Introduction: ways of learning

Chinese medicine is grounded in medical practice and in texts – in experience and in its transmission from one generation to another. It changes over time as its social and historical contexts change, but these changes do not occur uniformly. This book explores variations of key terms in Chinese medicine and examines ways in which they are understood in different social contexts. In particular, it concerns the extent to which the understanding and social significance of these terms depend on the way in which they are transmitted and learnt.

Why should the understanding of specific concepts depend on the way in which they are learnt? Knowledge is generally assumed to depend on what one has learnt, regardless of how one has learnt it. This study contests the idea that there are contents of knowledge that can be transmitted and learnt regardless of how the actors involved, in their social relationship to each other, relate to knowledge. It shows that styles of knowing differ according to one's perception of and attitudes to knowledge, and that the meaning of the same term may change as the ways change in which one perceives, expresses, uses, credits, orders, and applies knowledge. The underlying question in this book is thus how far the way in which one learns these terms determines the way in which one knows them or, simply, how different ways of learning relate to different styles of knowing.

Modes of transmission

Central to this study are the ways in which Chinese medical knowledge and practice were transmitted and learnt in three different social settings. These different modes of transmission may be called 'secret', 'personal', and 'standardised', terms which refer primarily to the observed relationships between the medical practitioners and their acolytes, while simultaneously accounting for overall features of the settings in which the transmission of medical knowledge and practice took place. The 'secret', 'personal', and 'standardised' modes do not describe idealised

types; they were not starting assumptions nor hypotheses I set out to test, but have arisen from an interpretation of ethnographic data and correspond, in that sense, to the conclusion of the study.

'Secret knowledge' is much discussed in the anthropological literature, although it is in fact the process of transmission that is secret. This secretly transmitted knowledge is not to be confused with 'tacit knowledge' that refers, in contexts in which knowledge is proclaimed to be open and accessible to anyone, to those aspects of a practice that are transmitted without being explicitly mentioned. Secretly transmitted knowledge is intentionally made secret, and this is crucial for the social relationship of those involved. It may very well consist of explicit statements which may be the same as those transmitted in other ways, but the ways in which one knows them – their powers and dangers – differ significantly.

The personal transmission of knowledge and practice tends to be subsumed under the secret transmission of knowledge but my fieldwork observations call for singling it out: it depends critically on the personalities of mentor and follower and their choice to maintain a personal relationship of mutual trust within which the follower acquires medical knowledge and practice. The historical and crosscultural perspectives underline the relevance of these observations: the personal transmission of knowledge, as observed in ethnographic fieldwork, shares several features with the way in which Chinese medicine, according to textual records, was practised and transmitted among the literate elite in Imperial times, and some of its features are also found among the traditional elite in India and other parts of the Far East, the Hellenistic and Islamic world, and medieval Europe.

The standardised mode of transmission is generally considered a form of 'Westernisation', 'modernisation', or 'professionalisation', although it is in no way specific either to Western culture or to modernisation. Particularly in China and probably also in other highly stratified societies with a literate elite, government efforts to standardise medical knowledge and practice have a long history. In the People's Republic of China (PRC), *guifanhua*, 'to standardise', is the word with which many doctors in government institutions describe their endeavours. The notion of standardisation that I use as a meta-category for ordering ethnographic material is thus derived from the actors' point of view.

Styles of knowing

This study was designed to avoid discussing Chinese medical terms decontextualised from social practice, as is so common in textbooks and

textbook-like monographs. The aim was to focus not on words and concepts but on utterances and verbal reasoning in social practice. Moreover, I declined to approach this reasoning in terms of Western philosophical categories, valuable as such studies have been (e.g. Hutchins 1980; D'Andrade 1996:193–9).[1] Instead, I intended to become immersed in it, much as Duden ((1987)1991) leads the reader into a world of flows and stagnations – the monthly blood being 'stubborn', wind coming out of the ears, milk flowing off through the stomach, being excreted as the very same white fluid, and sweat smelling like the elderberry juice just drunk – which all give rise to women's illnesses, thereby revealing how a doctor of the early eighteenth century reasoned about mind–body processes.[2]

