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**Stones, demons, medicinal herbs, and the market:
Ethnic medicine and industrial aspirations among the
Qiang of Western Sichuan**

Manuel Filipe dos Santos Pinto Campinas

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Doctor of Philosophy of the University of London
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Department of Global Health and Development
Faculty of Public Health and Policy
London School of Hygiene and Tropical Medicine



Funded by the Economic and Social Research Council

For my father

‘I, Manuel Filipe dos Santos Pinto Campinas, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.’

Abstract

In global health it is commonly assumed that governments orchestrate a benevolent integration of “traditional medicine” into health systems and markets, through national policies and regulation, as in WHO’s “Traditional Medicine Strategy”. In China, rather than state orchestration, it is a healthcare market of products and services, operating within a nation-building framework, that shape “traditional medicine”. Furthermore, it is the country’s interests in developing materia medica for its domestic and export markets that are behind their long-lasting steering of the WHO’s strategy. In this thesis, I draw on my multi-sited ethnographic fieldwork to document how this development is unfolding among people of the Qiang (Ch’iang) minority in China. I show the attempts of city and town dwelling Qiang practitioners, academics, government officials and members of the pharmaceutical industry to standardise medicinal herbs and compound medicines, as well as to systematise disputed medical theories and practices. I argue that they do this, in order to articulate “Qiang medicine” as a discipline and “Qiang medicines” as products. I then contrast these efforts with the afflictions and choices of care among Qiang villagers, for whom “Qiang medicine” emerges as a foreign concept. What becomes evident is that differences in the desire and legitimacy to articulate “Qiang medicine” relate to diverging personal aspirations, professional connections and living milieus. Thus, I argue that the WHO “Traditional Medicine Strategy” and China’s “Chinese Medicine Law” predominantly favour the agendas of urban dwelling actors. These attempt to articulate “traditional” ethnic medicine and medicines by mirroring a scientised and state-sponsored contemporary Chinese medicine, for markets that are ultimately destined to cater for an ethnic Han majority. Ethnicity and medicine thus converge to serve a particular market dynamic. Such healthcare marketisation is embedded in a socio-political context that is specific to China, but relevant worldwide.

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Introduction

Entering the field

I spent my first year in Sichuan with this project in mind and a research proposal on paper. My arrival followed a first short visit to the region in 2011 that left an enduring impression, though it was through subsequent contact with the University of Oxford that I became interested in conducting anthropological research in southwest China.

Although fieldwork for my PhD was only to commence in 2018, in that year of 2015/2016 living in Sichuan I was already interested in researching what was taking place in terms of healing, health, and illness, both in villages of the Qiang (Ch'iang) ethnic minority and in clinics of Qiang medicine. Originally, I had planned to develop a methodology for facilitating the inclusion, or integration, of non-biomedical modes of healthcare into health systems. Such an idea was turned on its head as research proceeded.

My first encounter with a *shibi* (Qiang shaman) was in A'er village in late 2015. We talked of how he had learned his skills from his father, about the medicinal herbs growing in the surrounding hills, of demons and spirits. The following year I had a health consultation at a Qiang medicine clinic in Fengyi town. After that, it surprised me to find a photo of my foreign face on the clinic's website under the banner: "we are striving to push Qiang medicine to the world". At the time, facing the Qiang doctor as he took my pulse, I did not realise that the photo had been taken. The contrast between these two settings, of village and of town clinic, caught my interest and ultimately drove me to explore what Qiang medicine was to start with.

Later, in 2017, I had a preliminary interview online with the most influential practitioner of Qiang medicine at the government level, who I refer to as Dr Zhang throughout this thesis. As I asked permission to audio record the interview, I noticed that a tripod with a camera had been placed behind him so as to film the interview and the screen where I appeared. This encounter paved the way for what was to be my

apprenticeship under his guidance at his Chengdu clinic of Qiang medicine, the following year. With time, I became gradually aware that the more I peered into Qiang medicine, the more it peered back, doing so mostly for promotional purposes.

In that first encounter with Dr Zhang he told me of the systematic nature of Qiang medicine, in diagnosing and prescribing, and of the complexity of Qiang medicine theory. I took these aspects as cues, and later during fieldwork tried to map how Qiang medicine, in his approach, operated. With hindsight I realised that at the initial stage of my apprenticeship, by insisting on wanting to learn the details of such system, and of his “*stone disease* theory”, I was reinforcing his need to portray Qiang medicine as a theory-led system.

In total, there were twelve months of ethnographic research. One month into fieldwork, and I enrolled as an apprentice of Qiang medicine. I then continued multi-sited ethnographic fieldwork in two different Qiang villages, and among several Qiang medicine clinics in Maoxian’s county seat town. Back in Chengdu, this research came full circle in interviews with academics, individuals holding government positions, and others working in and with the pharmaceutical industry (often with overlapping roles). All of these Chengdu participants turned out to be somehow related to the prospects of creating a Qiang medical industry.

Research focus

At the point of starting fieldwork, my main objective was still to investigate the integration of ethnic medicine, more specifically Qiang medicine, in the Chinese health system. The successive WHO strategies and guidance documents attested to the relative importance that was (and still is (WHO, 2019)) given to this topic in global health (WHO, 1978a, 1978b, 2002, 2005, 2013). There were also calls for the very concept of the integration of non-biomedical healthcare into health systems to be examined further (Kadetz, 2012). Moreover, the importance of China in the steering of such WHO strategies (Foran, 2007; Kadetz, 2013; Saxer, 2013) confirmed the relevance of following integration from within the country. Although in WHO documents ethnic medicine appears under the umbrella of “traditional medicine” (WHO, 2009), a closer ethnographic look shows that questions of disputed tradition and modernity, and of

contested ethnic minority and majority attributions to particular forms of medicine abound (Marsland, 2007; Saxer, 2013). By taking these into consideration, the category of “traditional medicine” is rendered extremely blurry, and so is what it means to have such category integrated into global health.

My multi-sited approach aimed to clarify such issues. What began to emerge was not a transplantation or institutionalisation into urban clinics of something that originated in the countryside. Despite rural areas being the site of origin that most practitioners pointed to in their practice, as well as its connection to “traditional medicine” being emphasised by the WHO (2013), in practice there was no clear correspondence in what “Qiang medicine” was between village and urban clinic settings. Rather, what took place was a “crafting” (Farquhar and Lai, 2014) or “articulation” (Latour, 1999) of an ethnic medical discipline, that shunned *shibi* and often dismissed folk doctors as incapable of leading, and also of carrying through the “cause of Qiang medicine”. Therefore, these urban practitioners took upon themselves the “inheriting and developing” touted by the government, that they deemed Qiang medicine required. Moreover, what emerged was a chasm between the local afflictions and choice of care that I found in the villages, where a concept such as “Qiang medicine” was largely unheard of, and the organisation of practitioners, academics, and pharmaceutical industry, birthing an industry of Qiang medicine. Such dynamic went far beyond the ideas of loss, change, or gain that I presumed healing practices would go through as they “entered the clinic”. This was an assumption based on the work of others who, on one hand, have remarked that in this institutionalising step healing practices lose much of their relevance (Albert and Porter, 2015). Whereas, on the other hand, have stated that in such refashioning these practices gain a new form of state legitimacy that many healers are happy to embrace (Lai and Farquhar, 2015). What I found, in contrast, was a disputed articulation deeply directed by market considerations, of a new-born, albeit portrayed as ancient, ethnic medicine. Such marketisation was visible in the aspirations of developing proprietary medicines and of the creation of a commercial chain of Qiang medicine clinics.

If in global health strategy the focus is on the integration of “traditional medicine”, in this thesis, for the reasons mentioned above, I shift my analysis from integration to that of the articulation of one of these “traditional” medical disciplines and ask: what is

Qiang medicine? How is it articulated and how is Qiang ethnicity attributed to medicine and medicines? What is the role of industry, market, and government in this articulation(s)? How do these so called Qiang medicine and medicines feature in the lives of Qiang communities?

Although integration and articulation are analytical constructs and are both absent from discourse among the participants in this study, I find that the latter captures what was said and done, mobilised and dismissed, in a way that the former cannot. The simultaneously dispersed and coordinated efforts to get a Qiang medical industry off the ground, together with the dismissal of the existence of such medicine by Qiang non-stakeholders therefore place articulation at the centre-stage of this thesis.

As I explore these questions, I reveal Qiang medicine's disputed articulation into a medical system to be tied to ethnicity and to industrial aspirations, of services and products. In doing so, I contribute to the investigation conducted by others who have also taken a generative prism to understand medical disciplines and industries labelled as ethnic and "traditional" in this part of the world. Among their works, some were particularly influential in my research. *The making of modern Chinese medicine, 1850-1960* (Andrews, 2014) provided a historical background for issues surrounding "tradition" and "modernity" in Chinese medicine. With regards to the articulation of ethnic medicine and medical industry in China, *Manufacturing Tibetan Medicine. The Creation of An Industry and the Moral Economy of Tibetanness* (Saxer, 2013) and *Information and Its Practical Other: Crafting Zhuang Nationality Medicine* (Farquhar and Lai, 2014) gave me an in-depth look into how such projects unfold. Finally, *How Tibetan medicine in exile became a "Medical system"* (Kloos, 2013) laid out a useful critical approach to the articulation of medical systems. As an apprentice of Qiang medicine conducting ethnographic research in clinics, I benefitted immensely in insights and inspiration from the thick descriptions of *Knowing practice: The clinical encounter of Chinese medicine* (Farquhar, 1994), *The transmission of Chinese medicine* (Hsu, 1999), and *Chinese medicine in contemporary China: plurality and synthesis* (Scheid, 2002). In regard to my ethnographic work in Qiang villages, this was influenced by the seminal ethnographies of *Ways of being ethnic in Southwest China* (Harrell, 2001) and *The age of wild ghosts: memory, violence, and place in Southwest China* (Mueggler, 2001), for their attention to daily lives, ethnicity, and state projects. Finally, while not

dealing directly with medical industries, Comaroff and Comaroff's *Ethnicity, Inc.* (2009) resonated deeply with my work as I delved deeper into relations between ethnicity and marketisation.

What I put forth with this multi-sited ethnographic study, and that to my knowledge has not been produced thus far, apart from focusing on an under-researched ethnic minority, is the characterisation of an ethnically attributed medicine by uniquely and simultaneously drawing from four particular sources. The first is the teachings, or “inheritance” that I have received as one of the first officially (government) recognised apprentices of Qiang medicine. The second is the discussion of those medical teachings, of individual and collective aspirations with practitioners, academic, industrial, and governmental stakeholders, while gathering their views on the state of Qiang medicine, as well as on its present and prospective services and products. The third, and I argue that it constitutes what studies in this field lack the most, is an ethnographic account of the local landscape of health and illness in two villages populated by the said ethnic minority, while enquiring about their views on “Qiang medicine” as well as on its clinics, hospitals and products. The fourth consists of national and international strategy, policy and law on “traditional” and ethnic medicine and medicines.

In this work, by focusing on the Qiang, I aim to provide an ethnographic account that illustrates the articulation of a particular ethnic medical discipline and of ethnic medicinal products. By attending to differently situated individuals and medicines, the multi-sited dimension of this research allowed me in time to comprehend this articulation and the factors driving it. It has also led me in the end to not take for granted that there was something out there, a thing-in-itself called Qiang medicine, waiting to be integrated. Instead, it made me attend to the ever-present push, ambitions, and conflicts as Qiang medicine and medicines attempted to take form. Through this thesis, I situate this marketising phenomenon among a myriad of entities such as stones, demons, and medicinal herbs; promoted, feared, disregarded, dug up and endangered. Moreover, I contrast the unruliness of health, illness, afflictions, and healing practices with the aimed orderliness of a particular medical system. I will now turn to the reasons for and relevance of this study.

Why ethnic medicine and the Qiang (Ch'iang)?

Investigating the articulation of ethnic medicine in China is important because both ethnicity and medicine were at the heart of the nation building and post-colonial purposes that lead to the creation of contemporary Chinese medicine (Andrews, 2014; Taylor, 2005). China's weight in the WHO, specifically in this department, suggests that this model might have serious implications for global health strategy.

The relationship between China and the WHO has long been one of a special reciprocity, with key players such as Dr Margaret Chan, Hong Kong's former Director of Health, as the Director-General of the WHO from 2007 to 2017, strongly advocating for the integration of "traditional medicine" in global health (Chan, 2014), and the former vice-president of the China Academy of Chinese Medical Sciences (CACMS), Zhang Qi, placed as the current coordinator of the Unit of Traditional, Complementary and Integrative Medicine. With Dr Chan having played a pivotal role in the design of WHO's "Traditional Medicine Strategy", it is understandable that the Chinese experiences around "traditional medicine" institutions form a considerable part of what is recommended around the world (Saxer, 2013). The trend is for countries to follow China's lead of bounding forms of medicine for nation-state building purposes as well as for economic reasons. As an example, in the Philippines, although that which was categorised as "traditional medicine" referred predominantly to imported practices (Kadetz, 2012), subsequent accreditation guidelines state that "Hilot is the Philippine Traditional Medicine. It is the science and art of the ancient Filipino healing" (PITAHC, 2015).

Apart from global ramifications, there are also unwavering domestic ones that justify the research of this topic. Inside China and among its ethnic minorities, the development and promotion of ethnic medicine reinforces the idea of *duoyuan yiti* (多元一体), which translates as "ethnic diversity within national unity" (Wang G., 2015, p.35) and therefore also serves a political objective. Especially with the Qiang, ethnicity and its mobilisation acquire very instructive contours, since the term Qiang has a deep historical baggage in China for the definition of "otherness" (Wang, M.K. 1999a).

The Qiang are one of the many ethnic minorities living on the Eastern fringe of the Tibetan plateau, along the Sichuan-Gansu corridor of deep mountain valleys, at the heart of the Sino-Tibetan borderlands. The relevance for the study of this particular ethnic minority is heightened by the fact that they have gathered particular visibility in the country at large in recent years. That visibility is tragically connected to the heavy toll brought by the devastating earthquake of 2008 on Qiang communities.

In the following sections, I introduce the central themes that this thesis develops. Firstly, I offer an anthropological background to ethnicity and to ethnicity in China, as well as to the Qiang as an ethnic group. I then explore what the concept of Qiang has entailed through history. Secondly, I expand on what I consider to be the root to the overlooking of, and perhaps a catalyst for, the articulation of ethnic medicine. That is a focus on the integration of “traditional medicine” in global health and anthropology, which often does not pay enough attention to what exactly is being integrated, and directly or indirectly nudges the formation of such medical disciplines. Thirdly, I elaborate on the methodological troubles of approaching the materiality of medicines and healing practices in this particular context, and on my methodological approach to explore the articulation of ethnic medicine and medicines. Finally, I describe the fieldwork methods employed in this research, before giving an outline of the chapters.

Background

Ethnicity and the Chinese State

This thesis deals directly with the definition and articulation of ethnic medicine in China. Therefore, an understanding of ethnicity and the Chinese state is important for situating this research as it allows to grasp the complexity of how state ethnic classifications play into daily lives and medical disciplines. The word ethnicity is often used to refer to or distinguish particular groups of people. In the words of Fenton, it is a “a gather-all term to denote (...) dimensions of descent and culture and how they are mobilized to sustain public definitions of groups and the boundaries between them” (Fenton, 2003, p.7). In anthropology, ethnicity has been explored mainly under two theoretical currents. These are firstly the primordialist, that bases ethnicity on a group’s

inherent qualities (Geertz, 1963). Secondly, the relational one, which sees ethnicity as emerging solely out of social relations (Leach, 1965; Barth, 1969; Eriksen, 1993). There are also theoretical approaches that refute this dichotomy (Calhoun, 1993; Fenton, 2003), that point to gaps in these models (Bentley, 1987), offer alternatives (Seol, 2008) as well as others that privilege process-focused definitions, instead of group-focused definitions (Brubaker, 2004; Cohen, 1978; Jenkins, 1997). In this thesis, like Barth (1994), Eriksen and Jakoubek (2018), I refer interchangeably to ethnicity and ethnic identity, with both terms referring to an ethnic denomination that can be self-ascribed or ascribed by others, and defined in relationships and social boundaries. These will appear in a wide range of situations, from at times referring to a sense of belonging, while also being used to characterise nonhuman entities.

In Chinese, the word for ethnicity is *minzu* (民族), also translated as nationality. The Xinhua dictionary (considered the most authoritative in the Chinese language) defines *min* as “a people” and *zu* as “a people with a common origin, sharing inherited characteristics; a stable community with a common history, language, economic life and culture”. It is a contemporary definition that still does not differ greatly from Stalin’s four criteria for defining a nationality (*natsia* Нация), on which the ethnic classification project of the 1950s in China was based. Those are: common territory, common language, common economic mode of production, and common “psychology” or “culture” (Mullaney, 2011). For practical reasons, these criteria were not applied dogmatically in China (Heberer, 1989; Mullaney, 2011). Moreover, there was the notion that this project was not an academic endeavour, but a consciously political one, preparing the ground for future governance, its aim not to accurately describe existing communities, but to outline plausible ones (Mullaney, 2011). Under an idea of social evolutionism, and the guise of development, the identification project strove for political unity at the national level (Dreyer, 1993; Mullaney, 2011).

Apart from the Han majority, the Chinese government recognises 55 ethnic minorities, with many others considered sub-groups, as well as unrecognised ones. They make up roughly 110 million people, 10% of the country’s population (National Bureau of Statistics of China, n.d.) and inhabit 64% of the area of the country, most of it at its borders (Heberer, 1989). This particular geography is translated into a concern from the government that disloyalty may trigger serious issues of national security. Historically,

these peripheral regions have had a stronger military control, and a more relaxed administrative control enforced by central government than the rest of the country (Wang, M., 2010). Since the Cultural Revolution, during which the Chinese Communist Party (CCP) admits having pursued policies of forced assimilation (Heberer, 1989), more relaxed policies have been implemented at the periphery, in the hope to facilitate compliance and mending relations (Heberer, 1989; Mackerras, 1994).

The autonomy law of 1984 (*Zhonghua renmin gongheguo minzu quyue zizhi fa* 中华人民共和国民族区域自治法) eventually granted the autonomous units (administrative regions, prefectures, counties and townships created in the 1950s and constantly dissolved and reinstated until the 1980s), broader rights than in other areas, with more relaxed restrictions in planned parenthood and access to education and employment. It encouraged the use of minority languages as well as funding for the protection of heritage (Lai, 2009; Mackerras, 1994), which was then followed by an ethnic cultural industry that has grown ever since (Chio, 2014). However, this law is in its essence subject to the arbitration of the Communist Party.

Aba prefecture is one of those autonomous units. Outside of Chengdu, it was there that I spent most of the time conducting research. Aba is located in the vast Gansu-Sichuan corridor of deep mountain valleys, home to several ethnic minorities. Until recently, there has been a gap on the anthropological study of the Qiang, with a few exceptions (Wang, M.K. 1999a, 2002; Zevik, 2002). However, after the 2008 earthquake, there have been more anthropologists conducting such research (Bian, 2017; Oppitz, 2011; Wang and Prott, 2016; Zhang et al 2014; Zhang, 2016). Elsewhere in the Gansu-Sichuan corridor region, there has been a wealth of ethnographic research produced (Chirkova, 2007; Gladney, 1996; Harrell, 2001; Kolas, 2005; Mueggler, 2001; Oppitz and Hsu, 1998; Schrempf, 2006; Tan, 2013; Tapp, 2002; Wellens, 2010).

The Qiang ethnic minority

Those who are nowadays officially classified as Qiang live in the Northwest of Sichuan, both in the Aba Tibetan and Qiang Autonomous Prefecture (see Figure 1) and in the Beichuan Qiang Autonomous County, and according to the 2010 census number 309,576 (National Bureau of Statistics of China, n.d.). Many speak a Tibeto-Burman

language in local dialects that vary greatly, which often makes Chinese (Sichuan dialect) the preferred medium of communication between Qiang communities (Wang, M.K. 2002).

Following the devastating earthquake of 2008, which killed around 10% of the Qiang population (Companion and Chaiken, 2017), they have experienced some of the fastest changes in China, due to the intense take-over of regional affairs by the provincial government, under reconstruction pretences. At the time, there was extensive coverage in the Chinese media and a concerted effort to support the affected population, with a nationwide growing interest in the Qiang (Wang and Prott, 2016).



