

Articles

The AMS/Paterson Lecture: Becoming Alternative? Modern Transformations of Chinese Medicine in China and in the United States

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Abstract. “Becoming Alternative” offers an overview of the transformations of Chinese medicine at home and abroad since the mid-19th century. After coming into contact with biomedicine, China’s indigenous medicine was redefined in terms of national culture and history on the one hand, and a competitive alternative science on the other. Reimagined in terms of scientific syncretism in the PRC, and embraced as a counter-cultural alternative to bio-medicine in the United States, the medicine we call “Chinese” today emerges as a pluralistic system with global reach involving complex accommodations with local medical cultures and institutions both at home and abroad.

Keywords. Chinese medicine, modern history, alternative medicine, US, comparative medical systems, medical professionalization and globalization

Résumé. « Becoming Alternative » (La voie alternative) offre un aperçu des transformations de la médecine chinoise depuis le milieu du 19^e siècle, et cela tant au pays qu’à l’étranger. Après avoir pris contact avec la biomédecine, la médecine traditionnelle chinoise s’est redéfinie, à la fois comme manifestation nationale culturelle et historique et comme une intéressante alternative concurrentielle à la médecine dite scientifique. Ré-imaginée sous l’angle d’une science syncrétiste dans la République populaire de Chine, et adoptée aux États-Unis comme une alternative contre-culturelle à la biomédecine, la médecine « chinoise » d’aujourd’hui apparaît comme un système pluraliste mettant partout en jeu des accommodements complexes avec les cultures et institutions locales.

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Mots-clés. Médecine chinoise, histoire Histoire contemporaine, médecine alternative, Etats-Unis, systèmes médicaux comparés, professionnalisation du médical, globalisation

What does it mean to say a medicine is Chinese? This is a sly question, and there is a common sense answer: it comes from China and is a popular form of alternative medicine today. This answer assumes there is a known historical China which today exists in a world dominated by biomedical science. But it begs questions that are just under the surface: questions about the relation of historical and scientific knowledge, the nature of medical pluralism, and the local embeddedness of therapeutic practices in a globalizing world. On examination, neither the “Chineseness” of this medicine nor its description as “alternative” is transparent. This essay asks the reader to interrogate both concepts, using as examples here the state-supported medicine of the People’s Republic of China now called TCM and the practices of “Chinese medicine” in United States, with particular attention to California and the West Coast, where its contemporary American identity was first shaped in the 1970s and 1980s.

Let me start with two snapshots: In Shanghai the University of TCM (Traditional Chinese Medicine) has just moved its research headquarters from the old city (Xuhui district) to a new office complex in Pudong east of the river, the highrise centre of biotech research and development for the region. In Northern California in Mendicino County, a “local herbs” movement is trying to identify suitable microclimates to encourage the cultivation of Chinese medicinal plants—organic of course—for an American market.

What do these two snapshots tell us about the definition of any medicine today as “alternative”? A historical perspective will begin with the insight of the historian of medicine, Charles Rosenberg: there are two possible long-term historical trajectories relating learned medical traditions and their less prestigious competitors or alternatives, often identified as religious or popular medicines or as empirical local knowledge. In the first trajectory, practices over time are taken up and discarded, and what learned experts deem the best of them integrate into a developing mainstream we call scientific progress. In the second trajectory, which Rosenberg documents from antiquity down to today, every learned medicine has lived with its own “other.” Of course, problems of access—learned medicine’s cost, its cultural framing around elite expertise, its concentration in urban centres—have always been serious enough to render it inaccessible to the vast majority of poor people everywhere. But beyond this fact, alternatives appeal because there are always problems that learned medicine will not or cannot resolve, and because there will always be patients (and their clinical advisors) who seek help outside the

framework of their culture's elite "best practices." Some cases may be too serious—incurable; others are not serious enough—such as illnesses deemed psychosomatic; sometimes intervention is culturally taboo. Technical advances alone can never close the gap between the social experience of sickness and mortality and the guidelines of a bounded therapeutic professionalism.¹

Moreover, any medical "other" will reflect back to the mainstream the latter's weaknesses, fissures and failings. A contemporary biomedical form of this dialectic is analyzed in a slightly different idiom by the critical science studies work of Collins and Pinch, who discuss the perennial tension between what they call "science and succor." For scientists, wisdom dictates that one look for therapies based on collective judgment about the best scientific evidence. For patients and their caregivers, more benefits may accrue from a sympathetic human exchange between healer and patient, or hope may lie in a gamble rather than treatment according to the often dismal probabilities of scientific protocols.² Alternatives, in sum, may appear and disappear as mainstream medicine selects, refines or rejects them; but new alternatives are constantly generated by the limitations and weaknesses of the elite practices they oppose.

On the surface, the stories about Shanghai and Mendicino County, California have a common framework that is about technology, capitalism, and commerce; in today's world the provision of medical goods and services, along with everything else, must function in the economic marketplace. At a deeper level, these two stories lead back to historical paths by which Chinese medicine in the last 100 years has engaged with the dialectic of mainstream versus alternative in locally very distinct ways. Tracing these paths can show us how changing concepts of a medicine's "Chineseness" help us connect both Charles Rosenberg's historical theories and Collins and Pinch's perennial tensions to the tapestry of contemporary medical pluralism.

MEDICAL HORIZONS OF THE NINETEENTH CENTURY

Before the late 19th century, medicine in China wasn't "Chinese." The various forms of learned and popular practice there were the only medicine there was. If Western knowledge came first through missionaries, missionaries did not change this right away. The Jesuit and other Catholic sojourners in China in the 16th to 18th centuries did not feature medicine as one of the technical arts in which Europeans excelled. Even the mid-19th-century medical missionary project led by evangelical Protestants had only a limited impact.

Bridie Andrews and Ruth Rogaski have offered some suggestions as to why this was so. First of all, the medical missionaries' signature

technology, surgery, was often dangerous. Second, early anatomy texts that were written or translated into Chinese (like Benjamin Hobson's work on reproductive anatomy) implied theoretical questions about body and cosmology, but did not point to useful clinical interventions. In China, midwives were the ones who managed birth anyway. Much that came from Europe could fit into existing frameworks. Angela Leung has shown how Jennerian vaccination was adopted and propagated by the same lineages of medical technicians that had earlier served South Chinese communities as variolators.³ Finally, missionary doctors were interested in souls, not in Darwin and laboratory science. They adhered to the older holistic therapeutics that emphasized constitutions and environment; they taught more about temperance than about biology and chemistry.⁴

The China sojourns of many mid-19th-century missionary doctors overlapped chronologically with the career of Fei Boxiong (1800-1874), perhaps the most renowned scholar physician (*ruyi*) of the late Qing. Volker Scheid has given us a portrait that lets us see Fei as an example of what a good doctor looked like in the last decades before medicine like his became biomedicine's "other." Fei's medical training came from his lineage, i.e., the hereditary practice in his family. His authority as a physician also came from study of the written archive of medical classics, commentaries, and case histories, and from the civil service exams that allowed him to win a lower-level rank as a Confucian scholar. His medicine also had a distinctly local flavour, being identified with his home district of Menghe in the lower Yangzi delta, and with a therapeutic approach that was thought suitable to the damp climate and delicate constitutions of that region.

Among his fellow scholar physicians and his well-to-do patients, his style of prescribing was considered distinctive, involving individual judgment about each case. He emphasized that sometimes seemingly identical disorders require different treatments; diagnosis was especially challenging when the patient's pulse readings and his other symptom patterns did not agree. Making the best choice was a skill of balancing "principles" (*li*)—a neo-Confucian term for broad natural and social norms—against "circumstances" of the individual case. For Fei Boxiong, prescription pharmacy was the pre-eminent medical skill, and his style of prescribing was called "refined and simple," "harmonious and gentle," i.e., it involved large numbers of individual ingredients in low doses. He avoided potent herbs like *ma huang* (ephedra), *fuzi* (aconite) or *da huang* (rhubarb), and he expected his remedies to work slowly without undesirable side effects. A prominent doctor like Fei attracted followers and disciples who studied and imitated his cases. He thus came to be seen as the originator of a specific "current" (*xuepai*) or mini-tradition that can be traced down to today. In sum, he inhabited a medical culture which

appreciated variation in therapeutic styles, and saw prescribing as an art and eminent doctors as virtuosos.⁵

BIOMEDICINE AND CHINESE REFORM 1895-1930

If we looked closely at clinical practice in the West during the same historical era, we might find similar patterns of reasoning at work. Holistic perspectives on therapeutics remained commonplace in mid-19th century America, provoking a backlash against “heroic medicine” and an emphasis upon the healing powers of nature. In the West the laboratory revolution, which offered greater rewards and greater risks, changed the epistemological foundations of medicine; but we forget that through most of the 19th century, debate was very messy and contested, pitting contagionists against anti-contagionists, chemists against biologists. Germ theory triumphed only in the 1880s, and it is historically important that this happened just as the Chinese monarchy was collapsing under the impact of imperialist pressure. This pressure came not only from the West—the British, French and others who had created foreign enclaves (called treaty ports)—but from Japan, which had been modernizing since the 1870s and which went to war and destroyed the Chinese navy in 1894.

