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# A Doctor of the Highest Caliber Treats an Illness Before It Happens

Mei Zhan

“A doctor of the highest caliber treats an illness before it happens,” a seemingly antiquated doctrine in traditional Chinese medicine, is enjoying surging popularity among practitioners in urban China and the United States today. In this essay, I examine how the meanings and contours of traditional Chinese medicine have shifted in recent decades as it is molded into a “preventive medicine” through translocal encounters. From the 1960s and the early 1970s, the emphasis China’s socialist health care placed on preventive health among the rural poor shaped the practice of Chinese herbal medicine and especially acupuncture. This version of preventive medicine was also exported to the Third World, which China strove to champion. Since the end of the Cold War and especially during the 1990s, as China strives to “get on track with the world” (specifically, affluent nation-states, especially in North America and the European Union), traditional Chinese medicine has been rapidly commodified and reinvented as a new kind of preventive medicine tailored for cosmopolitan, middle-class lifestyles. The emergence of this radically new preventive medicine resuscitates certain stories of antiquity and continuity, emphasizing that traditional Chinese medicine has *always* been “preventive” while obliterating recent memories of the proletariat world and its preventive medicine.

*Key Words:* Africa; China; commodification; globalization; politics of difference; preventive medicine; spatiotemporality; the United States

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Legend has it that Bian Que has two older brothers. The eldest brother is able to prevent the onset of an illness. So only his family knows what a good physician he is. The second brother can treat illness at the earliest stage. So only his village knows how good he is. Bian Que treats serious illnesses. So the whole world knows about him.

Bian Que, who lived and worked during the Spring and Autumn Period (770 BC–475 BC), is one of the most celebrated physicians in Chinese history and a household name even today. (“Bian Que Jian Qihuangong”—Bian Que Meets Duke Huan of Qi—a chapter from the 1st-Century BC book *Shi Ji* [Historical Records], remains a required reading in junior high school curriculum in China.) Despite his fame, however, I had never heard of his “older brothers” until I took an introductory course on the basic theories in traditional Chinese medicine for first-year students at the Shanghai University of Traditional Chinese Medicine (SUTCM). It was a cold morning in December 1998 when I took my usual seat toward the back of the classroom. As I sat down, I noticed a couple of unfamiliar faces around me: a middle-aged woman who looked somewhat uneasy among the students, and a young man in a white lab coat. It was almost the end of the fall semester, and the lecture of the day was on life cultivation (*yangsheng*) and preventive medicine (*yufang yixue*).<sup>1</sup> The standard textbook treated preventive medicine as a lesser topic that required only a brief discussion, and the fact that the short chapter was tucked away at the end of the textbook and curriculum accentuated its marginality in relation to the body of basic theories and topics in traditional Chinese medicine.<sup>2</sup>

The instructor, however, had a very different take on the significance of preventive medicine. Having captured the attention of the entire class with the story of Bian Que’s mythical brothers, he concluded: “A doctor of the highest caliber treats an illness before it actually happens (*shanggong zhi weibing*). You probably all thought that Bian Que was a great physician, but his eldest brother was the greatest. Prevention has always been at the heart of traditional Chinese medicine, and I am confident that prevention will be a new growth point of Chinese medicine as we try to get on track with the world today.”

During the break, I struck up a conversation with the two newcomers. The young man identified himself as an advanced Master’s student who wanted to learn more about life cultivation and preventive medicine, especially because these were not emphasized when he took his introductory course four or five years ago. The woman, it turned out, was a mid-level administrator at SUTCM and a friend of the instructor’s. Having been trained in traditional Chinese medicine during the tumultuous years of the Cultural Revolution (1966–1976), she lamented that her education was inadequate,

an unfortunate historical fact now handicapping her promotion at SUTCM, which imposed increasingly stringent requirements in formal education and continued training for faculty and administrators alike. While understanding her dilemma, I was nevertheless curious about why she decided to come to this lecture in particular. She said, “Didn’t you hear? I think the instructor is onto something about preventive medicine being the future. Maybe this will open up a new door for me [as a practitioner] as well.”

This was the first of the several times that I encountered the allegorical story of Bian Que’s older brothers during my field research on traditional Chinese medicine in Shanghai and the San Francisco Bay Area. The storytellers, usually practitioners of traditional Chinese medicine, invoked this story to testify to the saying “*shanggong zhi weibing*,” which was first proposed in *Nan Jing* (the Classic of Difficulties).<sup>3</sup> The practitioners did not simply indulge themselves in myth making by relating the story of Bian Que’s brothers to me. Although the specifics and details of the story might vary, they made sure that I understood that this story was an eloquent testimony to the relevance of traditional Chinese medicine to health care today and in the future. They singled it out as a proof and reminder that traditional Chinese medicine is and has always been first and foremost a preventive medicine; with a focus on holistic concepts and practices of health and wellbeing, it is perfect for the emerging health care challenges of new, cosmopolitan lifestyles in urban China and the United States.

The deployment of the story of Bian Que and his brothers accentuates a sense of the historical depth and continuity of traditional Chinese medicine. However, why is *shanggong zhi weibing* enjoying a sudden surge in popularity on both sides of the Pacific at this particular historical moment? The presumption and enactment of historical continuity is what needs to be explained and not in itself a sufficient explanation for the resurgence of traditional Chinese medicine as a popular preventive medicine. In this article, I suggest that the burgeoning enthusiasm over the new preventive medicine for the cosmopolitan world is mediated by the forgetting of other routes and worlds in which traditional Chinese medicine traveled. It was less than half a century ago when traditional Chinese medicine was exported to Third-World countries as part of a preventive medicine primarily for the rural poor. In recalling this recent historical moment and contrasting it with discourses and practices of preventive medicine today, I examine the changing meanings and forms of traditional Chinese medicine as a preventive medicine as it is molded through various kinds of translocal encounters and routes. Rather than focus on continuity and endurance, I pay attention to the politics of exclusion and interrupted circulation. I suggest that the translocal movements, displacements, and refigurations—or what I call the “worlding”—of Chinese medicine are sociohistorically situated projects

and processes that not only shape health care discourses and practices but also produce multiple and uneven visions, understandings, and practices of what makes up the world and our places in it.

