The Body in Western and Chinese Medicine : Discourses and Practices

Diane M. Lemire
East Asian Studies Department
McGill University, Montreal
July, 2000

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Master of Arts.

Table of contents i

Abstract

This thesis is about the body and about how medical discourses conceptualise the body in health and in illness. However, any inquisitiveness about the body is determined by historical, social and political environment that nurtures the discursive formations of knowledge. I focus particularly on the conceptualisation of the body in the two distinct medical traditions of Western and Chinese medicine. I examine Michel Foucault's analysis on the medical *gaze* and on the external technologies of power deployed on the body of the individual and on the social body. The knowledge generated from the medical gaze is articulated through a normalising and prescriptive discourse. The gaze of Chinese medicine that looks at the workings of the cosmos to define the truth about the body generates similar authoritative knowledge that targets the individual and the social body. However, this effect of power, although it never disappears entirely, undergoes significant transformations when it enters the arena of human activities and the potential for improvisation in the behaviour of the human actor. There is always a gap between the text and the practice.

Résumé

Une étude qui porte sur le corps humain et sur les discours de la médecine qui le définit, se doit, d'abord et avant tout, d'analyser et de prendre en considération les circonstances autant historiques que sociales et politiques qui les entourent. Dans ce mémoire, je me concentre sur la conceptualisation du corps telle que décrite dans le discours de la médecine occidentale et de la médecine chinoise, ainsi que sur l'évolution historique de ces concepts. Je porte une attention spéciale à l'analyse de Michel Foucault sur le *regard* médical et sur les disciplines de pouvoir effectuées sur le corps individuel et le corps social. La connaissance qui découle de ce pouvoir du regard s'articule dans un discours qui définit l'être social normal, producteur, reproducteur et surtout apprivoisé. Le regard de la médecine chinoise qui se tourne vers le cosmos et associe le mouvement céleste à la vérité du corps en lieu de l'anatomie grecque produit pour autant une connaissance médicale autoritaire visant elle aussi le corps social. Malgré tout, ces notions de pouvoir et de connaissances se diffusent rapidement, sans pour autant disparaître, par rapport au champs d'action et d'improvisation de l'être humain. On se retrouve toujours à mi-chemin entre le texte et le vécu.

Acknowledgments

Writing the following acknowledgments is for me the most rewarding aspect related to the completion of this thesis. I can finally officially thank the people who contributed to the preparation and writing of this manuscript. This thesis could not have been written without the support of those around me and I would like to take this opportunity to express my gratitude for their involvement in this project. I would particularly like to thank my supervisor, Professor Robin Yates, for his academic guidance and his sustained support. His constant attention to details, especially colons and semi-colons, showed me the importance of precision in academic work and, most importantly, it made me realize how much time he spent correcting my papers. I am grateful for his faith in me, for his availability and for his exceptional patience. I would also like to thank my co-supervisor, Professor Allan Young for his support. Professor Margaret Lock's lectures and publications have been a great source of inspiration and I wish to extend my thanks to her as well. Special thanks to Professor Grace Fong who was always there for me when I needed assistance or encouragement. I also wish to thank all my classmates and also Suan Ong, the administrative assistant of our department, for her inestimable help and her great sense of humour and all of those whose name does not appear and who contributed directly or indirectly to the completion of this thesis.

These acknowledgments would be incomplete if I did not mention those who are dearest to me, my husband Bob and my parents. Thank you so much for believing in me. This thesis is dedicated to you with all my love.

Introduction

In this thesis, I wish to explore interpretations of the human body that relate to its ontology. I shall argue that medical discourse and the formulation of truth about the body are historically and culturally situated and that human activities contextualise that discourse through practice, embodiment and subjective agency. I shall focus primarily on divergent perspectives that view the body as a construct of medical knowledge, as a target site for the imposition of power, and as a subject body.

The complexity of this topic imposes severe limitations with regard to a conclusive or exhaustive research; the enigmatic nature of the body itself prevents this. Consequently, the analysis presented in this thesis is constrained by the vastness of the topic and by the want of general consensus manifest in the literature with regard to the ontology of the body. Therefore, the methodology of this work does not focus on a microanalysis of the Chinese and Western medical discourses and practices and chronology is not the primary concern of this thesis. Rather, I intend to peruse some of the general transformations in medical representations of the body as they evolved over time. The use of secondary literature as opposed to primary sources imposes some limitations with regard to chronology and homogeneity of interpretation by different authors. However, for the purpose of this thesis, reliable secondary sources do provide a broad and general survey of the historical

transformations of medical representations of the body, in both Chinese and Western medical contexts.

Concurrent corporeal and sentient idiosyncrasies of the body preclude any simplistic definition as to its elusive ontology. The perspectives of different medical traditions focus on the body to understand the processes involved in health and illness and to provide therapies. However, perception and interpretation of the healthy and sick body depend on historical contexts and perspective. Discursive formations of medical theories and practices that generate concepts about the body are intimately bound to the environment that nurtures them and, as Margaret Lock argues, the resultant epistemologies are not privileged with *a-historical* and *value-free* status, rather, they represent what Kuriyama refers to as "different versions of the truth" (Lock 2000, lecture; Kuriyama 1999).

Contemporary biomedical discourse suggests a representation of the body that is grounded in scientific facts and claims that universal scientific principles can be used to explain the causes of diseases and to suggest appropriate therapies. In this thesis, I wish to examine this particular scientific version of the truth about the body and diseases from Western medicine's own historical and developmental perspective and to establish a comparative analysis that investigates the discursive formation of the Chinese medical body of knowledge. Medical traditions are neither spontaneous nor static bodies of knowledge that emerge from the past unaltered by ideological, socio-political, economic, linguistic and foreign

influences. Rather, bodies of knowledge have evolved and have been transformed over their long historical development. Concepts of the body formulated by medical theories are influenced by historical and contextual transformations and remain susceptible to modulations. The integration of scientific principles into Western medical theories is a striking example of historical influences that instigated a radical change in theoretical framework and perspective with regard to concepts of body, health and disease. Concurrent factors involving demographic and economic changes, intellectual thought advocating reason and objectivity are some examples of the factors that contributed to the fundamental shift in the Western medical epistemic reorientation that occurred during the eighteenth century in Europe. Chinese medical thought was similarly influenced and transformed by the dynamics of different historical and contextual changes. However, the two medical bodies of knowledge did not merge into an ultimately identical body of medical knowledge. Rather, their paths did not converge because each perceived the world from a different perspective and generated medical knowledge based on that perspective (Kuriyama 1999). Furthermore, the contemporary integration of scientific medicine in China welcomed 'scientific' medical principles, yet it would appear that the Western body of medical knowledge has not been integrated as a whole into Chinese medical thought.

Nathan Sivin has argued that the cosmological concepts that govern Chinese medical thought were fundamentally moral and political from the start and continued throughout history, notwithstanding several changes in their meanings

(Sivin 1995, chapter IV, 2). Sivin's argument is congruent with Western medical thought from ancient Greece to contemporary biomedicine as evidenced in Michel Foucault's numerous publications on medical knowledge, power and bio-power. Foucault's analysis with regard to the formation of medical knowledge about the body and the consequent external disciplines of power deployed on that body are central to my thesis with regard to Western and Chinese discursive formations about the body and the intrinsic moral and political motivations that accompany the discourse. However, as discourses percolate within the sphere of human activities and practices, the truths or prescriptions they convey face an inescapable fate of translation and interpretation imposed by the interactive and dynamic networks of human agency and resistance (Bourdieu 1972; Latour 1984). However, albeit a concrete tangibility and apparent malleability as an object of knowledge and control, the body remains an enigmatic figure fluctuating from subject to object on an ontological continuum and the experiential subject body undoubtedly challenges a static ontological confinement to mere "construct".

I have divided this thesis into three chapters to examine the discursive formations of Western and Chinese medicine with a particular focus on the moral influences and the political designs that accompany such discourses and to explore the world of a subject body in the sphere of practice and experience. The first chapter investigates some historical aspects that contributed to the formation of Western medical discourse on the body. This chapter focuses specifically on the fundamentally scientific version of the truth that evolved the *medical gaze* as described by Foucault

and on the authoritative knowledge produced by a *gaze* that used the body as an object of knowledge. The first chapter discusses a new refinement in external technologies of power that could be effected on the body to benefit political and economic interests and help extend the surveillance and control of the social and political body. The second chapter explores the formation of medical discourse in the context of Chinese medicine and describes the cosmological principles fundamental to Chinese medical theories. Chinese medical theories disregard the anatomical focus so foremost in Western medicine and focus instead on the functional correspondence of body physiology. Of particular interest in this chapter is the contemporary integration of scientific medical theories into the Chinese body of knowledge and of a coexistence of biomedicine and Chinese medicine as official and distinct medical systems. In the last chapter I step down from the official medical discourse and explore the sphere of human activities and look at the impact of a prescriptive medical discourse on individuals and collectives. Pierre Bourdieu has stressed the inevitable embodiment of social and cultural prescriptions by individuals and collectives. However, he contends that human agency and improvisation involved in human interactions in everyday life are not always congruent with the rules. I hope this last chapter will demonstrate how the forms of embodiment and bodily practices of experiential subject bodies involve agency and resistance beyond the sphere of discourse.

Chapter 1

Conceptualisation of the Body in Western Medicine

In this chapter, I wish to examine the scientific version of the truth about the body and disease beginning with Western medicine's historical development and perspective. I shall describe how the Western medical tradition was transformed into a contemporary biomedical body of knowledge bearing so much authority with regard to the human body and its management. I shall first investigate some general propositions about the history of the Western medical tradition from its Greek origins to the present day with a focus on the eighteenth century epistemic shift that occurred concurrently with a consolidation of scientific positivism. The framework of this chapter outlines Michel Foucault's analysis of the development of Western medical constructs of the body, his notions of power/knowledge and bio-power. It is followed by a critical discussion of his theories from congruent or divergent scholarly perspectives.

There exists a rich variety of scholarly works written on the body by authors from various disciplines such as sociology, anthropology, psychology and philosophy, yet none is equal in impact to the massive work of Michel Foucault. Foucault produced a groundbreaking study on the historical evolution, in the context of eighteenth century France, of a medical *gaze* that focused on the body as its object of

knowledge, as the age of reason and scientific revolution progressed and, in the process, displaced the custodian role of the church from the body to the realm of the soul and the spiritual. He describes how the medical *gaze*, after penetrating the darkest secrets of the bodies of the dead, transformed medicine into a scientific and authoritative body of knowledge. Over time, this medical *gaze* acquired a privileged status of ownership of the knowledge it generated and, as a consequence, biomedicine and biomedical practitioners have inherited almost exclusive rights over the bodies of individuals. Moreover, Foucault describes how Western medicine gained the legitimate mandate to define health/illness within newly determined classificatory parameters of normal and abnormal physical and mental states (Foucault 1973). The scientific empowerment and legitimisation of biomedicine with regard to sick and healthy bodies offers appealing features that can serve the agendas and interest of third parties such as the State, pharmaceutical conglomerates, insurance companies, legal systems and other institutions.

Historical Perspective

It should not be assumed that medical traditions necessarily represent static and coherent bodies of knowledge. On the contrary, they represent the product of historical and contextual discursive formations and transformations of ideas (Foucault 1977; Unschuld 1984). To fully understand contemporary biomedicine's epistemological framework and medical practices, one must navigate the past back

to the origins and evolution of Western medical thought, in time and in space, as it was first formulated in ancient Greece and as it spread to Europe while being subjected to continuous transformations.

Naturalism and the Greek Humoral Tradition

A thorough and detailed description of ancient Greek medicine exceeds the scope of this thesis and I shall restrict my description to a general account of medical thought and orientations as recorded in literary discourse. In several ways, medical discourse in ancient Greece reflected more similarities with other medical traditions, such as those found in Chinese traditional medicine or Indian Ayurvedic medicine, than with its modern version. *A priori* concepts about the human body existing as an integral part of nature and the universe and subjected to natural phenomena with regard to bodily processes, health and illness were pervasive in ancient philosophical thought and Hippocratic theories (Nutton 1995, 23). Vestiges of a literary medical tradition can be traced back to the Hippocratic Corpus (circa 420 BC), which represents the earliest surviving medical texts of Greek medicine (Nutton 1995, 12). Pre-Socratic philosophers (sixth century BC) had already seeded subsequent medical theories with concepts of balance, analogy, correspondences, homologies and climatic influences over the body, health and disease (Nutton 1995; Foucault 1973; Kuriyama 1999). Notions of balance and homology were articulated in the humoral system, that portrayed the four humours of blood, bile, black bile and phlegm as elements of an intimate and interactive relationship with the four seasons,

human life cycles, the four elements of air, fire, earth and water and the four primary qualities of hot, dry, cold and wet (Nutton 1995, 24-25). The correspondence of the elements involved in the balance of the humoral system provided the framework and rationale for the treatment of disease: maintaining or restoring homoeostasis within the body remained the essential task of the practitioner as well as the individual's personal responsibility (id.). Kuriyama pointed out that accumulation of 'excess blood' (plethora), which originated in overindulgence and lethargy, was the greatest threat to internal homoeostasis and it led to putrefaction, fevers and inflammations (Kuriyama 1999, 206-23). The medical imperative to rid the body of 'excesses' in order to restore the inner state of the person promoted the liberal use of phlebotomy and evacuants (emetics and cathartics) (Kuriyama id.). A particular prophylactic emphasis was placed on "diet" or "regimen", which touched on all aspects of the life-style of individuals including food and drink, exercise, daily activities and the stringent management of pleasures, particularly those of a sexual nature (Nutton 1995; Foucault 1985; Kuriyama 1999). It should be noted that homoeostasis represents balance of the internal environment of the body thus suggesting an "internal environment that is universal" and precludes mutual influences with the external environment which represent a fundamental concept in Chinese medicine (Young 2000).

Within this system of correspondence, the body shared spatio-temporal affinities with the whole of nature. Man exists in nature just as other natural phenomena, subjected to the laws of the ordered cosmos and what differentiates him from other

animals is that he is endowed with 'reason' (Nutton 1995, 23). Climatic influences such as dampness or dryness, seasonal changes as well as the direction of warm or cold winds could induce all sorts of ills in the human body (Kuriyama 1999, 234). The body's integrity thus was directly susceptible to external influences, in particular, seasonal changes and winds (Kuriyama 1999). Kuriyama argues that winds, depending on their directional origin and seasonal factors, could bear life sustaining and character forming properties that defined the body (ibid.). He further claims that the concept of winds and their properties played an important role in the formation of Greek identity (strong, resilient and superior) and of the Greeks' perception of an inferior alterity in other peoples who were subjected to warmer climates and exposed to inauspicious winds (id.). Ambient air (winds), once breathed into the body, assumed the form of *pneuma*, a vital breath of spiritual and divine essence (soul), which travelled throughout the body via the nerves to the brain. Kuriyama describes how the internalisation of winds into the body helped shape Greek perception and boundaries of the "self" which consisted of a natural material form and of superior spiritual soul (Kuriyama 1999). This could be viewed as a potential seedling of a future Cartesian dichotomy.

From early on, the Greek literary tradition presented explanatory models of disease that were dissociated from the "supernatural" and structured within a theoretical and rational framework (Turner (1984) 1996). Turner further points out to the noble calling and moral qualities of the literate doctors who distanced themselves from the lowly 'manual' activities and pecuniary concerns of the 'wandering craftsmen' (id.,

90). The emphasis placed on the cultivation virtue for the accomplished Greek citizen ennobled the activities of such literate doctors. An emphasis on theory, which went beyond somatic symptoms enhanced the literate doctor's status and transferred the responsibility of curative failures to the patient (ibid., 93).

