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Everywhere and always, the transportation or globalization of powerful languages, objects, facts, and systems has required translation, which – as both science studies and translation theorists have shown us – is always a multifaceted transformation.

Farquhar in Levine (2012: 156)

Knowledge in translation: Global science, local things

Judith Farquhar

THE INDIGENOUS KNOWLEDGE MOVEMENTS that appeared around the world in the 20th century have appealed to public health policy-makers, anthropologists, pharmaceutical companies, New Age seekers and, not least, sufferers living with intractable ailments. Challenging the rigid positivism shared by biomedicine and the political economy of health, and proposing epistemological and therapeutic diversities that can only be partly tamed by the categories of 'complementary and alternative medicine' or 'traditional healing', non-Western healing knowledges continue to appear as wild cards in the politics of health. Even as they offer a certain promise to sufferers and even services planners, they also pose a definite threat in a variety of health-oriented discourses.

Why has indigenous knowledge appeared as a threat? One reason is that we live a cosmopolitan common sense that, in the 20th century at least, has presumed that true knowledge is the foundation of effective action; or, more to the point, *only* true knowledge *can be* the basis of effective action. If all action arises from knowledge, if you must *know* before you can *act*, you would naturally care about the truthfulness of knowledge representations. Perhaps the stubborn persistence of this structuring of what elsewhere I have called 'knowing practice' (Farquhar 1992) is closely related to our jobs in the academic knowledge industry. Universities, bioscience research labs, government agencies and so forth lend authority to knowledge, make it 'reliable', even as we all wonder whether the knowledge we have gained at such great expense is ever really acted upon.

If this epistemological foundationalism is the common-sense model of knowledge and action we generally work with, alternative and apparently incommensurate representations of the world present a problem. Indigenous knowledges seem to force us to face a hard choice, not only between ways of imagining reality but also between courses of action. In other words, we can be multiculturalists about diverse *beliefs*, but – insofar as our whole world of action seems to be at stake – we are quick to become dogmatic about *knowledge*. However,

people act all the time, often effectively and often ethically, without having a clue about the facts. Moreover, chronic anxieties about instability in the knowledge foundation of action lead to arrogance, dogmatism and blindness to the promise of both new and old resources for thought *and* action. These anxieties, or epistemological panics, especially afflict those who are most committed to hegemonic knowledge systems; all my biomedical friends get nervous when I tell them I study traditional Chinese medicine. They not only think I'm probably deluded, they think I might be dangerous.

Classical Chinese medicine is a unique example of an indigenous knowledge movement, though at this juncture I will cease calling it 'indigenous', because, as what follows should demonstrate, the field is constitutively transnational and makes very universal claims.¹ The field of 'Chinese' medicine began to organise professionally in the early part of the 20th century, and it has enjoyed official Chinese government support since the 1950s. So-called 'Chinese medicine' continues to flourish in China alongside and in collaboration with a large biomedical and public health establishment; but Chinese medicine's status is actively contested, even in its homeland – Is it science, a complement to scientific medicine, 'mere' culture, or even religious superstition? – and its practical relations with other forms of 'health service delivery' are full of friction.

In this chapter, I first recount some of the pertinent history of Chinese medicine in the 20th century, because this history offers instructive parallels with pluralistic medical development in many other parts of the world. Along the way, I focus on problems of translation, especially as the term has been developed in science studies (see Callon 1986; Hart 1999; Star & Griesemer 1989), as a way to understand the epistemological politics of traditional and indigenous medicine in modern states. I then turn to a translation project of my own, and present some insights drawn from the work of Chinese doctor and medical theorist Lu Guangxin. Dr Lu is not known outside the world of professional Chinese medicine in the People's Republic of China; he works entirely in Chinese and employs a technical and philosophical language even many Chinese readers find challenging. Yet, he asks hard questions that bedevil a crucial global process, extending far beyond Beijing, where he works as part of a large and active network of experts and experimenters: his critical epistemology addresses the literal, practical translation of medical knowledge and practice around the world and between past and present. What Dr Lu knows – insistently, contentiously – is *local*, but he insists on it partly because, like the rest of us, he is a global citizen. I will turn to his ruling questions in a moment, but we must think about knowledge and locality first.

