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Cultivating Competence:
Chinese Medicine Student Clubs in Taipei, Taiwan

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Content

1. Introduction

> "While walking around Xichang Street and Guangzhou Street next to Lungshan Temple, people could smell strong refreshing fragrance of herbs. More than one hundred years ago, medical care was quite expensive, so many people would pray for healthy body in Lungshan temple, and go to herb shop for folk remedies. In the course of time, herb vendors became a herb business cluster, which was known as Life-saving Street ([today called] Herb alley). Nowadays, the enchantment of herbs still appeal to numerous people to visit Herb Alley. Visitors could learn all kinds of herbal knowledge from the herb store owners."

This short text is displayed on an information board on the wall of Lungshan Temple Station, along with the original Chinese text directly above and a stylized map of the area complete with cute drawings of herb stalls and shops, their owners as well as customers. The streets described here lie in the historical Wanhua District of Taipei, Taiwan, and are part of the area around Lungshan Temple that Arthur Kleinman famously described in the beginning paragraphs of his *Patients and Healers in the Context of Culture* (1980). In Kleinman's account of 1970s Taiwan, this area is a rich and boisterous coming together of Western- as well as Chinese-style clinics, bone-setters, unlicensed eye doctors, dentists, fortune-tellers, geomancers, physiognomists, religious ritualists and sellers of paraphernalia, Chinese and Western pharmacies, vendors of medicinal foods, herbalists, as well as an old and run-down charity hospital that was replaced three years later by "a modernistic glass and steel high-rise" (Ibid., 1-3).

Today, parts of this area still seem like a relic of bygone days. The city is making an effort to preserve the Japanese colonial-style buildings. The Buddhist temple dating back to 1738 draws numerous visitors local and foreign every day. As the info board suggests, some of the shops Kleinman describes still exist, but the clamor of the diversity of medical businesses in the past can only be imagined today. Nevertheless, although a certain reframing of the area as a tourist spot is happening, not all vendors have turned their shops into the fancy versions of their older selves typical for many tourist destinations, and regular customers frequent their businesses. The forms of medical care mentioned above can all still be found in Taiwan if one knows where to look, but just like most aspects of culture and society they have undergone great transformations in the country's rapid development since the 1960s as one of the so-called Four Asian Tigers (Taiwan, Hongkong, Singapore, South Korea).

Chinese medicine (from here on "CM") in Taiwan, and more specifically CM education, will be the aspect of this transformation that I want to examine in this thesis.[1] I want to address changes in professional licensing regulation that developed along with larger societal transformations in Taiwan's recent history and how they influence CM education and practice today. Based on three months of field research in two Taipei-based student clubs (*shetuan*) devoted to the teaching of CM to the interested public, I will trace the tensions and contradictions that especially young prospective practitioners of modern CM face and their strategies to navigate them.

1.1 Literature review

In the anglophone literatures of medical history, medical anthropology, as well as Chinese studies, CM has been examined as an amalgamate of different historically situated ideas (Unschuld 1980), as product and tool of a communist regime (Scheid 2002; Taylor 2005), comprised of considerable diversity in its "modes of transmission" (Hsu 1999), or as something that is as "modern" and "global" as it is "traditional" and "Chinese" (Hsu 2009; Zhan 2009). What most publications focused on contemporary CM have in common, even when they employ a global perspective, is a – sometimes implicit – framing of today's CM as descended from the "Traditional Chinese Medicine" (TCM) constructed in the early Maoist period (1949-1976) of the People's Republic of China (PRC) – whether it is its infusion with Maoist ideology (Farquhar 1987; Taylor 2005), its role in the PRC's pursuit of global competitiveness (Farquhar 1994, 19), or its transformation into an object of "intangible cultural heritage" and national pride more recently (Zhan 2009, 21).

Mei Zhan calls this bias the "out-of-China narrative." She writes: "It seems easy, perhaps too easy, to begin the narrative of globalization with a departure from China – the place of origin to be left behind in the globalist narratives of transition and transcendence" (Ibid., 19). While her intervention to this narrow perspective is a centering of the emergent and transformative global "worlding" of CM, what is often left out are its different local histories in places that also lay a cultural claim on CM. Arielle Smith (2018) has produced such an account for the case of Singapore, observing the "mercurial assemblage" of CM in a "global hub for cosmopolitan science and medicine with a supposedly Asian orientation" (Ibid., 2). Linda

[1] The term TCM originally referred to the formalized and standardized system developed in the PRC in the 1950s and exported from there (see Taylor 2005). It was specifically coined for English-language usage (Taylor 2005, 83). In the Chinese language, in the PRC as well as Taiwan, the term *zhongyi*, simply meaning "Chinese medicine" is used. In this paper, I will use "Chinese medicine" or "CM" when not explicitly referring to TCM, in order to acknowledge the particularity of the latter term.

Barnes (2003; see also Baer et al. 1998) traces the development of CM from a "countercultural guerilla practice" to a profession seeking legitimacy and recognition in the US. Influential for this development, besides the mostly white American countercultural promoters of CM, were also the Chinese American practitioners who immigrated to the US before the establishment of the PRC and therefore before ever coming into contact with what Barnes calls a "politicized PRC-TCM" (Ibid., 265). While these actors and their heritage quickly became marginalized in favor of a hegemonial standardized American version of this PRC-TCM (Ibid., 267, 274), their story points to the development of CM in Republican Mainland China (1911-1949) – a story that was continued not only in the US and the PRC, but also in Taiwan, after the retreat of the Republican government under the Kuomintang (KMT), the Nationalist Party of China, there in 1949.

The specific trajectory of CM in Taiwan has rarely been considered in both anglophone anthropology and history. The most notable exception is Arthur Kleinman's (1980) aforementioned *Patients and Healers in the Context of Culture*, whose study of "universal clinical processes" in culturally diverse healthcare settings draws heavily upon ethnographic material gathered in Taipei in the 1970s. Paul Unschuld's (1973) dissertation research on the practice of CM in Taiwan covers a similar timeframe. Sociological studies with the goal of surveying the state of CM in Taiwan as a basis for its inclusion in the National Health Insurance (NHI) system in the 1990s have been published in English (Chi 1994; Chi et al. 1996). In recent years, Taiwan has been established as somewhat of a center for East Asian Science and Technology Studies (EASTS), so publications theorizing the "provincialization of STS" have drawn from case material from Taiwanese CM practice (Lin and Law 2014; Lin 2016; Law and Lin 2017).

1.2 A Chinese medicine "out-of-Taiwan"?

However, there is currently no comprehensive account of a contemporary CM in and "out-of-Taiwan." Kleinman's study provides a rich picture of the medical landscape in urban Taiwan, but it is an image that precedes, among other drastic nationwide "modernizations," the inclusion of CM in the universal coverage of the NHI, whereas the latter studies by Lin and Law focus on current, but rather individual cases of CM practice. But Taiwan is an active player in the contemporary construction of CM through "transnational frames" (Zhan 2009), expressed not only in global trends and discourses of modernization, professionalization and standardization, but also in the rather physical flow and exchange of resources as well as (dreams of) human migration, as the material presented in this thesis will show.

Two further issues point to the relevance of Taiwanese CM. The first is its historical particularity that distinguishes it from PRC-TCM. It shares with the developments in the PRC its imperial history (see especially Unschuld 1985) as well as that of the Mainland Republican Period (1911-1945). This was a time when CM practitioners first had to organize professionally in the struggle for recognition against the overwhelming adoption of a "scientific," and therefore biomedical, approach to legislation by government bodies that regarded CM as unsuitable for the nationalist project of a modern Chinese society (Lei 2014; Luesink 2015). The other influence impacting the development of CM in Taiwan is the restrictive approach towards it employed by the authorities of Japanese colonial rule (1895-1945). With the retreat of the KMT to Taiwan after its defeat in the Chinese Civil War against the Communists (1927-1949), CM there grew out of the continuities and disruptions emerging from these impactful historical moments (Ye 2013).

The second issue is the particular importance medicine in general plays for Taiwan's international relations. Precariously positioned in the global arena, with being recognized as a sovereign state by only 16 out of 193 UN member states, Taiwan heavily relies on soft power to secure its international allies (deLisle 2014), especially as that number is shrinking each year (see e.g. N. Smith 2018). Medicine is one domain in which Taiwan continuously tries to strengthen its ties and "shine on the international stage," and thus provides humanitarian and development aid of considerable scope to its allies, mostly countries of the "global South" (Peng and Hsiao 2017). Its ability to do so, however, has been severely restricted with its exclusion from the World Health Assembly (WHA) in 2017. Due to its contested status, Taiwan is not a member of the World Health Organization (WHO) among other international bodies but had acquired the right to attend the WHA as an observer in 2006. Since 2017, it has continuously, albeit at the time of writing unsuccessfully, campaigned for the recognition of its contributions to Global Health and a re-inclusion in the WHA, emphasizing its geographical location as a hub of transport and trade in East Asia and thus as a key player in epidemic prevention, it's contribution to the containment of the SARS crisis in 2003, its efforts in building medical capacity abroad, esp. in Malawi, and other issues (Cheng 2017). Taiwan's exclusion from the WHO and WHA has been brought to international attention anew during the outbreak of COVID-19 in China, current at the time of writing (Hale, February 06, 2020). Efforts to increase Taiwan's visibility are envisioned to be extended to international cooperation in the field of CM and other traditional medicines in the context of the so called "New Southbound Policy," a government initiative aimed at strengthening cooperation with 18 states in South and Southeast Asia (MOHW, Department of Chinese Medicine and Pharmacy 2018a). Mirroring

these efforts, the PRC's provisions of medical aid to African countries has been motivated in part by this competition with Taiwan for seats in the UN and related international bodies (X. Wang and Sun 2014).

These three issues, Taiwan's participation in the worlding of CM, its distinct history, and the importance of the medical domain for its political status and recognition, cannot be comprehensively analyzed in the scope of this thesis. They do, however, illustrate the relevance of a look at CM as emerging in and from Taiwan. It was also these three themes that stimulated my initial curiosity about this topic, and they will inform the analysis of my own ethnographic material in the following chapters.

1.3 Chinese medicine student clubs

Researchers observing the transmission and practice of CM have predominantly followed seasoned or even senior doctors, those already well advanced in their careers (see Farquhar 1994; Hsu 1999). In those studies, as well as those focusing on larger scale institutionalization or on epistemological questions (e.g. Scheid 2002; Farquhar 2012; 2015 for the latter), students might appear, but their perspectives are generally not centered in these accounts. There are two problems with this: Observed are mainly people who are in full command of their knowledge and skills. These protagonists were also likely educated under medical education systems very different from those encountered by young prospective practitioners today. Therefore, this thesis aims to center the experiences of students and their struggles to position themselves in and negotiate the contradictions and tensions present in contemporary Taiwan's medical education system.

My field research, conducted from February to May 2018, took place in two *shetuan* dedicated to the teaching of CM to fellow students and the interested public. One was located at National Taiwan University (NTU), Taiwan's highest-ranking university, and one at another prominent university whose name I will omit to increase anonymity. Both universities are located in the capital, Taipei. These clubs are common in Taiwanese universities and exist among film and sports clubs, debate clubs, environmental organizations and other student-organized associations. However, especially the CM *shetuan* at NTU, by virtue of being affiliated with Taiwan's top university, enjoys a heightened level of prestige and some extent of societal influence in comparison to similar *shetuan* at other universities. The students participating in the *shetuan* were distinct from students enrolled in CM programs at university. They were instead specifically students who, for various reasons, could *not* enroll in these official

programs, or had no interest in doing so. I chose the clubs as my field because they worked with CM in a way that, as I will argue, frequently crossed the boundaries between lay and professional engagement. They found their own ways to actively shape the landscape of CM healthcare in Taiwan.

Prior to my field research I was under the impression that participation in these clubs could serve as a steppingstone for a career in CM. I had hoped that through this entry point I would meet people interested in pursuing CM as a profession and could follow their trajectories. Soon upon arrival, however, I learned that this was not that simple anymore. Following a shift in medical education policy in 2011 towards the academization of CM, university education became the only way to obtain a license for the legal practice of CM under the NHI. This eclipsed previous measures of professionalization, where a variety of ways to gain CM expertise – e.g. university education, self-study, or training in the context of a master-disciple relationship – could lead to the same doctor's license.

One aim of my thesis is to show the ways in which this policy restricts access to CM education and by extension the qualification to legally practice for those who want to pursue it. A barrier of competitive minimum entry grades into medical universities represents the straightforward way of reserving both biomedical and CM education to elite students. Secondly, both entry requirements in the form of high school grades and entry exams, as well as the CM curricula themselves heavily, and in the case of the exams exclusively, feature the biomedical sciences and ensure that students' perspectives on CM are already and always fundamentally pre-shaped by biomedicine. As I will show, students who desire to take a for example more "traditional" Chinese scholarly approach to CM, focusing on history, philosophy and knowledge of classical texts, are disadvantaged under this system.

The students I encountered in my research engaged with CM on different levels of seriousness and commitment. Some see it as merely a hobby, a personal interest in the context of the *shetuan*. Others indeed have professional ambitions. This latter subset of my interlocutors was actively preparing for entry exams into post-baccalaureate programs of CM reserved for those already holding a bachelor's degree in any field, which was seen as an alternative, but nevertheless challenging way of accessing CM education. A second aim of my thesis therefore is to portray in more detail the ways in which these students strategize to claim CM knowledge and practice for themselves despite the challenges they face.

Lastly, I want to address the role and function of these *shetuan* themselves in the context of modern CM in contemporary Taiwan. During the welcoming events for new members in the

beginning of the semester, both clubs emphasized the fact that they have brought forth many famous CM doctors in the past. With the 2011 change in policy, this causal relation had become much more indirect and improvised. The general position, alignment and purpose of the clubs' activities in Taiwan's contemporary medical landscape was a topic of concern for the students. I want to argue that they not only exemplify a communal and accessible form of CM transmission not previously discussed in anthropological literature, but that they also play a vital role in maintaining the competence of the Taiwanese popular sector of healthcare (Kleinman 1980).

2. Theoretical approaches to a global profession

Ever since the WHO declaration of Alma-Ata in 1978 encouraged governments to incorporate traditional healers in efforts to achieve "primary health care for all people" (WHO 1978), many traditional medicines around the world have experienced some degree of professionalization and institutionalization. While in some cases, such as CM and Ayurveda, these processes long predate 1978, the declaration further influenced the standing of traditional medicines in the framework of the modern nation state. In a more recent interrelated and overlapping trend, especially CM, Ayurveda and Tibetan medicine have come to circulate transnationally as a "global commodity" while being inscribed "within a large system of governance which has actually evolved in parallel with the expansion of the circulation itself" (Coderey 2020, 1-2). CM has been conceptualized as a *global form*, with its ability to move and re-settle in various locales, delineated more by local as well as international regulations and "value regimes" than by "the vagaries of a social and cultural field" (Collier and Ong 2005; Zhan 2009; A. Smith 2018; Coderey and Pordié 2020). When writing about CM in Taiwan, I consider its history and present of professionalization as embedded in such a global assemblage, a story both of local and cultural historical origin *and* of re-contextualization and reorganization in a global assemblage (Collier and Ong 2005, 4).