Notions of correspondence, analogy and resonance between man, nature and the universe present similar characteristics to those of traditional Chinese medical theories and other medical traditions. However, basic differences in perspectives, such as focussing on a quantifying rhythm of the pulse as opposed to metaphorical descriptions of the qualities of the Chinese pulse, and in "ways of understanding" the language of the body eventually led Greek and Chinese medicine to a bifurcation in orientation (Kuriyama 1999). The practice of animal dissections and a focus on anatomy entailed a visual and empirical orientation of medical inquisitiveness, a feature that persisted until the present in the quest for a single and universal truth (Unschuld 1992). Sivin remarks that most fundamental difference between the Chinese medical tradition and the Greek tradition lies in the propensity for Greek culture to encourage debates and disputation in philosophy and in science as opposed to the Chinese emphasis on consensus (Sivin 1995, chapter IV, 8). While the Greek medical tradition replaced the old with the new, and several schools or traditions of medicine coexisted, the Chinese tradition accumulated knowledge by integrating the new in the old (Sivin 1995).

The writings of Galen (second century) acquired a special authority in the evolution of Western medicine probably because of his "impeccable rigor and consistency of applied logic" (Nutton 1995, 64). He used the writings of Hippocrates as a model and stepping-stone for his own writings (Nutton 1995, 63)) and favoured experimentation (Nutton 1995). His conception of the male and female body reveals some interesting features in that they share the same anatomical structures as well as isomorphism of the sexual acts in the following manner: " turn outward the woman and turn inward the man and you find the same in both in every respect" including the "emission of sperm by the women" (Foucault (1984) 1988, 106-112). An important feature of Galen's work focuses on the sexual act and its medical implication on the health of the body. For Galen, the sexual act is extremely violent during ejaculation that withdraws not only sperm, but also vital *pneuma*, and, while sex is not harmful, it can be dangerous (Foucault 1984 (1988), 106-112). The consequences of not ejaculating implies an imbalance of the humors leading to retention and pathological excesses, while the consequences of unlimited ejaculation leads to the depletion of vital breath, which is just as dangerous (ibid). Such ambiguity with regard to the sexual act can only prescribe the careful management of sexual activities, not as a moral issue but rather as a health issue.

During the same period, a new actor emerges in the spheres of healing practices in the form of Christianity. The spread of reports with regard to the miraculous healings performed by Jesus Christ and his disciples as well as the charitable dispositions of this new religion that advocated tolerance to/and comfort for human

suffering brought some controversy in the medical world with regard the non-secular nature of healing proffered by the church (Nutton 1995, 73-77). However, the ethic and benevolence that were associated with Hippocratic teaching could easily turn the Hippocratic physician into "a model of Christian medical charity" (Nutton 1995, 74).

The fundamental concerns of Christianity with regard to an 'eternal soul' and 'sins of the flesh' suffused the Greek concepts of a natural sexual act with a morality that restricted the performance of the sexual act to monogamous couples exclusively for reproductive purposes in the privacy of their bedroom (Foucault 1976). A church that was the legitimate guardian of the soul needed to protect the body and the soul against sins of the flesh together with sins committed in the mind (id.). Hence the requirements for prescriptive discourse with regard to the moral conduct necessary for salvation and embodied within this discourse was the need for surveillance by means of the confessional (Foucault 1976, 1973). Surveillance through confession was an important characteristic of the Christian world that was reformulated as an external technology of power in the form of psychoanalysis, a necessary complement to a secular medicine of the Cartesian legacy (Foucault 1976, 1973).

Cartesian Dualism

Discursive formation and practices of Western medicine, albeit a continuous ebb and flow of transformations since Hippocrates and Galen, continued throughout to seek knowledge in the anatomical mappings of the body by means of human dissections. Dissections of human bodies symbolised a bodily transgression of Christian morality which eager anatomists of Southern Europe resolved by performing dissection on the bodies of executed criminals as a form of redemption (Wallis 2000; Lock 2000). Medical knowledge about the anatomy and functions of the body observed through dissections readily appropriated the emerging and popular "mechanical" philosophy of seventeenth century Europe and applied it to the body (Wear 1995). Empirical and mathematical experiments, such as those that led Harvey to his theory of blood circulation and the pumping action of the heart (1628), permeated the sphere of medical discourse (ibid.). The overwhelming embrace of a "secular" worldview with regard to the workings of the body and disease somewhat distanced learned medicine from Christianity's beliefs in the relationship between disease and the retribution for sins. However, death and dying remained a religious event from which doctors were excluded, at least for a short period (id., 240-241). Nonetheless, Foucault alludes to the covert activities of grave robbing, which were widespread and provided doctors with bodies for dissection prior to the more general acceptance of the practice (Foucault 1973).

The 'age of reason' and the scientific revolution associated with the Renaissance period in Europe stimulated fragmentation and multiplication of philosophical thought, and it is during this period that Rene Descartes postulated his problematic theory of the body as a machine and of the mind/body dualism whereby 'the mind is a superior immaterial substance beholding consciousness and the body is a material substance subjected to the laws of physics' (Armstrong 1999, 3; Wear 1995). Although the concept of the mind/body dualism is attributed to Descartes, Margaret Lock pointed to recent thinking, which argues that other lesser known philosophers were possibly already involved in developing this theory (Lock 2000). Armstrong argues that Descartes' dualism created a significant break with the Aristotelian tradition that viewed the human body as part of the natural organic world whereby all organic things possessed a "vegetative soul", animals a "sensitive soul" and humans a "rational soul" (Armstrong 1999, 12, 25 notes, 2). It should be noted that this same Aristotelian theory focused on the person in the context of free man/citizen and viewed women and slaves as inferior beings and non-persons (Turner 1984; Foucault (1984) 1988, 160). Some contemporaries and later philosophers rejected Descartes' mind/body dualism, but his theory provided medicine with a free access to a material body unhindered by spiritual connections and tied to secular laws (Armstrong 1999; Wear 1995; Scheper-Hughes and Lock 1987, 9).

The Foucauldian Body

Michel Foucault posits that, in France, the eighteenth century constituted a temporal epicentre of change in the trajectory of Western medical epistemology and a fundamental shift in the spatial reorganisation of bodies and diseases (Foucault 1973). He describes how the reorientation of medical perspective was not a spontaneous isolated event but rather it was a historical process influenced by social, political, demographic and scientific factors (id.). The following explores Michel Foucault's analysis of the historical evolution of medical constructs of the body and of diseases and of the repercussions such constructs implied for the status of medicine, of the individual and of society. The following section does not, however, consist of a chronological and meticulous historical account of Western medicine, rather it explores the overall transformative process of what Michel Foucault refers to as the 'medical gaze' which originated in eighteenth century France and with regard to the body and the accession of medical discourse to the status of authoritative and prescriptive discourse. The medical gaze embodies the long Greek tradition of observing nature and the form of things. Kuriyama points to the particular importance given to the form and the outline of muscle in the Greek artistic representations of the human body (Kuriyama 1999). Hence the importance of a medical gaze that can now look at tissues that are tangible and most of all because the Cartesian reasoning argues that reality lies in perception (Foucault 1973).

The Body as an Object of Knowledge: the Medical Gaze

The most important legacy of Cartesian dualism for an emerging scientific medicine resided in the secular body. An arbitrary mind/body dualism provided medicine with a *carte blanche* to appropriate the body in the name of empirical and legitimate scientific pursuits. Earlier Greek concepts that the body was an animal endowed with reason did not entail the radical division of Cartesian dualism. Any residual links of the human body to nature or the spiritual gradually evaporated (from the official lines of discourse) under the scrutiny of an "objective" medical gaze that peeled away the impenetrable layers of the body to reveal its hidden truth (Foucault 1973). The first breach of bodily boundaries and of religious propriety took place with the medical invasion of the bodies of the dead in search of etiological organic lesions within the internal organs. Foucault refers to this process in vivid terms: "Knowledge spins where once larva was formed" (Foucault 1973, 125). Originating in a new power over the body, the accumulated data obtained from these autopsies disclosed pathological lesions and processes and yielded knowledge with the potential to become a new source of life for the living diseased body (Foucault 1973, 1980). In this manner, medicine gained a privileged and practically unlimited access to the bodies of the dead and of the diseased and assumed the power over life (id.).

The knowledge revealed through the autopsies provided information that proved invaluable in the treatment people afflicted with diseases, which meant that the

health of the population could be improved. Healthy bodies can produce more and cost less to the state (Foucault 1973). To facilitate this access, the bodies of the sick were uprooted from the traditional home and family environment and placed within the more controlled environment of the hospital under an omnipresent medical gaze (Foucault 1973). The transfer of sick people to hospitals created a controversy because, at the time, hospitals were perceived a nesting ground for diseases and a place for the poor and destitute, but the transfer was effectuated and has continued to this day (id.). Foucault points out that a growing incentive from the State to provide social assistance for the destitute and to keep epidemics under control created a decisive *rapprochement* between public health, medicine and the State that led to the institutional spatialisation of disease and resulted in the inclusion of the individual and the collective body of the military, schools, work place, prisons, religious bodies and families (Foucault 1973, 20-23).

Spatial relocation of sick individuals to within the scope of a knowing and medical gaze had several ramifications with regard to concepts of the body and of the individual. Firstly, it dislocated sick individuals from their natural environment and aggregated them in the controlled environment of the clinic whereby they would be observed, evaluated and classified by what Foucault refers to as the "normalizing gaze" (Foucault 1977, 184). Secondly, the medical examination performed within the clinical setting and the meticulous recording of all observations and findings in the patient's chart transforms the individual into a "case" (Foucault 1977, 191). As a result of the empirical orientation of medical knowledge and newly developing

language of rational thinking and objective causality, the ontology of the body needed to be "objectified" and the patient abstracted in order to *know* the embodied disease (Foucault 1973). The medical gaze could now peruse a body that existed as a reified, individual and pathological entity. The clinical setting whereby a medical gaze carried on unimpeded fostered a new "way of teaching and saying" and became a "way of seeing and learning" (Foucault 1973, 64).

The observation of clinical symptoms combined with anatomical knowledge enabled doctors to *decipher*, *translate* and *interpret* the language of bodily symptoms into the language of positive science using differential diagnosis (analogy, reduction and elimination) to determine specific localisation of pathological lesions and their nosology (Foucault 1973). Perceptual acuity of the gaze could then, in theory, begin to differentiate between organic and non-organic pathologies, the normal and the abnormal. Foucault points out that medical positivism provided the medical gaze with "absolute epistemological privilege" with regard to a pathological anatomy that was "objective, real, unquestionable and increasingly predictable" (Foucault 1973, 129-30). However, Lock commented that Foucault did not provide sufficient information "to understand why this was so" adding that this change "is much more problematic than Foucault suggests" (Lock 2000). However, Foucault focuses on the structures of the state and the hegemony of the medical gaze but neglects the cultural aspects of human interactions and the more specific activities involving resistance and agency (Lock 2000).

External Technologies of Power and the Transparent Body

By the end of the eighteenth and the beginning of the nineteenth century the concept of "pathological", hence "abnormal", aetiology of disease was establishing itself in the modern discourse of biomedical knowledge and practice. Moreover, it has granted science the right to congregate all forms of deviance, including idioms of distress of social or political origin, under the wing of medical expertise (Scheper-Hughes, Lock 1987; Foucault 1973). Turner and Foucault claim that biomedicine appropriated the former power of the Church in regulating the morality of individuals and of collectives by means of medical labels and medical regimens while further legitimising its power through the political mandate for a healthy society (Turner 1984; Foucault 1973, 1977).

In both works, *The Birth of the Clinic* and *The Birth of the Prison*, Michel Foucault stresses the importance of observation in the production of knowledge and points to the intimate relationship between power and knowledge (Foucault 1973, 1977). The introduction of panoptic structures into medical institutions facilitated the thorough spatio-temporal surveillance and regulation of individualised patient cases. Foucault describes panopticism as an apparatus of external technologies that facilitates the constant monitoring of the individual, the regulation of his/her activities by means of schedules, medical regimens and disciplinary rules: a power that produces knowledge (Foucault 1977). For Armstrong, panopticism is best described as a "creative arrangement of power" which facilitates the fabrication of

an individual body crystallised into existence by a "disembodied gaze" (Armstrong 1983, 5). External technologies of power, including biomedical secular rituals of routine compulsory physical examination, assessment, diagnostic investigations, prognosis and treatment, subject the body to expertise of the gaze, which in turn justifies medical interventions (id.). The enhancement of medical expertise calls for a division of labour into specialised fields of knowledge namely surgery, obstetrics, neurology, internal medicine, psychiatry and others and their consequent appropriation of isolated sections of the body. Furthermore, a hierarchy of medical professionals participate in the process of observation, assessment, teaching and enforcement of medical regimen as well as the meticulous legal recording of all details deemed pertinent for each case (Foucault 1973, 1977). In my opinion, medical panopticism and specialisation represent a primary aspect of biomedical reductionism whereby the body is spatially dissected by medical specialisation and simultaneously stripped of its social resonance making it difficult for the patient to resist the medical gaze (Yates 2000).

Physical examinations that require patients to remove their clothing to subject their objectified body to medical probes, also proceed to strip patients of their social identity and place them in an inferior position to a hierarchy of authority rooted in medical expertise. Biomedical practices have thus acquired a legitimate right to cross the boundaries of conventional and permissible "social distance", which vary from one social group to another. Consequently, the bodies of patients can be subjected to any kind of probing and invasive procedure whether for diagnostic or

therapeutic purposes. Reported symptoms, observed signs (pallor of the skin, cold and clammy skin etc.), medical history and laboratory test results (blood, urine, biopsies, scans etc.) all converge towards the determination of a conclusive diagnosis of specific pathologies. Irrelevant to the diagnostic process are the identity of patients, their beliefs, their life-style or emotional state unless these identify with established categories of "abnormal" behaviours (smoking, alcohol intake, obesity, elevated blood cholesterol, depression, psychosis etc.) and therefore become subject to corrective measures (Foucault 1973, 1977; Turner 1984). Complaints of pain or general malaise that elude confirmation from biomedical diagnostic and scientific objectivity emerge from the screening process deprived of legitimacy and, all too frequently, of medical attention (Scheper-Hughes, Lock 1987; Kleinman 1988). The biomedical positive identification and scientific deductions of organic pathologies represent the exclusive determinants of disease.

Power/Knowledge and the Control of Bodies

Inventing the Body in Health and Illness

The fundamental logistics of biomedical knowledge lie in the scientific normalising framework with regard to the body and its functions. Scientific and mathematical applications have determined arbitrary "normal values" or "normal parameters" for

various diagnostic test results such as the normal range for highs and lows of blood haemoglobin and electrolytes, for heart rate and blood pressure, normal and abnormal behaviour and so on. The ability to detect values that go beyond the established normal parameters can not only indicate a potential pathology of excess or deficiency, it can guide and monitor the effect of applied corrective measures. Foucault points out that the normalising medical judgement that can probe at the cellular level of human organisms can in fact extend to the construction and reconstruction of the "social body" (Foucault 1977). Mental illness first comes to mind, quickly followed by habits that are viewed as detrimental to health, for instance, drug and alcohol abuse, sexually transmitted diseases and deviant sexual behaviour, to name a few. However, the most covert manifestation of the normalising medical discourse transgresses the boundaries of nature into the life cycles of the human body (Foucault 1973, 1977; Lock 1993a). This tendency towards medicalisation of the excessive, the deficient and the abnormal calls for an attentive medical gaze that can bring truth to life and provide mappings of a normalised social and political body by means of its extension to institutions such as the schools, the prisons, the mental hospitals, the army and so on (Foucault 1977).

