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The History of Chinese Medicine in the People's Republic of China and its Globalization

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Abstract This introductory article provides an overview over the history of Chinese medicine, as it evolved in the People's Republic of China over the last 60 years. In particular, it highlights how Traditional Chinese Medicine (*zhongyi*), as invented in the 1950s during a period of nationalism marked by idealism and pride in China's ancient philosophy and cultural heritage, has evolved into a medicine that thrives on the contemporary global health market in a neoliberal climate. This latter form of Chinese medicine, which the author, in accordance with its Chinese promoters, calls *zhongyiyao* "Chinese medicine and pharmacotherapy," has led to a further materialization of the once scholarly medical currents of Chinese medicine. However, as this volume will show, the globalization of Chinese medicine should not merely be considered in respect of those aspects that are being sold in those niches of society that offer a cure for bodily ailments but also in respect of those that—in accordance with the way Cartesian dualism has divided health care—are increasingly consumed as aspects of preventive medicine, namely *taijiquan*, and *qigong*.

Keywords Traditional Chinese Medicine · *qigong* · TCM · invention of tradition · globalization of medicine · People's Republic of China

1 Introduction: Outline of the History of Chinese Medicine in the People's Republic of China

In this introductory article, the history of Chinese medicine and meditation practices in the PRC is briefly outlined, followed by few comments on the history of their introduction into other regions. This should provide a background for understanding the current processes of globalising Chinese medicine and meditation practices discussed in this volume. Two stages can be discerned. The first dates to the early days of the People's

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Republic, when the late 1950s saw the standardisation of Chinese medicine and some meditation practices in TCM colleges and hygiene schools, hospitals and clinics. Establishing these TCM institutions in every provincial capital was part of the Communist state-building project. It emphasised China's cultural heritage and celebrated as a distinctively 'Chinese science' a rationale that formerly was decried as old-fashioned and superstitious. The second stage becomes very obvious in the 1990s, as the Chinese economies rapidly expanded and became ever more entangled with global economies and as those aspects of TCM became central to its further development that could be commodified and propelled through semi-private industries into the global health markets. Chineseness continues to be celebrated; sentiments of nationalism have not died down, yet the ways in which Chinese medicine presents itself have altered in emphasis. The material aspects of the Chinese *materia medica* (中藥) are now put at the forefront and, in creative processes of ethnochemistry, are hybridised with elements of a now widely accepted global science. Yet, as this volume shows, the commercialisation of Chinese medical archives has not merely resulted in the commodification of medicine and the flooding of the health markets with Chinese propriety medicines. We simultaneously observe a proliferation of Chinese meditation practices, similarly lucrative, in an era that commercialises well-being.[1]

2 TCM

Researchers coin their concepts in accordance with their intellectual project and the field of scholarship to which they contribute. In the educational contexts of the PRC in the 1980s, Traditional Chinese Medicine was a sociologically and conceptually distinct phenomenon. It made sense to call it TCM on the grounds of the anthropological principle of respecting the actors' viewpoint and their rendering of *zhongyi* 中醫 in English translation as TCM, although the Chinese term *zhongyi* (literally 'Chinese medicine') was used indiscriminately, regardless of whether they talked about ancient or contemporary Chinese medical practices and officially sanctioned ones or not. Chinese medical professionals distinguished between the *xueyuanpai* 學院派 (the party of the TCM colleges) and other forms of Chinese medicine (Hsu 1999). Sociologically, TCM is the form of Chinese medicine promoted in government-run institutions on a nationwide scale, or at least it was, between the late 1950s and early 1990s. Conceptually, TCM was based on the *Zhongyixue gailun* 中醫學概論 (*Outline of Traditional Chinese Medicine*) and a 50-year history of textbooks. In cross-cultural perspective, it is comparable to other revived scholarly medicines, which paradoxically are called "traditional" (*chuantong* 傳統), while aiming to become modernised (*xiandaihua* 現代化), scientific (*kexuehua* 科學化), systematic (*xitonghua* 系統化) and standardised (*guifanhua* 規範化).[2] This is said in awareness that the notion of the medical system has been

[1] For an earlier version of this article, see Hsu (2007a). The present version has benefited from valuable comments by Fu Daiwie and Lei Xianglin to whom I wish to express my gratitude.

[2] Hsu (1999: 6–8). See also 'Five Phase Theory as a Construct of TCM Teachings', given in the panel "TCM in the PRC and its Globalisation" at the 9th International Conference on the History of Science in East Asia, 23–27 August 1999. The three other panelists were Høg (2002), Hokari (2002) and Taylor (2002).

contested, not merely for African (e.g. Last 1981; Last and Chavunduka 1986) but also for South Asian (Attewell 2007) and PRC contexts (Scheid 2002).

Based on archival work and fieldwork-based research, Taylor (2005) has since much substantiated this argument that the government of the PRC initiated the establishment of TCM in the 1950s.[3] Yet recent developments suggest distinguishing between TCM as a nationalistic project, an 'invented tradition', from the 1950s–1980s, and Chinese medicine and pharmaco-therapy, *zhongyiyao* 中醫藥 (CMP), an 'alternative modernity' (Knauft 2002) or 'global assemblage' (Collier 2006), in the twenty-first century. In contemporary medical fields, commodified CMP and physiologised acupuncture are the hybridised aspects of Chinese medicine that have gained centre stage, while *taijiquan* 太極拳, *qigong* 氣功 and other meditative practices populate the wellness markets.

3 TCM as a Communist Project and an 'Invented Tradition' in an Emergent Nation-State

If one calls 'invented traditions' those projects that set out to construct new identities within a context of nation building, TCM clearly belongs among them. The process that Taylor (2005: 103–35) calls the "standardisation of TCM" consisted of institutionalising education and practice in TCM colleges and of writing TCM textbooks, which in her estimation took 7 years only, from 1956 to 1963 (or, more accurately, 8 years, to 1964). The first textbook called *Zhongyixue gailun* (*Outline of TCM*) was composed in Nanjing (南京) in 1958 (Nanjing zhongyi xueyuan 1958), and the first set of 18 textbooks was completed in 1962. A second set of 16 textbooks was published in 1964, which, together with the fifth edition of 1984/1985, is thought to represent the core work of TCM. The first four colleges were set up in Beijing (北京), Shanghai (上海), Chengdu (成都) and Guangdong (廣東) in 1956. They numbered 20 by 1960. With their institutionalisation in provincial capitals, the state signalled its presence nationwide.

