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# Chinese Medicine on the Move into Central Europe: A Contribution to the Debate on Correlativity and Decentering STS

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**Abstract** Contributing to the ongoing debate on decentering science, technology, and society (STS) from Western contexts, this article elaborates on and reconsiders Wen-yuan Lin and John Law's proposal for correlative STS ("A Correlative STS" 2014). Like them, we empirically draw on Chinese medicine (CM) and its relation to biomedicine, but we explore the modes by which CM was enacted in the historical, political, and sociomaterial settings of socialist and postsocialist Central Europe. We show that not only specific correlations but also correlativity itself—as the ontological stance of the actors—are situated and can shift. Our argument regarding STS is twofold. First, while Lin and Law argue that STS needs to develop an appropriate mode of betrayal when translating across ontological differences from a source language to a destination language (Western analytics), we show that in our case an ethnographer cannot find any single source language. Consequently, we argue that STS should study actors' modes and moves of betrayal and their doing ontology as an open process. Second, unlike Lin and Law, who postulate the Chinese mode of international as "subtle" and "minimalist" and an alternative to the Western mode (Lin and Law 2013), we argue that with the rise of China and the changing world political economy, STS needs to be more attentive to dominating expansions that come from non-Western locations as much as from the West.

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What can Chinese Medicine (CM) offer science, technology, and society (STS)? As two previous special issues of *East Asian Science, Technology and Society* ("The Globalisation of Chinese Medicine and Meditation Practices," *EASTS* 2, no. 4; "Beyond Tradition: Asian Medicines and STS," *EASTS* 8, no. 1) suggest, CM is a stimulating issue for STS thinking and conceptual development. In the 2008 issue, leading scholars on CM explored various exchanges and mutually constitutive encounters between CM and biomedicine, including the physiologization of acupuncture under the regime of randomized controlled trials (Tao 2008), the revitalization of CM through biomedical realities such as menopause (Scheid 2008), and the global marketization of CM under the "TCM" brand (Hsu 2008a). These encounters offer STS cues for rethinking the usual script about who does the colonizing and who gets colonized (Hsu 2008b). Recently, Volker Scheid and Sean Hsiang-Lin Lei (2014) collected articles on current developments in the "living traditions" of Asian medicines—for example, articles on the various ways to understand and deal with the English-language standardization of CM (Pritzker 2014) and objectifications of CM pulse-reading practices (Farquhar 2014)—that challenge notions about the exclusiveness and homogeneity of Western science (and technology and medicine). Here, CM, with its globalizing, heterogeneous, syncretic, and plural outlook, opens up many issues that STS enjoys theorizing on and researching.

Nevertheless, the most far-reaching move of CM into STS was recently proposed by John Law and Wen-yuan Lin with their embrace of "correlativity," grounded in both everyday CM practices and the concept of *shi* (勢) from Chinese classical philosophy (Lin and Law 2013, 2014; Law and Lin 2017; Lin 2016). In their study of CM as it is practiced in contemporary Taiwan, Lin and Law (2014) offer an insightful lesson on postcolonial STS. They argue that the particular version of CM they studied is correlative and suggest correlative reasoning as a possible conceptual inspiration for STS theory and research. In their study, CM's correlative reasoning "*hybridizes without purifying*; gives priority to *situated* knowing; enacts a version of the body that is *non-reductive* even in principle" (Lin and Law 2014: 4). More specifically, they observed a respected Taiwanese practitioner who had undergone "double training" in both CM and biomedicine, who, during her consultations with patients, "*adds* the biomedical results to her findings. They supplement her diagnosis. Yes, there is a biomechanical body with its specific anatomy. But she *also* works with a body that has circulating qi and meridians. This means that she is relating *two* kinds of bodies together. But *how*?" Lin and Law (2014: 10) ask. They suggest that the practitioner "is not wrestling with a colonizing body, on the one hand, and a colonized body, on the other. She is not *reducing* the qi body to a biomechanical alternative. She is not setting them up against one another in an attempt to generate relatively simple sets of causes. *Instead, she is correlating them*. She is putting at least parts of them *alongside* one another and relating them contextually and correlatively" (2014: 10).

The authors argue that, contrary to the postcolonial approach (regarding CM, see, for example, Karchmer 2010), this coexistence of CM and biomedicine should not be

viewed simply as the colonization of CM by biomedicine but should be understood in the same correlative language that has characterized CM throughout its long tradition. Drawing on Eduardo Viveiros de Castro's study of Amazonian perspectivism (2004), they insist that the analytical language should get shaken up by the realities under study, which should not just be smoothly translated into established theoretical frameworks but should destabilize them. A good translation is one that "betrays the destination language, not the source language" (Viveiros de Castro, 2004: 5, quoted in Lin and Law 2014). By drawing on CM's own "*logic* of hybridity" (Lin and Law, 2014: 4), Lin and Law's correlative reasoning seeks to articulate a possible reconfiguration of STS as it has thus far primarily been pursued in Western (European) analyses.

Here we seek to contribute to Lin and Law's line of argument with a study of CM in Central Europe in which we elaborate on and question some of the authors' insights into the "*appropriate* mode of betrayal" (2014: 3). Thereby, we seek to join the wider debate that has flourished in recent years particularly in East Asian scholarship on decentering STS and developing theory and analytics that would be to some extent connected to, but would nonetheless defy, the established Western scholarly canon (Fu 2007; Lie 2008; Lin and Law 2015). We explore the practice of CM and its relations to biomedicine in the Czech Republic (CR), where it has been developing along two different paths: one path is represented by the growing number of Czech practitioners of CM who since 1989 have been striving to bring about the professionalization and institutionalization of their field and secure recognition for it, and the second by a Czech-Chinese government and business initiative that was launched in 2012 and made rapid progress after 2015.

We believe that situating the study in Central Europe, with its particular post-socialist history, helps prevent the reification of "postcolonial" and the "West" and of CM and its correlativity. Persuaded that political economy should not be ignored in ontological inquiry, we track not only the practices that go on in the offices of CM practitioners but also the regulatory, commercial, and political negotiations and enactments of CM in a country where CM has not yet firmly established itself. In other words, we deploy a "strategy of working at the meso-level" (Lin and Law 2015: 118–19), which devotes attention simultaneously to the "institutions," "representations," and "variable realities" that enact CM and are enacted by it. In tracking the enactment of CM through diverse encounters, conflicts, and routinizations in the CR, we show that not only the specific correlations but also the correlativity itself—that is, the actors' ontological stance—are situational and can shift. In the final part we reconsider the lessons for STS formulated in Lin and Law's (2015) article in light of the changing world political economy and in a situation where there is no single "source language."