While historians like Duden must be content with an archaeology of textual fragments, anthropologists can observe the actual incidences of reasoning as social practice. The aim of my research on Chinese medical reasoning was to focus on the situation in which it took place, to account for the actors involved – it went without saying that their social positions determined much of the significance of their assertions – and I was attentive to the variation and variability of access to specialised knowledge and practice. Concepts are not shared to the same degree among the members of a group; some know things others do not know, and some can say things improper for others to say. A statement is not the same if uttered by a child or an elder. Depending on the audience, things otherwise not mentioned can be said. Individuals differ: 'Some people are quick to see the point of a joke, others are slow. Some see a suggestiveness about it which others miss. Some have fertile, inventive and daring imaginations; others, more stolid, remain earthbound, literal, and poetry is lost on them' (Lewis 1980:6). Dispositions change: 'We differ in our preoccupations, our moods, the state of our desires, in our readiness to see something' (p. 116). Reasoning is a creative act. Utterances are not propositions. They have pitch and intonation underlining the mood and modality in which they are uttered. They may be more expressive than descriptive and have a 'speech appeal' (Bühler (1934) 1982:28–9). They may represent an 'illocutionary' or 'perlocutionary' act (Austin 1962:109). They need not be well-formed to be understood, and people attribute different values to them depending on the actors and the occasion.

[1] Hutchins (1980) has provided a formal analysis of how the Trobriand Islanders, deemed incapable of intentional and causal reasoning, did in fact make logical inferences during disputes concerning land ownership.

[2] Duden claims that these recordings reflect the women's own perceptions, but this is difficult to know. They certainly are not to be mistaken for representing the scholarly Galenic traditions.

Verbal reasoning, just like ritual, can be over-intellectualised. In Chinese medicine, we are often confronted with concepts comparable to 'empty notions' such as *evur* (witchcraft power) among the Fang (Boyer 1990:24–45). Boyer has convincingly contested the structuralist and intellectualist approaches to such *mana* concepts, which consider them either as central cultural symbols marked by a so-called 'semantic vacuity' (postulated by Claude Lévi-Strauss) or as 'theoretical principles' comparable to laws in the modern Western sciences (postulated by Robin Horton). The more viable approach to such empty notions, according to Boyer (1990:30), is to 'distinguish between several interrelated "registers" or "styles" of discourse'. He distinguishes between 'common discourse' which is generalising, not related to any precisely defined source of knowledge, and willingly inconclusive; 'gossip' which is very definite, centred on singular cases, and of no use in the contexts in which truths are supposedly expressed; and 'experts' utterances', which are definite, focused on singular cases, and fairly reliable. This study concerns almost exclusively experts' utterances. We will see that registers of discourse or, rather, 'styles of knowing' will vary even among experts, and the so-called 'empty notions' of Chinese medicine will be shown to vary accordingly.[3]

The notion of 'style' in the idiom 'styles of knowing' alludes to the aesthetic in art and literature, and in this sense it may also be used to refer to ways of doing science or medicine. When Fleck ((1935)1980) coined the term *Denkstil* (thought style), he spoke of 'style' in a slightly different way. A certain *Denkstil* belonged to a certain *Denkkollektiv* (thought collective): 'The force of explanation was dependent on the possibility of relating a term to other *stylistically matched* terms' (p. 51, italics added). While this aspect of Fleck's notion of 'style', which stresses the socially approved within a collective, should not be overlooked, I shall use the word 'style' more in Hacking's (1992) sense, emphasising fluidity and individualistic endeavour: 'Every style comes into being by little *microsocial* interactions and negotiations' (p. 10, italics added). 'Style' may be 'generalised' or 'personalised': 'There is a Balzacian style and there is Balzac's style. Equally, in swimming, there is the Australian crawl and freestyle, as opposed to the style of Patti Gonzalez, that can be imitated but is inimitably hers. It is entirely natural to talk of the style of an individual scientist, research group, programme or tradition' (Hacking 1992:2). I have investigated the styles

[3] According to Boyer (1990) all three registers of discourse together give the actors an idea of what is meant by *evur*. However, the Chinese actors discussed in this monograph had access to only one style of knowing.

of three individuals; whether these styles can be generalised remains to be seen.