2.1 Professionalization

Eliot Freidson (1994) has provided the following definition of professionalization: "Professionalization might be defined as a process by which an organized occupation […] obtains the exclusive right to perform a particular kind of work, control training for and access to it, and control the right of determining and evaluating the way the work is performed" (Freidson 1994, 62). He adds that the occupation must convince the government or other holders

of power to actually grant these privileges, listing criteria such as the profession's importance to the functioning and well-being of society, its "cultural importance," and, most importantly, "that there would be grave danger to the public if there were no control over those who offer their services […]" (Ibid., 174). Murray Last (1990) delineates specifically traditional medical professions as an "extended self-conscious group of healers with defined criteria for membership (whether through licensing, certification, or registration) and an expertise over which it seeks primary control, and an expertise that claims to be more than a craft and has in addition an esoteric, theoretical basis" (Last 1990, 350). Lee, Hong and Huang (2005) in addition identify "the production of ideology to sustain this [medical] tradition" (Ibid., 138) as a necessary criterium for successful professionalization of traditional medicines.

Achievement of these steps or criteria in the process of professionalization is accompanied by struggle between supporters and practitioners on the one hand and healthcare administration and governments on the other in many histories of traditional medicine. Moreover, the conditions under which professionalization happens are contested often even within the profession, or it is debated whether or not professionalization is beneficial to the occupation at all (see e.g. Barnes 2003). The tension between a professionalization "from above," i.e. through government endorsement and/or instrumentalization and "from below," i.e. arising from popular support and self-organization (Last 1990, 351), fundamentally shapes the development of traditional medicines worldwide. The case of Taiwan, as the following chapters will show, is no different. Processes of professionalization have a long history in the context of CM. To refer to the most recent restriction of CM licensing to university graduates distinct from the larger transformations in the field I will use the term 'academization' throughout this thesis.

2.2 Biomedical hegemony

When it comes to professionalization, the negotiation of power and privileges between a state government and practitioners of traditional medicine is always intersected by the role of biomedicine in the respective national framework as well as on a global scale. This necessity to consider, and in most cases submit to a biomedical framework is referred to as *biomedical hegemony*, based on Antonio Gramsci's (1971) conception of hegemony as the exertion of power disguised in internalized popular values and norms. In the words of Claire Wendland:

> Seen through a Gramscian lens, biomedicine could be understood as a set of norms, values, tools, and technologies with which the powerful think about, measure, inspect, discipline, and work upon the bodies of the disempowered, with nearly everyone involved accepting such interventions as appropriate – or even as moral goods (Wendland 2010, 12).

She goes on to argue that this "authority of medicine" has emulated and replaced the structures of colonial authority in a postcolonial world, privileging scientific rationality over all other forms of knowledge (Ibid., 13). How this dynamic of authority takes shape in the context of CM is a matter of complex discussion. Surviving outright attempts of abolishment (see e.g. Lei 2014), CM has entered a state of "dynamic negotiations" with biomedical ideas and institutions (A. Smith 2018, 19). It is in constant collaboration, but also tension and friction with the biomedical and public health establishments in China and elsewhere (Farquhar 2012, 154). The use of combined of biomedical and CM diagnostic tools, classifications and treatment methods is now a ubiquitous sight in contemporary CM practices around the world. According to Law and Lin, an interpretation of this as an "expression of biomedical, colonial, and postcolonial power," seeing CM as "under pressure to absorb biomedical realities," is simply the conventional postcolonial narrative (Law and Lin 2017, 9-10). They propose an alternative perspective that interprets this situation in CM's own relational, non-reductive terms, in which an incorporation of other epistemologies is historically rather "Chinese medical business as usual" (Ibid.). Indeed, CM practitioners throughout history have been uniquely flexible to accept epistemological elements that would seem incommensurable or mutually exclusive from a biomedical perspective, a quality Unschuld calls "patterned knowledge" (Unschuld 1992, 58). Volker Scheid writes of this plurality within CM:

> [...] plurality is woven into the very fabric of Chinese medicine, extending from perceptions of the body to the social relations embodied in learning, teaching, and practice; from the canonical texts of the Han dynasty to present-day research in urban hospitals (Scheid 2002, 10).

However, a flexible relational epistemology cannot simply negate CM's sociopolitical position in a field of power relations on a global scale. The fact that CM (and all other traditional medicines) must always first refer to biomedicine, even just to, and in only quite rare cases, reject it, is in itself an indication of what Judith Farquhar calls "violent translations," the forceful and politically motivated commensuration of the incommensurable (Farquhar 2012, 156). When referencing biomedicine, e.g. in order to establish efficacy, modernity or safety, it is usually CM that is compromised:

> To advance a claim based on efficacy, translators have had to make an unremitting comparison with the field of biomedicine as it has been institutionally, epistemologically and terminologically constituted over the last few hundred years in Western countries. If such a comparison is to operate on a common ground, it tends to confine attention to interventions in illness (as opposed, for example, to preventive medicine of life skills), structures of the anatomical body (rather than, for example, functional rubrics), entities that are directly or technologically visible (certainly not *qi*), and so forth" (Ibid., 165).

Acknowledging the inevitability of engagement with biomedicine and the necessity to comply with its frameworks, the investigation of contemporary CM practice has turned towards agency, both of individuals and communities, in negotiating their own practice and interests with biomedical and state agendas (A. Smith 2018). Most often, biomedicine and traditional medicine are related to each other in specific ways to ensure continued opportunity for and legitimacy of practice. Particularly practitioners in the role of spokespeople or leading positions find themselves in this practice of negotiation. Vincanne Adams (2002) describes how doctors of Tibetan medicine self-consciously and skillfully navigate a political environment employing "complicated cultural negotiations" in order to "awkwardly both accommodate and distinguish their medicine from its 'modern medical' counterpart" (Ibid., 203). Establishing scientific proof here is not simply based on scientific experimentation with traditional medical modalities, but a complex product of "competing political, nationalist, religious, economic, and culturally historical influences" (Ibid., 200). Mei Zhan relates a case in which a CM doctor used her biomedical expertise, her ability to "talk science," to be a convincing ambassador for CM, while also "gently" critiquing the "reductionist and universalizing tendency in biomedicine" (Zhan 2009, 138-140). Strategies for CM's survival or even flourishing in a system governed by biomedicine are diverse and not always aligned with each other. Efforts to fit into frameworks of modernization and standardization exist alongside appeals to tradition and purism, as well as a more recent (self-)identification with the framework of complementary and alternative medicine (CAM, (A. Smith 2018).

When it comes to professionalization, these "troubled relations" (Zhan 2009, 15) are perhaps the least flexible. After all, the abovementioned governmental privileges and the well-being of the public are at stake. It is in the design of curricula, exam sheets, licenses and insurance policies following a biomedical blueprint that biomedical hegemony becomes most visible. As Linda Barnes puts it:

> Biomedicine has routinely been elevated as being virtually synonymous with everything paradigmatic and even archetypal about the concept of 'profession.' Through a curious tautological looping, it has stood as a foundational example not only of what a profession is but also of how a particular group becomes a profession. Its example has thereby informed theories of professionalization to the point where biomedicine functions as both prototype and outcome. As such, it has also come to stand as the standard – in ways that frequently ignore historical and cultural variations – against which all other systems of healing are measured (Barnes 2003, 263-264).

The question of how to frame CM as a modern profession of its own with adequate quality and safety standards that cannot be separated from biomedicine itself is a dilemma frequently addressed in this thesis.

2.3 Lay Knowledge

In seeming juxtaposition to these processes and struggles of professionalization there is the realm of lay medical knowledge to consider. Kleinman, in identifying elements universal to all healthcare systems, distinguishes the popular sector from the professional and folk sectors of healthcare. The popular sector encompasses beliefs and practices related to healthcare on the levels of the individual, the family, the social network, and the community that mirror the "cognitive and value orientations of the popular culture" (Kleinman 1980, 50). Popular sectors in general are the driving force of healthcare systems, since it is here that decisions about treatments and first interventions happen, making it the "chief source and most immediate determinant" of healthcare (Ibid., 51). This is the case even more so in Taiwan, where self-treatment or treatment by family members was most common in the 1970s and 80s (Ibid., 68), but even today, as my material will show, this practice of sharing knowledge, recipes, practices, recommendations and even treating friends and family members continues. Tola Olu Pearce describes how in non-specialized, non-professionalized contexts of healing within the Nigerian healthcare landscape of the early 1990s "people draw on many different aspects of their environment and their daily lives to construct medical 'truths'" (Pearce 1993, 151). This kind of knowledge assembles indigenous beliefs and practices, personal experience, but also the ability to retrieve information from medical professionals, biomedical and traditional alike. Employing this body of lay knowledge constitutes a way to claim control and confidence, the ability to find "workable solutions to health problems" (Ibid., 161).

An association of this knowledge simply with tradition, being passed down over generations, would be an oversimplification. As the next chapter will show, there were moments of inhibition of CM transmission in the history of Taiwan. My interlocutors even lamented a loss of lay expertise with regards to CM in the populace (whether this assumed past depth of expertise ever existed is another question). Jeannette Pols' (2013) concept of patient knowledge is perhaps more instructive. Patient knowledge refers to the kind of knowledge that "patients use and develop in their daily practices in order to live with their disease" (Pols 2013, 75). This knowledge, rather than a comprehensive corpus, is a "matter of tinkering and weighing, of coordinating and translating knowledge, technologies, and advice from various sources, including medical practices and technologies. From an epistemological point of view, it is a 'messy' knowledge, involving many different techniques, values, and materials" (Ibid.). I will extend this notion of patient knowledge to a general lay engagement with questions of illness and healing, as seems fitting in a context such as Taiwan that is especially preoccupied with

preventative healthcare and health maintenance even in the absence of an illness (Kleinman 1980, 75). It also pulls into focus the influence of biomedicine and the global assemblage of CM on lay knowledge, rather than seeing it as somehow more local and "pure."

This kind of messy medical knowledge emerges in the work of the Taiwanese CM *shetuan*. The students aim to educate on CM, teach practical skills, provide a space to share skills, knowledge, and even treatment. Personal interests, pre-existing know-how, and past or present illness experiences flow into the exchange as well as references to biomedical studies and frameworks. Taiwanese medical (education) policy is frequently discussed and directly shapes the life paths of the students and informs their engagement with CM. Moreover, while many students stay in the realm of private lay practice or participate for entertainment only, for some the boundary between lay and professional knowledge becomes blurred. Their participation in the *shetuan* is motivated by their aim to become CM doctors, and they function as organizers, teachers, and practitioners-to-be. While they are not licensed professionals (yet), they show that lay and professional knowledge and activity permeate each other, and that the absence of a license does not mean lack of participation in the global form of CM.

In fact, the role of lay practitioners in the international spread and establishment of CM needs to be emphasized. They were largely responsible for the creation of the first training programs and underground practices for CM in the US and elsewhere. These first steps, in association with the New Age movements, were even born out of an anti-professional stance, but eventually led to the advanced institutionalization of CM in the US today (Barnes 2003, 271). Simeng Wang has shown how "behind all formal and institutionalized forms of promoting Chinese medicine in French society, there are also the illegal practices of ordinary actors, who participate actively in the transnational circulation of this medicine" (S. Wang 2020). In this French context, where only biomedical doctors with EU-citizenship are legally allowed to practice CM, practitioners utilize their own mobility, cross-professional alliances and particularly cooperation with Chinese universities to legitimize their practice in their own "gray areas of regulation" (Ibid., 152).

In the following chapters I want to trace how the work of the *shetuan* forms a space of intermingling lay and professional engagement with CM. They are also a space where all these global dimensions of CM are negotiated. At the same time, the students' encounters with CM are deeply shaped by local history, policy and discourse. By focusing on the challenges on their ways to become professionals I further want to highlight that the existence of such CM spokespeople as mentioned above, who confidently navigate a world in which CM needs to be

strategically defended and woven into a biomedical framework, is dependent on appropriate education and should not be taken for granted as naturally inherent to the practice of CM.

3. The Academization of Chinese medicine in Taiwan

To understand the history of CM and its institutionalization and professionalization in Taiwan, one needs to consider both developments on the island as well as the Chinese Mainland before the relocation of the Republic of China (ROC) under the KMT to Taiwan in 1949. This arrival of "Mainlanders" with the KMT and the preceding Japanese colonial period extensively shaped CM in Taiwan today to such an extent that both historical events were frequently referenced by my interlocutors when explaining medical and educational policy to me. Out of all changes throughout the course of history of CM in Taiwan, this chapter will focus on the history and status quo of licensing legislation.

3.1 CM in Republican China and under Japanese colonial rule

CM first arrived in Taiwan with the first settlements of Han Chinese during the Ming era (1368-1644). Well into the Qing era (1644-1911) CM remained the primary source of health care on the island. While the Dutch colonial settlers first brought Western medicine to Taiwan in 1624, it mostly remained within the circle of the colonial administrative personnel and had not taken root in Taiwan at the time of their departure in 1662 (Ye 2013, 15-16). Only with the arrival of medical missionaries in Taiwan from 1858 on Western medicine gained foothold on the island. Even though there was some resistance against this[2], CM slowly lost its original status during the late Qing, especially in the course of the so-called Self-Strengthening Movement (1861-1895) aimed at reform and modernization after a Western model especially in the fields of science and technology.

In 1895, Taiwan was given to Japan in conclusion of the first Sino-Japanese War. In continuation of the modernizing spirit of Meiji-era Japan, colonial rule in Taiwan was to be based on "biological principles" (Ye 2013, 90) and medical policy was to follow the same paradigm.[3] At this time, CM in Taiwan first became subject of direct state regulation and

[2] Western medicine, upon its first entry into China, was not initially seen as superior and at times as rather crude (vgl. Unschuld 1985, 195). Ye (2013) reports similar reactions in Taiwan. The Chinese were so suspicious of especially dissection and early surgical procedures that rumors arose that "the red-haired doctors" would cut up human bodies to use the body parts as medicine (Ibid., 17).

[3] These biological principles refer to those works of "Western science" that had in the previous decade gained substantial traction among Japanese and a little later by way of scholarly exchange Chinese intellectuals: Darwin's theory of evolution and Spencer's social Darwinism. The notion "survival of the fittest" was applied to

suffered an unprecedented crisis. Beginning in 1986, the colonial government implemented strict licensing regulations that had as their goal the control and eventual replacement of CM doctors by western style-doctors.[4] It implemented a mandatory qualifying exam (testing physics, chemistry, anatomy, physiology, pathology, internal medicine, surgery, and pharmacology) that was only held one single time, so that eventually almost all licensed practitioners died of old age with no successors (Ye 2013, 94). The number of registered CM doctors in Taiwan shrunk from 1223 in 1901 to 97 in 1942, while the number of Western medical doctors in the same timeframe rose from 259 to 2241 (Ibid., 97). The latter received official training beginning in 1899 with the establishment of the first Medical School for Western Medicine in Taiwan, while the only official education available for CM doctors was a retraining in Western medicine at the same school beginning in 1907 (Chi et al. 1996, 1330).

In the meantime, a general discourse of the superiority of Western scientific medicine took root in Republican China as well. Efforts to institutionalize the field of medicine were quickly dominated by doctors of Western medicine, who designed the first official curriculum for medical education and only included biomedical content. They demanded a state registration process as well as standards for clinics and doctors that were impossible to fulfill for the barely organized community of CM practitioners (Croizier 1967, 47, 51). This direct encroachment on CM mobilized a group of CM practitioners to found the „National Medicine Movement," which marked the beginning of a conflict that Ye (2013) characterized as a struggle of attack and resistance between Chinese and Western medicine in Republican China.

This National Medicine Movement successfully prevented the abolishment of CM by creating "a tactically useful association between their medicine and a presumed national essence" (Scheid 2002, 67). The encounter with hegemonic biomedicine in alliance with state power forced CM to present itself as a coherent corpus of knowledge and reduce its plurality of different schools and dogmas to a consensus resembling that presumed of Western medicine. This consensus included basic elements of the medical theory of correspondence, the Chinese materia medica, acupuncture as well as some aspects of traumatology, and excluded Buddhist oracle medicine, demonic healing and a variety of other methods still widely practiced in the populace (Unschuld 1985, 207).