David Armstrong best describes how an extended medical gaze, in the context of twentieth century England, penetrated the social body in search of the 'potentially ill' and focused both on the healthy and the normal in an attempt to canvas the 'geography' of disease (Armstrong 1983, 9). The movement of disease within the social body required of the medical gaze a more refined perceptual capacity, which

implied a more detailed knowledge attainable only by means of a thorough surveillance of the community at large (Armstrong 1983, 37). A medicine previously confined to deal with deviances has been restructured into a 'social medicine' mandated to determine the normal and implement the systematic prevention of dis-ease within the social body (Armstrong 1983; Turner (1984) 1996). Foucault's external technologies of power assume the form of the survey whereby the presumably 'normal' body and mind of the child, the adolescent, the adult, the pregnant woman, and the elderly become integrated into the medical body of knowledge. In addition, epidemiological studies can follow the movement of disease and abnormalities within the social body (Armstrong 1983). However, Armstrong and Lock both suggested that, in their practical application (as opposed to Foucault's more theoretical outline), these technologies only provide limited knowledge in as much as their penetration of the entire social body remains incomplete and selective (Armstrong 1983; Lock 2000). For instance, people may choose not to divulge certain personal information (even if confidentiality is assured) or to modify the content of the personal information that they provide (Armstrong 1983). Furthermore, surveys do not reach all segments of the population, thus cannot be assumed to represent the entire social body (id.). Margaret Lock argues that epidemiological studies target narrow and incomplete segments of the population and often reflect the biased interest of those who launch them, such as pharmaceutical companies that wish to promote their products (Lock 1993a). One can extrapolate this form of reasoning, for example, into epidemiological studies on the AIDS virus that would confine the scope of research

to a homosexual population and therefore reach misleading assumptions on the demographic distribution of AIDS. Nonetheless, surveys and epidemiological studies remain highly valuable tools for the medical gaze, the enhancement of medical knowledge and the invention of the human body in health and in sickness. The body as an object of knowledge becomes the subject that informs the medical gaze in the creation of its identity (Armstrong 1983, 72-102). Specialised disciplines such as sociology join forces with medicine in the quest for knowledge and further fragment the body. Both the state and medicine have penetrated the social body.

Bio-Power and Docile Bodies

Foucault describes how the materiality of the power of external technologies over the bodies of individuals renders the body transparent to analysis and knowledge while yielding power to the subsequent discursive formation (Foucault 1980). Foucault further points out that the invisible power effects of psychiatry and medicine on the social body are indeed very real and circulate freely through the web of social structures accentuating the political function of medicine (Foucault 1980). The gradual involvement of the state in eighteenth and nineteenth century France with regard to public assistance and public health demonstrates the increasing exigency to protect the social body by recruiting medicine's scientific expertise and other disciplines (police force, teachers, military and internment facilities) (Foucault 1973, 1977).

Contemporary state concerns with regard to the control of individual bodies for the welfare of the social body become manifest in mundane activities such as exercise or diet and broader issues such as sexuality and reproduction. Such dictates osmotically traverse the micro-structures of society from teaching institutions to parenting (id.). A monolithic discourse about what kind of body one should aspire to and is responsible for permeates all aspects of daily life. Whether it comes in the voice of the physician, the teacher, the media or the parents, a subliminal inflection of prescriptive personal hygiene (health and sexuality) and responsibility reflect a subtle normalising discourse. Foucault's analysis of the medical gaze with regard to "bio-power" suggests that the invisible power that is applied to the material body does so without arousing much resistance or even query about coercive manipulation (Foucault 1977, 1980). Armstrong demonstrates how the survey and epidemiological studies supply the medical discursive formation with data about the 'normal' obtained from the 'subject' individual, information that is then rearticulated into absolute facts and truths (Armstrong 1983). The disciplines of sociology, psychology or criminology, however, extract an isolate, an experiential subject from his/her historical and contextual environment, further alienating the subject from the normative medical construct. Suffering and distress of social origins that disrupt the harmony of the social and political body will eventually fall in the lap of medical expertise and undergo the convenient medicalisation process, thus refining scientific constructs of the body and preserving the integrity of the political body (Foucault 1977; Scheper-Hughes and Lock 1987).

At first glance, Foucault's analysis of the body as depicted by the medical gaze can certainly suggest an "invented" body/object deprived of all subjective selfhood and sentient consciousness. However, Nick J. Fox points out that "*which* body is the object of study" needs to be clarified with regard to the Foucauldian body to grasp the meaning of Foucault's work (Fox 1997, 40). Some of the criticism directed at Foucault's analysis rejects what some view as the docile and passive body subjected to the control of a repressive power and devoid of agency. In fact, Foucault pays little attention to a sentient body rather, he focuses on the *modus operandi* of power and knowledge and the effects of power over the social body

Fox describes Foucault's body as a passive entity, a discursive construct bound to the power of the gaze (Fox 1997). Fox points out that Foucault's interest in the body was not so much the body itself, rather, a focus on the effect of power on the material body and the truth or even untruth that it produced (ibid.). Tauber argues that Foucault understood power as an external means to define the self as object and compares him to Nietzsche who understood power as originating from within the self as subject, and self as responsible (Tauber 1997, 272-73). For Tauber, the Foucauldian body echoes a "nihilistic" position whereby even the self merely exists as a construct, "an object of power and of limiting definition" (Tauber 1997, 275-285). Foucault asserts the fundamental importance of Nietzsche's work on his own analysis of the 'will to knowledge' and 'will to power' (Rabinow 1984, 7, 76; Lock 2000).

Fox and Lupton point out that in his later work, Foucault (*History of Sexuality* and interviews) addresses issues of a more active and reflective self, a self that can be subjective and act out resistance (Fox 1997, 41; Lupton 1997). Fox further points out that Foucault transferred his concern with external technologies of power to the internal technologies of the self (Fox 1997, 42). However, this point could be argued with reference to Foucault's own emphasis on the invisibility of power that permeates the body thus suggesting the illusion of agency, subjectivity or even its creation. Rabinow, in a discussion on panopticism, comments that '[I]f the prisoner is never sure when he is being observed, he becomes his own guardian', which is congruent with Tauber's claim that Foucault's framework cannot integrate a self other than as a construct and that, for Foucault the "self" does not exist prior to the construct (Rabinow 1984, 19; Tauber 1997). It could be further argued that the prisoner is being controlled by his knowledge that he can be observed at any time thus implying the refined efficacy of external technologies of disciplinary power towards the embodiment of individual docility and responsibility. In contrast, David Armstrong offers yet a different perspective when he posits "perhaps the most profound lesson I take from the *Birth* is the subtext on the emergence of the individual" (Armstrong 1997, 22). Armstrong concurs with Foucault's suggestion that "the deployment of the clinical gaze forms an integral part of our individual experience and identity" (id.).

Other scholars have mulled over other aspects of Foucault's legacy, namely the spatialisation of bodies, diseases, and normative parameters (Armstrong 1997; 1983; Rabinow 1984). Rabinow explains how the practices of exclusion described by Foucault involve modes of objectification of the subject through the use of spatial divisions that isolated the body, classified diseases and introduced medicalisation and normalisation (Rabinow 1984, 8). Rabinow relates Foucault's explanation that bio-power "brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life [...]" (Rabinow 1984, 17). Bio-power manoeuvres within the realm of the human species, population and fertility and simultaneously in the realm of the objectified body that can be manipulated and controlled (Rabinow 1984, 17). Bio-power revolves around important spheres of human activities, namely *production* and *reproduction.* Historical contexts that helped shape the gaze and the disciplines included several economic, social and political transformations whereby the requirements of a capitalist regime, urban population growth and the new mandate of public health called for a new economy of the body and of the body collective (Foucault 1973, 1977). It should be noted that Foucault's operative premises of bio-power are not exclusive to the West. Concerns about *production* and *reproduction* within a changing socio-economic landscape were articulated in the traditional Chinese medical discourse of Song, Ming and Qing dynasties through the medicalisation of the female reproductive body and the general prescription for sexual economy and care of the self (Furth 1999; Bray 1997). Furthermore, bio-power becomes quite evident in contemporary China with the "one child policy" that limits the number of

live births to a single child per *legally married* couple and in the possible sterilisation of women who defy the policy (Dikötter 1995; Handwerker 1998).

As I shall discuss in the next chapter, Foucault's analysis of prescriptive medical discourses and the use of external technologies of surveillance and control of bodies, albeit their modern form, existed in ancient times in the Greek and Chinese contexts. As Kuriyama argues, it is the perspective and the manner in which one looks at the world that changes the ways of knowing and the dissemination of this knowledge (Kuriyama 1999). Moral and political undertones are always contained in the discourse whether in China or in the West (Sivin 1995, chapter IV, 2)

Chapter 2

Conceptualisation of the Body in Chinese Medicine

In this chapter, I wish to investigate configurations of the body in theoretical discourse and in the practice of the Chinese medical tradition. I am particularly interested in conceptual permutations of medical constructs of the body and of the socio-political circumstances surrounding these transformations. Traditional Chinese medicine is not a static body of knowledge that has emerged from the past, unaltered by ideological, socio-political, economic, linguistic, and foreign influences, rather, it is a body of knowledge that has evolved and has been transformed over its long historical development. This historical development is anything but linear, it is, as Unschuld so aptly put it, "a history of ideas" (Unschuld 1985).

The body's physical properties of generative and degenerative cellular processes and anatomical characteristics situate it in time and in space, particularly with regard to life cycles, sex, and corporeal mortality. This tangible materiality of the body stands vulnerable to the scrutiny of others through sensory perceptions, which are then translated, interpreted and articulated through social constructs (Turner 1984). Communication between the self and others is thus mediated through the body and through language (Turner 1984; Scheper-Hughes and Lock 1987). Kuriyama points out that the production of medical knowledge and concepts of the

body vary according to one's perspective and he argues that sensory perception of the expressions of the body reflects that perspective (Kuriyama 1999). Although restricted by common biological characteristics, conceptual representations of the body do not share a universal foundation, rather they are subject to the contextual and historical dynamic processes of change (Lock 1993; Lock 2000, lecture). This chapter focuses on Chinese constructs of the medical body and I wish to probe the conceptual formation and change that occurred historically. However, this chapter does not attempt to present either a chronological or comprehensive historical and regional analysis of Chinese medicine, nor does it focus on a specific source. Rather, it peruses the evolution of the conceptualisation of the body in medical literature.

In their article on the three-dimensional "Mindful Body", Nancy Scheper-Hughes and Margaret Lock suggest a comprehensive reconstruction of existing conceptualisations of the body (Scheper-Hughes and Lock 1987). The authors' description of the three bodies consists of the "individual" body representing the lived experience of the body-self, the "social" body referring to the representational uses of the body as a natural symbol and the "body politic" referring to the regulation, surveillance and control of bodies (individual and collective) (id). These three dimensions of a mindful body establish the framework of this paper and will appear throughout the text singly or in combination, yet always interdependent.

The Cosmological Body

Inquisitiveness about the sick and suffering body inevitably leads to divergent explanatory models to understand what the body is and how it works. I use the word "divergent" because various medical traditions, in time and in space, have developed significantly different modes of medical knowledge and practice with regard to the body. Several scholars have investigated the historical processes involved in medical discursive formations and of their impact on the interpretation and normalisation of the body (Kuriyama 1999; Foucault 1973; Latour 1984; Lock 1993; Furth 1999). The body and constructs of the body cannot be divorced from their historical and spatial context (id.), and it is from this historical perspective that I shall explore theoretical constructs of the Chinese medical body.

Cosmological Foundations of Chinese Medicine

Early Han philosophers devised theoretical assumptions with regard to the origin of the cosmos and of life itself. These cosmological concepts encompassed the human body as a resonant microcosm of the external natural universe and represented a most feasible theoretical framework for medicine to understand and explain health and illness (Sivin 1987; Furth 1999). Sivin argues that these 'cosmological concepts were moral and political from the start, and that in the long sweep of Chinese thought, as they took on new ranges of meaning, they remained moral and

political' (Sivin 1995, chapter IV, 2). He further argues that these concepts '[w]ere fitted into various doctrines that (among other aims) *legitimated* the workings of the unified Ch'in-Han *state as a model of Nature's process*' (ibid., italics added). These fundamental cosmogonic and generative principles that formed the basis of medical theory are those of *qi, yinyang* and the theory of the five phases (*wu xing*). For the purpose of this paper, I shall limit my discussion to a more general description of these concepts rather than cover in detail the various dialectics that accompany their evolution throughout history.

Judith Farquhar's translation of a modern version of a classical Chinese medical text describes the origins of all phenomena "The vast and limitless heavenly void is the foundation of the root and origin of the generation and transformation of matter, and it is the beginning of the production of the myriad things" (Farquhar 1994, 29). The source of this generative power lies in the " Heavenly *qi*" which is transferred and "embodied as human primordial *qi*"; it is the source of life and its absence means death (Furth 1999, 21). This primordial *qi* is the one that is transmitted through generations as the ancestral lineage, in contrast to Western concepts of bloodlines (Furth 1999). The *qi* must flow unhindered within the human body to ensure the natural process of its normal generative functions throughout the life cycles, including death; if ignored, stagnations and blockages of *qi* and blood could lead to serious and often fatal conditions (Furth 1999; Kuriyama 1999; Daly 1999; Hsu 1999). Elizabeth Hsu best describes the necessity to maintain harmony and unobstructed movement in the flow of *qi* : '[I]t was the chorus of mutually

resonating *qi*, perceived as analogous in micro-macrocosm that would give rise to disorder' (Hsu 1999, 235). Hsu's remark suggests the implication of both the external natural environment and the person's own internal organism with regard to the harmonious flow of *qi* as the potential source for disharmony/disease. However, there always exists the possibility of an invasion by noxious or evil *qi* that originates from the exterior of the body and can cause illness, and one must guard against these noxious influences by maintaining inner harmony (Farquhar 1994; Unschuld 1985; Kuriyama 1999; Yates 2000).

The generative properties of *qi* are bound to the dynamic and transformative interaction of *yin* and *yang* whereby the "myriad phenomena" are differentiated and subjected to "cyclical transmutation" (Furth 1999, 21; Farquhar 1994). Perceived as opposing yet complementary forces, the *yinyang* poles remain constantly in motion and cyclically grow and decline in a temporal pattern of change (Sivin 1987; Furth 1999). Farquhar points out that while some people view *yinyang* as strictly opposing forces, she describes them as "opposed aspects of phenomena tied in a relation of struggle and interdependence"(Farquhar 1994, 35). Hsu argues that the notions of 'opposition' and of 'struggle' represent the more recent and politicised rendition of a standardized version of Chinese medicine and directly reflect Mao's writings on 'materialist dialectics', rather than its classical meaning which did not allude to either opposition or struggle (Hsu 1999, 181-186). Along with the flow of *qi*, *yinyang* forms from within and from without the human body the dynamic process of harmony and balance which, if disturbed, will result in illness.

Furthermore, *yin* embodies analogies with the moon, with what is dark, cold, damp and with the feminine whereas *yang* categorises associations with the sun, with what is bright, warm, dry and with what is masculine (Sivin 1987; Furth 1999; Farquhar 1994). Furth points to the fundamental "qualitative oppositions of the body into masculine and feminine aspects, and into spatial divisions of upper and lower, inner and outer regions, extending to its somatic attributes of heat or cold, moisture or dryness" which are derived from *yinyang* functions (Furth 1999, 23). Her analysis leads to the concept of what she refers to as the androgynous medical body, which includes both feminine and masculine features of *yinyang* whereby *yang* comes first in a hierarchical function implying the superiority of *yang* and, by association, of the masculine (Furth 1999). This theory of the body in Chinese medicine excludes the overall external sexual characteristics of the body because they are included within the functional description of the kidney system (Yates 2000; Sivin 1987).