Figure 1: Map of Aba (Adapted from www.tibeto-burman.net/qiang/maps.html)

Although often associated with the “ancient Qiang”, the relation between the contemporary and the “ancient Qiang” is problematic. The earliest record of the ethnic label of Qiang (羌) is a pictograph appearing on oracle-bone inscriptions of the mid-Shang period (ca 1300BC). Composed by the representation of a sheep and a human, it was a blanket term that stood for “those people in the west who are not one of us”, covering a vast area on the eastern fringe of the Tibetan plateau and a wide range of peoples (Wang, M.K. 1999a).

It has been argued that the notion of Chinese nationality was not self-sustained through history, but one that required alienating boundaries such as the Qiang, labelling those on the periphery as uncivilised (Wang, M.K. 1999a). This is a phenomenon that has been named as “boundary-maintaining processes” (Barth, 1969), sustaining ethnic

attributions through efforts of inclusion and exclusion. The label of Qiang in particular, is considered the oldest, least stable, and blurriest boundary delineating the Han (Wang, M.K. 1999a). In time, more and more of the non-Han to the west, so called “barbarians”, were classified into new ethnic groups, and so demarked from the label of Qiang. As a result, in the Ming (1368-1644) and Qing (1644-1911) periods the label Qiang referred only to the non-Han living in the Beichuan area and the upper Min River Valley (ibid.). This was a premise borrowed from contemporary Chinese historians and taken by Rev. Thomas Torrance and David Crockett Graham between the 1920s and the 1940s conducting missionary and scholar work (Torrance, 1920; Graham, 1958). It was also taken up by those conducting the ethnic classification project of the 1950s and anthropologists such as Fei Xiaotong, considered the most renowned anthropologist in China. Their arguments were of a Qiang ethnic minority with a heritage directly linked to the ancient Qiang (Fei, 1988).

It is worth reiterating that in China’s ethnic classification project, the Qiang, like other ethnic minorities, were attributed an ethnonym that differed from their autonym. In the case of the Qiang, that autonym is *Rma*, which equates to the concept of “us”, transliterated into Chinese as *erma* (尔玛). This meant that before the 1950s, most of them had never heard of the term “Qiang” (Wang, M.K. 1999a). To complicate things further, even *Rma* was, historically, a widespread but not mutually agreed on denomination. Communities identified themselves and those inhabiting the same valley as *Rma* but excluded those upstream as *tshep* (barbarians) and those downstream as *erh* (crafty Chinese) (Wang, M.K. 1999a). Their state identification and categorisation under a common denomination of Qiang in the 1950s was, as I mentioned, one of practical governance. In this way, the ethnic boundary between Han and Qiang was refashioned into an accommodating one, under the spirit of the *duoyuan yiti* ethnic harmony.

In these recent decades, those Qiang who proceed into further studies, in a way, get to “learn about themselves” and of historicised narratives of descent. Many of the practitioners that I spoke with brought up the several historico-mythical figures in China that they were convinced of having been Qiang. This perceived ancient influence in China’s culture and society is something that practitioners held on to as a form of

legitimacy when defining Qiang medicine, positioning themselves as the inheritors of “ancient” knowledge, and as “the oldest ethnic minority in China”.

Such stance emerges as a way to navigate China’s sociopolitical landscape and carve a space that is valued in the Chinese healthcare market and in society at large. It also forms the means to establish an ethnic identity. Hence, being Qiang is a recent condition, a recently expressed identity, but performed as if it had been done so since immemorial times. In this thesis, I therefore refer to the Qiang as those self-identifying as such. I will now shift the background focus from ethnicity to ethnic medicine.

The articulation of ethnic medicine: integrating what?

Despite this thesis focusing on articulation rather than integration, in order to understand how ethnic medicine comes to be it is necessary to grasp what is usually recognised as the integration of “traditional medicine” into institutional settings. What are seen as different styles and forms of dealing with disease and illness have long been bounded in a myriad of ways, both academically and in popular discourse. This has been done along ethnic and regional lines, as well as through such categories as “modern”, “traditional”, “bio-” or “holistic” medicine. A way to capture the coexistence of these seemingly different forms has been through the concept of medical pluralism. Such concept has been much embraced and contested in medical anthropology and global health (Baer, 2011; Kadetz, 2012; Krause et al., 2012; Leslie, 1980; Penkala-Gawęcka & Rajtar, 2016; Press, 1980). It has moved from a focus on medical systems, with the seminal works on Asia in the 1970s and 1980s by Charles Leslie and others (Leslie, 1976; Kleinman, 1980; Lock, 1984), to a focus on the diversity of medical practices from the 1990s and onwards (Leslie and Young, 1992; Scheid, 2002). The criticism that promoted this shift was both linked to the accusation that this “pluralism” was ignoring power relations (Baer, 2004; Cant & Sharma, 1999; Ernst, 2002) and to the overly confining idea of “medical systems” (Hsu, 2008). It has been further treated as “hegemonic pluralism” by Scheid in China (2002) and “orchestrated pluralism” by Lock in Japan (1990).

The encouragement of this “co-existence” has been expressed in public health and policy in the form of a process that the WHO designates as “integration of Traditional and Complementary Medicine” (WHO, 2013). The strategies dedicated to it claim to

harness the best that each form of medicine has to offer to then include it in national health systems. Such process is dependent, however, on a prior formatting that is intimately connected to legislation, registration, regulation, standardisation, and the creation of institutes and national policies (WHO, 2002). Taking this into consideration, the research on what exactly is being integrated is on the one hand relevant for example when it comes to practices and practitioners of the widely institutionalised Chinese medicine and Ayurveda. On the other hand, it is arguably even more relevant when it comes to understanding those appearing as emergent “traditions”, since they shed a light on the origin of institutions and of industrial and market initiatives, rather than on the continuity of those that are already in place. Moreover, this kind of research uncovers who speaks for an ethnic group when defining what an ethnic medicine is to consist of. Finally, it also probes into the interest or disinterest towards it from those categorised into that particular ethnic group to start with.

The institutional enthusiasm with global integration and its results

Integration has been in the WHO’s agenda since the Alma-Ata declaration of 1978 (WHO, 1978a) and coincided with the perceived public health miracle performed by the People’s Republic of China with the phenomenon of the barefoot doctors. Large numbers of individuals received minimal medical training and were dispatched all over the country, drastically increasing life expectancy, reducing infant mortality and improving the access and affordability of care in the rural areas of the country. This was an achievement done arguably in combination with many other factors (Håklev, 2005; Li 1975).

In the early 1980s, the above mentioned academic exploration of the subject of medical pluralism induced a polarisation of stances regarding integration. At the initial stages of the WHO’s decision to integrate “traditional medicine” there were some warning of the danger in sponsoring practices with no biomedical validation (Velimirovic, 1984). Others, however, were enthusiastic at the inclusion of local practitioners around the world, with the prospects of empowerment and harnessing of alternative solutions to biomedicine (Neumann & Lauro, 1982; Pillsbury, 1982; Young, 1983). Some were advocating a “peaceful co-existence” instead (Van Der Geest, 1985), while those from the field of Critical Medical Anthropology (CMA), fearing the appropriation of

“traditional” practices for political and economic gain, were warning of the naivety of such an endeavour (Lock, 1990).

In the “Traditional Medicine Strategy 2002-2005” (WHO, 2002) the WHO used different classifications to categorise the extent of integration among different countries, albeit taking for granted what was being integrated as a thing-in-itself. By this I mean that, although clearly institutionally articulated, these forms of medicine are treated as bounded entities. They are, in this way, assumed to be inherently valued by and constitutive of a respective group, ethnic or national. In that global health strategy, countries were assessed in their incorporation of “Traditional, Complementary and Alternative Medicine” (TM/CAM) as having an integrative system (only including China, South Korea and Vietnam), an inclusive system (naming Equatorial Guinea, Nigeria and Mali, Canada and the UK), and countries with a tolerant system. In the “Traditional Medicine Strategy 2014-2023”, however, the WHO dropped this distinction (WHO, 2013). In other reports, it has defined the state of incorporation in legal terms, as having “no policy or legislation”, “legislation pending”, “legislation only” and “national policy” (WHO, 2001; WHO, 2005). In the latest report (WHO, 2019), however, there is a more thorough distinction between countries, based on laws, national policy, and the existence of institutions, committees and a national programme dedicated to T&CM (Traditional and Complementary Medicine). Scholars have also distinguished different integration approaches at the national level such as illegalisation, legalisation, and informal or tacit recognition (Dunlop, 1975; Dauskaradt, 1990); as well as unification, equalization, subjugation, and marginalisation (Holliday, 2003).

Kadetz has looked into these different categories as sitting on a continuum of integration that, he claims, regardless of however defined, unifies a system under a blanket term that does not match the reality on the ground, given the many local practices left behind (Kadetz, 2012). Regardless, in the past decades of WHO policies, a sense of assumed beneficence (Kadetz, 2011) has persisted. More recently, there has been research into the organisational and economic motives behind such an assumption, with a demand for integration to be empirically examined (Adams et al., 2009; Bodeker, 2001; Kadetz, 2013). Additionally, there has been an attempt to find ethical solutions for this process (Tilburt and Kaptchuk, 2008). Partly, this coincides with a shift on

WHO policy towards privileging the commodification of plant resources (Kadetz, 2013).

In this thesis I argue that this shift towards an industry of “traditional medicines” is encouraging the flourishing of a marketisation that leaves behind the interests and healthcare preferences of small communities, to privilege large groups of consumers as well as the creation of brands. Moreover, that this economic imperative renders definitions of integration modes useless and obsolete, as the market takes over in determining what is worthy of being scaled-up. There has been research exploring related problems such as the seemingly imposed dilemma on Tibet, that of between integration or erasure (Adams and Li, 2008). Additionally, on the push in India for the spread of non-biomedical systematised practices that are locally irrelevant (Albert and Porter, 2015). The manipulation and appropriation of ethnic medicine for political purposes that critical medical anthropologists were cautioning about in the early 1990s (Lock, 1990), in the early age of post-socialist nationalisms, has now not only become more complex, but more economically driven as well.

It has also been argued that the WHO fails to contemplate the possibility of a practitioner-led integration, away from state guidance (Kadetz, 2013). However, in this thesis I offer a glimpse of exactly what happens when the state steps aside, leading practitioners with particular aspirations to form healthcare companies, lobby for accreditation, and operate in a market logic when defining and articulating ethnic medicine. I thus argue that in recent years the WHO’s focus on industrial harmonisation has had economic interests at heart. These are imbued with the beneficence of sustaining “traditional medicine”, not directly through state support, but through the state encouraging the conditions for such industry and market to flourish.

In more recent years, there has been a wealth of research showing how government, market and industry have spurred the articulation of ethnic and national medical disciplines and industries. Apart from Chinese (Andrews, 2014; Chee, 2015), Tibetan medicine (Kloos, 2013; Saxer, 2013) and those attributed to other ethnic minorities in China (Farquhar and Lai, 2014; Lai and Farquhar, 2015), there has been research on the articulation of Vietnamese (Wahlberg, 2014), Korean (Ma, 2015), and Myanmar (Coderey, 2020) medicine, as well as that of Ayurveda in India (Pordié and Gaudillière, 2014a). I argue that the efforts of neatly and ethnically packaging these medical

disciplines and industries facilitates their uptake as things-in-themselves. Such a move amounts in a large degree to a strategy for an ethnonationalistic “branding” (Islam, 2017) that feeds into the discourse of integration in global health and that in the case that I put forward in this thesis, does not reflect on, and as it odds with, the practices and wishes of those living in Qiang communities.

Ethnic medicine and the Chinese context

Although the WHO insists on its role as mediator and advisor in the design of policies of integration, what would seem like a model that leaves the adjustment to socio-political contexts in the hands of member states, reveals the historical baggage and internal power struggles that have marked its present direction (Foran, 2007). The inspiration from a Chinese model that had produced a highly systematised form of medicine, under forceful circumstances (Kadetz, 2013), has transpired to guide the organisation and articulation of what are considered to be local practices worldwide. In China, the institutional presence of ethnic medicine can be seen at different levels. Firstly, although scholars have spoken of ethnic medicine as a different modality from Chinese medicine (Lai and Farquhar, 2015), it is important to consider that the latest policies (People's Republic of China Twelfth National People's Congress, 2016) refer to Chinese medicine as composed by the Han majority medicine, together with that of the minorities. This means that there is a similar approach to “inheriting and developing” as well as to innovation. Therefore, the recognition, regulation, and standardisation of medicinal products and services follow similar procedures (Zhu, Z. et al. 2016).

Secondly, when it comes to hospital and clinic settings, this can happen as simple co-existence with what is labelled as Western medicine, with 95% of the general hospitals in China having a department of Chinese medicine (Robinson, 2006). Apart from working in co-existence in biomedical institutions, as a small department with its own pharmacy, Chinese medicine can also have a stronger presence in hospitals designated as “integrated hospitals”, with doctors making use of both biomedical and Chinese medicine diagnosis and treatment methods. That is something also seen in some villages and townships, with reports of clinics where practitioners have had the leeway to make use of whatever resources are available, often performing peculiar and very diverse blends of practices and technologies (White, 1999; Lai and Farquhar, 2015).

Finally, there are also hospitals named simply as “Chinese medicine hospital”, or “Qiang medicine hospital”. These make extensive use of diagnostic technologies and treatments widely associated with biomedicine, all part of the “inherit and develop” strategy.

The literature available on what is considered the medicine of the different ethnic minorities of China reveals very different relations between minority and the state if one compares the Tibetan case with other minorities in more central areas of China. Tibetan practitioners attempt to claim a version of modernity distinct from the one of the Chinese state (Adams, 2001), while striving for international recognition. With most of other minorities, this medical ethnonationalism tends to take an inclusive form, borrowing the standards from the state, and often materia medica and practices, to show how they feature superiorly within a state framework, rather than as opposed to it (Lai and Farquhar, 2015).

In terms of medical services, the first minorities to have their own ethnic medicine hospitals were the Tibetan, Mongol and Uyghur, considered to have “the most prominent medical systems” among China’s minorities (Yu and Amri, 2016), they are also the ones with secessionist movements. Decades ago, they received their own medical schools (Croizier, 1965), and in 1992 their own pharmaceutical centres (Permanent Mission of the People’s Republic of China to the UN, 1999). Other minorities then installed their own hospitals, such as the Yao, Zhuang and Tujia (Lai and Farquhar, 2015) among others. Many more have expressed the desire to follow suit (ibid.). In 2005, there were 15 ethnic minorities with their own ethnic medicine hospitals (Central Committee of the Communist Party of China and the State Council, 2006), and the number of these hospitals has grown from 127 in 1999 (Permanent Mission of the People’s Republic of China to the UN, 1999) to 253 in 2015 (WHO, 2019), with also 550 ethnic minority clinics registered at the end of that year (WHO, 2019).

In regard to the status of institutions of Qiang medicine, in China there are two hospitals designated as Qiang medicine hospitals. There is a third that although is named as a Chinese medicine hospital, has a Qiang medicine museum, and at one point hosted a Qiang medicine research centre. The three are located at the three most populous Qiang

autonomous area county seats, in the Aba prefecture. Most of the doctors and directors at these hospitals have biomedical training, and the technologies and specialties available are those that can be found at roughly any other of China's "Western medicine hospitals". At present there are also several Qiang medicine clinics in these county seat towns, as well as one in Chengdu. When it comes to local care in Qiang villages, some have shamans (*shibi* in Qiang language or *duangong* (端公) in Chinese). These can hold an important position in their communities (Oppitz, 2011) and one that can cover many aspects of social life. In terms of healthcare, *shibi* are famed for their competencies in using medicinal herbs for emergency care, as well as bone setting and massage, as musculoskeletal injuries are a common ailment in such mountainous areas. They also deal with afflictions that are endemic to such communities, many of demonic nature. Among villagers, however, I have found no association between the *shibi* treatments or the villagers' own self-care to any concept of "Qiang medicine".

Harnessing political and economic gains

In China, emerging ethnic medical disciplines such as Qiang medicine take shape in a socio-political framework of nation state building and economic growth. These disciplines legitimise agendas of a nationalism that is not only state-centred but also multiculturalist (Lai and Farquhar, 2015). Lai and Farquhar (2015) are careful to point out that there is a convergence of rational and charismatic forms of authority, as ethnic minority medicine is enacted, itself not being a mere product of state domination. I agree to the extent that there is ample freedom for practitioners to practice as they see fit. However, I argue that the development of Qiang medicine is guided by what many practitioners, together with academics and the pharmaceutical industry, take to be suitable for a market that is dominated by the Han ethnic majority. This aspect is very telling of the priorities of contemporary China, as it blends its nationalism with a market economy. It does not boil down to a state forcing itself on what ethnic medicine should be. On the contrary, the state draws its legitimacy from the prosperity that the healthcare market and industry brings, albeit with the widespread unequal benefits that result from such enterprise.¹

¹ This "market-state nexus" of pharmaceuticals has been reviewed extensively in anthropological literature, see Hardon and Sanabria, 2017.

As I mentioned previously, the enterprise of ethnic medicine has been included in recent years in that of Chinese medicine. Before elaborating on the relevance of Chinese medicine not only as a discipline, but as a provision of medical services and products for nation state building purposes, I would like to clarify one point. Throughout this thesis I do not refer to Chinese medicine as TCM (Traditional Chinese Medicine) for two main reasons. The first is one that is also invoked by Volker Scheid in “Chinese medicine in contemporary China: plurality and synthesis” (2002). In Chinese language the term used is *zhongyi* (中医), which literally means Chinese medicine. The term TCM was created in the 1950s for publications in foreign languages, aiming to instil a particular notion of Chinese medicine abroad (Scheid, 2002). The second is that through the course of my fieldwork, only very rarely was Chinese medicine (as well as Qiang medicine) referred to or described as “traditional” (*chuantong* 传统), even if often contrasted with “modern” (*xiandai* 现代) or “Western” (*xi* 西) medicine. On the contrary, and likely due to researching questions of ethnicity, it was the fact of it being Chinese that was emphasised the most. Precisely for this thesis exploring attributions of ethnicity, modernity, tradition, and inheritance, I attempt throughout to stay as close as possible to what was related by the people I spoke with. Should this research have been conducted outside of China, in settings where the discipline was referred to as TCM, then I would refer to it in that manner too.

The shift of the 1950s that marked the Chinese state’s sponsorship and transformation of Chinese medicine has divided scholars. There are those who refer to this break as marking the creation of a different discipline altogether, and the further adoption of medicine from the West (Croizier, 1976; Kadetz, 2012; Taylor, 2005; Unschuld, 2010a). Additionally, there are also those who see it as just another transformation, not so distinct from previous ones in history (Porkert, 1976; Scheid, 2002). The former insist that it marked an unprecedented systematisation and professionalisation of Chinese medicine (largely by western criteria), as well as conformity to western ideas. Comparatively, the latter remark that Chinese medicine always had a pluralistic character, borrowing from different currents of thought and medical traditions.

The idea that healthcare in China became plural with the arrival of biomedicine needs to be contended with the recognition that, in a way, pluralism had always been present. In this sense, synthesis may be considered a more recent phenomenon. Medicine in China has always upheld a very rich diversity of descriptions and explanations of bodily structures, functions, and cosmologies, as well as examinations and treatments (which has varied amongst different scholars and physicians, regionally and historically) (Scheid, 2002). Furthermore, there was no such thing as a “Chinese medicine” until the introduction of medicine from the West (Croizier, 1976). The move to create a system that would integrate and compete with Western medicine, in the early days of the People’s Republic of China (PRC), had at its core a political trend of post-colonial nationalism and Chinese inspired modernity (Croizier, 1976; Taylor, 2005). Among practitioners, there was an active selection of ideas, filtering of practices, adjusting of procedures, and “purging” of certain elements in the attempt to make it “scientific”, “modern” and “non-superstitious” (Chang, 2014; Xu et al., 2013). However, it was such political refashioning, that beyond having produced the Chinese medicine that is practiced and taught in Chinese medicine institutions nowadays, has also set the foundation for the framework within which the medicine attributed to ethnic minorities is expected to operate.