These events coming together made reform urgent for the Chinese, and made biomedicine part of the reform agenda from the beginning. But the small cohort of Chinese innovators did not simply look directly to the West but next door to Japan. Beginning in 1870s, the Japanese Meiji reform government had promoted biomedicine both as a laboratory science and as a state system of public health. The German university system provided the model for modern Japanese universities beginning in the 1870s, and young Japanese scientists soon were working in German research laboratories on projects that pioneered modern bacteriology and immunology.⁶ Among other Meiji era sanitary and hygienic measures were regulations requiring that after 1875, all new doctors have a biomedical degree, marginalizing most traditional doctors, who worked within the paradigms of classical Chinese medicine.⁷

Similar ideas began to catch on among Chinese reformers in the 1890s, and by the beginning of the 20th century, there were public health initiatives in a number of Chinese cities. The state was becoming a supporter of medical reform. When epidemic disease in the form of bubonic plague travelled to China in 1894-95 and again in 1910-11, the imperial monarchy was forced by diplomatic and international pressure to take action. This was a turning point that made traditional Chinese medicine conceptually “alternative” for the first time.

The story of the Manchurian plague has been well told by Sean Hsiang-lin Lei. We know today that the plague source was fleas from

populations of marmots along the Manchurian-Siberian border, and that the disease travelled with marmot fur traders south along the new Russian-built South Manchurian railroad. Figuring this out was the work of an overseas Chinese doctor, trained in biomedicine under the British in Malaysia, who was called in by the Qing authorities to deal with the crisis. His name was Wu Liande, and his story is one of the great dramas of the heroic age of the “laboratory revolution” and germ theory of disease. Armed with microscopes, Wu Liande not only identified the microbe, but he also deduced that this was a pneumonic form of plague, transmitted through sick people’s respiration. The solution was strict quarantine of all identified as infected. In this crisis, doctors of traditional Chinese medicine, who stuck to environmental, configurationist models of disease causation, were heroes to the panicky citizens who were swept up in the quarantine enforcement. A number of traditional Chinese doctors also heroically went into the makeshift plague hospitals to administer herbal infusions. They refused to wear gauze masks—and died.⁸

After this for the next 30 years, battle lines were drawn. The abolition of traditional medicine was a Chinese reform goal, and in 1929 the new unified Nationalist government tried to make it law. However, in the intervening years, practitioners of traditional medicine had done a great deal to professionalize their craft. They had built schools and hospitals, formed professional associations and published journals. Old social relationships of master and disciple and family tradition were folded into these new institutions. And these things helped them become organized enough to beat back the abolitionist legislation. It also helped that many of these same Nationalist legislators were users and defenders of Chinese medicine, and that it was the only available medicine in almost all of the country.

Nonetheless, though Chinese medicine won politically in the 1930s, it had merely escaped being driven underground, and it was clearly still on the defensive. For example, under the rubric of a National Medicine Movement, state and private funding were channelled towards research projects that evaluated Chinese materia medica according to biomedical criteria. As Sean Hsiang-lin Lei has shown, the Chinese medical community was being pressured to reimagine its pharmacopoeia in ways that stripped drugs of their Chinese identity and rationale, paving the way for their transformation into raw material for the products of modern pharmaceutical industry.⁹ In sum, advocates and practitioners of Chinese medicine were wrestling with the problem of how to redefine and reimagine it in the new environment where medical pluralism was defined by a hegemonic biomedicine. The issues engaged then are still with us. In the 1930s and 1940s, the positions of individual stakeholders, whether they were political and cultural supporters of Chinese medicine

or leaders of its new professional networks, varied in complex and overlapping ways. But if we tease out the analytical positions available, three orientations emerge: empiricism, cultural traditionalism, and syncretism.¹⁰

The empiricist claim was that the value of Chinese medicine lies in prescriptions that have proven over the centuries they work. These did not depend upon the outmoded, useless cosmology and philosophy of the body that pervaded medicine's underlying doctrines, all of which could now be discarded as mystical nonsense. As a philosophy of medical practice, empiricism did not depend upon Western doctrine for its foundation. Some medical sceptics among Qing physician adherents of "Han learning" had already based their claims to efficacy on the classic prescription formulas of the third century CE *Discourse on Cold Damage Disorders* (Shanghan lun)—pruned of the centuries of interpretive commentary that had accumulated around this canonical work. Similarly inspired by "practical learning," a clinically distinct school of practitioners had developed in 18th- and 19th-century Japan who matched these "ancient prescriptions" directly to disease symptoms. In the 1930s this "Kohoha" faction within Japanese Kampo [Chinese-style] medicine attracted a sympathetic hearing among Chinese medical empiricists. (Interestingly, the advocates of an empiricist approach were slow to apply it to acupuncture, which was generally dismissed by the more learned physicians in both China and Japan as a less prestigious, popular medical technology.) The arguments for empiricism faced the intellectual problem that it is hard to be totally empirical, since any therapy codes an implicit if not explicit system of meanings in its language and manner of use.

The traditionalist argument was favoured by cultural nationalists, who argued that their indigenous medicine was a heritage of Chinese civilization that all should treasure. Its canons and concepts are nonsense only when viewed through the prejudicial eyes of biomedical dogmatists. As exposure to biomedical doctrine became more commonplace, traditionalist arguments could move to a more sophisticated counter-attack: biomedicine is reductionistic, has a simplistic notion of causality, and is narrowly materialistic, while Chinese medicine is validated by the accumulated clinical experience of generations of practitioners. Moreover, preserving it makes it possible to deepen our understanding of it. The traditionalist argument faced the problem that tying Chinese medicine to a specific cultural tradition risked defending its archaic aspects, and claiming history—whether embodied in text or experience—as the final source of medical authority.

The syncretist claim was that science is universal, and that Chinese medicine could be saved by scientizing it, and that an integrated approach drawing upon the best of both systems is both possible and

desirable. The syncretist argument faced the problem that once biomedical (and at that time largely positivist) standards of evaluation were accepted, defenders of Chinese medicine risked losing control of the terms of the debate, which would then favour the domination of bioscience.

In practice all three of these positions were argued in overlapping ways. But what they shared was a desire to accommodate change, and none appealed solely to the authority of the past. From the 1930s forward, those who have struggled to reform Chinese medicine from within have continued to contend with both the promise and the problems that each position entails. This has been true in the PRC's state medical system, and also in the world of "alternative" medicine around the United States.

FROM NATIONAL MEDICINE TO TCM: THE PRC STORY

As good Marxists and anti-traditional iconoclasts, Mao and his Communist comrades imagined science as integral to socialist revolution, and had no serious disagreements with the Nationalist policy of support for biomedicine. But the experience of fighting a civil war in the 1940s and after 1949 of governing China's vast rural population with minimal resources gradually pushed them towards an accommodation with Chinese medicine—home grown, culturally acceptable, and inexpensive. With the party's populist turn in the mid 1950s, Mao personally began to speak of Chinese medicine as a cultural treasure. However, the new Ministry of Health implemented Mao's directive by organizing remedial study of biomedicine for traditional physicians and by requiring that biomedical doctors include Chinese medicine in their training. This orientation had a profound influence on the later evolution of Chinese medicine as part of the state health system. The slogan "integration of Chinese and Western medicines (*zhongxiyi jiehe*)," adopted in 1956 and the point of departure for everything since, accommodated a sphere of autonomy for Chinese medical education and practice within the framework of a single system of state supported socialized medicine.¹¹ The question then is: have these policies resulted in integration or not?

Independent colleges and universities of Chinese medicine were established beginning with four in 1956, and expanding to 32 by the late 1980s, according to a recent estimate.¹² The Ministry of Health set a standard curriculum for them that has resulted in one third of all their classes being biomedically oriented. Although much less time is devoted to Chinese medicine in biomedical colleges, both kinds of institutions give the same Bachelor of Medicine (*yixue xueshi*) degree at the end of a four-year undergraduate program, a degree which entitles its holder to practice on a primary care level. In the last decade some schools have added seven and even eight-year graduate programs deemed closer to

those of an American MD—but these degrees too are offered both in Chinese medicine and in biomedicine.¹³ In sum a Chinese medical professional will be titled “doctor” and have access to the same levels of formal credential as one trained in biomedicine, no matter which kind of institution trained him or her. This means that a graduate from a college or university of Chinese medicine can prescribe biomedical drugs, and will commonly use a range of biomedical diagnostic technologies as well. In the state sector, such doctors may be employed in a hospital or clinic specializing in Chinese medicine, in a Department of Chinese medicine in a biomedical institution, or as individuals in a purely biomedical setting. Although biomedical practitioners occupy the most prestigious positions in the medical system, and although only a tiny fraction of total hospital beds are assigned to hospitals of Chinese medicine, its clinical reach may be better measured by the fact that the relevant current Five Year Plan under the Ministry of Health estimates that the Chinese medical sector accounts for 25% of China’s health care spending.¹⁴

Therefore, inside the PRC since the 1980s, a doctor in a biomedical hospital has been likely to have a specialist in Chinese medicine available on call to come in as a clinical support. Acupuncture alone is no longer used for surgical anesthesia, as it was during the Cultural Revolution in the 1960s and 1970s, but is routinely available as a supplementary treatment during surgery and for post-operative recovery. In the recent SARS epidemic, doctors of TCM were available and widely used to treat hospitalized patients with their preferred herbal infusions used for “warm factor” disorders.¹⁵ Although biomedical doctors may command greater prestige today, doctors of Chinese medicine can compete successfully in the marketized domain of “profit centers” attached to state medical providers that are becoming increasingly important in clinical outreach. Today doctors of Chinese medicine in China are mounting a campaign to gain the right to practice in emergency rooms—an acute care setting hitherto reserved for biomedical experts only.

