



Universität Bielefeld
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**Institut für
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Working Paper 01/2007

Chinese medicine and globalisation

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Abstract The globalisation of Chinese medicine is a process that has been going on for some thirty years. It can be seen as a diffusion of Chinese medical knowledge and practices around the world, and as an adaptation of Chinese to European and North-American knowledge and practices. In this article, I will argue that the globalisation of Chinese medicine is a cultural globalisation. Chinese medicine became modernised in the form of ‘traditional Chinese medicine’ as a canon of medical authors and in the college-based form of teaching, but not in the core medical conception. This modern as well as non-modern character made acupuncture and partly TCM acceptable within a Western medical environment. I will outline the expansion of biomedicine to China, the counter-movement of traditional medicine, and the acceptance of acupuncture in Britain and Germany as a globalisation of Chinese medicine.

Only few authors are discussing medicine in the frame of globalisation (cf. Hsu 2009; Stollberg 2006; Alter 2005; Barnes 2005; Frank/ Stollberg 2004; Hoerbst/ Wolf 2003; Hsu/ Hoeg 2002; Wolf 2003; Zhan 2001). As early as 1976, Leslie had opened a comparative perspective on ‘Western’ (‘cosmopolitan’), Indian, Chinese, and Arabic medical traditions (cf. also Leslie/ Young 1992). Kleinman (1980) adopted this approach in a cross-cultural study of Chinese and ‘Western’ medicine and psychiatry. The contributions to an earlier ‘Easts’ volume describe the globalisation of Chinese medicine as a process that has been going on for some thirty years. Earlier waves had taken place since the 17th century, but seem to have ended at about 1900 (cf. Barnes 2005; Bivins 2000).¹ This process can be seen as a diffusion of Chinese medical knowledge and practices around the world, and as an adaptation of Chinese to European and North-American knowledge and practices. In this article, I will first give an overview of modernisation and globalisation theories (section 1), and demonstrate that the globalisation of Chinese medicine is a cultural globalisation (2). Then I will outline the Chinese medical conception, and the debate about its internal modernisation (3). I will explain three aspects of this globalisation: its homogenisation, polarisation, and hybridisation. The expansion of biomedicine to China will serve as a first example of its homogenisation (4). The invention of ‘traditional Chinese medicine’ after 1949, and the development of a college-based education system will serve as a second example (5). My third example will be a sketch of the establishment of professional organisations that made acupuncture, but not

¹ Earlier waves quoted the physicians Willem ten Rhyne and Engelbert Kaempfer for reference, who had reported on acupuncture in about 1700. The last wave started with the French physician Soulie de Morant in 1934.

TCM, acceptable in the British medical context (6). A fourth example will be the randomised clinical trials that opened the way for the integration of acupuncture into the German medical practice. Polarisation will be addressed through the reports on acupuncture given by the British and German Medical Associations in the 1980s and 1990s (8). Acupuncture and biomedicine in German medical practice will be used as an example for hybridisation (9). I will conclude with some remarks on the modern as well as non-modern character of the Chinese medical conception (10).

1. Globalisation, modernisation, and world society in social theory

Globalisation has become a catch-all-word and has been observed in many different social areas, e.g. in economy, politics, religion, and culture. As a catch-all-word it has replaced modernisation. Modernisation theorists have looked at many societal fields (cf. Berger 1996): at the person, community, education, economy, politics, science, and culture, which includes education and science. Modernisation theories have been criticised for their optimistic reliance on the progress of mankind, which ignores violence and the possibility of regressive de-modernisation, of ecological costs, and of non-Western paths of modernisation (cf. Wehling 1992; Degele / Dries 2005; Evers, in: Joas 2001; Loo / van Reijen 1997). That modernisation processes converge in various fields, and in various countries, is one of the empirically weakest theses of modernisation theory (cf. Berger 1996: 59). For example, even in economy, which forms a core field of modernisation, ‘varieties of capitalism’ can be observed that do not necessarily converge in their developments (cf. Hall/ Soskice 2001). Thus, anthropologists criticise the top-down perspective:

‘That various aspects of modernization should progress at different paces or penetrate into some domains of practice but not into others ceases to be a problem and becomes a reflection of the particular local constellations of power, and hence of resistance and accommodation’ (Scheid 2002: 40).²

Most modernisation theorists expected tendencies towards a uniform modernity, and many globalisation theorists followed this expectation. Giddens (1990; 1991) linked globalisation and modernisation enumerating four institutional features of modernity: capitalism, industrialism, surveillance (political control), and military power. These features make modernity spread around the globe, and result in the capitalist world economy, the system of

² Harris/ Seid (2004) concentrate their argumentation on the negative consequences of economic modernisation for people’s health.

nation states, the military world order, and the global division of labour. Taking up traditions from Toennies, Simmel, and Max Weber, Giddens is an example for expecting a tendency towards homogeneity of modern social development.

In his version of systems theory, Luhmann goes down a similar road. He criticises globalisation theory³ for not acknowledging the global character of the existing world society. Historical evolution changed the internal differentiation of society from stratification to complete functional differentiation. Differently developed regions can use complete functional differentiation for comparison (cf. Luhmann 1997: 163). Local or regional particularisms are elicited by the universalism of globally operating functional systems⁴, because they compensate the ease of globally changing structures (cf. Luhmann 1997: 170).⁵

Theories of world society emerged from modernisation theories. Meyer et al. (1987) outlined tendencies of a homogenous world culture. By *culture* Meyer et al. understand the institutional models of society: God and nature become separated from society; individuals are rational actors and have a special moral status; justice is a culturally constructed perspective upon individual participation, and on the distribution of material goods etc. Stichweh (2006; cf. 2000) contrasted with multiplicity the following uniform and specific structures of world society: The differentiation of functional systems; the career of formal organisation; the de-location of networks; epistemic communities; the globalisation of knowledge; world events; markets; world general public, and world cities.

In their criticism of a homogeneous development, many authors take Shmuel Eisenstadt's 'multiple modernities' for theoretical reference. Eisenstadt stressed that 'actual developments in modernizing societies have refuted the homogenizing and hegemonic assumptions' of the Western program of modernity.