It has been argued that this refashioning might even have started earlier than the 1950s, by the initiative of Chinese medicine physicians who saw their livelihood under threat (Lei, 2014). In the more recent decades, with the healthcare reforms of the 1980s and 1990s (Ramesh et al., 2013), there has been a quick transformation of health care provision in China. From a public good provided by the state, it has turned into what has been described as a “set of marketised and commodified practices, products, and institutions” (Zhan, 2011, p.292). I would argue that with this change the government has dropped its centralised active pursuit of consolidating Chinese medicine as a medical discipline. On the contrary, this work has been left to practitioners who organise themselves, together with academics and the industry in formal medicine associations. In this work, they not only put forward what is seen as matching the previously set standards of systematisation, but advance new ones as well. Moreover, when it comes to ethnic medicine practitioners, these are invited to promote their medicine as something unique and exotic, while being constantly reminded of the rewards awaiting their hard work and success in scaling up. This is a phenomenon

particularly visible among the less established ethnic minority medicines recently joining the Chinese medicine enterprise. These disciplines of ethnic medicine, in the services provided and in its academic transmission, also act as vessels for the even more profitable industry of medicinal products (Saxer,2013).

Ethnic pharmaceutical industries

The essentialisation of ethnicity into a pharmaceutical product that bears little resemblance to what would be used by most people of that ethnicity in their self-care or by most of their own practitioners follows an alignment with the pharmaceuticalisation of Chinese medicine, which has run in parallel with its own articulation. It has been since the Republican period that the controversial slogan of “Abandon Chinese medicine, Retain Chinese drugs” (*feiyi cunyao* 废医存药) has brought materia medica used in China to the realm of biomedical pharmaceuticals. This influence arrived initially from Japan, who had started earlier to use chemical analysis in the search for active ingredients from Chinese medicinal herbs, to then reformulate them into preparations deemed admissible to biomedical practice (Chee, 2015). Chinese physicians who had opposed the motto, began to understand this essentialising move, that followed Western-style clinical trials, as providing a form of legitimisation to the medicines they prescribed. On 17 March 1929, in a Shanghai assembly hall, they hung posters with messages such as “Advocate Chinese medicine to prevent cultural invasion”, and “Advocate Chinese drugs to prevent economic invasion” (Lei, 1999). That day they mobilised a National Medicine Movement that lasted the following two decades and the ramifications of which have persist ever since (*ibid.*). It was around this time that the medical reformer Yu Yan set up his pharmaceutical factory in China, after having studied in Japan and learning about extraction of active compounds from medicinal herbal materials, re-formulating Chinese medicines to biomedical style pharmaceuticals (Chee, 2015). After the 1980s, with China’s economic reform, this kind of products became widely available (*ibid.*). In regard to the reformulation of these medicines, this was not only a matter of form but also of biomedical indications. Indeed, as early as 1956, in a meeting between doctors of various ethnic groups in Yunnan, there was a total of 1794 prescriptions published under two volumes, categorised under Western medical specialities (Chee, 2015).

Overall, in anthropological research this pharmaceutical transformation has been referred to as “re-formulation”, with Chinese materia medica feeding into drug-discovery and drug-making at an industrial scale (Chee, 2015), “re-networking”, with Chinese medicine doctors giving way to scientists in the production of medicines (Lei, 1999) and with Chinese proprietary medicines constituting an “alternative modernity” (Hsu, 2009). The size of this industry has been hard to assess, and it has been argued that this is due not only to over- and underreporting for economic and political purposes but to different inclusion and exclusion criteria that coexist, reflecting “partially overlapping pharmaceutical assemblages” (Kloos and Blaikie, forthcoming). Such conflicting accounts on this matter have varied from an annual output of Chinese medicine products in China of between 100 billion USD (with a nine-fold increase since 2003) (Di Tommaso et al, 2017), to exceeding 120 billion USD (Dang et al, 2016) for the year 2014. In relation to exports in that same year there are also contradictory figures, with these being assessed as worth 1.54 billion USD (Di Tommaso et al, 2017) as well as 3.2 billion USD (Zhang, 2015).

If there is confusion over Chinese materia medica numbers, this “overlapping” is even more accentuated for the industries of ethnic pharmaceuticals. Since 1992, with Tibetan, Mongol and Uyghur medicine acquiring their own pharmaceutical centres (Permanent Mission of the People’s Republic of China to the UN, 1999), there has been a “race between minorities” for the monetary output of ethnic medicines, while it has remained unclear which output from minority areas is counted as ethnic or as Chinese medicine, as it has been verified in Tibet (Saxer, 2013). This blurriness has probably been enhanced with the recent law changes designating all ethnic medicines as part of Chinese medicine (People's Republic of China Twelfth National People's Congress, 2016). Individual reports have included 2.4 billion USD in 2013 from sales of Miao medicines (Yang and Peng, 2015) and 113 million USD from those of Mongolian medicines in 2016 (Li, 2016).

The prominent role that Chinese and ethnic minority medicines play in China’s economy is likely related to the country’s trend of renaming Colleges of Chinese medicine (*zhongyiyuan* 中医院) as Universities of Chinese Medicine and Pharmacotherapy (*zhongyiyao daxue* 中医药大学) (Hsu, 2009). Still, given the diversity

and importance of materia medica in China, both in industry and in community use, its anthropological study is particularly limited in its volume and scope (Hsu, 2006, 2009; Saxer, 2013; Springer, 2015; Staub, Geck and Weckerle, 2011; Weckerle et al, 2010; Chee, 2015).

Not “modern” nor “traditional”, but “inherited and developed”

I will now conclude the background section of this thesis by positioning these medical and pharmaceutical initiatives along lines that defy the “modern” and “traditional” dichotomy and will present the reasons for doing so. In ethnographic research, representing change under the guise of “modernity”, usually a west-centric one, has been criticised by Englund and Leach (2000). Doing so, they claim, amounts to advancing “meta-narratives of modernity” (Englund and Leach, 2000), that undermine the reflexivity of the ethnographic method by removing authority from people in defining their contexts. In regard to China, there are those who avoid that pitfall but still use “modernity” as an analytical tool. Among those, some suggest a contrast with the “West”, that instead of an opposition between modernity and tradition, in China “modernity is superimposed on tradition”, that “the ancient is preserved in the modern” (Keith et al, 2013, p.289). Others use the concept of “alternative modernity” (Ong and Nonini, 1997; Hsu, 2009), to refer to a trend that does not equate to “Westernisation”.

These approaches tend to follow or reflect on state discourses and projects and might work in a more normative analysis of some sort of a looming zeitgeist. In that sense, I consider more accurate to think of different projects and industries in China selectively dismissing, preserving, or inventing “traditions” under what is deemed to constitute modernisation (Meinhof, 2017). In regard to Chinese medicine, Lei (2014, p.5) argues that “the historic confrontation did not take place directly between the two styles of medicine but between Chinese medicine and the modernising Chinese state”. Also, in *The making of modern Chinese medicine, 1850-1960*, Andrews (2014) speaks of idealised notions of “Chinese” and “Western”, “traditional” and “modern” imposed on a spectrum of medical practices. However, when it comes to ethnographic work on material practices, I believe that understanding how (and if at all) the qualifiers of “modern” or “traditional” are used among participants is of paramount importance. This has also been a concern in the seminal work of *Chinese medicine in contemporary*

China: plurality and synthesis (Scheid, 2002). The distinction between “modern” and “traditional” that Scheid found in the discourse of the people he worked with did not translate into practice, as he saw practitioners drawing effortlessly from different techniques and materials that would not fit the “traditional” and “modern” dichotomy on which they elaborated on (*ibid.*).

In contrast, throughout my fieldwork, the labels of “modern” and “traditional” were very rarely used. In fact, “modern” was not something that practitioners aspired to, as it was associated with dismissing the past and forsaking one’s “historical inheritance”. Such break is one that Latour (1993) often drew from when characterising the “moderns”. Instead, the idea that was reinforced constantly was that of a medical inheritance that was to be carried forward. It has been argued that the official rhetoric of “inheriting and carrying the heritage” gave a high status to senior Chinese medicine doctors in the 1980s and 1990s, but that after the mid-1990s such heritage lost its weight, with priority given to scientific skills (Wang and Farquhar, 2009). I find that such slogan has gained a new connotation that distances itself from the question of “modernity” and “tradition”, holds on to ethnicity (Chinese and Qiang), and embraces technology as a mere tool for “development” or “carrying the heritage forward”. The first article of the 2016 “Chinese medicine law” (People's Republic of China Twelfth National People's Congress, 2016) states clearly:

“this law is formulated for the purpose of inheriting and carrying forward Chinese medicine, safeguarding and promoting the development of the cause of Chinese medicine, and protecting the health of the people.”

Rather than emerging technologies being valued by young doctors who wrestle out of the medical authority of their professional elders (Farquhar, 1994), I found most Qiang practitioners, young and old, being open to the combination of their practices and their medicines with the latest technologies in a bid to “develop Qiang medicine”. Doing so was also pointed out as necessary to avoid the label of a “backward minority”, showing that the widespread notion of a social evolutionist prism among ethnic minorities, and majority, persists. Such unquestioning attitude towards the need for what is seen as development has been reported widely also among Han majority practitioners (Scheid, 2002). One of the areas of such “development” is that of transmission of skills. The

different modes of such transmission have been described as “secret”, “personalised” and “standardised” in *The transmission of Chinese medicine* (Hsu, 1999) and more broadly under the two different formats of discipleship and studentship (Scheid, 2002). The weight of institutions and institutionalisation in forging the discipline of Chinese medicine has been explored by Farquhar (1994). So has the convergence of institutional rationality and healing charisma among the medicine attributed to China’s ethnic minorities (Lai and Farquhar, 2015), while medical theories and ethnic medical disciplines take shape (Farquhar and Lai, 2014). Moreover, it has been argued that in recent years the Chinese medicine project has taken another turn through the demands that such institutions become self-sustainable or even profitable, while promoting Chinese medicine to a global market (Scheid and Lei, 2014). Among the Qiang, I found institutions of ethnic medicine following such trends, with academics, the pharmaceutical industry and practitioners coming together in order to find viable solutions for “the cause of Qiang medicine”.

What is articulated and then taken to be “cultural heritage” has also been described as going through a process of “heritagising” (Klein, 2018). In China, such “heritage” has the dual function of a political tool for internal legitimacy and a form of marketing and promotion at home and abroad (Ai, 2012). Because such nationalism and ethnonationalism is so entangled in a fast contemporary Chinese market economy, it can be said that it is with the rise of the entrepreneurial subject that heritage becomes a product, and ethno-preneurialism (Comaroff and Comaroff, 2009) rises among “heritage entrepreneurs” (Grasseni, 2014). For ethnic minorities, this adaptability operates in a growing cultural and medical industry, of services and of products, and is contingent on following both requests for conformity and the imaginaries of the majority (Wu, 2014). I will now move on to the methodological approach carried through in this research and explain the reasons for having oriented my investigation in this particular direction.

A matter of methodology: materiality meets *yin* and *yang*, and silence

My attention has for a long time been drawn to the materiality of medicine and medicines (see my master’s thesis: Campinas, 2013). This has to a great extent been due

to my professional background as a community pharmacist, which endowed me with an acute awareness of how biomedical authority is afforded to those who are seen to command the possibilities of matter. More specifically, I refer to the officially-sanctioned “predictions” relative to the behaviour of bodies and medicines. It is this same authority that dismisses “lay” and non-biomedical explanations for all things medical. Therefore, I have been constantly unconvinced by arguments of symbolic or social efficacy, socio-economic and cultural interpretation, all of which leave materiality to be defined by biomedicine.

This is the reason material semiotics (Law, 2009) has resonated with me at such a profound level, as it turns one’s gaze towards how matter is organised and classified, and to how things turn to (and are articulated into) objects (Latour, 2000) or artefacts (Hirsch, 2004). Material semiotics does not take such objectifications as the pure product of social concoction, instead, it shows how they are very often grounded in concrete material features. As Law and Mol (1995, p.274) put it:

“Perhaps, then, when we look at the social, we are also looking at the production of materiality. And when we look at materials, we are witnessing the production of the social.”

In this research, Qiang medicine and Qiang medicines (the second which refers to both preparations and medicinal plants, since *qiangyao* (羌药) generally stood for any of the two) are treated as composed artefacts. These were built up among and with entities such as stones that caused blockages in the body, x-rays, endemic demons, medicinal herbs, the market, and an array of institutions. The proliferation of techno-social artefacts that is associated with development, especially in medicine, with diagnostic devices, treatments, and medicines, and also the presence of symbiotic and pathogenic microbes, all came up in the course of this research. If this variety of entities reinforced my commitment to make use of such methodology, its shortcomings in the course of fieldwork equally made me reconsider its form, applications, and limitations. Given that material semiotics works as a tool to build theory with, the obstacles that I found when using it made me step back and focus on ethnographic details in a less prescriptive way, allowing for a slower grounded theory to emerge than what I had envisioned. Therefore, that is why this thesis is weighted towards ethnography rather than theory, as I feel that

the biggest contribution that I can make, and the richness of what I can bring forward, is ethnographic. Moreover, by attending to the articulation of a medical discipline that attempted to be theory-led, I became self-aware of my own theorisations and articulations. Therefore, in this approach of minute detailed description, even if the “bones” are not obviously displayed, then I would still rather provide the “flesh and blood” (Cepek, 2019) of this Qiang medicine enterprise.

I will now proceed with a brief summary of the work that has been produced with material semiotics, and that to a certain extent constitute the methodological background for this doctoral research. Then, I will elaborate on the criticisms that have been made to such approach. Lastly, I will advance my own argument as to why this approach needs to be taken in very loose terms when investigating medicine in China, given the few pitfalls that I have identified in the course of my fieldwork.

Latour’s “We have never been modern” (1993) arguably marked the beginning of a more widely discussed critique of the nature culture divide that had long persisted in anthropology. Such a take was embraced broadly in the social sciences as a call for dislodging the diversity in the social from “culture” and perceptions of a natural world defined by science, onto socio-material configurations. These configurations had already been studied using an approach that was to be known as “Actor-Network Theory” (ANT), developed most extensively by Latour (1996a, 2005), but borrowing heavily from the work of Callon (1984), Mol and Law (1994). By overriding what Latour called a “Kantian” separation of the subject from the object (Latour, 1993), he proposed a flat ontology that did not take an a priori privilege between humans and non-humans. Such symmetry spurred a wealth of anthropological and ethnographic research that has investigated networks of humans and quarks (Pickering, 2010), trees (Kohn, 2013), mushrooms (Tsing, 2015), dogs (Haraway, 2003), microbes (Dunn, 2007; Paxson, 2008) and others (Kirksey and Helmreich, 2010). It also advanced a critique to such network approach, as evident in Ingold’s life-centric meshworks (Ingold, 2008). In medicine, the most influential work taking on a material semiotics approach was arguably Annemarie Mol’s “The body multiple” (Mol, 2002), which drew from extensive ethnographic work in a hospital setting, and portrayed different objectifications of atherosclerosis in a sea of practitioners, patients, and apparatuses. In regard to medicines, there has been research done also on their different objectifications

and materialities (Blaikie, 2015; Ecks, 2013; Geissler and Prince, 2010; Prout, 1996). Finally, there has also been the attempt to bring the disciplines of ethnobotany and medical anthropology together largely via a material semiotics approach (Hsu and Harris, 2010). Through this approach, scholars attempt to include non-humans as participants in social practices, instead of relegating them to the background. Some, however, insist on going further, and there have been calls for anthropology to go “beyond the human” (Kohn, 2013), and to position itself “after the human” (Rees, 2018). Despite these authors insisting that they have no intentions of doing away with the human, and rather rethink what “human” means, such call for “deanthropologising anthropology” (ibid.) has been met with fierce criticism (Dobler, 2019).

I argue that the main criticisms that have been levelled against material semiotics and the subsequent “ontological turn”, the latter which shared the concern of ethnographically described entities being taken seriously (Kohn, 2015), fall under two main accusations. The first is that of such approach being ahistorical (Fortun, 2014) and the second of being apolitical (Graeber, 2015). Regarding the first, Latour’s historicity certainly is a particular one. By grounding interactions in actuality, he aims to lose the baggage of an assumed historical continuum and focus on the action at hand (Latour, 1999). When it comes to the second, despite the claims of defending the “ontological self-determination of peoples” (Holbraad et al, 2014), it has been argued that it is counterproductive to think of an “implicit ontology” shared in a particular geographical setting (Graeber, 2015). Graeber (2015) gives the example of the “Merina” of Madagascar who do not refer to themselves as such, and draw instead from a variety of denominations depending on status, context, and others. This echoed deeply with my own work with the Qiang, where given the fairly recent state designed unification and official categorisation, it is impossible to speak of a “Qiang ontology”. The reason that I develop on these criticisms is that because in China, and surely elsewhere, the questions of historicity and politics take a life of their own. Starting with a methodology that has these predefined hinders one from fully engaging with local explanations and causalities.

In relation to the first question, of historicity, those who use a framework that refers to the current age as “late industrialism”, one characterised by a “modernist mess” (Fortun, 2014) are perhaps unwittingly reinforcing a label broadly used, at home and abroad, to

refer to East Asian countries: that of “latecomers” (Wang, F.L. 2016). This is a “lateness” that I found justifying most things related to “progress” and “development”, of China in relation to the world, of ethnic minorities in relation to the ethnic majority, and of the Qiang in relation to other ethnic minorities. Such “lateness” always seemed embedded on a social evolutionism that fed the industrial aspirations of many participants.

In regard to the second, that of politics, it is interesting to note that those coming from a structure and agency approach are the most frustrated with the tendencies of posthumanists to attribute agency to non-humans (Gregory, 2014; Martin, 2014; Laidlaw, 2010). In the vein of Marx’s “Theses on Feuerbach” (Marx, 1998)², they defend an active role for anthropology, in the sense of changing the world rather than interpreting it. Their focus on inequality and exploitation, drawing greatly from humanist and Marxist values is pronouncedly hostile to what they consider a demotion of the human. In China, however, Marxism is used constantly in political discourse to support a social evolutionism and a collective emancipation that justifies the need for industrialisation and marketisation, with all the inequalities thus produced. Privately, I found entrepreneurs brushing Marxism aside. Chinese anthropologists who I have met, told me how they have to regularly pay lip service to Marxism in their publications, and despite some being fascinated with Marx’s writings, they do not see Marxism present in Chinese society in any form. On the other hand, Chinese scholars who devote their career to the study of Marxism do not consider China’s society to be a capitalist one (Hu, 2010). In fact, they see it as a “socialist market economy” and dismiss western scholars as having a notion of Marxism that is based on Soviet textbooks (Ping, 2007). The point that I am making is that although it might be interesting to study China through a “western” Marxist lens, I find it more relevant to understand the weight of endemic political ideas that attempt to spur and justify the market as a benevolent force, as a system that is in place to “benefit the masses”.

This takes me to my own approach that I use throughout this thesis, an above mentioned “loose” material semiotics. Despite the use of the term “actors” having become commonplace in material semiotics approaches, given how central the notion of agency

² Written in 1845, first published in 1924.

is to these, I choose to predominantly refer to “entities” instead. In previous research for my MSc degree, based on ethnographic fieldwork conducted on “folk medicine” (*narodnaya meditsina* народная медицина) in Siberia (Campinas, 2013), I have indeed used the terms “actors” and “agents” to refer to medicines. The reason for doing so was tied to the fact that in Russia I found people expounding at length on the actions of medicines. On the contrary, in the Sichuan’s village fieldsites the question of “what does this medicine do?” was met with silence, as villagers found no sense in it. Instead, it was “what do you use this medicine for?” that would elicit a response. In some clinics there were mentions of the actions of medicines, but those came often with a distributed agency that operated in a web of *yin* and *yang*, and *qi* transformations. Ironically, the seemingly discrete agencies that ANT maps and pieces together in its network-distributed agency, appear here all distributed to start with. Therefore, the problem and the inadequacy that I discovered with taking agency as the methodological guiding principle is distinct from the common accusations put forth against it. The difficulties of conciliating this with material semiotics and common STS approaches have been recognised (Farquhar, 2017; Scheid, 2002), and explored under an attempted “correlative STS”, in a Taiwanese Chinese medicine clinic (Lin and Law, 2014), and with the notion of “propensity” (*shi* 勢) in practices of cancer care in a Taiwan’s hospital (Lin, 2017). The idea of “propensity” never surfaced throughout my fieldwork, and the correlativity of *yin* and *yang* was not relevant to healing in my village fieldsites, so I do not make use of either concepts.

