Traditional Medicine and the Postcolonial Condition

It was a gray and chilly November morning in 2002, two years after my graduation from the Beijing University of Chinese Medicine. I had returned to Dongzhimen Hospital, the main teaching hospital of my alma mater, to spend two months studying with several senior physicians, trying to master the clinical skills I needed to become a doctor of Chinese medicine. I was walking briskly to get to the hospital before the outpatient clinic opened at 8 a.m. Because the outpatient clinic is first-come first-served, throngs of patients were already filling the waiting room and hallways of the clinic. As I approached the hospital, I began to prepare myself for the intense focus I would need for the next four hours. I was going to be shadowing a senior clinician during his morning shift. It would take my full concentration to follow, understand, and take good notes on his clinical work, as he efficiently worked through two dozen or more patients. I was determined to make the most of this opportunity. I had completed a five-year medical school degree in Chinese medicine, but as a foreign expatriate, it probably would have been legally impossible for me to work in a Chinese medicine hospital and follow the standard career trajectory of a doctor through residency, attending physician, senior physician, and so on. My opportunities to learn the clinical craft of Chinese medicine from experienced physicians were now limited to occasional short visits to China like this one. I envied my Chinese classmates, who would be able to gradually hone their skills through such mentoring relationships in the hospitals and clinics where they were now working.

While I was concerned about my development as a physician, I knew that many of my Chinese classmates were even more apprehensive about their own futures. A significant number, in fact, wished to gāihang “change professions.” I had recently caught up with Chen Yao, a classmate who was working for the multinational medical nutrition company, Nutricia, in their Beijing office. She told me that in the two and a half years since graduation, almost one-third of our 60 Chinese classmates were now working for pharmaceutical companies as drug representatives. Chen Yao did not dislike Chinese medicine. Indeed, like most of our classmates, she had a certain affinity for the profession after having devoted an entire college career to studying it. But she clearly preferred the financial benefits of working for a...
global pharmaceutical firm over the difficult and poorly compensated work of a doctor of Chinese medicine. The other classmates that I caught up with during my visit shared Chen Yao’s ambivalence about Chinese medicine. They seemed to be either reluctant doctors or were in search of other career opportunities. Some of the graduate students that I met at the Beijing University of Chinese Medicine took another path out of the profession, transitioning from an undergraduate degree in Chinese medicine to a graduate program in Western medicine. Wang Bo, the teaching assistant for my biochemistry class, was one such example. She and her husband both studied Chinese medicine as undergraduates. She was able to test into a Master’s program in Biochemistry at the Beijing University of Chinese Medicine. Not long after completing her M.S., she followed her husband to New York City in 2003, when he got accepted into a Ph.D. program for oncology research at New York University.

This ambivalence about pursuing a career in Chinese medicine is widespread, particularly among students and young doctors. I consider it one of the defining traits of what I call the “postcolonial condition” of Chinese medicine. In postcolonial studies, scholars such as Dipesh Chakrabarty have defined the “postcolonial condition” as a state in which the West continues to exercise a cultural dominance over the formerly colonized, making the West the necessary point of reference for any historical, sociological, or scientific claim made about the East (Chakrabarty 2000: 8). In other words, the power inequalities of European colonization have often persisted in the contemporary period, even though the vast majority of formerly colonized societies achieved political independence by the early 1960s. Instead of overt political domination, these societies struggle with colonial-like power inequalities that take subtle, cultural forms. Taking contemporary China as an example, the unquestioned prestige of Western medicine is reminiscent of Frantz Fanon’s analysis of how settler values were privileged over native ones in colonial Africa (Fanon 1963). The ambivalence of young students and doctors toward Chinese medicine also resonates with Fanon’s insights into the psychology of colonized.

All colonized people . . . position themselves in relation to the civilizing language, i.e. the metropolitan culture. The more the colonized has assimilated the cultural values of the metropolis, the more he will have escaped the bush.