The textbooks that developed to support this curriculum in the last quarter of the 20th century have been written in modern vernacular Chinese, often with the goal of explaining Chinese medicine to readers imagined as coming from a biomedical background. *Traditional Medicine in Contemporary China*, Nathan Sivin’s important introduction to the field, is in fact a partial translation of such a textbook, the 1972 *Revised Outline of Chinese Medicine*.¹⁶ This textbook, like its fellows, did not include selections from the medical classics, for which students had little linguistic preparation. Rather, selected vernacular editions and commentaries have pretty much replaced originals in classical Chinese. They are in effect translations. Not surprisingly, textbooks do not talk about “principle” (*li*) with its neo-Confucian cosmological resonances as Fei

Boxiong did; instead they stress “theory” (*lilun*) using the language of modern philosophy and Marxist dialectics. Clinical reasoning is defined by a term: “pattern differentiation and treatment determination” (*bianzheng lunzhi*), which was popularized in the 1930s and adopted as standard in the 1960s to designate the core of a modern diagnostic protocol. Theoretically, it encourages doctors to think about a dialectic between “patterns” (dynamic processes expressed in Chinese medical language) and “disease” (including biomedical taxonomic or descriptive nosologies). In fact it allows clinicians to find overlaps between traditional Chinese and biomedical nosology for diagnosis. TCM doctors commonly say that a single biomedical disease diagnosis may point to a number of different Chinese patterns. The recommended clinical strategy is to select the pattern best suited to the case at hand, and then to use Chinese remedies—chiefly herbal prescriptions or acupuncture—for the therapy. Over time, this has encouraged clinicians to think of “patterns” as increasingly reified, standing in for identifiable disease names rather than guiding toward insight into individual cases.¹⁷

One method for evaluating and transmitting TCM knowledge is through collections of exemplary case histories. Case histories as records of efficacious therapies have a very old pedigree in Chinese medicine. They emphasize the irreducible individuality of a clinical interaction between a particular doctor and a particular patient, with implications that personal judgment shapes treatment. Case histories continue to be central to the transmission of Chinese medical knowledge in contemporary clinical settings, but the official printed forms on which they are recorded contribute to the spread of biologized nosologies and standardized treatment protocols: pre-packaged ready-made prescription formulas pegged to specifically named diseases, including a biological equivalent for every Chinese medicine diagnosis.

These biomedical influences also shape state-supported research according to a laboratory model. Understanding Chinese materia medica using the tools of chemistry has been a goal of medical modernists since the 1930s, when the “national drugs” project was first undertaken under Nationalist sponsorship. Such research has long focused on attempting to isolate the chemically active agents in individual medicinal plants, and then to test their efficacy on laboratory cultures and experimental animals. My standard modern Chinese dictionary of Chinese materia medica records such experimental results under each entry;¹⁸ In their search to demonstrate clinical efficacy of TCM formulas, state-funded researchers have aspired to follow the model of randomized clinical trials, and a Sichuan-based “Chinese Cochrane Center” is currently designated an official research body charged with applying the statistical methods of evidence-based medicine to the evaluation of clinical research studies.¹⁹

This biomedical model of research into TCM therapies has plenty of critics within the TCM world. Practitioners have defended the case-based individuality of their craft that makes it extremely difficult to find uniform diagnosis and treatment patterns based on large numbers of real life clinical encounters. Many have consistently objected that a chemical “magic bullet” cannot duplicate the complexity of a formula compounded of many ingredients out of natural plants. They argue for the absurdity of randomized clinical trials using “sham acupuncture”—which can fool neither doctor nor patient about the intervention that is occurring. While some stick to the position that Chinese medicine and biomedicine are epistemologically incommensurable, others look for ways to design experiments that will pass the scientific sniff test without violating the integrity of the medicine itself.

The latest state five-year plan for Chinese medicine mediates these contradictions by calling for the expansion of large scale growing and testing of both farmed and wild-crafted Chinese medicinals, and the expanded use of Chinese medicine in both hospitals and outpatient clinics around the country. It also promotes more research that will meet current global standards of scientific validity. Currently there are a number of state funded and private research programs for the laboratory analysis not just of individual medicinals but of herbal formulas involving multiple ingredients. The aim: to identify chemically what “works” in major TCM formulas, and separate it from both toxic elements and what are deemed useless natural plant products.²⁰ Such prescription formulas of Chinese medicine, designed in the laboratory, produced on an industrial scale as standard products, may then be marketed internationally.²¹ The foregoing overview of the last 40 years in the PRC suggests that the syncretic strategy for scientizing Chinese medicine has been a smashing success, but many believe this is because biomedical standards have become overwhelmingly dominant. Research into pharmacy is coming to aspire to be a variant of biotechnology. Doctors of TCM are more like a secondary kind of specialist within an institutional framework shared in common with doctors of bio-medicine; their medical degrees, clinical environment, and resort to the authority of science are all part of this.

The idea that there are two recognizable Eastern and Western medicines is preserved at the level of discourse—in the Chinese language. The rhetorical trope *Zhong/xi* (Chinese/western)—inherited from the early 20th-century reform struggles—survives in everyday usage. A biomedical pharmacy sells *xi yao* (western drugs), but probably also has a *Zhong yao* (Chinese drug) patent medicine section, and an outpatient clinic will direct the biomedical patient to the “western medicine” section (*xiyi shi*), as opposed to the “Chinese medicine” section (*Zhongyi shi*) down the hall. These usages perpetuate citizens’ identification of biomedicine with the West. Further, in English language usage, the PRC’s state medicine

has gotten a new acronym, “TCM,” to distinguish it from either the classical or other popular forms of the practice. But neither the Chinese nor the English linguistic usages adequately capture the hybrid that has evolved on the ground and that is still changing, so much so that even the label “hybrid” risks seeming out of date.

However, it is also the case that the state’s drive to scientize Chinese medicine has in fact created space for experts in Chinese medicine that is not found anywhere else in the world. This space has given them authority to present counter claims about what science is, to offer therapies to millions, to do research and experiment on ways to improve and develop their craft. This bears on the central question posed at the beginning of this essay, about whether a reformed Chinese medicine has come to relate to biomedicine as an alternative. Inside the PRC, whatever the balance of power between the two sectors, whatever the tug and pull of rivalry or of co-operation, the Chinese medicine I have just described is not really “alternative” at all. It is both culturally at home and built into the state medical system as a whole—making for what Scheid calls “orchestrated pluralism.”²²

COUNTER-CULTURES OF MEDICINE IN THE USA

How was it that in the second half of the 20th century Chinese medicine, and not some other tradition like Aruyvedic medicine or homeopathy, came to dominate the discourse about the alternative medical scene in the US? Pioneer American practitioners, who learned their craft in the 1970s and 1980s, and who are today senior clinicians and teachers, point to the “new age” counter-cultures of the 1960s, where many drop-outs from mainstream society engaged with Eastern spiritualism and embraced natural lifestyles. In these years interest in Chinese medicine did not come from Asian-American communities frozen by immigration restrictions and the Cold War, but from members of the Woodstock generation inspired by the Beatles and Pink Floyd, ready to try out *taiqi quan*, meditation, and natural healing. The path followed by Z’ev Rosenberg, today a senior professor and chair of the department of herbal medicine at Pacific College of Oriental Medicine in San Diego, is instructive. His efforts to become skilled in a natural system of healing led first to Santa Fe, New Mexico, and Boulder, Colorado, where there were institutes teaching macrobiotics and naturopathy, in which “Oriental” approaches to dietetics, herbal medicine and body work were taught by Japanese émigré masters. Only gradually did he learn of the classical Chinese sources of this techno-practice, and begin to seek out teachers of it.²³ Rosenberg and other Anglo-American pioneers like him found their early China connections in marginal places. An American Buddhist who had studied in Taiwan (Michael Broffman) took students using a home

study course that had been created by a Chinese émigré in Vancouver. Some travelled to an institute of Oriental Medicine in Macao; others became followers of a British expert, J. R. Worsley, who had seen Asia first as a physiotherapist in World War II and who after returning home, developed diagnostic doctrines and techniques out of his own personal interpretation of “Five Element” energetics. A Chinese Christian refugee who had been a hereditary doctor in Taiwan (James Yin Tao So) was persuaded to start a college near Boston; a group of émigré Chinese in Los Angeles formed a society dedicated to giving Christian medical missionaries some Oriental medical training (it became Samra University of Oriental Medicine).

The demand for medical alternatives that was driven by members of American counter-cultures acquired a closer Chinese coloration after the Sino-American rapprochement in the 1970s. Many believe a turning point occurred in 1971, when the journalist, James Reston, had an emergency appendectomy in Beijing and wrote in *The New York Times* about receiving acupuncture as part of his post-operative recovery. Acupuncture quickly became the premier Chinese medical technology for students of Chinese medicine, and the drive to legitimate this medicine in the 1970s and 1980s revolved around campaigns to establish a state-authorized licensing system for it. State by state, coalitions of advocates succeeded in passing laws authorizing the holders of such licenses to set up shop as “primary care providers” in what came to be designated as AOM (Acupuncture and Oriental Medicine). California decriminalized acupuncture in 1975 and passed its first basic licensing law in 1978, and in 2008 Mississippi became the 44th state to establish a state licensing board.²⁴

There is no doubt that acupuncture led the way in claiming respect for Chinese medicine in America, producing a disproportionate percentage of biomedical interest and clinical research in the field. The entry level qualification for practitioners today continues to be a state acupuncture license (herbal medicine and body therapies remain unregulated). However, American acupuncture was not embraced merely as a technology like chiropractics, but instead was connected to a new iteration of medical holism, now identified with the traditions of a foreign civilization. The end of cold war barriers between China and the US in the late 1970s, and the flow of new Asian immigration after 1965, all served to make people from China—and Korea and Vietnam as well—a resource for increasing knowledge and popular acceptance of Chinese medicine in the US and particularly on the West Coast. But from this beginning, American Chinese medicine was never a straightforward Chinese transplant, and its identity as a holistic alternative to bioscience reflected a distinctively late 20th-century American multiculturalism.²⁵ The place of ethnic Chinese practitioners and their authority in this

American system has been an ambiguous one. In China the authenticity and authority of Chinese medicine has rested on its classics, traditions and language, and on its cultural familiarity for users. But American practitioners were caught between the need to claim a Chinese legacy for themselves, and their own remoteness from its culture of origin.