Rather than set against the background of a singular, ready-made global stage, the worlding of Chinese medicine charts out various worlds that are deeply entangled in shifting terms of difference and constantly reimagined. From the 1960s to the early 1970s, the Chinese government organized and promoted the export of traditional Chinese medicine as low-cost, low-technology, preventive medicine that is Chinese in essence and at the same time suitable for health care in Third-World countries, including those in Africa (Hutchison 1975; Shi 1997; Snow 1988; Wang 2004). Since the 1990s, however, China has endeavored to “get on track with the world” (*yu shijie jiegui*) through comprehensive reforms, especially the privatization and marketization of China’s economy. As part of these reforms, Chinese medicine becomes rapidly commodified, and the international trafficking of traditional Chinese medicine now takes place most intensively between China and North America, Europe, and East Asia. In San Francisco and across California, traditional Chinese medicine as a naturalistic, preventive medicine has come out of Chinatown and departed from its counterculture roots in the 1960s. Herbal medicine and especially acupuncture have now become a mainstream, largely white, middle-class practice: acupuncture and herbal medicine are now standard components of Complementary and Alternative Medicine (CAM) and oftentimes more “complementary” than “alternative” to biomedicine.

Through trans-Pacific routes, practitioners, educators, and entrepreneurs of traditional Chinese medicine in Shanghai have quickly got on track with this recent shift in CAM. In clinical practice and everyday life, they forge new professional and social alliances and networks in reinventing traditional Chinese medicine as a new kind of preventive medicine by repositioning traditional Chinese medicine at the cutting edge of an emerging “cosmopolitan medicine” and by associating the marketing and consumption of traditional Chinese medicine with a cosmopolitan and urban middle-class lifestyle. In competing with biomedicine for both medical authority and patient-clientele, they redefine the scope of health conditions in which traditional Chinese medicine specializes, as well as fashioning a particular clientele at home—emerging middle-class consumers who aspire to the affluent lifestyles in the West. To this purpose, practitioners and proponents of Chinese medicine have also come to rethink and redefine the history of traditional Chinese medicine as a preventive medicine: they insist as much on continuity and antiquity, cosmopolitanism and globalization, as they are ready to leave behind or even forget the preventive medicine of the proletariat world.

## TRACING THE WORLDS OF KNOWLEDGE

My fieldwork on the translocal movement and refiguration of traditional Chinese medicine began in 1995 and lasted a decade. From summer 1998 to the end of 1999 in particular, I conducted 18 months of fieldwork in Shanghai and the San Francisco Bay Area. This was followed by continued field research among communities of traditional Chinese medicine in the Bay Area as well as more field trips to Shanghai. In Shanghai, I conducted the majority of my institutionally oriented participant observation at the Shanghai University of Traditional Chinese Medicine, and one of its teaching hospitals. In San Francisco, I worked mainly with the American College of Traditional Chinese Medicine (ACTCM) and its community clinic, as well as the American Foundation of Traditional Chinese Medicine (AFTCM), a non-profit organization that engaged in the education, dissemination, and legislation of traditional Chinese medicine and provides consultation services to biomedical hospitals. I worked as a volunteer at AFTCM and as a student/intern at SUTCM and ACTCM, where in-depth conversations took place at work during and between patient visits. I observed and recorded daily activities in these settings, including but not limited to clinical and pedagogical practices. I focused on the interaction between practitioners and patients, among practitioners and students and interns, patients, and practitioners. I paid specific attention to the ways in which clinical and broader social knowledges of medicine, tradition, modernity, culture, and science are constructed through everyday sociality.

While working with these institutions, I also followed my key informants as they traveled across various institutional and social networks to practice and teach Chinese medicine. Many successful practitioners of traditional Chinese medicine are avid travelers: they journey to several clinics, participating in health fairs and engaging in community outreach activities. For example, it is quite common for a successful practitioner in Shanghai to teach at SUTCM, practice at a “home hospital” as well as “expert clinics” set up by other hospitals or herbal pharmacies, and participate in neighborhood health fairs, which became popular in the 1990s. Many of them also travel extensively in China and sometimes abroad on both official business and private tours. I was able to follow these practitioners to various institutions and interview them in order to tease out the ways in which their “travel” experiences shape their teaching and clinical practice.

These multisited research experiences have enabled me to focus on the processes of interaction, connection, and displacement in translocal social formation. Just as important, the research focus on institutions, people, ideas, and networks renders visible how the production of knowledges and our visions and understandings of the worlds we inhabit are deeply

entangled and mutually constituted. Instead of simply underscoring the transformation of traditional Chinese medicine within the context of globalization, my research experience has nudged me toward a critical reconsideration of “globalization” and its historicities.

With a focus on the development of modern capitalism from the 15th century to the 1970s, world-system theorists such as Wallerstein and Wolf argued that the modern world not only shares the same historical trajectory defined by the global expansion and consolidation of European capitalism but also serves as “a unified stage for human action” (Wallerstein 1974; Wolf 1982:24). As they both draw on and depart from the world-system model, a new generation of social scientists has shifted their analytical attention to the newest “stage” of capitalism: late capitalism, or, as some call it, Global Capitalism (see, for example, the works of David Harvey, Frederic Jameson, Saskia Sassen, Arif Dirlik, Mike Featherstone, among others.) They describe late capitalism as a compressed global timespace, organized by the new global finance and division of labor, and propelled by the regime of flexible production and accumulation.