This article draws on ongoing ethnographic fieldwork started in January 2015. The fieldwork included participant observation in a thriving private CM clinic in the CR, which, for reasons of anonymity, we shall here refer to as Zdraví, with a team of practitioners both with and without a biomedical degree. At Zdraví, we accompanied practitioners during their diagnostic and therapeutic practice working with patients and during their meetings in the clinic's common room. We were also able to participate in a number of meetings and events connected with the Czech-Chinese initiative in the current top-down introduction of CM to the CR. We also attended a course in CM for medical students at a public university, and we conducted interviews with Czech CM

practitioners, representatives of the Czech Chamber of TCM, health-care managers, officials involved in the Czech-Chinese initiative, and CM patients.[1] Our efforts to grasp current developments in CM in the CR also included a close reading of relevant legal and policy documents and of the debates on the subject in the media.

Now let us enter a medical world on the move.

## 1 Historical Trajectories of Chinese Medicine in the Czech Republic

To speak about CM in "our" corner of the world requires that attention be paid to particular versions of CM that come to life in distinctive historical, political, and sociomaterial circumstances. We were able to track the first traces of CM to military and civilian medical professionals, in what was then still Czechoslovakia, who were sent to North Korea in the 1950s. One of them, a physician named Richard Umlauf, witnessed there the use of acupuncture firsthand and after returning to Czechoslovakia became an enthusiastic promoter and practitioner of acupuncture in the 1960s. At the same time, since Czechoslovakia was one of the first countries to recognize the new People's Republic of China, lively diplomatic relations were established between the two countries that resulted in numerous agreements on trade in goods and services (Bakešová 2003; Fürst 2006). One such agreement, on friendship and cooperation in the field of health care, made it possible for physician Josef Vymazal and several others to go to China and study acupuncture, which they then brought back to Czechoslovakia.

However, since the 1960s CM has been developing in the CR along its own path independently of East Asia. Unlike African nonaligned socialist states (for example, on the case of Tanzania, see Langwick 2010), the CR was firmly aligned with the "Second World" of the Soviet bloc, and cooperative agreements with China were mostly put on hold as a result of growing tensions between the Soviet Union and Maoist China. It should be no surprise under these circumstances that it was a book on acupuncture (not CM) that Vymazal and Milan Tuháček published in 1965. While providing an account of acupuncture's philosophical-theoretical background in "Chinese folk medicine," the book also offered a "scientific explanation" for its possible effectiveness in accordance with the theories of Soviet neurophysiology (Vymazal and Tuháček 1965). Later, the first independent department for acupuncture was officially established by the Czechoslovak Ministry of Health in a regional university hospital in 1975, two physicians obtained medical certification in acupuncture in 1976, and gradually individual acupuncturists were allowed to join various medical associations.

"Medical acupuncture" thrived and spread from the 1970s, owing to its state socialist virtues—it was cheap, it was easy to practice and reproduce, it reduced the use of

[1] Both local CM practitioners and the Chinese delegations currently exporting CM to the CR usually attach the adjective *traditional* to their references to "Chinese medicine." However, the meaning behind their use of *traditional* varies widely. While local CM practitioners use the adjective to distinguish the versions of CM that are not connected to the Chinese state or government, the version of CM promoted by the current corporate-governmental initiative refers to the integrative "Traditional Chinese Medicine" that "thrives on the contemporary global health market in a neoliberal climate" (Hsu 2008a: 465). Except for direct quotes and names of institutions, we mostly stick here to the generic term *Chinese medicine*, like Lin and Law (2014) and others (Andrews 2014; Scheid 2002; Zhan 2009).

pharmaceuticals, and it was researched in the Soviet Union. It was not uncommon, for example, for some Communist Party members, including high-ranking apparatchiks, to undergo acupuncture treatment; appliances for electroacupuncture were patented; and later a large, state-owned electrotechnical firm started to manufacture its own appliance for electroacupuncture (called the Stimul 3, the company produced hundreds of thousands of such appliances). In 1977 the Ministry of Health issued the first decree defining the methodical guidelines for using acupuncture and established it in law as an "interdisciplinary method" (of medicine) (Pára 2006a: 3) to be practiced by physicians licensed by the Institute for Postgraduate Medical Education, where acupuncture started to be taught. It is important to note that this same decree (amended in 1981) is still in force and is what defines in legal terms who is allowed to practice acupuncture in the CR today. Since its introduction into postgraduate medical education in 1978, around seven thousand physicians have completed the specialty in acupuncture. In 1989 the Czech Medical Acupuncture Society (CMAS) was established and became part of the Czech Medical Association of J. E. Purkyně, the main voluntary association of Czech biomedical professional societies. Today the main aim of the society is to "seriously cultivate acupuncture on a scientific basis" (Czech Medical Acupuncture Society, n.d.).

Despite the CMAS's commitment to practice acupuncture on a "scientific basis," the society became the target of criticism, which culminated after 1997 when a new law removed acupuncture from the services covered under public health insurance. According to Eva Křížová (2004) this move was justified because of acupuncture's questionable grounding in science, and, politically, because of its association with the preceding communist regime and with Communist China. Thus the CMAS, after being threatened with expulsion from the Czech Medical Association of J. E. Purkyně for three years, decided in 2002 to close two of its most "scientifically" contentious divisions: for electroacupuncture and auriculotherapy. In their place, the CMAS established a new department for "the study of diagnostics and therapy in acupuncture and related techniques using research based on EBM [evidence-based medicine]" (Pára 2006b: 6). After that, the number of members of the CMAS, which had been in the thousands, dropped significantly; currently the CMAS has around five hundred members.[2]

Meanwhile, attempts to translate acupuncture into a scientific method and secure its recognition from the socialist state gave rise to another version of CM that emerged more on the margins of the medical establishment. For example, one young psychiatrist—who later became a well-known and very popular practitioner of alternative medicine—started, while head of a psychiatric department in a municipal hospital outside Prague, to explore CM beyond the scope of medical acupuncture; he immersed himself in the theories of qi and the Five Phases, learned about herbal remedies, and experimented with dieting and meditation. Shortly before the political regime change, he finished a book about the body and health from the point of view of the theory of CM (Jonáš 1990); this book can still be found on the bookshelves of many Czech homes and has been reprinted twenty times since it was first published.

[2] On the rich history of medical acupuncture in socialist Czechoslovakia, see Stöckelová and Klepal forthcoming.

Yet not all biomedical dissenters who were charmed by CM's complex knowledge and techniques of treatment had the same luck during the state-socialist period. These GPs, internists, and medical students stuck to biomedicine in spite of their dissatisfaction with what in their practice they experienced as biomedicine's chemical, reductive, and impersonal nature. "I experimented with it [CM] on myself. I practiced it mostly on my family and close relatives. It used to be 'home-made' way of doing it because I had no chance to practice it at my place of work [a university hospital]," Dr. Bylinná, as we refer to her here, told us; in the state-socialist period she was officially an internist and medical researcher whose research and civic activities focused on a healthy diet even made her a target for the state secret police, because she was allegedly "dismantling the socialist system of nutrition." Explorations of CM that extended beyond just acupuncture benefited from any connections a practitioner had with the "West." The dissenters used books, correspondence, and occasional visits abroad to satisfy their yearning for "traditional" CM, an *authentic* version of CM carried on by schools and families that set up base outside China and away from the Chinese state's integrated version of CM dominated by "scientific materialism."