Another philosophical theory that became integrated into medical epistemology is the theory of the five phases. Sivin refers to the five phases theory as an alternative way of thinking with regard to the same process that involves *yinyang* functions. The theory of the five phases also suggests temporal and spatial interaction of "body functions, celestial motions or political change" (Sivin 1987, 75-78). The theory of the five phases suggests a sequential pattern of "mutual production and mutual conquest [...] and the vitality or force that drives it" (Sivin 1987, 78). As described by Kovacs and Unschuld, the theory of the five phases established a '[b]asis to understand, and influence, relationships among organs and functions within the

organism, and, among the organism and its natural environment' (Kovacs and Unschuld 1998, 12). The theory of the five phases outlines the cosmological mutual generative and destructive sequence that involves metal, water, wood, fire and earth in the process of depletion and repletion that occurs within the organ system and is particularly useful for determining the pattern of the disease process and the ideal course of treatment (Unschuld 1985, 87; Hsu 1999). This pathological process within the organ system can be assessed externally in the skilful taking of the pulse (Farquhar 1994; Kuriyama 1999; Unschuld 1985).

From the Chinese medical perspective, internal organs of the body do not correspond to the biomedical understanding of anatomical and spatially located organs, rather they refer to a dynamic system network of function and correspondence (Liu 1988; Sivin 1987; Unschuld 1985; Farquhar 1994). Following Liu Yanchi's description, the *zang fu* system consists of five *zang* solid organs performing a storage function and six *fu* hollow organs with a function of transfer (Liu 1988). The *zangfu* system is interconnected through the support of channels, which move *qi* and other vital substances to ensure the nourishment and functional harmony of the organ system and the body as a whole (Liu 1988, 95-138; Sivin 1987; Hsu 1999). The integrity of a smooth process within this system of function and correspondence is of utmost importance with regard to the maintenance of balance and harmony within the body and with the cosmological order. In other words, the concept of the five phases provided the foundation '[t]o understand, and influence, relationships among organs and functions within the organism and among

its natural environment' (Kovacs and Unschuld 1998, 12). Elizabeth Hsu stresses its importance for doctors in their assessment for therapeutic action because the theory of the five phases allows the skilled physician not only to follow, but also to predict the course of the illness and thus apply therapy accordingly (Hsu 1999; Farquhar 1994).

Unschuld remarked on the early (circa Han dynasty) conspicuous absence in the medical system of ideas such as the five phases theory in the *Bencao* writings (pharmacopoeia) and pointed to the empirical data it provided on plants and their constituents suggesting the possible restrictive nature of the metaphysical within the realm of applied pharmaceutics (Unschuld 1977 in Kovacs and Unschuld 1998,18-19). However, he describes how a '[p]harmacology of correspondence was elaborated not earlier than the twelfth century' (ibid.). The theoretical aspects of medicine were elaborated within the circles of the scholarly and predominantly male elite and, as pointed to by Yates, the pharmacopoeia was used extensively within the practices of exorcism and demonic medicine, and thus, remained excluded from medical theories until the twelfth century (Yates 2000). Unschuld's suggestion that the efficacy of drugs in treating diseases could clearly remove the individual mandate of active responsibility with regard to the maintenance of health and order from moral behaviour and thus the integration of pharmaceutics in early Chinese medical texts may well have been excluded on those grounds (Unschuld 1985, 99).

Correlative Thinking and Functional Relationships

From early times in Chinese medical thinking the body was conceived as a whole, itself an integral constituent of the universe reflecting cosmic harmony (Unschuld 1985; Sivin 1987). Charlotte Furth describes how natural and social philosophers of the early Han 'imagine[d] the world in terms of a universal system by which all phenomena of Heaven, Earth and Humanity could be categorized and their transformations known.' (Furth 1999, 21). Philosophical visions and explanations of the workings of the universe were integrated into medical theories that located within the human body a microcosm corresponding to the resonant and cyclic qualities of the universal macrocosm (Sivin 1987). Absent from these medical theories are the biomedical scientific mind/body and nature/culture dichotomies, rather, a fluid intercourse of activity traversed the boundaries of the physiological, social, political and the cosmic order implying a disastrous chain reaction if any of the parts became dysfunctional (Sivin 1987). In Chinese traditional medicine, biomedicine's spatial and mechanical anatomy of organs and disease is superseded by a focus on the analogy and the dynamic process of resonance and flux within the body organs together with their relationship to one another and with the external environment. The paradigm of a cosmological body, by extension, becomes the social and political body not only with respect to the individual but also to the family, to the state and to the ruler. The exigency of a moral and harmonious life-style of the ruler will ensure his good health that in turn reflects on the health of his subjects (Yates 1999). The same applies to individual members of society with

regard to the state, hence the imputation of personal responsibility of individuals for their health and moral conduct, which warrants a fundamental emphasis on prevention (ibid.). The ruler's body enjoyed a greater immunity provided by the mandate of Heaven, which legitimised his power and his rule so that he could easily modulate mainstream discourses as well as exert influence on the cosmos and a continued malfeasance on his part could lead to him being removed (Yates 2000). However, his moral conduct, or lack of it, could readily transform him into a legitimised target for competitors to his power.

The *Inner Canon* is valued as being a primary classic of Chinese medicine. Unschuld situates its origin around the second century B.C. but, in view of recent discoveries, other authors imply that it originated closer to the first century B.C. or possibly later (Unschuld 1985; Furth 1999; Sivin 1987, 5n). However, present day scholars, namely Sivin, Unschuld and Hsu, concur that this classic medical canon represents a heterogeneous compilation of the writings from different periods and from different traditions whose authors came from various 'medical lineages' (Furth 1999, 20; Sivin 1987; Unschuld 1985; Hsu 1999). The inherent inconsistencies and contradictions found in the *Inner Canon* never constituted an epistemological problem in China at any time (Unschuld 1985, 99), rather, throughout history, medical scholars have diligently qualified discrepancies by integrating explanatory annotations, appendices, commentaries and other writings with the original texts (Unschuld 1985; Furth 1999; Sivin 1999; Kuriyama 1999). In a sense, the cementing of the *Inner Canon* into a seemingly uniform epistemological foundation

and framework has articulated the body of medical knowledge into a powerful referent for the mainstream imperial political body. The medical discursive formation itself originates within the political and administrative framework of the imperial state, not only from its authors who are scholar officials of the state, but also the metaphorical analogies of the body to the topography of the land and of the state. Nigel Daly looks at the hydrologic metaphor of waterways in the theoretical development of the *mai* channels in acupuncture establishing, the correlation between the land and the body (Daly 1999). Daly's suggestion that correlative thinking with regard to theoretical formation supports my argument that any discursive formation draws directly from the historical and contextual environment.

Discursive Production and Practice

Official medical discourses often share an intimate relationship with mainstream political goals, moral concerns and economic considerations of the elite or the state that participate in their formation. In the context of China, and other historical and regional contexts, official discursive formation originated within elite or governing circles and yielded normative prescriptive discourses that promoted moral and political order.

Kovacs and Unschuld have argued that "[...] the social reality we live in, or the social reality we aspire to, shapes our approaches to health and illness, as does the nature of our physical environment" (Kovacs and Unschuld 1998, 18).

The following will explore the medical discourse and its link to historical and contextual moral and political influences.

The Canons as Normative Medical Discourse

In Confucian (and neo-Confucian) China, male literati maintained hegemony over authoritative discourse, thus implying that all medical discourse was also a "male dominated discourse" (Blake 1994). Charlotte Furth proposes a conceptual metaphor of "the Yellow Emperor's Body" as an explanatory model to analyse the medical construction of the Chinese historical body, while Elizabeth Hsu refers to a 'body ecologic' of the medical discourse to stress the emphasis on the internal and external environment in medical concerns (Furth 1999; Hsu 1999). The previously discussed cosmological theories adopted by medical authorities focused on the body as a whole and as a microcosm of the natural universe, discarding the material body as largely inconsequential as an individual unit. Furth's 'Yellow Emperor's Body' and Hsu's 'body ecologic' are quite distinct from a biomedical body in that they reflect a cosmological and presumed "androgynous" body of generative functions rather than a dichotomised mind/body individual (Furth 1999; Hsu 1999).

The medical terminology in the Chinese as well as other traditions frequently embodied political, social, and even military metaphors within the inner mappings and functions of the bodily organs. Military metaphors are used repeatedly in

medical literature "to compare between the preservation of peace in the empire and peace of health in one's body" (Unschuld 1992, 56). Unschuld also comments on how the drugs should be deployed in the same manner that soldiers are deployed and points to references to the vigilance required to protect the body from external invasion (ibid.). Charlotte Furth describes how the bedchamber arts were "imbedded in medical and religious discourse" and used several military metaphors to emphasise the risks to health involved in the unrestrained practice of sexual intercourse: "[s] exual intercourse as combat, with its representation of the partners as 'enemies' destined for victory or defeat" (Furth 1994, 134-135). Other medical traditions use similar military metaphors such as the biomedical reference to bactericidal drugs, antibodies or the body's defence mechanisms. Unschuld points out that as a result of fundamental economic changes, earlier medical terminology referred to the human organism as being composed of "granaries", "storage facilities", "depots", "palaces" and "transportation channels" and "trade" functions (Unschuld 1985, 79-80). Unschuld also points to harmful external influences that can invade the body through the skin and enter through one specific depot and cause a chain reaction, which will reverberate harmful effect to the networking of the five depots (Unschuld 1985, 88). References to a "hierarchy" of drug action in herbal prescriptions are also enunciated in traditional medical texts, a hierarchy that reflects the imperial administrative order (Unschuld 1985). Farquhar describes this hierarchy of drug combinations (Chinese prescriptions always include more than one drug) with regard to their functions and responsibilities: 'the ruling drugs, the supporting drugs, the assisting drugs and the sending drugs which in feudal times

represented an allegorical allusion to the monarch and minister, the assistant and the emissary in a reflection of their role in social order' (Farquhar 1994, 181-183). Unschuld and Sivin both argue that these linguistic metaphors are imbued with symbolic value and follow the major currents of social, political as well as economic changes and that any adequate interpretation of their meanings remains bound to historical context (Unschuld 1985; Sivin 1987).

As the reification of historical, social and political organisation within the body organs and their functions echoed the cosmological order, it clearly denied an arbitrary dichotomy between nature and culture, reinforced the individual's sense of belonging to that order and validated the prescription for his/her own moral conduct. The individuals' failure to abide by the prescriptive moral conduct upset the balance of the natural order inside and outside the body, which inevitably resulted in disease of the individual and social body. In contrast, Brian Turner points out in a discussion about Michel Foucault's theories of power/knowledge that, with regard to biomedicine, it is the "disease categories" that constitute the moral control of individuals and of populations (Turner 1997, ix). Such a contrasting difference supports Kuriyama's thesis that styles of knowing are intrinsic to one's adopted perspective and deliver divergent versions of normative discourses and of the truth, particularly with regard to the aetiology of disease (Kuriyama 1999).

Thus far, I have examined a textual perspective of the Chinese body of medical knowledge. This textual tradition of a normative discourse on the body and health

and illness provides the practitioner with a basic theoretical framework of reference that is not always suitable for the resolution of problematic issues encountered in clinical practice. Furthermore, the normative and androgynous cosmological body of Furth's Yellow Emperor's body or Hsu's 'body ecologic' seldom corresponded to the more material body afflicted with illness and, increasingly, with regard to the physician's encounter with the alterity and incongruent androgyny of the female body, which Furth associates with the development of *fuke* and the construction of gender in the Song dynasty (Furth 1999; Hsu 1999). This construction of gender referred to by Furth would suggest a medical construct because Confucian ideology already incorporated a gender construction of female in its gender hierarchy that placed women in an inferior and subservient position to that of men. Furthermore, an earlier medical text that appears to have been specifically devoted to female health disorders is recorded in the bibliographical catalogue of the Han imperial library in the Han Shu, but unfortunately this text has not been preserved (Yates 2000). In addition, Hsu argues that the contents of texts on *fuke* in the Song are practically identical to that of *neike* (internal medicine) and do not necessarily reflect a separate medicine for women (Hsu 1999, 161 footnote 40 citing Farquhar 1986, 375).

In order to preserve the integrity of medical classics and enhance performance as healers, Chinese practitioners escaped theoretical constraints by focusing on a customised and experienced practice and later on personalised record keeping of medical case histories (Furth 1999; Farquhar 1994; Hsu 1999). Western scholars

who study Chinese medical texts have pointed out the transformative nature of the medical terminology as well as annotations, appendixes and explanatory texts, as in, for instance, the *Nanjing* (Canon of Problems), in an effort to untangle textual discrepancies and contradictions contained in the Inner Canon. Nonetheless, it should be noted that the medical literary tradition rather than being exclusive, is a cumulative one. In what he refers to as intertextual approaches, Nick J. Fox argues that "authority is observable only at its site of action; that is, at the site of reading. Bodies of 'knowledge' are thus a feature of reception rather than authorship, while resistance becomes possible in the re-reading (and hence rewriting) of texts as readers substantiate or discredit the discourse with which they engage" (Fox 1997, 32-33). Fox's insight on authority and the reading and rewriting of texts is particularly relevant to the Chinese context. As discussed previously in this thesis, it was common practice for medical scholars to add their own commentaries, explanatory annotations and other writings to original medical texts thus establishing authority through their interpretation of the medical classics.

The Sick Body

The epistemological reasoning of a system of correspondence which links the inner workings of bodily organs in spatial and temporal resonance to the natural order also governs diagnostic and therapeutic principles followed by medical practitioners (Unschuld 1985; Sivin 1987; Farquhar 1994; Furth 1999). The body represents the

most evident primary locus for medical investigation of disease. However, the cosmological model and theories of correspondence become constrained by the body's intrinsic materiality and biological processes as well as by the subjective experience of a sentient body, which often elude medical theories (Blacking 1997; Lock 1993). Medical practitioners were expected to decipher and interpret the clusters and signs of symptoms, trace the process and evolution of the embodied disease and provide an appropriate therapy. Somatic expressions of the covert disease process that took place within the body were revealed to the practitioner through his/her own somatic sensory structures and the interpretation of a shared referent of what he/she perceived depended on what he/she was trained to look for (Scarry 1985; Kuriyama 1999).

In his discussion on winds, Kuriyama describes in a rather elegant style, how the "skin" epitomises body boundaries and through its innumerable "orifices" (pores, nose, mouth, etc.), usually considered to be five in number (Yates 2000), permits the movement of "individual breath and cosmic breath" (Kuriyama 1994, 34-35). As a boundary of the inner and outer cosmological realm, the osmotic quality of the skin reflected the status quo of inner processes for the medical practitioners to read and interpret. Disease itself originates from three possible sources which include '[f]irst, the intrusion of pathogenic quantities of the so-called "six excessives" (wind, heat, dryness, dampness, cold, summer heat); second, a pathogenic surge of the seven emotions (grief, anger, pondering, sadness, joy, worry, fear, and fright); and third, injuries caused by accidents, animals' (Kovacs and Unschuld 1998, 65-66) as well as 'demons and ghosts' common in popular medical beliefs, but not in

the medicine of systematic correspondence (Yates 2000). In order to trace the pattern of the disease process to the 'root' and prevent the progression of the disease, doctors performed an examination of patients that could then be interpreted within the theoretical framework to provide a diagnosis and therapy. The *Inner Canon* describes four methods of diagnostic examination based on the sensory perceptions of visual observation, olfactory and auditory perceptions, palpation (mostly the pulse) and questioning (Farquhar 1994; Kuriyama 1999). Illness processes always reflected on the exterior of the body and expert physicians could perceive and interpret the subtle nuances in the complexion and colour of the skin, in the coating of the tongue and in the qualities of the pulse providing him/her with fundamental data for his/her diagnosis and treatment (Farquhar 1994; Kuriyama 1999).