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international politics, and those states fittest to survive competition in the global arena seemed to be those equipped with Western science and technology (see eg. Sumika 2016).

[4] While I generally use the term biomedicine throughout this thesis, "Western medicine" or *xiyi* in Chinese is the term that was used in China and Taiwan during this period and in the present. When referring to biomedicine in this context I sometimes use the term Western medicine.

These dynamics did not only set the stage for the creation of TCM in the PRC (Taylor 2005), but also for that of the development of CM in Taiwan. When Taiwan was returned to the ROC after World War II in 1945, the number of licensed CM doctors there was as low as eight. Due to the political turmoil in the first half of the 20th century in China[5], discourses and political struggles around medical policy were never legally implemented. Therefore, the CM had not suffered as much in Republican China as it had in Taiwan under colonial rule, and among the Chinese immigrants coming to Taiwan from the mainland starting in 1945 were a number of Chinese-style doctors who somewhat replenished the dwindling state of CM there (Ye 2013, 109).

3.2 Martial Law, the China Medical College and the *zhongyi jianding tekao*

During the interim-period between the end of the Japanese rule and the relocation of the ROC to Taiwan the ROC government implemented preliminary licensing procedures for CM doctors, loosening the regulations imposed by the Japanese. No matter the mode of study, any individual could practice CM after a licensing examination. This examination was the precursor of the *zhongyi jianding tekao* (in short from here on *tekao*, as is common use), the special licensing examination for CM practitioners discussed in this thesis. CM doctors who could prove long-term practice and a good reputation were simply grandfathered in (Ibid., 111). While this saved CM in Taiwan from imminent extinction, the licensing criteria were arbitrary and subject to frequent change, leading to a situation where almost anyone from experienced doctors, apothecary apprentices, autodidacts to those simply desiring a career change could obtain a license if they were determined enough (or knew who to bribe). The number of practitioners quickly grew into the thousands (Ibid., 122). Simply hidden underground during Japanese colonial times, all flavors of CM practices began to sprout in private clinics, some hospitals, backrooms of bookshops and market stalls (Unschuld 1973, 24). Ye (2013) comments that this laissez-faire environment did not actually lead CM into a direction of modernization and institutionalization, but rather left it to fend for itself while all such efforts were concentrated on – and discursively shaped by – Western medicine. In 1946, for example, the director of the NTU Medical Hospital attempted to establish a CM department there and was immediately vetoed by the university administration who claimed that CM was backwards and unscientific and not worthy of their institution (Ibid., 110-111). The fact that the NTU Hospital, the biggest

[5] This includes the era of the Warlords (1916-1928), the Second Sino-Japanese War as part of World War II (1937-1945) and the Chinese Civil War between the Communists under the Communist Party of China and the Nationalists under the KMT (intermittently between 1927-1949).

and most prestigious hospital in Taiwan, to this day does not have a CM department was frequently pointed out by my interlocutors as a reflection of the general situation of CM in Taiwan.

Shortly after the ROC government relocation in 1949 and the proclamation of the PRC on the mainland, martial law was declared on the island of Taiwan. This period, also known as the White Terror, saw the persecution of known or perceived political dissidents, and lasted for almost four decades. However, this authoritarian rule also brought the beginnings of a countrywide medical administration system, a process during which CM entered a more competitive relationship with biomedicine. Under a discourse of reclamation of Chinese culture after Japanese colonization, CM grew more popular again among the people. President Chiang Kai-shek endorsed CM as part of the essence of Chinese culture and spoke in favor of its revaluation. Similarly to the development under the PRC on the mainland, this meant an endorsement of those elements of CM that could be validated by science and an appeal to discard everything that did not fit the modern bioscientific paradigm (Ye 2013, 117ff.). For this purpose, the first teaching institution for CM physicians, the China Medical College (CMC, today's China Medical University, CMU) was established 1958 in Taichung.

The founding of the CMC brought the first standardized curriculum geared towards official recognition and licensing for CM physicians. However, this also opened the door for what has later been called a "brain drain from Chinese to Western medicine" (Wiseman 2000, 6; see also Ye 2013 throughout). First, the curriculum includes an evolving but always majority proportion of biomedical content. After graduation, graduates from the dual CM and biomedicine programs could and still can choose to obtain a biomedical instead of a CM license. Consistently high numbers of graduates choose to do so since the founding of the CMC.[6] Second, the establishment of several exclusively biomedical departments and only one combining CM and biomedicine led Wiseman to comment that "as the college has grown, the Chinese medical element has shrunk proportionally" (Wiseman 2000, 6). In the 1980s, the post-baccalaureate program frequently addressed later in this thesis, was designed as a response to this trend towards BM. Its five-year course, eligible for those already holding a Bachelor's degree, intended to attract "graduates from other schools and departments that have less lucrative career openings" (Ibid., 7).

[6] For example, from 1972 to 1984, out of 735 people who graduated from the China Medical College, 517 received a CM license. However, 441 out of those 517 received a biomedicine license afterwards (Ye 2013, 128). For similar numbers see Chi et al. (1996, 1331).

The special licensing examination, the *tekao*, continued to exist. Examination standards still fluctuated, and anyone, long-term CM disciples and autodidacts alike, could obtain an official license after passing a single exam. This co-existence of the CMC (now CMU) and later other universities with the *tekao* meant that both university graduates and *tekao* certificate holders obtained a license that provided the same rights to professional practice. From the mid-1990s onwards this included the ability to process health insurance claims. This led to a high variety in the quality of care and next to no means for patients to distinguish and evaluate the quality of practitioners. In 1989, for example, only 6% of CM physicians had a medical degree and 88% had no more than high school level education (Chi et al. 1996, 1332). This latter group did not have access whatsoever to an official educational channel. This also led to a majority of those with a *tekao* license not actually practicing CM or practicing part-time or entirely in their private circles (Ibid.).

While the establishment of the CMC was a positive development, a look at administrative conditions provides some perspective. The CMC was privately funded and received no government support at all in the beginning. Even so, its trajectory was continuously steered towards a "westernization" (*xiyihua*) of CM. For example, for several generations the board of directors consisted mostly of members with a background only in biomedicine. More drastically, the requirements for CM resident training were unattainable for many CMC graduates at the time. For instance, there were not enough accredited training hospitals for CM to satisfy the demand, so many of these graduates eventually moved on to earn a license in biomedicine (Ye 2013, 128-129; Kleinman 1980, 62).

There were also active attempts to further restrict CM. With the formation of the Health Bureau under the Executive Yuan (the executive branch of the Taiwanese government) in 1971 came the establishment of a respective CM committee, which constituted the first official governing body for CM. However, this organization was reduced to merely a consulting role. The respective offices for (bio-)medicine and pharmacology were in effect made responsible for the development of CM in Taiwan. There were repeated proposals to abolish the CM department at CMC, the "grandfathering paragraph" from the licensing legislation, as well as the *tekao* throughout the decades of the martial law period. Pressure and protest from CM associations and the intellectual community garnered support from prominent KMT politicians, which prevented these measures from implementation (Ye 2013, 126). However, the initial exclusion from the first health insurance schemes starting in the 1950s, such as laborer's and civil servants'

insurance, caused CM to lose some of its foothold as the main healthcare provider in the population (Ibid., 129).

3.3 Democratization and academization

With the lifting of martial law in 1986 ringing in Taiwan's transformation into a constitutional democracy, international discourse on medical human rights entered Taiwanese healthcare policy planning. Especially the WHO declaration of Alma-Ata enabled a synergy between several developments which finally led to an increased recognition and support of CM. The encouragement by the WHO to incorporate traditional medicines into national healthcare schemes lent more credibility to the embrace of CM as national treasure by members of the intellectual and political spheres. Compliance with such international guidelines and regulations despite its exclusion from international bodies since 1971 has ever since been utilized by Taiwan as a showcase of its commitment and ability to participate in an international community. And finally, the international trend towards traditional and alternative medicines combined with the democratic opening of Taiwanese society invigorated the CM community to push openly for more government support (Ye 2013, 148-149).

Some signs of success were the first substantial government subsidies allocated to the CMC beginning in 1986. The CM committee under the Health Bureau became its own administrative department in 1995. Also beginning in 1987, health insurance schemes individually began to include CM outpatient treatment. A point of contention was the exclusion of CM inpatient treatment in hospitals from all insurance schemes, which remains the status quo to this day. The fact that CM hospital inpatient treatment must be paid out of pocket was seen by some of my interlocutors as the reason for contemporary CM doctors' lack of experience with the treatment of "serious" diseases as well as with emergency medicine. This, in turn, was judged as a hindrance of CM development specifically in Taiwan and one of the reasons some of my interlocutors thought CM to be more "advanced" in the PRC, where CM inpatient treatment is covered by insurance and offered in many hospitals. Nevertheless, the general inclusion of CM outpatient treatment in the NHI established in 1995, offering universal health care coverage in both Biomedicine and CM, was a breakthrough for CM in Taiwan.

In the new millennium, CM proceeded to be assimilated further into the Taiwanese healthcare system and general medical administration. The WHO Regional Strategies for Traditional Medicine in the Western Pacific 2001-2010 and 2011-2020 (WHO Regional Office for the Western Pacific 2002; 2012) provided a reference point with strategic objectives such as the

establishment of appropriate standards for traditional medicines using an evidence-based approach; the development of national policies for traditional medicines; the promotion of public awareness, knowledge and access to traditional medicines; as well as the strengthening of international cooperation "in generating and sharing traditional medicine knowledge and skills" (WHO Regional Office for the Western Pacific 2012, 30). Under the in 2013 newly established Ministry of Health and Welfare (MOHW) and its reformulation of the former CM committee into the Department of Chinese Medicine and Pharmacy (DCMP), CM was slowly included in various public health campaigns, such as the "Chinese medicine involvement in drug rehabilitation and therapy model" in 2016 (MOHW, Department of Chinese Medicine and Pharmacy 2018c).

In the 2010s, the now four teaching institutions for CM in the country (CMU in Taichung, Chang Gung University in Taoyuan, Tzu-Chi University in Hualien, and I-Shou University in Kaohsiung) trained on average 365 new CM physicians in both CM and biomedicine each year (MOHW, Department of Chinese Medicine and Pharmacy 2018c, 2). This achievement of institutionalization and professionalization is accompanied by its counterpiece, the abolishment of the *tekao* in 2011. Originally meant to be a gateway for immigrants from the Chinese mainland to legally practice their profession, the *tekao* was to be a temporary measure. Many even within the CM community therefore supported its eventual abolishment. They also pointed towards the abandonment of similar licensing models for traditional medicine in Korea (1997) and China (2000), and argued that Taiwan should follow this trend now that CM university education was available (Ye 2013, 181). Others opposed the abolishment, claiming that it interfered with the individual freedom to choose a profession. It was also questioned whether the healthcare needs of the population could be met without the *tekao* (Ibid.).

This topic had been debated for decades, often accompanied by a surge in applicants and graduates of the *tekao* process every time it seemed serious (Chi et al. 1996, 1332). In 2002, the Physician's Act was finally amended – after 2011, only those with a completed university CM education were allowed to apply for the licensing examination, while the *tekao* was terminated (MOHW, Department of Chinese Medicine and Pharmacy 2018c). This is the situation today, with four universities offering CM bachelor, master, PhD, and/or post-baccalaureate programs.

In his thesis following his research in Taiwan in the 1960s, Unschuld made the following suggestion regarding the lack of a standardized qualification system and the wildly varying competency of CM doctors:

> "This difficulty can only be solved by providing a nationally standardized training to a sufficient number of physicians, no matter western or traditional style, by having them face fair examinations and by finally letting them practice for very low treatment costs or under a social insurance system, and on a high medical standard" (Unschuld 1973, 33, translation mine).

It seems that several decades later, the Taiwanese healthcare system has largely fulfilled these requirements. While CM has gained a strong foothold in the system, many details, such as the exact structure and content of curricula or the issue of hospital accreditation and inclusion of inpatient treatment in the NHI remain topics of change and debate. Especially the relation between CM and biomedicine is not fix and several strategies are employed by communities and administrative entities on both sides to co-shape the relationship, both in competitive and collaborative ways. CM has become more recognized in the last couple of decades, benefiting from WHO directives and global trends of popularity of traditional medicines, but the overall idea of scientization is still powerful and a biomedical terminology and worldview provides the overall frame of reference for policy makers.

4. Joining the club: Research site and methods

From February to May 2018 I conducted ethnographic field research in two CM university *shetuan*, the *Chuanyi She* ("Traditional Medicine Club") at NTU, and the *Guoyi She* ("National Medicine Club") at another public university, both located in Taipei.[7] I learned of their existence at a previous exchange semester at NTU, and contacted them online to ask if I could participate in their activities as a foreign research student working on a master's thesis in medical anthropology about CM in Taiwan. Both responded positively, and so I joined their welcoming sessions shortly after my arrival in Taiwan and became a member for one semester.

4.1 Research site

University *shetuan* in general are self-organized by students and usually hold weekly meetings. They are embedded in a larger culture of extracurricular student clubs which cover activities ranging from sports, hobbies and entertainment to artistic, academic, social and political work. They are financed through a mix of members' fees and limited budgets provided by their host

[7] In order to allow for an as much anonymity as possible, I chose to not specify the name of the second university. Additionally, I will use pseudonyms and will not specify the exact position of interview partners in the clubs. Otherwise, their identity could easily be looked up online. I chose to name NTU as the site of the *Chuanyi She* because its position as the most prestigious university in Taiwan and one of the top universities in Asia is important for my analysis. To anyone familiar with the field it would also be obvious which club I am referring to. Here I will still use pseudonyms and will be vague about matching interview quotes to specific people and positions.

universities. The clubs are run by a team of *ganbu*, which translates to cadre or official, and are elected by a general assembly of members each year.

The two CM *shetuan*'s main activity were weekly classes on CM. Both saw it as their mission to "study, carry forward and spread" traditional medicine in society (fieldnotes, welcoming sessions, March 1 and 3, 2018). Beyond these general characteristics the two clubs were quite different from each other. The *Chuanyi She* at NTU was founded in 1973. It was bigger, more influential and had more resources than the *Guoyi She*. After around 80 people participated in the welcoming session, the number of weekly regulars settled down at around 50 members. Among those regulars were also a group of ten nonstudent members, all of them seniors. In general, the gender proportion was close to equal, albeit with more female than male *ganbu* and senior members. The group of *ganbu* was made up of the club's president, three vice presidents and several other supporting posts, all assigned individual tasks such as accounting, social media, communications, curriculum, etc. They formed the core of the *shetuan* and a close group of friends. Most of them were enrolled in medical programs such as medicine, psychology, nursing, pharmacy, or public health.

The weekly meetings were mostly lectures held by a different CM doctor each time. The topics covered fundamental theory (such as *yinyang* and the five phases, *wuxing*), the four diagnostic techniques of observation, smell, questioning, and touch (*wang-wen-wen-qie*) including tongue and pulse diagnosis, CM pathogenesis (*bingji*), the fundamentals of CM drug formula prescription, and others. In addition, a study group met on several Saturdays to deepen and expand their study. The club also organized a volunteer group who went on a yearly field trip to provide basic clinical work and public health education to remote indigenous mountain villages in central Taiwan. The other yearly highlight was the so-called Hua-Tuo-Camp[8], a summer camp for high school students in which club members teach CM fundamentals to the younger generation. These kinds of activities have attracted the attention of the Ministry of Education which has repeatedly acknowledged the *Chuanyi She* as one of the top ten service-oriented clubs in the country (fieldnotes, welcoming session, March 3, 2018). This points to the extraordinary position of the *Chuanyi She* in the landscape of student clubs. My interview partners and friends outside of the research context frequently pointed out that the club's strong engagement and resourcefulness is tied to its association with the NTU as Taiwan's elite university.