'While a general trend toward structural differentiation developed across a wide range of institutions in most of these societies – in family life, economic and political structures, urbanization, modern education, mass communication, and individualistic orientations – the ways in which these arenas were defined varied greatly, in different periods of their development, giving rise to multiple institutional and ideological patterns' (Eisenstadt 2000: 1f.).

The history of modernity is a story of continual constitution of a 'multiplicity of cultural programs' (ibid. 2). Since the 1970s, globalisation has weakened the centrality of the nation-state. New social movements, like the women's and the ecological movement, developed new visions. Later on fundamentalist religious and particularistic ethic movements gathered

³ He mentions explicitly Giddens, Robertson, and Archer. Cf. Luhmann (1997: 159 fn. 217).

⁴ This applies to medicine: cf. Luhmann 1990.

⁵ This last passage addresses values; but it can be transferred to knowledge and practices.

momentum. Nevertheless, modernity forms a 'major frame of reference' to all these movements (ibid. 20). Thus, Eisenstadt steers a middle course between the theses of a homogenous and a multiple character of modernity. In contrast to the title of his book, and many of his followers, he is not limited to the thesis of multiplicity.

If we take the globalisation of medicine as the global expansion of a functional system, it should produce similar, though not identical structures worldwide. Then the focus would be on its relative autonomy from other systems like religion or economy, and politics. The relationship to both the latter systems is an issue of comparative health politics, constructing policy types in different nation states, and asking for convergent or divergent tendencies.⁶ As for the global level, Inoue/ Drori (2006) focus upon the development and function of global medical institutions and organisations. Adopting John W. Meyer's neo-institutionalist perspective mentioned above, they construct the medical systems as an organisational field characterised by a tendency towards similar organisations.

The question of the globalisation of Chinese medicine, however, does not refer to the development of national health policies, nor of global medical institutions. It rather aims at the expansion of medical conceptions. A medical conception is a triad of conceptions of the body and soul, of explaining disease, and of therapy (cf. Rothschild 1978: 9). It is framed by economy and politics, and the relationship to religion may be part of the conception. Thus the globalisation of a certain medical conception is an issue of cultural sociology and anthropology; it is an issue of cultural globalisation.

Modern sociology takes culture to consist of learnt norms and values, knowledge, artefacts, language, and symbols that become exchanged within given societies every day (cf. Rehberg in Joas 2001: 68f.). Modern anthropology takes culture to consist of learnt norms and values, and of collective knowledge (cf. Schweitzer 1999: 4).⁷ Thus cultural sociology and anthropology may converge in their perspectives.

Historians have used comparisons between nation states since the decades of modernisation theory. They are leaving this road for conceptions of transfers, *histoire croisée*, or entangled history. While comparisons look for differences and similarities, di- and convergence in a

⁶ The most prominent model (Esping-Andersen 1990) is based on national pension schemes. Schmid (1996) widened the perspective on health policy in European states.

⁷ Geertz (1973; 1983) paved the way for a development from functionalist towards interpretative anthropology. In symbolic anthropology, Sahlins (1976: 211) looked for institutional integrations of the symbolic scheme; they may be economic in Western or religious in third-world societies. Dolgin et al. (1976: 4f.) looked for the elements through which people understand: objects, persons, relations, acts. Cognitive anthropology widened this approach by integrating psychological processes (cf. D'Andrade 1995) into an explanation of cultural meaning (cf. Strauss/ Quinn 1997).

number of cases (cf. Haupt 2001), transfer looks for the changes that take place when norms, pictures, representations etc. are transferred from one national culture into another (cf. Espagne 1999). Entangled history is the history of transfers between culture areas (*Kulturkreise*), between different world regions, between colonisers and the colonised etc. (cf. Conrad/ Shalini 2002). The concept of cultural globalisation comes quite near to this entangled or shared history.⁸

Meanwhile, social scientists reflect upon homogeneous *and* heterogeneous aspects of globalisation.⁹ The economist Aulakh and the political scientist Schechter (2000) assembled heterogeneous approaches towards globalisation. The sociologist Tyrell (2005) offered an overview of the use of the terms *modernisation*, *globalisation*, and *world society*, both in the singular and plural. The sociologist Schwinn (2006: 18f.) observed that world society theory and the theory of multiple modernities criticise and compete with each other. But nonetheless they share many observations; even their blind spots complement each other: Society or 'world' has differentiated into different social spheres like science, economy, and politics. The specific order in these spheres may be multiple or uniform (ibid. 29). Randeria's (2002) 'entangled modernities' fit into this perspective. She pointed to the black economy, the power of transnational enterprises, the declining autonomy of nation-states, health and education systems, to poverty and joblessness as new phenomena in European, but old ones in African, South Asian, and Latin American states.

2. Cultural globalisation

Despite the 'varieties of capitalism' mentioned above, economy is taken to be a central arena of global homogenisation, while culture is often taken to be a centre of worldwide diversity. Building on Therborn, Wimmer (2003) takes the perspective of *longue durée*. He speaks of

⁸ Chakrabarty (2000) opens a differentiated perspective on modernity. On the one hand, there is a Europe-based tradition of universals of mankind; this tradition Chakrabarty especially connects with Marx. On the other hand, there is a hermeneutic tradition, especially connected with Heidegger, which opens a path to diversity, thus to provincialising Europe. From one now can derive different or various futures. One now thus cannot be traced back to one past. – I got some problems with this approach: 1) I do not know whether Heidegger has been interpreted adequately. 2) I cannot properly relate Chakrabarty's thesis to the globalisation of Chinese medicine.

⁹ Aiming at developing a perspective common to modernisation and cultural theories, Bonacker / Reckwitz (2007) nevertheless draw too clear a distinction between both sides: They characterise the modernisation narrative by pointing out differences between structure and culture, and modern and traditional society, by supposing a discontinuity between traditional and modern, and by an internal unity and rationality of the modern. On the other hand, cultural theories are said to assume a cultural constitution of the social, to make permeable the border between tradition and modernity, and to stress the diverse and conflicting character of modernity, and the cultural production of rationality.

waves of globalisation¹⁰ when analysing the relationship of economic and political globalisation, on the one hand, and cultural globalisation, on the other hand. Wimmer proposes to synthesise ‘isomorphisation’ (as discussed in Meyer et al. 1997 for educational and political institutions in nation-states) or ‘parallel development’ (as observed by Larkins, 1997) into a single economic, political, and cultural model that includes the possibilities of ‘heteromorphisation’, ‘de-synchronisation’, and ‘differentiation’. Accordingly, globalisation may cause a hetero-morphisation of the global social system, and does not necessarily result in its homogenisation. Wimmer conceptualises globalisation as a non-linear process producing bi-furcations: similar developments in politics and economy may cause different transformations in culture, and vice versa.