Taylor (2005: 8) characterises the standardisation of TCM as a Communist project, where the ideology of the Chinese Communist Party (CCP), early party policies and their interpretation, and Mao's own interventions played an active role, while that of Chinese medical practitioners was fairly passive. She implicitly argues against the view that the contemporary project of standardisation can be viewed as yet another in a 2,000-year period of government through bureaucratic institutions. She says the project was unique in that it was Communist.

However, this Communist project, it is argued here, was also a nationalistic one. It needs to be kept in mind that, after the fall of the Imperial order in 1911, China was subject to warlordism, World War II (1937–1945), and a civil war (1947–1949), and the Republicans (1911–1949) never had the same control over the country as the Communists (1949 onwards) eventually effected. In other words, it was in the aftermath of the Communist revolution in 1949, when China saw a period of unprecedented nation-state building, that TCM was invented.

[3] Taylor (2005: 1–2 and 84–87) differentiates between 'Traditional Chinese Medicine', i.e. TCM, and 'traditional Chinese medicine', used in an unspecific way, much like some speak of 'Chinese medicine'.

Many observers have pointed to the dire circumstances of health care that the CCP faced in the early 1950s and to the self-generated acute famine during the Great Leap Forward (大躍進 1958–1961). These were the time periods during which the rapid standardisation of TCM was effected, no doubt, due to pragmatic considerations (e.g. Croizier 1968; Lampton 1977; Taylor 2005). Estimates are that Chinese medical practitioners outnumbered Western medical practitioners up to 50 times; they were estimated to be 500,000 as opposed to about 10,000 to 20,000 (e.g. Taylor 2005: 34). Chinese herbs were readily available, and crude forms of acupuncture, which required minimal equipment, were comparatively easy to learn and apply. Taylor (2005: 117) notes that it was barely coincidence that three innovations in acupuncture were made during the Great Leap Forward. And Palmer (2005: 60) comments on a simultaneous great leap forward in the institutionalisation of medical *qigong*, which had the unrivalled advantage of enhancing health without any equipment at all.

The Communist insistence on combining Chinese and Western medicine is unique in the history of twentieth century medicine. No doubt, the Communist vision built on views of Republican reformers of combining the best of East and West (e.g. Unschuld 1980: 208) and the very heterogeneous ideas of what Chinese historiography calls the "School of Merging" (*huitong pai* 匯通派; Zhao 1989: 237–241; Ma et al. 1993: 480–523; Scheid 2001: 370–371). It drew its force from its determination to overcome earlier tensions between the old and new, the Chinese and Western, the experiential and scientific (e.g. Lei 2002), and the processes that resulted in the standardisation of TCM were thus not only revivalist and reformist, as in other burgeoning nation-states within which the middle classes and bourgeoisie were growing (e.g. Leslie 1976a), but aimed at being revolutionary. The goal was to blaze a trail of integrated medicine that attended to the wants of the masses and future generations (Taylor 2005).

Nevertheless, TCM, as taught and practised in government-run institutions of the People's Republic of China, appears to fit the definition of 'invented tradition' perfectly because it was constructed and formally instituted within a brief and dateable time period and established itself with great rapidity. As Hobsbawm (1983: 3) remarks, it is their rapid appearance and establishment rather than their survival that marks 'invented traditions'. This is said in awareness that the book *The Invention of Tradition* flourished more from its (misunderstood) polemical stance and its Marxist attack on conventional British historiography than anything else.

As Post (1996) points out, the idiom itself caught fire. Many used it in a sense that alluded to either an unmasking and demythologising or a manipulation from the above. Although these connotations figure prominently in Hobsbawm's later writings, Post (ibid.: 93) remarks that they are not contained in his publication of 1983 where Hobsbawm speaks of a "cultural construction of history" or, more accurately, a "construction of identity". The new identities Hobsbawm researched were those of an emergent nationalism. They were expressed and shaped in secular public rituals and their performance was relevant both in the social and political sphere. It is this aspect of the concept of 'invented tradition' that is usefully applied to TCM, namely as a medicine that was instituted in the course of a nation-building programme.[4]

[4] Although the Republicans rather than the Communists are usually called nationalists in Chinese history writing, many projects of nation-state building that affected the entire country could be undertaken only after the Communist Revolution, when the government was capable of reaching out to its territories.

4 TCM in Cross-cultural Perspective

If one views TCM as the result of a nationalistic project and compares it to other traditional medicines worldwide, it becomes evident that Communist governmental commitment to an integration of traditional and modern medicine is remarkable if not unique (e.g. Leslie 1976b; Leslie & Young 1992; Hsu & Høg 2002; Alter 2005). Nowadays, most governments discourage the integration of biomedical and local medical theory and practice (e.g. Ferzacca 2002). New regulations of traditional medicine and complementary and alternative medicine (T/CAM), which have started to be issued by the Ministry of Health rather than the Ministry of Culture, prohibit integration between the two outright (fieldwork on Chinese medicine in East Africa between 2001 and 2008). Local biomedical professionals carefully guarded the boundaries of their jurisdiction and local intellectuals felt a policy of integrated Western and local medical practices would promote charlatans who were innovative but not firmly rooted in their own tradition. This makes the Communist project of the PRC, which had its opponents exactly along these lines, all the more remarkable (see Table 1). However, the PRC was not the first nation-state to institutionalise traditional medicine.

In India, which was under British colonial rule from the eighteenth century to 1947, revivalists underwent a century-long struggle for state recognition, from the implementation of Macaulay's minute on educational policy in favour of an entirely European curriculum in 1835 to the registration of the first trained indigenous practitioners in 1938. Jeffery (1988) stresses, however, that on initial contact in the late seventeenth century the general view among British officers had been that local illnesses are best taken to local doctors. When the Native Medical Institution was established in 1822, it taught Ayurveda and Unani Tibb alongside European medicine. It was only with Macaulay's minute that it ceased doing so and the Bengal government insisted on European vaccination (Jeffery 1988), although the local inoculation against smallpox was at the time superior and culturally much more sensitive (Arnold 1993).