Whereas the world-system theory stresses the importance of world-“system” as the analytical unit for social change (Wallerstein 1974), analyses of late capitalism and globalization have focused on the global economic process. Despite this important difference, however, much of the literature on Global Capitalism continues to envision globalization as a totality—to be more exact, as an economically driven, all-encompassing, homogenizing force, and as a space that transcends the divisions of nation-states. Dirlik, among others, argues that a sense of totality may be more important than ever, and any repudiation of totality would only deprive us of the ability to map out the relations that constitute the world (1994:79).

For anthropologists, this globalist analytical framework proves both useful and challenging. It has been tremendously productive in helping us pay attention to the roles of interconnection, movement, and imagination in social formation. Increasingly, ethnographic writings have come to hold in tension the global on the one hand, and local cultural politics and everyday life on the other. At the same time, critical ethnographic inquiries into globalization have also generated an emerging set of anthropological and feminist critiques of globalism, suggesting that in our rush to embrace the global as the unified context for human action we may have assumed too readily that we always know what this thing called “the global” is, and that we always mean the same thing when we speak of the “global era” or the “global context” (for example, Gibson-Graham 1996; Malkki 1994; Maurer 2000; Rofel 2007; Tsing 2000, 2005). These literatures do not assume a priori that the global is a finished product, a monolithic, expansive economic force, or the sum of geographic locales. Nor do they treat the “local” as

invariably the focal site of culture and cultural difference where the global is fragmented and transformed into something particular and where global flows are consumed, incorporated, and resisted (Ferguson 2006; Gupta and Ferguson 1997; Rofel 2001, 2007; Tsing 2000, 2005).

Building on these critiques and inquiries of globalization, I suggest that the worlding of traditional Chinese medicine offers an alternative point of entry into an empirical, ethnographic examination of how various globals are—and can be—made in sociohistorically contingent ways. This article is thus not an account of how the universal markers of the global are articulated locally but is instead a close examination of the specific translocal networks and processes through which various worlds are constituted and experienced in everyday knowledge production on the ground. My choice of the word “worlding,” then, is a conscious effort to distance from globalist assumptions of totality and transcendence. It is critical to bear in mind that globalization does not invariably produce free-floating nomads. Nor does it literally and equally embrace all corners of the world. Difference, I here argue, is neither entrenched in the local nor easily transcended through the global. Turning away from local/global binary that has habitually framed studies of globalization, I examine instead how politics of difference are produced and reinscribed *through*—not *outside* or *in spite of*—knowledge- and world-making projects that are always partial, uneven, and contingent. The term “worlding” indexes the constant making, unmaking, and remaking of the histories and routes through which knowledges travel and, in due course, take on new and sometimes unexpected meanings and forms. Persistent terms of difference surrounding race and class are produced, negotiated, and subverted through the worlding of Chinese medicine: be it the proletariat world China once strove to champion or the affluent world with which it endeavors to get on track now.

Furthermore, the worlding of Chinese medicine today is deeply entangled with translocal processes of marketization and commodification of health care and medicine—not just in “centers” of globalization such as the United States but, perhaps more importantly, in urban China as well (see, for example, Chen 2003; Cochran 2006; Farquhar and Zhang 1995, 2002; Hsu 2002; Langwick 2004). The early 1990s saw the drastic dismantling of socialist health care system. This not only involved the withdrawal of state funding from health care system and the transformation of health care from the realm to social goods to commodities, but it also involved a shift in health care policies and practices from the village to the city, from prevention to treatment, and from low costs to high technology and high costs (Wang 2004). Some may take this transformation as a sign that Chinese medicine has gotten on track with Global Capitalism. Yet I am wary of such a conclusion. Processes of commodification, as I will discuss, redefine what



Chinese medicine is all about—from its objective to its clientele. Yet commodification has not brought about a flattening of meanings. Nor does it readily translate differences into neoliberal market logic and thereby subsume or obliterate them. As I will show, familiar terms of differences are renegotiated and deployed through the commodification of Chinese medicine in China, the United States, and, yes, Africa.

By juxtaposing two historical moments of worlding, I highlight that what counts as preventive medicine, what it prevents, and for whom it works are part and parcel of sociohistorically specific world-making projects and processes, and are subject to negotiation, creative reinterpretation, and contestation. To do so, I draw on insights from both medical anthropology and anthropological studies of science. Traditionally, medical anthropology has been concerned with non-biomedical discourses and practices of illness, body, and healing, as well as the use of biomedicine outside of the “West” (including ethnic minorities in Europe and the North America). Science studies, in contrast, largely focused on knowledges and practices whose scientific status is much uncontested and, increasingly, new scientific and technological innovations. Recently, however, this division of labor is becoming increasingly blurred with the emergence of transnational and urban studies in both medical anthropology and science studies, and especially efforts from medical anthropologists to embrace theories and methodologies developed in anthropological and feminist studies of science.