In regard to materiality, the “expanded materialism” (Farquhar, 2020) deemed to be required to approach materials and practices in Chinese medicine has been referred to previously as “material materialism” (Latour, 2007a) and as “open materialism” (Campinas, 2013). Such approach, I argue, has the advantage of not dealing with an essential truth of objects faced against multiple subjectivities, an “ideal materialism” (Latour, 2007a), but rather considering the conceptual move made from conceiving things to conceiving objects (*ibid.*), as one of objectification (Latour, 1996b). In that sense, rather than following past anthropological approaches that analysed medicines in terms of symbols at work (Turner, 1967), or as products of mystification (Boston, 1971), I attempt to take medicines and material practices in all its different objectifications. I do so in what has been called a “symmetrical anthropology” (Latour, 2007b). This approach is also distinguishable from that of considering different

perceptions by different individuals along “Social Lives of Medicines” (Whyte, van der Geest, and Hardon, 2002), something originally inspired by Appadurai’s “The Social Life of Things” (1986). I find the latter approach to reinforce the gap between what the natural sciences describe and what is “socially perceived”, a gap connected to the distinction of primary and secondary qualities of objects, famously theorised by Locke (Graham, 2012). The first stand for “real” properties of a universe described by science, while the second are “perceived” ones, people’s subjective representation of that same universe (Latour, 2000). By focusing on the ethnicity of medicines and medical healing practices, I was able to record the intertwining of properties, as well as the lack of them, in defiance of such division, while they constituted the objects of Qiang medicine and medicines. Such articulation of ethnic objects happened among competing claims that not only drew from material aspects, but shed light on what “Qiang” is. The extent to which such artefacts become political (Winner, 1980) or marketable (Croll, 2006) was also considered. Moreover, taking ethnicity as a property itself, and having it described not only by Qiang, as by Han participants, helps one to unpack what those ethnic attributions consist of, as they are used to qualify both non-humans and humans alike. Because of the group-making character of ethnic attributions, I attempt to attune not only to expressions of self-ascribed ethnicity, as well as to formal designations of ethnicity ascribed by others. I seek also to give room to instances where objectification is not relevant or is actively denied, as the matters of that which is unknown, uncomprehended, and unarticulated by participants can often be overlooked in anthropology (Graeber, 2015).

Overall, this thesis uses a grounded theory rather than any pre-determined theoretical framework. Nevertheless, the methodology that I make use of is in general theoretically informed by material semiotics. For the reasons that I explained above, it does so in very loose terms, instead of following a particular school of thought such as ANT. In order to grasp how Qiang medicine and medicines come to be, this thesis and its research stand on three dimensions. The first one is about doing anthropology in the vein of a “following science”, with the ambition of elucidating elements from within rather than classifying them from without (Jensen, 2012). The second consists not of “following the actor” as urged by Latour (2005), but rather “following the entity” as I trace medicines and practices through different settings. The final one draws from the second and is that of a multi-sited ethnography (Marcus, 1995). Such approach is ideal

when investigating entities that sprawl over a number of institutions, in this case an emergent ethnic medical discipline and industry. Moreover, it allows an insight not only into the providers but also to those who seek or dismiss such services and products. It is also useful for dealing with notions of unification and separation on an ethnic level, and document how these are enacted in different settings. Finally, when it comes to medicines, this approach facilitates their tracing from collection to processing and use. The articulation of Qiang medicine and medicines, as well as the industrial push that I describe is not analysed as a product of national or international policies, but something that is developed alongside such policies. In this way, both government laws and WHO strategies are taken as setting the stage for the developments that unfold.

Fieldsites and fieldwork methods

There are two parts to the ethnographic fieldwork I conducted in order to produce this thesis. The first was set in clinics and other institutions (medical, pharmaceutical, and of academic research), as well as in Qiang medicine conferences. The second was set in two villages. Overall, fieldwork lasted twelve months, starting from February 2018. Mainly, I made use of three ethnographic research methods, participant observation, semi-structured interviews, as well as detailed conversations. With materiality at the core of this project, participant observation provided a tacit understanding that greatly improved the depth of ethnographic description and analysis (DeWalt and DeWalt, 1998). The advantage of using in-depth semi-structured interviews was to have the benefit of allowing interlocutors, to a certain extent, to direct the conversation (Bernard, 2006), bringing in new factors that I wouldn't have considered beforehand. This method was also useful for pointing out matters of concern (Latour, 2004) and aspects of varying relevance and irrelevance in my questions that guided the adjustment of later interviews. Such awareness to matters of concern informed my research continuously, as well as directed my efforts to the critical themes emphasised by the participants. In the villages, the arrangement of interviews felt unnatural, and so I made use of detailed conversations instead. These conversations appeared in numerous visits, as well as at home, and their duration depended on people's availability. They were also permeated by other visitors dropping by, as well as by several daily tasks.

I will begin by giving a brief background to how the fieldwork and fieldsites were determined and arranged. In this way, I will explain how the logistics of fieldwork unfolded. Back in 2014, I met a visiting scholar at the University of Oxford from the Chengdu's Southwest Minzu university. Thanks to her, I was later fortunate enough to collaborate with the institution's Qiang Research Centre while studying Chinese language in Chengdu from November 2015 to July 2016. Several of the researchers at the university became good friends and helped facilitate not only preliminary visits in Aba prefecture but also later access to the rural fieldsites for long-term fieldwork.

Apprenticeship in the clinic

In September 2017, upon returning to Chengdu to continue Chinese language studies, I met with Dr Zhang, who ran the only Qiang medicine clinic in the city. We had communicated remotely for the year prior, and as we finally met in person, he agreed for me start fieldwork at his clinic after Spring Festival, in February 2018. Later, he went on to invite me to become one of his apprentices. The “ceremony to honour the master” (*bai shi yishi* 拜师仪式) took place in March 2018 and marked the beginning of my apprenticeship. Dr Zhang was aware that I would only be able to complete several months out of the three years required for graduation.

Throughout the four months that followed, and for a brief period eight and twelve months after, I visited the clinic regularly, either for full days or half days length. During that time, I conducted participant observation by taking part in the daily life of the clinic. I was invited to join in consultations with patients, where diagnosis and treatment were explained to me. I also helped prepare the poultices that were used in the clinic. Moreover, I shared work breaks and lunches together with the staff, and brought them some of my cooking as well. In addition to participant observation, I conducted three in-depth interviews with Dr Zhang, and had countless detailed conversations not only with him, but with every other staff member. This included his wife and sister, who were both also practitioners at the clinic. I also had brief conversations with several patients while they waited to be seen by one of the doctors.

Yanwo village

Halfway through the summer, with the collection of medicinal herbs still taking place up on the hills, I headed to the first village fieldsite. Situated in Mao county, China's most Qiang populous (The Central People's Government of the People's Republic of China, 2009), Songping valley is well known for its wealth and diversity of medicinal herbs. Thanks to the scholar Bian Simei, who is partly Qiang, I had the opportunity to visit one of the valley's villages, Yanwo. There, Bian conducted extensive fieldwork (Bian, 2017) to produce a remarkable ethnography that focuses on local cosmologies and adaptation. Within a week, I realised that there were plenty of opportunities to join medicinal herb collectors and explore local concepts of health, illness, and treatment, all worthy of staying longer. I was very fortunate to be able to benefit from the networks and relations that Bian had established, many of whom quickly became friends. In the three months that followed I joined medicinal herb collectors in three occasions for three full days up the hills, and spent countless hours having detailed conversations with the village doctor, who also dried and sold medicinal herbs. I also met with the (self-entitled) village *duangong* (端公), or shaman, and participated in the local "temple festival", when the anniversary of its construction is celebrated (see Figure 2).



Figure 2: Burning paper money at Yanwo temple festival

I came to know and chat with many villagers not only on special occasions such as the "temple festival", but in several social gatherings and as they went about their days.

Living with a very caring family during those months gave me a very special outlook into daily life, their work, and their daily tasks. On a couple of occasions, I helped the family digging potatoes, although amusingly my technique was not the most suitable for the job. I also came to see how the family dealt with the minor ailments that appeared during that time, as well as carried out general self-care. Outside Yanwo village I paid a few visits to a *Fritillaria* (*beimu* 贝母) cultivation base, as well as to a medicinal herb seller who kept all his produce drying out on his yard. With the medicinal herb collection season coming to an end, and after the first week of snow I decided that it was time to move to the second village.

A'er village

My connection to the second village goes back to the 2015 previous visit to its *shibi*. A'er village is located in Yanwo's neighbouring Wenchuan county, which saw the epicentre of the devastating 2008 earthquake. The earthquake recovery in the nearby Longxi village has been extensively researched by Zhang (2016). The point of spending the early winter in A'er, in a shorter stay of one month and a half, was mainly to study local (and not so local) afflictions and treatments, as well as choice of care. By doing so, I was able to engage in a form of comparison and confirmation in relation to Yanwo, especially important when studying ethnicity, given the fragmented nature of the Qiang as an ethnic group. A similar approach has been used by Stevan Harrell with the Yi minority, while "comparing ways of being ethnic" (Harrell, 2001).

Staying in A'er was a more home-immersed experience, whereby I shared a house with a small family of mother and son. The colder weather meant that people mainly congregated at home, and this facilitated prolonged conversations with several villagers, many of whom were relatives of my hosts. The family kept and sold a variety of medicinal herbs. However, given that the medicinal herb collection season was finished, the topic of collection appeared in detailed conversations, rather than in the form of participant observation. I was also able to help in a number of tasks at home, such as collecting the vegetables that the son cultivated in the surrounding hills. When the son was away, I would help the mother tending to the pigs, by preparing their food, feeding them, and clearing their waste. While in the village, I visited the *shibi*, and conducted an in-depth semi-structured interview with him. He remembered me from my previous

visit three years prior, so I took the opportunity to bring him printed photos that I had taken, as a gift.

Fengyi town

After leaving A'er, the following month was spent back in Mao county, but this time in its county seat town, Fengyi, where a few Qiang medicine clinics are located. Some of the contacts there were made in the summer, during the week before heading to Yanwo village. It was my status as Dr Zhang's apprentice that facilitated establishing those contacts. It was also in that week that I took part on a Qiang language class for children. Despite staying in the same guesthouse, the fieldwork and its logistics in the winter were made difficult due to constant police surveillance. What had been a bustling tourist spot in the summer had turned into a sleepy winter town. Perhaps it was boredom that had reached the police force, to which my presence provided some relief, with the opportunity for them to stay busy. During the standard police registration that takes place when staying at any Chinese accommodation, upon understanding that I would be conducting interviews, the police required that I shared all contacts of the people I was to meet. Furthermore, I was obliged to report every morning where I would be spending the day, who I would meet, and to provide explanation of how I had come to meet each particular individual. Suspecting that my contacts would receive police phone calls to confirm them knowing me, I warned them in advance of the situation. Regrettably, I noticed a few encounters to have an aura of initial uneasiness, in contrast to previous meetings, that I could only attribute to the police monitoring situation.

Despite this, I completed five in-depth interviews, with three Qiang medicine doctors, one hospital director of the Maoxian Chinese medicine hospital, and the hospital's Chinese medicine pharmacist. I also conducted short-term participant observation in four of the clinics and had detailed conversations with seven practitioners overall. While in Fengyi, I also paid a visit to the town's Industry and Commerce Bureau (*gongshang ju* 工商局) and sat down for a chat with a few of the officials regarding the registration of Qiang medicine companies.

Chengdu interviews and conferences

The final month of fieldwork was dedicated predominantly to interviews in Chengdu, ten in total, as well as to visiting Dr Zhang's clinic. Among those interviewed were four academic researchers who also held positions at the Qiang branch of the Chinese Medical Association of Minorities (CMAM), one of whom worked on the standardisation of Qiang medicine. I also interviewed two other academic researchers who ran the “*Qianghuo* research group” at the Sichuan College of Chinese Medicine. They had spent the past twenty years developing a particular cultivar of *Notopterygium incisum* K.C.Ting ex H.T.Chang (*qianghuo* 羌活), and invited me to visit their main cultivation base, in the Xiaojin county of Aba prefecture, as well as their Chengdu laboratory. *Qianghuo* is a medicinal herb with a disputed attribution of Qiang ethnicity (see Chapter Four). Among the other four participants were a practitioner, who was the former director of the Qiang medicine research centre at the Maoxian Chinese medicine hospital, a Qiang medicine strategist, one leader of the “Sichuan Provincial Research Association of TCM Appropriate Technology”, and a pharmaceutical representative of a company selling a medicine herb labelled as Qiang. All of the ten participants liaised with the government in some way, and five of them did so with the pharmaceutical industry.

Many of these contacts were made by virtue of me participating in three CMAM conferences, and presenting in one of them, as an academic researcher and apprentice of Dr Zhang. I also took part in the founding conference of the “Sichuan Provincial Research Association of TCM Appropriate Technology”. Apart from networking, these conferences provided the opportunity to understand matters of concern, the planning, and the state of Qiang medicine as well as of other minority medicines.

Data collection and analysis

I registered observations and detailed conversations daily in a field diary in chronological order. Throughout fieldwork I made sure that the organisation of fieldnotes took place daily, and was concurrent with the data collection. All fieldnotes were written in English, with relevant words and concepts entered in Chinese and Qiang language. Detailed conversation, especially in the villages, would sometimes go on for hours on end, as I scribbled fieldnotes. I would visit, usually bringing snacks, and

spending the morning, afternoon, or whatever time the host was available for. Recording was not practical, as hosts often went on about their tasks, while also receiving other visitors as the day went on. After returning home, I would organise my fieldnotes, recall the conversations in order to fill in the missing gaps in them, and write up any clarifications that were needed for a next encounter, as these were individuals that I could always visit again.

In regard to the semi-structured interviews, these were all audio-recorded, transcribed, translated, and analysed. Their duration was in average of one hour, with the shortest lasting half an hour, and the longest two hours. Given that my Chinese was fairly fluent and also due to the logistic difficulty of having long-term assistants in remote locations, I conducted fieldwork without field assistants. However, for the sake of time and thoroughness, the audio-recordings from both interviews and conferences were transcribed verbatim into Chinese script by selected students. These were students recommended by fellow scholars. They were briefed and guided throughout the process, and remunerated accordingly, at rates recommended by their teachers. Also, the apprenticeship ceremony was video-recorded by the organisers, and made available to me. After converting it into an audio file, this was also transcribed by the students. Its Qiang language dedication to the deities, however, was translated by a Qiang friend into Chinese language.

I translated all transcriptions myself, while being in frequent contact with the transcribing students to clarify certain passages. I listened frequently to the interviews myself, especially when clarification was needed, identifying recurring concepts and medicines that the students were not familiar with. My inability to speak Qiang language made it impossible to understand conversations when people used it among themselves. However, that would happen only in a fraction of the time since the Sichuan dialect of the Chinese language was frequently employed. Villagers from different locations also tended to use Sichuanese between them, as their languages varied greatly. Moreover, standard Qiang language is not commonly understood in Yanwo. These are factors to consider when attempting to learn (any form of) Qiang language, something also described by Bian Simei in her work (Bian, 2017). When coming across specific local words that I considered of interest in the villages, I would ask if my interlocutors could explain them to me, and transliterated these myself. The

names of medicines and medicinal herbs employed in the villages were always in Chinese, and for the transliteration of their Qiang names from clinics I used the standard in the *Ermasibai* compendium (Li, 2013). The Latin nomenclature for botanical identification that I used throughout this thesis was that of the Chinese Pharmacopoeia (Chinese Pharmacopoeia Committee, 2015). I am aware of inaccuracies around a state sanctioned uniformisation and species substitution, but my intention is having a categorisation that reflects local institutional definitions.

I also made use of photography that illustrated the written data collected, linking the different data sources. When it came to the analysis of data, I used a coding software (NVivo, Version 12; QSR, 2018) in order to visualise and organise different themes. However, such software was only of partial use since after the initial organisation of themes, I mainly did an in-depth analysis of specific themes directly on interview transcriptions and fieldnotes. This way, I could attend to how they featured in the whole conversation, and not as detached information. I also analysed regional and national strategy and policy documents on minority and Chinese medicine before and after fieldwork, looking to “trace policy connections between different organisational and everyday worlds” (Wright and Shore, 1997, p.14). Through doing so, I was constantly attuned towards the practical relevance and irrelevance of such directives for the daily life of my interlocutors when asking questions.

Research ethics

Ethical considerations were of paramount importance throughout the course of this research. At its core, this project is motivated by ethical concerns for minority populations in China, mainly in the understanding of how their lives and their aspirations feature in and are affected by state and market initiatives. Prior to fieldwork commencing, in January 2018, the project proposal received ethical approval both from the LSHTM Ethics Committee (ref 14378) and locally from the Southwest Minzu University in Chengdu (16/01/2018).

I followed the ethics guidelines of the UK’s Association of Social Anthropologists (ASA, 2011) and so implemented their recommendations for good research practice when it came to informed consent, anonymity, autonomy, confidentiality and ensuring

the safety of the participants throughout this research. In all participant observation, interviews, and detailed conversations, I was careful throughout to make it very clear to my interlocutors my purpose as a researcher as well as the purpose of this project. Moreover, all participation was conducted through informed consent, and with participants assured of their ability to withdraw. This was done in the written form (Chinese) for interviews, but orally in participant observation and in the villages, as I gathered that paperwork would instil suspicion among those less literate, and make for an uncomfortable experience for patients receiving care. I was respectful at all times when participants stated the family secrecy of information related to treatments and healing practices. In that way, and in general, I have never insisted for participants to disclose anything that they were not comfortable with. In occasions when information was asked to be kept confidential, this was excluded from the thesis. Given my own professional experience in running clinics as a pharmacist, I am very familiar with handling personal and sensitive information, and have always upheld the greatest level of integrity while doing so.

My position as Dr Zhang's apprentice required that I "do not bring shame" to Qiang medicine. If on one hand, in my work I do not willingly provide the promotion of the discipline that might have been expected, on the other, I made the conciliation of my position as an academic and an apprentice clear from the start. Therefore, I strove at every instance to have balanced and fair assessments in my ethnographic analysis. During fieldwork, and in thesis writing, I did my best to avoid taking sides in occasions of dispute and contradictions between participants and instead to report these phenomena as faithfully as possible. Regarding concerns with participant identification, all individuals participating were anonymised and given pseudonyms throughout the thesis. Also, I attempted to take photographs from angles that make it difficult for participants to be recognised. Photos of practitioners were taken at their request. Finally, all data collected was protected at all times and backed up safely. It was only accessible by me, and although the transcribing students accessed the audio-recordings, they were instructed on how to handle them and to delete the respective files upon completion of their work.

Positionality

My awareness of the way that I positioned myself when interacting with the different participants in this study was accompanied by the notion of how my position shifted throughout fieldwork. Such positionality was contingent on particular settings, encounters, and experiences and was not fixed (Robertson, 2002). When being introduced, introducing myself, in the course of a conversation, or of a longer established relation, together with the label of an academic, several other labels would take primacy, often resulting in the irrelevance of the former. At the Chengdu clinic I was an apprentice, and felt the expectations and responsibility, as well as the hierarchy that came with it. That same position opened doors for conversation at the clinics of other practitioners, where I was treated as a visitor. When interacting with people working in the pharmaceutical industry, it was my position as a pharmacist that they seemed to engage with the most. Both in the clinic and in conferences, I felt that as a foreigner apprentice my presence was often harnessed for the promotion of Qiang medicine. In the villages, the intimate family shared setting allowed for a more communal and relaxed interaction, and there I was simply treated as a curious question-asking foreigner.

Throughout this thesis, I alternate between making such shifting positionality visible in the ethnographic descriptions of different encounters, and between taking a step back, as I describe interactions that do not involve myself. Even if much of my ethnographic writing does not explicitly expose positionality, that very concern was at the forefront of my ethnographic praxis, in how I framed my questions and related to others. Despite that concern, it generally came down to a matter of constant adjustment to new situations, while trusting my own understanding of how I was being perceived in each.

In this work, despite it being more ethnographic than theoretical, I became aware of how I, too, perform an articulation as I write, by defining what is and is not important and relevant for the production of this thesis. I do so as I try to arrive at a unified picture, amidst the effort to produce a coherent piece of research. In a way, the struggle to unify ideas is at the core of the craft that many of the participants in the study, like I, by virtue of our work being institution-based, perform. On this dimension that we share, of standards and unification in the name of relevance, the question remains: relevant for

whom? My sincere hope is that this thesis is so for any interested reader, inside and beyond this academic circle of ours.

The chapters

The different chapters that compose this thesis are organised in a manner so as to take the reader through different settings of health and illness among the Qiang, and beyond them. As the chapters progress, I show Qiang people not only as providers but as recipients of medico-healing care, and as well as both, in instances of self-care. While doing this, I examine how ethnicity is articulated, enacted, and experienced, not only in relation to people, but to medical practices and medicines. Additionally, I focus on daily lives and aspirations, the latter not only of lifestyle but of an industrial nature, for people, products, and services. Throughout, I frame this among national and international policies, laws, and strategies.