[8] The camp is named after the historical Chinese physician Hua Tuo (ca. 140-208 AD), a famous and iconic figure in Chinese medical heritage.

The *Guoyi She* was also founded in 1973. While it was also attached to a well-regarded public university, it was much smaller and more limited in terms of resources. During my membership it had 15 regular participants, five of which were *ganbu*: a president, a vice president, and three other posts. This small membership was a cause of concern for the *ganbu*. Due to their own study workload and other obligations and the lesser number of shoulders to carry the various responsibilities, this club was run more tightly. However, the smaller size also made the group more interactive and familial. The lessons were presented by just one teacher, a young, entertaining and spirited doctor who was a former member of the *shetuan* himself. Most members were enrolled in the social sciences and humanities, particularly Chinese studies.

4.2 Research methods

4.2.1 Participant observation

Participant observation constituted a major part of my field research. I was present at the weekly three-hour meetings of both *shetuan*, held at Tuesday and Thursday evenings, respectively. I was also allowed to audit in the study group on Saturdays and so had the opportunity to see students' presentations on topics beyond the regular curriculum. Near the end of my stay in Taiwan I participated in a fieldtrip organized by the NTU *Chuanyi She* to a medicinal botanical garden in the mountains around Taipei, followed by an afternoon of communal free time at the beach. I also regularly ate lunch with members of the *Guoyi She*, a smaller group that also gathered for drinks a couple of times.

During the weekly meetings I tried to keep up with the lectures to the best of my ability, participated in hands-on exercises, talked to the other club members during break time, or simply observed what was happening. In the beginning I assumed that I would just be able to integrate into the clubs as someone wanting to learn about CM, rather than strictly a researcher. This was partly based on my own past as a CM practitioner who was curious to refresh and expand her pre-existing knowledge and skills. As natural as that seemed to me before setting out to Taiwan, as difficult it turned out to be.

In her study on transmission and heterogeneous "styles of knowing" in CM, Elisabeth Hsu (1999) describes how the contradiction inherent in the notion of "participant observation" is intensified in the experience of the researcher as apprentice:

> The anthropologist who decides to be simultaneously fieldworker and apprentice is cast in roles that are not always compatible. First, the topics of interest do not always coincide, and even when activities are of interest to both the fieldworker and the student the problem

> arises of what to pay attention to. [...] These two roles also posed problems for some people I worked with. Not knowing whether they were relating to a fieldworker or to a student evoked an uncomfortable reserve in some of my teachers and colleagues […] (Ebd., 15).

At first I was surprised that I seemed to be able to somewhat follow the lessons, as I had been anxious that my language skills might not be sufficient. Soon however I realized that I often only understood exactly what I already knew. To learn something new, not to mention analyze the content of the lessons, it would have been necessary to thoroughly re- and preview the material and memorize specialized vocabulary that was often difficult to master even for the Taiwanese students. I had acquired funding for my stay in Taiwan for a language class I did simultaneously at NTU, which on the one hand enabled me to do the research in the first place by drastically lifting my language skills, but also took up a large portion of my time. The ambition to focus on the content of the lectures was one I simply had to give up, which is why questions of CM epistemology and of what exactly one learns to become a practitioner are de-emphasized in this thesis.

4.2.2 Informal conversations

Until about halfway into my research I assumed that I would gather most of my material through informal conversations, especially discussions and chats during break time and outings. I thought that casual, "naturally" occurring exchanges would be easier for me to manage in Chinese than potentially long, more formal interviews. It turned out to be very difficult to follow spontaneous conversations around me, especially in group settings. In addition, nothing about my presence in the clubs felt "natural," surely not to the other club members and least of all to myself (see last section of this chapter). My interactions with other club members was, with a few exceptions, shaped by caution and a feeling of not quite knowing what to do with one another, almost until the end of my (too short) stay. Still, there were people I had regular conversations with that I was able to note down in my field diary, for example with Yen-Cheng[9], my curious and witty seat neighbor who liked to practice his English with me and often pushed me to overcome my shyness and talk to new people. Other opportunities were the lunches and dinners with members of the *Guoyi She.* Conversations with Taiwanese friends and acquaintances outside of my narrower research context about their experiences with and perspectives on CM also proved enlightening.

[9] All personal names used for my interlocutors are pseudonyms. I also did not specify their exact position in the *shetuan* to maintain anonymity.

4.2.3 Semi-structured interviews

It was much more productive to straightforwardly approach people to schedule interviews. This seems obvious to me in retrospect but at the time it seemed intrusive and like a break with my desired role as a mere guest participant in the clubs. These interviews lead to a more relaxed relationship with my interview partners afterwards, which in turn helped me be more comfortable and confident in my role as a researcher. In most cases my interlocutors started to invite me to events and activities, facilitated contact to others, or sent me articles they thought were relevant after developing a more personal connection through the interviews.

I led exclusively semi-structured guided interviews. Out of a total of nine interviews, six were with club members, three of each *shetuan*. Two of each were *ganbu* and one of each was a regular member. The other three interviews I led with a friend I had known for a few years who had no medical background but frequently used CM; with a young doctor who had just graduated from the CM department of CMU in Taichung; and the cousin of another friend who was studying CM privately in something akin to a master-disciple-relationship.

I began all interviews with "grand tour questions" (Spradley 1979) about their relationship to and previous experiences with CM. I followed up with questions about the management of past or present health problems, their own or of family members, to get an impression of the different healthcare options they relied on. The club members among my interview partners I then asked how and why their interest in CM began to intensify, how they learned about the clubs and why they decided to join, followed by questions about the organization of the clubs and their own roles within it. I also asked how they imagined their engagement with CM in the future, both in terms of their own health, future study or potential professional plans.

A minority of the interviews were conducted in a mix of English and Chinese. I could not deny my difficulties with the language and was happy to accept the occasional relief of speaking a language I was more comfortable with, especially since some interlocutors expressed their wish to practice English. However, this sometimes led to a lack of precision in the statements, as at least one of us always had to speak in a non-native language. Language use was a compromise in either case. As a result of the majority of interviews conducted entirely in Chinese I had a wealth of information on paper after transcription and translation, but in exchange I had to notice many missed opportunities for further questions, some misunderstandings and an often somewhat awkward flow of conversation long after the fact.

All interviews except one were audio recorded and then partially transcribed with the help of a native speaker. The interview with the young doctor I could only record from memory afterwards, as he showed me around the CMU campus and parts of Taichung as we talked.

4.3 Ethics and positionality

In preparation for field research I imagined that I would integrate into the clubs as a regular albeit foreign participant and that I would as much as possible mingle with the other students as a like-minded person interested in CM. While that might seem naïve in retrospect, some factors made this seem plausible to me at the time: I was not "just" a researcher, but also a language student at NTU, and had previously spend an exchange semester there. Exchange students are a common sight at NTU and at other larger universities in Taiwan. I also thought that my background in CM would make it easy for me to connect to people, as would being a graduate student at home, just like many of them. It turned out to be not so easy.

In the smaller *Guoyi She* I was welcomed enthusiastically. The meetings were convened in a small classroom and when I arrived accompanied by a German friend who happened to study at the same university, our entry caused a bit of a scene. One club member immediately exclaimed in Chinese "Wait, we have a foreigner here??," perhaps assuming I would not understand. A young man, who introduced himself as the *shetuan*'s president, approached me right away. This way I got the chance to introduce myself and my wish to join the club and do research on CM right away, in front of the whole class.[10] Subsequently, it seemed that the open announcement both of my foreignness and my intentions helped diminish some of the distance between us, and I usually felt welcome and included in the club.

In the *Chuanyi She* at NTU it took a lot longer to even build a casual connection with the club members. The meetings were held in a large auditorium, and at the welcoming meeting I entered the room together with about 80 others. While I am certain that my presence was perceived as unusual it was left mostly unacknowledged. I presented myself to the registration desk and told them I wanted to participate and do research, but I did not get the chance to assume a more visible position as a researcher. Only near the end of my research I realized that it might have been beneficial to ask for the opportunity to introduce myself to the whole group rather than just the individual people I talked to. I felt like more of a strange intruder in this club than in the other one. As a white non-native speaker, I was generally assumed to not really be capable

[10] While I had sent them a request via Facebook before coming to Taiwan, it seemed like those present on that day were not aware of that. It's possible that someone else had been responsible for communications when I had messaged with them the previous semester.

of understanding CM theory, as often suggested by my interlocutors, however always politely followed by the addition that it was difficult for them as well. They were not entirely wrong as I could not follow the class enough to discuss their content in detail.

Another factor that created distance was my age. I started university five years after finishing high school, which is not unusual in Germany, but more so in Taiwan. The students were all five to ten years younger than me. When learning my age, they sometimes said "Oh, so you're my *xuejie*,[11] I had no idea!" While my Taiwanese friends explained to me that most students nowadays do not take these hierarchical designations very seriously, this discovery often seemed like an accentuation of the already existing difference between myself and my interlocutors.

My positionality as a white European foreigner also played a role in my access to the field and my interactions with people. My obvious foreignness led to an assumed language barrier that often kept people from approaching me. I had assumed that people would not be interested in speaking to me if my Chinese was too awkward and slow. After making some connections it turned out that it was the other way around – the students generally did not assume that I spoke Chinese at all and frequently were reluctant to rely on their English.

On the other hand, there were some students who approached me enthusiastically, often at some point remarking that they were happy to have the opportunity to practice English or simply get to know a foreigner. Others responded similarly after I approached them to schedule an interview. While this always seemed genuine to me and while I believe that as CM enthusiasts, they were happy to share their views on their topic of interest, the larger structural dimensions of these encounters should be acknowledged. Pei-Chia Lan wrote about white English-speaking Westerners in Taiwan that they are generally "warmly welcomed as 'global talents' and perceived as 'superior others' who can benefit the economic development and cultural enrichment of the country" (Lan 2011, 1679). This attitude drastically differs from the treatment of for example South-East Asian contract workers, who are often met with racial prejudice. Consequently, locals gain from contact to white foreigners "cosmopolitan cultural capital" associated with wealth and social prestige (Ibid., 1684). About whiteness in the global South she writes that it is a "marked, visible identity – the superior other – and a site of power intrinsically linked to the global circulation of capital, culture, and people" (Ibid., 1690).

[11] A Chinese term for a female student older or more senior than the speaker, implying a hierarchical relationship.

My starkest and most uncomfortable experiences that seemed to illustrate this point, such as when I, the only white person in a clothing store, was also the only customer to be spontaneously offered a discount, or when a complete stranger tirelessly tried to invite me to dinner with her friends but ignored my Taiwanese friend next to me, happened outside of my immediate research environment. As described above, most interactions with my interlocutors were shaped by mutual carefulness and polite curiosity. However, I must assume that these power dynamics of race and cultural capital resulted in the comparative ease with which I was able to exist in Taiwanese society and in the context of the *shetuan*.

5. "They haven't studied it well" – accessing Chinese medical education

"It always seems as if the problems facing Chinese medicine are too complex and interwoven. Which issues are more important? Which are more crucial, more pivotal?"

(Liu Lihong 2019)[12]

As introduced in chapter two, recent anthropological literature on CM and other traditional medicines often centers seasoned doctors as representative spokespeople who are shown to masterfully conduct "complicated cultural negotiations" to ensure continued legitimacy (Adams 2002, 203). These protagonists, such as Lin and Law's (2014) Dr. Lee, are experts who skillfully weave together biomedical and CM diagnostic and treatment methods and are able to "talk science" as well as "gently" criticize biomedicine, like Zhan's Dr. Huang (Zhan 2009, 138-140). However, considering the fluctuation in the conditions of CM education of recent decades, these expert figures must be considered products of a different historical moment. The previous chapters introduced the circumstances under which CM is studied in contemporary Taiwan. As I have shown, the academization law of 2011 has severely restricted access to CM education. This chapter will focus on my interlocutors' experiences with and attitudes to this problem. While they all shared an interest in and a passion for *zhongyi*[13], their paths each took quite different turns under the current educational policy, shaped by the past and present of CM, its relation to biomedicine, economic and organizational concerns, as well as the transnational

[12] Liu Lihong is a Chinese CM doctor and best-selling author. In his book "*Sikao zhongyi*" (engl. "Considering Chinese medicine") he comments on the predicaments CM is currently facing due to its continuing integration into biomedical healthcare systems. It sold 1 mio. copies in China since its original publication in 2003 and was published in English in 2019.

[13] *Zhongyi* is Chinese for Chinese medicine, *xiyi* is Chinese for Western medicine.

dimensions of CM. The restrictions they face invite a closer look at the process of becoming a professional or even an expert. They raise the question whether current conditions allow for a reproduction of this modern skillset necessary to nurture and defend continued practice of CM.

Chang Chih-Wei, *ganbu* in the *Guoyi She*, points out a dilemma arising from the current state of CM education in Taiwan, which he calls an "awkward situation":

> The students of [the] "official way," after they graduate from the department of Chinese medicine, they don't pursue Chinese doctor. They have double major with Western medicine, so they... because it's the major thought of our times, they get into the Chinese medicine department first to double major in the Western medicine. So after they graduated they will pursue their career as a Western doctor.
>
> So the opposite side of this condition is that the students who pursue a bachelor's degree of Chinese medicine after their own bachelor's degree, we can call them "unofficial way" students. Because before they have decided this career, have made this decision, they had to determine strongly in themselves. So actually, they have decided to be a Chinese doctor before they have determined to take the test […] (Interview, May 2, 2018). [14]

What Chih-Wei is referring to is what Ye and others have called a brain drain from CM towards Biomedicine (Ye 2013; Wiseman 2000). Students entering a CM university program in which *zhongyi* and *xiyi* are taught in tandem directly after high school (the "official way") end up pursuing a more financially lucrative and socially prestigious career in biomedicine, or have even planned to do so all along.[15] Students with a talent or interest in the natural sciences are privileged in this process, as grades in the related school subjects, such as chemistry, physics and biology, carry the most weight in the university entrance examination for CM colleges. As the example of one of my interlocutors will show below (p. 34ff.), even those with a genuine interest in *zhongyi* may be pulled towards practicing biomedicine under these circumstances.

Those who pursue the only other option to receive a CM license, a post-baccalaureate program or the "unofficial way," as Chih-Wei calls it, must pass an exam testing the natural sciences as well as English. They must commit to five more years of study and more tuition fees after their first degree. It's obvious for Chih-Wei that those following this path are determined to actually become *zhongyishi* (CM physicians) as opposed to those graduating from "the official way." The fact that the most passionate *zhongyishi* seem to emerge from "the unofficial way" compelled him to comment that it was perhaps not a good idea to "close the gate for them" by abolishing the *tekao* (Ibid.). This chapter will focus on my interlocutors' experiences with and attitudes to this problem.

[14] Some of these interview excerpts stem from interviews conducted in a mix of English and Chinese. Wherever necessary they have been edited lightly for readability.

5.1 Where to start from – the classics and the sciences

In their study of young medical students training to become doctors, DelVecchio Good and Good (1989) argue that a juxtaposition between competence and care is the source of contradictions and tensions in the process of becoming a medical professional. Associated with "competence" are the knowledge of the natural sciences as the basis of biomedicine and the technical skills of the physician; "care," however, points to "the art of medicine," e.g. to the ability to listen and be compassionate (Ibid., 305). The former is elevated and explicitly taught in medical education, whereas the latter is not and rather assumed a "natural attribute," leading students to fear "that they will not be able to balance these two components that they perceive as essential to the ideal physician" (Ibid.). In a global field of multiple biomedicines (Mol 2003) it has been shown that the ratio and emphases on either the "art" or the "science" of medicine and their relation to each other highly depend on location and medical socialization (Wendland 2010; Schühle 2018).