Biomedicine's basic examination methods also rely on very similar visual, auditory, which includes the recording of medical history, olfactory, and tactile sensory perceptual mechanisms to those used in traditional Chinese medicine. However, sensory perceptions are interpreted from distinct epistemological perspectives and convey incompatible patterns of *knowing*. Furthermore, Western medicine's propensity for invasive techniques, on and into the body, did not enjoy the same favoured status in Chinese medicine except with regard to older practices such as lancing of abscesses, cataract extraction and bloodletting (Unschuld 1985; Kuriyama 1999). It should be noted that surgical procedures involved with cataract extraction can be traced to Buddhist influence and Indian medicine and that such

practices, although recorded in the Song medical texts of the early Tang doctor Sun Simo (Yates 2000) might well have remained confined to the activities of Buddhist monks and not widespread among Chinese doctors (Kovacs and Unschuld 1998, 43, 81). Similar exchanges of knowledge with other medical traditions possibly suggest a link with Chinese bloodletting practices with the same Greek practice (Kuriyama 1999). Also worthy of mention with regard to surgical procedures performed in China is the surgical castration of the eunuch population (Croizier 1968, 25). Croizier suggests two possible reasons for the unpopularity of surgical procedures in China. First, Confucian ideology which viewed the body as sacred and strongly discouraged such practices on the body as a violation of filial piety. Second, it would be unthinkable for the scholarly doctors to lower themselves to perform such disdained 'manual' activities (Croizier 1968, 25). However, while anatomy and dissection are incompatible with Chinese medical theories there is early textual evidence of surgical practices (Kovacs and Unschuld 1998; Yates 2000). The mention of "manual" practices implies an additional dimension to the scholarly medicine of the literati: that of pluralism within the sphere of healing practices.

Scholarly Medicine and Pluralism

Eclectic forms of healing activities, whether overt or covert, have been the norm rather than the exception in Chinese history (Unschuld 1985). Evidence of such activities can be traced to inscriptions on archaeological finds of oracle bones and tortoise shells that were used for divination purposes in the Shang dynasty (second

millennium) (ibid.,17; Yates 2000). There is also evidence of a long oral and secret tradition of the *wu* shaman or doctor, "an important persona who will remain throughout the entire history of healing practices in China" and of the *Chu* priests who were associated with the rites of exorcism of demonic medicine (religious healing) (Unschuld 1985, 33-34). The advent of a discursive formation that began with the compilation of the *Yellow Emperor's Inner Canon* served to disseminate cosmological theories that formed the core of a shared language for lay and medical people alike (Furth 1999; Hsu 1999). Non-scholarly forms of healing originated in the lineages in the lower class stratum and included those that were developed by family medical lineages, traditions of healing with master-disciple apprenticeship, religious healers, female healers, midwives and drug peddlers who continued their observance of oral and scrupulously secret modes for the transmission of medical knowledge and practice (Unschuld 1985; Sivin 1987; Furth 1999; Hsu 1999). However, prior to early Han, exorcism was an elite practice and many of these healers often enjoyed the favourable patronage of the imperial court itself and of other scholarly officials (Yates 2000).

From the Song and Ming dynasties, the status of medical activities gained momentum and reached the upper class stratum of the gentry and literati. However, these medical activities of the scholar doctor were supposed to be performed as acts of benevolence or charity and not for personal financial gain. Nonetheless, some scholar doctors frequently profited significantly from their medical activities (Croizier 1968, 30; Hymes 1987). According to Furth, this shift occurred along

with changes in the socio-economic context, which involved official state support and the appearance of printing, although Hymes argues that much of the 'Yuan changes in the status of medicine were the result of private decisions, not state promotion' (Hymes 1987, 66; cf. Furth 1999;). Nonetheless, Yuan rulers privileged medical knowledge and medicine and participated actively in sponsoring local and state medical schools and pharmacies (Hymes 1987; Leung 1987, 138-138). The ability to perform basic medical care became viewed as a prerequisite of Confucian filial piety and heads of gentry and literati households were eager to acquaint themselves and the females of their household with medical skills and to acquire easily accessible household manuals on medical knowledge (Furth 1999; Leung 1987).

However, Song physicians became preoccupied with the observed divergence of the female body, particularly the gestational body, from the overall androgynous and generative cosmological body of medical theory (Furth 1999). The perceived requirement for physicians to regulate menstruation in women and the need for different prescriptions in caring for women paved the way for the innovative field of medical expertise called *Fuke*, which focused solely on the female body and its ailments as well as on childbirth (id.). Furth points out that in the case of childbirth, scholarly physicians, rather than participate in the actual delivery, relied on the expertise of midwives, female healers, ritual specialists and of women resident of the household while limiting their involvement to emergencies (id.). She argues that "menstrual taboos represent women as a source of dirt and disorders yet mistresses

of generation" (Furth 1987, 43). Female blood in the form of the placenta is also associated with female pollution and female power and must be disposed of in the proper ritual fashion by female healers and ritual specialists (Furth 1999, 1987).

Leung points to the separate category of female practitioners who enjoyed considerable popularity among the common people, especially women and children, and she argues that '[f]emale healers were inescapable in a sex-segregated society' (Leung 1987, 153). Francesca Bray remarked on the presence of these female healers present in the household to assist during childbirth (Bray 1997). In Ming, the seclusion of women ensuing from the escalation of Confucian orthodoxy erected a barrier, albeit a permeable and negotiable one, that distanced the female body from physicians' direct medical examinations, specifically with regard to observation and pulse taking, consequently eventually diverting medical attention away from *Fuke* (Furth 1999). The Ming construction of the body aspired towards the achievement of longevity through self-discipline, self-cultivation, sexual economy and procreation (id.). The sole purpose of the sexual act was, and would remain until the evolution of the socialist state, strictly for reproductive purposes within the legal family unit (Furth 1999; Dikötter 1995).). However, it should be noted that the Ming period was a flourishing period for talented courtesans and *ars erotica* literature circulated freely as described in Li Yu's novel the *Carnal Prayer Mat*, as well as the popularity of the *bound foot* which was perceived by many as refined form of eroticism (Ko 1997) suggestive of a significant gap between discourse and practice. Nonetheless, the Confucian and neo-Confucian dictates

maintain that "[N]ot to bear progeny was a sacrilege that violated the first principle of filial piety" (Blake 1994, 696).

The burgeoning involvement of scholarly physicians in the sphere of secular medical practices along with the unprecedented proliferation of medical texts served to inflate the authority of the physician and, for all intent and purposes, to discredit other forms of healing activities (Unschuld 1985; Furth 1999). Nonetheless, as Hymes points out, many of the healing activities in the Song were still largely performed by itinerant doctors many of whom were Daoist or Buddhist religious healers and lay doctors of low or middle class origins (Hymes 1987, 16). The very process of "medicalisation" of female bodily functions represented a propitious form of legitimisation for scholars to be seen as medical authorities. As Furth points out, medical discourse led to the 'medicalisation' of birth blood pollution at the expense of popular ritual healing and, in the process, transferred the pollution to the child afflicted with smallpox (Furth 1999). However, the popular medical knowledge, the persistent activities of other healers, and conflicting opinions among physicians created a breach in the hegemony of scholarly medicine (Furth 1999; Hymes 1987; Hsu 1999; Unschuld 1985; Leung 1987).

This chapter described how discursive formation is not a *value-free* production of truth. Rather, it remains closely linked to the elite and the desire to maintain social order and morality. However, throughout my discussion of the text, some inconsistencies occur that are indicative of a human agency that can both generate

the text and resist it. In the next chapter I shall look more closely into the sphere of subject bodies that can live by the text and yet live outside of it.

Chapter 3

Bodies of Knowledge and the Body in Time and in Space

Medical bodies of knowledge and the discursive formations that accompany them originate from within historical and geographical contexts that shape perspective, focus and modes of perception that emulate knowledge and make sense of the world. Kuriyama most accurately refers to these bodies of knowledge as 'versions of truth' because ways of *knowing* diverge in space and over time (Kuriyama 1999). Medical discourses can reach multiple levels of the social sphere, even different societies or cultures, and yet the impact and implementation of the official lines of discourse may well be quite heterogeneous. As mentioned above, discourses often reflect social ideals and aspirations rather than what the social context actually is (Kovacks and Unschuld 1998, 18). That is not to say that the discourse is irrelevant, on the contrary, it emerges as a constant throughout human history and belongs in the arena of human activities whereby the need to know the world and to organise that world into a structured and ordered society is perceived as fundamental. However, there exists a certain disparity between the text and practice, which involves human agency. The following explores the interactions of the two.

Western Medicine and the Chinese Medical Body

Mutations in the orientation of medical epistemologies are sometimes too subtle to be determined in time. Michel Foucault and Bruno Latour suggest that innovations

and epistemological orientations emerge through complex historical processes and through a movement in the *rapports de forces* and *rapports de pouvoir* within a network of interest and social forces (Foucault 1973; Latour 1984). In the previous section, I have discussed some of the discrete transformations in the constructs of an earlier cosmological and androgynous body, of a Song *Fuke*'s female androgynous body with a difference and of a Ming social body of sexual economy and reproduction (Furth 1999; Unschuld 1985; Sivin 1987). In this section, I wish to examine how twentieth century Chinese thought (medical and other) may have adopted and modified biomedical scientific concepts of the anatomical body into the mainstream of Chinese medical knowledge.

Refurbishing the Language of the Classics

As the last vestige of the imperial age in China melted into the twentieth century and Western science, imbued with Western values, gained ground, practitioners of Chinese medicine found themselves scattered and offering diverse levels of skills and knowledge (Unschuld 1985). Chinese medicine as a symbol of traditional values faced the onslaught of new modernising intellectual currents that swept China in early twentieth century condemning all that was traditional as backward, outdated and superstitious in favour of science and modernity (Croizier 1968, 2). Croizier adds that there was a sustained counter-attack from conservative intellectuals who refused to discard such an ancient and essentially Chinese tradition in favour of an import of culturally foreign origin, and for the first time in history

Chinese medicine became aware of itself as a single tradition in the face of the Western model (Croizier 1968, 2; Yates). Nonetheless, the debates continued and, albeit its precarious position, Chinese medicine survived as a 'distinct system' in a form that was modified significantly and that is still being transformed (Croizier 1968, 3; Unschuld 1985; Hsu 1999). In the early Maoist era, Chinese medicine did not survive for its own sake or efficacy, rather it served to enhance a Chinese national identity and essence that neutralised the foreign elements of scientific medicine and, most importantly, it provided medical care at a lower cost and easier accessibility than Western medicine (Croizier 1968). Furthermore, Chinese medicine was well accepted, even preferred by and easily accessible to the rural population and in remote areas, and the scarcity of resources (including doctors trained in Western medicine) to implement modern medical care all over China determined the pragmatic necessity to preserve (and gradually scienticise) Chinese medicine as a system of health care (Croizier 1968). Chinese medicine practitioners never managed to put up a united front until, under communist rule, Chinese medicine became, for the first time in history, standardised and institutionalised as well as mandated to include the intimate and co-operative existence with Western scientific medicine (Croizier 1968; Unschuld 1985; Sivin 1987; Farquhar 1994; Hsu 1999).

The imperative to expurgate classical medical texts originating in the movement of *rapports de forces*, previously mentioned, involved various sources of interest either singly or combined. Urged by the new communist regime, Chinese medical

practitioners were compelled to scienticise the language of the classics to raise their own status in China, a status that could reflect on that of China and by association the communist government's own prestige and recognition abroad as a modern nation (Unschuld 1985; Dikötter 1995; Croizier 1968). Sivin points out that one of the major changes effected during that period was the translation of classical texts into vernacular language suffused with changes in meanings and interpretations (Sivin 1987).

The traditional medical canons were saturated with contemporary "politically incorrect" as well as backward references. The socialist government implemented a systematic purge of all offending terms that conveyed ideas of feudal, religious and superstitious elements with the explanation that these were not topics worthy of study (Sivin 1987; Unschuld 1985). Gone were the kingly metaphors of the *Yellow Emperor's Body* and hierarchical models of the functions of the inner organs. Rather, a politicised language on 'dialectic materialism' rehabilitated the imperial influence of the *yinyang* theories into politically acceptable notions of revolutionary 'opposition' and 'struggle' (Hsu 1999; Unschuld 1992, 51; Croizier 1968). Sivin provided an analysis of such linguistic changes with a partial translation of 'Revised Outline of Chinese Medicine' (1972). He points to the new focus on loci with regard to the circulation tracts and their role in treatment with acupuncture and moxa rather than their role in the circulation of *ch'i (qi)* and *hsueh (xue)* (Sivin 1987, 120-145). Hsu remarked on the new emphasis given the organs and bowels with regard to the 'Tracts and Links' in *acumoxa* (Hsu 1999, 200). Sivin views

these processes of 'pruning of ambiguities' and the integration of Western diagnostic nosology as an attempt to synthesise the old and the new into a more accessible medical canon (Sivin 1987, 120-145).

As demonstrated in Liu Yanchi's book on traditional medicine written in 1988, the integration of scientific language, scientific explanatory theories and changes in meanings provide for a newly interpreted reading of the traditional canons. Liu Yanchi provides a striking example of a transformed medical discourse by his following description of a 'sinking *qi*': '[...] includes gastroptosis, nephroptosis, prolapse of the uterus and rectum, distention and heaviness in the abdominal and lumbar regions, lassitude and feeble voice. The pulse is thready and forceless' (Liu 1988, 183). Liu refers to several other fundamental changes in theoretical and linguistic conversions that appear to have become the norm, a process of constant *becoming* referred to by Daly as a form of *hybridisation* (Daly 1999). For instance, he discusses physiological functions, metabolism, pathogenic and antipathogenic factors of illness, deficiencies and even micro-organisms (Liu 1988). In addition, Hsu stresses the tendency towards a standardised theory that is formatted according to the biomedical model. Thus, Chinese medicine divided its curriculum into subjects namely, '*Organ Clusters, TCM* (traditional Chinese medicine) *Etiology and Pathogenesis*, and *Outline of TCM Preventive Health Care*' (Hsu 1999, 159).

Biomedicine's anatomical and physiological model of the body takes precedence over the cosmological model. However, a distinct mind/body dichotomy

(particularly with regard to mental illness) is less emphasised and mental disorders remain more intimately linked to the traditional view of disharmony within the organ system (Liu 1988). It would be wrong to assume that the absence of an arbitrary mind/body dichotomy implies that Chinese medicine did, and does, not recognise emotional problems or mental disorders. On the contrary, for example, the concept of the *shi shen* (Loss of Spirit), according to Hsu, conveys through the person's behaviour and appearance several signs associated with certain conditions of mental illness (Hsu 1999, 218-222). Kleinman's study of neurasthenia in China clearly demonstrates that the somatic expression of mental illness or personal distress remains the preferred, and often only acceptable, mode of expression for emotional distress (Kleinman 1986). The inclusion in Chinese medical theories of excessive emotions as potential factors that cause diseases further supports the attention paid to emotional and mental disorders. Kleinman discusses how the lingering stigma attached to mental illness is best avoided through the more legitimate somatic expression of emotional distress and suffering or managed within the less official sphere of religious healing (Kleinman 1986).

Despite the recent drastic changes in the language of the classics, semantic fluctuations and the scienticising of classical texts follows the path of a continuing tradition of textual manipulation and, in sharp contrast to the Western medical tradition that discards the old for the new, the Chinese medical tradition accumulates and integrates the new with the old (Unschuld 1992, 58). Many of the Chinese drugs are being scientifically investigated as well as combined with

Western pharmaceuticals (Yates). However, Sivin fears these last changes represent a point of no return as the rationality of science stands to gain the upper hand (Sivin 1987). Croizier speculates that larger cultural issues involved with Western science will lead to the demise of Chinese medicine as a distinct system (Croizier 1968, 238).