And then came the change of regime in Czechoslovakia in 1989. In 1990 Dr. Bylinná and a few of her colleagues founded the Czechoslovak Sino-Biological Society with close support from Université Européenne de Médecine Chinoise in France. The main purpose of the society was to create an institutional basis for "the first school of Traditional Chinese Medicine" in the CR that would systematically educate students in "all five fields": acupuncture, phytotherapy, dieting, Tui Na massage, and Qigong. Later, besides education, the Sino-Biological Society also roofed various other activities (publishing, inviting Western CM experts) and enterprises, including a firm specializing in the import and distribution of CM herbal substances coming from Italy, Taiwan, or China through Western European distributors.

Another important figure for CM in the CR was a doctor whom we will call here Dr. Zelený. Although a skillful gastroenterologist, his commitment "not to treat people but help them to cure themselves" and to "medicine without borders" led him to become one of the first students at Dr. Bylinná's school of CM and eventually go on to teach there (research interview, July 2015). In the mid-1990s he traveled to study in China, and while there he gathered around 250 kinds of CM herbs and herbal substances that he sent back home. After returning he prepared herbal remedies for distribution and for use in his own practice. With a mixture of, in his words, "enthusiasm, naivety, and a pioneering effort," Dr. Zelený eventually created a small but functional world of CM (research interview, July 2015). This world includes a CM school with a curriculum that stresses, like Dr. Bylinná's school, "all five fields" of CM, a CM clinic that enjoys a steady flow of patients (around ten thousand examinations are conducted each year), and an herbal pharmacy that imports various CM herbal substances for sale in the Czech market and produces its own herbal mixtures and substances that the CM clinic prescribes to its patients.

Liberalization and marketization after 1989 brought the various approaches and techniques of unconventional medicine to the public's attention (Křížová 2004, 2015; Heřt 2010), and, for example, homeopathic substances were recognized in state legislation as medicinal products (registered through a simple procedure for obtaining authorization). During the 1990s, a plethora of new commercial subjects were established with the purpose of importing and selling items for use in unconventional

medicine and particularly in CM practice. Czech CM practitioners were consequently able to replace the Czechoslovak acupuncture needles for branded ones that are disposable and cheaper, often imported from Japan. Also, several practitioners of Chinese origin came to the CR to work in private CM facilities or independently. One of them, Guo Li, has become well known, in particular due to the fact that she treated Czech president Václav Havel.

Like previous generations of medical acupuncturists, the proponents of "traditional" CM longed for professional recognition and started to work toward obtaining it in the postsocialist period. After many years of debates and preparations, around one hundred CM practitioners met in 2011 to found the Czech Chamber of TCM; unsurprisingly it immediately became a member of the European Traditional Chinese Medicine Association (ECTMA). The main role of the chamber, as defined in its statutes, is to "collect and to act as an umbrella organisation for the practices of Traditional Chinese Medicine; to promote, protect, and improve the standards of good practice and status of TCM methods" (Czech Chamber of TCM 2011: 2). The participating practitioners committed themselves to embracing CM in all five of its fields and its theories, ethics, and "spirituality."

The standardization of education became a key focus. Dr. Bylinná's and Dr. Zelený's school curricula were restructured to meet the criteria of the ECTMA, especially in terms of a minimum required qualification in Western medicine for their students, many of whom lack any university medical education. The chamber also put much effort into self-regulation (drawing up a code of conduct for CM practitioners, defining "good practices," establishing a register of practitioners) in an effort to renegotiate the legal status of CM in the CR. The chamber thus aims to change the current legal framework in which medicine (both conventional and unconventional) rests wholly in the hands of professionals with a degree from a biomedical school and acupuncture in particular can only be practiced by medical professionals who have been certified by the Institute for Postgraduate Medical Education. Recently, the chamber circulated an open letter and petition to the Czech president, government, and state institutions to urge them to disentangle CM from the legislative, professional, and moral gray zone it is in (Bílek, 2014). Politicians and corporate businesses, however, have (together) embarked on a different path regarding CM.

## 2 Integrated Medicine: "Western Features Are No Problem"

Recently, China has rediscovered the region of Central and Eastern Europe (CEE), which a few decades ago was part of the Communist bloc, and one part of which joined the EU after the fall of communism. In early 2012 a meeting was organized between Chinese officials (and hundreds of Chinese businessmen) and prime ministers of sixteen, mostly postsocialist, states in the capital of Poland. The meeting resulted in what is called the "Warsaw Initiative," which was intended to revive the outdated "friendship and cooperation" between China and CEE states and boost new economic trade (Long 2014). Based on the idea of a "new Silk Road," the CEE states appeared in Chinese eyes as an economic bridge region for "China's strategy of expanding its opening-up westwards" (Liu 2014) and "a good place to launch an expansion into Western Europe and a favourable destination to locate investments targeted at the EU

market" (Kaczmarski and Jakóbowski 2015: 3). On the national level the involvement of the CR in the Warsaw Initiative marked a change in the Czech political elites' relations with China, which had hitherto been dominated by the rhetoric of human rights inherited from Václav Havel and his followers (Fürst 2014). While until 2004 there were no official visits between Czech and Chinese leaders, in the years following the Warsaw Initiative dozens of meetings took place, resulting in various agreements being signed, not just between high-ranking representatives of the two states but also between regional officials. The tangible results of this shift in Czech-Chinese relations have been growing numbers of Chinese tourists spending their yuan in Czech towns, direct flights established between the two countries, and Chinese investments in the CR amounting to 3.1 billion Euro (making China the CR's fourth-largest trading partner) (Du Bois and Davidová 2015).

Before the reluctant politicians, it was Czech capitalists who rediscovered China. The leading figure in this has been Petr Kellner, a billionaire and majority owner of the investment house PPF Group, whose activities in China date back to 2004 and whose Home Credit became the first foreign firm to be granted an independent license to offer consumer loans in China in 2010 (Groszkowski 2014). In 2012 Kellner's PPF group acquired a biotechnology firm called Sotio, originally started by Dutch investors and two prominent Czech immunologists who were researching dendritic cells and their use in cancer treatment. In the same year, Sotio found its way into an international business incubator in Beijing. However, to penetrate the Chinese health-care market, given its specific nature and regulations, the company needed support from a particular ally—the Czech state. Sometimes it is difficult to say where the Czech state ends and private enterprises start; the fact nevertheless is that Czech-Chinese collaborations in the field of health care emerged almost simultaneously with Sotio's business plan. The revival of agreements premised on "friendship and cooperation" that existed in socialist times created a new blueprint for boosting corporate business. If there were vaccines, laboratory equipment, clinical trials, or medical beds moving in one direction, to China, there should "reciprocally" (a word used by all our informants involved in this process) be pharmaceuticals, spa patients, and CM, China's "national treasure," moving in the other direction.