Local knowledge

So let me begin with 'local knowledge' (Geertz 2000). What does it mean to say that knowledge is local? Does it speak of facts that are locally owned, as patent applications for traditional herbal medicines would have it, controlled by those who originally discovered useful facts about nearby things? In other words, is it intellectual private property? Does local mean limited in the scope of its applicability, as in arguments that knowledge about acupuncture or Chinese herbal medicine is true (and, thus, undergirds medical effectiveness) for Chinese people in China, but not otherwise? This form of locality might use the language of belief rather than knowledge. Or, does local mean that some knowledge is true and the objects it recognises are real for only part of the universe? Examples might be family ghosts whose powers fade away outside of the village or, as Margaret Lock (1993) has argued, 'hot flashes' that are real for menopausal women in Canada but not Japan? This approach would lead us toward a plurality of 'real worlds'. Perhaps, local means that knowledge tends to be controlled by experts and elites, such that much of it is simply not available to most of the people. Examples might be immunology or geophysics, requiring the mediation of engineers and health educators to become useful beyond the experts' club. This kind of local knowledge might lead us into a sociology of networks. Finally, does local mean that knowledge is everywhere constituted by its practical genesis, as in the observation that the 'discovery' of microbes and the rise of bacteriology required (and still require) laboratories, experimental animals, agreement on systematic protocols, observers and investigators occupying a certain social position and enjoying a certain level of funding, and a lot of co-operation from quirky non-human creatures (Latour 1988)? This kind of local knowledge leads us to the methods of science studies, in which a substantive notion of translation beyond the linguistic has been important (Latour 1983; Keating & Cambrosio 2000; Stengers 2003).

In the last couple of decades, anthropology, history, science and technology studies, and global public health studies, have fully recognised that formations of knowledge tend to be stubbornly local in at least one of these senses. Historical studies have richly shown that even the most universalist abstractions, the most self-evident facts, the most natural entities, emerge in unique histories, develop in localised communities, are claimed by interested political actors, and travel in particular networks. Once developed, the most charismatic forms of knowledge, materialised in dictionaries or mortality and morbidity datasets, antibiotics or anaesthetics, transcendental meditation or acupuncture, can certainly travel, but they travel, and root themselves in foreign soils, only with difficulty. One could even say there is a certain amount of violence, conceptual and bodily, involved in the transplantation of knowledge forms to places beyond their local countries of

origin. This violence is not only visited upon the bodies of populations denounced as noncompliant or uncomprehending, as, for example, everyday life resists being reorganised around drug regimes, or appetites refuse to be tamed by dietary or other behavioural disciplines. The violent translations now taking place in a world where everything moves transform knowledge itself. In the United States, acupuncture gets allied with New Age spirituality and treats only pain; in Thailand, intravenous antibiotics become a form of daily nourishment or preventive medicine; a virus culture developed in New York mutates into a new organism under laboratory conditions in Cape Town.

Everywhere and always, the transportation or globalisation of powerful languages, objects, facts and systems has required *translation*, which, as both science studies and translation theorists have shown us, is always a multifaceted *transformation*. I shall return to the implications of this insight, or rather, Lu Guangxin will bring it up again; but, first, I want to provide some historical context that specifies some of the constraints operating in the translations of knowledge that have affected the contemporary form of Chinese medicine.

Mr Science and Chinese national medicine

Thus far, I have emphasised a certain relativism, one that acknowledges the local character of knowledge. This point of view took on critical significance in the 20th century, which witnessed the apparent triumph of science over ancient error and superstition. Triumphalist accounts of science put it at home everywhere; biomedicine should be the best thing for everybody no matter where it lives. (As a result, it remains contentious to call science or biomedicine local in any of the senses I have outlined above.) The conflict has been massively clear in China, where the replacement of superstition by something called science was a clear aim of the modernising and communist project. In Chinese studies, the ideology that accompanied this project has been called 'scientism' (Kwok 1965): the unquestioning faith of moderns and modernisers in something – one thing – they call science. In early 20th-century China, 'Mr Science' marched through nationalist modernising movements alongside 'Mr Democracy'. Up-to-date people of many sorts thought of this 'science' as modern, practical, systematic, standard and universally true. Even in Chinese communist theory, something called scientific socialism guided policy. Scientific socialism was a commitment to secularism, materialist analysis, positivism and Marxist political economy. In keeping with my emphasis on local knowledge, however, it must be pointed out that such understandings of science are *ideologies* of knowledge; critical theory, anthropology and science studies have widely called such ideologies into question, and have robbed them of foundations

but not of effectiveness or global importance (Biagioli 1999; Daston & Galison 2007; Wilson 1971).

The *circumstances* of the translation of Euro-American sciences (of life, of the cosmos, of society) into China must be noted in the very moment that we relativise. Both Chinese scientism and Maoist scientific socialism were crucially important interventions in the wretched material conditions of a huge nation in the grip of numerous crises before 1949: a colonial crisis of sovereignty, terrible poverty, widespread warfare, a chronic sense of cultural decline and loss, massive government corruption, acute awareness of global 'backwardness' (to list only a few of the problems of the 'old society'). Global science was a crucial actor in China's mid-twentieth-century revolution – Mr Science truly was on the march. After long experience of imperialism and partial colonialism, after a 19th- and 20th-century history that people still refer to as 'the century of national humiliation', the clean abstractions and universalist promises of science, as well as the powerful technologies that claim a basis in science, have had a tremendous appeal and usefulness to Chinese people of all kinds.

