Preamble

TCM or traditional Chinese medicine is an English-language term coined in the People’s Republic of China of the 1950s to translate the Chinese term *zhongyi* (Chinese medicine). TCM is known for its holistic approach to health and illness, its commitment to balance and moderation, its blurring of preventive and therapeutic interventions, and its attunement to seasonal, environmental, and personal life history-specific changes. However, as even the most exotically ‘Chinese’ thing or person is caught in a whirl of worlding (Zhan 2009), in that it is enmeshed in transcultural and re-localized encounters, any form of medicine that claims to be traditional is in fact ‘neo-traditional,’ ‘modern,’ or ‘alternatively modern.’ Just as the boundaries between tradition and modernity are blurred, so are those between anything distinctively Chinese, or other, despite nationalistic efforts to the contrary.1

Chinese medicine in the twentieth century: from *yi* to *zhongyi* to *zhongyiyao*

In nineteenth-century China, medical learning (*yi*) started to be referred to as Chinese medicine (*zhongyi*) after Christian missionaries began teaching ‘Western medicine’ (*xiyi*) in newly set up medical schools (Croizier 1976). This happened first in China’s ports that were accessible to European seafarers, businesspeople, militarists, and colonialists, such as in Guangzhou (Canton), Xiamen (Amoy), Tianjin (Tientsin), and Shanghai. Today, it is precisely in those coastal areas that Special Economic Zones have been installed which have made possible China’s recent ‘economic miracle.’ The developments in TCM from the 1990s on that pertain to ‘Chinese medicine and pharmacotherapy’ (*zhongyiyao*) have made an important contribution to this economic outburst.

So, how did we get from the nineteenth-century *zhongyi* to the twenty-first century *zhongyiyao* that features on the global health market? The obvious answer is: due to a turbulent twentieth century. Twentieth-century China saw great social unrest, unspeakable human suffering, and organizational ingenuity combined with admirable personal stamina. It saw the fall of the Chinese empire (1911) and World War I, followed by the Treaty of Versailles (1919) that legitimizing Japanese dominance in north-eastern China (which therefore would become
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China’s most heavily industrialized region). It saw the rise of Chinese nationalism, particularly from 1928 onwards; the Red Army’s Long March (1934–1935), giving rise to the ‘Red Capital’ in Yan’an (1936–1947); World War II (1937–1945); Civil War (1947–1949); and the founding of the People’s Republic of China (PRC) in 1949. After over a century of political unrest and military turmoil, the Revolution reinstalled nationwide stability, but not without causing unnecessary damage, specifically during the Great Leap Forward (1958–1962) and the Cultural Revolution (1966–1976). Yet the societal transformations before the death of Mao Zedong (1893–1976) fade in view of the more recent ‘Four Modernisations’ and the four decades of aggressive environmental exploitation and capitalist entrepreneurship that followed, culminating in the current One Belt, One Road initiative.

**TCM in the 1950s**

The ‘T’ in the acronym TCM dates to the mid-1950s when, during the first decade of the socialist government, in conjunction with China’s newly founded National TCM Academy (Zhongguo zhongyi kexueyuan), zhongyi started to be translated into English as traditional Chinese medicine (Taylor 2005: chapter 3). Other terms had been used during the nationalist period (1912–1949) when different currents of medical learning sought governmental recognition (Lei 2014) in a playing field marked by diverse epistemological pursuits (Chi-ang 2015). One such term, guoyi (the nation’s medicine), is still in use in Taiwan today. Meanwhile, the Communists, who were stationed in the remote north-western plains in Yan’an, Shaanxi province, had their first, legendary encounters with local practitioners proficient in what Mao Zedong then called the ‘old medicine’ (jiuyi) (Taylor 2001). Rather than playing to the essentialized nationalism of the term guoyi in Republican China, Mao, by calling it jiuyi, introduced temporality into its assessment: it was old in so far as it had a long history not exactly of 5,000 years, as uninformed proselytizers often claim, but, at least of 2,000 years, given that in the last three centuries BCE a textually-legitimized medicine became co-constitutive of the social processes leading to the establishment of the Chinese empire.