Chapter One opens this thesis by setting the scene on the city of Chengdu's only Qiang medicine clinic, and that of the most influential Qiang medicine doctor. It follows my own apprenticeship and the importance given to the transmission of a body of theories and practices, considered to be the inheritance of a long line of Qiang doctors.

Chapter Two explores the articulation at the same clinic of a variety of theories and practices into one medical discipline: Qiang medicine. It also uses two patient cases to illustrate how Qiang medicine operates in that clinic setting and contrasts it with a demonstration on stage, at a CMAM conference. It then contrasts the tenets of Qiang medicine that I had learnt with what is practiced and theorised in four other clinics in Mao county seat town. In this way, it takes the reader through a variety of stances on what a Qiang medical discipline is and should consist of. This chapter shows the problems with global health assumptions that there is something out there waiting to be integrated into health systems. In this way, it makes the case for such "traditional" medical disciplines to be approached as the product of disputed articulations, in struggle, accommodation, and attempted uniformisation.

Chapter Three shifts away from medical institutions and towards two village communities of ethnic Qiang people. It describes and examines the daily lives of the

resident villagers, their livelihoods, local afflictions, and choice of care. Overall, it reveals Qiang medicine to be a foreign concept in these settings, as well as the widespread lack of interest among these villagers in visiting any such provider.

Chapter Four turns to the articulation of ethnic medicines among institutional figures and the pharmaceutical industry, again with the disinterest of those in the village communities. Such contested ethnicity draws from, as well as rejects, a variety of factors taken to be ethnic markers with little agreement among participants on the defining features of Qiang medicines. The chapter goes further to explore the stories of two medicinal herbs in particular, *qianghuo* (羌活 *Notopterygium incisum* K.C.Ting ex H.T.Chang), and *wabu beimu* (瓦布贝母 *Fritillaria unibracteata* var. *wabuensis* (S.Y.Tang & S.C.Yueh) Z.D.Liu, Shu Wang & S.C.Chen). The association established among some between these plants and the Qiang ethnic minority is in the case of the first supported by what is taken to be “history” and legends. Regarding the second, the connection was only made by a pharmaceutical company who branded *wabu beimu* as a Qiang medicine for marketing purposes. Throughout the chapter, the recognition as well as the tensions produced by such attributions are explored, and ethnic medicines revealed as the key for the industrial expansion of Qiang medicine.

Chapter Five takes a broader approach to the motivations behind the push for a Qiang medical industry. It explores the standardisation of Qiang medicine and medicines as these get articulated, and frames the industrialisation of such services and products in a wider context of national and international “integration” and development strategies.

The conclusion brings all chapters together while arguing for the legitimacy of medical systems to be socio-politically and ethnographically situated, while attending to the way these are articulated. It also invites one to pay attention to the individual, collective and global industrial aspirations that assert such systems.

Chapter I. Inheriting Qiang medicine

Tucked in the corner of a residential community (*xiaoqu* 小区), Dr Zhang's Qiang medicine "orthopaedics clinic" (*guke zhensuo* 骨科诊所), the only in Chengdu, stood above a few concrete steps sided by metal rails, a hurdle for those with a lack of mobility, but to a certain extent minimised by staff ready to help anyone struggling to climb it. I arrived early on a Monday, right after the Spring festival's week of 2018. Dr Zhang, of Qiang nationality, was away on a government representatives' conference so that week the clinic was run by his wife, Dr Liu (of Han nationality), and by his younger sister, Dr Zhang Y., both trained Chinese medicine doctors. Although Dr Zhang Y. was the only one of the three who spoke Qiang language, she used the Sichuan dialect of Mandarin with her husband and child, having settled in Chengdu many years prior.

The clinic had been operating since 1992. Its main hall was rectangular in shape, with two desks facing each other in the middle by the pharmacy wall. Dr Liu started the day by printing a series of sheets. Dr Zhang Y. sat on the opposite desk showing photos taken during the Spring festival holidays to a younger girl, Fei Ling, a Han nationality nursing graduate who also worked in the clinic. The three wore long white coats. By the wall, propped on the desk, was a lighting board for X-ray viewing. On top of it laid a white quartz stone (of a special significance for some Qiang³) on a red cloth supported by a golden flat ornamented block. Each desk had a desktop computer where the staff logged in to check the records of their patients.

This was the third working day at the clinic after Spring festival. According to Dr Zhang Y., a few patients had come to the clinic already, but strangely that morning was a quiet one. The TV played a figure skating competition from the South Korea Winter Olympics, and the walls around were covered with frames that displayed awards, certificates, and mostly photos of events, meetings, conferences, some with foreigners, but all with Dr Zhang, the founder, usually wearing Qiang clothes. A large board held

³ Among the Qiang there is the worship of white quartz stones, these can represent all gods and can be found enshrined on roofs, towers and mountains (Zevik, 2002).

the license for the clinic to operate issued by the authorities with eight photos of practitioners and assistants. It also had two photos of the police officers responsible for the area, as most establishments in China do. The rest of the walls were covered by long red silk banners written with golden letters and donated by grateful and successfully treated patients praising the talent and excellence of the clinic doctors. One of the banners, left by a member of staff of the main electricity supplier company in China, read: "Ethnic Qiang medicine has made my life embody the sincerity and good faith of great physicians" (*minzu qiangyi shi wo sheng tixian dayi jingcheng* 民族羌医使我生体现大医精诚)⁴.

On the wall facing the entrance there was an old blue board where the services provided were listed in Chinese and in a phonetic Qiang script, as well as their respective prices which had been amended many times. Dr Zhang Y. told me she could perform them all, but most were not used often. Although in total there were twenty-nine, the most common was, unsurprisingly, "Qiang medicine manipulation treatment" (*qiangyi shoufa zhiliao* 羌医手法治疗). One of the services, "Qiang medicine ear acupuncture treatment" (*qiangyi erzhen liaofa*, 羌医耳针疗法) would be performed on children who would wake up at night for no reason, and the back of their ears would be pricked for bloodletting. She said that they did not perform massage (*anmo* 按摩, *tuina* 推拿) (which was not listed among their services) much, almost not at all, as in the case of injury it could make matters worse and increase the swelling.

According to her, in her hometown all these services were common practice and many people were familiar with them. Back when they lived there, the problem with their provision, as she put it, was that everyone was a relative or a relative's relative, and so they would end up providing all these services for free. Many of these services would be given when medicines were not necessary. Or, alternatively, when people could not or would not take medicines. Due to remuneration being difficult, at some point her family decided to move to Chengdu, as they "needed money to eat and live". It was in

⁴ *Dayi jingcheng* (大医精诚), or the "absolute sincerity of great physicians", is an expression that dates back to the name of a treatise written by Sun Simiao 孙思邈 (c. 581–682), a famous Tang dynasty physician, and an important source to understand medical ethics in China (Unschuld, 1979).

Chengdu that both Dr Zhang and Dr Zhang Y. studied and qualified at the Chengdu University of Chinese Medicine.

The clinic's three different rooms had signs above the door in traditional Chinese characters and in "Qiang writing"⁵. These were the pharmacy, the treatment room, and the manipulation room (see Figure 3). The main waiting hall worked often as a treatment room, with patients having their manipulation and poultices changed on a chair by the working desk. Every room kept its doors open, with the exception of the pharmacy which had a bridge-like metal counter that when lowered prevented people from walking in. On the pillar next to the pharmacy entrance was a paper sheet attached. It displayed both the Alipay and WeChat⁶ QR codes that patients and relatives could scan with their phones, in order to pay online for the services and medicines provided.



Figure 3: "Qiang writing" above traditional Chinese characters

At the entrance on the left there was the *white stone* (*baishi* 白石) and the *black stone* (*heishi* 黑石), both a central feature in Qiang medicine theory (Figure 4). Wrapped individually in red cloth with two apples (later replaced by two bowls with water⁷) standing in front as an offering, they stood above several medicinal plants on display in an old glass cabinet.

⁵ Although most scholars (and all that I have spoken to) agree that Qiang language, apart from a recent phonetic alphabet initiative, does not have a written form (Zevik, 2002; Stanford and Evans, 2012), the question of whether it had one in the past is debated. A legend speaks of a set of sacred texts that were lost, some argue that the extinct Xixia language (used in the Xixia kingdom (1038-1227AD)), with its written form, is related to the contemporary Qiang language, and others argue that it has never existed, see Chen et al, 2000 on this discussion. Scholars that I have spoken to either do not recognise the characters on display at Dr Zhang's clinic, or say it is either oracle bone script or Xixia language.

⁶ WeChat is the main application in China for online communication, and one of the two most common forms of online payment.

⁷ According to Dr Zhang, water was considered one of the most important medicines among the Qiang.



Figure 4: The *white stone* and the *black stone*

On the right there was the bust of Drs. Zhang's father, with the inscription of "Great Master of Qiang medicine" (*qiang yiyao dashi* 羌医药大师), and next to it a framed photo of their mother, wearing Qiang clothing and adornments. On the side door a large sticker displayed a minimalistic and stylish logo for Qiang medicine that consists of the shape of goat horns, which, as Dr Zhang had explained, depending on perspective, can also represent a womb and a tree (this replaced the old logo, which consisted of a goat's silhouette and a *yin-yang* symbol)⁸. An imposing long wooden board, a gift, painted black with golden carving, hung on the distant wall facing the entrance, it dated from 1999 and claimed that there "famous doctors of the Qiang nationality offer their wisdom and skill to cure disabilities and injuries" (*qiangzu mingyi xianlingshou zhican jiushang deshujing* 羌族名医献灵手, 治残救伤德术精).

The only patient coming in the morning was a young man who had injured his knee while playing football. Dr Zhang Y. pulled up the trouser of his left leg past his knee and then rubbed vigorously an alcoholic medicinal solution that they prepared. She did so on the knee and around it, swirling her hands in half-moon shaped movements, using the palms as well as the outer side of her hands, along her little fingers. This was a

⁸ The Chinese character for "Qiang" (羌) is composed by the characters "goat" (*yang* 羊) and "person" (*er* 儿), with the significance among the Qiang population of "goat" as a symbol being recent and disputed (Bian, 2017).

solution that needed to age for three months after preparation before it could be used, and so the staff always prepared large amounts in big containers that they then used sequentially from the oldest batch. She then took a poultice, also prepared in the clinic using a mixture of medicinal herbs, and warmed it right on a big fan-shaped electric heater with a reddish glow (a very common kind of electric heater in China). As the poultice folded easily in two, she then slammed the two sides against each other repeatedly in order to cool it, as the preparation in it flattened down. When the poultice was cool enough, she applied it directly to the skin on the knee, wrapped it with toilet paper and then with a bandage, both clockwise, then inserted metal pins and used thin white tape to keep the pins in place.

The patient was instructed to keep it on for five days. This poultice usually would need to be changed three days later. However, as he lived far away, he was instructed to return in five days instead, and left with two different lots of oral capsules, Chinese proprietary medicines (*zhongchengyao* 中成药). She later told me that the patient would still need to return to the clinic a few times. At lunch we ate together on a table set up by the wall where the list of services was displayed. There were no prayers before eating, and I found those happening only when Dr Zhang was present. The afternoon was filled with a dozen patients coming in with different injuries, one arriving with a crutch and holding a few x-rays of his ribs, knee, upper and lower back, while another patient came in with a foot injury. The treatment process was pretty much similar, with the application of the alcoholic solution and then a poultice. When an ointment was used instead, this was applied between a thick and a thin gauze, not directly to the skin. The recommendations were similar too, with Dr Zhang Y. advising her patients to avoid spicy food, hotpot, alcohol, and cold water. At one point, I saw Dr Zhang Y. taking a man's blood pressure, using a mercury manual blood pressure meter, while she pumped the black rubber pear. Although pulse examination (*haomai* 号脉) is a central form of diagnosis in Chinese medicine and Dr Zhang spoke often about it being used in Qiang medicine, this was performed rarely in the clinic.

In general, every patient received plenty of attention, even at busy periods, and there was always time for a chat and laughter. The privacy was minimal, with many being treated in the waiting area, for the sake of simplicity, even when the private rooms were

empty. One elderly patient was even treated outside by Dr Zhang Y., in the residential area inside a tuk-tuk style vehicle (in Sichuan called “fire three-wheeler”, *huosanlun* 火三轮). He was on a wheelchair and so would not be able to climb the steps to the clinic. A relative then came in to pay.

The pharmacy

One of the days started with a big family group in the waiting room, accompanying their frail grandmother. I asked permission to enter the pharmacy, and inside I found Dr Zhang Y.’s young son, as well as Dr Zhang’s teenage daughter sitting doing their homework and preparing for an exam, as the school New Year holidays were still ongoing.

Placed in a corner of the pharmacy there was a cupboard that contained “Western medicines” (*xiyao* 西药), and Chinese proprietary medicines (*zhongchengyao* 中成药). Among the “Western medicines” there were paracetamol drops, aciclovir (an antiviral), Vitamin D2 and B6 tablets, among other medicines. These were a minority, as most of the cupboard was filled with Chinese proprietary medicines. Among these there were both single medicine preparations such as *Rhizoma Gastrodiae* tablets (*tianma pian* 天麻片), and compound preparations, such as “compound bear bile and mint tablets”⁹ (*fufang xiongdan bohe hanpian* 复方熊胆薄荷含片), “lumbago tablets” (*yaotong pian* 腰痛片), which was one of the most commonly dispensed, and a famous Chinese medicine preparation called “nine flavours *Notopterygium incisum* pill” (*jiuwei qianghuo wan* 九味羌活丸).

The three large metal cabinets in the pharmacy had 28 drawers each, with each drawer containing four kinds of “herbal pieces” (*yinpian* 饮片), or “Chinese medicines” (*zhongyao* 中药), making a total of just less than 336 kinds of medicines (given that there were some empty bottom drawers). Each drawer had four stickers, with the bottom stickers referring to the compartments at the front, and the top stickers to those at the

⁹ For the historical significance of animal-based drugs in Chinese medicine see Chee, 2015.

back of the drawer. Each sticker had a standard format that appeared in many pharmacies around China (Figure 5):

Photo of plant upper part	Name
	2010 edition pharmacopoeia (<i>yaodian</i> 药典)
	Alternative names
Photo of rhizome, bark, or seed	Flavours
	Indications

Figure 5: Medicinal herb label format

Among the many medicinal herbs kept in those drawers, there was one that I was particularly interested in. With its crooked fragrant roots, kept in a lower drawer, and broken into lumps, *qianghuo* (羌活 *Notopterygium incisum* K.C.Ting ex H.T.Chang (*sige* in Qiang language)), shares the character *qiang* (羌) with *qiangzu* (羌族) or “Qiang nationality”, and its disputed ethnic significance will be explored later in Chapter Four (see Figures 6 and 7).



Figure 6: *Qianghuo* pharmacy sticker



Figure 7: *Qianghuo* (photo supplied by the clinic)

There were also others kept in plastic bags above the drawers, and some in the flat across from the clinic’s door at the stairway, a space that also belonged to the clinic. The medicines kept outside the drawers were the ones used to prepare their poultices, ointments, and solutions. It was her younger brother who supplied most of the medicinal herbs from their hometown to the clinic on an occasional basis, whenever they were running low on a particular one. Dr Zhang Y. told me that she used to collect from the

mountains often on holidays when she was younger but that she just did not have the time anymore. Back when she was growing up in the mountain village, she was shown the different uses for the medicinal herbs that grew around.

Facing the medicine drawers stood a desk above which were placed cupboards that were filled with metal and enamel tins with the different products that they produced on site. These were prepared using medicinal herbs coming both from Sichuan's Aba prefecture, and from Yunnan, the province bordering the South of Sichuan. These tins were marked with their own labels, the Qiang medicine logo and a QR code printed in burgundy coloured stickers. Among them, there was an ointment used to treat *water disease* (*shuibing* 水病), and also a "white stone standard ointment" (*baishi zegao* 白石则高), which could only be used in small portions to treat major *fire disease* (*huobing* 火病), a condition that usually involved fever, and occasionally festering ulcers. There was also an ointment for minor *fire disease*¹⁰, among several others.

On the top shelf there were the alcoholic solutions, labelled in the same style. Most of the bottles contained "King Rongtaer bone pain alcoholic solution" (*rongtaer wang gutongjiu* 绒塔尔王骨痛酒), the one they used the most. They prepared it in copious amounts, and I was later offered a small bottle as a gift. They also produced it in the form of a paste (which in Chinese shares the word with ointment, *gao* 高). This was the paste used to prepare their most common poultice, which was essential for the treatment of *stone disease* (*shibing* 石病). "King Rongtaer" did not actually refer to a king, it was instead an honorary name given to the grandfather of Drs Zhang. According to Dr Zhang Y., their grandfather followed an old family prescription, but experimented with several other medicinal herbs, adding some along the line, according to the success on his treatments. Just like with the other products prepared in the clinic, the preparation of the paste followed a family's "secret prescription" (*mifang* 秘方). This confidentiality had persisted for many generations and applied not only to the composition but also to the preparation or processing (*paozhi* 炮制) of these medicines. "Secret prescriptions" have been passed hereditarily among Chinese physicians for centuries (Chao, 2000). In contemporary China (including among ethnic minorities) these have gained different

¹⁰ These are conditions that fall under a "Qiang medicine aetiology" as defined by the practitioners at the clinic.

contours, given the prospect of large profits to be made (Farquhar and Lai, 2014). At the same time, given how recent the concept of intellectual property law is in China (Alford, 1995), I have come across worries elsewhere when it comes to disclosing “secret prescriptions” for production purposes (see Chapter Five).

Although I could not have access to the processing of the “King Rongtaer bone pain paste” (*rongtaer wang gutonggao* 绒塔尔王骨痛膏), I was fortunate enough at a later date to have the opportunity to use it while helping prepare the poultices used in the clinic (see Figure 8). With a bent knife and by trial and error, I learnt to dig out the right amount of paste from a pot to then spread it in wide strokes along a rectangular magazine cut that had been placed inside a see-through paper. The next step was to make the poultices even, and for that I removed the excess on top and out of the edges of each magazine cut with the bent knife. Following that, I would place long cotton wool cylinder-shaped strips around, finally covering each poultice with a sheet of gauze.



Figure 8: Poultice prepared with “King Rongtaer bone pain paste”

I was also told of the only oral medicine prepared in the clinic. The “bonesetter pill” (*jiegu wanzi* 接骨丸子) was used together with a poultice when a bone fracture was serious to the point that the Chinese proprietary medicines were not enough to help the patient. It was shaped like a small ball and needed to be kept in the refrigerator. A one-

month supply or less would be given to the patient, whom would have to return, as the treatment usually lasted three months. The pills would be taken twice a day in the beginning and once a day later in the treatment. Reportedly, it was used only very occasionally, and I never saw any. Dr Zhang Y. claimed that in her village these would be used a lot more than at the clinic.

Below the cupboards that contained the tins with the prepared medicines for external use and right next to the pharmacy's metal bridge, there was another computer where all the payments were registered. The medicines dispensed were recorded first in a large logbook on the pharmacy's preparation counter. Afterwards, the patients would come to the bridge, where the staff confirmed their details and swiped their insurance cards in a device connected to the computer. Sometimes these were cards from outside Chengdu, which were also referred to as "outside cards" (*waidi ka* 外地卡). It was at the bridge that the patients then paid in cash or using their phones, and finally collected their medicines, receipt, and received posology instructions. Throughout all my visits to the clinic, I only saw Chinese proprietary medicines being dispensed to patients.

Life in the clinic

The tasks in the clinic seemed to be distributed in a very homogenous, non-hierarchical way between Dr. Zhang Y. and Dr. Liu. Although Dr Liu was in charge of the administrative functions, she also prepared lunch often, alternating with an older lady who would come most days just for the cooking. This would happen while Dr Zhang Y. and the assistant saw patients. When there were no patients, Dr Zhang Y. would sometimes sweep the waiting room and the path outside while singing Chinese pop songs. During the quiet spells in the clinic she would also often go out on the porch to check her WeChat voice messages, many of which were verses of Qiang songs that she would then reply with either the following verses or with different songs altogether. These had a prolongation of sounds, a reverb and intonation that I encountered often when spending time in Aba's mountain villages, months later.