The notions of 'reasoning' and 'discourse' refer to verbal interaction, while 'knowing' involves, in addition, the non-verbal aspects of social interaction in an instance of medical reasoning, including knowing through the intellect, through feelings and intuitions, and through bodily automatisms or, as Csordas (1993) put it, 'somatic modes of attention'. Knowing is meant to emphasise that the instances of medical reasoning are instances of doing all kinds of things in addition to engaging in intellectual communication.[4] Although neither verbal reasoning nor knowing are likely to reach the same salience and emotional arousal as ritual performances, they are a form of action which Lewis (1980:118), with regard to ritual, describes as: 'A way of doing, making, creating, showing, expressing, arousing – a complex form of stimulus to which people respond.'

Knowing Practice

In *Knowing Practice*, Farquhar (1994a) has emphasised the concept of 'knowing Chinese medicine' as opposed to 'knowledge of Chinese medicine'. She does not define 'knowing', but it appears that 'knowing Chinese medicine' has something to do with the particular way in which Chinese medical knowledge is applied to Chinese medical practice. Examining the clinical encounter, Farquhar suggests that Chinese medical discourse has the peculiarity of moving along a gradient from more 'concrete' to more 'verbose' idioms and back again. In the process of what she calls 'looking at the illness' (*kan bing*), a doctor transforms concrete 'signs' (*zheng*1, complaints of the patient) into less concrete 'symptoms' (*zheng*2, the doctor's notations in Chinese medical terms) and then into verbose 'syndrome-therapies' (*zheng*3, also called Distinguishing Patterns), which I was taught generally consisted of a four-word phrase such as *feng shi tou teng* (a Wind Dampness Headache). In the process of 'syndrome differentiation and therapy determination' (*bianzheng lunzhi*), the verbose 'syndrome-therapies' are translated into more concrete 'formulae' (*fangji*) which are in turn composed of specific 'drugs' (*yao*).

Although Farquhar calls her book *Knowing Practice*, her model provides an idealisation of the clinical encounter rather than an account of

[4] Hacking (1992:3) makes a similar point: 'Reasoning is done in public as well as in private: by thinking, yes, but also by talking and arguing and showing.' Reasoning in Hacking's sense, like knowing in this sense, is a form of action.

observed ways of 'knowing practice'. The model nicely reflects the claim of doctors in government-run institutions, namely, that they have a step by step way of coming from signs to symptoms to syndromes,[5] although we do not know exactly how Chinese medical doctors get from patients' complaints to the prescription of specific drugs. Farquhar's book reflects the information presented to students in the more advanced courses on the *Diagnostics of Traditional Chinese Medicine* (*Zhongyi zhenduanxue*) and the *Formularies* (*Fangjixue*). It contains translations of seminal texts by leading figures in Traditional Chinese Medicine and textbook passages with which most practitioners are familiar. It aims at a comprehensive account of the clinical encounter throughout the PRC, but this aim has its disadvantages; Farquhar attributes more authority to written texts than to fieldwork observations, anecdotes of which tend to be recorded only in footnotes.