The case of CM adds another dimension to this variable juxtaposition of science/skill and art. The "art" here does not just refer to care or clinical skills, but quite non-metaphorically to the study of classical philosophical and medical texts and their translation into medical practice. Whether CM is art or science, and whether biomedicine or classical Chinese should be at the core of CM education, has been the focal point of not only discourse, but also of medical policy in China, Taiwan and elsewhere for a century (see e.g. Lei 2014, 69-96).

Lin Hsiao-Chen, a *ganbu* in the third year of her Bachelor of Chinese literary studies, spoke most passionately about her dedication to CM. Since she was 14 years old, after a consultation with a CM physician, she had wished to become a *zhongyishi* herself. However, her high school grades were not good enough to get into a CM department, so she decided to study sinology and apply for a post-baccalaureate program of CM after graduation. She thought that it was closely related to *zhongyi* and that training in classical Chinese would help her comprehend medical classics such as the *Huangdi Neijing*[16] and thus give her an advantage. However, in

[16] The *Huangdi Neijing*, or „The Yellow Emperor's Classic of Internal Medicine" is one of the most significant ancient texts in the field of CM. Unschuld (2003) writes that it "plays a role in Chinese medical history comparable to that of the Hippocratic writings in ancient Europe. Progress and significant paradigm changes have reduced Hippocrates to the honored originator of a tradition that has become obsolete. In contrast, many practitioners of Chinese medicine still consider the [Huangdi Neijing] Su wen a valuable source of theoretical inspiration and practical knowledge in modern clinical settings" (Unschuld 2003, ix). In popular discourse this work is often dated to several millennia B.C.; medical historians locate its early forms to the second or first century B.C. (Ibid.). It requires specialized education to read texts like these written in classical Chinese; they are not easily intelligible for a native speaker without this training.

order to succeed in the entry exam for the post-baccalaureate (*houzhong*)[17], she also had to study biology, chemistry and English. During our interview, she described her life at university:

> "So I feel like I'm a weird person, like half in the humanities and half in the sciences. At the institute for sinology I feel like I'm in literary studies and then when I return to the dorm I read about proteins and stuff (Interview, May 18, 2018).

This caused her great stress and often she felt overwhelmed with her workload: "I don't have any time to study [for the *houzhong*]. When I come back [to the dorm], there are like ten presentations I have to prepare." Indeed, she seemed quite stressed out about her schoolwork and we had to reschedule our interview once because of the growing pressure of the approaching midterm exams. Talking about her struggles, she exclaimed: "Oh, life is so sad!" Many of her expressions evoked a strong disconnect between the things she had to do to realize her dream. Her science studies seemed unrelated to her daily life and interests:

> "You want to blend these things into your daily life. You know I study Chinese literature, it's very useful for *zhongyi*. But it's a little distant from *xiyi*. So I read all day about glucose and fructose, but I'm not gonna go to the market and buy a pot of fructose, am I? It's very hard to understand, I had a humanities-focus since high school!" (Interview May, 18, 2018)

Ho Chia-Wen is a woman in her 40s who decided to study CM privately by "following a doctor," an expression commonly heard to describe a situation in which students are present in health consultations in order to observe and learn. Chia-Wen holds a degree in philosophy and wanted to pursue CM to improve her own health as well as her financial situation. However, she failed to pass the entrance exam to the post-baccalaureate program three times, the prohibitive barrier being organic chemistry: "In organic chemistry you have to do maths, calculate air, volume, pressure, etc. Because I couldn't do it fast enough I really had the lower hand in the exam. After three times I accepted that there was no way." She expressed her frustration with the general education system like this:

> "There was no way because right now in Taiwan the environment for *zhongyi* is controlled by *xiyi*. So […] in order to get into the *zhongyi* department, you have to pass an exam in English and Chemistry […]. Those who take this test often originally studied the natural sciences. They have no idea about Classical Chinese and they don't have to pass a test in Classical Chinese. They opened up [the post-baccalaureate] to give intelligent students the opportunity to study [*zhongyi*], but the kind of intelligent they mean are those who are successful in this particular aspect. Because [this system] uses the logic of *xiyi* to think about *zhongyi*, of course they need to understand chemistry and physics, and so those [already] studying *xiyi* are more solid. Therefore those *xiyi*-leaders use *xiyi* methods and thinking to approach the *zhongyi* system" (Interview, April 27, 2018).

[17] *Houzhong* is short for *xueshihou zhongyi kaoshi*, which means „[entry] exam for CM post-baccalaureate [program]."

She felt that this simply provided an easy career option for people who would have no problem with the exam – those with a biomedical background who would not approach CM with the right training and mindset. Chia-Wen claimed she didn't really trust CM clinics anymore because of this, judging: "[T]hey haven't studied it well, they haven't been trained under a rigorous *zhongyi* system" and "they don't do it to better understand Chinese culture or understand *zhongyi*, that's not where they are coming from at all" (Ibid.).[18] She eventually found a way to at least practice CM privately, avoiding the biomedical barrier. After studying with her master for three years and ongoing, she claimed to have successfully treated minor illnesses in herself and her husband.

These two women are struggling to find a way to turn their passion and interest for *zhongyi* into a career. Even though the post-baccalaureate programs were specifically designed to counter the brain drain from Chinese to Western medicine (Wiseman 2000), they remain relatively inaccessible for people with a background other than in the "hard" sciences. Chia-Wen has resigned to practice *zhongyi* in a private context, but her dedication was apparent in our interview, which at times resembled a *zhongyi* lesson for her cousin and his girlfriend, who introduced her to me. Hsiao-Chen and Chia-Wen also have in common that they find studies of the classical foundations of CM essential. They echo a prominent sentiment in current public intellectual discourse perhaps best represented by the Chinese CM physician and bestselling author Liu Lihong. He proposes that the perceived shortcomings of CM today are not caused by an inherent inadequacy, but stem from "failures in our own understanding" (Liu 2019, 9) and a loss of "the metaphysical immaterial portion" of CM (Ibid., 32). He therefore argues for the "longevity and continued importance of the classics" and an innovative gaze in studying them (Ibid., 44).

Fang Yi-Lin is another student whose interests align with Hsiao-Chen's and Chia-Wen's but whose background is very different. Like Hsiao-Chen, Yi-Lin had been interested in *zhongyi* since he was a teenager, and like her his grades in high school were not sufficient for medicine. Despite his deep interest in classical Chinese studies he decided to pursue a degree in public health at NTU, because he saw a relation to his passion: "And I think I love the... the thing about people's health and so study for it. And the Chinese medicine is also beneficial for our... it's a kind of… [in Chinese] close relation between the two […]. Public health is the health of all. And Chinese medicine is the health of individual" (Interview, April 25, 2018). By

[18] Senior CM physicians in China have even coined a sarcastic proverb for this phenomenon of prioritizing scientific explanation over CM understanding: "Knowing the why but not the how" (J. Wang and Farquhar 2010).

modifying the common definition of the relationship between medicine and public health to include *zhongyi*, he aligned his career path smoothly with his other interests and did not express much inner conflict at first.

The extent of his dedication to *zhongyi* and classical studies seemed quite extraordinary to me. After first encountering *zhongyi* at the Hua-Tuo Camp as a high school student he discovered that he was interested in "stuff like this." When he entered university, the *shetuan* "drew him in" and he soon occupied a *ganbu*. The extent of his interest in the Classics became clear when I asked why he felt these things were important to him. He said:

> This is a very long story. The short version is that I used to not be interested in these things at all, but then I went to a class on the 'Records of the Grand Historian' by teacher Lu Shih-Hao[19] and that's when I discovered that I really like these kinds of things. It changed me very much. There are so many things you can apply in daily life. After that I looked up the teacher of my teacher and found out that he left behind some memoires that I began to read. And then I joined an external [i.e. private] Academy where I continued my studies. This is how I started learning Chinese medicine, studying these kinds of things along with my regular studies [of public health] (Ibid.).

In addition to his studies of public health, his studies at this academy[20] and his regular tasks as *ganbu*, he also led the previously mentioned study group. In this context he contributed an entire session on the Confucian and Daoist origins of CM, as well as on practices of health maintenance and self-cultivation in everyday life (*yangsheng*).[21] He also taught acupuncture, basic *zhongyi* theory as well as *qigong* at the Hua-Tuo Camp every year. Confucianism, Daoism, *yangsheng* and *qigong* are not part of the regular curriculum at either of the clubs and neither are they prominent in CM university curricula. I suspect that they found a place in the *shetuan* entirely because of Yi-Lin's personal dedication.

5.2 Economic influences on access and decision-making

Another restraint my interlocutors were facing was money. Locating my field research at two of Taiwan's top-ranking universities placed my interlocutors in a relatively homogenous urban middle class environment. All of them are originally from Taipei or have a family home in one of Taiwan's bigger cities such as Kaohsiung, Tainan, and Taichung. Nevertheless, finances

[19] Lu Shih-Hao is a history professor at NTU. He gave a prominent TED-Talk as well as courses on history on the international online learning platform Coursera. See for example this talk on the relevance of the subject of history for daily life (in Chinese): https://www.youtube.com/watch?v=zsxQpxf6B20 (accessed August 23, 2019).
[20] I omitted the name of this academy for anonymity.
[21] *Yangsheng*, "nourishing life," is a term originating in Daoist practices of self-cultivation, historically associated with the goal of attaining immortality. Today the focus is on the cultivation of good health and prevention of disease. Related practices include gymnastics, breathing, sexual hygiene, diet, meditation and rules of everyday behavior (see Despeux 2008).

played a restrictive or at least guiding role in my interlocutor's life decisions with regards to CM. Questions of income and social prestige influence the choice between a career in biomedicine and CM. The fact that graduates of CM university programs must choose to practice one or the other has pulled the majority towards the more lucrative and socially esteemed option – biomedicine – in the past (Chi et al. 1996, 1331).

My interlocutors suggested that this tendency still prevails today. Ma Yu-Ting[22] is a recent graduate of the CM program of CMU in Taichung in his late twenties. Originally from Taipei, he moved to Taichung to study *zhongyi*. Like many of my interlocutors, he became interested in it after a personal experience of sickness that was successfully treated with *zhongyi*; in his case a back injury that only a combination of acupuncture and tuina massage would heal. Despite this experience, Yu-Ting decided to practice biomedicine after his graduation in 2017. After completing the mandatory army service of one year he had just started working in the gynecology department of CMU hospital where he was about to assume a position as resident doctor.

When I asked him about this decision I received a somewhat vague answer. He said that in order to pursue *zhongyi* after graduation it is only necessary to "follow a doctor" and it would be relatively simple. When it comes to biomedicine,[23] there are stressful 24h shifts, being "on duty," and it is very taxing and exhausting. He said that he wants to use the opportunity to do this hard work as long as he was young, and resort to CM at an older age when he felt the need for a less stressful pace. He seemed to avoid answering my question why he wanted to commit to biomedicine at all, especially when he was initially motivated to practice *zhongyi*. In retrospect, I suspect that he wanted to use his youthful energy to make more money, and then settle for *zhongyi* when he was older. He might have been aware that this had become somewhat of a stereotype and was perhaps embarrassed to admit it to me, especially knowing that I was interested in CM (fieldnotes, April 15, 2018).

But not just later earnings play a role in CM education. Nigel Wiseman (2000) stated about the CM post-baccalaureate that "[t]he five year course is particularly attractive to graduates from other schools and departments that have less lucrative career openings" (Ibid., 7). In order to get there, however, substantial financial hurdles need to be overcome already. Hsiao-Chen in

[22] Yu-Ting, his fiancée and I met in Taichung, where they showed me around the Medical University Campus, took me to a market and later to a café. Since I couldn't record or take notes during the interview, I cannot provide direct quotes and rely on notes made in my field diary later that day for this section.
[23] Yu-Ting, like some others, simply said "medicine" when referring to biomedicine; only "Chinese medicine" received a qualifier.

particular was struggling to figure out how to pay for the tuition of another five-year degree after her first Bachelor. Even though she stated that her family supported her decision, it was not enough to pay for another degree and she came up with various arrangements of study and part-time work in order to save up enough money. But it was not just the tuition itself that presented an obstacle. As shown in the previous section, preparation for the entrance exam is essential especially for those not already proficient in the natural sciences. Both Hsiao-Chen and Chia-Wen relied on cram schools for tutoring, which placed an additional financial burden on them. Having failed the exam three times, Chia-Wen stated: "If I had more money I would just keep trying, but like this it's impossible" (Interview, April 27, 2018).

Regarding financial restraints my research has some blind spots. While a university education itself does not indicate social class in Taiwan the same way it might in other countries, with more than 95% of high school graduates entering university (Chou and Wang 2012, 14), access to specific universities is highly competitive. While most Taiwanese have the opportunity to graduate from *some* university, a lack of quality and resources in the lower tier universities is a well-known problem contributing to the reproduction of class differences (Ibid., 17). Currently, there are only four universities in Taiwan offering undergraduate or post-baccalaureate degrees in CM. Thus, it became clear that despite their struggles, my interlocutors, attending two prestigious public universities in Taipei, still belong to a social group with better access to CM education than those without an urban, middle-class, educated background who do not appear in my study.

5.3 Integrating *zhongyi* and *xiyi*

Another dimension of tension but also potential has already been implicit in the preceding sections: that of the relationship between *zhongyi* and *xiyi*. In this section I want to look at personal struggles and solutions to the often conflictual co-existence of CM and biomedicine. Many related statements by my interlocutors have almost become commonplace and can be found almost verbatim in many ethnographic accounts of CM: *zhongyi* and *xiyi* are based on very different epistemological foundations; both have their strengths and weaknesses; *xiyi* might be harsh and have side effects, but works very quickly and is most effective for acute and serious conditions, whereas as CM is gentle and holistic and works well for chronic conditions.[24] I was surprised to find that, despite coming to CM from such different

[24] This assessment is so common that it has almost turned into a proverb: *Xiyi zhi biao, zhongyi zhi ben* – Western medicine treats the symptoms, Chinese medicine treats the root [of the disease]. Karchmer (2015) highlights the ahistorical nature of this common stereotype, arguing that "the slowness of Chinese medicine is part of the broader

backgrounds and perspectives, my interlocutors all agreed that one system could not objectively be declared to be better than the other, that it depended on the quality of education and personal skill of the physician, and that the best course of action for the future, the one most benefitting the quality of health care, would be some form of integration of *zhongyi* and *xiyi*. It was not the idea of integration itself that they struggled with or objected to, but rather that it happened under a system of inequality. In addition, my interlocutors each had their own perspectives on how exactly a fruitful integration could be accomplished.

When Yu-Ting told me about his plan to first practice biomedicine and then later shift to CM, he immediately pointed out that this might be difficult to achieve. Although his teachers in university strongly emphasized that he and his classmates, as students of CM and biomedicine, were expected to serve as a "bridge between medicine and Chinese medicine," he stated that trying to think them together created "a conflict in my brain." He thought that an integration of biomedicine and CM within one practitioner was an ideal, but almost impossible to realize. He recognized that some people perhaps could do it, and mentioned a teacher of his who researched liver function readings in terms of CM theory, but felt that it would take a lot of experience and specialized work. Instead he told me about a clinic where patients were cooperatively treated by a CM and a biomedical doctor within the same consultation. "[Relying] on colleagues to do this integration" seemed more realistic to him (Field diary, April 15, 2018).