Anthropologists often revert to Appadurai’s (1996) terms of cultural flows: Ethnoscapes, mediascapes, technoscapes, financescapes, and ideoscapes. They have been complemented by a ‘medicoscape’.¹¹ For Appadurai the configuration of these cultural forms in today’s world was fractal, but overlapping (1996: 46). The correlation of the flows differs for regions and times. Their open character, and Appadurai’s political activities, made his conception attractive for approaches critical of a US-dominated form of globalisation. This opposition is often politically motivated, stressing the dark sides of modernity, like social inequality, poverty, Western hegemonic structures etc. Elements of post-modern perspectives are taken up. Thus, ‘parallel modernities’ in postcolonial countries were discovered (cf. Larkin 1997), ‘alternative modernities’ or ‘alterities’ were proposed (cf. Knauff 2002). These approaches share with the conceptions they criticise many basic assumptions about modernity,¹² but differ

¹⁰ Therborn (2000: 158ff.) listed six waves: 1) The diffusion of world religions and the establishment of transcontinental civilizations (4th-7th centuries BC); 2) the European colonial conquests (15th-16th centuries); 3) the first global wars (late 18th-early 19th centuries); 4) European imperialism (mid 19th century to 1918); 5) The Cold War; 6) The financial-cum-cultural globalization since the 1980s. Borchardt (2001) hinted at a ‘global’ commerce system in the Middle East in about 1300. He criticised the world systems theories of Wallerstein and Braudel: There were no exchange processes between the Portuguese and Spanish empires, but clear internal differences between centres and peripheries. For Osterhammel/ Petersson (2003) Wallerstein and Braudel form a central point of reference, too: Before 1500, there were only runs towards globalisation. The Spanish and Portuguese empires established an irreversible world-wide economic network. A world economy emerged after 1750 and became an arena of competing European states after 1880. In the decades after 1945 there arose the structures of today’s globalisation, and the world became a community of fate.

¹¹ Medicoscapes are defined by Hoerbst/ Wolf (2003: 4; cf. Wolf/ Dilger 2003) as worldwide dispersed landscapes of persons and organisations in the curing field that may become locally concentrated in one place, but link far distant regions and institutions. They include persons and institutions demanding and looking for therapies on an international level; the WHO as a global guardian of biomedicine; organisations of so-called traditional healers; regional healing practices and their reception in other places, globally dispersed forms of therapy, and organisations of international development co-operation in the medical field.

¹² Meanwhile historians take Heidegger as a theoretical base for social diversity in the 19th and 20th centuries. Cf. Chakrabarty (2000).

in their normative orientations. Friedman shares and discusses critical approaches to modernity in detail,¹³ and concludes:

‘Modernity as the contemporaneous refers to a situation of integration within the capitalist world economy and to varying degrees within the capitalist world as such. (...) Modernity in the structural sense (...) refers to the cultural parameters of capitalist experience space, an outgrowth of the commodification of social relations which occurs to various degrees in time and space’ (2002: 307).¹⁴

Gaonkar propagates ‘alternative modernities’, reporting a ‘widespread feeling (...) that we are at (...) a turning point in the trajectory of modernity’ (1999: 13). The master-narratives have come to an end (cf. Lyotard 1984). Paraphrasing Habermas’ and Foucault’s criticism of modernity, Gaonkar nevertheless states:

‘That questioning of the present (...) which is taking place at every national and cultural site today cannot escape the legacy of Western discourse on modernity’ (p. 13).

A similar criticism of the homogeneous model of modernity makes Collier define global assemblages:

‘An assemblage is a heterogeneous collection of elements – scientific practices, social groups, material structures, administrative routines, value systems, legal regimes, technologies of the self, and so on – that are grouped together for the purposes of inquiry.’ (Collier 2003: 423)

This definition takes up the actor-network-theory. One of its proponents, Bruno Latour (2005), criticises the sociological differentiation of micro- and macro-perspectives, which take the small to be embedded in the big. Latour maintains that the big is connected, but not the small. The actor-network-theory postulates that these connections connect social and non-social phenomena. Latour therefore does not speak of ‘actors’ and ‘structures’, but of ‘assemblages’ of these phenomena. In a collection of essays, Collier and Ong (2005) bring together contributions dealing with ‘emergent temporalities’ of technological innovations, such as organ transplants or stem cells that can be transported across boundaries, be they biological, social or political. As ‘the product of multiple determinations that are not reducible to a single logic (Ong/ Collier 2004: 12), an assemblage is inherently heterogeneous and particular, as ‘global forms are articulated in specific situations – or territorialized in assemblages’ (Collier/ Ong 2005: 4).

The conception of a global assemblage comes near to the conception of hybridity, which have become prominent in anthropological studies of globalisation. The anthropologist Nederveen

¹³ For instance those of Comaroff/ Comaroff (1999), Kelly (2002), and Knauft (2002).

¹⁴ Therborn (2000 b: 68) proposed to stress the break with eurocentrism by talking of ‘lateral modernities’.

Pieterse (1994) proposed a hybridisation of hybrid cultures in the process of their expansion. The sociologist Holton (2000) saw three cultural consequences of globalisation: homogenisation, polarisation, and hybridisation. These perspectives were also used for medical anthropology. Høg / Hsu (2002) made the medieval Buddhist expansion as a form of globalisation responsible for the transformation of Chinese medical theories and practices (and their systematic exportation to Korea, Japan and Tibet). Frank/ Stollberg (2004) analysed forms of Chinese and Indian medicine in Germany with the concept of conceptual and transformative hybridisation.

3. The globalisation of the Chinese medical conception

Medical conceptions consist of conceptions of the body and soul, of explaining disease, and of therapy (cf. Rothschuh 1978: 9). In this sense, the globalisation of a certain medical conception is an issue of cultural sociology and anthropology; it is an issue of cultural globalisation. Holton (2000) saw three cultural consequences of globalisation: homogeneity, polarisation, and hybridisation. I will now apply this triad to the globalisation of Chinese medicine.