This monograph, by contrast, is intended to provide an ethnographic account for a particular place and time: three settings in Kunming city between September 1988 and December 1989. It discusses key concepts of Chinese medicine embedded in an ethnography of social practice, whether in a healer's consultation room, in the seminars of a self-constituted reading group, or in college classrooms. It aspires not to comprehensiveness but to accuracy and fidelity to what was observed and experienced. It is intended to provide an understanding of Chinese medicine that complements and sometimes calls into question the understanding derived from textbooks and the view that one gains from a focus on texts (Porkert 1974; Sivin 1987; Farquhar 1994a). It is meant to contextualise earlier accounts by medical anthropologists (Ots (1987)1990 and Farquhar 1994a) in that it is not limited to the medicine taught and practised in government institutions, and takes an approach Unschuld ((1980)1985) has long advocated by naming his book *Medicine in China*, which calls for abandoning the idea of a monolithic doctrine and practice of Chinese medicine.

TCM

The context of learning Chinese medicine that deserves particular attention, not least because it is the most discussed in the Western literature (see above), is the traditional medicine that is promoted on

[5] Farquhar's model strikes me as being so much in tune with the intentions of TCM textbook compilers that it would not be surprising to find it incorporated in their future teaching materials.

a nationwide scale in colleges, hospitals, and clinics. Its legitimation in the PRC, which took place only in the late 1950s and early 1960s, has led to a reforging that is driven by many different interests – among them nationalism, Confucian values, humanitarian ideals, reformist and 'Enlightenment' movements, the pragmatic politics of a party in pursuit of power, and economic considerations of how to allocate manpower and scarce resources.[6] This medicine is here called 'Traditional Chinese Medicine' and abbreviated to TCM. TCM, when used by Chinese authors in translation, implicitly refers to Chinese medicine in general. This study, however, proposes to narrow its sense down to refer to the government-promoted medicine only and use the more general term 'Chinese medicine' (inclusive of TCM) to refer to what in Chinese is called *zhongyi*.[7] Although there is no specific term for TCM in Chinese, there was among the people I worked with a tendency to recognise it on a conceptual level.

TCM, in spite of being called 'traditional' (*chuantong*), is generally referred to as the 'modernised' (*xiandaihuade*), 'scientific' (*kexuehuade*), 'systematic' (*xitonghuade*), and 'standardised' (*guifanhuade*) Chinese medicine. In awareness of how ideology-laden these attributes were, one doctor called TCM the 'school of the colleges' (*xueyuanpai*), which implied that it was just one of many 'schools' of Chinese medicine. However, government officials, if not aiming at its monopoly, advocated its predominance. TCM, like the professionalised Ayurvedic medicine in India (Leslie 1976a) or Kanpo in Japan (Lock 1980:109–54; Ohnuki-Tierney 1984:91–122; Oberländer 1996), can be regarded as the professionalised Chinese medicine.

Considering how intertwined Chinese medical practice is with shamanic (Kleinman 1980), temple-based (Gould Martin 1975), divinatory (Topley 1976), fortune-telling (Smith 1991), home-based 'herbal drug' (*caoyao*), and other practices, we may agree that 'it is unlikely that before 1949 TCM was a particularly discrete unit for the majority of practitioners' (Farquhar 1994a:15). Currently, however, TCM can be identified as such by investigating the educational scheme, its organisation of knowledge, its textual presentation in textbooks, and verbal reasoning in classrooms and clinics.[8] TCM knowledge is no longer represented as a

[6] A history of Chinese medicine in the PRC has yet to be written. Croizier (1968) and Lampton (1977) still provide most detailed information. On Chinese medicine in the Republican period, see Croizier (1968), Ma et al. (1993), and Andrews (1996).

[7] See also Farquhar (1994a:15) and Sivin (1995d:197). Sivin (1995c), however, speaks of 'Traditional Chinese Medicine' with reference to what I would call 'Chinese medicine'.

[8] On variations of TCM practice, see Scheid (1998).

medical 'doctrine', and in this respect differs from Chinese medical learning, which for many centuries ingeniously combined book learning with medical practice.