It was also old in so far, as Mao put it, as it needed renewal. As a Marxist and a revolutionary, Mao believed in progress. However, he was suspicious of renewals that came from overseas. Instead, he creatively applied the philosophy underpinning the Marxist theory of historical progress to a principle that pervasively organized Chinese societies: yinyang. The terms yin and yang existed already in Chinese antiquity, referring to the shady and sunny side of a mountain or a riverbank. They were often used as terms referring to relationally-defined locations: the outer and inner or the upper and lower parts of the body, where yin referred to the moist and dark and yang to the dry and light (Granet 1934). Today, regardless of whether one speaks to a Chinese peasant or intellectual, all have heard of yin and yang, and most associate yin with women and yang with men. However, this gendered understanding of yin and yang was not as explicit in antiquity.

Much ink has been spilled over the philosophical implications of yinyang complementarity, including in medical treatises. These debates have been continuously reignited as the attributes and meanings of yin and yang changed over the ages, and they even changed into their opposite. For instance, zhuo, meaning murky or turbid, transmuted from zhuo yang with yang qualities in antiquity to zhuo yin with yin qualities in late imperial China (see pages indexed in Hsu 2010: 401). So it comes as no surprise that Mao would aim to change their meanings too. He interpreted the understanding of change in terms yin and yang as a form of ‘ancient Chinese dialectics’ that provided the philosophical foundation for his formulation of Marxist

Two 1950s campaigns ensued directly from Mao’s understanding of historical change in terms of yinyang dialectics: ‘TCM physicians study Western medicine’ (zhongyi xuexi xiyi) and ‘Western medics study Chinese medicine’ (xiyi xuexi zhongyi). Although every Western medicine-trained doctor who attended the latter programme lamented over the waste of time and talent that it entailed, this Maoist policy will likely become increasingly important in the twenty-first-century healthcare of chronic conditions (see postscript).

TCM might best be interpreted as an ‘invented tradition’ resulting from a short-lived, intense nationalistic endeavour in the 1950s. Within few years after 1956, when the first four TCM academies were established, every provincial capital was bestowed with one in order to join the nationwide effort to render TCM standardized (guifanhua), modernized (xiandaihua), systematized (xitonghua), and scientized (kexuehua). The birth of TCM, however unique, nevertheless shared similarities with reformist strands of Ayurveda (e.g. Leslie 1976a; Leslie and Young 1992; Langford 2002, and this volume), kampō (e.g. Lock 1980), Tibetan medicine (e.g. Schrempf 2007; Pordié 2008; Adams et al. 2010), Korean (e.g. Ma 2010; Kim forthcoming), Vietnamese (e.g. Wahlberg 2008a, 2008b; Monnais et al. 2012) and Mongolian medicine (e.g. Pitschmann et al. 2013 on its materia medica).

The standardization of TCM theory: simplification and hybridization?

It was in Maoist China that TCM theory as a specifically ‘Chinese science’ was developed (Hsu 1999: 6–8, chapter 6). TCM theory put at centre stage an understanding of change in terms of yinyang, as well as a system of correspondences in terms of the ‘five phases’ or ‘five agents’ (wuxing)—wood, fire, earth, metal, and water—which relate to each other in cycles of becoming, insulting, and overcoming (Sivin 1987; Ots [1987] 1990; Farquhar 1994; Hsu 2007a). TCM practitioners reasoned in terms of these systemic correspondences when they designed personalized treatment (Zhang 2007: 87–104), intent on stripping TCM of its religious aspects. However, this was not always possible since key terms in Chinese medicine, such as qi (breath, air, energy) and shen (spirit), refer to dimensions of existence that connote the ‘spiritual’ and ‘religious.’

Mao’s main concern was to synthesize, unify, or ‘integrate traditional Chinese and modern Western medicine’ (zhongxiyi jiehe) (Taylor 2005). His was an attempt that built on a century-long history of movements within China’s intelligentsia that actively sought to combine modern and traditional medicine, by means of merging (huitong), joining together (tuanjie), and integrating (jiehe) them (Scheid 2001). In contrast to the ‘purificatory’ efforts (cf. Latour 1993) that most other ‘modern’ nation-states implemented in order to install clear boundaries between the traditional and modern (Ferzacca 2002), socialist China aimed at integrating ‘modern’ instruments, chemical substances, and technological routines into ‘traditional’ medicine. Today, its standardization efforts are notable in at least three domains, namely the composition of textbooks for training doctors, lab-based research undertaken on Chinese materia medica, and the recent institutionalization of so-called translation studies.