My own work on the worlding of traditional Chinese medicine is an effort to further break down the artificial divide between Western science (including biomedical science) and “Other” knowledges (Zhan 2001), as well as the division of labor between science studies and medical anthropology. Instead of subscribing to an analytical framework that allows either one universal, globalized science, or spatially defined and mutually exclusive local sciences, I examine the understandings and productions of medical knowledge and science in uneven, interactive, translocal networks and processes. Rather than assuming some inert quality or criterion that makes the “West” the normative referent for science and biomedicine, and traditional Chinese medicine its non-Western alternative, I show the ways in which the boundary between Western science and Other knowledges is historically contingent and open to negotiations (*ibid.*). Furthermore, drawing on insights from science studies—especially its strength in crossing boundaries and tracing networks and processes—I explore the ways in which knowledge production takes place at multiple and discrepant spatiotemporal sites; the invention of Chinese medicine as a preventive medicine is as much a about defining scope of treatment and clientele as it is about reshuffling histories and memories and reimagining worlds of differences.

### “SERVING THE PEOPLE OF THE WORLD”

The Maoist slogan “serve the people” not only spearheaded the spirit of sociopolitical reforms after the founding of the People’s Republic of China but also largely characterized China’s official health care policies during the Mao era.<sup>4</sup> In their implementation, these policies emphasized combining basic biomedical and traditional Chinese medical practices for the prevention of infectious diseases afflicting the working people (Taylor 2005; Wang 2004). On June 26, 1965, on the eve of the Cultural Revolution, Mao declared that China’s health care should focus on rural China (Mao 1999), where biomedicine remained largely unavailable to poor peasants despite the dominance of biomedical hospitals in large cities. Often simply referred to as the “6.26 Instruction,” it was upheld as the guiding principle of China’s health care policy that lasted into the 1980s.<sup>5</sup> This brand of “preventive medicine” focused on the prevention of large-scale epidemics and the promotion of low-cost and low-tech health care practices in rural areas. Acupuncture, herbal medicine, and *tuina* (therapeutic massage) became ideal candidates and standard components for China’s preventive health care.

Moreover, as the young communist government wrestled with questions of cultural legitimacy and continuity, Mao further promoted traditional Chinese medicine as “our motherland’s treasure house.” Even so, many urban Chinese still saw traditional Chinese medicine as backward and inferior to biomedicine, and the Chinese state was determined to modernize it. One of the first state-initiated campaigns to scientize traditional Chinese medicine lasted through the 1960s. The immediate goal was to develop a body of basic theories, which could then be rectified by scientific methods, especially through experiments (People’s Daily October 20, 1954). Remade in this manner, traditional Chinese medicine was posited as a quintessentially “Chinese science” that was distinctive from “western science” and needed to be integrated into modern science and medicine and even universalized.

The “Chinese science” was ready to be worlded. As part of the Cold War geopolitics, China, the United States, and the Soviet Union were all sending aid, including medical aid, to Africa, Latin America, and developing countries in Asia (Hutchison 1975; Larkin 1971). In crafting a distinctive geopolitical niche for China, the Chinese state fashioned a world that was epitomized in the construction of an “international proletariat,” and it was this world that China strove to lead. As part of its world-making effort, the Chinese government exported a kind of “preventive medicine” that was a mixture of biomedicine and acupuncture, strikingly similar to what was practiced in rural China at the time.<sup>6</sup> In Africa, compared with Chinese

railway projects, agricultural aid, and other economic aid, medical aid was one of the most successful forms of aid precisely because it targeted rural and disaster areas (Hutchison 1975; Larkin 1971). It was common to read Chinese newspaper articles in the late 1960s and the early 1970s that applauded the medical miracles Chinese medical teams produced in African countries: Somalia, Algeria, Mauritania, among others (see, for example, People's Daily 1966, 1967, 1970). Acupuncture was the most captivating feature of Chinese medical teams that distinguished them from other medical teams and "aroused interest throughout Africa" (Hutchison 1975:222). In Zanzibar, residents held acupuncture in such high esteem that islanders with a bad temper were told to take it to the Chinese—"they even have a cure for that" (ibid.). In Mauritania, the Chinese trained the first native acupuncturist. He was a local young nurse. After apprenticing with the Chinese acupuncturists, he was able to treat various pains by needling more than 60 acupuncture points. He exclaimed, "Chinese acupuncture is particularly useful in our country, where there is a lack of doctors and medicine" (People's Daily 1970:5).

The image of an international proletariat was thus embodied in the worlding of traditional Chinese medicine as a low-cost, low-tech, preventive medicine perfect for the poor and underprivileged of Africa. "Class" was doubly encoded here: first, China and Mauritania both as "Third-World" countries; second, the Chinese medical team served poor peasants and nomads. Moreover, the racialization of class compounded the centrality of Africa in the production of the international proletariat (and vice versa). In a widely quoted speech, Mao articulated his class analysis of race: "In Africa, in Asia, in every part of the world there is racism; in reality, racial problems *are* class problems" (People's Daily 1963:1; emphasis added). The Chinese state went as far as striving to construct a common racialized identity across China and Africa, urging that "*we* blacks stick together" against the "white race" (Hutchison 1975:179; emphasis added).<sup>7</sup>

This proletariat world, with its specific racial and class imaginaries, was also re-created back in China through the worlding of traditional Chinese medicine. In 1974, China and the World Health Organization (WHO) co-founded the International Acupuncture Training Center at the Shanghai College of Traditional Chinese medicine. The first class consisted of 12 students from 11 countries: with the exception of Laos, all other 10 were African countries (Shi 1997:782). The WHO and the Chinese government funded all the students.

However, the world of international proletariat was not readily embraced and enacted by all. Even those who participated in the worlding of Chinese medicine had doubts about the racialized proletariat brotherhood. On the one hand, many African students complained about racial discrimination

during their stay in China (Snow 1988). On the other, their Chinese hosts also articulated ambivalences toward African students. Dr. Huang Jixian, an acupuncturist and chief doctor said to me during an interview:

I started teaching international students in 1976. The guideline for the program [i.e., International Acupuncture Training Center] was to train useful practitioners for third-world countries. When I first started, my students were all black. A lot of these students were the offspring of African government officials. They lived in fancy hotels and got paid for studying Chinese medicine. So, it really took some devotion on our part to teach these students.