The Chinese medical conception has been explained in the *Huang Di nei jing*, a compilation of fragmentary texts written between the second century BC and the second century AD. It became the canonical text up to our time (cf. Unschuld 2003). As for the *body*, there are twelve big pipelines (meridians) sending blood and qi through each half of the body. There are further vessels forming a network between the big vessels. A third type of vessels links this network to the tissues. All twelve big pipelines are connected to individual organs. The organs together form a hierarchical structure. *Emotions* could empty the respective organs, and open the body to influences from the environment. Various forms of qi fight these invaders; if they fail, diseases may develop. The therapy will strengthen the qi, and transport to the place where it is needed. This is the core of the Yinyang and Five Phases doctrines.

Unlike medicine in ancient Greece, Chinese medicine was not clearly separated from religion. The corpus Hippocraticum (ca. 460-370) concentrated its explanations on 'natural' causes of disease. In a similar way, neither the Yinyang doctrine nor that of the Five Phases is compatible with religious or demonological explanations (cf. Unschuld 1985: 51ff.). But Chinese intellectual history is marked by syncretism, and there were medical references to demonological explanations as late as the 19th century (cf. Unschuld 1985: 223ff.). The

contents of Chinese medical knowledge remained polysemic and contradictory. Regarding the Huang Di nei jing, Unschuld (2003: 327) states:

An innovative ‘systematic approach to health and illness, based in an acceptance of the notions of an all-pervasive systematic correspondence, was fused with an ontic approach whose justification and plausibility lay in past centuries ...’.

Unschuld (2003 a: 192ff.) stresses the fact that this conception did not seriously change up to our times, though there were medical authors like Xu Dachun (1683-1771), who wrote an article about intra-abdominal abscesses that is hardly compatible with the traditional conception of flowing blood and qi. It rather comes near to Morgagni’s allocation of diseases in the organs, who at the same time criticised the Galenic conception of humours and their mixtures that were the supposed causes of health and illness. Unschuld’s position is contested by authors like Lu/ Needham (1980). They outline Chinese medical debates in 13th and 16th centuries,¹⁵ stressing a long and autonomous tradition of Chinese medicine and its relations to philosophy. Nevertheless they do not report changes between the 17th and the 20th centuries. Hsu (2001: 215) objects: the view ‘that Late Imperial China had little to offer by way of medical innovation ... is clearly outdated’.¹⁶ Scheid (2002: 40) observes changes in Chinese medical practices and doctrines at a local level, where traditional and modern elements ceased to be contradictory.

I cannot settle these debates. But certainly Western medical conceptions have changed much more and more in their principles than their Chinese counterparts: Since the Renaissance, mechanical, chemical and bio-dynamical medical conceptions have emerged beside the Galenic humoral tradition (cf. Rothschild 1978).

The Chinese medical conception became globalised. I will analyse this process under the aspects that Holton (2000) saw as cultural consequences of globalisation: homogenisation, polarisation, and hybridisation. As for homogenisation, I will first sketch the opposite development, the acceptance of (Western) biomedicine in China. Biomedicine aimed at dislodging the Chinese conception, but forced it to re-shape in modern forms. Secondly, I will sketch the establishment of these modern forms of the ‘Traditional Chinese Medicine’ (TCM), the integrated medicine and of the college system teaching this knowledge in China. Thirdly, I

¹⁵ For instance, the theory of daily and cosmic cycles of the *qi*, which had come up since the 13th century, was severely criticised in the 16th century (cf. Lu/ Needham 1980: 149).

¹⁶ For instance, in the 18th and 19th centuries a discourse on warm factor disorders (*wenbing*) emerged, which focused upon diseases of Southern China, and can be knotted to the rise of regionalism in Late Imperial China (cf. Hanson in: Hsu 2001). In Republican China a new medical case history adopted the biomedical model, but at the same time imposed a sense of unity to Chinese medicine of its time (cf. Andrews in: Hsu 2001). Birch/ Felt (1999: 38) mention a 19th century school of ‘independent’ moxibustion practice.

will trace the establishment of professional organisations that made acupuncture, but not TCM, acceptable in the British medical context. Fourthly, I will discuss the randomised clinical trials that opened the way for the integration of acupuncture into German medical practice.

4. The acceptance of (Western) biomedicine in China

Starting from France and Germany in the 1860s, biomedicine overcame other medical conceptions. Biomedicine in a broader sense comprises firstly, a scientific orientation towards natural sciences, especially biology,¹⁷ and a medical treatment specified for individual diseases;¹⁸ secondly, surgery, supported by analgesia and anti- or asepsis; thirdly, chemical drugs and vaccination methods; fourthly, a public health regime including quarantine, and the spatial concentration of ill persons; fifthly, medical statistics. The individual components are partly older than the orientation towards the sciences, and partly belong to the military and administration more than to curing. This European biomedical complex was able to penetrate other world regions because it became part of colonialist expansion. Public hygiene, an amalgamation of administration and medicine (cf. Rosen 1974), succeeded in the containment of epidemics, and strengthened the social position of biomedicine.

We can observe these processes in China, too (cf. Croizier 1968; Lei 1999). Since the 1810s, missionaries had introduced Jenner's vaccination to Guangdong (Canton), and it was in this very city that a missionary ophthalmologic hospital had been founded in 1834.¹⁹ The number of medical missionaries rose since the 1870's. 'By 1897, about 300 Chinese doctors had graduated from missionary medical schools' (Elman 2005: 343), as Sun Yat-Sen did in 1892. But biomedicine was also able enter Chinese medical knowledge and practice. In 1884, the physician Tang Zhonghai (1851-1908) published a textbook 'Essential meanings of the medical classics in the light of Chinese-Western eclecticism' (cf. Unschuld in: Leslie / Young 1992). Tang maintained that there was no difference between Western organ charts and the morphology outlined in the 'Inner Canon of the Yellow Emperor'. Chinese medicine was superior to Western anatomy because it realised in addition the cosmological embeddedness

¹⁷ Cf. Cunningham/ Williams (1992).

¹⁸ Cf. Sarasin et al. 2007.