Near the end of the week, as a token of appreciation for having been fed all those days, I brought in some homemade Portuguese style pumpkin soup, which everyone seemed to

enjoy, even if they found it unusual. After lunch, Dr Liu cut up some dressings and placed her bandaging material on the desk, next to where Dr Zhang Y. rested her head. She continued her afternoon nap (*wujiao* 午觉), and replied occasionally, with her mouth facing the wall.

The first glimpse I had of a disputed ethnicity of the medicines in the clinic was when Dr Liu asked me of my plans for the evening, I replied that I would check for names of Qiang medicines to then search in the clinic. To this Dr Zhang Y. interjected “Where are the Qiang medicines?” Following what I had been told by Dr Zhang, I replied “in the drawers”, to what she appeared unconvinced. My intention was to find cues for discussion and thought that names of medicinal herbs would be a good starting point. So far, in her eyes, only those medicines prepared by themselves with their secret family prescriptions seemed to qualify as “Qiang medicines”.

Like most Chinese, Dr Zhang Y attributed great value to written language (*wenzi* 文字). She told me how she would get offended if someone assumed that the Qiang do not have one. According to her, the writings on display in the clinic were quite ancient and there were very few people who could read them. She explained that the shamans (*shibi* 释比) and the headmen (*tusi* 土司) of Qiang communities, before the founding of the People’s Republic of China (PRC), concealed their writings from outsiders, and they were the only literate people in their communities. Therefore, when queried, the villagers would reply that there was no written language. In more recent times, children at school in Qiang areas learnt Qiang language (in a romanised phonetic system), standard Mandarin and English.

When I enquired about the books on Qiang medicine that they would have in the clinic, she confessed that she had not read any of them. After a short phone call to her brother, Dr Zhang, she eventually produced a copy of “The Divine Farmer’s Materia Medica Classic” (*shennong bencao jing* 神农本草经). Compiled between 200 and 250AD, from various sources, it is considered the oldest Chinese pharmaceutical written work, but not the oldest Chinese written source on pharmaceuticals available (Unschuld 1986, p.14). Dr Zhang spoke of it as containing the medical wisdom of the ancient Qiang people, given the book’s perceived geographic origins. When I showed the list of designated Qiang

medicinal herbs from the main compilation of China's ethnic minority medicines (Qi et al, 2000) to Dr Zhang Y., she had great difficulty in understanding the Qiang names described. Given that in different parts of Aba prefecture these names vary greatly, the book's authors must have picked what they considered to be a standardised form.

Life in the clinic was visibly intertwined with that of the *xiaoqu*, the residential community. It was common for neighbours (some of whom were also current, or past patients) to drop by for a chat. At some point, an elderly lady came in carrying cabbages and lettuces to give to the staff, a heap on one hand and a big pink full bag on the other. Dr Zhang Y. removed the ones in the bag and placed the large cabbage leaves on top of thin tree branches outside the clinic to dry, next to the stairs. On a different occasion, the same spot had circular drying baskets filled with very aromatic bark pieces of a certain twenty-year-old tree (the name of which Dr Zhang refused to disclose). These had already been processed and would be later used to prepare topical medicines in the clinic.

When it came to ethnicity, many of the patients arriving in the clinic seemed unaware of it being a clinic of Qiang medicine. At one point a patient arrived with a few relatives and one of them shouted "*Qiangzu!*" (Qiang nationality) with an air of intrigue and curiosity to the other, while reading the wooden board outside with the clinic's name (see Figure 9).



Figure 9: Entrance to the clinic

On the whole, ethnicity seemed to be an irrelevant detail for the visiting patients. The clinic was a first port of call for people with minor injuries, who came searching for

medical care and a solution to their health problems, with ethnicity not featuring at all in the patients' choice. In fact, I did not meet any patient in the clinic that came in search of a Qiang medicine clinic, they had all come because of the recommendation of friends, family, or neighbours who were treated there.

Some of the patients and relatives who would miss the sign outside, would find themselves in the waiting area surrounded by the framed photographs of Dr Zhang wearing Qiang clothes, and occasionally, in a very surprised tone, would ask Dr Zhang Y. if she was “of ethnic minority”, or “minority nationality” (*shaoshu minzu* 少数民族). I also did not meet any patient that was of Qiang ethnicity. One day, between the two of us, Dr Zhang Y. smiled and said: “here in Chengdu I am like you, a foreigner”.

Becoming an apprentice: The “ceremony to honour the master” (*bai shi yishi* 拜师仪式)

I met Dr Zhang in the clinic the day after his return. He was still fairly busy, so that day he did not see patients. However, he did manage to squeeze in a few minutes for the two of us to have a chat. We walked across the *xiaoqu* to the opposite corner, where a ground floor flat belonging to them had been converted into their Qiang medicine museum. Once inside, we entered the room where the altar (*tan* 坛) to the *pusa* (菩萨) was kept.¹¹

The altar was composed of three large scroll paintings of bodhisattvas (*tangka* 唐卡) hanging on the wall. They were, respectively, the “Bodhisattva of Longevity” (*changshou pusa* 长寿菩萨) on the left, the “Medicine King Bodhisattva” (*yaowang pusa* 药王菩萨) at the centre, and the “Bodhisattva of Life” (*shengming pusa* 生命菩萨) on the right. Each scroll held a white ceremonial scarf, as well as a thinner red one around it. Below the scrolls, there was a large dark wooden set of drawers with cupboards under. On top of it, in the centre of the altar there were the *white stone* and the *black stone* (that also embodied the heaven gods (*tianshen* 天神) and the earth gods (*dishen* 地神) respectively). These were similar to those at the clinic's entrance, but in this case the *white stone* was three times the size of the *black stone*. Each was covered

¹¹ It is common among Qiang people for *pusa* to refer to both bodhisattvas and gods (*shen* 神), and often these are considered the one same thing.

with a long red ceremonial scarf. Next to them there were two long thin jars, each containing a few long pheasant feathers (a common adornment among Qiang shamans). At a lower level there was a small table covered with a red cloth, on top of which were a few offerings such as water, which filled several small brass chalices, and a few pairs of apples, placed on top of each other, inside bigger chalices. Between the two stones there was a pile of *zuma*. *Zuma* in Qiang language designates the leaves of a variety of coniferous plants, such as cedar, cypress, and juniper. Apart from being used to light up a fire, its burning plays a role in some medicinal and religious practices among the Qiang, it is used for fumigation, maintaining health, skin problems, and for inviting the presence of *pusa*. Dr Zhang took a handful of it and started by lighting it up in a ceramic incense burner. We both held our hands together up to our chests, facing the *pusa*, and Dr Zhang said a prayer in Qiang language directed at them, while the fragrant *zuma* smoke filled the air. When the prayer was finished, we bowed to the *pusa* three times. After paying our respects by the altar, we left the room and sat down at the long meeting table.

According to Dr Zhang, all Qiang people had *pusa*, having had, in his opinion, a “homegrown” local form of Buddhism through history, not a Buddhism merely imported from India. He spoke of how the ancient Qiang included the ancestors of the Tibetans, the Yi, and the Mosuo minorities. Indeed, that these, as ethnic groups, were later offshoots, leaving the contemporary Qiang as the true inheritors of “Qiang culture”. He invited me to take part in the Qiang “ceremony to honour the master” (*bai shi yishi* 拜师仪式) and officially become his apprentice. He vouched that, in this way, I could formally learn Qiang medicine. Also, that because the ceremony implied receiving a document confirming my status as an apprentice, this would be beneficial for me, making matters “more official” as I continued my research elsewhere in Sichuan.

According to him, this was a ceremony that came from the old Confucian ceremony of “paying respect to one’s teacher before commencing to receive his or her knowledge”, but that in the case of the Qiang version it was distinct for involving worshipping the *pusa*. All over China, the “ceremony to honour the master” marks the beginning of a master-disciple social relationship, modelled on a Confucian filial relationship between father and son, and embodying a hierarchical relation of nonequals (Scheid, 2002). Dr

Zhang Y. later claimed that in Qiang villages there are such ceremonies, even if quite different, performed by the shamans, or *shibi*, and their apprentices¹². Back in the clinic, I was then shown a video of last year's "ceremony to honour the master", for the first batch of apprentices officially being trained by Dr Zhang. There were two male apprentices (one a stomatology Han student from Tianjin who studied in MIT for a while) and Dr Zhang's daughter.

Apprenticeship is considered to have constituted the predominant form of transmitting medical knowledge in China till the end of the 19th century (Scheid, 2002). Then, in the late Qing dynasty and Republican era, institutions sought to emulate Western education with the creation of universities and colleges. After the founding of the People's Republic of China, these institutions were expanded (*ibid.*). However, apprenticeships have always continued, both in private and public settings. When it comes to minority medicine, university degrees have been established for many years among the Tibetan, Uyghur, and Mongol minorities. Among other minorities, these degrees have been developed at a later stage, while the Qiang still have not established such programmes. This kind of institutional training has always run parallel with uncertified apprenticeships.¹³ Only after 2016 when the "Chinese medicine law" positioned minority medicines as part of Chinese medicine (People's Republic of China Twelfth National People's Congress, 2016), were formally recognised minority medicine teacher-physicians such as Dr Zhang (who has the official title of "Master, and Inheritance Mentor of Qiang medicine" (*qiangyi dashi, qiangyi chuancheng daoshi* 羌医大师, 羌医传承导师) able to run apprenticeships that confer a certificate in the end of the three years training, upon completion of an exam. However, these certifications were still of limited value, given that without a professional doctor qualification certificate (*zhiye yishi zigezheng* 执业医师资格证) in Chinese medicine, officially, they allowed graduates only to work under the management of a certified doctor.

On the day of the ceremony, I arrived with teacher Zhou, of Han nationality, who had worked with Dr Zhang for years and who was authorised to authenticate the ceremony

¹² For the importance of a different kind of ceremony, the "graduation ceremony" in Qiang villages, when a Qiang shaman receives his set of shaman tools after completing his training, see Zevik, 2002.

¹³ See Farquhar and Lai, 2014 for the contrast between institutional training and informal apprenticeships among the Zhuang ethnic minority in the South of China.

of admission of the new apprentices. She was one of the founders of the “Qiang Medicine branch of the Chinese Ethnic Pharmaceutical Association” and of the “Qiang Pharmaceutical Commission”. Teacher Zhou was based at the Southwest Minzu University in Chengdu, where she split her time between a low amount of teaching at the Pharmacy College, and laboratory and field research with her team at the “Qinghai-Tibet Plateau Research Institute” (*qingzang gaoyuan yanjiuyuan* 青藏高原研究院). She had dedicated her academic career to Chinese medicine, to the postdoctoral level and beyond.

Upon arrival at the clinic, we found Dr Zhang busy printing all the necessary paperwork for the ceremony. Apart from myself, there were two other future apprentices, of Qiang nationality. These were Dr Zhang’s nephew, a 25-year-old, and Dr Wang, in his 50s and older than Dr Zhang, who lived in Chongqing where he ran a massage shop (*tuinadian* 推拿店). They both used Qiang language throughout much of the ceremony, and started by changing into Qiang clothes, while Dr Zhang told me to keep what I was wearing.

Dr Zhang Y. wore a beautiful and intricate Qiang dress, red in colour and covered in embroidery, mostly yellow and pink flower patterns. Around her neck she wore a large silver medallion encrusted with two small green stones and a bigger red one in the middle, hanging by a thick heavy chain. She also wore long silver earrings. Dr Zhang wore a broad sleeved golden gown, covered with floral patterns, purposefully bought for the occasion. Teacher Zhou commented that it looked Tibetan, but he insisted that it was Qiang. The nephew wore a gown that I had seen Dr Zhang wear many times, in burgundy tones and with goat horn patterns on sleeves and chest. Dr Wang’s clothes, in turn, were less ornamented, with a goat fur vest (*piguazi* 皮挂子) (commonly worn among Qiang people on special occasions) over a discreet blue shirt, its dark grey goat fur sticking out of the shoulders and all around. There were cloud-like shapes sewn at the front and a goat horn pattern in the back.

Dr Wang was already carrying a rooster, and so I headed to the local market to buy a rooster myself, as well as two bottles of spirit (*baijiu* 白酒), both items necessary for the ceremony to follow. At a shop in the street market, only the chickens were kept in sight, while the two roosters were inside. I was told that the rooster with most of his body

covered in black feathers looked better, and so opted for that one. The shop owner tied his feet and put him in a bag that I carried back to the Qiang medicine museum.

Worshipping the *pusa* and the ancestors (*jing pusa, bai xianzu* 敬菩萨, 拜先祖)

The two other apprentices and I followed Dr Zhang and Dr Zhang Y. to the room with the altar. One offering had been added to the water and the apples: in a tin basin there was a plucked and cooked rooster. In front of it there was a smaller table that propped up a large ceramic incense burner with *zuma* inside. Only Dr Wang and I held roosters, clinching their wings together. We all faced the altar, with Dr Zhang and Dr Zhang Y. at the front. Dr Zhang started by lighting up the *zuma* in the burner until there was plenty of smoke coming up. He lifted his hands together to his chest in the form of prayer and facing the *pusa* started in Qiang language:

Oh, Great Heaven God Bodhisattva

Earth Bodhisattva

Medicine King Bodhisattva

Life Bodhisattva

Longevity Bodhisattva

Ancestor spirits,

Today, on the 22nd of March, on the sixth day of the second month, today on this auspicious day, three students came to our centre to study Qiang medicine. They will study hard, study conscientiously, study diligently. They will learn to understand, learn the essence, they will contribute to all Qiang people under Heaven. Excellent medical skills will be passed to honest and good people, to let them use humanity (in their work). Excellent medical skills to benefit the people, these can't be passed to the wrong person, don't let them harm anyone. Today, we have three people of goodwill, I have decided to teach them medicine.

He then turned back to Dr Wang. His sister handed him a big pair of metal scissors, and while Dr Wang held the rooster, Dr Zhang held its crest with one hand and clipped a fleshy protuberance with the other. The rooster clucked with pain, Dr Zhang turned around, placed the fleshy piece in the *zuma* fire and Dr Wang squeezed its crest so as to drip some blood onto the burning *zuma*. While still holding the pair of scissors, Dr Zhang spoke to the *pusa*:

Bodhisattva, today we are killing chickens to honour you. After blessing Wang's studies, he will use excellent medical skills to treat the sick and get them rid of the torments of disease.

Dr Wang then bowed three times, propping his hands against his chest in prayer, and retreated to the back of the room. I stepped forward, and Dr Zhang again clipped one of the fleshy caruncles sticking out on the rooster's crest. He threw it into the pot where *zuma* kept burning and then asked me to squeeze some blood into the pot, but as I squeezed close to the wound there was not enough blood to drip and all I could produce was a twist of the rooster's head, which was clearly in pain. Dr Zhang then continued in Qiang language facing the *pusa*, while the rooster clucked occasionally:

This is a Portuguese friend from faraway London, England. He has travelled thousands of miles to study Qiang medical skills, let him study it well, he must understand it. Let him use Qiang medical skills to treat and cure many people and let many people know our Qiang medical skills. Let him use Qiang medical skills to benefit all people.

I then stepped to the back of the room, the roosters were taken away to the kitchen by the nephew, and upon him coming back Dr Zhang continued in Qiang language while we all held our hands in prayer position:

Oh, Heaven gods, Earth gods, Medicine King Bodhisattva, we kill chickens with ancient rituals¹⁴. Today, three of us come to learn Qiang medicine. Just now, we kowtowed and toasted to respect the *pusa*¹⁵. Bless and protect them so they can understand and learn.

In this moment Dr Wang was about to get on his knees and Dr Zhang signalled that it would not be necessary. And so, taking turns, we bowed to the three *pusa*, each of us three times, with our hands in praying position against our chests. Then, the others

¹⁴ Animal sacrifices are a common practice when it comes to popular religion in contemporary China, sometimes by ritual specialists using Confucian texts (Dean, 2003). In Tibetan areas, animal sacrifices have historically been frowned upon by Buddhists, and predominantly carried out by Bon (indigenous religion of Tibet) practitioners. However, these are reportedly in decline among Buddhists as well as Bon (Samuel, 2013), along growing social institutionalisation. Among the Qiang, a blood sacrifice has the special significance of “expelling evil” (Bian, 2019, personal communication 24 June), and in villages whose religious practices are more aligned with forms of animism, with agency attributed to the “myriad things” (*wanwu* 万物), sacrifice by killing has historically been more common (Graham, 1958). In those villages whose practices are more aligned with Buddhism, animals are released instead (for gaining merit), contrasting the “sacrifice” by releasing life with the sacrifice by taking life (Bian, 2019, personal communication 24 June). In neighbouring Nepal, the sacrifice of chickens and their blood in shamanistic practices are done to remove physical pain from the patient (Desjarlais, 1989), or as an exchange for the patient's soul, so that this can be retrieved (Desjarlais, 1992).

¹⁵ In the previous year's ceremony, there had been alcoholic spirit (*baijiu*) poured into the burning *zuma*, but this time the *baijiu* was kept untouched. Also, the roosters were not killed in the actual ceremony.

present in the room followed suit, apart from the photographer and Dr Liu who kept photographing and filming, respectively. Dr Zhang then summarised in Chinese language what had taken place, that we had worshipped the heaven gods and the earth gods, and also the Medicine King Bodhisattva, the Life Bodhisattva and the Longevity Bodhisattva, and that now it was time to worship the ancestors in the room next door, “from the first generation to the fifth generation” (which according to him, comprised all the ancestor generations of Qiang doctors in his family).

We stepped out to the museum’s main hall and entered another room with an identical incense burner, burning *zuma* on the floor. This altar had the bust of Dr Zhang’s father, with water and apples as offerings. There was also a small *pusa* statue in a glass cupboard by the wall to the right. We stood behind Dr Zhang as he made a similar dedication to it in Qiang language through the glass:

(...) From today on, they should study hard, study Qiang medical skills, no matter where they are (...). Today, Baishu (百树 my Chinese name) comes to our Qiang people's place from very faraway to study, to learn well, to let many people know the medical skills of the Qiang people. From London, England to study in this Qiang people's place. This moves me, and I am glad to accept you. In the process of learning Qiang medicine, he will learn Qiang medicine theory and the anthropology of Qiang medicine with his whole body, heart and mind, and bring Qiang medicine to the world.

Both Drs. Zhang then bowed three times to the *pusa* statue. The three of us, apprentices, followed suit. After that, everyone bowed to the father’s bust in the same manner and order, and left towards the main hall.

“Wearing the red” (*guhong* 挂红) and serving the tea (*fengcha* 奉茶)

We all sat around the meeting table. Teacher Zhou welcomed everyone and introduced the next stage of the ceremony. The cameras kept flashing. As Dr Zhang Y. moved to a chair placed away from the meeting table, the nephew (who was about to become her apprentice) unwrapped a ceremonial red scarf and placed it around her shoulders, in what is called “wearing the red” (*guhong* 挂红), a sign of dedication, perseverance and

enthusiasm in “Qiang culture”, according to Dr Zhang¹⁶. The nephew then fell on his knees, over a magazine placed on the floor, and held a tiny cup of tea up to Dr Zhang Y.¹⁷. She drank it up amidst laughter and smiles, while they looked at each other with the complicity of close relatives. He bowed three times with his hands together by his chest, and she then placed another red scarf over his shoulders. Dr Zhang took his sister’s place on the chair, the nephew again served the tea, placed a scarf over Dr Zhang’s shoulders and bowed three times on his knees. He then received a second scarf and stepped aside. It was then my turn and Dr Wang’s to serve the tea and repeat the *guahong* to Dr Zhang, who would become our master. Before Dr Zhang placed the red scarf (*hongwei* 红围 or *qianghong* 羌红) on my shoulders he explained the historical significance of it, that the ancient Qiang used the red scarf and so do the modern Qiang. He explained further that in this ceremony it represented acquiring all kinds of knowledge in a prosperous manner (*honghong huohuo de* 红红火火的)¹⁸, and the wish for the prosperity of Qiang medicine. The awkwardness in bowing to someone on one’s knees, an act pervaded with submission as it is, was counterbalanced by the moving words of commitment and dedication spoken by Dr Zhang while performing the *guahong*.

Signing the documents

As we got back to the meeting table, teacher Zhou took centre stage. She sat across Dr Zhang, to the left of Dr Zhang Y., and next to Guang De. Guang De was the right hand of Dr Zhang, and a Chengdu People’s Congress deputy like him, who was trained in marketing and devised Dr Zhang’s development strategy. Teacher Zhou then followed a step by step sheet and started by asking each the three of us, apprentices, for an enrolment speech. Dr Wang spoke of the importance of being up for the task we were given, to make Qiang medicine prosperous, and above all to not let the teachers and organisers “lose face” (*diulian* 丢脸). She then addressed me as “our international friend, the first foreign apprentice of Qiang medicine in China”, and I mentioned the importance and privilege of having a mentor. She then turned to the nephew: “Your task

¹⁶ “Wearing the red” is also sometimes practiced in Qiang villages when receiving guests, as a sign of offering good wishes (Zhang, 2016).