Although CM had been marketed to Czech health-care officials from the moment of their first contact with the Chinese side in 2012, and many of them had visited CM universities, hospitals, and pharmacies or seen live demonstrations of CM diagnostic procedures and treatment, it was only in late 2013 that an official agreement was reached to establish a CM clinic in a public university hospital, providing CM with entry into the Czech public health-care system. The Chinese side would provide know-how, practitioners, and yuan for a new building to be built in the university hospital's complex. An important role in this agreement was played by a renowned Czech medical professor and then director of the public university hospital where the clinic was to be established (and since 2017 deputy minister of health). It seemed a perfect match when this professor became an instrumental figure in legitimizing the introduction of CM into the CR through the government initiative. Given his excellent career in vaccinology, who would dare question his commitment to this bona fide science and EBM. By his own account, when he was a member of the governmental delegation to China in 2013 and was asked in what field his institution could collaborate with the Chinese side, the professor realized that Chinese biomedicine offered little for the

Czechs to learn from. Yet when presented with CM he came to the conclusion that it was actually something he "knew about from the West," and particularly from the United States, where some prestigious hospitals and clinics have integrated CM into their health services. He decided his hospital would follow suit.

First, bringing in "genuine" Chinese experts in CM (also educated in biomedicine) would set professional standards for practitioners of CM in the CR and safety standards for CM patients, who would be treated in an established institution recognized as part of the state's health care system. Second, it would prove that methods of CM are economical: they could save money in comparison to the usual expensive usage of pharmacology or medical technologies. And last, CM would be proved effective in terms of treating particular maladies, such as chronic pain, or treating the side effects of radiotherapy in oncological patients. After some delays in and renegotiations of the initial plan, construction has begun in 2017 on the joint Czech-Chinese CM clinic. It is fully funded by a donation from CEFC China Energy Company Limited, a Chinese company operating in the Czech Republic. The plan is for the clinic to be operated jointly by the Czech public university hospital and Shuguang Hospital in China (CT24 2017).

Supporters of the project have already put much effort into identifying ways of combining CM with biomedicine to form a hybrid without, however, challenging biomedicine. Let us now look in more ethnographic detail at one instance of these efforts. What follows are our field notes from a meeting that took place in a luxury Chinese restaurant in Prague in April 2015, which brought together a group of Chinese practitioners, business people, and officials interested in bringing CM to the CR as part of the aforementioned initiative and two Czechs, a lobbyist, and a bioscientist (employed at a public university and running his own biotech firm). Also present were an interpreter and one of us (Jaroslav Klepal). The Chinese delegation and the lobbyist visited the State Institute for Drug Control before coming to the working lunch.

> As soon as we sat down in the restaurant's private room, the bioscientist pulled out two pill bottles and explained to us that these Chinese herbal medicines prevented him from catching a cold or even an inflammatory disease. Without them he would not be here today. The Chinese guests became interested. Who produces these herbal medicines? How can we get them into the CR? What exactly do these pill bottles contain? Together with the bioscientist we tried to answer their questions. Medicinal herbs are grown in Taiwan; they travel to Belgium, where they are processed by a firm; and then they go to laboratories in Switzerland for testing. They get here through a Czech physician and practitioner of CM from a provincial town who has practiced CM for many years and established a small business for importing and distributing these herbal medicines. The bioscientist's bottles circulated around the table. The Chinese guests examined the packaging. Some of them opened the bottles to see and smell what was inside. They asked the interpreter to read to them the information on the bottles. After a while a man in the Chinese delegation pulled out his own pill bottle. The man was a sales representative from a Chinese pharmaceutical company that specializes in producing "traditional herbal medicines." He handed the

pill bottle over to us, the Czech hosts. The simple plastic bottle was covered only with Chinese signs. Inside we found pills without any smell. Their shape and color resembled painkillers you can buy in any Czech pharmacy. A lively discussion broke out about what the pills and their packaging looked like. The lobbyist repeatedly stressed that it was necessary for Chinese herbal medicines to have Western features. This was a lesson they had learned from their visit that day to the State Institute for Drug Control. Herbal remedies just comply with state legislation, so no medicinal claims, Chinese or otherwise, can be written on the label. Instead they should show the names of the herbs used in them written in Latin and the recommended daily dosage. Remember, the Western features are important. Owing to the current legislation it would not be possible for Chinese herbal medicines to reach patients as "medicinal products." They would have to be registered as "dietary supplements," and because of this any information about their curative effect would have to be omitted from the packaging.

The Chinese delegation listened carefully to the lobbyist's words. Western features? Sure, that's no problem. Look at the herbal medicines we brought with us. Look at our pills. They look more Western than those the bioscientist showed us. However, for the Chinese visitors it was somehow problematic that the information about the curative effects of their herbal medicines could not be included on the packaging. They are not dietary supplements; they are medicinal products! And they want them to be medicinal products because in that case they can be covered under public health insurance and patients will be able to afford them and benefit from them. The lobbyist explained again that at the moment the only feasible way to get their herbal medicines into the CR would be to register them as dietary supplements. This is required under the state's current legislation. To change the legislation to accommodate Chinese herbal medicines would take time. What is important at this stage with respect to their "experiment" with CM in the public university hospital is to get herbal medicines here, to the CR. (field notes by Jaroslav Klepal, March 2013)

This meeting can be understood as an instance of "worlding" whereby knowledge and world making take place simultaneously through various mundane encounters between people and things, not by the globalization of ready-made technologies or cultures (Zhan 2009). As we could see, things do not travel in any pure form in this process. As at the Health Ministers meeting in May 2015, in Prague, where hundred-year-old needles were presented in the same display window as high-tech electro-acupuncture devices and diagnostic computer software and a quote from the Constitution of the People's Republic of China was highlighted that read "The state promotes modern medicine and Traditional Chinese Medicine to protect the people's health," the Chinese delegation stressed at the lunch meeting that Chinese herbal medicine is already mixed with biomedicine in China, where attempts to integrate the two systems have been under way since the Maoist period (Scheid 2002; Zhan 2009).[3]

[3] These kinds of integrated approaches seem to be common across East Asia. Similar combinations of modern Western and traditional Eastern medicine have been documented and studied in Vietnam (Wahlberg 2014) and South Korea (Kim 2006).