¹⁹ When the Japanese occupied Taiwan in 1895, they introduced biomedicine; especially biomedical hygiene and the containment of epidemical diseases (cf. Cheng 2003).

of the human body (cf. Lei 1999: 166). In 1893, Li Jingbang claimed that the placement of the brain in Western medicine had been adopted from the Inner Canon (cf. Elman 2005: 344f.). In the same year, the Emperor established the biomedical Beiyang Medical College, and later, in 1905, initiated public health organisations like the sanitary department under the Beijing police. The containment of the ‘Manchurian plague’ in 1910 was generally attributed to public health measures like quarantine, the control of migrants, forced cremation of the dead etc., which were proposed by a young biomedically oriented doctor, Wu Lien-teh, who had been trained in Cambridge. The measures were executed by the Qing-dynasty administration. In 1911, an International Plague Conference was held at Mukden. In 1915 the biomedical Peking Union Medical College, financed by the Rockefeller Foundation (cf. Spence 2008: 465), and the biomedical National Association of China were founded (cf. Lei 1999, chapter 1).

Though the number of Chinese Western style doctors remained small, their influence became strong due to a symbiosis with the Kuo Min Tang party (KMT). In 1928, the KMT troops ended the Warlord period, which had followed the overthrow of the Imperial system in 1912, and started building a unified nation state. In the same year, the KMT established a Ministry of Health at Nanjing, the place where the first National Public Health Conference was held in 1929. It was dominated by Western-trained physicians, and passed a proposal for ‘Abolishing old-style medicine in order to clear away the obstacles to medicine and public health’.

But at this point the development of a homogeneous Chinese biomedicine unexpectedly turned into polarisation. The 1929 resolution mobilised the previously unorganised traditional Chinese doctors into a massive National Medicine movement. They used the subscription lists of a popular Chinese medical journal for nation-wide communication (cf. Lei 1999: 94), and in 1929 rounded doctors up in a National Congress of Chinese Medicine Doctors. Within this Shanghai congress an umbrella organisation was founded, the Federation of Medical and Pharmaceutical Associations. The physicians called their medicine national, and not traditional. They felt in an ambiguous position between preserving a heritage of a nation that was being rebuilt in their times, and aiming at competing with or at least breaking up the symbiosis of biomedicine and the nation state. Additionally, the Chinese medicine doctors formed a strongly heterogeneous group. Lei (1999: 185ff.) identified two positions regarding the relation of Chinese to biomedicine. The first position was that Chinese medicine did not need scientisation. Zeng Jueshou for example claimed that Chinese medicine was based on theory, and confirmed by experience in the sense of experiment (cf. Lei 1999: 193). The second position was that Chinese medicine could be scientised. Tan Cizhong for instance

identified yin and yang, blood and qi etc. as ‘material bases’ of medicine (cf. Lei 1999: 189f.). The latter position resulted in the foundation of an Institute of National Medicine in 1931. In 1935, a Dictionary of Chinese materia medica was published (cf. Lei 1999: 222). The KMT government promulgated an equal treatment of Chinese and Western medicine in that very year (cf. Lei 1999: 198). Schools of Chinese medicine increased in number from some 10 or 16 in 1927 to some 54 or 58 in 1937 (cf. Lei 1999: 198).

5. ‘Traditional Chinese Medicine’ (TCM), the integrated medicine and the college system of teaching this knowledge in China

In the decades after the Civil War, Chinese medicine became canonised in its contents, and modernised in the form of its education. Though the Chinese communists did not principally differ from the reformers of the Qing times in their scientist orientation, they adopted traditional medical practices, and especially the Chinese materia medica, in a situation of deficiency during the Civil War and its aftermath. In the period from 1949 to 1965, Chinese medicine became formally institutionalised in the People’s Republic. According to Taylor, this process owed more to ‘a careful manipulation of (Chinese medicine’s) value as a ‘cultural legacy’’ than to ‘any consideration of its actual therapeutic value’ (quoted from Scheid 2002: 67). Up to 1956, the slogan was to ‘unify Chinese and Western medicine’. State-controlled examinations of Chinese medicine practitioners required an extensive knowledge of Western medicine. ‘Simultaneously ... Chinese medicine improvement schools ... were established throughout the country, and even older and well established physicians were required to attend’ (Scheid 2002: 69). Economic pressure seems to have changed the course from creating a unified medicine to strengthening the national heritage. In 1954, the Academy of Chinese Medicine was founded, and in 1956 Chinese medicine colleges were erected at Chengdu, Beijing, Guangzhou, and Shanghai, followed by 16 more in 1966. This development was interrupted during the ‘Ten Lost Years’ of the Cultural Revolution (1966-1976) (Scheid 2002: 85). In 2003, ‘there were 32 colleges and universities and 45 secondary schools teaching TCM in China. There were also TCM specialized departments in 184 health schools, 58 medical colleges and universities’ (Thieme Almanac 2007: 205). Though at least many older Western trained Chinese physicians practiced herbal in combination with Western medicine (cf. Harmsworth/ Lewith 2001), the following table shows the prevalence of biomedicine as well as a strong minority position of Chinese medicine:

Table 1: Traditional medicine doctors in China²⁰

1996	Number	Total personnel (%)	Health professionals (%)
Doctors of Chinese medicine	257,285	4.7	6
Doctors of Western medicine	1,207,349	22.3	28
Doctors of integrated Chinese and Western medicine	10,598	0.2	0.2

Scheid characterises the situation as a medical pluralism controlled by the Communist Party. In the Chinese medicine colleges a new tradition was constructed: The Traditional Chinese Medicine (TCM). Standardisation of knowledge and education is a central device in Chinese TCM policy today (cf. Wang/ Zhao 2007). Standardised is indeed the term used by Hsu (1999) in her anthropological field study to characterise the knowledge taught in these colleges. Shorter passages from academic textbooks were memorised. These textbooks tried to reduce the polysemic character of the classical texts, or in other words: The plural and diverse scientific tradition of Chinese medicine became homogenised and reduced for better memorising. The TCM approach to Chinese medicine forms the background of Western acupuncture etc. practices. While in the first decades after 1945 Japanese, Vietnamese and other non-Chinese acupuncture techniques had been prevalent, the TCM techniques have become stronger since the 1980s (cf. Birch/ Felt 1999: 66). This includes electrical applications and even a French innovation, auriculo-acupuncture (cf. Hsu 1995).