TCM is distinct also in respect of its institutional setting: the colleges, hospitals, and clinics are all institutions of the Chinese socialist state, so-called 'work units' (*gongzuo danwei*). It is within such socialist institutions that Chinese medicine has been modernised, Westernised, standardised, and made scientific. However, the modernisation of everyday life has affected all medical practices within and outside government institutions, often closely interrelated with a certain Westernisation, and 'science' or 'scientific' is a ubiquitously found attribute for any therapy. It is only in government institutions that the aim of standardising Chinese medical learning has been formulated and pursued. Comparison of this government-promoted medicine with other Chinese therapeutics will allow us to identify both strengths and limitations of the standardisation of medicine.

The settings

The settings for my investigation of the above-mentioned ways of learning and styles of knowing were selected from a wide range of therapeutics in Chinese urban society (see table I.1). My choice took into account that urban spaces were readily divided into 'work units' (*gongzuo danwei*) established by the government in the 1950s as separate cells of urban production and consumption, and the spaces outside them, which included residential areas as well as areas of 'private' or 'individual' enterprise (*getihu*) and 'collectives' (*jitihu*).[9] The government promoted the standardised mode of transmission in the work units. The other two modes of transmission, which were tolerated but not promoted, were overtly practised in the private and collective spaces outside the government institutions (see fig. I.1 on p. 14).

As setting for studying the standardised mode of transmission I chose a TCM college, the Yunnan TCM College (*Yunnan zhongyi xueyuan*). Enrolled between September 1988 and December 1989 as its first foreign student, I was treated with particular care and assigned two excellent tutors, one of whom was teacher Tao. A separate room was prepared for me in a newly built dormitory for 'minority nationalities cadres' (*minzu ganbu*), able medical doctors from the periphery of the province

[9] These urban spaces outside work units were never completely abolished in the PRC, and they significantly gained in importance as areas of functional specialisation during the reforms of the 1980s.

Table I.1. *Different medical practitioners in a Chinese urban setting (not comprehensive)*

temple praying monks	fortune tellers	herbalists (*caoyi*)[10]	*qigong* healers[11]	Chinese medical doctors (*zhongyi*)[12]				Western medical doctors (*xiyi*)[13]
				massage (*anmo*)	acumoxa (*zhenjiu*)[14]	Chinese medical doctors (*zhongyi*)	TCM doctors (*zhongyi*)[15]	
		(Qiu)	(Qiu)	(Qiu and Zhang)	(Zhang)	(Zhang)	(Tao)	
practise in temples		practise mostly outside government clinics 'folk-medicine'		practise outside and inside government clinics and hospitals			practise mostly inside government clinics and hospitals	

[10] 'Herbal medicine' (*caoyi*) was practised by doctors with no formal training or official recognition, and often consisted of applying home-based remedies with 'herbal drugs' (*caoyao*) made up mostly of various parts of plants collected in the hills around the city. The term 'herbalist' (*caoyi*) had in the PRC of the late 1980s a rather restricted sense whereas Topley (1975:243) had earlier observed in Hongkong that: 'All traditional practitioners are thus "herbalists". No traditional practitioner may call himself "doctor" (*yisheng*); this privilege is restricted to qualified, registrable Western-trained physicians. He may call himself *zhongyi* in Chinese . . . but in its English translation . . . he must include the term "herbalist".' In the PRC of the 1980s a Chinese doctor could call himself *yisheng*.

[11] *Qigong* is a compound word composed of two terms, *qi* and *gong*. *Qi* designates a dynamic force and quality in constant flux and flow. It is comparable to *pneuma* in Greek or *prana* in Indian philosophy. English renderings such as 'pneumatic stuff', 'air', 'vapour', and 'breath' all approximate to its meaning, but unsatisfactorily. *Gong* means effect, discipline, capability, achievement, and merit. *Qigong* (workings with the breath) refers to practices of nurturing and conducting the *qi* which enhance the efficiency of *qi* in the body.

[12] *Zhongyi*, a term coined in the last century in response to the presence of the West in China (Croizier 1976:361), comprises many more subdisciplines. Those mentioned here are directly relevant for situating the three main actors in this monograph. *Zhongyi* functions as a superordinate, referring to both government-promoted and government-tolerated Chinese medicine, but it can also refer to the government-promoted TCM alone.