The revivalists were exponents of the middle classes, which grew significantly between the 1860s and 1920s and aimed for a market of their medicines. Their main hurdle was their divided religious, linguistic and political alignments, apart from divisions within their medical traditions (Meulenbeld 1995). The establishment, in 1907, of a national representative, the All-India Ayurveda Mahasammalan, was a milestone achievement. When in 1928 the Indian Medical Association was founded, early leaders thought of including indigenous practitioners. However, the General Medical Council in London requested a clear distinction between "scientific" medicine and other medical systems before granting Indian degrees any international recognition. Although the head of the Indian Medical Society had noted that indigenous medical care had the advantage of low-cost education and fees, this was not considered reason enough to divert any state funding away from "scientific" medicine.

Jeffery (1988) notes that the average social position of the *vaids* and *hakims* (伊斯蘭國家的醫生) probably deteriorated during British rule and gives three possible reasons for the decline: firstly, disunity of indigenous practitioners; secondly, active policies of the state against them and their loss of patronage through the local elite; and thirdly, patients' perceptions that local treatments were not as effective as the European ones. Jeffery remarks that this last point was least

Table 1 Comparison of the nationalistic 'invention of medical traditions' in India, Japan and China

India	
Western medicine introduced by military and the colonialists	
Late seventeenth century	Local diseases are best taken to local doctors
1822	Native Medical Institution (NMI) teaches indigenous and European med
1835	Macauly's minute—European curriculum
1907	Revivalists establish national representative: All-India Mahasammalan
1928	Indian Medical Association for Indian biomedics only
1938	Trained indigenous practitioners first registered in Bombay
Ayurveda, Siddha and Unani Tibb practitioners are para-professionals	
China	
Western medicine introduced through missionaries and through studies abroad	
1915	Rockefeller Peking Medical Union College
1919	4th May movement: the old medicine is backward, superstitious, irrational
1929	KMT proposal for abolishing old-style medicine mobilises Chinese med docs
1949 ca	15,000 modern-trained physicians for a population of 500 million
1950s	TCM training courses, academies, textbooks
1966–1976	"Barefoot doctors" based on Western med but integrate Chinese med
1978	Examinations for university studies re-introduced
1986	39% government expenditure on health for Western med hospitals, 9% for TCM
TCM good for certain disorders, first choice in rural areas, Western medicine government-promoted	
Japan	
Western medicine introduced through merchants during Edo period (1600–1866)	
1868, 1869	Meiji restoration, Gov adopts German system of medical education
1875	Gov requires all physicians to study West med, 1st movement for *Kampo*
1895	Bill to revise regulation for physicians' licence rejected by small majority
1910	Wada Keijuro *Rules of Med World* published, founder of modern revival
1946	Prohibition of acu and moxa as "barbaric and unhygienic," revised in 1947
1960s	2nd revival of *Kampo*: Western med good at diagnostics, *Kampo* for therapy
1976	Government law that certain herbal prescriptions are paid by Nat Health Insurance
Kampo has a status of an alternative medicine	

founded; it is questionable whether European medicine was more effective at the time and he contends that India's morbidity and mortality rates arose from poverty which is a problem of social inequality and no medical system can remedy. While it is the case that Ayurveda, Siddha and Unani Tibb eventually were taught and practised in professionalised settings (Sivaramakrishnan 2006; Attewell 2007) and do so to the present day (e.g. Kaiser 1992; Langford 2002), by the late 1970s, they had merely para-professional status (Leslie 1976a).

China was never a colony. Although the Jesuits introduced their medical and, notably also, anatomical knowledge into Imperial China from the seventeenth century onwards and although missionaries set up medical colleges in the nineteenth century and wealthy Chinese (like Sun Yat-sen 孫中山) went abroad to study medicine in the early twentieth

century, a sustained training of Western medicine was only instituted in 1915 when the Rockefeller Peking Medical Union College (北京協和醫學院) was founded. At the wake of the Communist Revolution, it had trained most members of the Ministry of Health. The May 4th movement in 1919 had decried the 'old' medicine as backward, superstitious, irrational. This is the tone that prevailed in Republican China, led to the proposal of abolishing it in 1929 and resonated in Mao's early speeches on medicine (Croizier 1968; Lei 1999; Taylor 2005).

The breakthrough came in the 1950s as part of a nation-building project, with Mao's vision of a new unified Western and Chinese medicine; its force was intensified as resources declined during the acute crisis of the Great Leap Forward. The following acute crisis of the Cultural Revolution (1966–1976) saw the deaths and suicides of many of its renowned senior doctors, however, from physical torture or otherwise dehumanising experiences. These losses to the profession cannot be fathomed, although in 1978 the nationwide re-introduction of university entrance examinations recruited dedicated and intelligent students and in 1984/1985 the renowned fifth edition of TCM textbooks was published.

The social profile of young acupuncture teachers at the Yunnan (雲南) TCM College in the late 1980s revealed that most were offspring of locally high Chinese Communist Party cadres and university-trained intelligentsia; only one was from a senior doctor's household and had childhood experiences of Chinese medicine. Vocational students were mostly from rural areas and, more frequently than in other courses of higher education, from peasant families; a few parents were local teachers or (Chinese) doctors. This shows that, in the late 1980s, in a backwater like Yunnan, TCM fulfilled functions along the Maoist policies that aimed at overcoming the three divides between rural and urban areas, periphery and centre, and social class. There was a trend for students who had not attained the marks required for medical school to enrol in TCM, but it was not the only one; for instance, vocational courses in acupuncture and massage were very popular and attracted good students (Hsu 1999). Although TCM never enjoyed the same financial backing from the state as did Western medicine and most urbanites would turn to Western medicine for most problems, TCM was not a para-profession; it was granted its own standing and considered more effective than Western medicine for certain disorders (Ots 1987; Farquhar 1994 and Scheid 2002).