Even Hsiao-Chen thought that ideally one would study both *zhongyi* and *xiyi*, although she preferred *zhongyi*'s gentler approach. However, struggling with the necessity to prioritize *xiyi* at the moment because of the *houzhong*, she criticized the way they were mixed together in the current education system:

> I think it's good to study both *zhongyi* and *xiyi*, but I hope that when I study *zhongyi*, I get to finish studying its entire system. And then when I study *xiyi*, I get to study its entire system, and then integrate the two. And not when I study *zhongyi* that there are so many things from *xiyi* already mixed into it (Interview, May 18, 2018).

While Yu-Ting thought that integration in actual clinical practice was difficult to achieve, Hsiao-Chen believed that in order to successfully integrate *zhongyi* and *xiyi*, one first needed to master each of them separately. Her case illustrates the substantial organizational, financial, and cognitive difficulties in reaching this goal.

The case of Liao Pei-Chi, a pharmacy student at NTU and *ganbu* at the NTU *shetuan*, and her strategy were among the most interesting to me. Even after joining the club she remained

transformation of this medical system, that includes, among other things, a loss of knowledge and a collective forgetting about how to treat acute conditions" (Ibid., 189).

skeptical of CM for a while, and only several years of engagement as *ganbu* slowly changed her mind (see Ch. 6). Even though she had the good grades to go to medical school, she felt uncomfortable interacting with people, so she initially wanted to go into pharmaceutical research. She not only cultivated her interest in CM in the context of the *shetuan*, but also credits her activities there with strengthening her social skills and comfort around people. As a result, she discarded her original goal to work in research and development. She said:

> I can find out how each drug works within the human body, how it enters it, how it is discharged, how it is metabolized. And then joining the *shetuan* had a big effect, because I think I became a little bit more interested in Chinese medicine than in Western medicine. I think my path in the future will have something to do with the integration of the fields of pharmacology and Chinese medicine (Interview, May 23, 2018).

Inspired by reading about integrated practice of CM and biomedicine in China, she became interested in the use of both types of drugs in tandem, for example to alleviate potential harsh side-effects of biomedical drugs (*xiyao*) through the use of harmonizing Chinese herbal medicine (*zhongyao*):

> So if you administer Chinese drugs [after biomedical drugs] you can recover the body's balance more quickly, you'd feel more comfortable and you wouldn't feel so weak after defeating the symptoms of the disease, so I originally thought this integration of Chinese and Western drugs was necessary (Ibid.).

In the clinical practice of physicians in Taiwan, however, CM and biomedicine are kept relatively separate, despite being intertwined in (CM) education. This is where Pei-Chi began to see an opportunity with her pharmacy background and began to consider opening her own pharmacy, since pharmacists in Taiwan can obtain licenses for the administration of both Chinese and biomedical drugs. She was committed to take the additional credit hours necessary to realize this plan. She saw this as an opportunity to address people in her community directly and educate them about CM: "Just like I thought in the beginning that *zhongyi* wasn't worth anything, that was a misconception, and I want to let everyone know." Furthermore, she thought that this was one way to realize the integration of CM and biomedicine:

> [W]e [the pharmacists at her future pharmacy] would have many opportunities in the field of health education. I could explain to sick people why we use certain drugs […]. And then we can explain that they could also seek assistance from *zhongyao* simultaneously and suggest some useful formulas. This would help more people understand that you can use *xiyao* and *zhongyao* in an integrated way (Ibid.).

Pei-Chi was not concerned with a watering down of a presumed essence of CM in the process of integration like Hsiao-Chen, but rather saw it as a way to elevate its status in the public consciousness.

5.4 Transnational dimensions of learning CM

Closely related to questions of the foundations of CM, of access to education, and of finances are the transnational dimensions of *zhongyi*. In her monograph *Other-Worldly: Making Chinese Medicine through Transnational Frames*, Mei Zhan (2009) argues that what we call "traditional Chinese medicine" is actually "made *through* – rather than prior to – various translocal encounters and from discrepant locations" (Ibid., 1). CM in other places significantly shaped my interlocutors' engagement with it, both through the flow of ideas, materials and histories and, for some, through dreams and plans of migration.

Central in my interlocutors' imagination was CM in the PRC. The question of difference between *zhongyi* in Taiwan and in the PRC and my interlocutors' attitudes towards them was one of my central research interests in the beginning. While I ended up focusing on the role of the *shetuan* in Taiwan, the question of China did come up again and again. When asked about *zhongyi* in China, most people admitted that they didn't have any personal experience, many having never been there. When I encouraged them to share second-hand information, assumptions, beliefs, and rumors, it revealed the complex role China and cross-strait relations played in their imaginations and life-plans. This topic would warrant more space than available here, but I want to summarize some key points.

Some of the replies I received seemed contradictory at first. My interlocutors, depending on their pre-existing interests and inclinations, seemed to either regard CM in China as more advanced, which usually meant more integrated with biomedicine, or they saw it as more original and authentic. Those who claimed that it was more "modern" and "advanced," such as Pei-Chi, based this on the perception that scientific research into *zhongyi* was given more prominence there. She recalls:

> In the beginning I assumed that Chinese medicine had no experimental basis. But then I read a manuscript of a lecture in China and I discovered that over there they take scientific experiments very seriously. They really did some experiments to confirm the necessity to arrange herbal medicine in specific formulas, that they have a scientific foundation (Interview, May 23, 2018).

As a pharmacologist in training, her interest in CM mostly focused on *zhongyao*. A glance towards China helped ease some of her initial anxiety around the perceived incommensurability between her (biomedical) pharmacy studies and her interest in *zhongyi*. She also pointed out that it was easier in China to administer Chinese and biomedical drugs in combination, which she saw as most effective, while in Taiwan practitioners were only allowed to prescribe drugs belonging to the system they chose their license in. Something that almost everyone mentioned

was that the use of CM in in-patient hospitals and for acute conditions was much more widespread in China, and that as a result the experience with acute conditions was much greater, while in Taiwan CM was usually practiced in out-patient clinics and used for chronic conditions.

Some, however, also pointed to China in their search for a more authentic and original CM. Hsiao-Chen, for example, stated that when it came to CM, she would always choose China over Taiwan, both because she perceived China as the true origin of CM and also because according to her, more efforts were being made to preserve its authentic form than in Taiwan. She shared with me a kind of fantasy about studying CM in China:

> SY: "I heard that there are universities where there are only *zhongyi* [students]. That's just so cool, because [imagine] some students are playing basketball and one of them falls and dislocates his or her shoulder and a senior classmate just says: 'come here, bite on this towel' and then just 'click' and it's back in place."
>
> KB: [laughs]
>
> SY: "Or when you get sick, your teacher helps you figure it out, right? If it's a serious illness, the teacher can help you treat it, and if it's a minor thing, your classmates will gather round. They'll all discuss what's wrong with you and try to help you. On these campuses that have so many *zhongyi* students you'll find that there are very few sick people, because their lifestyle will just be that they get up early in the morning to do some Taiji, they really practice *yangsheng*, yeah yeah yeah, so they won't get the flu so easily, so if you do, you'll be an interesting medical case."
>
> [both laughing]
>
> SY: "And I also heard that there are some clinics, but I'm not sure on which campus, they have a health center, and when you go in they ask you: 'What do you think the illness is?" And then the student will say: 'Oh, I think it's this and this and this.' And the nurse will say: 'Okay, and what medicine do you think you should take?' 'I think I should take this and this.' 'Okay, then you can pick it up over there.' I think like this it's really awesome. This is how I want to live my life."

Here Hsiao-Chen shares a dream of a way of learning that is close to practice, integrated into everyday life, and, as she perceives it, doesn't have so "many things from *xiyi* already mixed into it" (Interview, May 18, 2018).

For some of my interlocutors, it's a progressed integration of CM and biomedicine that characterizes CM in China, for others, it is preserved authenticity. This seems contradictory, but on the other hand the diversity of CM in China has been demonstrated again and again (see e.g. Scheid 2002, 17ff.). It is no surprise that the students heard different stories and aligned them with their own perspectives. Interestingly, despite their contradictory assertions, all students justified their view on CM in China with the impression that there, CM is taken more seriously and people have more confidence in it. No matter which way they leaned, it seems

that they used the comparison to China, factual or not, to criticize the situation of *zhongyi* in Taiwan.[25]

Comparison is not the only dimension in which the students engaged with CM abroad. Especially Hsiao-Chen and Pei-Chi were also considering a move to China. Hsiao-Chen was drawn on the one hand by her perhaps idealized vision of CM in China, but also by the prospect of obtaining education for a cheaper price. However, under ever volatile cross-strait relations, she was unsure whether she could expect a CM license to be recognized in Taiwan in about seven years, the estimated time it would take her to graduate and then obtain a second degree in China. Currently this was not the case, and she acknowledged that a hope for change in that regard might remain unrealistic in the near future. Barring this possibility, she considered going to another country whose medical degrees Taiwan recognizes and in which she could obtain a standardized, government approved CM certificate, namely Japan and the US. She quickly discarded Japan because of lacking language skills. The heavy focus on acupuncture in the US eliminated this option as well: "I can't come back here and only be allowed to do acupuncture, that's not in line with my thinking at all" (Interview, May 18, 2018).[26]

When I asked Yu-Ting whether he had any questions for me after our interview, I was surprised to hear him and his partner ask quite eagerly about CM's popularity in Germany. Like many highly educated young people in Taiwan, stagnating wages as well as the ever-present threat of PRC-aggression lead them to contemplate emigration. Yu-Ting's fiancée, a nurse, told me they had often wondered if it would be possible to make a living as a CM physician in Germany. Interestingly, CM seemed to be a kind of back-up plan for him to "make it" abroad, whereas in Taiwan he relied on biomedicine for this purpose. Overall it seemed to me that my interlocutors were very aware of what is going on with CM in other places and often related their own engagement with it with its practice and transmission elsewhere. Virtually all of my interlocutors based this outward gaze on a perceived insufficiency of possibilities (of access to education, educational quality/orientation, and financial opportunity) in their home country.

I hope that, with this chapter, I was able to illustrate the specific economic, organizational and epistemological challenges that contemporary prospective practitioners of CM face. I argue that despite the epistemological flexibility inherent in CM, and evidence of skillful integration of

[25] Meanwhile, similar discussions are happening in the PRC at scholarly as well as popular levels (see e.g. Liu 2019). Taiwan is also occasionally pointed to as a point of comparison, as a place where the situation of *zhongyi* is relatively more advanced, as shown by Smith in the case of Singapore (A. Smith 2018).

[26] While CM is strongly associated with acupuncture in the US and perhaps most Western countries, most people in China and Taiwan first think about *zhongyao* when they hear CM. Although it's certainly not uncommon, several people I talked to in Taiwan had never experienced acupuncture despite being quite familiar with herbal medicine.

and collaboration with biomedicine in contemporary CM, a lack of appropriate and in-depth education may have consequences for its flourishing in the future. The protagonists often presented as figureheads of CM in anthropological literature emerged from a specific historical context that is not reproduced today. However, my interlocutors were quite aware of the potential consequences of the difficulties they were facing and actively searched for strategies to overcome them. In the next chapter, I will examine how these efforts translated into the work of the *shetuan* and show how they claim an informal and imperfect but nevertheless important position in the landscape of CM medical education in Taiwan.

6. Cultivating competence – the role of the *shetuan* in the Taiwanese healthcare landscape

After outlining the individual struggles faced by the students in the last chapter, I want to show here how these struggles also collectively shape and inform the work of the *shetuan*. During the first few weeks of fieldwork I began to wonder about a potential discrepancy between the clubs' projected self-understanding and their actual capabilities. Due to the policy changes addressed in this thesis, the strategies to realize their self-proclaimed mission to further the study into and preserve CM in Taiwan were not obvious to me at first. Indeed, in the welcoming session of the NCCU *shetuan*, the club leaders pointed out that whereas the club had brought forth "famous CM doctors" in the past, it is now faced with "the fate of change" (fieldnotes, March 15, 2018).

This issue was illustrated most explicitly one day before my departure from the field. The NTU club held their yearly general assembly to elect a new generation of *ganbu*. On this evening almost all seats of the auditorium were occupied and several former club members had shown up. A handful of them had gathered some seats away from me in one of the back rows. While the new *ganbu* candidates presented their plans for the new year in the front, I heard barely stifled noises and comments of exasperation from their direction. When it was time to pose questions to the prospective *ganbu*, they quite directly voiced some concerns and criticism. A woman who had been a member ten years ago challenged them by pointing out the crisis of relevance caused by the restrictions on CM education: When the clubs cannot officially lead to a professional status anymore, how do they contribute to the promotion of CM? Should the activities focus on entertainment to draw in new members, or should they focus on rigorous CM training, which might scare the more casual members away? Should the goal be to help

students prepare for the *houzhong*? But then, wouldn't the curriculum have to include biomedicine? And surely that cannot be the point of a CM *shetuan*? She was dissatisfied with the new candidates' lack of clarity on these topics and claimed that by ignoring these difficult questions, the club would fail to keep up with the times and become insignificant. This led to a debate to which some attendants contributed quite passionately, while others occasionally tried to interject by asking about new T-shirt designs and other mundane topics, perhaps to lighten the mood and decrease the pressure on their friends on stage. While in the end they did – barely – get elected as new club leaders, they were clearly unprepared for these existential questions and could not provide convincing answers (fieldnotes, May 24, 2018).

My goal in this chapter is to show that there is a collective purpose discernible in the work of the *shetuan*. Drawing on Hsu's (1999) work on modes of transmission of CM, as well as Kleinman's (1980) analysis of healthcare sectors in Taiwan, I will locate and contextualize the *shetuan* within the Taiwanese landscape of healthcare and medical education and outline their functional role therein. This role consists of the reproduction of interest in CM and the stimulation of professional trajectories, healthcare performed in the context of the clubs themselves, and a contribution to the maintenance and cultivation of lay competence and expertise within the popular sector of healthcare.

6.1 Reproduction of talent and interest

In her book *The Transmission of Chinese Medicine* (1999), Elisabeth Hsu identifies three modes in which CM is taught in the context of the 1980s PRC. The secret mode, exemplified by a qigong healer's master-disciple relations, relies on imitation and repetition of secret modalities such as incantations and movements, and a strong reliance on authority (Ibid., 25-56). The personal mode is similarly characterized by authoritarian and mutually dependent master-student relationships but focused on the attempt to convey personal experience and virtuosity, in this case through interpretative readings of classical texts (Ibid., 127). Lastly, the standardized mode of transmission equals depersonalized learning in the classroom. For Hsu, the defining trait of this last mode of transmission is not its setting or a particular standard content, but the idea that learning is to happen "systematically": step by step, with one concept after another, based on explanation and the idea that CM theory is a coherent body of knowledge that can be made accessible to anyone (Ibid., 158-165). This is in stark contrast to the secret and personal modes of transmission, where characteristics are teacher-students pairings based on personal choice, an entwinement of theory and practice (see also Farquhar 1994), and often confusing, contradictory and incoherent pieces of knowledge that are meant to bloom into

insight with personal practice over time (Hsu 1999, 227). In standardized learning, however, "knowledge is conceived of as having a structure and messages as having a point" (Ibid., 167). For Hsu, it is also this idea of systematic learning, rather than specific concepts or terminology, that represents the modern impact of biomedicine on CM (Ibid., 159).

The *shetuan* lessons mostly happened in a classroom with a teacher at the front and lessons were structured after textbooks. Literary exegesis, chants and secret movement sequences were not part of the classes and the interpersonal characteristics of the secret and personal modes of transmission were absent from at least what I could observe. The *shetuan*'s missions to promote CM to the wider public and spread its knowledge "to everyone," as many of my interlocutors expressed it, reflect the core characteristic of the standardized mode of transmission, and out of the modes proposed by Hsu it is most closely related to this latter one.