I was almost not allowed to teach them because I came from a family of intellectuals and capitalists—not a working-class family. The government was very strict about class backgrounds back then. I remember that our hospital appointed a textile factory worker to sit by the door of the acupuncture clinic. She would check the backgrounds of the patients. Those who did not come from “revolutionary backgrounds” [referring to factory workers, peasants, and soldiers] weren’t allowed to interact with international students.

Huang’s narrative is not a simple racist narrative that brands Africa as “backward” or “primitive.” Yet it is clearly fraught with racial and class imageries and allegories and deeply entangled in her own experiences during Maoist China. Coming from an upper-middle class family, Huang feels alienated by both her African students and the textile factory worker sitting at the door of her clinic. However, rather than seeing them as representatives of a unified international proletariat, she points out the class *difference* between her students and the textile worker, and thereby what she perceives to be the irony within the imaginary of an international alliance built on race and class.

### CATCH UP WITH THE NEW WORLD

Although the African votes in 1971 helped tip the vote for the People’s Republic of China to enter the United Nations, the Mao era came to an end within a few years. In the early 1980s, China began a comprehensive reform to revitalize its failing socialist planned economy and “open up to the West.” The Maoist worlding of traditional Chinese medicine came to a halt as the place of Africa in China’s vision of the world changed. Whereas Africa epitomized the international proletariat that Maoist China claimed to champion, in the 1990s Africa is re-imagined to be the undesirable land of poverty and backwardness. This spatial realignment is crystallized in the construction of a world that is middle-class and aspiring to be “white.” At SCTCM, beginning in 1983, the number of WHO- and government-sponsored international students at the Shanghai College of Traditional

Chinese medicine decreased year by year. Meanwhile, ACTCM started admitting self-funded foreign students and trainees, most of whom come from Europe, North America, and East Asia. In 1994, for example, 328 overseas acupuncture students, trainees, and observers visited the Shanghai University of Traditional Chinese Medicine and its teaching hospitals (Shi 1997:783). They came from Japan, Korea, Britain, Germany, France, Iran, Denmark, Italy, Austria, Belgium, Colombia, Australia, Canada, and the United States (*ibid.*).

The changes in the nationalities and funding of international students are indicative of broader sociohistorical shifts in the experiences, understandings, and practices of what makes up the world. Specifically, in the reform era, the place of Africa in China's map of the world has been eclipsed by affluent nations in North America, Europe, and East Asia. A 1999 poll in Shanghai shows that one of the most popular new expressions of the year was for China to "get on track with the world" (*yu shijie jiegui*), a slogan first initiated by the central government that quickly gained popularity in everyday discourse. But to say that China *needs* to get on track with the world indexes the anxiety many Chinese felt that, at the end of the 1990s, China was still not quite part of the world. How could this be? To begin with, the world China strives to get on track with now is distinctively different from the 1960s' world charted out through the worlding of traditional Chinese medicine. The Cold War era has come to an end. For the past 20 years, central and local governments have been pursuing economic and social reforms to produce a transnational market economy that promises to bring prosperity to China. Shanghai, which had a history and reputation of being one of the most cosmopolitan urban centers in East Asia, again sees itself at the forefront of these new geopolitical, economic, and social trends. During my fieldwork, I was struck by the fact that when discussing their conceptions of the ideal world Shanghainese from every walk of life often refer specifically to the United States and Europe to convey their thoughts on "how things could improve in China" and how China should position itself in relation to the world. These references are often articulated in complex and sometimes contradictory ways.

To get on track with the world then means more than simply opening up and reaching out: it entails constructing a particular kind of world at home. In the everyday life of the Shanghainese, this begins with imagining and fashioning a universalistic middle-class consumption pattern and lifestyle in the image of the white middle-class America and Europe. In particular, government policies since the 1980s have channeled a large portion of individual expenditure into private home purchasing, health care, and higher education.

The shifts in health care practices are marked by the dismantling of the socialist welfare system and the privatization of health insurance.

More importantly, the Shanghainese have seen the emergence of a new, naturalistic, preventive health concept and practice that bears strikingly little resemblance to the kind of preventive medicine worlded during the Mao era. This new preventive medicine, I will show, targets chronic illnesses associated with urban middle-class lifestyles and stresses long-term overall well being. California has been a key player in the production of this preventive medicine, as well as the worlding of traditional Chinese medicine in the 1990s. In what follows I describe the changing trajectories of traditional Chinese medicine in California, as well as how the practice and discourse of traditional Chinese medicine has transformed biomedical mainstream.

### TRADITIONAL CHINESE MEDICINE IN CALIFORNIA

Since the 19th century, acupuncture and herbal medicine had been mainly practiced behind closed doors in small Chinese-American communities. In the 1960s, the counter-culture movement recast traditional Chinese medicine as the naturalistic, holistic, and less commodified alternative to the biomedical establishment. In July 1971, the general public was presented with a sensational *New York Times* article titled “Now, About My Operation in Peking.” In the article, the journalist James Reston recounted his experience with acupuncture anesthesia, which Chinese doctors used on him for post-surgery pain (1971). Reston’s historic trip to China, which preceded Richard Nixon’s by seven months, triggered a stir among the scientific, biomedical, and the tiny but resilient traditional Chinese medical communities in the United States. Delegations of research scientists and biomedical professionals soon went to China to study acupuncture and herbal medicine (American Anesthesia Study Group 1976; American Herbal Pharmacology Delegation 1975). In California, acupuncturists, patient groups, and politicians began joining efforts in campaigning for the legalization of acupuncture. In 1975, California became the fourth U.S. state to legalize acupuncture (California Senate Bill 86). However, at the time of its legalization in California, acupuncture still could not be performed without prior diagnosis or referral by a “physician” (California State Senate Bill 86). It was not until 1997 that Senate Bill 212 finally included “acupuncturist” within the definition of “physician” and placed acupuncture within the coverage of Worker’s Compensation.