The translation of science into Chinese locales has not, however, been without friction. Garden variety 'superstition' (*mixin*) never went away among 'the people' (*laobaixing*), just as it has not left the North American domains of religion or baseball or electoral politics or even everyday talk in scientific laboratories. More importantly, existing Chinese approaches to the treatment of illness and the nurturance of life presented a highly resistant terrain to the foreign sciences (Farquhar & Zhang 2012). The Western sciences of the 19th century did not, after all, come to an empty epistemological and practical terrain. Variants of classical Chinese medicine, in particular, were well entrenched as ways of promoting life and preventing death, addressing suffering and maximising physical comfort. The foreign missionary doctors who opened clinics and hospitals from the 1850s onward could seldom see this, of course, and there is interesting missionary writing about how extremely mystifying and strange Chinese medicine was. In the 19th century, these medical missionaries learned Chinese and wrote textbooks, performed surgeries and taught anatomy, and in the 20th century they introduced antibiotics and public health interventions informed by bacteriology (Wong & Wu 1936).

Though the Western medical services put in place by foreigners before 1949 were never very extensive, a certain biomedical worldview became influential among modernising intellectuals and revolutionary activists, even those who did not study medicine. The great writer Lu Xun and his circle of leftist cultural activists in the 1930s and 1940s is an important example (Liu 1995; Heinrich 2008). Lu Xun hated Chinese medicine. In specifically professional politics, the scientific self-confidence of the first cadre of biomedically trained Chinese physicians led them to argue in the 1920s and 1930s that 'Western medicine' should be declared the only

legal and official form of treatment (Lei 1999). These biomedical policy initiatives ultimately failed. This is not surprising: not only would it have been impossible for the government of that time to deliver biomedical services to even a small fraction of the population, there was a sector of 'national medicine' doctors who organised themselves to mount vigorous political opposition to wholesale biomedicalisation. More interesting from the point of view of local and translated knowledges, however, as Hsiang-lin Lei has brilliantly shown, in the *political* encounter between Chinese and Western medicine, between medical vested interests and a struggling war-torn government, both biomedical and Chinese medical knowledge underwent profound changes.

Lei observes that the high-stakes struggles in the plural medical environment of the first half of the 20th century led to the perception and production of 'medical systems' – discrete, standardised groupings of literatures, institutions and people. In mid-century China, there were *two* such systems: no more and no less. Systematisation and endless comparisons between 'Chinese medicine' and 'Western medicine' have gone on apace since then, and we cannot understand Lu Guangxin's thought outside of the context of this comparativism and relativisation. But Lei makes the further point that Chinese medicine came to be thought of as 'experiential' (Lei 2002). It was experiential (that is, it invoked doctors' clinical experience and patients' experienced understanding of their own bodies) in direct contrast to biomedicine's claim to penetrate the hidden and unremarked pathological processes of closed and mostly inaccessible bodies. The long-term result of this fundamental alteration in understanding of the 'two' medicines has been the most common characterisation of today's pluralistic medical environment. Anyone will tell you this: 'Western medicine treats the branch (i.e. superficial symptoms) but Chinese medicine treats the root.'

It might be worth reflecting on the plant metaphor of this language. After all, surgery was the first, most unique, and most directly serviceable Western medical specialty to take hold in China. Is Western medicine seen, then, as a way of pruning off diseased limbs without considering the long-term pathological process that might have produced diseased parts in the first place? The image is powerful, and it also suggests that Western medicine causes a certain amount of damage even in the very act of eradicating pathology. In frequent comparisons made by ordinary consumers of health services, Western medicine is seen as quickly effective but rife with side-effects.

After the revolution

The twentieth-century era of translation of biomedicine into a mechanistic technology and of Chinese medicine into a modern 'system' with self-conscious local characteristics has remained a part of the political and epistemological legacy of all medical practice in today's China. We can see similar processes underway in other countries – India has an even earlier history of grappling with medical pluralism and with the formal legitimisation of Ayurvedic, Unani and Siddha forms of medicine (Leslie 1976). Leaping over the 20th century, in the 1990s and since, we have seen many countries adopting a kind of Chinese model for systematising indigenous medical 'systems'. Research institutes have been established, clinical trials and phytochemical analyses are well under way, pharmaceutical companies are reading pre-modern *materia media* texts, and 'traditional practitioners' around the world are seeking government certification. China's situation, however, remains somewhat unique. This is partly because of the revolution and the subsequent decades of socialist national health care provision. Though economic and medical policy are now, in the 21st century, thoroughly committed to neoliberal privatisation, knowledge has proven a bit conservative, but not for lack of a polemical environment and a great many divergent positions.