¹⁷ Tea plays an important ceremonial role in China, in events such as weddings, or when receiving guests, see Chow and Kramer, 1990.

¹⁸ Literally “red fire”.

is even heavier! Family inheritance (*jiazu chuancheng* 家族传承)! They are receiving a teacher inheritance, but you are receiving a family inheritance!” He spoke shyly in Qiang language, about making a contribution to Qiang medicine, translating it in the end into Chinese.

Teacher Zhou then asked Dr Zhang to speak, a speech that she later called a “foundational requirement for the transmission of teachings”: the “master’s precept” (*shifude xunyan* 师父的训言). This not only laid the foundation and rules, but also outlined the purpose of the apprenticeship:

Today is an “auspicious time and a good day” (*liangchen haori* 良辰好日). In terms of the geomantic omen of the Qiang people (*qiangzude fengshuixue* 羌族的风水学), it is the sixth day of the second month in the lunar calendar. This sixth day represents health for our people, and it represents health in Qiang medicine. It is also a healthy time (*shichen* 时辰¹⁹) for us. It also represents such a day when our whole mankind is peaceful and without problems. So, on this good day of this year, we invited our professor from the Southwest Minzu University and our representative of the Chengdu People’s Congress, to witness the “ceremony to honour the master” for the second batch of Qiang medicine students (...). Baishu comes from (...) such a faraway place to study Qiang medicine, because of a Baidu²⁰ search (...) for a Qiang doctor, he read many reports about me, in this way he came to China, “attracted by the fame of the name” (*muming erlai* 慕名而来), (...) and today, through this “ceremony to honour the master” he is formally accepted as an apprentice. In the original sense of inheritance, you are supposed to be the first foreigner, before there was a Korean man whose circumstances weren’t as ceremonious, and when he met me there weren’t such standards, this sort of legal requirements. Now, we are given this legitimacy and legality by the government (...). Hope you can master the basic knowledge of Qiang medicine (...), you should master the basic theory, and you should master our Qiang medicines well (...).

Then, turning to Dr Wang:

Surprisingly, the teacher here is my student, he is actually older than me. He learned some medical skills from our local places, that is, local inheritance (*dangdi chuancheng* 当地传承), some of the traditional Qiang medical techniques. He started around 1975, when he began to see patients in other places. But here with systematic learning, in our more systematic study of some of our Qiang medicine’s theories, its clinical side, and deep technology (*shen jishu* 深技术), it will be more detailed. Many times, several years ago (...) he sought me for a mentor, through a formal “ceremony to honour the master”, to come and systematically learn the techniques and theories of our Qiang medicine.

¹⁹ One of the twelve two-hour periods in the day, or “earthly branches”, according to an ancient system of telling time (originated in the Western Han dynasty (202 BC-AD 23)) (Tiqia, 2012).

²⁰ Baidu is the biggest Chinese online search engine, equivalent to Google.

We met through his cousin, Comrade Shang, our former Deputy Minister of propaganda department in Aba Prefecture, now he is the director and leader of our new Bureau of Culture in Aba Prefecture. He also deals with intangible cultural heritage²¹. Our brother (Dr Wang) still loves our own nationality culture very much, our nationality medicine. But we think that from this point of view of his, it's not enough! Because it's folk (*minjian* 民间)! Because through a Qiang medicine master, (...) with the systematic theory of Qiang medicine and clinical Qiang medicine, he can learn these things deeper and better, so today, through this ceremony, I hope all of you can learn better things.

Then, turning to his nephew:

Then Zhang Qing, he's my younger brother's son. Actually, his father was in last year's first batch of apprentices (...). So, he is in fact a close relative, it is a family inheritance. (...) he is also studying rehabilitation in the Chengdu University of Chinese Medicine. Today it's not your uncle, but your teacher. You should remember this. This teacher hopes you can pass on this family inheritance, which is already in its seventh generation. How, in this seventh generation, do you learn in-depth and master these things of our ancestors, from the angle of Qiang language, and medicine? This is the burden you shoulder.

Finally, to the three of us apprentices:

(...) learning is endless, learning requires our whole-hearted energy to master every technique and every technical knowledge. So, I hope that you will know the respect for your teachers, and second, also the respect for your elders, and third, hope that you will learn all kinds of knowledge in a well-grounded way, so that we can take Qiang medicine everywhere, so that it will shine. We can't bring shame to it, because we say the "half full jug of water jingles"²² (*banguan shuiding dangxiang* 半罐水叮当响). We hope that we can't become the half full jug of water. We want a full jug of water. It doesn't jingle, but it has a very high level.

I hope that every time we use it, we can really apply it to patients and solve their pain. Our Qiang medicine is very deep. We have prevention, psychotherapy, many psychological suggestion methods, and so on. These are the treasures of our Qiang medicine. As Chairman Mao once said, "Chinese medicine is a great treasure", "it is the medicine of China", so we'll have to unearth deeply our treasure house, there are numerous things that can be done and studied in-depth.

(...) how can we do better so that patients can solve their pain? In fact, what do we mean by "doctor"? Although we can't save a person's life immediately, we can pull life from the line of death. If you do well, you pull it over, and if you don't do well, you throw it over. So, I think it is our sacred duty as a doctor to treat every patient with our own kindest heart, including not only the patient, but everyone. As my

²¹ The concept of "intangible cultural heritage" has been borrowed from UNESCO and used throughout China by local authorities well beyond preservation, in the construction and marketing of local customs. See Pieke, 2014.

²² From the idiom "*manhubuxiang, banhudingdang*" (满壶不响, 半壶叮当), literally "the full jug does not ring, the half full jug jingles", meaning those who have real talents do not reveal themselves, while those who do not, in turn, like to show off.

experience for so many years, the main feeling from our family culture (*jiazu wenhua* 家传文化) is how we think about others. How to solve the suffering of others is the basic principle of doctors, so I hope that in this study of medicine, we can use our benevolence better, to be kind-hearted and to save more patients, including saving people's thinking, because now we have more sub-healthy people²³ (*yajiankang de ren* 亚健康的人). I hope you can learn a more solid foundation.

What followed was a discussion that reflected a common vision for the different parties sitting at the table on the establishment and development of Qiang medicine, even if approached differently by each. Teacher Zhou's wishes were partly academic, partly technocratic in nature. She wanted to institute a system of support between us that one could turn to, both teachers and students, in what she called an "academic team", and spoke of the recent work in the direction to launch the Qiang medicine training, examination, and minor degree textbooks at the Aba Health School and Aba Teachers College.

There was also a dimension of deep personal affection towards the clinic. For her, going there was like "walking into her own home", and she developed at length on how thanks to the clinic's doctors both her ailments and her elderly mother's had been splendidly treated and cured. This led her to position Qiang medicine against Western medicine, with the latter's invasive surgery, claiming that in bone injuries and diseases it alleviated the pain but could leave sequelae. Moreover, that it could worsen one's illness, aggravate the discomfort of patients, and reduce not only their quality of life, but their life itself. This was framed in compliance with, and taking advantage of the possibilities opened by the current "Outline of the "Healthy China 2030" Plan" (Central Committee of the Communist Party of China and the State Council, 2016) that placed an emphasis on preventive medicine, as she claimed that in the future, Chinese medicine would be more about preventing than curing, and that with the irreplaceable role and position of Qiang doctors "we will get the whole people's Healthy China", and reduce the use of medication in the country by 60%²⁴. The alignment with the government's plan was made more evident when she insisted that "we don't need perfection, but we

²³ "Suboptimal health" is a concept that gained track in recent years, as a state between health and disease, and has proved very popular among Chinese medicine practitioners, see Wang and Yan, 2012.

²⁴ Together with news of the "Outline of the "Healthy China 2030" Plan", there was a claim spread on social media regarding the target for the country's 60% reduction in use of medication. I did not find any policy documents supporting this, and it is something that has been discredited as misinformation by the Shanghai Observer (Zheng, 2018).

need special characteristics”, a guidance that she attributed to Chairman Xi (and made the point of referring that she spreads this kind of content to her circle of friends on WeChat), and that it is those special characteristics that one should “shout about” (*xiangxiang liangliang de* 响响亮亮的).

Then, she proceeded to position Qiang medicine among the medicine of other ethnic minorities, praising the treatment of bone injuries by the Naxi, Tujia, and Mongol minorities. In this way, she stated that these were confined to their geographical regions, and that in Sichuan, the Qiang doctors were the majority doing this kind of work. With the three most populous ethnic minorities in Sichuan being the Yi, the Tibetans and the Qiang, she related a discussion with the head of a certain committee in Chengdu, showing her pushing Qiang medicine forward in the Province:

He asked me if there was Yi medicine in our school. He compared Yi medicine with Qiang medicine. He asked which one is more developed, I said that in clinics, apart from Tibetan medicine, Qiang medicine is the best in Sichuan. Yi medicine is running in schools, and personnel are being trained, but their clinical practice hasn't started yet. When I said that, he was excited. He said “isn't the Yi nationality the one with written language? Then why hasn't the Yi nationality done it yet?” So, I said to him “those of the Yi nationality, the leaders of the Yi Autonomous Prefecture, are far worse than those of the Aba Prefecture, you know? I go to these places every day, so I know all about them”. I said “our teacher Zhang is the leader of our Qiang medicine (...) whether it is in the inheritance of academic ideas or the inheritance of our clinical experience he is the leader, and when it comes to either all the medical theories or the characteristic techniques, he is in an irreplaceable position”. This gave him confidence, so in the end he got in touch and now we want to work together to make a start on Qiang medicine in Aba Prefecture.

According to teacher Zhou, another ethnic minority that one should look up to is the Yao in Guangxi, Jinxiu county, given how they were bold enough to go ahead opening clinics without having a “line of defense” (*fangxian* 防线), a professional doctor certificate for Yao doctors. Only to be later terrified by the Commission of Discipline (*jiwei* 纪委) thinking it was illegal, but eventually setting up the certification procedure in the 1990s²⁵. This act of boldness was rewarded according to her, as in the end, the State Administration for Industry and Commerce (SAIC) took them as a special case of success. This was “to encourage the whole country to do so, why don't we do it? When

²⁵ For more on the institutionalisation of Yao medicine see Lai and Farquhar, 2015.

it becomes bigger, the country will pay attention to it. If you want to develop, you can't hold back, you know?".

She spoke of a desire of the Central Administration of China, to make ethnic medicine a “pillar industry” (*zhizhu chanye* 支柱产业), and of the great developments in neighbouring Yunnan, where thanks to the stubbornness and determination of one Professor, clinics are opening and others in the process doing so, with Naxi, Dai, and Yi medicine in “People’s hospitals” (*renmin yiyuan* 人民医院), some of the main hospitals in towns and cities. Together with a suggestion to change the name of Dr Zhang’s clinic, teacher Zhou had an ultimate message: the most important thing was to open and run clinics. To do so Dr Zhang should receive a number of apprentices every year in a “targeted way”, so that he would have a sea of apprentices by the time he would reach eighty years old:

You can put a clinic at the Provincial Hospital (...) I really believe that you can solve many problems that doctors of all nationalities can't solve (...). Aba prefecture can't restrict you, right? Although the state still has restrictions on this (...) if I have the suitable apprentices, I will accept them and send them to you (...). This way you can then open a hospital or many physiotherapy clinics (*liliaoshi* 理疗室).

This boldness in pushing legal boundaries is something that was not within the reach of everyone, at least not anymore. According to Dr Wang, in order for him and other doctors alike to carry Qiang medicine forward, it was really important to rely completely on Dr Zhang and his influence (in great measure due to his position in the government). In this way, the setting up of apprenticeships could also be a way for Qiang medicine practitioners to vouch for each other, and have some degree of protection, under the wing of someone influential, even if one had not completed the programme. According to Dr Wang, without a certificate his hands were tied, and that was the reason he came to study with Dr Zhang. As he saw it, only then could he be bold (*dada dandan* 大大胆胆). Dr Wang had learned Qiang medicine from Dr Zhang, and massage (*tuina anmo* 推拿按摩) in an institute in Beijing for two years, which conferred him the “certificate of senior masseur” (*gaoji anmo shizheng* 高级按摩师证), something that did not allow him to either perform cupping, or to prescribe medicines. He did not dare to dispense oral medication to patients, only poultices and other preparations for external use. The consequences of this absence of certification were felt

in his daily working life. He related that he had had occasions when customers either after some disagreement or right before paying, asked for his certificate, only to then “cause trouble”. These went on to accuse the staff of practicing medicine illegally, paying only a fraction of the due amount, or refusing to pay altogether. He said it was impossible not to charge, as “some medicines cost money”. At the time, he called his establishment a “physiotherapy centre” (*liliaoguan* 理疗馆), but insisted that later he would be able to call it a “Qiang medicine centre” (*qiangyiguan* 羌医馆).

Finally, it was Deputy Guang De’s turn to intervene. He too had been treated successfully years ago by Dr Zhang, for a broken wrist caused by a racing car accident (both him and teacher Zhou had left red silk banners in the clinic). They had become good friends since then. He put the fact of not only their meeting but of our joint presence in that occasion “witnessing the development of Qiang medicine” down to *yuanfen* (缘分), which stands for “fate that brings people together”. According to him, it was very significant and representative that in that year there were such three apprentices. As he saw it, the older man put forward a “cross-age inheritance”, the nephew a “family inheritance” and the “international friend” an “international inheritance”.

He expressed his admiration for likeminded Dr Zhang, an “outstanding hardworking person who can do good things”, praised teacher Zhou for all her energy, work, and thinking on how to industrialise the cause of Qiang medicine, and emphasised that without a career and an industry there will be no real development of Qiang medicine.

Why do I say that? Just like with “old” Wang (stretches his hand pointing at Dr Wang), if you can't get a certificate to practise medicine, there's no way to do anything. You can't participate in it and you will have no policy support. You can't earn money and you can't afford to eat. Would you still want to do this? You certainly wouldn't do it. Forget it. You'd do something else, right? Likewise, with our apprentices, do you actually realise the good prospects that await you after your apprenticeship? We can earn a lot of money and “face” with our own Qiang Medical Centre. With money and people's respect, would you say you want to do it? Absolutely... right?

So that's the way to do business. One must let people get what they want in every way (...). And when it comes to “inheriting”, some crafts are deplorable when I look at their state. Anything to do with developing inheritance, it must have its space, so that one can earn money, but also find a sense of achievement, happiness, and have value to society. If you “inherit” like this, then the industry will have value, and more

people will be willing to come in. Is it not like this?

For Deputy Guang De, the promotion of Qiang medicine had benefited thus far of the first-hand experiences of patients, friends, and neighbours, who “can witness how powerful Qiang medicine is”. However, in his opinion, having studied its market trend, Qiang medicine still lacked development. This was not only due to the small influence of the Qiang nationality, but also to those who although were likeminded had not done anything for its cause. As he saw it, under the current national policy there was a “qualitative development” that opened cooperation possibilities, promoted an understanding from top to bottom, and facilitated the integration of resources. However, this required everyone to work hard and bring strength to the enterprise, just like Dr Zhang had been doing for the past twenty years, with his research of techniques and theory. He saw an “explosive development” in the near future, for if one did well, there would also be greater government support. Qiang medicine had “a medical system that is complete, and an efficacy that is good, so the support is there for it to become an industry”. He had a final recommendation for Dr Zhang:

In the future your time and energy should be allocated more reasonably. It is not necessary to see so many people in the clinic. You have seen “hundreds of thousands” of patients in more than twenty years. It doesn't matter how many more people you see; it's about adjusting your energy to the development of Qiang medicine. What are the things that Qiang medicine has to do now? You should do them actively. You are the main force, the core. To participate, to lead. And I trust you to be able to do anything in the future (...).

The core of the purpose of us sitting here today is actually the development and growth of Qiang medicine, right? The core is this, whether it is in Chengdu, in Sichuan, or even in the whole world. The purpose is the same, so today I believe it will be a brand-new starting point. Don't you think so?

We then signed the apprenticeship enrolment documents while photos continued being taken. After that, a WeChat group was created, which included 13 members, participants from this and last year's ceremonies. Ever since, the group members have posted daily messages, from “good morning”, “good night”, to documents that need attention or signatures, conference related material, random news and political messages, such as excerpts of Chairman Xi's speeches (quickly approved and endorsed by the members of the group), Chinese medicine social media posts, as well as Qiang related news.

The next day while at the notary office to authenticate the apprenticeship documents Dr Zhang remarked that with these authenticated documents Dr Wang's clinic would be "more official" and "more legal", to which Dr Wang nodded. With Dr Wang living in a different city altogether, and in a tone that suggested that he did not want to leave the impression that the apprenticeship was a mere paper practicality for Dr Wang, Dr Zhang clarified his situation. He explained that although Dr Wang was proficient in many techniques, this was an opportunity for him to learn about Qiang medicine theory, as "he doesn't know the reasons behind what he is doing".

When it comes to ethnic medicine in China, the importance given to theory is paramount when aiming for recognition (Lai and Farquhar, 2015). With his influence at the government level, the official responsibility for the articulation of Qiang medicine theory fell on Dr Zhang's shoulders. The theoretical core of Qiang medicine and its highly disputed nature among other Qiang medical practitioners is something that I will be exploring in the following chapter.

Being an apprentice: structure and expectations

The apprenticeship followed the structure and requirements described in the teacher-student agreement document. In this document, the teacher was given the responsibility to strictly supervise and inspect the "successor's" learning and follow a teaching plan, while the student was responsible for respecting the teachers and observe discipline, learning modestly and diligently, taking notes, studying them, and "honestly accept the inspection and verification of the instructor". The structure of the programme included theory and practice, with the theoretical section stipulating that at least five of the eleven books listed should be read. This list included medical classics such as "The Divine Farmer's Materia Medica Classic" mentioned previously, "The Yellow Emperor's Inner Cannon" (*huangdi neijing*, 黄帝内经), compiled around the first or second century BC (Unschuld, 2016) and often considered the most important of the Chinese medical canons, the "Treatise on Cold Damage Disorders" (*shanghan lun* 伤寒论), also a central work in Chinese medicine, from the Han dynasty, and the *yi jing* (易经), or *I Ching*, also known as "The Book of Changes", an ancient divination text and one of the oldest Chinese classic texts. The list also included a book on ancient

Chinese history, one on the history of the Qiang nationality and one on Xixia medicine. When it came specifically to Qiang medicine, the two books were the “Qiang medicines records” (*qiangyaozhi* 羌药志), that Dr Zhang said was unavailable, and “Basic Qiang medicine theory”, due to be published soon by Dr Zhang. Finally, there were the “Qiang *shibi* scriptures” (*qiangzu shibi jingdian* 羌族释比经典), two massive tomes with collected *shibi* prayers and incantations from Aba Prefecture.

The student output required throughout the three years was quite extensive, at least 2000 words (characters) monthly totalling at least 30.000 a year, bringing together the notes from the literature reading and the acquired clinical experience, joined with 36 medical cases (12 a year). Before graduation, the student should also produce at least 10.000 words on clinical experience and academic thought that included the “successor’s” innovative ideas and have significant academic and clinical value.

In the months that followed, throughout my many visits to the clinic, I realised that the strict requirements on paper contrasted with the relaxed practice towards the apprenticeship, given that apart from Dr Zhang’s daughter, who would help out in the clinic occasionally, only once did I meet one of the other apprentices in the clinic. That was Dr Zhang’s nephew and we spent part of an afternoon reading through the “Qiang *shibi* scriptures”. I watched numerous doctor-patient encounters and I photographed occasionally, probably as much as I was photographed myself, as I provided an opportunity for Dr Zhang to document and promote his teaching. Every Friday, Dr Zhang would do home visits, often to places outside Chengdu. In the one occasion that I accompanied him, upon arrival, he signalled to me to carry his medicine box behind him, as we walked along a busy street to a patient’s home. The intrigue showing on the faces of neighbours for seeing a doctor with a foreign apprentice seemed to please Dr. Zhang.