It is true that American advocates of Chinese medical alternatives have echoed some of the rhetoric found among defenders of Chinese medicine inside China during their early 20th-century battle to resist legal abolition. The model of a good therapy even echoes Fei Boxiong. Chinese remedies are natural and gentle, attentive to the harmony of human being and environment, sensitive to patients' constitutional endowments and emotions, fostering harmonious balance of bodily functions, and validated by patient satisfaction. Nonetheless, in the US, practitioners of Chinese medicine came to these insights by moving backwards toward a "China" of the imagination. For healers and patients in the late 20th century, issues of cultural translation became central. This enterprise can be summarized around the emerging profession's engagement with three problems: the problem of education, the problem of philosophy, and the problem of language.

THE PROBLEM OF EDUCATION

Historically, Chinese medicine privileged a personal teacher-student relationship, inside and outside of medical lineages, and these quite local ties established a clinician's claim to be a legitimate practitioner. In the TCM training schools of the PRC, teachers and students could form publicly recognized master-disciple bonds even though these have rarely been as intense as in earlier times. In the US the pioneer generation at first had no teachers at all. They had to find their way to places like Taiwan, Hong Kong or Macao that were politically accessible, or locate sojourners and émigrés who could operate in an English language environment. Communication remained difficult and there was no easy way of negotiating the many local variations of the Chinese medical tradition which were embedded in different instructors and instructional products. The old fashioned label "Oriental" smoothed over some of these problems, but did not resolve them.

More formal practitioner education in the United States was stimulated by the need for training to pass acupuncture licensing exams, and the model of a (for profit) proprietary school, long used by chiropractors, osteopaths and assorted naturopaths, lay ready to hand.²⁶ The oldest such institution, The New England School of Acupuncture, was founded in 1975. But California and the West Coast led the way with 11 schools that opened between the late 1970s and the 1980s, as opposed to four along the eastern seaboard. The number of schools roughly doubled in

the 1990s, with 17 new institutions that were more widely distributed around the US. After 2000, as the number of new schools declined, the pattern remained: Acupuncture and Oriental Medicine (AOM) schools today are concentrated in urban settings along the two coasts, and are still scarce in the Midwest and South. I have identified 39 institutions which are currently fully accredited by the most important national supervisory body that has emerged over the last quarter century. This is the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM), a self-regulating committee of nine members established in 1982 that reviews AOM programs with an eye to the criteria for taking state licensing exams. Most state acupuncture examining boards use the ACAOM standard, and the organization has some additional leverage due to its being recognized by the federal Department of Education. Nonetheless, its standards are easygoing, accommodating a wide variety of local environments and pedagogical approaches. In this situation the largest single state player, California, insists upon its own separate standards, claiming these are more rigorous than those of the ACAOM,²⁷ and the 11 out-of-state schools that meet its criteria can and do advertise this fact as a recruiting device.²⁸

In sum, actual training has come to take place in private colleges of Oriental Medicine, which offer Masters degrees (three- or four-year programs). Today there may be as many as six to ten thousand students in these colleges, including those enrolled part-time or in distance learning. Most are Americans of all ethnic backgrounds, and the majority are women. Many if not most instructors are clinicians who teach only part time. The character of these schools varies by the leadership style of different owner/directors, by the faculty they recruit, and by local conditions. After 20 to 30 years, this American professionalization of AOM shows dramatically in the fact that most faculty teaching today in one of these schools have been trained in an American institution, often by the one that employs them. Finally, graduates, like the schools that train them, operate in a competitive private marketplace, and however their patients may regard them, unlike their counterparts in the PRC, they cannot formally claim the title of “doctor.” Status anxieties about this are among the drivers of an emerging movement in some colleges to offer advanced students a PhD degree (DAOM).

In this mix, only a tiny minority of schools appear designed predominantly to serve Asian-American ethnic or immigrant populations—three of them oriented towards Los Angeles’s Korean communities, and one looking to New York City’s Chinese. Additional outliers among accredited schools include a college in Northern California that specializes in Japanese acupuncture of the Kohoha tradition; and one in Manhattan where students follow a curriculum modelled on French versions of “meridian acupuncture.”

THE PROBLEM OF PHILOSOPHY

If PRC medical education in TCM is standardized through a national Ministry of Health, this decentralized American regulatory apparatus gives libertarian space for diverse philosophies. In advertising themselves on the web, AOM schools may offer a common set of visual props—yin yang symbols, calligraphy, dragons—drawn from the Orientalist imaginary; they may make similar claims for the centrality of a close doctor-patient relationship and for the efficacy of therapies tested by an ancient tradition of practice. But closer reading of their “mission statements” and the descriptions of faculty and curriculum reveal pre-occupations with the longstanding mainland Chinese controversies between syncretists and cultural traditionalists, as well as various flavours of mind-body spiritualism that echo distinctly Euro-American traditions of natural therapeutics. Interestingly, the empiricist position, held by influential mainland Chinese advocates for Chinese medicine in the Republican era and beyond, does not appear as a viable self-image for any of these schools. Rather, the typical “mission statement” of a school of AOM assumes that systematic doctrine underlies its educational practice.

The most distinctive American strategy for claiming a systematic foundation is to embrace some version of mind-body holism. Here the psychological dimensions of healing are important, as are the Asian body-work technologies of taiqi or medical qigong which are understood as having spiritual benefits. The teachings of J. R. Worsley, the British creator of a personal system of “Five Elements” acupuncture not practiced in China, have shaped the philosophy of several schools on the East Coast. Several other schools that have been grafted onto existing colleges of naturopathy or chiropractics present AOM as complementary to these older American forms of alternative medicine. A few schools define themselves outright as Daoist, either based on the authority of school leaders as initiated descendents of Daoist lineages, or simply by finding inspiration in the classics of Laozi and Zhuangzi. School mission statements promise to teach all the variants of Oriental medical techno-practice, assuming harmony among them.

Here the term “integral” crops up often, but it does not necessarily refer, PRC style, to the integration of Oriental medicine and biomedicine. Other meanings are suggested. The goal may be to integrate mind and body, or to integrate human and natural worlds, or to integrate different Asian traditions (such as Chinese, Japanese or Korean schools of acupuncture), or to integrate older and newer forms of alternative medicine (say, AOM and naturopathy). In sum, one philosophical task these American institutions face is to synthesize variant traditions within Oriental or alternative medicine itself. Here the most available doctrinal resource

is an American new age ideal of mind-body harmony more beholden to classic anti-Cartesian, anti-materialist, holisms in Western philosophy than to any distinctively Chinese inspiration.

Other schools of AOM—perhaps 25-30% of the total—emphasize in their mission statement that they teach the integration of AOM and biomedicine. Some of these are able to offer clinical training opportunities for their students in biomedical hospitals or clinics, though clinics affiliated with the schools themselves are more common. In the American setting some of these biomedically oriented institutions deal with the tension between Chinese culture and standard scientific paradigms of authority by modeling their programs directly after TCM training in the PRC, defending this as the only authentic “Chinese medicine” there is. Five such institutions were founded in the 1990s, have Chinese presidents or CEOs, and have hired PRC natives for one-half or more of their faculty posts.²⁹ Ironically, then, it is a group of schools which are direct imports from the PRC which build their image both on their cultural identity as Chinese and their medicine’s claimed affinity with the biomedical mainstream.

On the other hand, five schools, all on the West Coast, advertise their commitment to training students in the Chinese language, including literacy in the Chinese medical classics as essential. Three of these are among the oldest colleges of AOM in the country (founded between 1979 and 1989), none is led by a PRC native, and although all list faculty from the PRC, in every school, these are in the minority.³⁰ In these schools, arguments for Chinese language training are based on respect for canon and the old “scholar physician” ideal, and a belief that the epistemological foundations of the practice are embedded in the linguistic forms of Chinese. They also are presented as opening the door to medical research published in Chinese, and as helping students navigate the pitfalls of translated materials. Above all, AOM faculty literate in Chinese see themselves as uniquely positioned to develop a viable Chinese medicine in English. In sum, syncretistic rhetoric is associated with relatively recent immigrants from the PRC, who bring China’s own TMC style of training to schools where they are influential, while the appeal to a classical model of Chinese tradition and a techno-practice linguistically grounded in Chinese has been embraced most strongly by West coast institutions dominated by Anglophone experts who learned their Chinese medicine first from afar.