By the early part of this decade, more than 25 years after the legalization of acupuncture, more than 5,000 licensed acupuncturists in California were authorized by the State to practice acupuncture and to prescribe herbs. In addition, a number of leading insurance companies now offer coverage for acupuncture; hospitals in the Bay Area and elsewhere are beginning to

offer services in traditional Chinese medicine; and so too, medical schools are including acupuncture and other “alternative” therapies within their curricula.<sup>8</sup> In clinical practice, acupuncture and herbal medicine are primarily used for conditions that are associated with urban lifestyles and where biomedicine is less effective or ineffective. These conditions include, for example, allergies and asthma, certain pain syndromes, certain types of cancers that are resistant to biomedical therapies, and other chronic illnesses (Eisenberg et al. 1998; National Institutes of Health 1997).

The pace at which acupuncture and herbal medicine have become mainstream in California, in terms of institutional, clinical, and market success, has been truly remarkable. Not all practitioners, however, consider the mainstreaming of traditional Chinese medicine a comprehensive success. Many doubts linger. Some worry about traditional Chinese medicine losing its distinctiveness, in terms of educational and clinical structure, as well as the objectives and ethics of medical practice. The mainstreaming of Chinese medicine in California is deeply entwined in its changing relations with not only hospitals and medical schools but also health care policies and the health insurance industry. The success of Chinese medicine in California is also a story of commodification and market success—from fashioning a middle-class patient-clientele to inventing acupuncture as a suitable object embraced, increasingly, by the economy of health care. It is perhaps no surprise that some of those practitioners who are most ambivalent about the commodification and mainstreaming of traditional Chinese medicine are those who first pursued it as part of the counter-cultural stance on health and medicine; whereas most locally trained acupuncturists in the San Francisco Bay Area have close ties with various professional associations of traditional Chinese medicine, a few of these older practitioners refuse outright to join these organizations but would rather, in their words during interviews with me, “practice the kind of Chinese medicine that got me interested in the first place.”

Yet I think it would be too quick to equate the market success of traditional Chinese medicine with the triumph of the market. First, for many recent immigrants from China, a viable clinical practice—treating patients successfully and making a profit at the same time—is absolutely part and parcel of their immigrant experience. In California, there is now an alumni association of SUTCM, spearheaded by those who came of age in China during the socialist era and especially at the height of the Cultural Revolution. For these people, a successful career and life in the United States is not just about financial success. These practitioners are frequent transnational travelers. In my interviews with them, they would often compare their careers and life trajectories with their own cohorts in Shanghai, many of whom had lost jobs while bearing the brunt of the dismantling

Shanghai's industries as the city became transformed into a cosmopolitan center of commerce, service, and recreation. The success of these practitioners is also a commentary on the socialist era and the proletariat world and those who still live in its aftermath.

Second, the market success of Chinese medicine entails negotiations and contestations of racial discourses. As Barnes has argued, acupuncture and traditional Chinese medicine in the United States have always taken place in a racialized framework in which early immigrant practitioners were discriminated against on the basis of their racial profiles while white practitioners today feel no qualms in claiming a place in the world of traditional Chinese medicine (Barnes 2005). As part of the campaigns to legalize and mainstream traditional Chinese medicine, some acupuncturists sought out non-Chinese patient populations. Many of those practicing in middle-class neighborhoods such as the Noe Valley and the Sunset informed me that over 70 percent of their patients are "white." Yuen Chau, an activist and well-known practitioner who has practiced in San Francisco for more than 20 years not only orients his practice toward white patients but has also moved his family into a white, middle-class neighborhood.

I interviewed Dr. Chau at his acupuncture clinic in Fall 1999.<sup>9</sup> Brought up in a family that had practiced acupuncture and herbal medicine in south China for generations and educated at a well-respected traditional Chinese medicine college in China, Chau preferred the title "Doctor." His clinic was located on the second floor of a Victorian house in Noe Valley, a predominantly white, upper-middle-class neighborhood. Dr. Chau told me that he came to San Francisco in the early 1980s along with many other practitioners from China. Since then, he has witnessed the diversification of ethnicities among practitioners. He notes that the predominant majority of his patients are white. More interestingly, all his students are white with the exception of a few Chinese Americans. He sees the changes in the ethnic composition of practitioners, patients, and students as a matter of progress. Yet he is also acutely (and perhaps a bit painfully as well) aware that the demographic majority of California does not automatically become the "mainstream," as the mainstream is deeply embedded in power-laden configurations and discourses of race, ethnicity, and class. He did not simply cross the Pacific to bring the worlding of traditional Chinese medicine to a new geographic and social locale. Although not everybody deliberately seeks out white patients, many acupuncturists, with the exception of those who work within predominantly ethnic Chinese neighborhoods, claim that 85 to 90 percent of their patients are white. Today in San Francisco, Chinese medicine is primarily used for chronic illnesses. Moreover, although California is becoming increasingly ethnically diverse, the ethnic composition of traditional Chinese medicine practitioners has instead bi-polarized.<sup>10</sup>



Leaders of traditional Chinese medicine organizations in California estimate that over 50 percent of California acupuncturists are of Caucasian descent, and the rest consist of Chinese, Korean, Vietnamese, and Japanese. According to Veronica Nelson, a physician who has been training with a Chinese herbalist, most of the patients are “between the ages of 25 and 40, white, upper-middle class. Those are the patients who have the money and smarts to seek alternative therapies.” And it is the image of this white, middle-class California that comes to occupy a central place in the worlding of traditional Chinese medicine in the 1990s. Where, and how, does traditional Chinese medicine fit into this re-racialized, class-girded world? To answer this question, I will go full-circle back to Shanghai.