Shortly after the 1949 founding of the People's Republic of China, in the mid-1950s, the Communist Party-led national government explicitly legalised the practice of traditional Chinese medicine. Medical licenses were not required for traditional practitioners at that time, but schools of Chinese medicine were established and textbook and curriculum committees got down to work to design the training of new generations of Chinese medical practitioners. The translations required to collect and teach the vast diversities of classical and folk medical practice in textbooks, in clinics, in classrooms, on the part of newly collectivised groups of men who had only a few years before been private competitors in an unregulated medical market, are an important part of this history (Scheid 2007). Systematisation and institutionalisation were undertaken under direct state control, in the revolutionary climate of high nationalist feeling as a result of the Cold War break with the West (and, by the late 1950s, China had broken even with Russia, but not with the so-called non-aligned world, including much of Africa). The establishment of official Chinese medicine was achieved under conditions of continuing shortage: biomedical treatments were in short supply and traditional medical services were

needed for primary healthcare delivery (Lampton 1977), and it was accomplished by and with a population that felt more comfortable with the experiential logic and non-invasive treatments of traditional medicine. The newly crafted field of 'Chinese medicine' was part of a national public health policy that needed to be at once *pluralist*, capable of being *administered*, and *medically responsible*.

We still do not have the historical study we need of Chinese medicine at mid-century (but see Taylor 2005). The situation would be radically different today if the modernisation of traditional medical knowledge and practice had *not* coincided with the ambitious China-wide imposition of strong state control over the daily lives of communities, families and individuals. The socialist logic through which the new state adopted a paternalistic strategy was crucial to health services: the state and the party had to claim to be the loving 'father and mother of the people' because the regime had, after all, arisen from among 'the people' (that's how the rhetoric went, anyway). Yet, Chinese socialism was, as I have pointed out, 'scientistic'. The practical result of this combination of agendas just after the People's Republic of China was founded included, for example, a lot of short-term training of medical practitioners to prepare them for triaging care. That is, they had to be able to recognise appendicitis, breach birth or lung cancer under village conditions, and they had to be empowered to get people who needed biomedical services (surgery, radiation) to the nearest biomedical clinic. At the same time, these newly paramedicalised practitioners had to know how to use 'local', 'traditional' resources to manage health in ways that worked well with common-sense everyday lives. The father and mother state had a great stake in meeting the needs of the people, both with the radical interventions of biomedicine and with the 'traditional' toolkit of a widely trusted Chinese therapeutics. The combination of agendas made for structural conditions that produced a deeply hybrid terrain of practice. This can be expressed as a situation of translation: though the worldviews of Chinese and Western medicine were deeply incommensurate, somehow in the terrain of practice set up in Maoist China, they were constantly being commensurated.

At the same time, as I hope will be heard echoing through Lu Guangxin's ideas, there have been vast ongoing efforts to re-purify the 'traditional' field with reference to the 2 000-year-old archive of medical writing. Authentic Chinese medicine, or at least a healing practice authorised by some very old classic texts, has remained an issue even in postmodern China, under changing logics of legitimisation. In the important Chinese project of modernising public health for a particular people with particular popular needs and desires, Chinese medicine presented a complex cultural resistance; it was only partly transformed, only partly remade using Western medical models, as it was translated.

Chinese medicine as traditional culture?

How should we understand the persistence and local specificity of Chinese medicine in twentieth-century China? No kind of cultural essentialist lens is adequate to the case: Chinese medicine is not pre-modern or indigenous culture. Under pressure of modernisation and nation-state formation, medical knowledge radically narrowed and cleansed its wide array of texts and techniques. Thus, gods and ghosts, divination and trance were mostly banished from the field (although, as I also suggest, they keep sneaking back into practice with new language and new rationales) (Sivin 1987). The broad everyday-life emphasis of a past medical expertise – summarised in the oft-quoted saying, 'the highest doctor treats the not yet ill' – was also narrowed: 'medicine' addresses disease, does it not? The older, more miscellaneous powers of 'traditional' healing methods for attacking the roots of all kinds of affliction, ranging from chronic arthritis to business failure, simply were rendered irrelevant when the two medicines became official systems. Nowadays, the term 'Chinese medicine' is taken by many to refer only to acupuncture techniques and herbal remedies, not even to the classical theory and philosophy that many of us still feel should undergird therapies. Even the most scientised manifestations of Chinese medicine – hospital case histories, clinical trials, phytochemical analyses – are still local, but they translate and transform through global networks. When Chinese cultural essences are perceived in this field, they can result only from a fair amount of creative interpretation.