Japan, like China, was never a colony. During the Edo period (1600–1868) its contacts with European medicine had been very limited and mostly mediated through merchants (e.g. Elman 2008). The Meiji restoration, however, had the government adopt the German system of medical education in its entirety in 1869 and forced all physicians to its study in 1875. The two attempts in 1875 and 1895 to effect a revival of Japan's traditional elite medicine *kampo* (かんぽう; 漢方) failed. It was not until 1910 that Wada Keijuro (和田啓十郎) successfully instigated a movement for *kampo.* Even after World War II, in 1946, the practice of acupuncture and moxibustion was prohibited on the grounds of being "barbaric and unhygienic", a bill that was, however, quickly revised in the following year. It took another two decades for the second revival of *kampo* to arise and it was not until the late 1970s that Japan's National Health Insurance started to cover herbal prescriptions. The status of *kampo* in Japan in the 1980s can thus be compared to that of a CAM in Germany and elsewhere in Euro-America (Lock 1980; Ohnuki-Tierney 1984; Oberländer 1995).

In summary, all above "invented medical traditions" were an emblem of national identity and their position in society was not unaffected by government policies towards Western medicine and its ensuing history in these nations. By the late 1970s and 1980s, they had reached the status of a para-profession in India and of a CAM in Japan. The PRC stood out for its brief history with Western medicine and the government's insistence on integrating Chinese and Western medicine. This gave TCM an unparalleled status of its own.

5 TCM Theory

Just as the institutionalisation of TCM can be shown to be both part of a nationalistic phase in history, yet specific to Communist China, its teachings show traits of an invented tradition. They were celebrated as providing the seed corn to a critical alterity. One of the most salient features of TCM theory is its insistence on *bianzheng lunzhi* 辨証論治 (pattern differentiation and treatment determination), an aspect mentioned in all secondary literature, and most extensively discussed by Farquhar (1994) and Scheid (2002). The concept *bianzheng* (lit. to distinguish patterns) describes the diagnostic process, which Farquhar (1994: 55–59, 212) beautifully schematised as one moving from the patient's 'concrete' complaints to 'verbose' (or seemingly abstract) expert statements. TCM diagnosis typically makes use of the four methods (*si zhen* 四診) of inspecting the complexion, asking, smelling/hearing and palpating the pulse (*wang* 望, *wen* 聞, *wen* 問, *qie* 切), although historically this was not always so.

The complaints a patient presents are interpreted in terms of classificatory schemas like the eight rubrics (*bagang* 八綱: *yin* 陰, *yang* 陽, outer, inner, repletion, depletion, hot, cold), the five viscera (*wuzang* 五臟: liver, heart, spleen, lungs, kidneys), the six warps (*liujing* 六經: *yang* brightness, major *yang*, minor *yang*, major *yin*, minor *yin*, dull *yin*), the triple burner (*sanjiao* 三焦: the upper, middle and lower burner), the four sectors (the defensive *qi* sector (*wei* 衛), the active *qi* sector (*qi* 氣), the nutritive *qi* sector (*ying* 榮), the blood sector (*xue* 血)) and six illness factors (*liuyin* 六淫: wind, summer heat, fire, cold, damp, dry). Incidentally, the words the patients mention in their complaints (e.g. hot or cold, liver or heart) often are identical to the ones the doctor arrives at after an examination with the four methods. The words patients use in their complaints are thus simultaneously technical terms, which in a second step of diagnosis lead to the formulation of a differentiation pattern (often, but not always, a four-syllabic idiom). TCM theory does not prescribe which of the schemas should be used in the face of what kind of disorder. This has been relegated into the domain of tacit knowledge and is said to depend on the doctor's experience (*jingyan* 經驗) and his or her virtuosity (*ling* 靈).

From a medical anthropological viewpoint, "differentiation patterns" are what Nichter (1996) called "illness labels" that outline a "task-onomy" and contrast with "disease taxonomies". Although the implied contrast between illness as psychosocial construct and disease as biological dysfunction has since been contested (e.g. Lock 1993), the notion of "task-onomy" is useful in that it stresses that every diagnosis has implications for treatment and affects the patient's social standing. The beauty of the differentiation pattern is that, apart from being seemingly comprehensible to the layperson, it contains hints at how to design the therapeutic intervention. As told in

class, a "wind-cold flu" (*fenghan ganmao* 風寒感冒) need not mean that the patient was out in wind and cold on the previous day or that he sat in a draught, although the patient himself may understand the diagnosis in this way. For a TCM professional, it outlines a treatment strategy and means that a wind-eliminating (*qufeng* 去風) and a warming (*wenli* 溫里) formula has to be prescribed.

Treatment strategy (*lunzhi* 論治) involves, as Farquhar (1994: 212) noted, also a two-step process. One has to first identify a suitable formula and then, in a second step, add and subtract different constituent drugs of the formula to respond to the particular pattern the patient presents. TCM professionals emphasise the importance of matching formulae to patterns and of structuring the composition of drugs according to rules that apply to formulae in general, although the rules are not always applied in practice, e.g. the rule of using sovereign (*jun* 君), ministerial (*chen* 臣) and assistant drugs (*zuoshi* 佐使). According to this schema, folk medicine takes a "shortcut" in that it administers a separate drug for each complaint and unskilled doctors perform "symptom management", whereas *bianzheng lunzhi* makes possible treatment of the overall pattern of the particular patient.

The slogan *bianzheng lunzhi*, as Scheid (2002: 200–237) points out, has a variety of meanings in the PRC and, as Karchmer (2007, p.c.) suggests, is a TCM invention. To be sure, it re-formulates scholarly Chinese medical reasoning. However, although presented as the core of TCM rationale, the *Yellow Emperor's Inner Canon* (*Huangdi Neijing* 黃帝內經) of the Han dynasty, which generally is taken as the foundation of TCM theory, does not actually refer to it, certainly not explicitly, and if implicitly, only indirectly. Rather, the seed for its rationale is given in the *Treatise for Cold Damage Disorders* (*Shanghanlun* 傷寒論) of ca 220 CE, where differentiation patterns were named according to the decoction used for their therapy (Sivin 1987: 110). The slogan *bianzheng lunzhi* thus represents a barely noticeable shift in TCM rhetoric, away from the *Neijing* to the *Shanghanlun* and away from cosmological speculation to clinical maxims.

In this context, Ågren (1986) comes to mind. He noted that the *Neijing* emphasises synchronous correlations while the *Shanghanlun* relates a diachronic understanding of illness changing over time. In his view, the teachings of the *Shanghanlun*, which for over a millennium had been valued more in Japan than China, facilitated the Japanese acceptance of Western medicine. With this in mind, one notes that paradoxically *bianzheng lunzhi*, which is meant to emphasize a distinctively Chinese medical heritage, implicitly gives prominence to the *Shanghanlun*, which with its diachronic understanding of illness events represents Chinese reasoning that translates particularly well into Japanese and Western medical rationale. Thus, despite TCM rhetoric to the contrary, its emphasis on *bianzheng lunzhi* may express a subtle form of adjustment to Western medicine.