This mixed nature of their medicine should have been an asset, from the Chinese delegation's point of view. It, however, is not Westernized enough for EU legislation: CM information cannot be printed on the pill bottles in the CR because of the regulation of pharmaceuticals, and Chinese herbs cannot be imported as "medical drugs" without making a great effort to translate their effects into the language of biomedicine. For representatives of the Czech Medical Chamber, the Chinese "integrated approach," unlike medical acupuncture, does not adequately prioritize the biomedical protocol of EBM. And, interestingly, "integrated medicine" is also largely rejected by Czech practitioners of "traditional" CM for giving too much space and weight to biomedicine, thereby depriving CM of the autonomy that it has been fighting for since its emancipation after the change of regime in 1989. Their patients, they would claim, are not seeking biomedicine in a new guise but something fundamentally different. At first glance it seems that everyone is obsessed with purity in the Czech context, which is consistent with Law and Lin's (2017) argument about the dominance of Western analytical terms. However, as we will show, current efforts to "normalize" (Wahlberg 2008) CM in the CR are much messier and more complicated when there is more detailed scrutiny.

## 3 Translating CM into EBM, Rendering the Hybridity of Biomedicine

A forerunner to the stand-alone CM clinic in the public university hospital mentioned above, the Czech-Chinese Centre for Traditional Chinese Medicine Research, opened to the public with a small affiliated outpatient department in September 2015, a few months after the center's opening ceremony, in the presence of Czech and Chinese ministers of health, high-ranking politicians, and a representative of the World Health Organization (*Global Times* 2015). There were two main reasons for starting with this research center. First, practitioners from China cannot legally provide medical care in the CR as their medical degrees are not recognized in the CR under the state's current legislation. They can only be granted a short-term exemption by the Ministry of Health, or they can work in the position of researchers. Second, the plans to introduce CM into the Czech public health care system provoked a strong negative reaction from some parts of the medical establishment, with the Czech Medical Chamber declaring that nothing like traditional CM exists at all and introducing such a thing into the public health care system will open a Pandora's box of charlatans and unscientific approaches (Cikrt 2014; DVTV 2015; Tesař 2015). The proponents of the CM project insist in this context that the introduction will proceed on a strictly scientific basis and that the center is presented as a way of establishing domestic evidence about the efficacy, safety, and profitability of the CM treatment—the center has been conducting a trial concerning the use of "acupuncture in migraine prophylaxis in Czech patients" since October 2015 (Valis 2017). It should be no surprise that the collaborating Chinese institution is Shuguang Hospital, affiliated with Shanghai University of Traditional Chinese Medicine, which since its inception in 1956 has promoted a "Shanghai style" of CM that embraces and applies biomedical concepts and methods (Zhan 2009). Public exchanges in the media between a proponent and an opponent of the CM initiative usually look like this one, between two renowned professors of medicine transcribed from a radio program:

> The reporter asks about the benefits of CM for Western patients. A professor, who is the head of the hospital introducing CM, responds, "Look at the websites of prestigious US universities and hospitals where it is offered as a standard complement to Western biomedicine. Certain elements of CM are appropriate in particular for the treatment of pain and the side effects of oncological treatment."
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> A professor opposed to CM, who is the head of the nephrology clinic at another university hospital, responds that he agrees that perhaps CM is often used in the West, but says that CM is conceptualized in a way that it could add anything meaningful to European biomedicine. It is a culturally specific phenomenon which can surely be studied but is based on prescientific principles; its theory is unscientific and its methods are in principle untestable. He is afraid that to establish CM by law as an official branch of medicine would create room for it to become an "'alternative" (not complementary) to established methods.
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> The professor defending CM says that it is absurd he is labeled a charlatan. "Look at my scientific qualifications and work—I have published six papers in *The Lancet*." Enough scientific work exists that clearly proves acupuncture works. ("Pro a proti" 2015)

While proponents and opponents of CM disagree on whether CM can be subjected to scientific testing, they basically agree that only the version of CM translated to biomedical protocol can be allowed to enter into the public health care system. This translation concerns not only diagnostic procedures and treatments but also the scientific control of imported Chinese herbs in the country and their registration. As the Czech lobbyist emphasized at the lunch meeting with the Chinese delegation described above, Chinese herbal substances have to speak in Western scientific language and conform to the language of state legislation.

This surely looks like hegemonic scientism (Farquhar 1987). While the official imperative in the CR is to translate CM into biomedicine, it would be wrong to identify the Czech medical establishment that is involved in normalizing CM in the country with hegemonic scientism. When in research interviews with us the proponents of the project reflected on their everyday life and work as medical professionals or health-care managers, the self-confident hegemony of Western biomedicine was much weaker. A physician, health-care manager, and a former minister of health who was active in negotiations with the Chinese in the early stages of the project talked at length with us about his skepticism about the procedures and results of randomized clinical trials, about the huge share of non-EBM methods used in everyday treatments, and about the placebo effect that occurs inside biomedicine (research interview, February 2015). Similarly, the current deputy minister of health and then director of the university hospital that opened the Czech-Chinese Centre for Traditional Chinese Medicine Research argued that even though the efficacy of CM might be difficult to prove in standard biomedical clinical trials, it still makes sense to make use of it, regardless of whether we are dealing with placebo or not. During an August 2015 research interview, he told us, "If there will be a placebo effect of, let's say, 26 percent and produced almost gratis, with the use of needles, I'll be happy. We have a number of methods in biomedicine that are not as effective and we pay a lot of money for them." Many Czech physicians would also agree, especially in private conversations, with Dr. Hsu (featured in Lin's 2016 article) that their "accumulated experience on clinical cases" is

more important in their practice than lab experiments published in Science Citation Index journals (Lin 2016: 4).

We can see that while translating CM into EBM may have the effect of taming the correlativity of CM, the process sheds light on the hybridity of biomedicine itself. The critics of the current Czech-Chinese initiative may be right in suspecting that CM's entry into public health care opens up space for reflection on the uncertainties in biomedical knowledge and interventions, the use of placebos in biomedicine, or the economic interests invested in the production of evidence through randomized clinical trials. Moreover, economics is no less important than epistemics in CM's current move into the CR. Unlike the postcolonial situation depicted by Lin and Law (2014) in Taiwan, China is not arriving in the CR as a poor relative. It is coming as a massive investor (Fürst 2015). As such, the CM's current expansion is powered, and perhaps crucially so, by Chinese yuan. We shall come back to this point after discussing in the following section another mode of relating biomedicine and CM in the CR today.