First, ‘standardization’ efforts (guifanhua)—as people at the grassroots called them—consisted—for knowledgeable scholar-practitioners—of a ‘simplification’ of many different medical theories of different medical lineages (Scheid 2007). Such simplification can be taken as an intrinsic aspect of any government-instigated standardization effort, such as those repeatedly undertaken in dynastic China (Hsu 1999: 2), but the compilation of TCM textbooks
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in Maoist China has been characterized as a distinctively communist standardization project (Taylor 2005), derived from one single source: the textbook Zhongyixue gailun (Outline of the Study of Traditional Chinese Medicine) of 1958 (Porkert 1974). One of the more radically reformulated textbooks (partially translated by Sivin 1987) aimed to be intelligible for ‘peasant, soldier, and worker’ (gongnongbing) students during the Cultural Revolution. This was a specifically socialist effort reviled by some, but praised by others for its ‘simplification’ of TCM theory.

Meanwhile, the second edition of the early 1960s (cf. Taylor 2005: chapter 3) and the fourth of 1984/1985 (cf. Hsu 1999: 168–224), published just before and after the Cultural Revolution, remain the most revered. These two textbook series are valued for their coherence, internal consistency, and relative complexity in the presentation of medical knowledge, as well as for their richness in quotes from pre-twentieth-century Chinese medical authors and commentators. The textbooks of the early 1960s comprised five subjects, while the textbooks of 1984/1985 had thirty-two subjects, ranging from acupuncture and moxibustion (zhenjiu), to TCM materia medica (zhongyaoxue), formulae (fangjixue), classical Chinese for TCM students (yiguwen), and the various clinical subjects from TCM internal medicine (zhongyi neike), to women’s medicine (fuke), paediatrics (erke), and the like, to nurturing life exercises (yangshenggong).

Second, over the years, standardization efforts have been marked by increased ‘hybridization’ (e.g. Frank and Stollberg 2004). Alongside international efforts of standardizing terminology (Pritzker 2014), and as the aspirations to globalize TCM have become increasingly manifest, ‘translation studies’ have been instituted on an unprecedented scale. Ye and Zhang (2017) identified four schemes for translating TCM: translation into biomedical terminology (exemplified by Xie Zhufan), translation based on the conceptual history of a term (e.g. Li Zhaoguo), translation reflecting the etymology of a term (e.g. Manfred Porkert), and translations that are figurative and create neologisms. (e.g. Nigel Wiseman). How these different translation principles will affect TCM practice remains to be seen.

Third, in the assessment of materia medica standardization has also played a role. On the one hand, it took account of its lab-based chemical profile and, on the other, provided traditional treatment strategies and outcomes in specifically Chinese medical terminology. Thus, the compilation of the Zhongyao dacidian (Jiangsu xin yixueyuan 1977), a Maoist project initiated during the Cultural Revolution, juxtaposes traditional and modern knowledge in a mutually complementary way. Since its mode of standardizing the Chinese materia medica encouraged ‘hybridity,’ it could be interpreted as paving the way for recent developments within TCM, which are best interpreted as a manifestation of an ‘alternative modernity’ (see next section). Without being explicit, the WHO seems to have used this Chinese standardization project as a blueprint for recording traditional materia medica worldwide (Hsu forthcoming).

Chinese medicine and pharmacotherapy

Zhongyiyao, here translated as ‘Chinese medicine and pharmacotherapy’ (CMP), has more recently become the most predominant aspect of Chinese medicine worldwide, as from the late 1980s and early 1990s onwards the Dengist government promoted the innovative design, production, and export of so-called Chinese formula medicines (zhongchengyao). Those are patent medicines in so far as they can be dispensed over the counter. They generally are composed of Chinese materia medica derived from plants, animals, and/or minerals (zhongyao), and sometimes include purified chemical compounds (xiyao); furthermore, their composition
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does not strictly endorse TCM rationale (Hsu forthcoming). Zhongyiyaow, or CMP, points to the development of a Chinese pharma-industrial complex, oriented towards competing on a global health market legitimized by a global science.

The 1990s saw a shift in official language from zhongyi, TCM, to zhongyiyaow, ‘Chinese medicine and pharmacotherapy,’ as is evident, for instance, in the change in appellation from zhongyi xueyuan, a TCM college, to zhongyiyaow daxue, a CMP university. So, TCM is no longer celebrated as the nation’s ancient science but is rather celebrated for its herbal, animal, and mineral medicinal substances (the yao in zhongyiyaow), validated by a materialistic global science (Hsu 2008). While the Chinese government does not attribute any significance to this difference in wording, a social scientist may find it useful for analytic purposes: TCM, zhongyi, was celebrated as China’s national heritage and therefore has traits of a nationalistic ‘invented tradition,’ rapidly installed in the 1950s. By contrast, with the increase in facilities to pursue lab-based research in the 1990s, zhongyiyaow has traits of an ‘alternative modernity’ that, however, ultimately defers to the regime of a global science.