Fanon 2008 (1952)

As we will see in the ethnographic vignette below, physicians of Chinese medicine must also position themselves in relation to the dominant practice of biomedicine in order to engage in clinical work.

Historically, we can also trace how Chinese intellectuals positioned themselves in relation to the “civilizing language” of European and Japanese imperialism (1840–1949) and the effects of this relationship on the Chinese medicine profession in general. In the early 20th century, a vocal opposition to Chinese medicine emerged among China’s most educated elite, the first generation of Chinese intellectuals to study the Western sciences and humanities, often at European, American, or Japanese universities. For these elites, Chinese medicine was not only false and incorrect, but a superstitious practice that made the populace at large resistant to modernization. Although some of these intellectuals became important figures in the Nationalist government (1927–1948) and sought to use their political position to promote Western medicine and restrict Chinese medicine, they had little effect on the general prestige of Chinese medicine. Skilled physicians of Chinese medicine remained highly sought after in both rural and urban communities (Karchmer and Scheid 2015). A critical mass of trained doctors of Western medicine did emerge during this period, creating the foundation for the later development of a national health care system under the Communists, but they were vastly outnumbered by doctors of Chinese medicine (Karchmer 2015: 199–201).
of the Communist Revolution in 1949, there were an estimated 500,000 doctors of Chinese medicine compared to 38,000 doctors of Western medicine, who practiced almost exclusively in urban centers (Cui 1993: 67).

In the early years of the People’s Republic, the fate of the Chinese medicine profession was in doubt. The Chinese state was more centralized and powerful than it had been in decades. Colonial possessions had been returned; the political opposition had been destroyed. The Chinese Communist Party (CCP) could turn to the urgent task of building a modern Chinese nation, including a national health care system. Within the CCP, not unlike the Nationalist Party (KMT) that preceded it, there was strong opposition to Chinese medicine, particularly among the technocrats in the Ministry of Health, who were almost all trained in biomedicine. Following an internal party struggle that led to the purge of the He Cheng, the Vice Minister of Health, in 1955, the promotion of both Chinese medicine and Western medicine became official CCP policy (Croizier 1968; Lampton 1977). Although the place of Chinese medicine in China’s modern health care system was ensured from this point going forward, the state has nonetheless given clear priority to development of Western medicine throughout the Communist era. When I finished my medical training in Chinese medicine in 2000, the Ministry of Health was reporting that there were 1.33 million doctors of Western medicine, compared to 337,200 doctors of Chinese medicine. The number of doctors of Western medicine expanded more than thirty-five-fold in the Communist era, while their Chinese medicine counterparts had actually declined (Editorial Committee of the China Medical Yearbook 2001).

The ambivalence of contemporary students and young doctors of Chinese medicine begins with the structure of the national health care system, which contains two parallel but unequal systems of medicine. There are state-run schools, hospitals, and research institutions for both Western medicine and Chinese medicine, but the former are more numerous, more respected, more authoritative, and considered more scientific than the latter. The hegemonic place of Western medicine in contemporary Chinese society leads to other important asymmetries, despite some government policies to address this imbalance. For example, students of Western medicine are generally required to take a semester-long introduction to Chinese medicine, but this training, even in the rare case that a doctor goes on to use some Chinese medicine in his or her clinical practice, is irrelevant to the doctor’s professional advancement. By contrast, students of Chinese medicine have a curriculum that devotes nearly 50% of allotted course time to topics in Western medicine. Moreover, as we will see below, a good command of Western medicine is an essential requirement for practicing Chinese medicine today.