However, there are some differences that place the *shetuan* outside of the framework of these three modes. While the core lessons are taught by professional doctors, students often teach each other, for example in the short review sections at the beginning of each class, in the study group, in the welcoming sessions, or at Hua-Tuo Camp. Reviews and little exercises are done in the form of games. While the doctors lead the class, the students often pick the general content and prepare the slides. This is because, as Hsiao-Chen and Chih-Wei told me, they themselves are best able to assess their previous knowledge and what they personally wish to learn. This way, knowledge is transmitted as it is acquired and co-created between students and teachers.

However, the effectiveness of this transmission, that is whether students actually retained this knowledge, was questionable to me. Often unable to follow the lessons, I looked around the room and observed the other students. Frequently I saw eyes glazing over, heads put to rest on tables, and Facebook opened on laptop screens. My seat neighbor Yen-Cheng complained that the lessons went on too fast and without pause. Once he even put this feedback down in writing to the *ganbu*. When I expressed that I frequently gave up listening to the teacher because of difficulties with the language, he and many others retorted that it was not just my Chinese that made things difficult to understand.

The atmosphere in the smaller *shetuan* was much more attentive and livelier, perhaps due to the young teacher's spirited and entertaining teaching style. But when I asked Chih-Wei whether he thought students really understood and retained what they learned in class, he said that he wasn't sure: "The material is not too difficult to understand but it's not easy either. Although our mother tongue is Chinese we have to ponder the meaning of the Chinese

characters." He stated his doubts that foreigners could understand CM teachings at all and added: "But for Taiwanese, we can understand, but in good effort" (Interview, May 2, 2018).

Not everybody put in this effort. In contrast to those who followed a doctor outside of class, who practiced Qigong in their free time, who studied classical Chinese like Hsiao-Chen and Yi-Lin or who devoted themselves to teaching their fellow students, many just joined the club to make friends and perhaps get a basic idea of what CM was all about. Their knowledge and skill must remain superficial. It seems to me that the purpose of the *shetuan* did not lie directly in the transmission of knowledge or skill, because this seemed inadequate without complementary activities in addition to the lessons. Instead, I argue that their main accomplishment is a reproduction of interest in CM and through that the stimulation of professional trajectories.

An important tool for this purpose was the Hua-Tuo Camp. In 2018, the camp was conducted in the winter break before my arrival in Taiwan, so I was not able to attend. The camp, however, was prominent in my interlocutor's conversations, our interviews and the *shetuan*'s introductory presentation. For Yi-Lin, attending the Hua-Tuo camp in high school was fundamental. As mentioned in the previous chapter, this was when he discovered his interest in CM and "stuff like that." After the camp he was motivated to study harder to get good grades and study CM. Upon failing this, he enrolled in public health and became one of the most active and engaged members of the NTU *shetuan*. When I contacted him again in July 2019 he had successfully applied for a transfer and passed the entry exam for the CM program at the CMU. He began his studies there in September. The work of the *shetuan* stimulated his interest in what would become a passion, maintained it during his studies and also offered an outlet and a training ground for his ambition to teach. It supported him in reaching his goal to transfer and finally enter the "official way" of studying CM.

Pei-Chi expresses this self-replenishing purpose of the *shetuan* and the camp clearly:

> The team allows high school students to learn through entertainment. [The task is] to blend the *zhongyi* knowledge into the more fun activities. [...] This leaves a deeper impression on them, so we can further spread things related to the field of *zhongyi* among the students, and maybe it'll lead them to decide to go in this direction later or maybe they'll want to study at NTU knowing that there is this *shetuan* for traditional medicine (Interview, May 23, 2018).

Special tasks like teaching at Hua-Tuo Camp had a big impact on Pei-Chi's interest in CM. She was "dragged" into the club by one of her friends. At first, she was skeptical and only joined because she wanted to give it a chance and not disregard it without further investigation. She remained somewhat indifferent towards CM for a while, until she was prompted by the club's

president to take part in some of the more involved activities. She says, again about the Hua-Tuo Camp:

> I was part of the organizing team. This forced me to take some classes, because you have to deal with the students' questions. […] when I read some of the material I realized that when I really thought about some things in Chinese medicine for myself I gained a feeling of deeper understanding. […] And only when I studied for this I realized that I had some misconceptions [about CM] after all (Ibid.).

For Pei-Chi, the club not only stimulated an interest in CM, but led her to overcome a previous disregard for CM. The social nature of the club contributed here, since Pei-Chi emphasized the role of her friends in persuading her to enter and then stay in the club. Eventually, as mentioned in the previous chapter, she had cultivated her commitment to *zhongyi* to such an extent that she now dreamed about opening her own pharmacy, where she could find her own way to practice integrated *zhongyi* and *xiyi* and educate the public about it.

These examples show that it is not mainly the direct transmission of knowledge or skill that makes up the *shetuan*'s contribution to CM, but the reproduction of interest, talent and dedication to CM in the younger generation. In a subset of club members, this acquisition strategy directly stimulates their career choices and support and maintains pre-existing career interests. In the context of the academization of CM in Taiwan, where entry into the profession has become more difficult, the clubs provide a network of support and an environment in which students can act on their interests and hone their skills.

6.2 Healthcare skills and patient knowledge

While I judge this reproductive aspect to be the more prominent contribution of the *shetuan* to the world of CM in Taiwan, transmission of knowledge and skill still played an important role. This knowledge and skill is a kind of competence that was communally cultivated in the clubs. It did not just come from a teacher or from textbooks. Sometimes material was also collected by the students and given to a teacher who then brought the material to life with his[27] expertise. Often, however, competence was cultivated among the students and shared with a wider public in a horizontal rather than vertical way. I see this competence as a "messy" (Pols 2013, 75) mixture drawing from elements of knowledge provided by the CM teachers, students' regular fields of study, external teachers and teaching institutions, books, magazines, online sources, family members, scientific studies, and many other sources.

[27] With one exception, the doctors teaching in the *shetuan* while I participated were all male. Only the introductory talk at the NTU *shetuan* on weight loss was held by a female doctor.

Becoming a more competent patient of CM is a motivation to take part in the club for some of its members. One such such member was a senior named Lee Wei-Cheng, who told me that he joined the club because he wanted to supplement the little information he got from the very short consultations with his CM doctor (fieldnotes, March 27, 2018). One of the non-student members of the *Guoyi She*, a high school teacher named Hsien-Wei in his 40s, used a casual dinner with other club members and *ganbu* to ask various questions about herbs, foods, and supplements he had tried or wanted to try for a number of minor ailments (fieldnotes, May 13, 2018). Pei-Chi and Hao-Cheng, another member of the *Guoyi She* who had also previously been a member of the NTU *shetuan*, told me how they learned how to self-medicate minor illnesses using herbs and prepared formulas they had stored in the *shetuan* office, often leftovers from volunteer work.

In addition, I frequently observed students giving each other neck massages using acupressure points or feeling each other's pulses. Pei-Chi also added that when a formula she used on herself didn't work she would usually ask a senior club member for advice. Advice in general was something that circulated also between teachers and students. Especially in the smaller and more familiar club students often walked up to the teacher during break and described either their own or other people's symptoms, for example a family member's insomnia, in order to ask for treatment recommendations. Often the teacher referred to these questions during the lectures (Fieldnotes, April 11, 2018).

In addition to becoming a more competent patient, nearly all club members I talked to listed the ability to help friends and family as one of their motivations in joining the club. In this case people usually referred to basic knowledge about acupressure points or simple herbal formulas. Chih-Wei for example said that he "preferred practical skills or knowledge" that "you can use in the rest of your life" and he appreciated CM for providing exactly these kinds of practices. He said:

> "I'm going to cure myself or even cure my family members and my friends. And I don't have to ask others. Of course when I got sick I have to go to the doctors. But I can use some Chinese medicine knowledge to get my body more healthy" (Interview, May 1, 2018).

This notion of being able to treat family members is deeply rooted in Confucian notion of filial piety – the duty to respect and take care of one's parents. The obligation to command at least elemental medical skills for this purpose has been the impulse for many personal transitions into professional medicine in times of less regulated CM education and qualification (Unschuld 1973, 20-21; see also Kleinman 1980, 62-63). Several club members shared stories of how they were able to treat minor illnesses within the family. When I asked about the history of

engagement with Chinese or Western medicine in their families, I was surprised to hear that for many, it did not play a role in family health management until they themselves started to become interested. Yi-Lin for example told me that his family had started to see CM doctors only in recent years, when he became more active in the *shetuan* (Interview, April 25, 2018).

6.3 Competence of the popular sector of healthcare

Some members, as I have shown, also aim at becoming professionals and not just competent patients. Beyond that, club members and the *shetuan* as a group are concerned with making an impact beyond just their own life path. In the rest of this chapter I want to show that the work of the *shetuan* (and similar groups) helps maintain and cultivate the competence of what Kleinman (1980) has called the popular sector of healthcare. It contributes to the retention and elevation of CM lay knowledge in the wider public on the levels of the individual, the family, the social network and the community. With prevalent practices of self-treatment and most healthcare decisions being made within the family, Kleinman sees the popular sector in Taiwan as more pronounced than in other cultural contexts: "Most families […] saw themselves, rather than the government, the practitioners consulted, or the sick person himself, as most responsible for making decisions about health care" (Ibid., 68).

Interestingly, a lack of trust in CM or a sense of danger around it was quite often referenced in the conversations with my interlocutors, even though all my main interview partners were favorable of CM and relied on it themselves. I also had some conversations with people who were somewhat skeptical of CM. A pharmacy student and former club member who joined the field trip with the NTU *shetuan* doubted that anyone really understood the theory underlying CM. He believed in a scientization approach where especially pharmaceutical CM knowledge should be mined for verifiably effective substances, transferring them into the domain of biomedicine (fieldnotes, May 6, 2018). Most of the concerns around CM, however, revolved around uncertainty in terms of quality control and came up when talking about the *tekao*. Despite the personal difficulties the students experienced due to the academization of CM, none of them rejected this policy entirely. Hao-Cheng and even Hsiao-Chen went so far as to say that they would not take the *tekao* even if they could today, because they believed that the quality and safety of a *tekao*-practitioner was difficult to determine and preferred to go through what they deemed a complete and comprehensive education (Interviews May 17 and 18, 2018).

Others were also concerned with potentially dangerous practices offered by contemporary *zhongyishi*. A synthesis of these stories of concern would paint a picture of practitioners often

of old age offering an amalgamate of therapies originating as much from Daoism, folk religion and medicine, as it does from CM in the form discussed in this paper. In these stories, the practitioners live in the countryside and got their licenses through the *tekao* or have no license at all. They are frequented mostly by the elderly who might occasionally bring along their grandchildren visiting from the city. While some of my interlocutors simply rejected this type of practice, such as Yu-Ting who described it as *mixin* – superstition – and as "still a big problem in Taiwan" (fieldnotes, April 15, 2018), some also thought that on a case by case basis such a practitioner could be either outstandingly skilled or a dangerous charlatan.

Chih-Wei also talked about general negative stereotypes around CM that he wanted to disperse by promoting CM through the work of the *shetuan*: "A lot of Taiwanese people have a bad impression of *zhongyi* and I think that's a shame" (Interview, May 2, 2018). When I asked him why he thought this was the case, he pointed to a prevalence of charlatans in the history of CM. He used the word *jianghu langzhong*, a term that literally translates as "those roaming beyond rivers and lakes [i.e., throughout the whole country]" and historically referred to itinerant doctors (Unschuld and Zheng 2012, 75). Today it is used to simply mean quack or charlatan. "A deceiver" is the English translation that Chih-Wei himself chose.

Indeed, as I have touched upon in chapter 3, the modern history of CM in Taiwan is marked by this kind of insecurity about the safety and quality of CM practice. During the early decades of beginning CM legislation in the 1960s and 70s career paths of CM practitioners were confusingly heterogeneous. Qualification exam standards fluctuated dramatically in the beginning (Unschuld 1973, 30). At the same time, the introduction of registration and certificates itself encouraged many autodidacts to attempt change of career (Ibid., 32). Countless others were practicing without any license whatsoever, often advertising easy cures for at the time incurable diseases, most often cancer. Unschuld writes about the patients' experience: "He can encounter a 70-year-old white haired man who has only been dabbling in the healing arts for two years, or he can meet a 40-year-old physician with 20 years of experience. The patient does not know his doctor's standard of education" (Ibid., 29, translation mine). This has led to a situation where it seems that for many people an interest or reliance on CM is intermingled with carefulness and a degree of skepticism.

The club members shared a worry that without a solid base of knowledge, many people in Taiwan would be exposed to what they deemed inappropriate or deceitful examples of CM and that already existing perceptions of CM as useless, slow, backwards or dangerous would continue to prevail. Every *ganbu* I talked to wanted to promote CM as a healthcare option that

was effective, safe, and different from, but at least potentially up to the standard of biomedicine, if practiced by a competent practitioner. Yi-Lin said the following:

> Overall, many people in Taiwan know a little bit about Chinese medicine, but this knowledge is all very scattered and some of it may be true and some of it false. It may be the same with Western medicine. Both CM and WM should let everyone know more about their correct concepts. […] [B]y consulting each other they should be able to jointly reach their goal of elevating the health of all. So I think that there should be more communication, dialogue and understanding (Interview, April 25, 2018).

Hao-Cheng was also concerned with dialogue. He criticized what he identified as secretive attitudes among *zhongyishi*:

> It's just that *zhongyi* is not so united yet, whereas *xiyi* is very united. In Taiwan many *zhongyishi* still have a secretive attitude, for example their healing technique is very good but they don't want to teach it to other people, whereas in *xiyi* they are encouraged to publish articles. When they discover a new therapy method, they'll publish an article quickly to share the knowledge with everyone, so *xiyi* just progresses more quickly than *zhongyi* (Interview, May 17, 2018).

So in addition to co-creating patient knowledge and cultivating healthcare competence, working towards visibility and acceptance of CM in Taiwanese society is a core function of the *shetuan*. Specifically, CM is here lobbied for as something that should both be accessible to everyone in a form that is perceived as culturally authentic *and* have a certain standard, quality and safety. Drawing these functions together, I argue that the work of the *shetuan* seen as a whole contributes to the competence of the popular sector of healthcare insofar as it furthers and maintains its inclusivity of and expertise with CM against the backdrop of decades of uncertainty around it in Taiwan.

7. Conclusion

During my research in Taiwan and the subsequent analysis and writing, I asked myself two broad questions. The first one concerned the Taiwanese structure of (Chinese) medical education. How does one become a practitioner of CM? What brings one to want to pursue this career and what steps need to be taken? At the same time, I was interested in lay knowledge and practice. The CM *shetuan* I joined were an interesting semi-formal setting of instruction that was situated at an intersection between lay and professional knowledge transmission. Questions of regulation, qualification and certification came up frequently. Thus, my second question became: What is the point of these clubs? What function do they fulfil? How do the clubs engage with, support, critique or even circumvent the regulatory system of medical education?

To answer these questions, I first attempted to contextualize the current CM education system in a wider historical and theoretical context. Its local history is inherently trans-regional, as it combined the modernist influences of Late Imperial Chinese, colonial Japanese and then Republican Chinese healthcare governance (Lei 2014; Ye 2013). In the later 20th century, CM became a global form, its spread and regulation not confined by cultural belonging but directed by global markets, migration, and governance (Ong and Collier 2005; Zhan 2009; Coderey 2020). CM educational policies in Taiwan are influenced both by idiosyncratic local developments and international trends, such as WHO regional development strategies for traditional medicines, policy-making in China, Japan, and Korea, and the emergence of a global interest in CM as CAM (WHO Regional Office for the Western Pacific 2002, 2012; Zhan 2009; Ye 2013; A. Smith 2018).