**CMP as alternative modernity?**

So, has a medicine been reduced to being valued for its disparate medicines? Has Porkert’s lament from decades ago that the nation’s ‘treasure house’ was on its way to becoming a ‘quarry’ (quoted in Hsu 1999: 194) become true? Has, in medical anthropological jargon, a coherent ‘medical knowledge system’ (Leslie 1976b) become but a ‘pharmaceutical assemblage’ (Kloos 2017)? Or might it do CMP more justice to treat it as an ‘alternative modernity’ (Gaonkar 1999; Knauft 2002) that thrives on the integration of its modern and traditional, Western and Chinese, philosophical and material heritage, and thereby challenges the usual ‘purificatory’ tendencies of being modern?

CMP production draws on a wide range of innovative forms of phytochemistry and biotechnology, and has given rise to a flourishing ethno-chemistry, so to speak. The distribution and consumption of formula medicines furthermore entails the reformulation of regulatory and legal conventions, as has been detailed for the Ayurvedic industry’s ‘reformulation regime’ (Pordié and Gaudillière 2014). In many ways, CMP exemplifies such a ‘reformulation regime’ of polypharmacies produced through similar ‘reverse engineering.’ Regardless of whether they are reformulated Ayurvedic drugs, Chinese formula medicines or sowa-rigpa pills, these polypharmacies (medications made up of a variety of different medicines) can be seen to challenge basic axioms of chemistry (Schwabl and van der Valk 2019). This is another reason for considering CMP an alternative modernity in that it challenges axioms of modern chemistry.

As I observed in my ethnographic fieldwork in Africa (2001–2008), prescribing CMP formula medicines requires physicians to engage in some diagnostic procedures, even if not extended ones. Some formula medicines have features of ‘magic bullets’ derived from secret ‘folk medicines’ known to treat specific symptoms effectively. Other formula medicines are manufactured through novel combinations of different Chinese materia medica, to which occasionally a vitamin, steroid, or other chemical substance is added, say, against hypertension. Yet others are composed of Chinese materia medica that make up a classic formula and require long-term use as they are thought to effect gradual improvement. Meanwhile, practitioners working within the CMP reformulation regimes are only occasionally proficient in more sophisticated TCM treatment (Hsu forthcoming).
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**CMP as a highly commercialized, transnational ‘reformulation regime’**

The highly commercialized and transnational CMP sector is a ‘reformulation regime’ (cf. Pordié and Gaudillière 2014), no doubt. Governmental and private firms in the PRC often form enmeshed conglomerates that span the globe (Zhan 2009), thereby enabling CMP formula medicines to flood the global market (Hsu forthcoming). CMP has also engendered an industry with ethnicized medicines in greater China. What previously was entwined with primary care (e.g. White 1998), has morphed into an herbal trade (e.g. Campinas 2020). Even in remote areas of the Tibetan plateau, pharmaceutical firms may closely observe good manufacturing practice (GMP) standards, in order to export their wares to both the industrialized North and South (Saxer 2013). People in remote areas are thereby tied into the global market (Blakie et al. 2015), which, with its fluctuating prices, reinforces their precarious existence, and turns them into marginalized populations. Any social scientist who recognizes a reformulation regime in these developments, will note prestige, surveillance, and fiscal reasons, alongside historically grown and practical motivations for the Chinese government to insist on considering CMP an aspect of government-promoted TCM.

**CMP and the exploitation of the natural environment**

CMP’s pharma-industrial complex has not only opened up new business avenues and trading possibilities with ‘natural’ compounds but also increased social inequality and spurred non-sustainable, even ruthless, exploitation of the environment. Several CMP polypharmacies, which include *materia medica* derived from animals, have led to an alarming decimation of wildlife, and even of domesticated species (e.g. Cheung et al. 2021). Animal conservationists have rightly become vocal, and TCM has become their target. Even species that were not particularly endangered only ten years ago have been brought to the brink of extinction, such as the pangolin, as its scales enhance the suppleness of tendons, sinews, and connective tissue. (The pangolin can be seen to have ‘struck back,’ as it is presently considered the intermediate vector for the novel coronavirus to get from bats to humans, much like the civet cat was the intermediary for transmitting the SARS virus from bats to humans [see Liu 2020]). In a similar vein, donkeys are endangered due to the popularity of donkey hide (*ejiao*), both as a lozenge favoured by teenage girls coming to terms with their periods, and as a *materia medica* in formula medicines, like ‘men’s treasure’ (*nanbao*), purchased over the counter to enhance sexual virility (Hsu forthcoming). Because of *ejiao*’s alleged tonifying properties, it is possible for male household heads in Africa and Asia to sell off donkeys at exorbitant prices, depriving their toiling women of their main support and transport animal. Among conservationists, TCM has thus become a dirty word, when from a social scientific viewpoint, the accurate target really should be CMP.