On the other hand, Euro-American observers like to overemphasise the Western impact and stress the contrast with the West because the West is their known reference point. Along a similar line of argument, one may have thought that TCM's reasoning in terms of the five viscera (*wuzang*) resulted from an adjustment to Western anatomy. Yet these recent developments are best interpreted as one step within a long history of Chinese medical rationale, developing from what Allan Young (1976) called an 'externalising' towards a more 'internalising' medicine. Research into the genealogy of the terms of *wuxing* 五行 (five agents) has made this

most evident (Hsu 2007b), based on earlier research that the organisation of basic TCM knowledge (Hsu 1999: 186–206), with its thematic focus on the discussion of *yinyang*, *wuxing*, *zangxiang* 臟象 (organ clusters) and *qixue* 氣血 (*qi* and blood) in separate chapters has its roots in the Ming dynasty *Canon of Categories* (*Leijing* 類經) of 1624, which completely restructured the Tang and Song editions of the *Inner Canon* (內經).

Some observers have complained that TCM represents a "piecemeal assimilation" of Western medical ideas and remarked that the treasure house has been turned into a "quarry" (as claimed by e.g. Porkert 1982: 569). However, one could also argue that TCM has been subtle in its ways of appropriating Western materialism, Marxist–Maoist materialist dialectics and Western medical ideology and technology. A nice example is how a case of jaundice was explained on a clinical round during fieldwork in 1988–1989: it was diagnosed as the liver overcoming the spleen (*mu ke tu* 木克土). In canonical doctrine, the patient's yellow complexion, i.e. the colour of the Earth and the Emperor, which is associated with the centre of the world, correlates with an affection of the spleen, located in the centre of the body. However, in Western medicine, jaundice arises from an infection of the liver. Since complex reasoning continues to be cultivated in Chinese medical circles, it was possible for TCM professionals to show that teachings as disparate as the above would appear contradictory only on a very superficial level of analysis.

6 The Story of Qigong

The Communist invention of TCM was paralleled by the invention of *qigong* 氣功 during the nation-building project in the 1950s, when *qigong* was promoted in the medical realm (Despeux 1997; Palmer 2005).[5] Although the term can be traced to the Tang and Song before it emerges in Republican times endowed with new meanings (Despeux 1997), it is widely promulgated particularly in the PRC, stripped of religious overtones. It is called a "breathing technique", a kind of "physical training", rather than a "meditation practice" (Hsu 1999: 23).

The history of *qigong* differs in interesting ways from that of TCM, as does its historiography. The French publications by Despeux and Palmer give remarkable people due attention: Liu Guizhen (劉桂真), its founder; Yan Xin (嚴新), celebrated in the 1980s; Zhang Hongbao (張宏堡) and others, known in the 1990s. By contrast, the mostly Anglo-Saxon scholarship on medicine, amply quoted above, centres on social, institutional and political processes. This difference in writing style may reflect a difference in subject matter. *Qigong* masters were celebrated in a kind of personal cult, reminiscent of Mao's, among whom, as Palmer (2005: 185–200) stresses, the most influential ones combined high educational status (University degrees) with the social skill of aligning themselves with important political cadres. Their therapeutic efficacy clearly depended on charismatic authority. This may explain the different histories of *qigong* and TCM in the PRC.

[5] The founder of *qigong*, Liu Guizhen (1957: 85, quoted in Palmer 2005: 57), presented *taijiquan* as an auxiliary method of *qigong*. However, from a social scientific viewpoint, there are important reasons to discuss the two separately.

Qigong was institutionalised as a curative therapy insofar as it was promulgated mostly in rehabilitation centres. The first one was established in Tangshan, in the year in which its founder's patron became party secretary of that city, in 1954. It was called the "Rehabilitation centre for the working class people of Tangshan" (*Tangshan gongren liaoyang yuan* 唐山工人療養院). Two years later, in 1956, the head of Hebei province's Ministry of Health (河北省衛生部) decided to transfer it up the social scale to Beidaihe (北戴河) on the shores of the Northern Sea, the favourite resort place of high party officials. This became the main institution for the practice of *qigong* until 1965 (Palmer 2005: 49–54).

No campaign was ever launched against TCM, but *qigong* was heavily criticised from the early 1964 onwards resulting in a complete ban of publications on *qigong* after 1965. It was defamed as "superstitious" and a "rotten leftover of feudalism", which with its focus on tranquility produced counterrevolutionary bodies, for it was the "active body" that contributed to "socialist re-construction". Its founder was expulsed from the CCP, lost seven points in the administrative hierarchy and was sent to a re-education camp (Palmer 2005: 63).

The attack on *qigong* can be viewed as an early sign of changes in the high echelons of the CCP, which led to the fully fledged Cultural Revolution after 1966. *Qigong* did not regain its official backing until, in 1978, a reformist government proclaimed the Four Modernisations (*sige xiandaihua* 四個現代化). This did not mean that meditation practices derived from Daoist, Buddhist and Confucian traditions nor that those of the martial arts stopped to be practised during those years (Palmer 2005: 74). Although Palmer (ibid.) claims the practice went underground, the *qigong* healers I worked with gave no such impression (Hsu 1999: 21–87). People pursued it quietly and unobtrusively and generally not in public spaces. Those who did so nevertheless were discouraged by chicanery (Palmer 2005: 72–73) but in the case mentioned not sent to prison.