Students of Chinese medicine must take Western medicine seriously from the start of their education. The significance of this dual training becomes apparent in the third year of medical school, when clinical clerkships begin and students observe doctors using both medical practices in their everyday clinical work. Under these unusual training conditions, perhaps it should not be surprising that many students gravitate toward Western medicine and struggle to embrace Chinese medicine. As my classmates often reminded me, the language, concepts, and principles of Chinese medicine were almost as foreign to them as they were to me. Their high school education was focused on biology, chemistry, and physics—the foundations of Western medicine—not on Chinese philosophy and other disciplines more useful to the study of Chinese medicine. One of my classmates, who graduated third in our class, thereby earning an automatic admission to the Master’s program of her choosing, told me quite unabashedly after our graduation that she couldn’t “grasp the Chinese medicine way of thinking.”

What have these power inequalities meant for the actual practice of Chinese medicine? In the vignette below, I will show that postcolonial power inequalities are an unavoidable feature
of every clinical encounter and have profound consequences for the theory and practice of Chinese medicine. Doctors of Chinese medicine cannot practice a “pure” Chinese medicine, willfully ignoring the world of Western medicine around them. Rather, they must adjust their clinical work to the standards of Western medicine, an intellectual burden that does not apply to their Western medicine counterparts. These power inequalities are further institutionalized in the structures of China’s health care system. Thus, the Chinese state has created a separate institutional sphere for the practice of Chinese medicine, but it has also constrained the profession by imposing regulations on Chinese medicine practice that have no parallel in Western medicine institutions. For example, hospitals of Chinese medicine require that medical records for all admitted patients contain a “double diagnosis,” one for each medical system. There is no such requirement for biomedical institutions, where it would be scandalous if the state were to try to impose one. The result of the “double diagnosis” is that doctors of Chinese medicine also frequently use both medical practices to treat their patients, whereas doctors of Western medicine rarely treat with two types of medicine.

As doctors move back and forth between these two medical systems, they must also negotiate an epistemological quandary: what is the truth status of Chinese medicine claims about the body, illness, and healing? The answer is fraught. Chinese medicine is defined by its difference with Western medicine; difference marks its “Chinese-ness.” At the same time, this difference is inherently problematic. Any deviation from the standards of Western medicine can be interpreted as error and evidence that Chinese medicine is not scientific. Doctors of Chinese medicine resolve this postcolonial dilemma by embracing a position of “double truths”: Western medicine is scientific, they concede, but “Chinese medicine is scientific too.” By insisting on this adverb “too,” the all-important supplement that makes this claim work, doctors are implicitly recognizing the power inequalities between Western medicine and Chinese medicine. Chinese medicine can only be true if it is a lesser truth.

The Contemporary Clinical Encounter

I hustled through the waiting room of the outpatient clinic just a few minutes before 8 a.m., pulling off my winter jacket and slipping into my white doctor’s coat, standard attire for all doctors and hospital technicians, just before striding into the consultation room. On this day, I had arranged to work with Dr. Sun, who had been the main lecturer for our important fourth-year class, Chinese Internal Medicine. In a pedagogic environment where most professors stayed close to the textbook materials, Dr. Sun had stood out, with his carefully researched lectures, dynamic speaking style, and memorable anecdotes from his own clinical cases. I was hoping that his clinical skills would match his rhetorical talents.