Ironically, TCM practitioners and famous senior doctors, rational and educated members of China’s intelligentsia, who are attentive to the environment and care for the ‘body ecologic’ (Hsu 2007a), have become environmentalists’ targets. They are accused for endorsing unethical medical practices and critically endangering species. This situation prompts more reasons for medical anthropological and social historical scholarship to differentiate between TCM and CMP, with TCM as the government-promoted and regulated discourse of Chinese medicine and CMP as a commercially driven pharma-industrial complex, which creates opportunities to ruthlessly extract wildlife from pristine environments.
CMP’s shady margins

As already noted, many formula medicines are sold on the basis of a ‘one symptom, one medicine’ rationale, reminiscent of the rationale of ‘simples’ in ‘folk medicine’ or the quick fixes of ‘popular medicines.’ They solicit drug consumption to participate in an overheated leisure industry, enhancing individuals’ performance in morally shady interstices of social life. This is exemplified by ‘PartySmart,’ which uses plant ingredients discovered through ascetic practice to treat hangovers, thereby enabling the enhanced consumption of alcohol, necessitated in late liberal leisure activities (Pordié 2015).

Chinese formula medicines typically are dispensed in TCM clinics, but in 2007–2008, in Kampala, I found that local Ugandan patients confused Chinese formula medicines with Southeast Asian herbal health products, dispensed by an organization called ‘Tiens’ (although, Wan [2017] tells us, their headquarters were in Tianjin, PRC). This sort of ‘healthcare’ had people suffering pain and illness sit in a circle, as in Pentecostal prayer meetings, and instigated patients, initially strangers to each other, to begin disclosing their emotionally-moving illness narratives, transporting themselves and their ephemeral peers into a confessional state and an emotional ‘high.’ Once in this communal state of heightened hopes, the patients were sold health products en gros on credit and tasked to sell them on to their friends. This practice, manipulative if not exploitative, has as yet barely been researched by social scientists. While the general public in Kampala confused ‘Tiens’ as an outgrowth of TCM, the Chinese practitioners who ran TCM practices did not and would not have anything to do with it.

Calisthenics instead of CMP

Somewhat ironically, at the same time as randomized controlled trials are validating TCM/ CMP medicines for bodily ills by the materialistic standards of global science, practitioners seek out Chinese medicine’s energetic and spiritual aspects as calisthenics. Practices of nurturing life, like qigong, and of the martial arts, like taijiquan, are outside their Chinese homelands known as ‘meditation practices’ that ‘balance the person’ and ‘calm the mind.’ Those practices largely centre on bringing qi into movement and circulation, where qi is understood as an animating ‘energy’ (Sagli 2017).

Thus, the reception of Chinese medicine on the global health market largely follows a mind-body fault line: it is either consumed as a medicine for regulating the body or as a meditation practice for calming the mind. The middle-class consumers of ‘formula medicines’ as somatic medications are not necessarily the same middle-class clientele attracted to qi meditative practices. In a similar vein, the reception of acupuncture treatments in North America and Europe has been marked by either its psychologizing (Barnes 1998) or its physiologization (Tao 2008). Having said this, TCM decoctions and CMP formula medicines are often consumed on the assumption that the regulation of the body will regulate the mind and, vice versa, meditative practices can reduce physical pain and disease.

Continued state support for TCM and CMP

While TCM travels the world, and through its ‘worlding’ morphs into different forms, it has recently been heavily attacked in its homeland. Popular science writer Fang Zhouzi (2011) argues that TCM is cultural heritage, not science, and hence should not be supported by the state. To date, these debates have been restricted to specific platforms on social media, and the Chinese government has continued to support TCM (which they consider to include CMP.
and some calisthenics, like qigong and taijiquan). During the COVID-19 crisis of 2019–2020, TCM has resurged with unabated vigour (e.g. Sun and Hsu 2020).