6. The establishment of professional organisations that made acupuncture, but not TCM acceptable in the British medical context

While in China Chinese medicine is mostly herbal medicine according to the Chinese materia medica, in the USA and Western Europe TCM as an herbal medicine is mostly used in migration contexts, and in the wellness area. In medicine, Chinese medicine is mostly acupuncture.²¹ In the German and British indigenous populations, *qi gong* and *shiatsu* have

²⁰ Source: Scheid 2002: 89; from Chen Minzhang 1997.

²¹ Chinese formula medicine, as an industrial form of herbal medicine, seems to be spreading over Britain (cf. Hsu 2009).

become popular in the wellness and massage areas; Chinese herbal teas are served in expensive wellness hotels; Chinese herbal medicine is spreading over the UK; and acupuncture is practiced by many biomedically oriented physicians as well as by non-medically qualified personnel. China is no more than a frame of reference for all of these groups.

In the UK, acupuncture is taught at acupuncture colleges, at universities (in departments of primary health care or community health care, for instance), and within professional societies who offer short- and long-term courses. There is also a plurality of acupuncture organisations, medical and non-medical. There is furthermore a substantial body of Chinese medical doctors of Chinese origin who offer mostly Chinese herbal medicine, though medical doctors of Chinese origin only seldom offer training.²²

Table 2: Membership of acupuncturist associations in the UK, 2003²³

	Relevant Acupuncture Organisation	Estimated Number
Medical practitioners	British Medical Acupuncture Society (BMAS)	2,200
Traditional acupuncturists	British Acupuncture Council (BAcC)	2,400
Traditional Chinese medical doctors, including acupuncturists	-Legislative Association for Chinese Medicine Practitioners: -Association of Traditional Chinese Medicine (ATCM), (since Nov 23 03 includes British Society of Chinese Medicine) -General Council of TCM, which includes the following three: -The Association of Chinese Medicine Practitioners (ACMP) -Chinese Medical Institute and Register -Chinese Healthcare Institute Register	1,200
Auricular acupuncturists / substance abuse	-SMART (Self Management and Recovery Training) -NADA (National Acupuncture Detoxification Association) -Society of Auricular Acupuncturists	2,500
Physiotherapists	Acupuncture Association of Chartered Physiotherapists	2,650
Dentists	British Dental Acupuncture Society	100
Nurses	British Academy of Western Acupuncture	250

²² According to some authors (cf. Gervais / Jovchelovitch, 1998; Sproston et al. 1999), they practice Chinese medicine outside the formal professional system.

²³ Cf. Acupuncture Regulatory Working Group (2003): Appendix 3.

Acupuncture is taught at specialised colleges of acupuncture, at universities, and within professional acupuncture associations. The BMAS offers basic and advanced courses to healthcare professionals who are registered by statute in the UK. This includes nurses, midwives, health visitors, physiotherapists, osteopaths, chiropractors, and podiatrists. The BAAC offers education for non-medical acupuncturists.²⁴ The BAAB²⁵ has accredited seven colleges in the UK, and another four are currently stage one accredited and committed to the ongoing development of the course to reach full accreditation.

In 2000, the House of Lords published a report on complementary and alternative medicine (CAM). The report resulted in the recommendation that practitioners of acupuncture and herbal medicine should be allowed to strive directly for acknowledgement following the Health Act of 1999, while practitioners of other CAM disciplines should establish effective organisations first. These other disciplines include TCM. Thus, acupuncture and TCM were differentiated for their professional organisation and training. The acupuncture organisations became organisational patterns for professional CAM training, in general. In Britain, the globalisation of Chinese medicine divided acupuncture from Chinese herbal medicine. It is less the medical conception than the stage of professionalization that makes Chinese medicine acceptable in the British political context. The globalisation of Chinese medicine requires a homogeneous professional structure.

7. Randomised clinical trials that opened the way for the integration of acupuncture into the German medical practice

German official medical organisations moved from scepticism about acupuncture to acceptance. Scepticism is represented by the memoranda of the *Scientific Advisory Council of the German Medical Association* (Wissenschaftlicher Beirat der Bundesärztekammer) in 1957 (cf. Gleditsch 2001: 181) and 1992, and by the *German Physicians' Drug Commission* (Arzneimittelkommission der deutschen Ärzteschaft), which in 1998 recommended not to include CAM in the public health insurance schemes. As late as 2001, the *Federal Joint Committee* (Bundesausschuss der Ärzte und Krankenkassen)²⁶ published a sceptical report

²⁴ Personal information provided by John Wheeler, London, February 2002.

²⁵ This board was set up in 1989 by the precursor of the BAAC as an independent body which was intended to set the standards of accreditation for courses offering training in acupuncture.

²⁶ Its members come from the federal organisation of physicians practising in the statutory sickness funds, and from these funds themselves. The Committee authorizes new diagnostic and therapeutic methods etc.

about acupuncture: its efficacy was said to result for the most part from the care given by the healer, and such efficacy was not considered to depend on the healer's training or on a specific medical conception. Thus acupuncture was seen as situated on the level of many other therapies that have not been tested in randomised clinical trials (RCTs) (cf. Bundesausschuss 2001: 8). But in 2003 the *German Medical Association* (Bundesärztekammer) published special rules for further education in acupuncture which are becoming models for corresponding rules published by the medical chambers of the German states. These rules establish an additional title (*Zusatzbezeichnung*) 'medical acupuncturist'. These medico-political changes are due to the results of huge RCTs regarding the efficacy and efficiency of acupuncture. Because the results were most astonishing, I will give some more details.

In 1999, a group of German health insurance companies initiated acupuncture RCTs. Patients who had been treated for chronic diseases such as lower back pain, arthrosis, and migraine for a long time were offered an acupuncture treatment. In a first stage of the tests, the patients were interviewed by members of scientific institutes about their subjective wellness. The second stage of the tests consisted of one-side blinded²⁷ randomised studies, which were performed at the physicians' offices and supervised by university institutes.²⁸ The physicians were required to hold the (less rigorous) *A diploma* at least, and they received special training for the tests. Patients who were willing to take part in the trials were divided into groups according to their diseases, and then further subdivided into three groups:²⁹

- The first group received a series of 12 semi-standardised acupuncture sessions. They were needled at certain basic points according to a common acupuncture textbook; some other points could be needled in addition. The physicians aimed at producing a *de qi*.³⁰
- The second group was supposed to be the control group. These patients received sham-acupuncture, which was called minimal acupuncture in the directory. Physicians were told not to talk of a placebo. They were neither to manipulate the needles nor produce a *de qi*. The needles should be stabbed to at least 5 out of 10 points which varied for the three diseases treated, and which were no common acupuncture points. Three experienced acupuncturists and two associations³¹ had agreed upon the localisation of these points (cf. Linde et al. 2003: 187).