Established in 1958, Dongzhimen Hospital is one of the older hospitals of Chinese medicine in China. The well-worn state of its buildings belies the clinical excitement that sometimes transpires inside. Dr. Sun’s consultation hours were being held in a long, narrow room on the second floor that had almost surely been converted from some other use to a consultation space. Dr. Sun sat at a yellow desk, the same basic wooden desk that could be found in all of the consultation rooms, positioned halfway between the hallway door and a tiny window on the far wall. The room was so narrow that when Dr. Sun sat at his desk, I would have to awkwardly squeeze between the wall and his chair to get past him. The desk was where all the action took place. Dr. Sun would spend the entire morning seated in front of it, conducting consultations and writing prescriptions, too busy on most days to even stand up for a break. The patient would enter from his left and take a seat at a small, three-legged stool at the side of the desk nearest the entrance. Students, such as myself, would sit to his right, huddling around the far side of the desk as we took notes.
On this morning, I was sharing the far end of the desk with another medical student, who
turned out to be a distant cousin of Dr. Sun. We were participating in the time-honored tradi-
tion of “copying prescriptions chao fangzi,” in which a student follows a senior doctor, making
notes about the consultation and recording the doctor’s prescription for later study. As this
expression suggests, the prescription is central to this training method. Far more than a record
of the doctor’s treatment for an individual patient, the prescription is a condensation of the
doctor’s therapeutic strategy, both with respect to a specific disorder and his overall clinical
style. Unlike Western medicine prescriptions, Chinese medicine prescriptions often contain a
dozen or more herbs that the patient usually cooks together in water to make a decoction. Doc-
tors of Chinese medicine assert that the clinical efficacy of a prescription depends not so much
on the properties of any single item but on the collective action of the herbs together. More-
over, prescriptions are not standardized for medical conditions. Indeed, physicians generally
try to individualize the prescription to the patient’s unique presentation to the greatest degree
possible. Writing a prescription is therefore an art, based on the physician’s interpretation of
the patient’s underlying condition, drawing on a mastery of hundreds of Chinese medicinal
herbs and centuries of formulary scholarship on how to best combine them. By copying these
prescriptions, the student hopes to inscribe and ultimately embody the teacher’s art.

On most days, the rush of patients is so overwhelming that doctor and student may have
little opportunity to discuss prescriptions and treatment strategies. But on this day, a light
drizzle had begun, thinning out the usual morning crowd, giving us occasional opportunities to
talk. Around 9:30 a.m., an 84-year-old woman shuffled into the room, her daughter supporting
her as she took a seat. The daughter opened her purse and pulled out her mother’s outpatient
record book, a worn and folded yellow notebook, the size of an elongated index card. Dr. Sun
took the notebook and placed it on the desk, pushing aside the blood pressure cuff he had used
for the last consultation. He scanned the notes from previous consultations and then looked
at the patient, asking, “What’s bothering you today?” “My whole body aches,” she said in the
Beijing patois, as she put her hand to her chest.

While she spoke, Dr. Sun flipped through the many laboratory tests and other exam results
that had been folded and stapled into the record book. They included an electrocardiogram from
a month ago with a depressed ST section, indicating mild cardiac ischemia. Blood work from a
visit two weeks ago showed that her white blood cell count had been high (14.3 × 10^9 cells/liter)
and her neutrophil distribution elevated (84%), both signs of infection. A biochemical panel did
not indicate conclusively any one problem, but Dr. Sun declared it “chaotic” with eight abnor-
mal results. The daughter handed Dr. Sun a recent chest X-ray. Holding it up to the light and
angling it toward us, the students, Dr. Sun pointed out cobweb-like interstitial markings caused
by a pulmonary infection and drew our attention to the increased spacing of the ribs indicative
of emphysematous changes. Putting down the X-ray, he then showed us the notes from her last
hospital visit, in which a different doctor had diagnosed her with coronary heart disease, chronic
nephritis, and interstitial pneumonia.

Turning to a fresh page in the record book, Dr. Sun began writing today’s entry, asking the
patient questions as he wrote. He noted complaints about heart palpitations and back pain
and then asked her to stick out her tongue. The tongue exam is one of the distinctive features
of the Chinese medicine exam. Doctors consider it one of the most important and reliable
ways to assess the patient’s overall condition. Dr. Sun carefully noted the shape and color of
the tongue, as well as the texture and color of the tongue coating. Next he gestured toward
the patient’s wrist to begin the pulse exam, another distinctive feature of a Chinese medicine
consultation. She extended her arm. Dr. Sun put three fingers on her radial artery, letting his
fingertips gently roll over the artery, sensing its resilience as he varied the pressure, recording
the texture in terms of the 28 basic pulse presentations recognized in Chinese medicine. He
repeated this process with the other wrist. In Chinese medicine pulse taking, the three sites on both wrists, six positions all together, are significant because minute differences in pulse presentation at each site might indicate the pathological changes of a particular region or organ of the body (Kuriyama 1999; Farquhar 2014). Like the tongue exam, the pulse is considered an excellent indicator of the patient’s overall condition and an essential part of any consultation. The pulse exam is so iconic to Chinese medicine clinical work that some patients will silently extend their wrist at the beginning of a consultation, expecting, or sometimes challenging, the doctor to make a diagnosis based on the pulse exam alone.