## 4 Cultivating the Autonomy of CM—with the Help of Biomedicine

Czech CM practitioners working under the umbrella of the Chamber of TCM are aware of the Czech-Chinese governmental initiative, and some of them participate in it. They do so, however, with some reservations. While they are interested in securing recognition for CM in the Czech health-care system, they don't necessarily have the same interests as the proponents of the initiative. They are not primarily interested in having their herbal substances registered as medicinal products. CM herbal substances currently sold in the CR as dietary supplements are presented as "natural" and their "naturalness" is valued in contrast to the denounced "chemical," "toxic" nature of pharmaceuticals. Registering the substances in the CR (and the EU) would require that they look and operate as Western as possible, whereby they would lose their ontological distinction from pharmaceutical pills. Simply put, some CM practitioners and patients we worked with do not want Chinese herbal substances to be and look "Western." With regard to the regulation of the profession, CM practitioners support this move (graduates of CM schools who do not have the title of MD are not authorized to provide health services and operate in a gray zone), but they are also concerned that the possible new regulation could be unfavorable to them. They are afraid it may focus on securing authorization for practitioners from China to provide treatment within the Czech system and the current Czech practitioners would all be completely shut out.[4]

Most important for our argument, the Czech CM practitioners we worked with insist on the ontological and epistemological difference between biomedicine and CM itself. CM practitioners are not opposed to biomedicine in principle, and they often work with the lab tests and documentation that patients bring to their offices, but they cultivate the

[4] The amendment to Act 96, 2004, on the conditions of obtaining and recognizing qualifications for nonmedical professions and activities related to the provision of health care, which is being discussed in the Czech Parliament in 2017, proposes regulating the professions of TCM therapist and TCM specialist on the grounds that "today a number of subjects operate on the territory of the CR [and] claim that they provide traditional CM, but it is impossible to unequivocally verify their education and the extent and quality of the provided care" (Vyzula 2017).

ontological and epistemological autonomy of CM. "TCM cannot be translated in any way into our modern language. To attempt to do this is to do 'integrated medicine'—that is death! . . . The integrated approach is not about having an internist's office and acupuncture working side by side. That's OK. The integrated approach is what they do today in China, which means doing pulse diagnostics and CT at the same time. This is done by one person and it can only be done if I just learn one-half of this and one-half of that, which means in fact to abandon both the treasure (of CM) and quality bioscience," exclaimed Dr. Zelený during a July 2015 research interview with us. He insisted that he is only in favor of integration if it respects the original Latin meaning of *integrare*, which is "to keep something whole and intact."

"Forget everything you know about biomedicine," is an often-repeated instruction that patients hear at Zdraví. The practitioners at this clinic also often warn their patients that a biomedical and a CM "liver" (and other organs) are homonyms and the difference between them must be remembered. The head of the Chamber of TCM believes that it is possible to gradually develop an awareness of the distinctive meanings of concepts that biomedicine and CM only seem to share. He argued in his university course, Introduction to TCM, that for medical students that like the word *mouse*, which quickly acquired new meaning as a piece of IT hardware, one must be sensitive to the specific meanings of concepts in CM, such as the liver, which refers to a system of relations within and beyond the body and is not just an organ. Dr. Zelený explained his view of the biomedical concept of the body and biomedical diagnostics when we asked him in a research interview what happens if someone comes to him with a biomedical liver test or results from computer tomography: "I'm very happy I'm a physician; I can look at it and I understand it. I think about what are my limits for this disease. You're taking pharmaceuticals? OK. And then I close the test results, slant my eyes and do China. And at the end I say: repeat your liver test in a month. But I will not do acupuncture for the liver, I will treat the person in my own way."

He takes both types of medicine into account, yet clearly differentiates between the biomedical and the Chinese body and disease. He even portrays his own body as a (stereotypical) Chinese one by "slanting his eyes." In the view and practice of Czech CM practitioners, the scientific dominance of biomedicine needs to be tamed and the autonomy of CM cultivated. There needs to be a buffer zone protecting CM. These Czech practitioners understand and strive to practice CM as something fundamentally different (though not necessarily contradictory) to biomedicine. One important reason that these Czech practitioners favor CM when they are treating chronic medical conditions in particular is that, unlike biomedicine, CM treats the "causes of a disease," not just its symptoms. In the same vein, they also criticize the current trends in CM they witnessed when they visited China for having incorporated elements otherwise usually associated with biomedicine—most notably the lack of a personal approach to patients, manifested, for example, in a decrease in the amount of time set aside for interviewing patients or the use of "too many needles" (instead of inserting a smaller number of needles into well-chosen acupoints that suit the individual patient). They view "Chinese" CM as an industry that resembles the kind of hospital "factories" they know from their previous experience as medical professionals during either the socialist or post-socialist periods.

This stance is far from correlative. It orientalizes and essentializes "traditional" CM. Practitioners associated with the Chamber of TCM look to ancient, not modern-day,

China as the source of authentic CM, or now to the West, where CM migrated before being distorted by the biomedical industry in China. Similarly, Chinese herbs grown in China are imported to the CR through Western countries in order to be purified of the traces of dirty industrial modernity—heavy metals and other pollutants. For these Czech CM practitioners, the correlativity of CM in China in fact seems self-destructive as the endless hybridization leads to the contamination and the ultimate evaporation of CM.

Notwithstanding this categorical rejection of (Chinese) integrated medicine and despite the imperative that greets clients on their first visit to Zdraví that they "forget everything about biomedicine," the relationship to Czech biomedicine we observed in practice at Zdraví is more nuanced. The head of the clinic told us that she created the diagnostic questionnaire Zdraví uses by "drawing on what we had in internal medicine and adding CM to it." When staff at the clinic meet with clients, especially the ones who are more seriously ill, biomedicine is not only taken into account, it may actively be drawn into play. The account below describes a consultation between a doctor at the clinic and a woman who had gynecological problems but refused to go for a sonogram.

> While we're walking to the consultation room, the head of the clinic, Dr. Živá, tells me that this is a complicated case. The woman has an abdomen full of fibroids but refuses to go for a sonogram. She has been coming to the clinic for roughly two months. When we enter, the client already has acupuncture needles applied to her back, but she is sitting up, not lying down. Given the size of her abdomen, she may not even be able to lie comfortably. Dr. Živá removes the needles and asks if she has been for a sonogram. The woman says no, but her response is somewhat confused and suggests that she thinks that a sonogram is an X-ray and that it is harmful. Dr. Živá tells her this is not true. It is apparent that the woman prefers everything "natural" and tries to avoid biomedicine altogether.
>
> The woman is concerned that if the results of the sonogram are bad the doctors will pressure her to undergo surgery. Dr. Živá repeatedly stresses that sonography does not equal or imply surgery and promises her that if she goes for a sonogram they will then treat her at the CM clinic. "If you don't go, they will arrest me," Dr. Živá insists. "What?!!" the woman exclaims, "this is my business." "If you don't want to do it for yourself, do it for me," Dr. Živá tries to persuade her. Then she starts talking about herself. Six months earlier she too had been diagnosed with a small fibroid during a check-up with her gynecologist. It looks as though all women suddenly have fibroids nowadays. This does not mean that women didn't have fibroids before, but diagnostic equipment is more precise now. Her gynecologist in fact told her that she had recently acquired a new machine. Dr. Živá continued to explain her own case and that the gynecologist had told her that fibroids respond to hormonal activity and disappear, so given Dr. Živá's age the gynecologist would not suggest surgery. Dr. Živá told the gynecologist that she could "make the fibroid disappear with needles." "So do it," the gynecologist supposedly replied. Dr. Živá tells us that this means she would have to go "under the needles" herself, which she does not like. "After all, I'm a 'Western doctor,'" Dr. Živá stresses, "and if it's not essential and the fibroid will probably disappear on its own, I am not keen on it."