It would be misleading to assume that scientific medical theories represented an unproblematic "graft" of *value-free* epistemology onto the Chinese body of medical knowledge (Lock 2000, lecture). It would probably be more accurate to regard scienticised theories of Chinese medicine and of the Western medical system in China as having been processed, sanitised, and naturalised as Chinese (Croizier 1968). Latour and Foucault's notions of dynamic process involving the movement within networks of *rapports de forces* and *rapports de pouvoir* imply a discriminatory integration of biomedical knowledge and its scientific orientations (Latour 1984; Foucault 1973). David Arnold provides a detailed description of the involvement of an emerging scientific medicine in the colonisation process in nineteenth century India and of the subsequent interplay of confrontations, negotiations, compromises, and appropriations involving medicine and the power relations within the Indian population and caste system (Arnold 1993). However, in the context of India, Western medicine was imposed on the Indian population by a colonising foreign power, as opposed to the Chinese context whereby the import of Western medicine was voluntary. Biomedical knowledge, despite its claims to

empirical universality, is not a static body of knowledge and remains subject to the transformative powers of history and of human interventions.

Bio-Power, Local Autonomy and the Control of Bodies

The following explores aspects of the power of medical knowledge and of the Chinese State with regard to the control of bodies and the networking of forms of local autonomy. Foucault points out that concerns about production and reproduction as well as the need for the state to exert its control over human bodies with respect to these issues is closely related to demographic changes (Foucault 1973). Brian Turner stresses the importance of the Protestant ethic within a capitalist economy with regard to the evolution of the disciplines for the surveillance and management of the human body (Turner (1984) 1996). By adopting the disciplinary gaze of biomedicine, China could, in effect, benefit from effective technologies of power to implement a systematic and selective purification of the Chinese race and Nation (Croizier 1968, 59-60; Dikötter 1995). Grounded in scientific rationality, biomedicine can be viewed as a legitimate advocate for political agendas and the least susceptible to be challenged. In view of its desire to rid China of all her feudal and superstitious elements, the Chinese state could not find a better ally in the scientific objectivity of biomedicine with which to implement its control over the Chinese population. However, cultural aspects intrinsic to Western medicine emphasised its 'foreign' identity and overpowering saturation of 'bourgeois' elements so offensive to the ideology of a communist state

needed to be tamed and amalgamated into a more appropriately Chinese discourse and practice (Croizier 1968).

Biologising the Body and the Effects of Power

The erosion of neo-Confucian ideology with regard to gender hierarchies and social order represents a slow process that began in late imperial China as a result of changing socio-economic realities (Dikötter 1995, 14). Concepts of a cosmological and social body were losing ground to the appealing scientific concept of a biological body, a seed of change, which might even have been embedded in Song *Fuke* (ibid.). The adoption of a biologised concept of the body as opposed to a cosmological one represents a shift in perspective and in values and further delineates gender hierarchy of male superiority yet changes little with regard to the material body's susceptibility to represent an ideal site for the exercise of control (Evans 1997). Dikötter stresses that, in the early Republican period in China, discourses on sexuality and reproduction were not articulated through a single authoritative source such as the state or an institution, rather they came from several interest groups and divergent intellectual currents and echoed the concerns of a modernising discourse as opposed to a medical one (Dikötter 1995, 5). Furthermore, he argues that '[C]onflicts between modernizing discourses and State policy were common, and there is little evidence of a strong and unambiguous link between science, medicine and the State before the establishment of a socialist regime in 1949' (Dikötter 1995, 6). Hence, the body became a live representation

for the diseases of modernisation through scientific discourse. The controversy of science and modernity versus the traditional and non-scientific spurred endless debates, which focused not only on medical issues, but spread to the core of Chinese national identity, her quest for modernity and the health of the nation (Croizier 1968).

Dikötter's description of the evolution of discourses on sexuality and reproduction in Republican China focuses on similar issues to those raised by Foucault in his history of sexuality in Europe, namely onanism, sexual desire, marital sex for procreation, and homosexuality (Dikötter 1995; Foucault 1976). Evans remarks on the new marriage law of 1950 that recognised monogamy as the only form of legal marriage, and on the communist party's goal for sexual equality which proposed an interesting remodelling of the body into a 'revolutionary' body characterised by androgynous contours and revolutionary essence, which would rightly focus on the production of revolution and the reproduction of revolutionary bodies (Evans 1997). In the contexts of Europe and of China, the problematic of the body seems to revolve around moral issues that concentrate on 'production' and 'reproduction' and implies that the 'sexuality' of a natural biological body should be regulated for the welfare of the whole socio-political and economic body. This could possibly be interpreted as a rewording of Confucian morality by means of scientific and political language.

The transfer from a primarily social body to a biological body creates a schism within the cosmological harmony and relocates the body within nature as a separate sphere from that of culture (Dikötter 1995). Nonetheless, it should stressed that a biological construct of the body retains the original moral and political mandate of any discursive formation, as argued by Sivin 1995, chapter IV, 2). Thus reified into an 'object' of observation and knowledge the body appears stripped of the subjective resonance of the embodied "self" which greatly facilitates the presumed authenticity of biologically based normative categories such as sexual deviancies, gender and race (Foucault 1973; Dikötter 1995). Dikötter stresses that the newly shaped discursive formations concerning the naturalisation of the body were not a direct result of the Western normative discourse, rather, he claims that a cultural reorientation began to take place as far back as prior to the seventeenth century (Dikötter 1995, 180-181). The practice of foot-binding, for example, suggests such a cultural manipulation of the body as a natural being as opposed to a microcosmic reflection of the cosmological order (Blake 1994). Although not prescribed in official medical discourses, foot-binding in late imperial China reflects Foucault's thesis that power follows a multidimensional dissemination within society, which in this case was located in the internal dynamics of the neo-Confucian family unit (Foucault 1976). Furthermore, footbinding could represent a form of resistance directed at the new Manchu government whereby the Chinese maintained their racial identity by refusing to comply with the prohibition of the practice by the Qing state and possibly as a retaliation against the imposition the Manchu hairstyle for the Chinese males (Yates 2000).

Scientific medical achievements owe much to the accelerating development in technology. From pharmaceuticals, diagnostic equipment to advanced genetic research, technology can offer tremendous power to the state supporting Michel Foucault's discussion of panoptic surveillance and the regulation of bodies and of populations (Foucault 1977). In the context of the Chinese socialist state, a selective adoption of medical technologies focuses, albeit not entirely, on reproductive technologies. Dikötter describes how from the origins of the socialist State, Chinese leaders have mobilised medical technologies against undisciplined and deviant sexuality for the greater health and strength of the nation (Dikötter 1995; Evans 1997; Croizier 1968). The sexual act must lead to 'procreation' within the legal marital unit and sex strictly for pleasure is classified as 'deviant' and is perceived as 'decadent and immoral' (Dikötter 1995; Handwerker 1998). Dikötter further points to the 'extreme' methods of scientific control used to curb deviant sexual behaviours and to prevent 'inferior' births that could result from mentally retarded parents or suffering from infectious disease, and congenital conditions (Dikötter 1995). State policies and coercive means of regulation of sexuality encompassed a number of technologies, namely eugenics, birth control programmes, abortion, mass sterilisation, hormone and electric shock therapies and even *in vitro* fertilisation (Dikötter 1995, 183-186; Handwerker 1998).

Possibly the most publicised and important policy implemented by the Chinese government with regard to birth planning is the "one child policy" (1979) aimed at

curbing the alarming population growth occurring in China. The level of surveillance and regulation required to implement such a policy provided the government and its delegates with a vehicle for an intimate invasion of people's lives and, one should add, an intrusion within the 'family' (Handwerker 1998). Women from 'neighbourhood committees' are delegated the function of 'policing' the proper enforcement of the birth planning policies as they observe, often with morbid curiosity, what goes on within the households of the neighbourhood and report any indiscretions, pregnancies and non-compliance to the policies of the state (Yates 2000). These women serve as the ideal extension of the power of the state into the microstructures of society. The birth planning policies also fuelled an unexpected paradox as described by Handwerker: " the overly (re) producing (defined as giving birth to more than one child) must curtail their births, non (re) producing women are stigmatized and encouraged to fulfill the one-child quota established by the Chinese government " (Handwerker 1998, 178). Handwerker relates how the childless woman becomes perceived as a deviant 'other' through social stigmatisation and through the official medicalisation of infertility as well as how she can resist these pressures by seeking assistance by means of reproductive technologies such as *in vitro* fertilisation or even adoption (Handwerker 1998). While some women will go to great lengths to conceive a child, the "voluntary" childless women present the most threatening form of rebellion against the State (id.). Handwerker interviewed a doctor who said that "it was 'natural' (*ziran*) for every Chinese woman to want a child" (Handwerker 1998, 195). Harriet Evans also supports this statement that motherhood is natural and a women's duty to the state

(Evans, 113-121). Handwerker claims that forms of resistance are manifest in some television programmes or on the radio such as talk shows, whereby suggestions of personal initiative with regard to childbearing are articulated quite clearly (id.). Evans points to a positive response to 'the one child policy': she remarks that women who were burdened by numerous pregnancies welcomed a policy that that could free them of their childbearing obligations (Evans 1997). The State's control mechanisms of surveillance by means of compulsory gynaecological exams (semi-annual), restricted access to birth control products (pills, condoms, intra-uterine devices) and abortions all become significantly diffused at the local level of practice where bribery and *guanxi* are more tangible than the gaze of the state; even women from the neighbourhood committee could compromise or negotiate on occasions (Handwerker 1998).

The Subject Body

Discursive formations about the body, health and illness, rather than defining an objective reality or truth, will construe reality through translation and interpretation (Latour 1984). Bruno Latour argues that no concepts or discoveries are reducible to static historical events, rather all are related to the result of movements and points of intersection between forces and actors within interactive networks that remain in constant flux much like a chain reaction (Latour 1984; 1999). In a similar fashion, Michel Foucault insists that 'power isn't localised in the State apparatus and that nothing in society will be changed if the mechanisms of power that function outside,

below and alongside the State apparatus, on a much more minute and everyday level are not also changed (Foucault 1980, 60). Such statements imply that discursive formations are a product of these interactive networks and also dependent on them. Furthermore, the interpretive constructs that they generate cannot penetrate the network in monolithic fashion without being integrated in the dynamics of Latour's conceptual interactive chain reaction. Within this framework, the body as object of knowledge and power can be disclosed as a subject body involved in human activities while embodying an interpretation of discourse.

Michel Foucault focuses on the State and power at the expense of culture while Pierre Bourdieu investigates cultural aspects of human activities and practices (Lock 2000). Bourdieu's theory of practice implies the necessary adaptive autonomy of individuals and collectives within a given contextual environment (Bourdieu, 1972). His theory does not entail the outright rejection of prescriptive discourse, rather it emphasises individual subjectivity together with an embodied *habitus* as a *constant* in everyday activities (ibid.). Bourdieu's *habitus* represents the process of embodiment that is directly related to the social structures and the socialisation process that takes place within these structures. This form of embodiment of rules and regulations with regard to comportment explains how the social world works and what one's status is in that world. The concept of *habitus* is quite relevant with regard to my discussion on footbinding later in this chapter.

Bourdieu does not disclaim Foucault's concept of external technologies of power and discipline over the body. On the contrary, his concept of *habitus* reinforces Foucault's analysis with regard to the process of embodiment of social constructs, prescriptions and disciplines. However, Bourdieu focuses on the subjectivity of individual *action* in practice with the influence of the unconscious *habitus* (Bourdieu 1972). I tend to view Bourdieu's theory of practice as an essential complement or even continuation of Foucault's perspective on the body, a lively articulation of social constructs and human activity.

Theory, Practice and the Clinical Encounter

Both in China and in Japan, biomedical practices, particularly with regard to the use of pharmaceutical drugs, have gained a reputation for their potency and rapid efficacy as opposed to the more gentle and lengthy therapies of traditional Chinese medicine (Lock 1980; Farquhar 1994). Liu Yanchi stresses that neither medical model is complete in its approach to diagnosis and that Chinese biomedical and traditional doctors alike regularly refer patients whose condition cannot be diagnosed or does not respond to therapy to either medical system (Liu 1988, 288-89). However, Liu Yanchi's account of a flexible cooperation between the practitioners of the two medical systems and of an unproblematic integration of biomedical and traditional therapies remains confined to the official sphere of medical practice and downplays possible competitive frictions among practitioners. Furthermore, Liu focuses on institutionalised Chinese and Western medicine and

neglects to discuss other sectors of healing practices existing outside of the official sphere. Elizabeth Hsu's investigation into healing practices outside of government appointed institutions of Chinese medicine and of biomedicine demonstrates the existence and popularity of alternative health sectors that reflect different micro-economic bases of income, social relations, and religious practices while remaining mutually interdependent (Hsu 1999, 5-14). Her analysis points to the agency of individuals in their choice of medical therapies, whether influenced by financial, social or religious considerations, as well as to the simultaneous or successive recourse to one or more kinds of therapies. Liu's mention of the transfer of patients from one official system to another and Hsu's description of patients' own decision in their choice of a suitable therapy could be perceived as a pragmatic solution to deal with chronic and acute medical conditions and a rather astute way to circumvent the problematic mind/body dichotomy experienced in North American biomedical systems. The transfer from one system to another and/or the personal choice of alternative therapy legitimises patients' claimed ailments while maintaining their ontological integrity as patients.

Scheper-Hughes and Lock posit that a mind/body dichotomy separating matter from the spirit has led the medical gaze and the clinical applications of medical knowledge to a remarkable efficacy within the sphere of 'matter' (Scheper-Hughes and Lock, 1987, 8). The mind/body dichotomy of the biomedical framework also imparted the medical range of vision and action with an inescapable rigidity when dealing with a subject body that defies fragmentation. Pain would be such an

example and the human experiences of pain and suffering that elude the rigid theoretical framework of biomedicine are funnelled into a medicalisation process that can only defer the problem and alienate the individual. This medicalisation process will only accelerate until the biomedical assumptions of a reducible individual are revised and reformulated. Furthermore, in the North American context, beliefs and expectations with regard to the absolute efficacy of biomedicine leave those who experience distress and suffering entangled in a medical world that fails to provide them with the relief they seek (Lock 2000; Kleinman 1988). This, however, does not preclude personal and subjective interventions on the part of a large number of biomedical practitioners who are invariably aware of the lacunae inherent to the scientific model and who will either refer their patients towards potential alternatives or engage in a therapeutic intervention by means of listening to patients' narratives and offer guidance.

Arthur Kleinman has done intensive research into chronic pain and suffering in the United States and into depression and neurasthenia in China. He focuses on the social origins of distress and disease and their commonly articulated somatic expressions (Kleinman 1986; 1997). Biomedicine readily classifies depression as a mental disorder, a separate category not recognised in traditional Chinese medical theory because emotions and mental states are intrinsic to the organ system and functions. Furthermore, in China, mental illness carries a social stigma that is best avoided through the somatic expression of distress as a form of compromise (Sivin 1987; Tung 1994; Kleinman 1986). In China, in view of the scienticisation of

Chinese medicine, its coexistence with a biomedical system and the common practice of referrals between the two medical systems, one must ponder whether the Cartesian body of scientific medicine has permeated the traditional Chinese body or, if possibly it articulates its duality in the two official and contemporary bodies of medical knowledge.