Having completed his exam, Dr. Sun looked up from his notes and addressed the two women. He recommended that the patient be admitted to the hospital. Her condition was too complicated and unstable to be treated on an outpatient basis. Since Dr. Sun has recently joined the Nephrology Department, he suggested that the patient be admitted to this ward. It would be permissible with her chronic nephritis, and he could personally care for her in that department. They quickly agreed to this plan, and the daughter gathered up the record book, the X-rays, and other belongings and escorted her mother out of the room to begin the admissions process.

The next patient did not enter right away, so Dr. Sun turned toward his two students to discuss this case with the excitement that only a devoted teacher might have. “What formula would you use for that patient?” he quizzed. Dr. Sun’s cousin and I looked back at him blankly. I felt overwhelmed by the complexity of the case. Could a single formula address the patient’s heart, lung, and kidney problems? Each one alone would be difficult to treat. “First of all,” Dr. Sun broke the silence, “the patient should be diagnosed as having Chest Blockage xiongbi, due to Cold and Phlegm. In the sixth edition of the Chinese Internal Medicine textbook, Chest Blockage was misleadingly renamed Chest Blockage and Heart Pain xiongbi xintong. But interstitial pneumonia corresponds perfectly to Chest Blockage, which can also account for the patient’s mild cardiac ischemia as well. The proper formula should be Trichosanthes Fruit, Chinese Garlic, and Pinellia Decoction gualou xiebai banxia tang to ‘invigorate Chest yang zhenfen xiongyang.’” Dr. Sun was asserting that the patient’s interstitial pneumonia was her most urgent issue and needed to be addressed first.

I was instantly intrigued by this explanation that went to the crux of the patient’s condition and was also critical of standardizing conventions in Chinese medicine, particularly as represented by the sixth edition of the national textbook. Dr. Sun continued his explanation, demonstrating his mastery over both Chinese medicine and Western medicine, moving nimbly between these two different medical systems and showing us how to navigate the potential pitfalls that awaited the inexperienced physician. “This formula is an excellent choice for this patient. Antibiotics are generally not very effective in treating interstitial pneumonia. In Western medicine, one might also consider steroids. But this approach compromises the immune system and could actually exacerbate the infection. In a similar fashion, we must not use the related formula Unripe Bitter Orange, Chinese Garlic, and Cinnamon Twig Decoction zhishi xiebai guizhi tang, because Cinnamon Twig is too warming and might also worsen the infection. We could consider replacing it with Ephedra mahuang, which is also warming but won’t intensify the infection because of its strong Lung dispersing properties.”

Although Dr. Sun had proposed a unique solution to the patient’s complex medical condition, his approach was typical of the contemporary Chinese medicine clinical encounter in many ways. Doctors of Chinese medicine continually tack back and forth between “Chinese medicine” and “Western medicine” as they determine a diagnosis and design a treatment. Western medicine has become so intertwined with the contemporary practice of Chinese medicine that one professor at the Beijing University of Chinese medicine told me: “Chinese medicine today cannot exist without Western medicine.” Hybrid medicine is utterly mundane.
As the vignette above suggests, these hybrid practices are complex. On the one hand, doctors use both medical systems in tandem, as if they have little in common with each other. Dr. Sun’s examination of the patient could be considered a dual exam, producing two diagnoses appropriate to each medical system. And once the patient had been admitted to the hospital, it is highly likely that she would have also been prescribed some form of Western medicine treatment. Even though Dr. Sun seemed to suggest that Chinese medicine treatment would be superior, Western medicine therapies are widely used in the inpatient wards. During my training at Dongzhimen Hospital, I did not observe, or hear about, any admitted patients that were treated with Chinese medicine therapies exclusively. (Outpatients are much more likely to be treated with only Chinese medicine therapies.) At the same time, doctors are not just practicing two types of medicine at once. They are also continually strategizing about how to integrate the two medical systems. For example, Dr. Sun equated the Chinese medicine disorder of “Chest Blockage” with the Western medicine diagnosis of interstitial pneumonia. He argued that the Chinese medicine treatment principle of the “invigorating Chest yang” could cure the Western medicine pathology of a lung infection. He cautioned against using certain herbs that, according to Chinese medicine classifications, would be too “warming” and might exacerbate the infection.