[13] 'Western biomedicine' (*xiyi*) is generally contrasted with Chinese medicine, *zhongyi*. The Western medicine practised by these doctors is neither homeopathy nor scholastic medicine, but biomedicine. Frankenberg (1993:220) rightly draws attention to the 'customary social science conflation of the biological and medical concealed within the term biomedicine, which seems to embody an ideological assumption and a rhetorical claim that need to be explored rather then uncritically accepted'. The term 'biomedicine' is used here precisely because there are basic ideological differences between the Western life sciences and the notion of life and death in Chinese therapeutics.

[14] 'Acumoxa' (*zhenjiu*) comprises both therapies of 'needling' (*zhen*) and 'moxibustion' or 'moxa' (*jiu*), and is throughout this monograph used in place of the term 'acupuncture'. Porkert (1976:1242) coined the term 'Aku-moxi Therapien'.

[15] 'TCM' (*zhongyi*) refers to the standardised medicine that has been promoted at government colleges since the 1950s. The term is used in a narrower sense here than is usually adopted in PRC journals, where TCM is the English term for the Chinese word *zhongyi*.

who had been recruited during the Cultural Revolution and were enrolled for brush-up courses. The sanitary installations were supposed to be better there than elsewhere, and the room was, 'for safety reasons', not easily accessible. I was registered as a first-year student in 'acumoxa and massage' (*zhenjiu tuina*), which was a three-year course that had just begun to be offered by the college for training 'specialists' (*zhuankesheng*), but I also attended classes at higher levels with 'regular students' (*benkesheng*) enrolled in a five-year course on TCM (*zhongyi*). A special curriculum and timetable were set up for me at the beginning of each term, two lectures in different courses every (other) morning.[16] After six months I spent every other morning and after a year every morning at an acumoxa clinic with students who were in their year of clinical practice.

Considering that Yunnan is a 'frontier area' (*bianjiang*) in the south-westernmost corner of the PRC, one may wonder about the representativeness of my experiences at college. College education was largely subject to nationwide policies, and the curriculum, textbooks, and examinations were supposed to accord with the national standards set up in 1984. The architecture and general setup of the work unit also followed the nationwide model. The living conditions in this particular unit were, however, among the worst in Yunnan's provincial capital.[17] College members repeatedly referred to it as the smallest, financially least supported, and academically least respected of all of Yunnan's institutions of higher learning,[18] and this low status is perhaps not characteristic of all TCM colleges in the PRC.

I had chosen to specialise in acumoxa rather than herbal medicine because I considered it important to feel comfortable in delivering the medical treatment about which I was to write after only eighteen months of fieldwork, and herbal medicine appeared to me too vast a subject. As the number of acu-points (*xuewei*) is limited, comprising three to

[16] Namely: *TCM Fundamentals (Zhongyi jichu lilun), Classical Chinese for Medics (Yiguwen), Interpretation of the Inner Canon (Neijing jiangyi); and [The Study of] Acumoxa [for TCM regular students] (Zhenjiuxue), TCM Diagnostics (Zhongyi zhenduanxue), Acumoxa Loci (Shuxue), Tracts and Links (Jingluoxue), Needling and Moxa Techniques (Zhenfa jiufaxue), Acumoxa Therapy (Zhenjiu zhiliaoxue)*.

[17] This changed in the late 1980s, when the college acquired land in a southern suburb of the city. In 1996 some of the staff was lodged in a new compound, and the Department of Traditional Chinese Pharmaceutics (*zhongyaoxi*) was in course of being transferred there.

[18] One exception was Prof. Zeng Yulin of the Department of Traditional Chinese Pharmaceutics who was rewarded for his research on extracting the pure and active substances from traditional herbs of some of Yunnan's ethnic minorities. The Yunnan TCM College had apparently enjoyed higher recognition in the 1960s, before excellent staff left or died in the Cultural Revolution (Zhang 1989).