The Cultural Revolution is often thought to have promoted traditional health practices but, as seen above, leading *qigong* masters fell into disgrace and senior Chinese doctors were, like all intellectuals, humiliated as the "Stinking number nine". While research activities were selectively retained, teaching at TCM academies temporarily ceased. But in rural and remote areas the state's presence became more pronounced. An innovative health scheme was instituted. It was not an "invented tradition" but a socialist project, which made an explicit link between health provision and increased production and economic development (Wilenski 1976: 51). The barefoot doctor scheme is sometimes considered to have promoted the use of traditional medicines, but a glance at *The Barefoot Doctor's Manual* (Anon. 1977) and related coursework reveals that it focused on the basics of hygiene, wound dressing, vaccination, family planning and primary aid. It also discussed contents of acupuncture, moxibustion, and herbal medicine (e.g. a list of common *materia medica*) but in a very simplified form. For instance, of the 365 acupuncture points, only six were taught: *yanglingquan* 陽陵泉, *zusanli* 足三里, *huantiao* 環跳, *hegu* 合谷, *quchi* 曲池, and *jianzhen* 肩貞 (Taylor 1994: 26, 34).

In other words, although, ironically, some of the most lasting achievements in the realm of traditional medicines were made during the Cultural Revolution, as for instance the unearthing of the Mawangdui (馬王堆) medical manuscripts, the invaluable edition of the *Dictionary of Chinese materia medica* (*Zhongyao dacidian* 中藥大辭典) or the systematic screening of the Chinese medical formularies and

drugs, which led to the discovery of the to date most effective anti-malarial, artemisinin (*qinghaosu* 青蒿素), it was not until after Mao's death in 1976 that "traditional" medicine and *qigong* gained new impetus.

The 1980s experienced a "*qigong* fever" (*qigong re* 氣功熱). The medical anthropologists (Ots 1994; Chen 1995; Hsu 1999), who then did fieldwork on TCM, could not escape the phenomenon. Their rendering of *qigong* was kaleidoscopic, and they outlined an array of loosely connected themes: *qi*'s different qualities (high-quality "inner *qi"* versus "outer *qi*") and *qigong*'s many faces ("soft *qigong*", "hard *qigong*"); its promulgation in the 1950s as "inner nurture" (*neiyang gong* 內養功) in medical institutions; its widespread popularity in the 1980s; its appeal to the military; its therapeutic and vitality- and identity-enhancing effects (e.g. of making one's body produce pleasant smells) and also extra-ordinary abilities (*teyi qigong* 特異氣功). Despeux (1997) and later in particular Palmer (2005) took up these themes, dealt with them in depth and widened the medical anthropologists' medical focus to religious studies.

Palmer's (2005) gripping narrative, which is substantiated with relevant detail of names, dates and contents of important documents, identifies three themes that marked the history of *qigong*: the "medical institutionalisation" in the 1950s, the "religious explosion" in the 1980s and the "political crisis" in the 1990s. In accordance with Despeux (1997), who also heavily relied on texts, he emphasises the claim *qigong* made to science. The emphasis on scientific experimentation, also of para-normal abilities, which already since the 1980s had become subsumed under *qigong*, appears to have peaked in the early 1990s and is striking mostly in textual materials.[6]

Indeed, much like TCM, *qigong* was said to be scientific (*kexue*), but whereas TCM combined traditional and scientific practice, the relation between *qigong* and science was different. It was the effects of *qigong* that were subject to scientific study, sometimes in the belief that they testified to techniques more advanced than those of conventional science. The scientific experiments generally had no protocol that would satisfy Western standards (Despeux 1997), but they had an ideological value[7]. In Palmer's (2005: 224) view, *qigong* offered "reconciliation". However, this explanation cannot explain its popularity, as the "reconciliation" that *qigong* no doubt offered is not much different from the "integration" of tradition and science that TCM embodied, and TCM did not enjoy the same popularity.

In the 1980s, people practised *qigong* openly in parks and at home and readily attended meetings in a work unit setting if a *qigong* master was scheduled to perform in a local auditorium. Nevertheless, not everyone was taken by the fever, and, even if every park of China had been filled with people practising *qigong*, there were many more who did not venture into parks and observed the spectacle with slight amusement and sometimes outright reserve (Hsu 1999: 23). *Qigong* was performed in the name of science and was said to be under the patronage of some few very high party officials, but it did not have the same institutional backing as TCM. At the Yunnan TCM College, it became part of the official curriculum by the name of

[6] Palmer was three times in the field between 1994 and 1997, but otherwise studied texts (journals, the Chinese press, books by *qigong* practitioners, encyclopaedias, websites and a non-academic chronicle).
[7] In the late 1980s, *qigong* appealed more to "the development of science in China" than to a global one, as it currently does.

Table 2 The history of *qigong* in the PRC

Palmer (2005) distinguishes three periods
The period of "medical institutionalisation" in the 1950s
The period of "religious explosion" in the 1980s
The period of "political crisis" in the 1990s
Re-interpretation of Palmer into four periods
A period of *qigong* as "invented tradition" in the 1950s
A period of "superstitious practice" in the 1960s and 1970s
A period of "popular phenomenon" in the 1980s
A period of clearly "structured worlds of *qigong*" in the 1990s

yangsheng gong 養生功, not *qigong* (*corrigenda* to Hsu 1999: 158). With hindsight, this difference in semantics is telling.

When Ots (1994) described crane *qigong* that flourished in the early 1980s, he spoke of the expressive body and used a hydraulic metaphor of living out suppressed emotions. A more sociologically oriented explanation points to introspection, the discovery of one's own body and self, and new values of individuality in a time period that many characterised by the same term *luan* 亂 (chaotic) as the Cultural Revolution (Hsu 1999: 24–25). A latent political crisis may have spurned the *qigong* fever of the 1980s. The individual identity crises may have ensued from a general disillusionment with politics and a "crisis of faith" in the CCP (not in god, as Palmer 2005: 224n suggested). The people who practised *qigong* were generally not religious; the experiences they made were not religiously framed; nor did the esoteric quest of mystery that is often observed in the West seem to play a role. People said *qigong* was a "social problem" (*shehui wenti* 社會問題). Notably, *qigong* was framed as a "question", "puzzle" or "problem", not a religious one but a "social" one and, as Palmer also notes, "social problems" have always had political implications in China (Table 2).[8]

If one tweaks Palmer's analysis slightly, in the light of the above, the story of *qigong* is marked by four periods: *qigong* falls into the category of "invented traditions" in the 1950s, belongs among the "superstitious" practices in the 1960s, re-emerges as a "popular phenomenon" in the 1980s, out of which arise clearly structured "worlds of *qigong*" in the 1990s. In the 1980s, there was no distinctive "world of *qigong*" (*monde du qigong*). People tried it out; they stopped and tried again with someone else; techniques were varied, relations loose, and often ephemeral. Its popularity seems to have expressed a lingering political crisis (some said power struggles in the CCP and military were put to an end with the Tiananmen event 天安門事件), which seemed to find expression in a personalised quest for identity. For the 1990s, Palmer (2005: 285ff.) provides evidence of often extremely hierarchical lineage organisations, to which was added a personal cult of their leaders. During these years of the accelerated economic boom, *qigong* was either commercialised or medicalised (Chen 2003) or transformed

[8] Palmer (2005: 26–28) is well aware that *qigong* adherents would disagree with him that they were part of a "religious explosion"; he refers to religion in a more sophisticated sense.

into a religious movement (ter Haar 2001), with a militant organisational structure, that in 1999 started to be persecuted and went underground (Palmer 2005: 339–404).