THE PROBLEM OF TRANSLATION

All engagements with foreign cultures are exercises in translation. Given that teaching, learning and clinical practice all take place in an Anglophone environment, it is not surprising that American practitioners can

experience epistemological unease about translatability itself. Just about everyone deals with the issue on the ground: how to manage the gulf between Chinese sources and origins and Anglophone students, practitioners and patients. There are heated and ongoing debates about the proper strategies for learning Chinese medicine in English, an issue that is raised sometimes in the classroom where students may struggle to understand the speech of their Chinese instructors, but that becomes critical where written materials are concerned. The field is flooded with a diversity of texts to choose from: some are based on textbooks used in the PRC, many done in China by translators with little training in either medicine or English; some come from Anglophone senior physicians who have learned Chinese; there are also collections based on Korean and Japanese originals. Textbooks used in US licensing examinations, like the works of Giovanni Maciocia, have a built-in advantage regardless of criticisms of their merit. There is contention over whether a native of China or a native speaker of English is better qualified to produce an authoritative translation. Historical classics get translated and retranslated without much reference to analytical historical scholarship on these works. Seekers of the Dao can chime in, and do.³¹

In this environment, the vast majority of students and practitioners are forced to juggle a variety of translations with one another, without access to any common reference point in the language of origin, and with little exposure to the context-dependent framing of Chinese meanings in a wildly diverse literature. One important set of would-be gatekeepers of English-language writing on Chinese medicine are publishers of the books used as classroom teaching materials. Here the American AOM community recently has been riven by what have been called “terminology debates.”³² One group, led by the principal author of a learned *Practical Dictionary of Chinese Medicine* (Nigel Wiseman), argues for translations that evoke the historical textual tradition—what linguists call a “source based” translation philosophy. Only this, they say, can convey an authentic appreciation for Chinese medicine’s roots. Even if classical Chinese medical terminology has changed over the centuries, making it hard to come up with single essential meanings for any terms, translation should both aim for precision and pull the student toward the symbolically rich, deep, culturally specific knowledge of the body on which Chinese medicine is founded.³³ Opponents of this translation philosophy, led by a leading Oriental medicine publisher (Daniel Bensky) criticize it as obscurantist, and as likely to make Chinese medicine into a cultural relic, unable to connect with today’s patient population or to foster communication with the biomedical mainstream. They call for a “target centered” translation strategy—an English that is relatively transparent for readers, provides context-sensitive multiple interpretations, that communicates meaning to a lay public as well as to experts, and is

free of off-putting Orientalist imagery. Eastland Press in Seattle, where Bensky is a director, has published on-line its own glossary of Chinese medical terminology as a partial alternative to Wiseman's *Practical Dictionary*. People in Bensky's camp think that the Wiseman approach produces essentialist and archaic definitions that nonetheless reify terms in the manner of disease names; Wiseman's partisans think Bensky is a popularizer who oversimplifies and paraphrases. At issue is whether Chinese medicine has a true technical terminology—communicating precise meanings important to experts where consistency is essential; or whether medical Chinese shares the aesthetic of the classical language from which it is derived, and should be translated artfully as “more akin to the language of wine-tasting than of biomedicine.”³⁴ While both groups claim to be sensitive to the polysemic and metaphorical qualities of written Chinese, and neither wants Chinese medical language to be “biomedicalized,” their conflict raises what for many is the spectre of an imposed standardization of Anglophone Chinese medicine. Another medical publisher, Bob Felt of Paradigm Press, has proposed an uneasy compromise in the form of a suggested “open standard”—an internet data base that would allow viewers to examine all variant translation strategies currently in play for any term.³⁵ None of these Anglophone experts is looking for translation to bridge the gap between Chinese medicine and biomedicine. That agenda has been pursued most forcefully by international organizations—chiefly the World Health Organization (WHO) and the World Federation of Chinese Medical Societies (WFCMC). The WHO is working to fold Chinese medicine into an ambitious internet database encompassing the “traditional medicines” of the entire Pacific Rim. Its dictionary project, recently published, was strongly shaped by a PRC terminological dictionary, Xie Zhufan's *English Translation of Common Terms in Traditional Chinese Medicine*, and by workshops dominated by Chinese, Japanese, and Korean experts. Here Asian experts from different language communities found common ground in biomedically oriented terminology, which suited their conviction that Chinese medicine can be understood as science using conventionally recognized methods of experimental laboratory and clinical research.³⁶ The WFCMS, which is PRC led, also believes that the route to international scientific acceptance of Chinese medicine lies in gaining credibility with the biomedical establishment, with an eye to the developing global markets for PRC-produced medicinals.

The “terminology debates” show how the issue of naming leads to the question of power. Four compilations now circulate, each tied to specific national, commercial and academic interests, while none, apparently, controls the unfettered publications marketplace on either side of the Pacific. Here the sharpest division is between the international and pan-Asian organizations which are committed to some form of biomedically

oriented standardized terminology serving global agendas, and the Anglophone community of AOM which embraces intellectual freedom and allows multiple viewpoints to contend. North American arguments about translation that pit terminological precision against multiple meanings and literary nuance carry with them fundamental questions about what kind of alternative this medicine can be. Can it draw upon the historical resources of the learned tradition in Chinese to be its own science, possessing an expert language needed to convey complex facts with the same level and kind of authority that bioscience commands? Or will it claim the ground of a medical humanity, challenging hegemonic values of exactitude and precision in favor of an epistemology based on relativism and the irreducible facts of individual difference? Not just philosophy of language, but future careers in American AOM, will be affected by the outcome.

The result for American practitioners today is a free market place of linguistic practices which keeps issues of translation and translatability constantly in the foreground of consciousness. Historical, culturally specific sources of authority are explicitly juxtaposed to those of a science presumed to be universal. Models of translation that emphasize the context-dependent plurality of meanings are challenged by those who want terminological precision.

The results for students are paradoxical. A student may be told in one class that the English terminology in a standard textbook is important for passing a licensing exam, but clinically useless; in another class the same student may hear that without knowledge of classical Chinese medical texts in the original, she will remain essentially clueless. A third mentor may tell her that this linguistic anarchy in the classroom actually challenges students to think for themselves and connect book learning to experience.³⁷ The ironical result is that many apprentice practitioners are led away from the heritage of this highly literate, text rich tradition, and towards an epistemology of “experience” and “practice” that bypasses formal book learning.

Of course the problem of clinical application of textual knowledge goes deep, and also has deep historical roots in Chinese medicine. When AOM schools emphasize their clinical education, as some do very strongly, and when long-time practitioners say that issues of language and epistemology lose importance as they gain experience, whether they are self-conscious about this or not, they can be seen as tapping into another venerable dimension of the Chinese medical tradition. Supported by a master-disciple model of education, generations of pre-modern Chinese medical practitioners have endured long apprenticeships, and have judged clinical success by “efficacy”—successful clinical outcomes validated by patient satisfaction and understood as evidence of experience vested in the person of the doctor himself or in his medi-

cines. Even as they picked up their writing brushes and committed their thoughts and case records to paper, physicians like Fei Boxiong warned that the essence of medicine eludes words. As today's leaders of AOM struggle to create a body of writing adequate to the task of consolidating Chinese medicine in the English language, they live with similar upwellings of clinical skepticism.

CONCLUSION: ALTERNATIVE MEDICINE AND CHINESE IDENTITY

From these two portraits of Chinese medicine, we might conclude that Chinese and Westerners have simply changed places. In the PRC they worship science, and in the US we are suckers for the mysterious East. This essay has oversimplified the internal diversity that exists under the surface of the state system in China, and has probably overemphasized the fractures in American practice. Nonetheless, we can generalize that in the PRC today we find a state supported medical system that aims to mainstream Chinese medicine by putting syncretists in charge; they also hope that their indigenous medical tradition and the products that can be marketed in its name can spread globally. In the American settings I have offered here, the largely private community of study and practice is clearly alternative and self-consciously critical of biomedical hegemony, but operates with libertarian freedom born of counter-cultural convictions and a lax regulatory environment. The issue of "Chineseness" plays out differently on these two sides of the Pacific.

One dimension of the "Chineseness" of this medicine is ethnicity. Where some in the PRC may complain that their traditional medicine has been corrupted in the course of modernization under state supervision, no one can deny that its past and present are theirs as Chinese. In the US, while the cultural politics of Asian-American ethnicity certainly helped build political support for AOM along the West Coast, the profession and its clients are largely Euro-American. PRC immigrants have found a niche in the colleges of AOM but it is a minority one, where their ethnicity cuts two ways. On the one hand it confers automatic authenticity, but this is compromised when they must operate as foreigners, while the "scientized" TCM they import on the basis of their PRC training and experience clashes with the counter-cultural, critical stance of "alternative medicine" in the Anglophone world. For both Chinese and non-Chinese, ethnicity is not the source of a secure identity politics, but a site of negotiation of all the complex issues surrounding Chinese medicine's global directions.

In the US, teachers and practitioners of AOM assume that it contains an underlying substrate of Chinese meaning independent of ethnicity. This meaning is what lifts their experience of Chinese medicine above the level of raw empiricism. But such meanings are plural. Some

articulate doctrines of new age holism. As Linda Barnes has argued, Chinese medicine in contemporary America has become psychologized, claiming the terrain of “wellness” and “spirituality,” harmonizing mind and body, incorporating emotions into the diagnostic picture without implying the stigma of mental illness.³⁸ For others, the model of TCM as practised in China serves as an authentically “Chinese” path of integrating Chinese medicine with the scientific mainstream. Here one often finds the older cosmological abstractions of qi, yin yang, and the Five Phases translated into biomedically friendly idioms of organic function—“energy, balance, and reserves” or “homeostatic flow.” For still others the key is to imagine knowledge as experiential and embodied in practice that one learns and transmits without words (the “feel” of the patient’s pulse, or of qi in needling techniques) and that requires the physician’s own personal self-cultivation. Finally, for some the Chinese language become a touchstone, leading to a goal of a learned profession whose leaders are proficient in classical and modern Chinese, able to interpret the classics, historical and modern schools of interpretation, and to become master translators themselves. Nonetheless, however multifloral this symbolic bouquet may be, all still want to say that these flowers spring from Chinese seeds.

On both sides of the Pacific, these multiple paths are generating new forms of the dialectic between mainstream and alternative. What looks like alternative medicine in the PRC today? This has not been systematically researched, but there are anecdotal reports of a vogue for some foreign therapeutic practices. Tibetan medicine, based on materia medica from the Himalayas, has attracted followers, and has even been subsidized by the Chinese state, cashing in on its popularity while possibly compromising its integrity. In sophisticated cities like Shanghai, it is possible to find clinics offering naturotherapy, aromatherapy or yoga. More important may be traditional style therapies offered by private qigong masters, purveyors of “secret formulas,” or practitioners of ritual healing. Shamans, dealers in ritual *fu* charms, and temple-based Daoists can still be found almost everywhere among the poor and in the countryside. Faith healing has been a central theme in the teachings of the outlawed Falungong movement. In rejecting “superstition,” TCM in the PRC today follows the precedent of learned medicine in imperial China, claiming a rational and naturalistic basis for its therapies by contrast with the appeals to the supernatural of popular religion, or the quackery of miracle cures peddled by presumed unscrupulous private practitioners.