Admittedly, for the Chinese government, the development of TCM was never as important as that of Western medicine. Nevertheless, TCM occupies an important position in Chinese civil society, in its homelands, and in the various forms, it has morphed overseas, particularly among non-Chinese people in search of ‘holistic’ care by ‘natural’ means. As this section has also shown, the Maoist vision promoted hybridity and eased the way for TCM to develop ‘alternatively modern’ formula medicines, CMP. Those that are competitive on global health markets are sometimes consumed for a morally-questionable enhanced performance and often instigate unsustainable ecological extraction.

The distant past in the present: Huangdi’s Inner Canon as a living authority

One might have been inclined to call TCM a professionalized medicine, stylizing itself on the processes of professionalization described for twentieth-century biomedicine, but one profound difference is the reverential attitude TCM practitioners have towards the medical knowledge of past generations. Huangdi’s Inner Canon (Huangdi neijing) is composed of two books, each with eighty-one sections. It is generally available in editions that draw heavily on interpretations by Zhang Jiebin (1562–1640; e.g. Hsu 1999: 186–198). It is treated as a living authority, and its overall philosophy guides medical practice with renewed vigour in TCM. Its status has been likened to a classic, as Enlightenment scholars referred to works of their Greco-Roman past. It has also been likened to a canon that is a living authority for a religious community. However, neither of these approximations as classic or canon is entirely satisfactory.

The Inner Canon’s textual history is very complicated (Sivin 1993). Aspects of its grammar and figures of speech suggest that some passages date to the third century BCE, but the earliest text in block print of the first book, the Basic Questions, dates to the Ming dynasty (1368–1644), claiming to reproduce a Song dynasty (960–1279) edition of 1067 (Anonymous [1956] 1982). The Song dynasty editors’ preface, in turn, states that they significantly updated roughly a third of the version of the text transmitted to them. The text they received is thought to be based on a revised edition by Wang Bing, a Tang dynasty (618–960) physician who submitted it to the throne as a medical examination text in 762.

Thus, any Western, philologically trained scholar would consider it a mistake to consider the textual fabric of the Inner Canon in its currently transmitted form to be a reliable source for informing us about medical practice in the Han dynasty (205 BCE–220 CE). However, this is precisely the status it continues to have among most Chinese medicine scholar-physicians, although some are becoming aware of the text-critical considerations that its reading demands.

The all-pervasive Qi

A key concept in the Inner Canon is qi. Accordingly, qi constitutes and permeates the universe and has agency as it affects change and causes transformations. Simultaneously, qi is also matter that, like air, wind, or vapours can be channelled, gathered, densified, diverted, or dissipated. However, while it can be tactually identified and recognized, it cannot be grasped. Qi is in constant flux and flow, ever elusive, yet ever present. The Chinese concept of qi, which naturally has changed over time, has certain striking affinities with pneuma in the Greek tradition but also distinct differences (Kuriyama 1999: 233–272; Lloyd 2007). The scholarship of
the stratified societies of ancient China and of classical Greece had much in common, and most evidently, a predilection for thinking in terms of correspondences (Farmer et al. 2000). However, there were important differences too, not least in regard of the philosophical understanding of substance and matter, spatiality, and temporality. Although early observers considered Chinese medicine a ‘humoral medicine,’ qi is not a humour (Bates 1995; Horden and Hsu 2013). Rather, it has affinity with mana (as described e.g. in Munn 1986) or with the power in the powder ifá (Holbraad 2007).

Qi often takes on the qualities of the places in which it is, thus qi in the liver becomes liver qi and when it moves to another place, say the heart, it becomes heart qi (Hsu 1999: 78–83). The qi of the heart may feel on one day ‘small’ (xiao) and ‘swift’ (ji) when one palpates the pulse on the wrist, yet depending on the circumstances, on another day, it may feel ‘flood-like’ (hong). These different ‘images of the pulse’ (mai xiang), together with other diagnostic signs, assist the TCM practitioner in identifying patterns of disharmony (see ‘Practice’ section in this chapter). There are qualities of qi that can be likened to the concepts of ever-elusive fortune and luck in Southwest China (da Col 2012), Mongolia (Empson 2011), or Japan (Daniels 2003), which in medical contexts may translate into family-given, place-specific, or body-constitutional aspects of health and wellbeing. It is important to understand that qi cannot be nailed down to a place or reduced to an essence, that is essentialized. It takes on its qualities in relation to others and depending on its locality. In medical contexts, the term qi generally indicates that the conversation is about a potentiality for or an ongoing process of change.