7 *Zhongyiyao* in the 1990s and Beyond

When Taylor (2005: 12–13) identifies three phases of the Communist project, she emphasises that throughout the twentieth century Chinese medicine defined itself in contradistinction to Western medicine: cooperation (1945–1950), unification (1950–1958) and integration between Chinese and Western medicine (1958–today). Taylor (2005) notes that Mao, in particular, promoted the idea of a unifying Chinese and Western medicine and in effect aimed at a radical alignment of the traditional to the scientific but that in 1958 a more accommodating line was adopted as Mao's attention turned to other issues. It was the weaker programme of integration that had an enduring impact on the nationwide curriculum and provincial colleges and that resulted in TCM as a newly standardised form of medicine.

Recent years have seen the rise of a commodified interpretation of TCM. Colleges of TCM have now become "Universities of Chinese medicine and pharmacotherapy" (*Zhongyiyao daxue* 中醫藥大學). Considering that the term "Chinese medicine" (*zhongyi* 中醫) has always embraced "Chinese pharmacotherapy" (*zhongyao* 中藥), this change in semantics points to a shift away from the culturalist stance that emphasized Chinese ideological aspects of medical practice. Rather, it signals an appraisal of material culture, i.e. Chinese medical drugs, which, validated by a globally accepted science, can be commercially exploited. The PRC has become implicated into transnational entrepreneurship (Table 3).

Here, a word on 'Western medicine' (*xiyi* 西醫) is warranted. A close reading of Scheid (2001) highlights that the examples he raises of 'Chinese medical' practice would have been termed examples of 'integrated Chinese and Western medicine' 10 years earlier in Kunming (昆明). Mao's vision has thus stipulated processes of which the actors themselves may not be all too aware, as definitions of what constitutes TCM change over time. While the comparison with India and Japan highlighted that in the 1980s TCM had a stronger and more revered position vis-à-vis Western medicine in PRC, indices are that 'integrated Chinese and Western medicine' and CMP today are much more oriented towards global science and Western biomedicine as the main arbitrator of medical legitimacy.

Table 3 The history of Chinese medicine in the PRC

Taylor (2005) distinguishes three phases
Cooperation (1945–1950): Western medicine is taught to Chinese medics
Unification (1950–1958): Chinese medicine is taught to Western medics
Integration (1958–today): TCM (Traditional Chinese Medicine)
Modification of Taylor
1958–late 1980s: TCM, an invented tradition
1990s–today: CMP (Chinese medicine and pharmacotherapy), an alternative modernity

8 The Global Perspective

In the Northern hemisphere, acupuncture is the most widely practised sub-discipline of the Chinese medical sciences. Earliest reports on acupuncture in Europe are usually traced to the late seventeenth and early eighteenth century, to Jesuits and physicians of the Dutch East India Company (Lu and Needham 1980), but there is evidence of even earlier accounts (Barnes 2005). Their descriptions exude fascination with the needles and needling, while only limited attention was given to Chinese medical rationale. Their so-called acupuncture, which initially had been met with esteem, soon encountered with severe critique from the quarters of the medicine that started to be taught at the universities in Germany and elsewhere. In the early nineteenth century, it enjoyed an outright flurry of enthusiasm in institutions of the nascent hospital medicine in France but fell into oblivion again towards the end of the century. A renewed effort of introducing acupuncture into Western health care was made in the early twentieth century with the explicit aim to take account of Chinese medical rationale (e.g. de Morant 1934). It led to a flowering of many different acupuncture schools that coalesced around charismatic figures, who each provided their own interpretation of the Chinese medical archive and populated the health field in- and outside the professionalised biomedical sphere (Candelise 2008).

The invention of TCM in the PRC had repercussions on a global scale in so far as the recognition of acupuncture in Europe and North America was spurned by an innovation in acupuncture: acupuncture analgesia (Hsu 1996). It was a modern technique, apparently invented by a nurse in Shanghai during the period of the Great Leap Forward (Zhang 1989), which during the Cultural Revolution became known worldwide, not least due to Nixon's visit to the PRC in 1972 (Zhan 2001). The Western public was often not aware of the difference between acupuncture analgesia, which consisted of needling select acupuncture *loci* during minor operations to reduce the threshold of pain instead of relying on a local anaesthetic, and acupuncture (*zhenjiuxue* 鍼灸學), a sub-discipline of Chinese medicine that traces its beginnings to writings from the third and second century BCE.

Intent on increasing their therapeutic repertoire, mostly biomedical European and American professionals started to attend short-term acupuncture courses in the PRC and in their own countries. Acupuncture has asserted itself since as a separate therapy, first through long-term vocational training offered in private acupuncture colleges for full-time acupuncturists and more recently in universities, often in departments of primary care. In the 1970s, acupuncture treatment became popular as an alternative medicine to the professionalised biomedicine. This status in the health field led to its *psychologisation* (Barnes 1998). Acupuncture was delivered in a spirit that valued lifestyles alternative to those of the mainstream in industrialised countries and was esteemed as a gentle form of therapeutics.

In the 1980s, biomedical professionals started to recognise other forms of therapeutics as complementary to their own, and some actively promoted them as CAM. Within the CAM framework, acupuncture belonged among the most professionalised medicines, in status comparable to chiropractic or osteopathy, particularly as clinical research developed experiments to demonstrate mechanisms explaining its effectiveness (stimulated acupuncture *loci* released endorphins like

naloxone). The mechanistic application of acupuncture was furthermore promoted with the increased influx of Chinese immigrants who had been trained in TCM in the PRC but did not speak English at a level that would encourage talk therapy. As Tao (this volume) suggests, acupuncture is currently undergoing a process of becoming *physiologised*, as CAM promoters aim to legitimise their therapeutics through the scientifically recognised double-blinded RCT.