Purification and Hybridization

The clinical encounter described above challenges us with a very basic question: “What is Chinese medicine?” Is it possible to define Chinese medicine as the specific moments in the above clinical encounter—the tongue and pulse exam, the unfamiliar terms of diagnosis (Chest Blockage, the pattern of Cold and Phlegm obstruction), the formula and herbs—that are distinct from the other, more familiar moments—EKGs, X-rays, blood work, interstitial pneumonia readily recognized as Western medicine? Or should we consider the entire mélange of practices to be Chinese medicine or perhaps some third form of medicine?

Most contemporary scholars have not written explicitly about the hybridity of contemporary practice (Sivin 1987; Farquhar 1994; Hsu 1999). But most doctors do not write about this phenomenon either, even though they are deeply enmeshed in it through their clinical work. In my many years of studying Chinese medicine, I have never encountered a theory of medical integration. Doctors tend to talk about a “pure” Chinese medicine, while tacitly blending it with Western medicine in practice. These two tendencies—to speak about a purified medicine while producing a hybrid one—are reminiscent of Bruno Latour’s analysis of modernity. Latour has argued that we are continually trapped in the predicament of modernity because we give great credence to work of purification—in which “Nature” is opposed to “Culture”—and pay little attention to the work of hybridization—in which “Nature” and “Culture” are always being intermingled (Latour 1993). In considering the contemporary condition of Chinese medicine, I argue that a similar dynamic defines its “postcoloniality”: we can’t understand the hybridity of contemporary Chinese medicine—the “integration of Chinese medicine and Western medicine”—without also understanding its opposing purifications—the constructions of “Chinese medicine” and “Western medicine” that doctors attempt to combine.

Returning to the diagnosis of Dr. Sun, we can now better understand how these two processes of purification and hybridization operate in clinical practice and what it means for the truth claims of Chinese medicine. While Dr. Sun could have made his diagnosis of “Chest Blockage” without any reference to Western medicine, he clearly felt the need to relate it to the patient’s known biomedical diagnosis. This move, the “double diagnosis” mentioned above, would be required for any admitted patient and is rarely omitted in outpatient care.
either. The first step in this process is to equate a biomedical disease category with a similar nosological category in Chinese medicine, known as bing. In fact, this term also means “disease” in the context of Western medicine, but I leave it untranslated here to distinguish its different connotations in Chinese medicine. Each Chinese medicine bing category is defined by a loose cluster of symptoms, which may overlap with some disease categories of Western medicine but frequently do not correspond exactly. Taking “Chest Blockage” as an example, it is defined in the popular fifth edition of the Chinese Internal Medicine textbook as: “tightness and pain in the chest, with severe cases producing pain that pierces to the back, shortness of breath, wheezing, and an inability to lie down” (Zhang, Dong, and Zhou 1985: 108). Because of the postcolonial imperative to relate Chinese medicine concepts to Western medicine ones, many doctors take this definition, drawn from classic sources and using primarily the original language of those texts, as a close approximation of coronary heart disease. But Dr. Sun criticized this kind of reductionist thinking, which was given a prominent place in the sixth edition of the national textbook, the one he was required to teach to my class. In this edition of the national textbook, “Chest Blockage” was renamed “Chest Blockage and Heart Pain,” and its definition was rewritten in the biomedical language of coronary heart disease. Although Heart Pain is a traditional term, Dr. Sun was suggesting that the editors appended it to Chest Blockage to strengthen the implied correlation to coronary heart disease.