However, the sense of *specificity* we all get when we study and benefit from Chinese medicine is palpable. Lu Guangxin will make this clearer when I cite him at length below; but think, by way of preparation for him, about *qi*. *Qi* is usually translated as 'energy' or 'matter-energy', though more careful scholars have tried translations such as 'configurative force', and nowadays most of us leave the word *qi* untranslated. Few who have worked in the field of modernising Chinese medicine have seriously considered abandoning the word and concept of *qi*. Perhaps the similarity of the notion to some key insights of quantum physics helps to sustain its claim on modernity, but *qi* is also an ordinary Chinese word, useful in talking about everything from the weather to personalities, soft drinks to indigestion. It would be hard to make sense in Chinese without using the word fairly often; yet it is not really translatable. *Qi* is real. It is not spirit or abstraction. It is as real as any of the pathogenic entities or organic networks that have been constituted in scientific practice in the short history of modern biomedicine (Collins & Pinch 2005) – syphilis disease (Fleck 1971), the immune response, Tobacco Mosaic Virus (Rheinberger 2010) – but no anatomist, physiologist or biochemist can quite capture *qi* for structural analysis. Chinese medicine clinicians know, though, that in a *qi*-driven and *qi*-configured world, illness emerges in many more forms than the International Classification

of Diseases can recognise (Bowker & Star 1999). In a *qi*-driven and *qi*-configured world, effective treatments reach far beyond the active components of plants or therapies supported by a statistical evidence base (see Human in this book).

Ontological disease?

The short discussion of *qi* above suggests that objects or things are very much at stake when knowledge systems translate and transform (Daston 2000). In the remainder of this discussion I am going to let Lu Guangxin explain to us the problem of the object-on-the-move-in-translation, and present some of his solutions to the risks and promises of transformation that are inherent to translation. The foregoing historical and contextual discussion has been necessary in order to see the significance of Dr Lu's insights, as well as to heighten their comparative force. Lu Guangxin himself does not bother to explain why his philosophy of medicine is important. You have to have been there, as it were; as medicine in China modernised, only committed participants fully understood the stakes. Still, even people in places as far away as South Africa or the United States stand to learn something from epistemological activists like Lu Guangxin.

Lu Guangxin tends to ask the following questions: On what philosophical basis can heterogeneous global networks of world medicine be responsibly built? Can multiple natures, with their incommensurate entities and untranslatable first principles, co-exist and even be *usefully* linked in both knowledge and practice? These questions persistently inhabit Lu's work, and they especially haunt both its local claims and global aims. Focusing especially on the question of entities, let me show you how Dr Lu develops some answers.

Bearing in mind that he is fighting not just a symbolic but an ontological battle, he and his colleagues make unending efforts to present to a sceptical world Chinese medical objects and processes that can take on at least as much reality as microbes, hormones, pneumonia, cirrhosis and the doctor-patient relationship. Consider, for example, in what follows, how Lu contrasts the mode of being (or *benzhi*, root materiality) of Western medical 'disease' (*jibing*) with the contingent reality of Chinese medicine's 'pattern of disorder' (*zhenghou*). He conventionally defines a pattern as a 'diagnostic outcome arrived at under the guidance of Chinese medical theory and through the symptoms and signs collected in the four examinations once they have been submitted to synthesizing thought' (Lu 2001: 335). In the 1980s, Lu points out, when definitions like this were collectively crafted in a highly political process, and when they were widely debated, many in the field came to agree that *zhenghou* is not an observed object. The pattern defined in this way is not a disease discovered in nature, but a 'diagnostic outcome' (*jielun*, resolution) resulting

from skilled and educated human activity. Perception of a pattern was dependent both on 'the symptoms and signs collected in the four examinations' and the 'synthesizing thought' to which discerning physicians subjected such appearances. This is a complicated concept, but anyone who understands clinical practice in Chinese medicine can see what it means. Read the definition carefully: it is not claiming that *zhenghou* provides a name and a category corresponding to a natural and pre-existing thing; nor is it suggesting that a pattern of disorder is simply dreamed up by doctors. Rather, the very being of the pattern results from the structured collective activity of knowing (including the knowing of symptoms on the part of patients).

In the context of the broader definitional and pedagogical debates that stimulated this comment about the difference between *zhenghou* and *jibing*, however, Lu expresses discomfort with the thoroughly pragmatic definition I have just cited. He seeks, ultimately, to find a stronger naturalist logic that makes (Chinese) pattern and (Western) disease able to really and truly articulate with each other, under today's conditions. He discusses, for example, the solution of many of his colleagues, whose strategies he knows well. These strategies for making a translation between the concepts of Western medicine and Chinese medicine mostly involve making disease foundational, and pattern a mere manifestation of ontological disease. Thus, for these synthesisers, different patterns might cluster as versions of one disease; 'tuberculosis' might be diagnosable as one of five patterns, and its pattern-classification might shift from one *zhenghou* to another even while the condition of tuberculosis remains as the diagnosed 'disease'. In this model, however, patterns are mere disease 'expressions', not ontological diseases, not entities in themselves.