The four diagnostic examinations (sizhen)

When Chinese patients go to see a doctor, they say they go ‘to see the illness,’ that is to have their illness looked at (kanbing) (Farquhar 1994). This process involves, in fact, more than ‘looking.’ In TCM, the diagnostic process is said to comprise four examinations (sizhen): looking, asking, smelling/listening, and taking the pulse (wang, wen, wen, qie; Deng 1984). Diagnosis involves integrating information from several different sources (see Zhang 2007: 105–137, for analysis of a single case). Findings made through objectifying measuring devices are not ignored in TCM, and, in fact, are encouraged, especially since the integration of Chinese and Western medicine has, in general, been encouraged. However, for a Chinese medical practitioner, the ‘medically meaningful’ relates to the lived experience and is bodily appreciated through the embodied experience of the patient.

To put it more specifically, the ‘medically meaningful’ can be seen to reside in the patient’s colloquial language for expressing pain and discomfort, which is preserved verbatim as it is transported into technical Chinese medical language. For instance, pa leng, ‘to dislike cold,’ is a technical term and not merely a subjective experience that can be reduced or replaced by objectifying biomedical Latin terminology. Chinese medical theorizing insists on working with the same linguistic terms and colloquialisms that the patient uses, which is ingenious. Most Chinese medical terms have a wide semantic stretch. Rather than understanding these terms in an analytic framework that differentiates between literal and metaphorical meanings, these terms are better understood as figuratively speaking (Fogelin 1988) about concrete issues that can be understood to sometimes have more encompassing meanings. Figurative speech, widely encountered in medical contexts, has been shown to be empowering for both practitioner and patient (Csordas 1994). Historically grown terms, as just seen, tend to be ambiguous and vague, but TCM promoters underlined their scientifically approved aspects. For instance, a binomial, such as ‘blood fluid’ (xueye), in place of ‘blood’ (xue), unambiguously refers to
what science recognizes as ‘blood.’ Arguably, this change drastically reduces the evocative powers of figurative speech that spur the imagination and instigate (self) healing processes.

**TCM distinguishing patterns (bianzheng)**

By means of the four examinations, TCM practitioners determine patient-specific patterns, so-called distinguishing patterns (bianzheng). A distinguishing pattern, unlike a disease, has no temporal depth; it can change by the day, depending on the changes detected through the diagnostic four examinations, wang wen wen qie. Since TCM’s legitimacy largely derives from a claim to science, practitioners are well aware that causal reasoning is a prerequisite for being considered rational or scientific (for the ironies this historically gave rise to in Republican China, see Unschuld 1992). However, contrary to their claims, the names of the patterns do not actually contain much information about the cause of the disorder. Rather, they contain hints for the strategy of treatment. For instance, biomedically-diagnosed depression can manifest in many different distinguishing patterns, such as liver qi stagnation (qizhi tanyu), stagnant qi transformed into fire (qizhi huahuo), heart yin depletion (xinyin kuixu), or yin depletion leading to rampant fire (yinxu houwang; Zhang 2007: 87–104), and the treatment strategies these distinguishing patterns hint at are ‘to bring qi into motion,’ ‘to disperse the phlegm,’ and so on.

The treatment of patients presenting distinguishing patterns can involve acupuncture and moxibustion (zhenjiu), and/or a polypharmacy of herbal, animal, and/or mineral ingredients simmered over a small fire to a decoction (tangyao) that the patient has to ingest. Treatment consists of regulating (tiao) imbalances and expelling (chu) afflictions by means of inducing perspiration (han), vomiting (tu) or micturition/evacuation (xia). It may also involve dispelling (san) qi or bringing qi into motion (xing qi) or, when bodies are depleted, watering/nourishing yin (zi yin), and so on. It intervenes at an intermediary [ethno-]physiological level. Patients are expected to regularly visit the clinic for minute adjustments. Mental health is maintained through herbs and needles rather than by means of talk therapy.

**Fieldwork experiences of TCM in the PRC**

During my fieldwork, when I did practical training in an acupuncture ward, first in Chengdu (1985, six weeks) and then in Kunming (1988–89, eighteen months), there was no heating in winter and people wore padded trousers and jackets. They knew there was no need to undress for diagnostic purposes and that they merely would be asked to poke out their tongue and stretch out their arms, such that the physician could take their pulse (after shoving aside multiple layers of clothes) at the wrist, which was rested on a small padded cushion, however greasy, that always lay somewhere on the table. Patients who needed to sit would wait in the corridor, while most others crowded in to stand by the physician’s table, without actually showing much interest for the ongoing diagnostic process. Rather, they were just chatting and mulling around, producing the sort of ‘red-hot’ sociality known to be intense at religious events like temple festivals (Chau 2006). The visit to the acupuncture ward has been likened to a day centre for the elderly (Ots 1990).