When a Chinese medicine bing category is equated with a single biomedical disease, the epistemological value of the Chinese medicine term is diminished, even erased. Dr. Sun’s critique of the sixth edition textbook was addressing precisely this problem. In fact, the editors of the national textbooks, first published in 1960 under the auspices of the Ministry of Health and then periodically revised every 5 to 10 years, have grappled with this very issue over the past 50 years. The most popular editions, the second and the fifth, scrupulously avoided any direct reference to Western medicine concepts, even though they were not impervious to more indirect influences. Perhaps inspired by the growing role of Western medicine in clinical practice in the mid-1990s, the editors of the sixth edition decided to incorporate limited elements of Western medicine, such as the new definition of Chest Blockage. Dr. Sun’s critique was not just an academic one either. By suggesting that “Chest Blockage” could also be considered an equivalent for interstitial pneumonia, Dr. Sun was also arguing that a series of formulas from the second-century canon, Essentials from the Golden Chamber, where the term “Chest Blockage” originates, can be used to effectively treat interstitial pneumonia. That this formula treats certain presentations of coronary heart disease made it even more appropriate for this case. Whether Dr. Sun was correct or not, his approach was certainly unique. In an historical moment where working across the two medical systems is an imperative, most contemporary doctors would probably treat interstitial pneumonia with formulas thought to address lung function rather than framing the problem in terms of Chest Blockage.

Dr. Sun’s creative use of “Chest Blockage” was only the first step in his clinical assessment. He also cautioned us to be aware of the problems of Cold and Phlegm. These terms refer to what contemporary practitioners call the patient’s “pattern” zheng, a general description of the patient’s underlying pathological condition, as understood within the principles of Chinese medicine. Despite Dr. Sun’s emphasis on bing in this particular case, the pattern is usually the physician’s main focus. Typically, it would be stated more robustly, with a four- to eight-character phrase that describes the quality of the condition (in terms of hot or cold, excess or deficiency), the nature of the pathogen (which might refer to external factors, like wind, heat, cold, dampness, summer heat, dryness, or internal ones, such as qi constraint, blood stasis, phlegm), and the location of the problem (such as, in the organs, meridians, qi, or
blood) (Deng and Guo 1987: 94–141). Taking Dr. Sun’s recommended formula, Trichosanthes Fruit, Chinese Garlic, and Pinellia Decoction as an example, this formula would be indicated for patients presenting with a pattern of “flagging chest yang, qi constraint and phlegm obstruction xiongyang buzhen, qizhi tanzu” (Duan, Li, and Shang 1995: 180). The treatment principle for this formula is to reverse these pathological tendencies, “opening yang and dispersing clumps, moving qi and eliminating phlegm.” This clinical approach is called “pattern recognition and treatment determination” bianzheng lunzhi, and it is universally celebrated as the central methodology of Chinese medicine.

In order to explore the problem of “double truths,” we need to dig a little deeper into the relationship between disease, bing, and pattern, which can only be fully understood through the hospital medical record and the practice of “double diagnosis.” When making a “double diagnosis,” doctors actually make two levels of comparison. First, the bing is matched to disease, as discussed above. At the second level, a pattern is determined and added to the Chinese medicine side of the diagnosis as a subcategory of bing. If the disease presents in several common forms or has well-known complications, then the pattern will be matched to the disease variant or sequelae, although equivalency at this level is not considered essential for writing a proper medical record. For example, “Wasting and Thirst” xiaoke is widely recognized as the Chinese medicine bing that most closely matches the biomedical disease of diabetes mellitus. But depending on whether the patient has type I or type II diabetes or presents with complications, such as neuropathy, retinopathy, arteriosclerosis, nephropathy, and so on, the admitting physician will try to match the pattern to these disease variants or complications. Elements of this relationship are also visible in the structure of the Chinese Internal Medicine textbook. This textbook presents about 50 of the most commonly seen bing. Treatment for each bing is broken down into roughly five or six commonly seen patterns; each pattern will indicate a treatment with a well-known formula.