²⁷ Blinding has been introduced into clinical trials (originally of drugs) in order to correct personal influences. One-side-blinding means that the physician knows whether he gives a verum or a placebo, while the patient does not. In double blinding neither the physician nor the patient knows.

²⁸ There were two research associations: the ART (Acupuncture Randomised Trials), comprising researchers from Berlin and Munich, and the GERAC (German Acupuncture) Studies, comprising researchers from the Rhein-Ruhr-area.

²⁹ Cf. Linde et al. (2005); Melchart et al. (2005); Witt et al. (2005) (ART); www.gerac.de.

³⁰ An itching feeling of the circulation of qi, starting from the needled point, and caused by manipulating the needle.

³¹ The DÄGfA and the *International Society for Chinese Medicine*, both situated in Munich.

- The third group received verum acupuncture, but only after six months on a waiting list.

Some results are shown in the following tables:

Table 3: Response rates³² of acupuncture patients with osteoarthritis of the knee³³

Verum group	Minimal acupuncture group ³⁴	Waiting list group
52%	28%	3%

The researchers had expected response rates like these: A good result in the verum group, a result coming close to normal placebo rates in the minimal acupuncture group, and a clear distance to the waiting list.³⁵ But in both the other diseases, the results were most astonishing.

Table 4: Response rates of acupuncture patients with headache:³⁶

	Verum group	Minimal acupuncture group	Waiting list group
GERAC (cf. www.gerac.de)	33%	27%	?
ART (cf. Melchart et al. 2005)	46%	35%	4%

Table 5: Response rates of acupuncture with migraine:³⁷

Verum group	Minimal acupuncture group	Waiting list group
51%	53%	15%

Indeed, the results for the sham (or minimal) acupuncture groups are most astonishing. What are potential consequences of these results? If the classical ‘very’ acupuncture points are less relevant than the needling process itself,³⁸ this may firstly strengthen the tendency to dis-embed acupuncture from its philosophical and cultural background, and secondly weaken the

³² Defined by a reduction of at least 50% on pain days.

³³ Cf. Witt et al. 2005 (ART).

³⁴ The authors of the ART-Studies call the control group sometimes minimal (Melchart et al. 2005) and at other times sham acupuncture group (Linde et al. 2005).

³⁵ A Norwegian study on sinusitis patients produced no clear results regarding the effectiveness of either verum or sham acupuncture (cf. Rössberg et al. 2005).

³⁶ For a smaller study on acupuncture for chronic headache, see Coeytaux et al. 2005.

³⁷ Cf. Linde et al. 2005 (ART).

³⁸ Cf. Tao in an earlier EASTS volume.

motivation of Western physicians to achieve the higher diplomas offered by the acupuncturist organisations. Trigger or acupuncture points, Indian chakras or Chinese meridians:³⁹ a great melting pot of medical conceptions is offered behind a number of convergent practices.

Referring to the ART and the GERAC studies, the *Federal Joint Committee of Physicians, Dentists, Hospitals and Insurance Companies* decided in April 2006 to add body acupuncture to the ‘acknowledged methods of diagnosis and treatment’ in the cases of chronic low back pain and of arthrosis of the knee.⁴⁰ The globalisation of Chinese medicine requires an adaptation to biomedically shaped RCTs.

8. Polarisation

In Western states, Chinese medicine and acupuncture in particular have become part of medical pluralism. Biomedical disciplines and some CAM techniques form a pluralist medical scene; as we have seen in the previous section, the acknowledgement of CAM techniques differs from nation state to nation state. Asian medical conceptions like Chinese medicine or the Indian Ayurveda have been integrated into the Western wellness scene, and to some degree also into the medical areas. In Britain, the 1999 Health Act opened a field for medical pluralism by registration of practitioners. In (West) Germany, pluralism was introduced through a 1976 act on registering drugs not only of biomedical, but also herbal, anthroposophical, and homoeopathic origin. While even registered drugs often were not refunded by the public health insurance scheme, some CAM techniques became integrated into this scheme, as was acupuncture for certain indications. Nevertheless, this pluralism was often contested by medical organisations, as is shown in the acupuncture statements of the German medical association outlined above. Also, the British Medical Association did an about-turn in its policy towards acupuncture.⁴¹ In 1986 it presented complementary therapies as ineffective, not evaluated, and sometimes harmful to patients (cf. Fulder 1988: 17). In 1993 it stressed the necessity of regulating education in heterodox practices, and of establishing codes of medical ethics for all forms of medicine (cf. Sharma 1995; Tovey 1997). In 2000 it

³⁹ Cf. Shang (in: Stux / Hammerschlag 2000) for a comparison.

⁴⁰ Cf. www.g-ba.de (Gemeinsamer Bundesausschuss der Ärzte, Zahnärzte, Krankenhäuser und Krankenkassen). Some experts expect acupuncture to become dried out by low insurance payments. The ART and GERAC studies on acupuncture in patients with low back pain have not been documented well: cf. Becker-Witt et al. 2005 (ART); Haake 2004 (GERAC).

⁴¹ Saks (1995) criticises the medical profession for countering the ‘heterodox challenge’ by incorporating acupuncture in biomedical models. But this view takes for granted, that such a challenge exists.

recommended formalising education in acupuncture and even integrating this treatment into the NHS (BMA 2000).

9. Hybridisation

Hybridisation, a playful combination of various elements, has been used for analysing the production of personal identities in post-colonial times (cf. Babha 1994). In social anthropology, the term was generally prominent for challenging essentialist discourses in the 1990s.