> When we asked later how the treatment proceeded, Dr. Živá told us she had ceased treating the woman because she refused to get a sonogram. (field notes by Tereza Stöckelová, April 2015)

There is no one way in which biomedicine manifests itself at the CM clinic. At some points it may be entirely displaced and at others called on and mobilized, as we show above in the description of consultations with one patient. It may sometimes be treated as incompatible with CM and other times and for other purposes as perfectly compatible, all the while maintaining claims about the ontological distinctiveness and autonomy of CM. We might call this incoherence, but as Annemarie Mol (2002) tells us, incoherence is a mundane part of medical practice. The key point in our argument is that there is no single "source" language or ontological stance that we as researchers can adopt and remain loyal to. We shall now discuss this issue in conceptual terms, going back to the initial argument put forth by Lin and Law (2014) and Eduardo Viveiros de Castro (2004).

## 5 Whose Others' Terms?

Lin and Law (2014) suggest that the *correlative* approach in theory and practice is contrary to the established (Western) STS canon, which is *analytical*. STS has brought a desirable symmetry into the analysis of Western and Other forms of knowledge and practices, but this still happens in Western terms. A more radical move needed according to the authors is to explore ways of articulating the symmetry in the Other's terms—terms that would be grown out of Amerindian societies, Taiwan, or the People's Republic of China (15).

Such formulations make us strongly reflect on our own positioning. Given the fact we come from the "Second World" in Central Europe, where the life of the social sciences (including STS) was somewhat erratic in the second half of the twentieth century, we cannot easily say that the terms of STS are ours. Scholars in this part of Europe have shaped the current STS vocabulary significantly less than have scholars from Western Europe and the United States. Twenty-six years after the change in political regime in 1989, there is no study program in STS in the CR, and research is only slowly finding its (institutional) feet. On the other hand, it would be misleading for us to position ourselves as alien to the terms and style of reasoning of Western STS (and other social sciences). While our mother tongue is Czech, we tend to speak English, French, or German more than Chinese, and our fellowships have taken us westward not eastward. And regarding medicine, we have been brought up and medicalized primarily by biomedicine and in a biomedically driven (socialist and later postsocialist and capitalist) health-care system.

With the feeling that we don't easily fit either in the "West" or the "'Other" world, we are not interested in claiming our own "third" way. Nor do we see ourselves as a "bridge" between the East and the West, which is a rhetorical and a visual metaphor used by the Czech-Chinese governmental initiative.[5] We actually want to argue that

[5] The Charles Bridge in Prague was used in the logo for the Health Ministers Meeting in June 2015 to smoothly link Prague's Old Town with the profile of a Chinese city.

geographical metaphors are not useful for developing a critical disciplinary reflection of STS. Suggesting that terms have a clear geographical or geopolitical origin in fact replicates the (Western) obsession with purity. Instead of associating particular ways of knowing and intervening in the world with certain geographic locations, we are inclined to see those forms of knowledge as distributed and their origin always already impure. Unlike Lin and Law, who, however carefully, start from the big categories of "Western" and "Other" ways of knowing and intervening in the world (2014: 2), we suggest exploring the different ways (in both social science and medicine) without tying them strongly (that is conceptually) to different geopolitical parts of the world.

In highlighting several versions of CM that were enacted in the socialist and post-socialist CR we have shown that there is no single ontology of CM that could correlate with or counter the Western/colonial/purified/analytical ontology of biomedicine. Rather, we observed how various actors, such as the Chinese that brought CM to the CR in a recent government initiative, Czech medical doctors, and Czech CM practitioners, switched and moved between different ontological-cum-epistemological stances on the bodies, knowledges, and technologies. While they seek purity in some contexts, they invite hybridity in others. The switches and moves may be strategic and planned in their purpose, yet are also the result of the inconsistence and uncertainty that characterizes their ontological commitment.

There is no singular source language that we as researchers can resort to. There are multiple source languages mobilized by people and things (such as medication boxes) in the field. Unlike Lin and Law in Taiwan, we didn't encounter any easily correlative CM in the CR but rather various ongoing struggles and transactions over which attachments and translations in CM medical practice should be cultivated and how, and which should be abandoned. We believe we have to take seriously not only the multiplying attachments but also various detachments of CM, as they are strategically done by Czech biomedical practitioners, Czech CM practitioners, and Chinese politicians, government officials, business people, and managers currently exporting CM to the CR. If we say that the versions of CM practiced by Czech CM practitioners, medical acupuncturists, and the Chinese business-political establishment are only impure variations on the original version (and are less correlative than the version that existed in the Yellow Emperor's China), we would apparently be essentializing CM in the name of preserving its correlativity.

On the basis of our study of CM, we would claim that if the different ways of knowing were ever characteristic of specific geopolitical regions, such as China or (Western) Europe, these associations have nowadays grown looser to the extent that using the geographic labels (even if carefully) obscures more than it helps to clarify. STS rather needs to trace how the different ways of knowing and intervening in the world travel and get transformed in different places. Having said that, we are aware of the huge geographical and geopolitical asymmetries in STS and (social) science knowledge production, and we fully share the concern of Lin and Law (2014) and others about "provincializing" or decentering STS (Stöckelová 2012, 2013). Based in Central Europe, we observe, like Lin and Law (2013), that the "Taiwanese university campus looks very like one in Michigan with the same kinds of departments and concerns: journal publication, rankings, the Science Citation Index, and all the rest" (10). Or if campuses in many parts of the world don't look like the one in Michigan, they at least wish to look like them; or at least they claim they wish to do so. In our view,

however, it would be too easy to say this is a product of "a colonization by 'Western' ideas" (10). Even if we viewed companies like Technopolis that give advice on the restructuring of non-Western universities as "colonizing armies," we need to acknowledge that these armies were called for and contracted by local policy makers and academics in the countries whose research systems and academic institutions were to be transformed. As one of us argued in relation to the CR, domestic actors have more agency in these processes than the postcolonial dictum would suggest (Linková and Stöckelová 2012; Stöckelová 2015). It is strategically used by actors for various purposes, including, perhaps paradoxically, in a way that the recognition conveyed by rankings and the Science Citation Index may allow domestic academics, at least in the social sciences, to pursue more politically, theoretically, and empirically radical projects (Stöckelová 2016).