In the United States, on the other hand, as “alternative medicine” has grown in popularity since the 1960s, efforts by the biomedical establishment to incorporate practices deemed scientifically promising has generated the Complementary and Alternative Medicine movement (CAM). Spurred on by Congressional concern, the National Institutes of

Health established an Office of Alternative Medicine in 1992. However, its agenda quickly attracted such hostility from prominent biomedical professionals that its leadership and name were officially changed in 1999.³⁹ Today the acronym CAM marks a whole range of practitioners, clinics, research and publications that seek to evaluate alternatives with the tools of evidence based medicine. In short the words “complementary” or “integrative” are codes for somewhat overlapping but distinct projects aspiring to “scientize” alternative medicines and co-opt them into the biomedical mainstream.⁴⁰ Interestingly, here Chinese medicine, particularly acupuncture, may be pre-eminent among “coming alternatives” in attracting the attention of CAM researchers, but in the crowded American market place of New Age alternative practitioners and their clients, it may have neither market dominance nor a clearly distinct identity for many.⁴¹

Our questions about reform from within and adaptability abroad continue to be asked. They have concerned everyone involved in the field ever since Chinese medicine was first “othered” by bioscience. They push us to look for some essential “Chineseness”—authority or authenticity rooted in history and culture. But my historical narrative about the process of “becoming alternative” show us that the definition and even the location of the “Chineseness” changes over time. The historical dialectic implied in Rosenberg’s two trajectories hints we need to take an evolutionary view. There is a historical chain/thread that leads step by step from Fei Boxiong to today’s researchers and practitioners on both sides of the Pacific. But it is more like a game of telephone, or what the anthropologists call traveling theory. As doctrine/learning moves from place to place, it shapes and is reshaped by the alteration of context and circumstances, alterations that involve both time and space. As time passes, history gets refashioned, its threads rewoven to fit today’s wearers. Moreover, as the play increasingly occupies a global stage, this motion continues, and even accelerates.

Today the Chineseness of Chinese medicine still matters on both sides of a Pacific that is becoming increasingly interconnected. Today’s practitioners must find a balance between being reduced to purveying empirical therapies adopted into a biomedical universe as simple technologies, and becoming swept away in the ever shifting oceanic tides of spiritual healing. By preserving their connections to a rich yet culturally specific history while also innovating in ways that open out from this history, such practitioners work to keep the “Chinese” in their medicine both as a source of identity and a resource for practice.

Table 1
ACAOM-Accredited Schools of Acupuncture and Oriental Medicine

Name	Location	Date Founded/ Date First Accredited	Highest Degree	President or CEO	Number of Students	Number of Faculty Listed	PRC Links	Philosophy
* Academy of Five Element Acupuncture	Gainsville Fla.	1988/1998	MA	Dorit Reznek	67	33; no MDs, no Asian names	none listed	Five element energetics and Daoism
Academy of Oriental Medicine at Austin [C]	Austin, Texas	1993/1996	MA	William R. Morris	211	26; 3 MDs, 13 Chinese; 13 TCM/PRC	Chengdu U. of TCM – exchange program, many faculty taught there	Integrate TCM and bio-medicine
Acupuncture and Integrative Medical College, Berkeley (formerly Meiji College of Oriental Medicine)	Berkeley, Cal.	1990/1998	MA	Terri Powers	138	34; 2 MDs, 7 Asian names; 4 Japanese, 3 TCM/PRC	none listed	Emphasize Chinese and Japanese clinical practice. Specialty in Japanese acupuncture taught by masters from Japan.
American Academy of Acupuncture and Oriental Medicine	Roseville, Minnesota	1997/2003	MA	Dr. Changzhou Gong (business degree)	100	22; 2 MDs, 12 Chinese names; 11 TCM/PRC	field study programs at "sister school" Shandong U. of TCM	Integrate TCM and bio-medicine
American College of Acupuncture and Oriental Medicine [C]	Houston, Texas	1991/1996	MA	Ben de Spain, Ed.d.	149	not listed	Study abroad in TCM hospitals in Dalian, Zhejiang, Tianjin	Integrate TCM and bio-medicine

* American College of Traditional Chinese Medicine	San Francisco, Cal.	1980/1991	MA	Lixing Huang, MS, conservationist	?	59; no MDs, 15 Asian names: 10 TCM/PRC, 2 Japanese	none listed	Eclectic, holistic, respect Chinese tradition
Asian Institute of Medical Studies	Tucson, Arizona	2000/2006	MA	Alex Holland	?	19; 1 Asian name, all American trained	none listed	New Age - mind-body-spirit energetics; prepare for evolving change in consciousness
* Atlantic Institute of Oriental Medicine [C]	Ft. Lauderdale, Fla.	1994/1999	MA	Joanna Chu Yen, MD (China)	?	20; 1 MD, 13 Chinese names: 11 Chinese MDs and/or TCM/PRC	Sister school is Shanghai University of TCM; internships and study at several locations	Integrate TCM and bio-medicine
Bastyr University [C] (AOM program within the College of Natural Medicine)	Seattle, Wash.	College founded in 1978, AOM added in 1987/1994	MA, DAOM	Daniel Church	995 in all fields; 152 in AOM program	51 in College; 13 in AOM program, 4 TCM/PRC	none listed	AOM as a complement to naturopathy, emphasis on herbal science research
Colorado School of Traditional Chinese Medicine	Denver, Col.	?/2002	MA	not listed	111	32; no MDs, 8 Asian names: 3 TCM/PRC, 2 PRC trained martial artists	none listed	"Both traditional and modern" knowledge. Asian bodywork classes required.

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Table 1 (cont'd)

Name	Location	Date Founded/ Date First Accredited	Highest Degree	President or CEO	Number of Students	Number of Faculty Listed	PRC Links	Philosophy
Dongguk University Los Angeles (part of Dongguk University Seoul, Korea)	Los Angeles, Cal.	1979/1994	MA	In Shik Kim, MBA	191	only 4 listed; 3 Korean names	none listed	Serve Asian ethnic communities; classes in Chinese, Korean, and English. Korean language webpage.
Dragon Rises College of Oriental Medicine	Gainesville, Fla.	2001/2004	MA	Dr. Leon Hammer, M.D., Autumn Grubb	10 graduates in 2008	11; 2 Asian: 1 TCM/PRC	none listed	Holism based on Dr. Hammer's pulse diagnosis teachings, Five Elements, western psychology, and Chinese traditions
East-West College of Natural Medicine ☐	Sarasota, Fla.	1994/1999	MA	Cynthia O'Donnell, MA in holistic health	121	25; no MDs, 8 Chinese; 7 TCM/PRC	elective 3 week study tours to China, to Hangzhou University of TCM	Holistic natural health wisdom. Combination degree in AOM and "natural medicine."
Emperors College of Oriental Medicine	Santa Monica, Cal.	1983/1989 (DAOM in 2004)	MA; DAOM candidate	Yun Kim (daughter of founder, Bong Dal Kim)	211	34, no MDs, 9 TCM/PRC, 4 other Asian	none listed	Eclectic, train practitioners to succeed in California setting

Finger Lakes School of Oriental Medicine of the N.Y. Chiropractic College	Seneca Falls, N.Y.	2003 (program started in the college)/2008	MA	Frank J. Nicchi	?	18; 2 TCM/PRC	A three week study tour in China as an elective	Integrate AOM with other complementary medicines, inc. chiropractic and natural health
Five Branches University Graduate School of Traditional Chinese Medicine	San Jose and Santa Cruz, Cal. (two campuses)	1984/1996	MA; DAOM candidate	Ron Zaidman	450	95; 2 MDs, 29 Asian names: 19 TCM/PRC, 8 lineage trained, 10 senior physicians, 4 MDs	Zhejiang College of TCM, cooperation on doctorate	Eclectic, respect for Chinese tradition and lineage learning. Classes in Chinese and English.
Florida College of Integrative Medicine	Orlando Florida	1990/1997	MA	Larry Han	134	11; 4 Chinese: 4 TCM/PRC	none listed	Teach AOM solutions to bio-medical problems. CAM oriented
Institute of Clinical Acupuncture and Oriental Medicine	Honolulu, Hawaii	1996/2002	MA	Wai Hoa Low	?	19; 1 MD, 8 Asian names: 1 TCM/PRC	none listed	Integrate biomedicine and oriental medicine
Midwest College of Oriental Medicine (originally a naturopathic college)	Chicago, Ill. And Racine, Wisc.	1979 (naturopathic school)/1993	MA	William Dunbar	130	29; 9 Asian: 3 TCM/PRC	Guangzhou Medical U: trained 6 non-Asian faculty. Student internships offered.	Bring PRC's TCM curriculum to American education. Joint degree in nutrition and AOM

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Table 1 (cont'd)

Name	Location	Date Founded/ Date First Accredited	Highest Degree	President or CEO	Number of Students	Number of Faculty Listed	PRC Links	Philosophy
Minnesota College of Acupuncture and Oriental Medicine (part of Northwestern Health Services University)	Bloomington, Minnesota	college in 1990/1999	MA	not listed	?	47; no MD, 10 Chinese names; 9 TCM/PRC	none listed	Help chiropractors and naturopaths get AOM degree
National College of Natural Medicine (College of Classical Chinese Medicine)	Portland, Oregon	1998/2000	MA	David Schleich	?	10; 1 MD, 4 Chinese names; 4 TCM/PRC (Chengdu)	Exchanges with Chengdu University of TCM	Parent school trains naturopaths. AOM program seeks to return Chinese medicine to classical roots. Led by Heiner Fruehauf.
* New England School of Acupuncture <input type="checkbox"/>	Newton, Mass.	1975/1988	MA	not listed	220	60, 1 MD, 12 Asian names; 11 TCM/PRC, 1 Japanese trained.	none listed	Integrate Chinese medicine and biomedicine
New York College of Health Professions <input type="checkbox"/>	Syosset, Long Island, N.Y.	1981/1996	MA	Lisa Paimintuan	?	28, no MDs, 7 Asian; 5 TCM/PRC	The dean (Chinese) directs a college owned "Health Center" in Loyang. Students take 3 week trips.	Holistic health, emphasis on Asian bodywork therapies.