Michel Foucault's concept of the external technologies of power deployed over the individual body and extending to the social body (in the context of Europe) bear striking similarities to the Chinese focus on the social and political body, if not in form, at least in essence. Foucault's insistence on the invisibility of the mechanisms of power over the body appear to have a much more visible form in the context of China. It is possible however, that in the context of socialist China, where the technologies of power are more visible than those implied by Foucault, meet with a more invisible form of resistance.

Embodiment and Agency

Much of what occurs in the sphere of human activities and practices prompts a significant dilution of the official versions of discourse whereby personal and social influences inject new parameters for interpretation of health and illness and for associated behaviours (Bourdieu 1972; Turner 1984; Lupton 1997). In fact, subjectivity, agency, covertly embodied *habitus* and instinctive potential for

improvisation form the essence of human interactions, whether in social or medical context. Individual members of collectives are active participants in human activities with regard to health or illness who, during their interactions with others, often modulate the articulation of official discourses through negotiations and compromises (Bourdieu 1972; Lupton 1997). Deborah Lupton suggests that 'the medical encounter involves a continual negotiation of power that is contingent upon the context in which the patient interacts with the doctor' (Lupton 1997, 104). As implied by Lupton, the patient and the doctor both become interactive during a clinical encounter and both are equally influenced by factors such as 'age, ethnicity and gender' as well as by their personality, emotional state and their accumulated embodied experience (Lupton 1997, 104). Furthermore, she argues that 'the medicalisation of the body is a constructed frame of reference which, if replaced by another, may well lead to different, but no more authentic modes of subjectivity and embodiment (Lupton 1997, 107). Her statement is relevant to the frame of reference in Chinese medicine, which views the body as a monistic articulation of the cosmos and provides a shared referent of the world order, and its own mode of subjectivity and embodiment.

A Mindful *and* Biological Body

Scheper-Hughes and Lock's *mindful body* comes to life in the human activities of everyday life. Francesca Bray offers a glimpse into women's individual and collective agency with regard to fertility in late imperial China whereby

reproductive technologies were either negotiated with the doctors (and/or male household head) or concealed by means of personal initiative and within the sphere of the permissible such as the regulating of menstruation (Bray 1997). The official medical discourse, which stressed the importance of regulating menstruation, created a conundrum for physicians in their administration of potent blood releasing drugs that would provoke blood flow as well as possibly terminate a pregnancy (id.). Bray points out that women who were likely aware of the state of their body (pregnancy) could manoeuvre within the official discourse to control their fertility for access to these drugs was also available through drug peddlers (id). According to Hill Gates, contemporary Chinese women may have welcomed official birth planning policies as a form of liberation from the rearing of a large number of children, and in their voluntary acceptance expressed resistance to unlimited pregnancies through compliance with the "one child policy" (Gates 1996, 202). Human sex drive can lend 'agency' to the biological body and generate resistance to discourse as demonstrated by Harriet Evans in her mention of the promiscuous activities of young red guards who were left unattended by parents or guardians at a time when sex could not be mentioned in public (Evans 1997, 7).

Official medical discourses create their own space of activity and, although the content of these discourses target the society as a whole, the influence that they generate appears strongest within the sphere of the elite population and within an urbanised core population (Hsu 1999). Unschuld has mentioned how pluralism of healing practices persisted throughout Chinese history and Hsu emphasises its

contemporary presence within the creation of spaces beyond official delineation for eclectic forms of healing activities such as non-standardised practices and teachings of Chinese medicine and the healing practice of *qi gong* (Unschuld 1985; Hsu 1999). Kleinman has also discussed the recourse to religious healing rituals performed in shrines, particularly when the illness involves a potentially stigmatising label such as mental illness (Kleinman 1988). Furthermore, access to the more sophisticated medical care offered in urban areas and the cost involved in procuring expensive medicines, such as Western medicines, can greatly influence the decision of those seeking care (Yates 1999; Croizier 1968). Personal choice over determining which type of healing practice is most suitable is often the major factor prior to consultation (Yates 1999; Croizier 1968). Pluralism with regard to healing practices opens multiple avenues for individual action of a covert or overt nature and their very existence attests to the human agency involved in creating social spaces for their practice.

The physical body that is biologically programmed for survival and reproduction remains fundamental in determining social and cultural constructs of gender, spaces, hierarchies and power relationships (Gates 1996, 201; Blacking 1977). Margaret Lock raises the neglected issue of the biological attributes of the body and regrets the frequently inflated importance accorded culture in the socialisation process and formation of identity. However, she cautions against excessive tendencies in either direction (Lock 2000). Lock and Blacking stress the important, albeit frequently overlooked role of the biological and affective processes that serve as a blueprint for

social constructions (Lock 1993a; Scheper-Hughes and Lock 1987; Blacking 1977). Biological features of a biological body that breathes, eats, talks, reproduces and dies imply a shared universality yet remain dependent on specific indigenous, cultural, historical and environmental contexts (Lock 1993a; 2000). Intensive research in Japan by Margaret Lock with regard to menopause clearly identifies discrepancies in the physical experiences and symptoms such as 'hot flashes', associated with menopause in North American medical literature (Lock 1993a). She claims that, while the cessation of menses occurs as a universal biological phenomenon in women's natural life cycles, the symptoms associated with it and the perceived essentiality for their medicalisation are not necessarily congruent within localised contexts (ibid.). Lock's suggestion of potentially localised biologies raises important issues with regard to the body's environment, namely cultural, social, physical, dietary practices and life-styles (ibid.). More importantly, Lock acknowledges the 'biological' body to be a fundamental actor in the arena of life and dynamic interaction of individual, social and political bodies (Lock 1993a; 2000). Margaret Lock's concept of localised biologies could translate into the concept of a bio-social ecosystem that, while encompassing universal principles also implies the relativism of indigenous contexts and practices whereby biological, individual and collective agency coexist by means of continual and mutual adaptation, complicity, resistance, compromise, compliance and negotiations.

The Bound Foot: a Bodily Practice

The binding of women's feet in late imperial China represents one among many bodily practices effected by culture on nature by means of intentional human practices on or in regard to the body. The practice of foot binding in China compares with other bodily practices in other parts of the world, such as female circumcision, body piercing, slimming corsets and stiletto heels as culturally modulated practices that use the material body to participate in the social world (Turner 1984). In the following discussion on footbinding, I wish to provide an example of interactive agency and the body and of the complexities and implications such a practice generates with regard to power relationships, whereby power cannot exist in a static or single form. This concept of a dynamic network draws from Bruno Latour's argument to the effect that even 'microbes' participate with humans in life events, and that all actors are thus *irreducible* entities. However, each actor is influenced and influences the movement of forces originating within dynamic interactions (Latour 1984).

The binding of young girls' feet in China reflects a form of cultural embodiment that reveals prominent facets of the dynamics of human activities. It implicates both directly and indirectly the biological body, eroticism and sexuality, economic production, female agency, power and resistance. Furthermore, as intimated by Dorothy Ko and Francesca Bray, it implies a women's culture and the creation of a liminal space in the core of a male dominated world (Ko 1997; Bray 1997).

Footbinding is a bodily practice that uses cultural criteria to manipulate and transform nature on the locus of the body (Lock 2000). The binding of the feet required prolonged and extremely painful bone-crushing manipulation of the feet of small girls (from the age of five to seven until puberty) to impede the growth of flesh and bones and maintain a tiny and delicate foot structure (Blake 1994). Blake refers to Elaine Scarry's statement with regard to pain's resistance to language and the sentient experience of pain as unsharable, which he relates to the painful discipline of foot-binding as symbolising the muted voice of women in the male articulated discourse of neo-Confucian China. (Blake 1994, 677; Scarry 1985: cited in Blake). Elaine Scarry argues that the experience of pain cannot be expressed in language, which is part of the embodied *habitus* and represents the world. Consequently, pain destroys one world, and a new language will become embodied and thus create a world with shareable referent (Scarry 1985). Blake focuses on this traumatic discipline with regard to the embodiment of self and management of space (female inner sphere), and the preparation for women's easier transition into the male dominated social world of production and reproduction (Blake 1994). However, Blake fails to feature Scarry's dominant thesis that pain both makes and unmakes the world, which, in my opinion, relates even more powerfully to his description of this painful form of socialisation (Scarry 1985). It could be argued that the 'muted voice of women' referred to by Blake is not a voice articulated through words, rather, the tiny feet as a creation *is* the articulation of female power in the male world and audaciously defies the oppressiveness of the male dominated

world of Confucianism in the intentional mutilation of the Confucian 'sacred body' (Blake 1994).

Dorothy Ko describes how Chinese courtesans of the Ming dynasty enjoyed surprising mobility of women with bound feet in the male public world and simultaneously embodied the sensuous and the erotic in the bound foot and the world of the male literati in her literary and artistic abilities (Ko 1997, 76). In late imperial China, much of the elite male and female disciplines reflected their aspiration towards refinement and civilisation through moral cultivation, and one of these measures of civility became embodied in the female bound foot in the form of *cultural capital* as suggested by Pierre Bourdieu (Blake 1994; Bray 1997; Ko 1997; Bourdieu 1972). According to Blake, the practice of foot-binding originated within the female realm and communicated female agency and participation in the neo-Confucian family system while embodying the power of (male talent) virtue (Blake 1994). In this most "un"Confucian and intentional display of bodily mutilation, women shielded themselves behind the veil of exclusion from the male dominated world, and while males excluded themselves from the binding process, they reaped the "face" enhancement and sexual magnetism that such a practice brought (Blake 1994). Bray points out that any polarisation that did occur did not fundamentally oppose male and female, rather it created a distinction between the "cultivated and the uncultivated" (Bray 1997, 375; Blake 1994). However, Dorothy Ko mentions that the practice of foot-binding did percolate to the lower classes and peasantry where it was perceived by the elite as a "vulgar imitation" (Ko 1997,76-98).

According to Blake, the process of footbinding appropriated "women's bodies into a labor- intensive economy by capturing their 'uterine power' to produce biological units of labor but also by commandeering their 'labor power' to produce economic goods" (Blake 1994, 678). However, factors other than the simple "appropriation" of women's bodies by the male dominated world of production and reproduction should be considered. Hill Gates intimates that footbinding enhanced the value of women's bodies as commodities with regard to advantageous marriage prospects, to bride-price or for the direct sale of daughters for marriage or prostitution (Gates 1996). Women's own desire and active agency to produce and reproduce in order to enhance the family's social and economic status as well as their own status within the household should be considered equally important factors. Blake's concluding comment expresses this best: "Foot-binding was the way women in China supported, participated in, and reflected on the neo-Confucian way of being civilized" (Blake 1994, 708). Interestingly, Blake points out that mentions of the practice in official medical discourse is scarce despite the pervasive popularity of the practice (id.). It should be noted that footbinding did not enjoy the same popularity in all regions of China and among different ethnic and religious groups, such as the 'Hakka', the Manchus and nuns who never considered adopting the practice (Gates 1996; Yates 1999). Footbinding by Han Chinese elite women persisted in spite of the official ban on the practice by the newly established Manchu dynasty: the bound foot had become a symbol embodying the ethnic identity of Han

Chinese and an overt act of resistance against the new non-Han government (Ko 1994, 148-49; Yates 1999).

Conclusion

Explanatory and prescriptive medical discourses generate a considerable impact on the forms of embodiment experienced by individuals and yet the relationship remains fluctuating and dynamic between the core and the margins of social structures. Lock quoted Lawrence Kirmayer who pertinently argues that there are two orders of experience, "the order the body and the order of the text" (Lock 1993b, 142). Whom does official discourse address? Discussions in the first two chapters on the discursive formations, medical discourses and bodies of knowledge from two divergent medical traditions suggest that the official lines of discourse originate within elite circles of educated and predominantly male population (Lock 1993a; Turner 1984). Brian Turner insists that a patriarchal hegemony and Protestant ethics greatly influenced prescriptive medical and moral discourses towards stringent disciplines of the body, particularly the female body, because a healthy and moral body were both compulsory for capitalist production and the accumulation of capital (Turner 1984; Foucault 1977). Consequently, the content of the discourse overflowed into the social body to target the commoner and the worker who were directly involved in production (Turner 1984; Foucault 1977). Confucian patriarchy and hierarchical social structures shaped the dominant features of Chinese life and human activities from early times to the socialist elite, particularly with regard to gender constructions. The Chinese moral and medical discourse, albeit within a different epistemological framework with regard to health

and illness, aims at maintaining order, thus extending to the social and political body.

Medical discourses mirror the environments that nurture them and thus are subject to historical, social, economic and demographic transformations (Unschuld 1985; Sivin 1987; Foucault 1973; Lock 1993). This assumption is best represented in Liu Yanchi's theoretical outline of traditional Chinese medicine, which is heavily accented with scientific undertones as a result of the new *rapport* between scientific and traditional medicine (Liu 1988). Science and technology yield a high level of authority with regard to the legitimisation of medical constructs and prescriptive medical discourses. Scientific discourses on health and illness can create the illusion that the reality and universality of the body dwell firmly anchored within the framework of its knowledge. In this thesis, I have examined several historical transformations and mutations of the Chinese medical discourse from its traditional inception to the more recent systematic integration of scientific knowledge. I further looked at how Western medical concepts of the body have been transformed over time from a notion of belonging with the natural order to a fragmented object of knowledge and discipline, a knowledge, which itself is being transformed by new computerised visualising technologies (Lock 2000). It would be misleading to look at ancient or divergent medical constructs of the body as fundamentally naïve or misconstrued, particularly in view of contemporary cyborg technologies, genetic manipulation, epidemiology of risk and theories of the immune-*self*, which extricate the body from nature into the realm of culture (Haraway 1993; Tauber 1997; Lock

1993a, 1993b; 2000). The transmutations and trajectories of medical discursive formations suggest a fluctuating embodiment of prevalent ideologies and technologies together with the accompanying and modulating social, economic and political factors.

The power that is derived from scientific knowledge transfers authority to its beholder, be it an institution or the State itself, for the implementation of control and regulation of individual, social and political bodies, yet it would be prejudiced to view biomedical pursuits as the sole perpetrators of hegemonic imperialism over human bodies and their management. Economic and political interests stand to benefit immensely from a docile, disciplined and medicalised body. (Foucault 1973; Lock 1993a; Turner 1984).

However, embodiment of rules and regulations of prevalent ideologies through the agency of parents, schools and social structures which consolidate the essentials of Pierre Bourdieu's "*habitus*" cannot escape the phenomenological variables encountered in everyday life (Bourdieu 1972; Foucault 1977). The individual remains an active participant in social life involved in the dynamic interplay of negotiations, compromise, improvisation and voluntary compliance. (Bourdieu 1972; Arnold 1993; Lock 1993b; Latour 1984; Lupton 1997). Margaret Lock insists the "the body refuses to hold still" Lock 1993b, 154). Instead, the body appears to fluctuate from object to subject and stands irreducible to a static ontology and passive status.

References

Armstrong, David. 1983. Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century. Cambridge: Cambridge University Press.

-----. 1997. "Foucault and the Sociology of Health and Illness. A Prismatic Reading". In Alan Petersen and Robin Bunton eds., Foucault, Health and Medicine. pp. 15-30. London and New York: Routledge.

Armstrong, D.M. 1999. The Mind-Body Problem. An Opinionated Introduction Boulder, Co.: Westview Press.

Arnold, David. 1993. Colonizing the Body. State Medicine and Epidemic Disease in Nineteenth-Century India. Berkeley, Los Angeles and London: University of California Press.

Berkow, Robert, et al., eds. 1992. The Merck Manual of Diagnosis and Therapy. Rahway, N.J. Merck Research Laboratories, Division of Merck and Co. Inc.

Bernard, H. Russell. 1988. Research Methods in Cultural Anthropology. Newbury Park, London, New Delhi: Sage Publications.