We may well agree that in order to cultivate creative, diverse, and meaningful social sciences, and medicine for that matter, we need to build correlative links and alignments across scholarly communities. But these links and alignments don't seem to be a result of specific non-Western modes of knowing and doing, in the same way that the domineering modes don't seem today to be exclusively driven by the West. The clear-cut geopolitical labels of "West" and "the rest" may not be a particularly useful way to understand the current world asymmetries, hierarchies, and inequalities.

Equally, we should be careful about making generalizing claims about China and Chinese practical ontology. Even if Lin and Law insist on the specificity of their Taiwan-located study of CM (2014: 5), in the companion paper titled "Making Things Differently: On 'Modes of International,'" the authors make a far-fetched argument about the possible different modes of international that could be an alternative to the Western, analytically driven expansion that has been going on since the sixteenth century. Drawing on their study of CM, they speculate about a possible "correlative international" that is "flexible," "subtle," and minimalist (Lin and Law 2013: 12). In effect, the "international" itself would dissolve, as there would no longer be a single space within which actions take place. The authors conclude by asking what would the world have been like had the Chinese not withdrawn from the Western Ocean in 1433? "The answer is that we will never know," they say (2013: 12).

We may never know what the world would have been like if the Chinese had not withdrawn from the Western Ocean in the fifteenth century, but we are starting to learn what the world will be like when China goes global in the twenty-first century. "TCM goes global" was indeed the name of one of the panels at the Health Ministers Meeting. Apart from introducing CM through the Czech-Chinese initiative, Chinese business is interested in Czech health spas, which have a long tradition in the CR. A Chinese development company called Risesun signed a contract in June 2016 to construct a new spa, Pasohlávky, on a greenfield in South Moravia. The Chinese are supposed to invest around EUR 70 million in the project and the spa should become the biggest spa resort in Central Europe (iDNES.cz 2016). On a correlative note, it should combine European spa care with methods of CM. However, it does not look like a very minimalist, supple, or subtle mode of going international.[6]

[6] For a view of the project, see iDNES.cz (2016).

We want to argue that in their apt critique of the (Western) expansionary mode of international, Lin and Law (2014) have, in fact, essentialized the (potential) Chinese mode of international as an alternative. Even if correlative and flexible in relation to local medicines and biomedicine, the ongoing Chinese expansion looks more similar to than different from the Western mode of international with its focus on economic growth and capital accumulation. And it correlativity looks like a good therapeutic and market strategy at the same time. A presentation one Chinese doctor and director of an orthopedic clinic at a general hospital made at the Health Ministers Meeting in June 2015 was especially instructive. He was very syncretic, not only when he stressed the need to combine "ancient knowledge" with the "most modern biomechanics" but also when he presented the global success of their CM practices. We were able to witness that this was what made some of the Czech medical officials who were present truly uncomfortable. The Chinese doctor stressed that his clinic is collaborating on projects worldwide, including in such places as Cuba, and he read out a list of their "VIP patients," which included the North Korean "supreme leader," Kim Il-Sung, who, after being cured at the clinic, allegedly declared it "the national treasure not only of China but also of North Korea" (field notes by Jaroslav Klepal, June 2015). Such inclusive and in fact correlative geopolitics was apparently even more unacceptable to some present in the Czech audience than was the idea of mixing CM and biomedicine.

As mentioned above, the import of CM has been closely connected with China rediscovering the region of Central and Eastern Europe and, in the opposite direction, with the activities of PPF investment group and in particular Sotio, its biotechnical company, moving to China. Currently, Sotio is developing therapeutic vaccines for the treatment of prostate, ovarian, and lung cancers (diseases that take a huge toll on the Chinese population) and experimenting to incorporate CM into particular stages of treatment design with an imminent interest in introducing them to the Chinese market once they are approved.[7] It probably comes as no surprise that it was also PPF group that was the main sponsor of the Health Ministers' meeting. And it was PPF group that, via the Czech-China Chamber of Collaboration, sponsored the treatment of some one hundred twenty Chinese children suffering from respiratory diseases at a Czech spa resort and sponsored the establishment of the Czech-Chinese Centre for Traditional Chinese Medicine Research. The Western and Chinese modes of international cannot be neatly separated. Given the economic capital of contemporary China, its hand in shaping these processes can hardly be overlooked or superimposed by the analytical terms of either Western colonialism or postcolonialism.

## 6 Conclusion

Inspired by and drawing on the proposition of Lin and Law (2014), in this article we traced CM and its relation to biomedicine in the CR and further explored the possibilities and limits of the decentering and correlativity of STS. Lin and Law (2014) argued for a correlative STS that would develop an appropriate mode of betrayal in the

[7] Clinical trials in various stages are under way for the three vaccines; see www.sotio.com/clinical-trials/clinical-trials.

process of translation from a source language (the language of the realities under study) to a destination language (the language of Western analytics). So far, STS has betrayed the source language much more than the destination one. And this should rather be otherwise in the view of Lin and Law (2014).

In our CM case study, however, there is no single and coherent source language of CM to be—or not to be—betrayed. CM in the hands, words, and eyes of different practitioners was variously enacted, and variously integrated with, translated into, routinized as, or differentiated from biomedicine, depending on economic and political interests, legal possibilities, and actual medical encounters with individual patients. We are *not* the ones purifying in analytical terms a syncretic and correlative practice. It was in the first place the CM practitioners and other concerned actors who variously engaged in purifications, translations, or hybridizations or who even "slanted their eyes." They did not stick to a unique and stable ontology of "their own" but *ontologized*. They don't *have* ontology, they *do* ontology, and do it in various ways. On this point we think David Graeber is right when he identifies a conservative tendency in some streams of the "turn to ontology" in writing and criticizing it. "Indigenous" ontologies are dynamic, not stable: doubts and hesitations, sarcasm and jokes, reflexivity and strategic switches are part of the game, as Graeber (2015: 7) reminds us. If STS stayed true to tracing how reality is done, and not what it is in general terms, it would be foregrounding the actors' ontological moves and modes and how they are, translocally, tinkered with. And if we must at all speak in the morally loaded terms of a betrayal on the part of researchers, then this betrayal is better tested and substantiated in actual research scenarios than in efforts to solve these issues for the discipline as a whole.

This is not to say geography and geopolitics do not matter. However, based on our case study we argue that STS should be more attentive to the changing geopolitics and world political economy. Today Prague, Shanghai, and London can, in many respects, be even more closely connected, owing to the existence of various "silk roads," than places within Europe or even within individual countries are. Not only must we acknowledge that knowledges and practices historically cultivated primarily in Western settings, such as biomedicine, have been actively, creatively, and syncretically "worlded" in other places, we also have to be attentive to the possibility in the currently changing world political economy that the dominating expansions may stem from "non-Western" locations. STS should cultivate methodological and theoretical approaches that enable us to trace the multiple and sometimes contradictory sociomaterial, political, and economic asymmetries of today's world.

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