New York College of Traditional Chinese Medicine	Mineola, Long Island, N.Y.	1996/2002	MA	Yemeng Chen	?	31; 1 MD, 19 Chinese; 13 TCM/PRC	Exchange with Beijing University of TCM	Teach "authentic" Chinese medicine as practiced in PRC. Chinese web page; ESL classes. Serves NYC's ethnic community.
* Oregon College of Oriental Medicine [C]	Portland, Oregon	1983/1989	MA, DAOM	Michael Gaeta	266 (not FTE)	34; no MDs, 8 Chinese; 6 TCM/PRC	none listed	CAM and biomedicine oriented
Pacific College of Oriental Medicine	San Diego, Cal. (Chicago, New York branches)	SD campus 1986/1995; NY 1995; Chicago 2004	MA, DAOM	not listed	249 in Chicago campus	no data available	none listed	Eclectic, train practitioners to succeed in California setting
Phoenix Institute of Herbal Medicine and Acupuncture	Phoenix, Arizona	1996/2004	MA	Catherine Niemic	102 (72 FTE)	28; no MDs, 6 Asian names; 1 TCM/PRC	Internship with Chengdu University of TCM	Eclectic, a joint program with a naturopathic college
* Samra University of Oriental Medicine (originally Sino-American Medical Rehabilitation Association)	Los Angeles, Cal.	1979/1989	MA	Hyung Joo Park	160 (106 FTE)	25; 22 Asian names; 6 TCM/PRC, 9 South Korea trained	2 month internships at Dongzhimennei Hospital, Beijing	Serve ethnic communities, Korean and Chinese; classes in English, Chinese, and Korean; teaches medical classics, offers Korean AOM.

Table continued on page 34

Table 1 (*cont'd*)

Name	Location	Date Founded/ Date First Accredited	Highest Degree	President or CEO	Number of Students	Number of Faculty Listed	PRC Links	Philosophy
Seattle Institute of Oriental Medicine ☐	Seattle, Wash.	1996/1998	MA	Paul Karsten	36	24; 1 MD, 7 Asian; 5 TCM/PRC, 1 trained in Japan	none listed	Clinical training with Chinese fundamentals, inc. medical classics and current Chinese language research. Chinese language required.
South Baylo University (on probation with accreditation agency over DAOM)	Los Angeles (Anaheim)	1977/1993	MA	Jason Shin	573 (555 FTE)	33; no MDs, 28 Asian names; 8 South Korea trained, 8 TCM/PRC.	none listed	Eclectic. BA in "holistic science." Biomedical diagnosis emphasized. Chinese, English and Korean classes.
Southern California University of Health Sciences	Los Angeles (Whittier)	2001 for college/2005	MA	Ronald D. Kraft	558 (502 FTE)	33; no MDs, 20 Asian names; 5 TCM/PRC	none listed	AOM training for chiropractors, joint degree offered. Oriented toward physical medicine.
Southwest Acupuncture College ☐	Albuquerque, N.M. (branches in Santa Fe, Boulder)	1980/1989; Albuquerque 1995; Boulder 1998	MA	Anthony Abbate	88	34; no MDs, 7 Asian names; 5 TCM/PRC.	2 month study tours to Heilongjiang U. of TCM	Eclectic: teach "all the paradigms of Chinese medicine."

Swedish Institute School of Acupuncture and Oriental Studies	New York City	1996/1999	MA	Paula Eckardt	?	29; 1 MD, 4 Asian names; 1TCM/PRC.	none listed	AOM program shaped by Jeffrey Yuen (dean), emphasis on classical roots as transmitted by Daoist lineage.
Tai Sophia Institute 	Baltimore, Maryland	1975/1985	MA	Bob Duggan	423	150 named, no details given.	none listed	"Wellness education" based on spirituality and mind-body learning; J. R. Worsley's "Five Element" acupuncture.
Texas College of Traditional Chinese Medicine	Austin, Texas	1990/1996	MA	Lisa Lin, Paul Lin (from Taiwan but PRC trained)	not listed	no information on teaching faculty	none listed	"Authentic" Chinese medicine based on PRC. TCM. Chinese language web page; international students encouraged.
Tri State College of Acupuncture (originally a branch of Institute of Traditional Chinese Medicine of Montreal)	New York City	1979/1993	MA	Mark Seem	162	58; including 10 Master Practitioner teachers. 1 MD, 7 Asian names. No further details.	none listed	Curriculum based on French schools of Chinese medicine; emphasize flexible clinical application of all existing styles of acupuncture.

Table continued on page 36

Table 1 (*cont'd*)

Name	Location	Date Founded/ Date First Accredited	Highest Degree	President or CEO	Number of Students	Number of Faculty Listed	PRC Links	Philosophy
University of East-West Medicine	Sunnyvale, Cal.	1997/2005	MA	Ying Qin Wang, MD (China)	171	47; no MDs, 42 Chinese names; 14 TCM/PRC, 14 PRC trained in bioscience.	Exchange with OM universities in Beijing, Anhui, and Heilongjiang	"Vital core medicine" from PRC; reintegrate traditional and modern medicine. Chinese and English classes, international students encouraged.
World Medicine Institute (formerly Tai Hsuan Foundation)	Honolulu, Hawaii	1974/1991	MA	Chang Yi Hsiang (64th generation Daoist lineage master)	not listed	teaching faculty not listed	One month summer field trips visiting four cities	Daoist health and longevity teachings, including ritual and meditation.
Yo San University of Traditional Chinese Medicine	Los Angeles, Cal.	1989/1993	MA	Daoshing Ni and Maoshung Ni, from Chinese medical lineage	143 (116 FTE)	38; 4 MDs, 19 Asian names; 9 TCM/PRC.	none listed	Combine Chinese medical lineage-based teachings of Ni family with professional training suitable to California.

Schools of Acupuncture and Oriental Medicine in the US

Explanation: the above table considers 39 schools which currently are fully certified by the national Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) as qualified to offer an MA degree in AOM (Acupuncture and Oriental Medicine). The information concerning each institution is based on its current web page (as of July 2009), and simply reflects the features that the school selects to advertise itself and its program.

The category "faculty" counts everyone identified by name and credentials. It does not distinguish between full-time and part-time, and follows the web sources when they include practitioners affiliated with the school, occasional visiting experts, administrative and business staff, or others. "MD" refers to a US medical degree. The label "MD (China)" indicates a biomedical degree earned in the PRC, and "DAOM" is the acronym for a doctoral degree in AOM.

The category "number of students" does not always distinguish between full-time and part-time students currently enrolled, or between undergraduates and graduate students. (It is the only information in the table not supplied by the institutions' own web pages, but where available comes from the site "Braintrack" which offers students shopping for a school some comparative data). The category "philosophy" suggests my own sense of the flavors of medical pluralism emphasized by the institution in question, and in no way summarizes the totality of a school's range of offerings. Non-profit institutions are indicated by an asterisk *, and the [C] indicates the non-California based schools whose programs are considered by the State of California Acupuncture Board as adequate preparation for its state licensing exam.

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NOTES

- 1 Charles E. Rosenberg, *Our Present Complaint: American Medicine Then and Now*, (Baltimore: Johns Hopkins University Press, 2007), chap. 7: "Alternative to What; Complementary to Whom?"
- 2 Harry Collins and Trevor Pinch, *Dr. Golem: How to Think about Medicine* (Chicago, Ill., University of Chicago Press, 2005), p. 2-3.
- 3 Angela Ki-che Leung, "The Business of Vaccination in Nineteenth-Century Canton," *Late Imperial China*, 29, 1 (2008): 7-39.
- 4 Ruth Rogaski, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China* (Berkeley, California: University of California Press, 2004), chap. 3, 4; Angela Leung and Charlotte Furth, eds., *Health and Hygiene in Chinese East Asia* (Durham, N.C.: Duke University Press, forthcoming). See especially the essays by Leung, Li Shangren and Yu Xinzhong; Bridie Andrews-Minehan, "What Missionary Doctors Learned from the Chinese," paper presented to the Conference on "Medicine and Culture: Chinese-Western Medical Exchange (1644-ca. 1950)," Matteo Ricci Institute, University of San Francisco, 9 March 2007.
- 5 Volker Scheid, *Currents of Tradition in Chinese Medicine 1626-2006* (Seattle, Wash.: Eastland Press, 2007) p. 86-94.
- 6 Particularly notable was Kitasata Shibasaburo (1852-1931) who spent six years in Robert Koch's laboratory working on the bacteriology of typhus, cholera and tetanus, and is considered one of the founders of humoral immunology as developed in serum antidotes. See James R. Bartholomew, "Japanese Nobel Candidates in the First Half of the Twentieth Century," in Morris F. Low, ed., *Beyond Joseph Needham: Science, Technology and Medicine in East and Southeast Asia* (Osiris, 13 [1998]: 238-86).
- 7 Because older doctors already in practice were grandfathered in, these reforms worked gradually. Moreover acupuncture and massage were made exceptions, since these were a vocational specialty of the blind. See Bridie Andrews-Minehan, "Medical Reforms in Japan and their Influence in China 1868-1937," paper presented to the International Society for the History of East Asian Science, Technology and Medicine, Johns Hopkins University, Baltimore Md., 18 July 2008.
- 8 See Sean Hsiang-lin Lei, "Microscope and Sovereignty," in Leung and Furth, eds., *Health and Hygiene in Chinese East Asia*.
- 9 See Sean Hsiang-lin Lei, "From *Changshan* to a New Anti-Malarial Drug: Re-networking Chinese Drugs and Excluding Chinese Doctors," *Social Studies of Science*, 29, 3 (June 1999): 329-33. Research on *mahuang* (ephedra) at Peking Union Medical College was a visible early example of this process.
- 10 My analysis here follows Volker Scheid, *Currents of Tradition in Chinese Medicine, 1626-2006*. See especially chapter 8.