This approach is now mainstream in teaching; but Lu rejects it. Instead, he grounds illness patterns, or *zhenghou*, in the natural process in which two great classes of *qi*, the orthopathic (*zheng qi*) and the heteropathic (*xie qi*), encounter each other, and in that encounter produce bodily conditions. These days, orthopathic *qi* is often explained with reference to the immune system, and seen as referring not only to the body's biological defences but also to its most wholesome yin-yang harmonies; heteropathic *qi*, on the other hand, when it is not translated poetically as 'external evil', is taken to refer to pathogens such as poisons, climatic factors and internal excesses or deficiencies. Orthopathic and heteropathic *qi* are classes of physiological and environmental activity, made up of both force and substance; using them to analyse pathology and health makes a certain intuitive and even experiential sense in many kinds of embodiment.

In this complex, technical argument about the causes of bodily disorder, Dr Lu re-grounds the Chinese medical illness pattern in a local nature, beyond the community of discourse referred to in the conventional definition of *zhenghou* mentioned above. He renders the pattern more real by demonstrating that a great many clinical problems can be analysed effectively with reference to the (only

sometimes antagonistic) interactions of wholesome and pathogenic *qi*. (Of course it is important within his polemic that these two kinds of *qi* are not recognised by Western medicine and their powers are not well understood by biomedical doctors. Practitioners of modern traditional Chinese medicine like Dr Lu are well aware of the problems of standardisation, intuition and excess discussed by Oliver Human in this book.) Because the dynamics of *qi*, and the manifold forms it takes in nature, are not mere products of human thinking, the products of the interplay of these forms are also real objects. Moreover, because orthopathic and heteropathic *qi*, like yin and yang, are able to generate an infinite number of states of play, it would be foolishly reductionist to try to include the patterns resulting from that play to something as limited as the symptomatic phases subsumed entirely within (biomedically recognised) disease. (Recall the 1980s consensus definition above, which gave ontological priority to biomedical diseases.)

If we accept that the primordial struggle of wholesome and pathogenic *qi* is at the root of illness patterns, then it must be at the root of 'disease' processes as well. In this move, biomedical pathology is translated into terms and things derived from the ancient metaphysics that gives coherence to Chinese medicine. In Lu Guangxin's argument, some powerful metaphysical principles have suddenly ridden to the rescue; both historical and explanatory priority is accorded to entities – forms of *qi* – recognised only by Chinese medicine. Put another way, only Chinese medical knowledge can account for the strange reality of Western medical diseases; biomedical materialism is shown up as, in a sense, blind to the real forces that produce symptoms in knowable clusters. The obvious (in Chinese) play of orthopathic and heteropathic *qi*, and the common-sense actuality of *qi* itself, provide elegant explanations of suffering and symptomatology. With reference to them, 'pattern of disorder' and 'disease' become one highly 'processual' and emergent thing that is as well (or better) understood by Chinese medicine doctors as by Western medicine doctors. The national-cultural triumph in this careful definitional work is hard to miss.

The solution Dr Lu proposes to the philosophical-linguistic problems posed by the pattern of disorder in Chinese medicine, then, is formally elegant, aesthetically appealing and strategically aggressive, but it relies entirely on our acceptance of the reality of *qi*. Once you start using *qi* to think with, it works pretty well to account for experience, but this untranslatable mixture of process and object, force and substance, matter and energy is real for only a portion of the world's population. To peg the ontological status of the illness pattern on '*qi*' is, at best, a gamble.

The problem of pattern signals the larger dilemma faced by theorists of Chinese medicine like Dr Lu who must deal with the global hegemony of biomedical categories. In the modern era, Chinese medicine's ultimate claim to transnational value is its therapeutic efficacy as *medicine*. No amount of recognition for ancient philosophical elegance or aesthetic literary appeal will pay the institutional bills;

few clinicians are willing to settle for mere social-symbolic efficacy or for a psychological placebo effect. To advance a claim based on efficacy, translators have had to make an unremitting comparison with the field of biomedicine as it has been institutionally, epistemologically and terminologically constituted over the last few hundred years in Western countries. If such a comparison is to operate on a common ground, it tends to confine attention to interventions in illness (as opposed, for example, to preventive medicine or life skills), structures of the anatomical body (rather than, for example, functional rubrics), entities that are directly or technologically visible (certainly not *qi*), and so forth.