New inventions, as for instance sham acupoints, can be shown to have arisen as direct consequence of the pressure to conform with epidemiologists' standards but, as Tao argues, they are absurd in the light of the history of the concept of the acupuncture *locus.* Debates over the legitimation of acupuncture also have led to interesting re-classifications, as in the UK, where mechanistic biomedical models and statistical evidence have made possible the recognition of acupuncture as a "professionally organised alternative therapy", for which there is scientific evidence of its efficacy, in contrast to TCM, for which no convincing evidence of efficacy was reported (House of Lords Select Committee on Science and Technology 2000; see also Department of Health 2008). The science invoked by the UK legislative bodies is a globalised form of the biosciences, while practitioners, anthropologists and historians emphasize Chinese–scientific continuities, as acupuncture and moxibustion (*zhenjiu*) were historically considered a sub-category of Chinese medicine (*zhongyi*; Zhen and Zhuan 1984: 59).

In Europe, acupuncturists are mostly vocationally trained local practitioners or physicians who attended short-term courses in China or at home, while TCM practitioners are mostly Chinese, who generally have a university degree (5 years of training in Chinese and Western medicine) and often several years of clinical experience. Some TCM practitioners have instigated importation of the TCM *materia medica* in order to treat their patients individually with decoctions according to TCM rationale. The *materia medica* for the decoctions they dispense consists of dried and specifically prepared plant and animal and mineral ingredients and their consumption requires considerable time commitment from the patient. Since the 1990s, a comparatively smaller number of European and North American practitioners have also become interested in forms of Chinese medical practice that involve Chinese medical diagnostics and treatment with decoctions (Frank & Stollberg 2004). Some call themselves TCM practitioners; others claim to provide 'classical' and/or more 'authentic' Chinese medical treatment, unadulterated by Mao's Communist project. The treatment of menopausal syndromes, for instance, is grounded in a TCM rationale that accommodates to Western biomedical knowledge, while Scheid (this volume) draws attention to other, potentially more 'authentic' treatment regimes.

Neither acupuncture nor TCM treatment with decoctions enjoyed much popularity in the southern hemisphere. Rather, the Chinese health care scheme that was to make history in the mid-twentieth century when independent nation-states started to establish themselves was the barefoot doctor scheme. It was taken as a model case in 1978 when the World Health Organisation (WHO) formulated the Alma Ata policies of "Health for All" through primary health care (Fee et al. 2009), ironically just as it started to be dismantled in the PRC (e.g. Bloom and Gu 1997). To date, the barefoot doctor scheme probably has had a greater impact on health care worldwide than has Mao's project of TCM as an integrated traditional and modern

medicine. Primary health care schemes can be viewed as part of state-building projects in so far as they required funds to be channelled through government institutions from the centre to the periphery. However, they often did not last very long. They were doomed by corruption, lack of regular supply, lack of communication and so-called "non-compliance". The latter, as Farmer (1999) suggested, often was a consequence of structural violence or it arose, as Samuelson (2004) argues, from the village health station often lacking in social and cultural capital, which meant more to locals than its economic and symbolic capital. Since the barefoot doctor scheme appealed to the mobilisation of the masses, i.e. to social capital, with hindsight, primary health care programmes were more successful in countries that experienced a revolution and had become socialist (e.g. Nicaragua, Cuba etc.)

In line with the turn to neo-liberal health systems in Europe and North America, the WHO called for an economically more viable health care provision in the early 1990s. It abandoned the primary health care schemes, which required monies to move through government organs, and enabled the World Bank to increasingly become involved in health care and commercialise medical landscapes worldwide. This commercialisation has been aided by an increasingly widespread ideology of self-care. Health food shops have become widespread, and over-the-counter transactions and web purchases of non-licensed drugs for both preventive and curative purposes have become frequent. Patients diagnose and treat themselves based on information from the media, the internet and the advertisement industry, rather than listening to the advice of the general practitioner. By bypassing the authority of the medical doctor, who is meant to act as responsible gatekeeper, the pharmaceutical industry can now reach its clientele directly. Its expansion is furthermore fuelled by an ideological trend within the medical establishment towards a commodification of medical problem solving, with genetic research that reifies material aetiologies of disease being at its forefront.

It is in this context of commodified global health that the term *zhongyiyao* (CMP) has arisen in the PRC. The commercial potential of *zhongyiyao* and its aims for recognition by the globally accepted biosciences have overridden TCM's appeal to China's cultural heritage. As in the current risk society an economically strong middle class clientele is driven by a belief in personal agency and individual responsibility, the commerce with CAM medicines in general (e.g. Bode 2004) and 'Chinese propriety medicines' (*zhongchengyao*), in particular (Hsu 2009), have become lucrative. These Chinese propriety medicines, which were developed within the Maoist programme of integrating Chinese and Western medicine, are currently flourishing on the neo-liberal health markets both in the southern and northern hemisphere.

Hand in hand with the currently observed physiologisation and commodification of Chinese medical practices into hybridised forms of therapeutics that conform to the materialistic demands of global health, Chinese meditation practices and the martial arts have increasingly colonised niches of preventive medicine and well-being markets (Ryan this volume). A Cartesian mind–body dichotomy appears to have shaped the landscape of the global health market and split the ensemble of the Chinese healing arts into hybrid forms, which have been either physiologised or spiritualised, with either predominantly therapeutic or preventive medical

functions. This is said in awareness that Chinese medicine and meditation practices cannot be straightjacketed. Rather, one observes a tension intrinsic to their globalisation, as Chinese propriety drugs can be used as preventive medicine and meditation practices are valued as a form of therapeutics. Furthermore, as Sagli (this volume) intimates, the practice of Chinese meditation practices, which is meant eventually to lead to a bodily felt experience of *qi*, can make a person experience the body in a wholesome way. It remains to be seen whether, as the neo-liberal health market faces a crisis, this holistic experience of the self ultimately may give rise to more integrated consumption patterns of Chinese medicine and meditation practices.

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