### ENVISIONING A NEW “PREVENTIVE MEDICINE”

When I began field research in Shanghai in 1998, “subhealth” (*ya jian kang*) was just beginning to appear in the vocabularies of a few most innovative practitioners in Shanghai. By the early 2000s, subhealth has become a buzz word among communities of traditional Chinese medicine—through conferences, Web sites, journals, and especially herbal products. Whereas the “preventive medicine” of California focuses on chronic illnesses affecting the urban middle-class, “subhealth” directly targets the health state of the white-collar workers (*bailing*). Although there is no official definition of “subhealth,” proponents of the concept describe it as a state between perfectly healthy and seriously ill, manifested in insomnia, headaches, allergies, low energy, and so on. As China’s health care becomes marketized, “subhealth”—and traditional Chinese medicine as its perfect antidote—has become a new growth point for traditional Chinese medicine.

Li Fengyi, a well-known herbalist, now actively seeks out and even helps construct particular neighborhoods and communities to market this new preventive health concept—as well as its products. Coming of age during the Cultural Revolution, Li was among the “sent-down youth” who went to the rural area to help its development and to be reeducated by revolutionary peasants. He worked his way up in a rural factory and eventually made his way back to Shanghai by way of studying traditional Chinese medicine. In 1994, inspired by Deng Xiaoping’s much publicized speech that promoted private entrepreneurship, Li resigned his job at from Shuguang Hospital and started networking with local and overseas capital to open the Jiren Clinic and Research Institute of Traditional Chinese Medicine, one of the first private clinics in Shanghai. This is a multi-functional enterprise, where he and his employees treat patients, train interns, conduct clinical research, and market his own patent medicines. Li also travels

extensively within and outside of China. He insists that traveling to North America and Europe has put him in touch with the cutting-edge developments in medicine. And he makes sure that he keeps attuned to the latest trends in medicine by reading up on translated medical literatures. During our conversations, he oftentimes refers to himself, a bit sheepishly, as a “businessman.” There is no doubt that he takes great pride in his success—there is also little question that he continues to struggle with his identity as an academic and medical practitioner as well as an entrepreneur. He is actually critical of the commodification of medicine and traditional Chinese medicine in particular. He insists that he is in the business for a reason that has nothing to do with making money: he wants to realize a “dream.” Like his cohort classmates who practice in California today, he is painfully aware of the predicament of those from his age group who are now struggling to feed their families and raise their children. He said to me, “I feel that I have been extremely fortunate. I am in a position unattainable to so many people of my age, and I have a responsibility to make a difference—for myself and for Chinese medicine. Chinese medicine needs to be revitalized, and I think that the market is the best venue to do it.”

Li’s success and his “dream,” which is mediated by and in turn mediates the multiple, at times seemingly disparate translocal networks and activities that he engages in, has made him an icon, albeit a somewhat iconoclastic one, of Shanghai’s medical circle. His colleagues, students, and fans have repeatedly told me that Li has a “vision,” a vision that would transform traditional Chinese medicine into a naturalistic, preventive, cosmopolitan medicine and locate it at the cutting-edge of modern medical science. Li argues that many people in Shanghai are complaining about how tired they are. He believes that fatigue is the most common health worry among cosmopolitan city dwellers today. This kind of fatigue, he insists, is different from what affects manual laborers and peasants with which he became familiar during his sent-down years. The new fatigue is “mind-body fatigue” that refers to fatigue caused by stress, tension, psychological and emotional trauma, and prolonged overuse of the brain. Li argues that whereas manual fatigue depletes *qi*, or life energy, mind-body fatigue hurts *xue* (blood) and *jinye* (bodily fluid). This is noteworthy because, according to the theories of traditional Chinese medicine, it is more difficult to treat syndromes affecting *xue* and *jinye* than just *qi*. The long-term consequence of the mind-body fatigue is thus more serious than physical fatigue.

The kind of mind-body medicine that Li refers to in this narrative was first explored by a number of medical scientists and doctors in the United States at the end of the 1960s. Although research articles about mind-body health started appearing in authoritative science and medical journals such as *Nature*, *the Journal of the American Medical Association*, *New England*

*Journal of Medicine*, and *Lancet* as early as 1975, it is only within the past few years that behavioral medicine became a popular health concept and practice, especially in California's corporate culture. Li, in a few words, has captured the gist of this cutting-edge and controversial approach to medicine and health—not only its focus on the mind-body connection but also its clientele, the white-collar middle class. More importantly, he squarely locates traditional Chinese medicine at the cutting-edge of this scientific cosmopolitan medicine and, in doing so, seeks out and helps construct emerging middle-class neighborhoods and lifestyles that stress preventive health and overall well being.

Interestingly, Li was also one of the first people to tell me about the story of Bian Que's older brothers. He is as insistent about Chinese medicine being cutting-edge as he is adamant about its historicity and antiquity as a preventive medicine. For him, looking forward is just as much about looking back or, more precisely, looking back selectively. A survivor, in his own words, of the Cultural Revolution, Li is not sentimental about the proletariat world or its preventive medicine. Instead of dreaming about the proletariat world, Li anticipates a future for traditional Chinese medicine that reinterprets, recuperates, and transforms its roots in preventive medicine.