In relation to the scope of the actually existing archive on which medical people have historically drawn in China, however, this is rather restricted turf. The terrain hegemonically constructed by global biomedicine also forecloses the vast range of popular and esoteric techniques through which affliction and everyday bodily experience have been managed over the years in China. As Chinese medicine, following a scientific model, speaks ever more systematically of natural causes, the experiential, textual, practically learned past drops away (Bowker 2005). Yet, in Lu Guangxin's synthesis of disease and pattern, at least some of the forces recognised in 'traditional medicine' regain scientific importance. Or claim to.

Relational objects

Lurking in this discussion are many of the modern dilemmas of Chinese medicine. Linguistic translation in a scientific setting requires that words become well-defined and conventionally used technical terms. At the same time, technical terms must have a common-sense (read materialist and modern) object as referent. A signifier must be supplied for the signified, an object must come forward to make the word consistently meaningful to a large group of interlocutors; but Lu Guangxin insists that objects are not simple. He operates his own very creative translation even at this most basic level: what is an object? For Dr Lu, it is a *duxiang*.

To see how he uses this very particular Chinese notion of an object, we can turn to some comments he made in 2001, in which he argued that medicine is *about* people, a form of humanism in the broadest sense. In a paragraph that addresses the responsibility of the Chinese medicine researcher, for example, he says the following:

The self-health and self-curing capacity of human life-generating *qi* is the object we serve and the object we study; it is the object through which Chinese medicine researchers must diligently become 'great doctors of the masses;' it is that by which Chinese medicine researchers may or may not become touchstones of genuine Chinese medicine. If we depart from this

'root' of life-generating qi that must be sought in the nurturing of life and in the treatment of illness, then we cannot expect any genuine Chinese medicine to survive.

Hence ... 'the Way is not far from man, let the body/person of the patient be your respected teacher.'

The root of the Way of Chinese medicine is the study of the human: Learn from the objects of your own service [e.g. patients, students]; learn from the objects on which medicine relies [e.g. drugs, symptoms]; learn from the objects that develop medicine [e.g. scientific results, historical research]; learn from life-nurturance and disease treatment in practice, and seek development only out of practice. Medicine at root is humanism.
(Lu 2001: 7)

This very general comment picks up on a number of themes that have been important throughout Dr Lu's career. Like every good Maoist (and he is one, still, I think), Dr Lu insists on learning from practice (Mao 1967). Though he is known as a theorist, Lu acknowledges no separate conceptual domain for theory or even for knowledge, no ideal realm in which the 'real world' could be represented such that signifiers would correspond neatly to signifieds, and words would correspond without remainder to things. Instead, he insists on learning from the *objects of practice*, while engaged in practice.

The word he uses for object has much clearer philosophical content in Chinese than in English. It is *duixiang*, literally translatable as *the image we face*. It is a perceptible element of the manifest world, not necessarily a massy object, and it is irreducibly relational. A *duixiang* exists only in relation to a perceiver or an actor: common translations of the word are 'target' or 'partner'; translation as 'interlocutor' or 'objective' also works in some contexts. A *duixiang* is a complex entity that emerges from practice, but it does not do so merely as a product of the investigator's imagination: if this object were solely imagined, how could one learn from it? Implicitly, a whole network of human and non-human agents is active in producing contingent *duixiang* 'objects' for clinical and theoretical attention. Entities such as 'the self-health and self-curing capacity of human life-generating qi' are complex *duixiang* from which insights about natural processes (or even the Way of medicine) can be gained. Heterogeneous entities like the body/person of the patient or the combined efficacies of a herbal medicine formula realise new conjunctures of diverse natural-cultural processes. Contradictory and abstruse interlocutors like the medical works in the huge Chinese medicine canon can supplement the experience of living patients and doctors with a heritage of 'clinical records'.² The *object*,

thus, is a site at which specific processes (always more than one) converge; it is by definition spatio-temporally unique and requires a situated perceiver for its unique existence. From each such located conjuncture we can learn something. This is especially the case if our learning from objects is cumulative, collective and oriented toward practical medical service. The local specificity of Chinese medical knowledge is not just found in a modern nation or linguistic community or set of institutions – it is found above all in a multitude of practitioners and researchers at work among, and learning from, other people.

Conclusion

By way of conclusion, let me return to Lu Guangxin's ruling questions, this time in reverse order. Can multiple natures, with their incommensurate entities and untranslatable first principles, co-exist and even be usefully linked in both knowledge and practice? I think Lu would say that, in fact, multiple natures are already being woven together in practice everywhere. Even in places where there has been little official interest in traditional medicine, clients and healers at various levels are cobbling together interventions, situation by situation, that address more than infection, more than structural alterations in vulnerable bodies, more than the short-term challenge to comfort and social coherence. What objects are now under construction in healing, and in talking about healing? What networks and social worlds are ramifying out from the contestations of medical knowledge? Practice is ahead of philosophy in this respect, so it behoves us to be anthropologists of knowledge. To adopt language from Isabelle Stengers (2005), we should be thinking more slowly, investigating more thoroughly, yet acting all the time. On this last, we hardly have a choice.