Although the nuances of the textbooks and medical record writing are beyond the scope of this chapter, the key point is that the relationship among disease, bing, and pattern is a product of the postcolonial moment. Prior to the 1950s, most doctors of Chinese medicine had little to no knowledge of Western medicine, and among the small elite that knew both medical systems, there were no established conventions on how to integrate them. Because the vast majority of doctors practiced in private clinics, there were no legal or institutional requirements to do a double diagnosis in the extremely small number of hospitals of Chinese medicine that did exist. Moreover and most importantly, due to these vastly different circumstances, the Chinese terms of bing and zheng had very different connotations. Before the 1950s, it would be incorrect to translate zheng as pattern, because it was neither a term of diagnosis nor a subcategory of bing. Rather, I believe zheng is best translated as “presentation,” which explains why it was sometimes used interchangeably with the new biomedical term for symptom during this time period (Karchmer and Daidoji forthcoming). Further evidence for this translation can be found in the first dictionary of Chinese medicine, published in 1921 by the respected physician and scholar Xie Guan, where zheng is defined as the “external expression of an internal bing” (Xie 1994 [1921]).

With the rapid growth of the biomedical profession in the Communist era, Western medicine soon, perhaps by the late 1950s, became the dominant form of medical practice in China. With this shift in power relations, doctors of Chinese medicine became increasingly oriented to the epistemological standards of Western medicine. The meaning and use of concepts, such as bing and zheng, began to shift in an emerging era of hybrid medical practices. Because bing could be equated to disease, it facilitated the process of hybridization, but it did so at significant cost. The proximity of the two concepts weakened bing, making it expendable, except when a skilled physician like Dr. Sun can demonstrate creative new applications. Because zheng
took on the meaning of “pattern” (of pathological process), which had no corresponding term in Western medicine, it contributed to the process of purification. Doctors frequently assert, and the national textbooks acclaim, that the methodology of “pattern recognition and treatment determination” bianzheng lunzhi is one of the defining characteristics of Chinese medicine (Yin and Zhang 1984: 8). As a result, when comparing the two medical systems, most doctors will make the following claim: “Western medicine differentiates disease; Chinese medicine differentiates pattern” (Karchmer 2010).

Although these epistemological shifts are quite profound, contemporary doctors are generally not aware of them. Or more accurately, they have been “forgotten” through a process of normalization that Thomas Kuhn argues follows every scientific revolution (Kuhn 1970). What is evident to students and young doctors is that Chinese medicine can only be practiced in a world of “double truths.” While pattern is not an expendable truth like bing, it remains a lesser one. I suspect that these power inequalities and the conundrum of double truths contribute significantly to the ambivalence of young doctors discussed above. They easily recognize the relative weakness of Chinese medicine vis-à-vis Western medicine, and the disappointed ones seek out other professional opportunities. However, if we take Dr. Sun at his word, this postcolonial form of medical practice is not ineffective and far from impotent. When a doctor develops the degree of clinical experience and proficiency to see beyond the conundrum of double truths, to rethink the conventions around hybrid medical practice that can delegitimize the claims of Chinese medicine, Chinese medicine may indeed (once again) become a potent therapy. In short, the practice of Chinese medicine is deeply constrained by the hegemony of Western medicine in contemporary China. But Dr. Sun’s clinical case above suggests that the first step out of this postcolonial predicament may be a critical examination of these power inequalities, so that doctors may more effectively deploy the conceptual tools they already possess.

References


Further Reading