Blacking, John., ed. 1977. The Anthropology of the Body. London, New York, San Francisco: Academic Press.

Blake, Fred C. 1994. "Foot-Binding in Neo-Confucian China and the Appropriation of Female Labor". Signs: Journal of Women in Culture and Society 19.3: 676-712.

Bourdieu, Pierre. 1972. Esquisse d'une Théorie de la Pratique Précédée de Trois Études Ethnologiques. Genève, Paris : Librairies Droz.

Bray, Francesca. 1997. Technology and Gender. Fabrics of Power in Late Imperial China. Berkeley, Los Angeles, London: University of California Press.

Comaroff, Jean. 1993. "The Diseased Heart of Africa. Medicine, Colonialism, and The Black Body". In Shirley Lindenbaum and Margaret Lock eds., Knowledge, Power and Practice. The Anthropology of Medicine and Everyday Life, pp. 305-326. Berkeley, Los Angeles, London: University of California Press.

Conrad, P., and J. Schneider. 1980. Deviance and Medicalization: from Badness to Sickness. St. Louis: Mosby.

Croizier, Ralph C. 1968. Traditional Medicine in Modern China. Science, Nationalism, and the Tensions of Cultural Change. Cambridge, Massachusetts: Harvard University Press.

Daly, Nigel P. 1999. Hybridizing the Human Body: The Hydrological Development of Acupuncture in Early Imperial China. Master's Thesis presented to the Faculty of Graduate Studies and Research. McGill University, Montreal.

Darwin, Charles. (1859). The Origins of Species by Means of Natural Selection. Ed. J.W. Burrow. Harmondsworth: Penguin Books. 1968. Reprinted in Penguin Classics. 1985.

Dikötter, Frank. 1995. Sex, Culture and Modernity in China. Medical Science and the Construction of Sexual Identities in the Early Republican Period. Honolulu: University of Hawaii Press.

-----. 1998. Imperfect Conceptions: Medical Knowledge, Birth Defects, and Eugenics in China. London: Hurst and Co.

Eckman, Paul. 1977. "Biological and Cultural Contributions to Body and Facial Movement". In John Blacking ed., The Anthropology of the Body, pp. 39-80. London, New York, San Francisco: Academic Press.

Eisenberg, Leon, and Arthur Kleinman, eds. 1981. The Relevance of Social Sciences for Medicine. Dordtrecht, Holland, Boston USA, London, England: D. Reidel Publishing Company.

Ellen, R.F. 1997. "Anatomical Classification and the Semiotics of the Body". In John Blacking ed., The Anthropology of the Body, pp. 343-370. London, New York, San Francisco: Academic Press.

Evans, Harriet. 1997. Women and Sexuality in China. Female Sexuality and Gender Since 1949. New York: Continuum.

Farquhar, Judith. 1994. Knowing Practice. The Clinical Encounter of Chinese Medicine. Boulder, San Francisco, Oxford: Westview Press.

Foucault, Michel. 1965. Madness and Civilization. Trans. Richard Howard New York: Random House.

-----. 1973. The Birth of the Clinic: an Archeology of Medical Perception. Trans. A.M. Sheridan Smith. New York USA: Tavistock Publications Limited.

-----. 1976. Histoire de la Sexualité. Volume 1. Paris: Gallimard.

-----. 1977. Discipline and Punish. The Birth of the Prison. Trans. Alan Sheridan New York: Vintage Books.

-----. 1978. The History of Sexuality. Volume 1: an Introduction. Trans. Robert Hurley. New York: Vintage Books.

-----. 1980. Power/Knowledge: Selected Interviews and Other Writings 1972-1977. Trans. Colin Gordon, Leo Marshall, John Mepham, and Kate Soper. Colin Gordon ed. New York: Pantheon Books.

-----. 1985. The Use of Pleasure. Volume 2 of the History of Sexuality. Trans. Robert Hurley: New York: Vintage Books.

-----. The Care of the Self. Volume 3 of The History of Sexuality. Trans. Robert Hurley: New York.

Fox, Nick J. 1997. "Is There Life After Foucault? Texts, Frames and *Differends*". In Alan Petersen and Robin Burton eds., Foucault, Health and Medicine pp. 31-50. London and New York: Routledge.

Furth, Charlotte. 1986. "Blood, Body and Gender: Medical Images of the Female Condition in China 1600-1850". Chinese Science 7: 43-66.

-----. 1987. "Concepts of Pregnancy, Childbirth, and Infancy in Ch'ing Dynasty China". Journal of Asian Studies 46.1: 7-35.

-----. 1994. "Rethinking Van Gulik: Sexuality and Reproduction in Traditional Chinese Medicine". In Christina K. Gilmartin, Gail Hershatter, Lisa Rofel and Tyrene White eds., Engendering China. Women, Culture and the State, pp. 125-146. Cambridge, Massachusetts and London, England: Harvard University Press.

-----. 1999. A Flourishing Yin: Gender in China's Medical History, 960-1665. Berkeley, Los Angeles and London: University of California Press.

Gastaldo, Denise. 1997. "Is Health Education Good for You? Re-Thinking Health Education Through the Concept of Bio-Power". In Alan Petersen and Robin Burton eds. Foucault, Health and Medicine, pp. 113-133. London and New York: Routledge.

Gates, Hill. 1996. China's Motor: A Thousand Years of Petty Capitalism. Ithaca

and London: Cornell University Press.

Handwerker, Lisa. 1998. "The Consequences of Modernity for Childless Women in China: Medicalization and Resistance". In Margaret Lock and Patricia A. Kaufert eds., Pragmatic Women and Body Politics, pp. 178-205. Cambridge: Cambridge University Press.

Haraway, Donna. 1993. "The Biopolitics of Postmodern Bodies. Determination of Self in Immune System Discourse". In Shirley Lindenbaum and Margaret Lock eds., Knowledge, Power and Practice. The Anthropology of Medicine and Everyday Life, pp. 364-407. Berkeley, Los Angeles, London: University of California Press.

Ho, Peng Yoke. 1985. Li, Qi, and Shu: an Introduction to Science and Civilization in China. Hong Kong: Hong Kong University Press.

-----. 1997. A Brief History of Chinese Medicine. 2nd ed. Singapore, Edge NJ: World Scientific.

Hoffman LaRoche Ltd. 1969. From Emotion to Lesion. Montreal, Canada: Hoffman LaRoche Ltd.

Hogle, Linda F. 1999. Recovering the Nation's Body. Cultural Memory, Medicine and the Politics of Redemption. New Brunswick, New Jersey, and London: Rutgers University Press.

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

Hymes, Robert P. 1987. "Not Quite Gentlemen. Doctors in Sung and Yuan". Chinese Science 8: 9-76.

Kleinman, Arthur. 1974. Medicine in Chinese Cultures: Comparative Studies of Health Care in Chinese and Other Societies. Peter Kunstadler, et al. eds. Papers and discussions from a conference held in Seattle, Washington, U.S.A. Feb. 1974. U.S. Department of Health, Education, and Welfare. Public Service National Institute of Health. DHEW Publication no. (NIH) 75-653.

-----. 1980. Patients and Healers in the Context of Culture: an Exploration of the Borderland between Anthropology, Medicine, and Psychiatry. Berkeley: University of California Press.

-----. 1986. Social Origins of Distress and Disease - Depression, Neurasthenia, and Pain in Modern China. New Haven and London: Yale University Press.

-----. 1988. The Illness Narratives. Suffering, Healing, and the Human Condition. New York: Basic Books Inc. Publishers.

-----. 1988. Rethinking Psychiatry: from Cultural Category to Personal Experience. New York: Free Press; London: Collier Macmillan.

-----. 1990. Psychosocial Aspects of Depression. Hillsdale, N.J.: L. Erlbaum

Associates.

-----. 1995. Writing at the Margin: a Discourse between Anthropology and Medicine. Berkeley: University of California Press.

Kleinman, A., Veena Das and Margaret Lock eds. 1997. Social Suffering. Berkeley, Los Angeles, London: University of California Press.

Ko, Dorothy. 1994. Teachers of the Inner Chambers: Women and Culture in Seventeenth Century China. Stanford: Stanford University Press.

-----. 1997. "The Written Word and the Bound Foot: a History of the Courtesan's Aura". In Ellen Widmer and Kang-I Sun Chang eds., Writing Women in Late Imperial China, pp. 74-100. Stanford: Stanford University Press.

Kovacs, Jurgen and Paul U. Unschuld. 1998. Essential Subtleties on the Silver Sea. *The* Yin-hai jing-wei: *A Chinese Classic on Ophthalmology*. Trans. Jurgen Kovacs and Paul U. Unschuld. Berkeley, Los Angeles, London: University of California Press.

Kuriyama, Shigehisa. 1994. "The Imagination of Winds and the Development of the Chinese Conception of the Body". In Angela Zito and Tani E. Barlow eds., Body, Subject and Power in China, pp. 23-41. Chicago: University of Chicago Press.

-----. 1999. The Expressiveness of the Body and the Divergence of Greek and

Chinese Medicine. New York: Zone Books.

Latour, Bruno. 1984. Les Microbes Guerre et Paix suivi de Irréductions. Paris : Éditions A.M. Métaillé.

Leung, Angela Ki Che. 1987. " Organized Medicine in Ming-Qing China : State and Private Institutions in the Lower Yangzi Region". Late Imperial China 8.1: 134-166.

Leslie, Charles, and A. Young, eds. 1992. Paths to Asian Medical Knowledge. Berkeley, Los Angeles, Oxford: University of California Press.

Levins, Richard, and Richard Lewinton. 1985. The Dialectical Biologist. Cambridge, Mass: Harvard University Press.

Lindenbaum, Shirley, and Margaret Lock, eds. 1993. Knowledge, Power and Practice. The Anthropology of Medicine and Everyday Life. Berkeley, Los Angeles, London: University of California Press.

Liu, Yanchi. 1988. The Essential Book of Traditional Chinese Medicine. Volume 1: Theory. Trans. Fang Tingyu and Chen Laide. New York: Columbia University Press.

Lock, Margaret. 1980. East Asian Medicine in Urban Japan. Varieties of Medical Experience. Berkeley, Los Angeles, London: University of California Press.

-----. 1993a. Encounters with Aging. Mythologies of Menopause in Japan and

North America. Berkeley, Los Angeles, London: University of California Press.

-----. 1993b. "Cultivating the Body: Anthropologies and Epistemologies of the Bodily Practice and Knowledge". Annual Review of Anthropology 22: 133-55.

Lock, Margaret, and Patricia A. Kaufert, eds. Pragmatic Women and Body Politics. Cambridge: Cambridge University Press.

Lu, Gwei-Djen and Joseph Needham. 1980. Celestial Lancets: a History and Rationale of Acupuncture and Moxa. Cambridge, New York: Cambridge University Press.

Lupton, Deborah. 1997. "Foucault and the Medicalization Critique". In Alan Petersen and Robin Bunton eds., Foucault, Health and Medicine, pp. 94-110. London and New York: Routledge.

McDougall, Lorna. 1977. "Symbols and Somatic Structures". In John Blacking ed., The Anthropology of the Body, pp. 391-403. London, New York, San Francisco: Academic Press.

McKnight, Brian., trans. 1981. Sung Tz'u 1186-1249. The Washing away of Wrongs: Forensic Medicine in Early Thirteenth Century China. Ann Arbor: Center for Chinese Studies, University of Michigan.

Merleau-Ponty, Maurice. 1962. Phenomenology of Perception. Trans. Colin Smith. London: Routledge and Kegan Paul.

Nutton, Vivian. 1995. "Medicine in the Greek World, 800-50 BC". In Lawrence I. Conrad et. al., eds., The Western Medical Tradition 800BC to AD 1800, pp. 11-38. Cambridge: Cambridge University Press.

Ohnuki-Tierney, Emiko. 1984. Illness and Culture in Contemporary Japan: an Anthropological View. Cambridge: Cambridge University Press.

Pelletier, Kenneth R. 1977. Mind as Healer, Mind as Slayer. A Holistic Approach to Preventing Stress Disorders. USA: Delacorte Press, Seymour Lawrence.

Petersen, Alan and Robin Bunton, eds. 1997. Foucault, Health and Medicine. London and New York: Routledge.

Porkert, Manfred. 1974. The Theoretical Foundations of Chinese Medicine: Systems of Correspondence. Cambridge, MA: MIT Press.

Rabinow, Paul., ed. 1984. The Foucault Reader. New York: Pantheon Books.

Scarry, Elaine. 1985. The Body in Pain: the Making and Unmaking of the World. New York: Oxford University Press.

Scheper-Hughes, Nancy, and Margaret Lock. 1987. The Mindful Body: a Prolegomenon to Future Work in Medical Anthropology. Articles. Department of Anthropology, University of California, Berkeley. Department

of Humanities and Social Studies of Medicine, McGill University.

Seremetakis, Nadia C. 1991. The Last Word. Women, Death, and Divination in Inner Mani. Chicago and London: University of Chicago Press.

Sivin, Nathan. 1968. Chinese Alchemy: Preliminary Studies. Cambridge: Harvard University Press.

-----. 1973. Chinese Science; Exploration of an Ancient Tradition. Cambridge: MIT. Press.

-----. 1977. Science and Technology in East Asia. New York: Science History Publication.

-----. 1987. Traditional Medicine in Contemporary China: a Partial Translation of Revised Outline of Chinese Medicine (1972): with an Introductory Study on Change in Present Day and Early Medicine. Ann Arbor: Center for Chinese Studies, University of Michigan.

-----. 1995. Medicine Philosophy and Religion in Ancient China: Researches and Reflections. Aldershot, Hampshire, Great Britain; Brookfield, Vt. USA: Variorum.

Sontag, Susan. 1978. Illness as a Metaphor. New York: Farrar, Straus and Giroux.

Tauber, Alfred I. 1997. The Immune Self: Theory or Metaphor? Cambridge: Cambridge University Press.

Tung, May P.M. 1994. "Symbolic Meanings of the Body in Chinese Culture and 'Somatization'". Medicine and Psychiatry 18: 483-492.

Turner, Brian S. 1984. The Body and Society. Explorations in Social Theory. Oxford and New York: Blackwell.

Turner, Brian S. (1984) 1996. The Body in Society. Explorations in Social Theory. London, Thousand Oaks, New Delhi: Sage Publications.

-----. 1997. "From Governmentality to Risk. Some Reflections on Foucault's Contribution to Medical Sociology". In Alan Peterson and Robin Bunton eds., Foucault, Health and Medicine, pp. ix-xxi. London and New York: Routledge.

Unschuld, Paul. 1985. Medicine in China: a History of Ideas. Berkeley: University of California Press.

-----. 1992. "Epistemological Issues and Changing Legitimation: Traditional Chinese Medicine in the Twentieth Century". In Charles Leslie and Allan Young eds., Paths to Asian Medical Knowledge, pp. 44-61. Berkeley, Los Angeles, Oxford: University of California Press.

Wear, Andrew. 1995. "Medicine in Early Modern Europe, 1500-1700". In Lawrence I. Conrad et al., eds., The Western Medical Tradition 800 BC to AD 1800, pp. 215-360. Cambridge: Cambridge University Press.

Weiner, Herbert. 1992. Perturbing the Organism: the Biology of Stressful Experience. Chicago: University of Chicago Press.

Zito, Angela. 1994. Body, Subject, and Power in China. Chicago: University of Chicago Press.

Other Sources

Latour, Bruno. 1999. Guest speaker at a conference held by the Department of Social Studies of Medicine, McGill University.

Lock, Margaret. 2000. Lectures.

Wallis, Faith. 2000. Lectures.

Yates, Robin D.S. 1999, 2000. Lectures and discussions.

Young, Allan. 2000. Comments and suggestions.