western solidify what is a flowing ever-changing incomparable mixture, each creates artificially distinctive boundaries between the other. The distinctions only serve to reinforce a perceived superiority of technological medicine, distance and hierarchical inaccuracy.

Summary of Findings

Inception and mission

The multi-modality healing circles arose out of a cultural ground characterized by: (1) a steady rise in the public's interest in complementary and alternative therapies; (2) a professional criticism of the impersonal, fragmented, dehumanizing treatment with biomedicine; (3) a recognition of the ineffectiveness of conventional health care for the treatment of chronic illness; and (4) a desire among some biomedical and alternative practitioners to exchange ideas about treatment and resources in what they thought of as a relatively neutral ground.

The subordination that practitioners feared was inherent in the structures of integrative medicine was not the primary obstacle to working in a successful interdisciplinary manner. Instead, the lack of

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skills and awareness in communicating, negotiating, and mediating among disciplines dominated the interactions. Tensions surfaced from this unbearable divergence, and the healing circle abandoned its multi-modality mode of operation for a circle designed to help chronically ill clients search for the meaning of their illnesses.

The deeply embedded stakes held by the practitioners regarding the superiority of their individual traditions prevented the emergence of a discourse for integration or at least a dialogic model of multi-modality treatment. This resolve was so embedded that the stakes went far beyond differences in epistemology, and touched upon ontological differences.

The healing circles served as a starkly evident touchstone for observing just how thoroughly unknowledgeable the different disciplines are in regard to the other's educational background, training, areas of expertise, and scopes of practice.

Positive effects and/or influences of the healing circle:

a. Practitioners experienced enhanced camaraderie and support in working with chronically ill patients; a step towards collaborative care versus isolated practice was achieved.

b. Chronically ill clients did receive a presentation of expanded array of healing options and wide range of viewpoints.

c. The advantages of group resonance and generous listening time may have fanned a spark of motivation, or initiated a new level of self-care in some clients.

d. The unpaid, volunteer aspect may have served as a placebo effect.

Questionable and/or negative effects and influences of the healing circle:

a) The ratio of several practitioners to one client can easily impose a dominant interpretive scheme upon the client in a formidable and unwelcomed way.

b) The single-intervention approach (e.g., only one healing circle per client) is unproven for lasting behavioral change.

Political climate

a. The level playing field that practitioners hoped to attain within the circle is possible on a philosophical basis, but more problematic on a political one. The current professional gatekeeping restrictions of biomedicine assure limited entry through licensure, credentialing, and qualifiers of insurance reimbursement. In some biomedical settings, there exists a milieu of mistrust, competition, and persistent discounting of the mounting evidence of alternative health's effectiveness in the management of chronic illness.

b. As gatherings of practitioners with varying degrees of education, licensure, and credential, healing circles could not be reimbursed according to the current health care system.

c. Just to participate in a healing circle would require a good deal of risk-taking on the part of licensed practitioners, since learning to take appropriate risks, and viewing failure as frequent and survivable, are not attributes of medical education.

Education and Training

a. The various branches of medicine (allopathy, chiropractic, osteopathy, homeopathy, naturopathy), nursing schools, and allied health training programs could include training in communication and negotiation, group psychotherapy, psychology and holistic counseling techniques.

b. Courses could explore ways for healers to tolerate uncertainty, the inability to cure, the lack of resolution or consensus, and the reframing of the healing process.

c. Integrative medicine curricula could include socio-cultural and medical anthropology studies in addressing diversity, different philosophies of healing, and epistemological differences.

Recommendations

Future study of a multi-modality healing circle could provide data for a "registry of effectiveness" for chronic illness conditions and related treatments. There were many times when the practitioners did come to agreement regarding the optimum choices for someone's condition. These agreements came about due to the lack of political interference, not competing for reimbursement dollars, and the ability to experiment with form and structure, independent and unhindered of the biomedical health care system.

If mainstreamed within the biomedical health care system, a multi-modality healing circle could supplement the work of medical peer review boards, or quality assurance and utilization review committees within hospitals. The practitioners could evaluate which type of medicine is most effective for certain ailments. A "best practice" approach to certain maladies could be defined as a result of outcome data on healing circles.

Cost-containment is another potential advantage to using a multi-modality healing circle within a hospital or clinical setting. The cost of managing chronic illness is the largest health care expense and expected to spiral upward in this next decade. Determining the most effective cost-containment measures by evaluating what treatments help patients decrease their utilization of services would help keep health care operations stable and solvent. Health insurers could sponsor a pilot project to evaluate the healing circle intervention programs as a means of cost containment and better management of chronically ill patients.

Closing Reflection

There is deep gratitude to the individuals who suffer with chronic illness, for the ways in which they taught these practitioners that our current models are still incompetent and lacking in fully humane, ethical, and compassionate care. As a researcher, I joined

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practitioners, both alternative and biomedical, as we retreated to the margins, looking to escape the dehumanizing modern-day health care terrain that we all took a part in creating. A generation raised to place science on a pedestal, the material over the spiritual, has now come full circle, and is hungry for other sources of healing wisdom. As a medical anthropologist, I suppose we are trying to heal the various personal, religious, familial and communal factors that impact our views of health and illness. As a practitioner in this new framework, I know the healing circle is just a start, and we do not just gather there for the sake of others. We are there to form community, to question where we have been, to ask forgiveness, and to come to terms with psychological conditioning that we have the right and privilege afforded by expert knowledge to dominate others. We think of ourselves as givers in the health care field; however, the healing circles teach us more about receiving. We gather to heal ourselves, and with enough humility and an act of grace, I believe when we circle, we have a chance to do just that. The findings of this research project may assist individuals and families to navigate the confusing new corridors of complementary and alternative medicine options with their health care professionals. The inclusion of historically "uncredentialed" caretakers, practitioners and healers in conventional health care settings can be of vital importance in helping to build alliances and bring wider dimensions of healing to health care itself.

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