A good acupuncturist typically varies the locations needled daily, just as a good cook avoids serving the same meal day after day. TCM cannot be practised in a regimented way (bie tai siban). Only once in my TCM training was I tasked with delivering the very same formula every other day for over one month in exactly the same order. For treating a heavily sedated psychotic patient, I applied the thirteen loci for treating ghosts (shisan guixue), a formula
developed by the Tang dynasty physician Sun Simiao (581–682 CE). Simultaneously, my tutor implemented one of the two methods developed during the Song dynasty, called *ziwu liuzhu*, which calculated circadian rhythms (for the other method, *wuyun liuqi*, see Despeux 2001). To ensure that treatment resonated with the daily fluctuations of environmental *qi*, the patient was made to come to the clinic at awkwardly varied hours in the day. So, also in this case, treatment involved variation (for details, see Hsu 2007b: 113–114, n. 9).

**‘Updating’ a classical formula**

Chinese medical treatment is generally celebrated for its dynamic and flexible treatment, implemented with ‘virtuosity’ (*linghuo zhangwo*; see Farquhar 1994). Formulae change over time. Scheid (2001) provides a compelling example, based on his fieldwork in Beijing (1994–1995), of a TCM physician who had developed a new formula for treating patients suffering Menière’s disease. Biomedically, this disease is not well understood; it manifests in sudden dizziness, nausea, and vomiting, and is linked to some dysfunction in the vestibular system of the inner ear. This physician ingeniously translated Menière’s disease into distinguishing patterns (*bianzheng*) marked by a phlegm congestion that affects the ear. Distinguishing patterns of this kind hint at a treatment strategy to attend to the liver, unblock phlegm, and guide it downwards. Since the gall bladder channel passes through the ear and the gall bladder is the outer aspect of the liver in TCM, the doctor prescribed a formula with ingredients that would find their way to the liver channel. One such formula was the Song dynasty Two-Aged [Herb] decoction (*Er chen tang*) from 1078, modified into the Guide Out Phlegm decoction (*Dao tan tang*) of 1253. The TCM physician added plantain, a botanical diuretic, also recognized in Europe, Africa, and India. His treatment rationale was that a diuretic brings waters into flow, thereby unblocking phlegm, wherever it stagnates, including the ear. This example shows that the foundations of Chinese medical formulae may go back hundreds of years, but they can be modified to treat biomedical diagnoses by seamlessly blending Chinese medical and Western biomedical rationales into a single integrated treatment.

**Postscript: the legacy of TCM**

TCM’s most important contribution to twenty-first century healthcare, however, might not lie in the aforementioned sophisticated personalized practice. Rather, TCM’s history contests the belief of contemporary health professionals that biomedical healthcare can be delivered without co-option of local medical knowledge, thereby resurrecting the Maoist motto ‘modern Western medics study traditional Chinese medicine.’

Ageing populations and those suffering from chronic conditions increasingly require long-term care. Hence, the co-option of traditional practitioners is a possible scenario. As chronic pain, fatigue, eating disorders, infertility, ‘stress’-related distress, and other so-called non-infectious diseases come to prevail globally, biomedical professionals will depend on collaborating with local medical personnel worldwide. However, ethnographic research shows that competent biomedical professionals who have the goodwill and idealism to collaborate with traditional healers encounter numerous problems. Ignorance of each other’s medical principles and practical ethics can result in the former accusing the latter of being unreliable tricksters, embezzling funds, while the latter feel the former treat them disrespectfully (Wreford 2008: 75–85). In a collaborative strategy that has worked, traditional healers first perform purificatory rites to change patients’ dispositions and prepare them for the subsequent biomedical...
intervention. This suggests a ritual structure, rather than a scientific explanation, can enable fruitful collaboration.

Practitioners of traditional medicine generally work with non-dualist, non-Cartesian bodies, known to be animated by life forces and spirits, the numinous, and sometimes even the divine. Biomedical professionals will need to take full account of the contextual framing of traditional medical interventions, including their temporality. A healing process can be drawn out over several years, requiring different, even contrary, therapeutic interventions at different stages. A good doctor will treat a disorder before it becomes blatantly manifest. For modern biomedical professionals, therefore, there are basics to be learned from traditional medical practitioners.

Note

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