The young prospective practitioners gathering in the *shetuan* and facing difficulties entering their profession of choice therefore did not only engage with their own local medical politics, but with CM as a field of medical, public health, economic and intellectual interest that had long become global in scale. For Taiwan, in its precarious position of contested or outright threatened sovereignty, a compliance with and participation in these global developments is of vital importance. While CM doctors in the past have argued that restrictions on licensing interfere with the freedom to choose one's profession (Ye 2013, 181), Taiwan's history of CM, summarized in chapter 3, has shown that a lack of regulation also did not lead to the flourishing of CM.

While CM legislation in Taiwan has come a long way since the 1950s, most notably with the inclusion of CM into the NHI, for my interlocutors there was still a lot left to be desired. They criticized the dominant position of biomedicine especially in CM education; CM's still unequal position within the Taiwanese healthcare system; a lack of integration of biomedicine and CM; and a prevalence of disregard and misinformation within the wider public. While some of these points seem contradictory, they point to two extremes resulting from the complex history of biomedical hegemony in Taiwan. On the one side is academized professional CM as standardized transmission (Hsu 1999). It is taught in classrooms and organized to emulate biomedicine. Biomedical knowledge is a requirement to even enter these classrooms and takes up a large amount of the curriculum. While the *shetuan* members agree with the idea of appropriate regulation and qualification procedures, they object to the inaccessibility and the lack of space for actual CM content.

On the other side there is popular or lay engagement with CM. Overall, *shetuan* members lamented a general lack of lay expertise or even interest and trust in CM in the general populace. Whenever my interlocutors talked about existing popular CM practice outside of the *shetuan*, they brought up the prevalence of misconceptions, dangerous practices, superstition, or more neutrally the difficulty to determine the quality of e.g. an unlicensed practitioner. Here, they criticized a lack of knowledge and understanding of the "correct concepts" (see p. 49). The students criticized biomedical hegemony and believed in access to medical knowledge, but at the same time advocated for safety and quality control. They wanted to spread and elevate CM knowledge in society but practiced this in maintenance of their own affiliation with the university complex. As Hsu (1999) has argued, the idea that CM knowledge can be taught to and accessed by anyone, rather than it being tied to the embodied virtuosity of a teacher that can only be transmitted through personal discipleship, is itself an outcome of the modern encounter with biomedicine (Ibid., 159).

Therefore, it seems that the students' engagement did not take the form of protest because their ideas are on a basic level in alignment with that of medical policy in Taiwan. They are equally concerned with issues of safety, quality, health, global competitiveness, scientific validity and the cultivation and protection of heritage. I argue that they use their semi-formal position at the university constructively to partake in the shaping of CM in Taiwan through the reproduction of talent and interest and the communal transmission of knowledge and skill. They use their freedom to curate the content of lessons and thus include topics that would normally not find their way into official curricula, such as *qigong* and other practices of self-cultivation. In this space, young prospective practitioners are supported to develop their interests and gain experience on their ways to become professionals. In this way, the clubs on the one hand cultivate dedicated talent and competence to feed into the official CM education system, where a prioritization of biomedicine leads to a brain drain away from CM (Wiseman 2000; Ye 2013). On the other hand they also contribute to an elevation of CM lay competence in the popular sector of healthcare, which is in line with MOHW plans "to enhance the literacy and correct knowledge of TCM among the public" (MOHW, Department of Chinese Medicine and Pharmacy 2018b). They thus illustrate how lay engagement with medical knowledge can cross over into professional spheres and co-shape healthcare landscapes from below.

8. References

Adams, Vincenne. 2002. “Establishing Proof: Translating Science and the State in Tibetan Medicine.” In *New Horizons in Medical Anthropology: Essays in Honor of Charles Leslie*, edited by Mark Nichter and Margaret Lock, 200–222. London: Bergin and Garvey.

Baer, Hans, C. Jen, L. Tanassi, C. Tsia, and H. Wahbeh. 1998. “The Drive for Professionalization in Acupuncture: A Preliminary View from the San Francisco Bay Area.” *Social Science & Medicine* 46: 533–37.

Barnes, Linda L. 2003. “The Acupuncture Wars: The Professionalizing of American Acupuncture--a View from Massachusetts.” *Medical Anthropology* 22 (3): 261–301. doi:10.1080/01459740306772.

Cheng, David Hui-Wen. 2017. “Taiwan's Contributions to Global Health.” WHA 2017: Partizipationsmöglichkeiten Taiwans, Berlin, May 16.

Chi, Chunhuei. 1994. “Integrating Traditional Medicine into Modern Health Care Systems: Examining the Role of Chinese Medicine in Taiwan.” *Social Science & Medicine* 39 (3): 307–21.

Chi, Chunhuei, Jwo-Leun Lee, Jim-Shoung Lai, Chiu-Yin Chen, Shu-Kuei Chang, and Shih-Chien Chen. 1996. “The Practice of Chinese Medicine in Taiwan.” *Social Science & Medicine* 43 (9): 1329–48. doi:10.1016/0277-9536(95)00429-7.

Chiang, Howard, ed. 2015. *Historical Epistemology and the Making of Modern Chinese Medicine.* Oxford: Manchester University Press.

Coderey, Céline. 2020. “Introduction: Governance and Circulation of Asian Medicines.” In Coderey and Pordié 2020, 1–23.

Coderey, Céline, and Laurent Pordié, eds. 2020. *Circulation and Governance of Asian Medicine.* Abingdon, Oxon, New York: Routledge.

Collier, Stephen J., and Aihwa Ong. 2005. “Global Assemblages, Anthropological Problems.” In *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, edited by Aihwa Ong and Stephen J. Collier, 3–21. Malden, MA: Blackwell Publishing.

Croizier, Ralph. 1967. *Traditional Medicine in Modern China.* Cambridge: Harvard University Press.

deLisle, Jacques. 2014. “Taiwan and Soft Power: Contending with China and Seeking Security.” In *Political Changes in Taiwan Under Ma Ying-Jeou: Partisan Conflict, Policy Choices, External Constraints and Security Challenges*, edited by Jean-Pierre Cabestan and Jacques deLisle, 265–95. Hoboken: Taylor and Francis.

DelVecchio Good, Mary-Jo, and Byron J. Good. 1989. “Disabling Practitioners: Hazards of Learning to Be a Doctor in American Medical Education.” *American Journal of Orthopsychiatry* 59 (2): 303–9.

Despeux, Catherine. 2008. “Yangsheng: Nourishing Life.” In *the Encyclopedia of Taoism Volume II, M - Z*, edited by Fabrizio Pregadio, 1148–50. London: Routledge.

Farquhar, Judith. 1987. “Problems of Knowledge in Contemporary Chinese Medical Discourse.” *Social Science & Medicine* 24 (12): 1013–21.

———. 1994. *Knowing Practice: The Clinical Encounter of Chinese Medicine.* London, New York: Routledge.

———. 2012. “Knowledge in Translation: Global Science, Local Things.” In *Medicine and the Politics of Knowledge*, edited by Lesley Green and Susan Levine, 153–70. Cape Town: Human Sciences Research Council Press.

———. 2015. “Metaphysics at the Bedside.” In Chiang 2015, 219–36.

Freidson, Eliot. 1994. *Professionalism Reborn: Theory, Prophecy and Policy.* Cambridge: Polity Press.

Gramsci, Antonio. 1971. *Selections from the Prison Notebooks. Ed. Quintin Hoare and Geoffrey Newell-Smith.* London: Lawrence and Wishart.

Hale, Erin. 2020. “Politics of Coronavirus: Taiwan, China and WHO.” *Al Jazeera*, February 6. Accessed February 19, 2020. https://www.aljazeera.com/news/2020/02/politics-coronavirus-taiwan-china-200205080601495.html.

Hsu, Elisabeth. 1999. *The Transmission of Chinese Medicine.* Cambridge: Cambridge University Press.

Karchmer, Eric I. 2015. “Slow Medicine: How Chinese Medicine Became Efficacious Only for Chronic Conditions.” In Chiang 2015, 188–216.

Kleinman, Arthur. 1980. *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry.* Berkeley: University of California Press.

Lan, Pei-Chia. 2011. “White Privilege, Language Capital and Cultural Ghettoisation: Western High-Skilled Migrants in Taiwan.” *Journal of Ethnic and Migration Studies* 37 (10): 1669–93. doi:10.1080/1369183X.2011.613337.

Last, Murray. 1990. “Professionalization of Indigenous Healers.” In *Medical Anthropology: A Handbook of Theory and Method*, edited by T. Johnson and C. Sargent, 374–95. New York: Greenwood Press.

Law, John, and Wen-Yuan Lin. 2017. “Provincializing STS: Postcoloniality, Symmetry, and Method.” *easts* 11 (2): 211–27. doi:10.1215/18752160-3823859.

Lee, Hyun-Ji, Seung-Pyo Hong, and Shu-Min Huang. 2005. “The Process of Professionalization of Traditional Korean Medicine.” *Asian Anthropology* 4 (1): 137–48. doi:10.1080/1683478X.2005.10552554.

Lei, Sean Hsiang-lin. 2014. *Neither Donkey nor Horse: Medicine in the Struggle over China's Modernity.* Chicago: University of Chicago Press.

Lin, Wen-Yuan. 2016. “Shi (勢), STS and Theory." *Science, Technology, & Human Values* 42 (3): 405–28. doi:10.1177/0162243916671202.

Lin, Wen-Yuan, and John Law. 2014. “A Correlative STS: Lessons from a Chinese Medical Practice.” *Social Studies of Science* 44 (6): 801–24. doi:10.1177/0306312714531325.

Liu, Lihong. 2019. *Classical Chinese Medicine.* Hongkong: Chinese University Press.

Luesink, David. 2015. “State Power, Governmentality and the (Mis)Remembrance of Chinese Medicine.” In Chiang 2015, 160–87.

MOHW, Department of Chinese Medicine and Pharmacy. 2018a. “The Development of Traditional Chinese Medicine in Taiwan: International Exchanges for Traditional Medicine.” Accessed November 26, 2019. https://www.mohw.gov.tw/cp-3702-38848-2.html.

———. 2018b. “The Development of Traditional Chinese Medicine in Taiwan: The Quality Control of TCM.” Accessed November 26, 2019. https://www.mohw.gov.tw/cp-3701-38847-2.html.

———. 2018c. “The Development of Traditional Chinese Medicine in Taiwan: Traditional Chinese Medicine Healthcare.” Accessed October 25, 2019. https://www.mohw.gov.tw/cp-3700-38841-2.html.

Mol, Annemarie. 2003. *The Body Multiple: Ontology in Medical Practice.* Durham, NC: Duke University Press.

Ong, Aihwa, and Stephen J. Collier, eds. 2005. *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems.* Malden, MA: Blackwell Publishing.

Pearce, Tola Olu. 1993. "Lay Medical Knowledge in an African Context." In *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life*, edited by Shirley Lindenbaum and Margaret Lock, 150–65. Berkeley, Los Angeles: University of California Press.

Peng, Wan-Hsin, and Sherry Hsiao. 2017. "Using Medicine as Soft Power to Strengthen Ties." *Taipei Times*, December 17. Accessed July 07, 2019. http://www.taipeitimes.com/News/taiwan/archives/2017/12/17/2003684133.

Pols, Jeannette. 2013. "Knowing Patients: Turning Patient Knowledge into Science." *Science, Technology, & Human Values* 39 (1): 73–97. doi:10.1177/0162243913504306.

Scheid, Volker. 2002. *Chinese Medicine in Contemporary China: Plurality and Synthesis.* Durham, NC: Duke University Press.

Schühle, Judith. 2018. "State-of-the-Art or the Art of Medicine? Transnational Mobility and Perceptions of Multiple Biomedicines Among Nigerian Physicians in the U.S." *Global Public Health* 13 (3): 298–309. doi:10.1080/17441692.2017.1337799.

Smith, Arielle. 2018. *Capturing Quicksilver: The Position, Power, and Plasticity of Chinese Medicine in Singapore.* New York, Oxford: Berghahn.

Smith, Nicola. 2018. "Taiwan Loses Third Diplomatic Ally This Year as El Salvador Defects to China." *The Telegraph*, August 21. Accessed July 08, 2019. https://www.telegraph.co.uk/news/2018/08/21/taiwan-loses-third-diplomatic-ally-year-el-salvador-defects/.

Spradley, James. 1979. *The Ethnographic Interview.* New York: Harcourt Brace Jovanich College Publisher.

Sumika, Masayoshi. 2016. "Nationalism, Religion, and Social Darwinism: Nation and Religion in the Works of Kato Genchi and Liang Qichao." *Religious Studies in Japan* 3:21–39. doi:10.20716/rsjars.87.1_1.

Taylor, Kim. 2005. *Chinese Medicine in Early Communist China, 1945-1963: A Medicine of Revolution.* Hoboken: Taylor and Francis.

Unschuld, Paul U. 1973. *Die Praxis des Traditionellen Chinesischen Heilsystems.* Wiesbaden: Steiner.

———. 1985. *Medicine in China: A History of Ideas.* Berkeley: University of California Press.

———. 1992. "Epistemological Issues and Changing Legitimation." In *Paths to Asian Medical Knowledge*, edited by Charles M. Leslie and Allan Young, 44–61. Berkeley: University of California Press.

Unschuld, Paul U., and Jinsheng Zheng. 2012. *Chinese Traditional Healing: The Berlin Collections of Manuscript Volumes from the 16th Through the Early 20th Century.* Leiden: Brill.

Wang, Jun, and Judith Farquhar. 2010. "Knowing the How but Not the Why: A Dilemma in Contemporary Chinese Medicine." *Asian Medicine* 5: 57–79.

Wang, Simeng. 2020. "Circumventing Regulation and Professional Legitimization – the Circulation of Chinese Medicine Between China and France." In Coderey and Pordié 2020, 139–56.

Wang, Xiangcheng, and Tao Sun. 2014. "China's Engagement in Global Health Governance: A Critical Analysis of China's Assistance to the Health Sector of Africa." *Journal of Global Health* 4 (1): 1–4.

Wendland, Claire L. 2010. *A Heart for the Work: Journeys Through an African Medical School.* Chicago: The University of Chicago Press.

WHO. 1978. "Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978." Accessed January 15, 2020. https://www.who.int/publications/almaata_declaration_en.pdf.

WHO Regional Office for the Western Pacific. 2002. "Regional Strategy for Traditional Medicine in the Western Pacific." Accessed December 22, 2019. https://apps.who.int/iris/bitstream/handle/10665/206953/9290610115_eng.pdf?sequence=1&isAllowed=y.

———. 2012. "The Regional Strategy for Traditional Medicine in the Western Pacific (2011-2020)." Accessed December 22, 2019. apps.who.int/medicinedocs/documents/s21364en/s21364en.pdf.

Wiseman, Nigel. 2000. “Education and Practice of Chinese Medicine in Taiwan.” Rothenburg, June 1. Accessed June 26, 2019. www.paradigm-pubs.com/sites/www.paradigm-pubs.com/files/files/TAIWAN.pdf.

Ye, Yong-Wen. 2013. *Taiwan Zhongyi Fazhan Shi. Yi Zheng Guanxi.* 台灣中醫發展史 - 醫政關係 [the History of Chinese Medicine in Taiwan. On the Relationship Between Medicine and Politics]. Taipei: Wunan Chuban.

Zhan, Mei. 2009. *Other-Worldly: Making Chinese Medicine Through Transnational Frames.* Durham: Duke University Press.