The imperative to think, even if more slowly, leads to question two: On what philosophical basis can heterogeneous global networks of world medicine be built responsibly? One could also ask: Do we need philosophy if we are to collaborate across the great ontological divides of the world? Why isn't modern science enough to provide the needed common ground, the knowledge foundation on which action can be undertaken? Lu Guangxin ultimately seeks to redefine science in order to avoid a simplistic or knee-jerk resort to it. If the only way to understand physical affliction scientifically is the concept of disease, for example, then he would say this is not good enough. We need the flexibility of illness patterns if treatments are to be truly responsive to every particular convergence of wholesome and malignant forces. Further, if the liveliness of objects is to be acknowledged in our analysis, we need a non-reifying language – a language of *duixiang* – that incorporates our own perceptual and knowing activity into the very character of things. As Lu Guangxin

argues elsewhere, inspired both by Maoist social epistemology and modern physics, anything we can know is a product of our point of view on it.³

These are only two of this scholar-doctor's many philosophical interventions into global science; and he is only one among many thoughtful writers and policy-makers who work only in Chinese, and who thus have no global voice. Are these men and women 'indigenous' subjects of knowledge (always rushing to 'catch up' with the prestige of scientists)? Is their relevance and their contribution confined to the dilemmas of the Chinese reading publics to whom they speak?

We should not forget the historical summary provided earlier: Lu Guangxin and his colleagues occupy a post-imperialist, state-modernising, cultural-nationalist and thoroughly hybrid terrain of knowledge and practice. They are translating and translated, ever-transforming citizens of a heterogeneous world, nodes in far-flung and very lively networks. They are, whether we read Chinese or not, our colleagues. As academics, professional subjects of knowledge, we must continue to learn from things in the great variety in which they present themselves – to the clinician and to the patient, as to the philosopher and the historian. We must, in other words, rise to the occasion of being creatures who are always being translated and transformed into and out of the local.

End notes

- 1 When the full array of Chinese medicine's forms of existence over several thousands of years is considered, there would be reasons the field should, perhaps, not even be called medicine. Ontology, cosmology, metaphysics or literature are all good candidates to supplement the category of medicine. This notion cannot, however, be developed here.
- 2 This term 'clinical records' is often used in relation to the Chinese medical archive, though the cases, formulae and techniques of the past were all generated prior to the birth of the modern clinic in China. See the essays in part 2 of Furth, Zeitlin and Hsiung (2007).
- 3 Classical Chinese philosophical perspectivism is much discussed in sinology. Two good sources for understanding this aspect of early Chinese metaphysics are David Hall and Roger Ames (1987) *Thinking Through Confucius*, and François Jullien (1995) *The Propensity of Things*.

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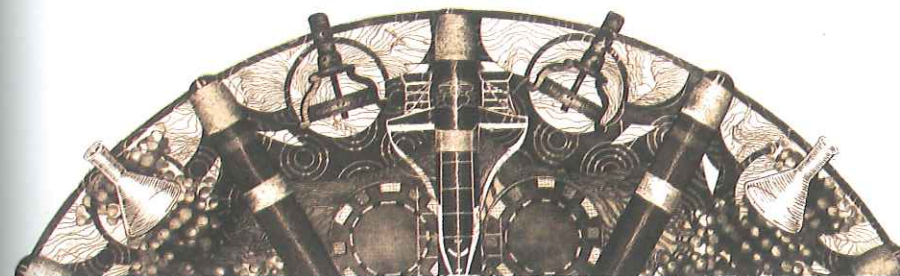
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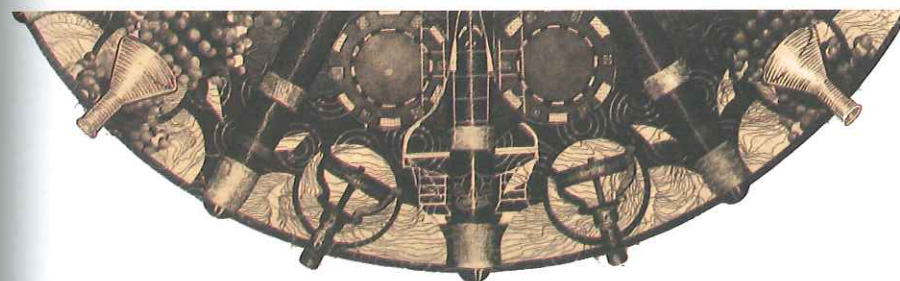
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