Ots (1987) has shown that the medical reception of acupuncture in modern Germany has been shaped by Western alternative medical ideas. Holism, harmony, energetic fluids etc. may mould professional education. Frank/ Stollberg (2004) found different types of hybridisation of Asian and biomedicine in German medical practice. From our interviews we constructed the following types of hybridisation:

Table 6: Types of hybridisation of biomedicine and Chinese medicine in Germany

gravitational centre	Biomedicine	heterodox medicine
degree of hybridisation		
Weak	<ul style="list-style-type: none"> - complementing biomedical practice with Asian medicine - criteria: biomedical disease category; patients' demands - no further meta-theory 	<ul style="list-style-type: none"> - complementing heterodox medical practice with biomedical procedures (at least diagnostics) - no further meta-theory - loose combination
Strong	<ul style="list-style-type: none"> - inclusion of Asian medicine in biomedical paradigms - use of Asian medicine in predominantly biomedical practice 	<ul style="list-style-type: none"> - fusion of all conceptual ingredients into universal model of medical theory and practice

The first field shows a biomedically dominated coexistence of biomedicine and heterodox medicine. Most of the medical acupuncturists we interviewed practiced acupuncture in this way.

The second field shows a coexistence of biomedicine and heterodox medicine subject to heterodox dominance. This heterodoxically dominated coexistence was practiced by a few acupuncturists working in private practice.

The third field shows a biomedical incorporation of Asian medicine. This pattern is widely represented in the teaching of Asian medicine,⁴² but we could rarely find it in medical practice.

The fourth field shows a great melting pot. Few of 'our' acupuncturists came close to this pattern.

10. Globalisation of Chinese medicine

Chinese medicine has influenced the Japanese (and vice versa) for more than a millennium (cf. Lock 1985). But why could it revive in our times of a new wave of globalisation, and become globalised itself?

TCM became accepted in the West as a modern as well as a non-modern medicine. Non-modern because it does not rely on chemistry or on industrialised mechanics. Modern because it relies on a formalised knowledge taught at colleges. TCM is somewhat complementary to the functional deficiencies of biomedicine.

From the 1960's to the early 1970's, the Chinese government organised the export of Traditional Chinese Medicine as a low-cost medicine for healthcare suitable in Cuba and African countries.⁴³ China's communist leaders aimed at gaining political momentum in the face of American and Soviet worldwide expansion.

In the 1980's, there started a new wave of Chinese medicine in the US and in Europe. Acupuncture especially forms a substantial part of complementary therapies in these regions. There are various explanations in the social sciences why biomedicine could not gain a total victory over competing conceptions even in its original countries. Most of them refer to post- or reflexive modern values (cf. Furnham/ Vincent 2003). There are various rights and consumer movements, the holistic medicine movement, self-care and fitness as values (cf. Lupton 1997; Gray 1998), which CAM fits to. Secondly there is the experience of a biomedical deficiency, of a gap between biomedical competences in diagnosing diseases and curing them (cf. Furnham/ Smith 1988; Gross et al. 1985; 1989). This gap is particularly

⁴² Cf. also Sagli in earlier EASTS volume.

⁴³ Cf. Mei-Zhan 2009: 4; Bibeau 1985; Hsu 2002 for Tanzania.

evident in the treatment of chronic diseases. While most infectious diseases can be prevented and treated quite well (this was and is the special domain of biomedicine), the prevalence of chronic diseases like rheumatism, pain, and migraine etc. has increased in modern society. And biomedicine cannot cure common or garden diseases like coughs and colds. It tends to combat chronic diseases with strong chemical drugs, which often have serious side effects. Thus physiotherapy and heterodox medicine were able to establish themselves in these fields. Thirdly there is the thesis of patient 'expertisation'. In a world where different experts give different pieces of advice, people have to be able to decide between them. This is also true for patients, who often seek a second or third type of expertise. Patients become well-informed citizens (cf. Schutz 1972). These different types of expertise particularly include heterodox expertise (cf. Giddens 1997: 138f.). Among North-American consumers of CAM therapies, Kelner/ Wellmann (1997) found many 'smart consumers'. But in our study on German acupuncture patients we came across a passive more than an active form of trusting the doctor (cf. Frank/ Stollberg 2004 b).

A fourth explanation is based on a generalised cultural orientation. Modern Western society tends towards 'gentleness' (Douglas 1996), which produces an acceptance of non-chemical, non-invasive, 'soft', 'natural' forms of medicine. Though acupuncture penetrates the skin, it is obviously perceived as a soft and natural form of medicine (cf. Schnorrenberger 1985).⁴⁴

9. Conclusion

Multiple or entangled modernities start out from modernity as framing the context of almost all regional cultures. It is not the difference of tradition and modernity that characterises the relations between West and East, but cultural traditions that become transformed in modern contexts (cf. Schwinn 2005: 18). The culture of modernity opens spaces for differences. 'Traditional' cultures are not uniform blocks of entities, which can only be changed as a whole or be destroyed by modernity. Rather, they form a rich pool of ideas and practices, which can be transformed and combined with strange elements in new forms (cf. Holton 2000). Hybrid forms of Indian, Chinese, and Western culture can be observed in many fields (cf. Schirmer et al. 2006).

I have demonstrated that Chinese medicine could go global in its modernised form of a non-modern medical conception. This process forms part of cultural globalisation. But

⁴⁴ For criticism towards the conception of Chinese medicine as a holistic medicine cf. Ots 1987.

globalisation of Chinese medicine can also be interpreted in the frame of a theory that normally forms the counterpart of cultural theories: in the frame of systems theory. In the first section I outlined this modern form of modernisation theory. Now I can conclude by stating that five out of the seven uniform and specific structures of world society, which Stichweh (2006) listed, may be applied to Chinese medicine:

- The differentiation of functional systems: With the conceptions of the Five Phases, and of systematic correspondence, medicine became principally differentiated from religion. Today, Western acupuncture is clearly divided from cosmic explanations of the world. (cf. Frank/Stollberg 2004 b)
- The career of formal organisation: Since 1929, Chinese medical doctors have founded their organisations. Professional organisations of acupuncturists etc. have been founded in many Western states. (cf. Thieme Almanac 2007: 107-192)
- The de-location of networks: Western acupuncturist organisations often co-operate with Chinese schools (cf. Thieme Almanac 2007: 195-238)
- Markets: Special market segments for Chinese medicine have emerged in many Western countries. In the UK and the Netherlands, a market for Chinese formula medicines is arising (cf. Hsu 2009).

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