- 11 For the history of Chinese medicine in the 1950s, see Kim Taylor, *Chinese Medicine in Early Communist China 1945-6* (London: Routledge, 2004).
- 12 These figures come from Volker Scheid, *Chinese Medicine in Contemporary China, Plurality and Synthesis* (Durham, N.C.: Duke University Press), p. 85.
- 13 Today there are also a “*yixue shuoshi*” or Master of Medicine; and a “*yixue boshi*” or Doctor of Medicine.
- 14 See Volker Scheid, *Chinese Medicine in Contemporary China*, p. 81-96. For the current Five Year Plan of the State Administration of Traditional Chinese Medicine, see the web page of *Healthcare Today Magazine*, 27 October 2006 (www.healthcare-today.co.uk). Accessed 8 January 2011. It estimates TCM sector at 300,000,000 visits a year.
- 15 See Marta Hanson, “Conceptual Blind Spots, Media Blindfolds: SARS and Traditional Chinese Medicine” in Leung and Furth, eds., *Health and Hygiene in Chinese East Asia*.
- 16 Nathan Sivin, *Traditional Medicine in Contemporary China: A Partial Translation of Revised Outline of Chinese Medicine (1972) with an Introductory Study on Changes in Present-day and Early Medicine* (Ann Arbor, Mich.: Center for Chinese Studies, University of Michigan, 1987).
- 17 For an informed discussion of “*bianzheng lunzhi*” see Scheid, *Chinese Medicine in Contemporary China*, p. 209-37.
- 18 *Zhong yao da cidian*, 2 vols. (Shanghai: Renmin chubanshe, 1977).
- 19 Marta Hanson, “Conceptual Blind Spots” notes that the Sichuan group is listed on the website of the Cochrane Collaboration, the British based international centre for meta-analysis of clinical trials.
- 20 In Japan, the state already regulates 148 materia medica and formulas containing them to produce a basic repertory of standard herbal prescriptions widely used in Kampo, the Japanese version of traditional Chinese herbal medicine. See wikipedia.org/wiki/kampoo+kai. Accessed 8 January 2011.
- 21 Consider, for example, the 11 June 2008 web announcement of the upcoming annual conference of the Consortium for the Globalization for Chinese Medicine (CGCM) to meet in Taipei in summer 2008. It originated in Hong Kong in 2003, and claims 16 institutional affiliations from Hong Kong, the PRC and Taiwan, including Peking Union Medical College, Chinese University of Hong Kong, Shanghai Academy of Sciences, the Research Center for the Standardization of Chinese Medicine, and the Academia Sinica (Taiwan). Cheng Yung-chu, Henry Bronson Professor of Pharmacology at Yale University School of Medicine, is current chair. The Consortium’s stated goal is a “modern quality control platform” for the standardization of Chinese materia medica and herbal formulas, that will assist industry and the work of world wide regulatory agencies. See www.tcmedicine.org/en/client_news_details. Accessed 8 January 2011.
- 22 Scheid, *Chinese Medicine in Contemporary China*, p. 88-106.
- 23 I am grateful to Z’ev Rosenberg for his personal reminiscences of these early stages of the professionalization of Chinese medicine in contemporary America.
- 24 The first states to legalize acupuncture were Maryland, Nevada and Oregon in 1973, followed by Hawaii, Montana and South Carolina in 1974. But AOM education was most developed in California. Figures come from the website of the American Association for Acupuncture and Oriental Medicine (AAAOM). See www.aaaomonline.org. Accessed 8 January 2011.
- 25 See Charles Rosenberg, *Greater Than the Parts: Holism in Biomedicine 1920-1950* (Oxford, UK: Oxford University Press, 1998). Rosenberg identifies four types of holism in 20th-century medical thought: historical, focusing on Darwinian evolution; organismic, stressing function over structure and body/mind integration; ecological, stressing the interaction of the individual and environment/social conditions; and worldview, interpreting disease within the framework of a moral and religious value system.

- 26 The following discussion of educational institutions is based on my analysis of 39 schools based on their most recent web-pages. The findings are tabulated in an appendix to this article: "ACAOM-Accredited Schools of Acupuncture and Oriental Medicine."
- 27 Most states regulate acupuncture alone, which requires a three-year program; but California requires a four-year program, including knowledge of herbal medicine as well. See www.acupuncture.ca.gov/schools. Accessed 8 January 2011.
- 28 These schools are indicated in the appendix by a [C].
- 29 These five are the Academy of Oriental Medicine, Austin, Texas; The American Academy of Oriental Medicine, Roseville, Minn.; Atlantic Institute of Oriental Medicine, Fort Lauderdale, Florida; College of Traditional Chinese Medicine, Long Island, New York; University of East West Medicine, Sunnyvale, California.
- 30 These five are the American College of Traditional Chinese Medicine, San Francisco, California; the College of Classical Chinese Medicine of the National College of Natural Medicine, Portland, Oregon; Five Branches University Graduate School of Traditional Chinese Medicine, San Jose, California; Samra University of Oriental Medicine, Los Angeles, California; Seattle Institute of Oriental Medicine, Seattle, Washington.
- 31 Ka-Kit Hui and Sonya Pritzger, "English Translation of TCM Terminology: Terminology Standardization in Chinese Medicine: the Perspective from the East-West Center for East-West Medicine," *Chinese Journal of Integrative Medicine*, 13, 1 (March 2007): 64-66. My thanks to Sonya Pritzker for discussing with me her dissertation research-in-progress on this topic.
- 32 Over the past several years, papers on these translation issues have been presented at the annual meetings of the American Association for Acupuncture and Oriental Medicine, the major professional organization for AOM. Two recent workshops also addressed them. The first was part of the annual meeting of the Council of Oriental Medicine Publishers held in San Diego, California, in November 2000, sponsored by the Pacific College of Oriental Medicine. The second was held in Austin, Texas in April 2006 under the auspices of the Sixth International Congress of Traditional Asian Medicine. See Marta Hanson and Andy Pham, "Enhancing the Practitioner's Sense of Time, Place and Practice: The History of Chinese Medicine for Practitioners Workshop," *Asian Medicine: Tradition and Modernity*, 2, 2 (2006): 319-54.
- 33 Nigel Wiseman and Feng Ye, *A Practical Dictionary of Chinese Medicine* (Brookline, Mass.: Paradigm Publications, 1998). With more than 6,000 entries, this dictionary includes large numbers of terms for symptom clusters, where translation encodes assumptions about causal process, as in "wind-fire eye" or "wind-heat fright palpitations." The former is quite easily connected to the biomedical disease "acute conjunctivitis," but the latter cannot be pinned down this way; the translations point to the common causal factor of "wind" which in Chinese medicine is not meteorological but a form of qi.
- 34 Website for Eastland Press, "Draft Glossary for Chinese Medicine, 2009," p. 1. Comparatively modest with about 1200 terms, the Eastland Press glossary offers little in the way of disease names, but stresses terms for actions, functions and processes. See also Nigel Wiseman, "Translation of Chinese Medical Terms," *American Acupuncture*, 40 (Summer 2007): 22-26.
- 35 Robert Felt, "The End of the Term Debate," Paradigm Publications website, 2009 (www.paradigm-pubs.com/blog). Accessed 8 January 2011.
- 36 *International Standard Terminologies in Traditional Medicine in the Western Pacific Region*. Published by the World Health Organization, 2008.
- 37 Sonya Pritzker, personal communication.
- 38 See Linda Barnes, "American Acupuncture and Efficacy: Meanings and Their Points of Insertion," *Medical Anthropology Quarterly*, 19, 3 (2005): 239-66.

- 39 James Harvey Young, "The Development of the Office of Alternative Medicine in the National Institutes of Health, 1991-1996," *Bulletin of the History of Medicine*, 72, 2 (1998): 279-98.
- 40 *Complementary and Alternative Medicine in the United States*, edited by the Institute of Medicine, Washington D.C., 2005. See also the review by Hans A. Baer of this and several other books on CAM in www.anthrosource.net. Accessed 8 January 2011.
- 41 See for example the article by Nahin, Pontzer and Chesney on the People to People Health Foundation web report of July—August 2005. It summarized an Institutes of Medicine analysis of 495 systematic reviews of research on CAM which suggests not only that CAM includes a wide variety of therapeutic techniques including chiropractic medicine, Alexander technique, massage therapy, biofeedback and homeopathy, as well as an undifferentiated herbal medicine; but also that the attention given a CAM therapy by professionals does not correspond to its use by the public. In particular acupuncture and homeopathy were near the top of the list of CAM therapies attracting research (3rd and 4th), but only 1.5% of the public uses these in a given year. In general physicians are most impressed with acupuncture, biofeedback and hypnotherapy, while the public is all over the map.