Like Li, many practitioners of Chinese medicine do not shy away from contesting for the scientific status of their knowledge production and practice (Zhan 2001). In public discourses, however, they are just as ready to embrace and advocate the historical continuity of Chinese medicine as a preventive medicine: a strategy that is well accepted by the general public in both China and abroad. Whereas many question the status of Chinese medicine as a science, few argue against its "cultural status"; in 2006, the Chinese government rushed to apply for World Heritage status for traditional Chinese medicine, a move approved and supported by many urban Chinese, even by those who do not seek it as their first choice of health care.

## CONCLUSION

The worlding of Chinese medicine is not about how a ready-made ancient medical practice goes around the world, carried by the waves of "globalization." My discussion in this article is a little less and a little more ambitious than giving an account of the globalization of Chinese medicine. I pay attention to the changing shapes of traditional Chinese medicine as a preventive medicine during two recent periods of worlding and through different trans-local networks and processes that privilege different visions of the world and

China's place in it. If Chinese medicine as a preventive medicine is always in the making, then so are the worlds in which it moves and stalls.

Furthermore, these worlds are by no means transcendental or innocent. Instead, they are deeply embedded in the production of difference. The worlding of Chinese medicine and its commodification has not created a uniform preventive medicine. Even though the worlding of Chinese medicine today as a commodified preventive medicine for the cosmopolitan middle class has eclipsed the preventive medicine of the international proletariat, it did not do so by obliterating discourses of race and class but rather by renegotiating and repositioning these terms of difference. It bears mentioning that Chinese medicine—a mixture of biomedical and traditional Chinese medical practices—continues to have a place in Africa (Hsu 2002; Langwick 2004). Strikingly, as Hsu points out, private clinics and commodified medicine have replaced state-sponsored medical teams, even though these private Chinese physicians continue to benefit from the reputation of Chinese medical teams during the Mao era (2002).

The worlding of Chinese medicine relies on strategies of discontinuity and continuity, forgetting and remembrance. It is no surprise, perhaps, that as China renews its interest in Africa today, this time as a potential resource for raw materials and a new market, traditional Chinese medicine and acupuncture in particular have again entered the center stage of China-Africa exchanges. During the China-Africa Summit in Beijing in 2006, newspaper reports of Chinese acupuncturists working in Africa were neatly inserted into reports of the summit. Perhaps Bian Que's older brothers will have a place in Africa as well?

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## NOTES

1. See Farquhar and Zhang (2005) for an in-depth discussion of how to understand *yangsheng*, cultivation of the self, through questions about biopolitics in contemporary China. Farquhar and Zhang argue cogently that life cultivation in contemporary China is not about overt socialist state power or the freedom from it. Rather, it is a form of the tactics of everyday life and especially pleasure that renders life itself an object of capillary power.
2. See Hsu (1999) for a detailed and in-depth discussion of the organization of textbooks of traditional Chinese medicine.
3. It is unclear when exactly *Nan Jing* was written and who wrote it. Scholars of traditional Chinese medicine believe that it was compiled during Han Dynasty (202 B.C.–220 A.D.), although part of the text might have originated from Bian Que himself. *Nan Jing* is nowadays considered one of the foundational texts in Chinese medicine. See Unschuld (1988) for a detailed discussion of the history of and medical concepts in *Nan Jing*.
4. On August 7, 1950, at the first National Conference of Health of the newly founded People's Republic of China, Mao Zedong wrote a preface declaring that China's healthcare policy should "serve workers, peasants, and soldiers, focus on prevention, and promote the solidarity of Chinese and western medicines."
5. These policies had profound impact on the practice of traditional Chinese medicine. First, beginning in 1956, by adopting the institutional, pedagogical and clinical standards of biomedicine, state-run traditional Chinese medicine colleges and hospitals came to replace family clinics and small academies (Farquhar 1994; Leslie 1977). At the same time, local priests, itinerant healers, and amateur literati doctors (*ruyi*) were ordered to abandon their "superstitious" or "unprofessional" practices, and thus excluded from the official version of traditional Chinese medicine.
6. Elisabeth Hsu specifically points out that the Chinese medical teams typically consisted of 9 to 10 biomedical professionals of different specialties and 1 acupuncturist (2007).
7. Hutchison further notes that the idea of a common China-Africa racial identity was met with skepticism in Africa as the Chinese who worked in Africa did not really mingle with the locals (1975).
8. Major insurance companies and HMOs that cover acupuncture include Blue Shield, Kaiser Permanente, and Lifeguard, among others. Stanford University and the University of California at San Francisco Medical Schools both offer courses on acupuncture and other alternative therapies. Bay Area hospitals that have acupuncture clinics or services include California Pacific Health Center, Chinese Hospital, and St. Luke's Hospital. At the same time, practitioners of traditional Chinese medicine, patient groups, biomedical professionals and politicians are working together to include acupuncture as a regular service at the San Francisco General Hospital.
9. Chau has a degree in traditional Chinese medicine from China but does not have a Medical Doctor degree from the United States. In China, there is no legal distinction between a biomedical and a traditional Chinese medical "doctor" (*yisheng*). In the United States, patients refer to practitioners of traditional Chinese medicine as "doctors" in everyday discourse to show their high esteem for the practitioners and the profession.
10. U.S. Census 2000 figures show that over the past decade California's non-Hispanic white population shrank to 46.7 percent, while Hispanic and Asian minorities grew at rapid rates. The size of African American population changed little. California also had the highest proportion of people in any large state who said they were of more than one race, 4.7 percent.

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