Apart from being present during consultations, as well as talking to staff during their breaks, I also had several one-to-one meetings with Dr Zhang during those months. The topics of discussion surrounded the theory, practice, and development of Qiang medicine. As I insisted on finding out more about Qiang medicines and prescribing habits at the clinic, I was deterred from approaching the topic by Dr. Zhang remarking my unpreparedness to understand Qiang medicine therapeutics. The extensive study that

Dr. Zhang claimed would be necessary before that could happen faced its own impossibility, given that there were no written materials to study from. He emphasised that Qiang medicine was not to be compared with Chinese medicine, that its method was a different one. The system of prescribing that he spoke about was not visible neither in the clinic, nor in the required reading of “The Divine Farmer’s *Materia Medica Classic*” (*shennong bencao jing* 神农本草经), nor in both the *Collection of Chinese minorities medicine* (Qi et al, 2000) or the *Ermasibai* (Li, 2013), the latter two being compilations of individual medicinal herbs associated with their indications.

At the same time as praising ancient works such as the “Divine Farmer’s *Materia Medica Classic*”, claiming that “our perception hasn’t reached their level”, he spoke of a divergent efficacy of Qiang medicines from what had been recorded thus far, and that it was something that could only be grasped through many years of practical study on the preparation of medicines. To understand the divergence from Chinese medicine that he claimed, through practice and in an experiential approach to medicines, was also something out of bounds, since the only and few medicines assembled in the clinic were done so secretly.

Inheritance and its sustaining network

In this chapter I have attempted to give an insight into the bustle of activity in this Chengdu city’s only clinic of Qiang medicine, as well as provide a glimpse of how Qiang ethnic identity or ethnicity are enacted in this setting. Moreover, through describing the *bai shi yishi* ceremony, I have shown the procedures and ritual performances, of gods and of bureaucracy, that not only set the tone and terms for this Qiang medical inheritance to be transmitted, but also establish a master-apprentice hierarchy. In this ceremony I argue that two things are achieved. Firstly, the value of such inheritance is made clear. Secondly, the purpose of inheriting it is put forward, while binding it tightly to the honour to receive such gift, as well as to the responsibility for its development.

If in previous ethnographic research in Chinese medicine institutional settings there has been a focus on different forms of knowledge transmission (Hsu, 1999), and on “becoming a physician” (Scheid, 2002), in this chapter I have shown these dimensions

taking the different meaning of “receiving an inheritance”. In this context, Qiang medicine was treated as a gift. Its minority status and narrow recognition gave it an aura of preciousness that transpired into the commitment of tending, developing, and spreading such legacy, the articulation and disputedness of which I will demonstrate in the following chapter.

This responsibility fell not only on apprentices but also on teachers, while still featuring along a hierarchical divide. Specifically facing Dr Zhang, was the particular tension revealed in the contrast between the requirements of patient-centredness in the clinic’s daily life and the programmatic and strategic approaches to the development of Qiang medicine. The need to devote oneself to the development and “the cause” of Qiang medicine was pulling his presence away from spending time in the clinic, where he nurtured and sustained relations with patients and within the residential community. Such pull was directly connected with articulating Qiang medicine, as that was the “higher task” summoning him, of lobbying, promoting, and pushing forth this ethnic medical discipline.

In regard to medicines in the clinic, the reliance on Chinese proprietary medicines to care for patients was striking. These were predominantly for oral administration, while the medicines prepared at the clinic were for external use, and therefore present in therapeutic practices, some rubbed and dispersed, some applied as poultices. The use of such oral medicines was far superior in number in relation to that of other Qiang medicine clinics. Dr Zhang aspired for the reliance on Chinese proprietary medicines to be a temporary one, and hoped to dispense Qiang proprietary medicines in the future (see Chapter Five). Along with his ambitions of Qiang proprietary medicines, this preference placed him at the forefront of an envisioned industrially configured Qiang medicine, disseminated as a singular body of unified theory, and practice. Such vision was not shared by all. In the next chapter I will describe not only how his articulation of Qiang medicine was performed as it headed for wide institutional distribution, with its medical theory and practice, but also show how such articulation was challenged and alternative ones put forward in a few different town clinics.

Chapter 2. Articulating Qiang medicine

In different clinics, the distinct ways of articulating Qiang medicine varied mostly in the degree of institutional aim for which they were performed. No practitioner put forth Qiang medicine as such a coherent and cohesive body of theories and practices like Dr Zhang's. Such a body was destined for institutional circulation, in academic transmission and in its promotion at the government and industrial levels. Given the extent of Dr Zhang's involvement in these circles, with the established priorities for marketising and expansion made clear in the previous chapter, it was of little surprise that his own articulation was geared in such way.

While drawing from my experience as an apprentice of Qiang medicine, in the first part of this chapter I describe what I have learnt of this “medical system” that was being put forth. I do so firstly by outlining Qiang medicine theory. Secondly, through elaborating on the dimension of practice in diagnosis and treatment, using two patient cases. Thirdly, by moving from the clinic to show how Qiang medicine was enacted “on stage”, at a Qiang medicine conference with a volunteer participant. In the second part of this chapter, I demonstrate how Qiang medicine was articulated differently in four different Qiang medicine clinics in Fengyi, the county seat town of Maoxian. Through doing so, I reveal the disputed nature of Dr Zhang's articulation, as it was set to reach academic textbooks. Overall, I lay out the difficulties of conceiving a unified Qiang medicine.

Qiang medicine in theory

According to Dr Zhang, Qiang medicine had several approaches that came together in the understanding of “heaven and earth”, the body and disease. Many of these resembled those found in Chinese medicine, the reason being, as he saw it, for Qiang medicine having developed alongside and even predated Chinese medicine, given its “ancient history”. One approach was the *black and white* theory, that reflected firstly the *white stone* embodying the heaven god, the mountain god, as well as all the gods. These

gods provided one with light, health, happiness, and positive energy. Secondly, it reflected the *black stone* condemning those who violated the *white stone* natural law, the “heavenly principles” (*tianli* 天理), (which Dr Zhang referred to as being simultaneously the Dao and “nature”) by giving them sickness. Even if one prevented disease and the other caused it, both still constituted a “kind of adjustment of the human body balance”, with their own balance bringing health and their imbalance drawing disease to the body. It was a sort of an imbalanced balance that could explain the bigger size of the *white stone* relative to the *black stone* placed in the altar. In regard to the understanding of the body, the *black and white* theory also mirrored the notion of *yin-yang*²⁶ in that *black*, just as *yin*, referred to the front of the body, and *white*, just as *yang*, referred to the back of the body²⁷. It also defined the sky and arteries²⁸ (*dongmai* 动脉) as *white*, and the earth and veins (*jingmai* 静脉) as *black*, in a communion of cosmological and bodily dimensions that is also at the heart of Chinese medicine (Unschuld, 1985). Dr Zhang claimed that the origin of Daoism rested with the ancient Qiang people, and that the concepts of *yin* and *yang* were originally thought of as *black* and *white*.

Another way to understand the relationship between *white stone* and *black stone* was through how essence (*jing* 精) and spirit (*shen* 神)²⁹ related to each other. When these combined there was health, and should they be absent there was illness. In Chinese, spirit (*shen* 神) also stands for god, and in Qiang medicine this double meaning seemed accentuated. There was the heaven spirit, the earth spirit, the human spirit (which was both the spirit of the ancestors and the spirit of the soul (*linghun* 灵魂)), and also essence-spirit (*jingshen* 精神) or vitality. When this essence-spirit was lacking, there was also a lack of expression (*shenqi* 神气), noticeable in affected people by their verbal reservation and unresponsiveness.

²⁶ Originally meaning the shady (*yin*) and the sunny (*yang*) side of a hill, see Unschuld, 1985, p.55.

²⁷ For the mapping of body parts in Chinese medicine see Unschuld’s annotated translation of *Huangdi neijing suwen* (2003, p.90).

²⁸ Arteries and veins were not associated to Chinese medicine until the early 20th century, see Luesink, 2015.

²⁹ See Kaptchuk, 1983 for an overview of the two.

The body was understood to be composed by *mosi*, *sa*, *zi*, and *jina*, which in Qiang language meant respectively: *qi*, blood, water, and nutrient substance (which included a variety of substances in the body). At the same time, and according to Qiang medicine's "four phases theory", both the body and "nature" were composed by *rao*, *mong*, *zi* and *mo*. In Qiang language, these stood for stone, wind, water, and fire. These phases produced illness out of an imbalance, when their relationships, formed both inside and outside the body, failed to reach a *black and white* balance. Out of these four phases it was the stone that was divided between "natural stone" (*white stone*), that did not cause illness, and "illness stone" (*black stone*) that did. *Stone disease* was a central feature of Qiang medicine. According to Dr Zhang Y., the Qiang took stone to be the origin of the universe, and everything to be ultimately made of stone, which explained *white stone* worship. According to her, stone was the basic material of "nature" and the human body, but was also the main cause of disease.

Aetiology

A *black and white* imbalance together with an out of balance *mosi*, *sa*, *zi*, and *jina* (*qi*, blood, water and nutrient substance) could trigger the formation of stones of different sizes, which ordered from the smallest to the biggest were: *bur* (mudstone), *raoushas* (sandstone), *zuobade* (medium stone) and *youbu* (big stone). These, by blocking the *sanmishashe ducts* (the vast network of ducts that connected the human body in Qiang medicine, in Chinese language known as *guandao* 管道), could cause illnesses in the knee joint, elbow joint, spine and vertebra, organs, and pretty much all over the body, with different sizes causing different diseases, "from atherosclerosis, to gout, to tumours". Among the numerous kinds of *stone disease* there were *cold*, *cool*, *ice*, *snow*, *water*, *fire*, *soft*, and *hard stone disease*, and these were designated by location in the body, such as *knee stone disease*.

Although *qi* and blood flowed in both the meridians³⁰ (*jingluo* 经络) of Chinese medicine (which are channels or pathways) and the *sanmishashe* ducts of Qiang medicine, the latter were pipes that also transported water and nutrient substance (see

³⁰ In Chinese medicine, *qi* and blood are not substances circulating in vessels, the way that blood is understood to circulate in biomedicine. For an overview of *qi*, blood, and meridians see Kaptchuk, 1983, p.105.

Figure 10). These were divided into *white ducts* (*bai guandao* 白管道), *black ducts* (*hei guandao* 黑管道), *sun ducts* (*taiyang guandao* 太阳管道), *moon ducts* (*yueliang guandao* 月亮管道), *star ducts* (*xingxing guandao* 星星管道), among others, in a total of 365³¹. The acupoints located along the *ducts* were designated *juda* and had different positioning to those on the meridians of Chinese medicine.

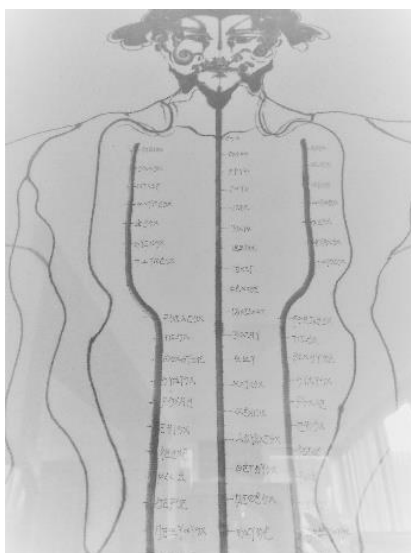


Figure 10: *Sanmisashe* ducts diagram

Just like with the previously mentioned arteries and veins, the framing of Qiang medicine on an understanding of the body and disease that involved substance moving in ducts aligned it closer to biomedicine, something which I argue amounted to a way of striving for legitimacy. This alignment can be further illustrated in a table presented by Dr Zhang at a conference where he distinguished the diagnostic criteria in western, Chinese, and Qiang medicine for *knee stone disease* (see appendix). Its Qiang medicine section, however, describes a Qiang medicine pathophysiological explanatory model, rather than any sort of diagnostic criteria. This leads one to think that unless Dr Zhang made use of unwritten criteria, then he actually used western and Chinese medicine diagnostic criteria to then support a Qiang medicine theory and pathology.

Unlike with *stone disease*, where pain was fixed in one place, with *wind disease* there was a pain that moved between places in the body in time, as wind had the property of

³¹ In Chinese medicine there are 365 acupuncture points (Kaptchuk, 1983, p.108).

changing. Wind was seen as a “natural phenomenon that promotes qualitative changes in natural objects” and was also the cause of disease. Wind outside the body could make for a healthy individual, but should one’s *qi* be decreased, *wind disease* would arise, for one’s blood and *jina* (nutrient substance) “will not be reaching the places where they need to be”.

On the issue of *fire disease*, Qiang medicine saw that since the human body was naturally warm, it could only function well with fire and *qi*. When the normal fire energy decreased in the body, there was a lack of *yang*, leading to coldness and disease. On the other hand, when there was an excess of fire energy in the body, a different kind of *fire disease* arose, leading to fever among other things. The idea was that “a weak body can’t adapt and gets ill”.

Finally, there was *water disease*. This disease could be classified as *inner water disease* and *outer water disease*. In the case of damage to the inner body environment, there was water swelling in the organs, whereby water would reside in the same spot, without moving, and blocking the *sanmishashe duct*. This could cause pericardial effusion, ascites, and renal oedema, which were all *inner water diseases*. *Outer water diseases* were effusions and oedemas caused by injury, exercise damage, in short, by externality. However, external injuries could also cause *inner water diseases*, such as severe injuries that by their shock and force caused rupture of internal organs. *Inner water diseases* could also be caused by unhealthy lifestyles that led to heart effusion or kidney oedema. Cirrhosis, sclerosis, and ascites were all *inner water diseases* caused by excessive long-term drinking.

“Six viscera and eight bowels” (*liuzang bafu* 六脏八腑)

For all the mechanical understanding of internal organs, with the accumulation of fluids and blockages of ducts, Qiang medicine appeared here more in line with biomedicine than Chinese medicine. Interestingly, Qiang medicine, as articulated by Dr Zhang, had an organ system that greatly resembled Chinese medicine’s organ functional structuration of the body. In Chinese medicine there are five *yin* organs, which are the heart, lungs, spleen, liver, and kidneys (with pericardium occasionally considered a sixth), and six *yang* organs, the gall bladder, stomach, small intestine, large intestine,

bladder, and triple burner (a highly disputed and ambiguous organ) (Kaptchuk, 1983). They are collectively referred to as “five viscera and six bowels” or “five depots and six palaces” (*wuzang liufu*, 五脏六腑) (Unschuld, 2003), and are organised in metaphors of bureaucracy and function that reflect their inter-relationship rather than the definition of isolated structures (Unschuld, 1985).

In Qiang medicine, however, Dr Zhang spoke of “six viscera and eight bowels” (*liuzang bafu* 六脏八腑). The six viscera were the same five in Chinese medicine plus the brain. The eight bowels included the gall bladder, stomach, small intestine, large intestine, and bladder, but omitted the triple burner, and added instead the pancreas, the male and the female reproductive organs (with the female genitalia including the anus). According to Dr Zhang, this system demonstrated the functions of internal organs in a way that was “not abstract, very specific, but very broad”. The fact that the “Divine Farmer’s Materia Medica Classic”, which Dr Zhang considered the most relevant medical canon in Qiang medicine, “a masterpiece of the ancient Qiang people”, makes no mention of the “six viscera and eight bowels”, but only of the “five viscera and six bowels” had its own justification. Dr Zhang’s reason for that absence was that it had been written in Chinese and not in Qiang language, borrowing such concepts from “The Yellow Emperor’s Inner Cannon”, compiled a few centuries prior. Another reason given was that such canons were compilations that accumulated information slowly through time, with some elements lost in translation, and others being constantly upgraded, while overall, in Dr Zhang’s view, retaining the core ideas from the Qiang.

In order to understand the connection between the “six viscera and eight bowels” and the body’s *ducts*, Dr Zhang exemplified with the process of the ingestion of food:

So, one aspect is “stable” (*an* 安), one is “to store” (*cang* 藏), the other is “to discharge” (*xie* 泄). What is “to store”? The six viscera, they have to store up, and the eight bowels have to be accessible. For example, if we eat food, do we not eat food through the mouth? This is the *big duct* (*da guandao* 大管道), the food is poured into the *big duct*, through what we after all call in Qiang language the *big mouth* or *big opening* (*yidakou* 一大口). *Dzedzep* is the lips, *shko* (Qiang language) is the oral cavity. Inside the oral cavity there is still *dzon*, what is *dzon*? It is the “mill”, do you know? The mill stands for the mill that grinds the flour, that mill. (...)

To mill flour, I put grains inside this mill. After pushing it, does it not turn into fine powder? Then we knead the flour and add water to make steamed bread so that we can eat it, right? To make cooked wheaten food, okay? So, this person's oral cavity is

the first mill in Qiang medical theory: *shko*. This mill is very crucial. What you eat must be refined through this mill and then pass through your mouth slowly and penetrate into the stomach, then transferred into the intestine. The intestine is divided into large intestine and small intestine, descending colon, transverse colon, rectum, and anus.

In the end, it is almost done with the absorption. The dirty things that it doesn't want are discharged out of the body. In this path is our duct, the *big duct*. There are also thin ducts, which connect our six viscera, and our eight bowels. They connect further to our heads, and our brains. These ducts are very thin, very very thin. This *duct system* is unique, the classification is unique.

Given the complexity of such a system, with its pathology, aetiology of diseases and understanding of the body frequently resembling biomedicine and Chinese medicine, and given the lack of written material to support it, I attempted to find out to what extent there was “theoretical creativity” involved, as Farquhar and Lai (2014) put it. This possibility was flat out rejected and Dr Zhang insisted that all these elements had been passed down by his ancestors, going back as far as ancient times, that the *stone disease* theory and the *sanmisashe duct* theory are not things that he came up with at random but that it is the “culture” and language handed down from Qiang ancestors, given for the Qiang people to communicate with each other, “felt in private, in our hearts and in our bones”.

Qiang medicine in practice

The connection between Qiang medicine theory and practice was made by following an all-encompassing method, according to Dr Zhang. It was a method that, reportedly, included and surpassed the diagnosis of Western medicine to look at personal changes from complexion, eyes, ear, nose, and tongue coating, to pulse and secretions. In the clinic and at home visits, the collection of this information was often done by the staff, using their phones to take photos of patients which were then kept in their individual computer files at the clinic. It was also common for the relatives of patients to come to the clinic and present photos on their phones showing how the condition was progressing. The staff would then decide if it warranted the patient to come to the clinic in person.

According to Dr Zhang, after examining a patient, one had to perform a “Qiang

medicine analysis of pattern differentiation”³² (*qiangyi de bianzheng fenxi* 羌医的辩证分析). This meant that after all the information was gathered “microscopically” it would go through what was called in Qiang medicine a “differentiation and calculation” (*biansuan* 辩算) method. In this step, the practitioner assessed the patient and the disease in all the presented changes, manifestations, signs, and symptoms, binding all the Qiang medicine theories together, to then reach a diagnosis and a treatment plan. He gave the example of liver cancer, in Chinese medicine known as “liver and gall obstruction” (*gandan yuzu* 肝胆遇阻), or “stagnation of liver qi” (*ganqi yujie* 肝气郁结), and in Qiang medicine as *sakhaduishkuish* or *sakhaji*, meaning *liver stone disease*. In this case, by going through the “differentiation and calculation” method, liver cancer could be “slowly softened, slowly absorbed” and the liver turned healthy again. Unlike with “modern medicine”, Dr Zhang claimed that Qiang medicine considered liver disease as not being simply a liver problem, but that covered other liver-related functions, in this way exploring the question regarding its source: “why does one get liver disease?”³³

When it came to treatment, he claimed that it was not simply a matter of blindly applying Chinese medicine techniques to directly treat and solve a lump, techniques such as “resolving hard lump” (*ruanjian sanjie* 软坚散结) or “activating blood circulation to dissipate blood stasis” (*huoxue huayu* 活血化瘀). He insisted that although the diagnosed disease could be the same for different patients, the disease manifestations as well as the patient body constitutions were different. Therefore, Qiang medicine’s “differentiation and calculation” methods and strategies would be different, taking many other factors into account. Following this assessment, there would be “targeted medication” given to the patient. Subsequently, there would be a follow up with “differentiation and calculation” analysis as well as the assessment of the treatment’s efficacy. In this step, a practitioner would decide which aspects of the prescription were to be adjusted and which were to be nurtured.

³²“Pattern differentiation”, usually accompanied by “treatment determination” (*bianzheng lunzhi* 辨证论治), became a tenet of contemporary Chinese medicine after the 1950s, emerging from a Maoist materialist dialectics, although Chinese medicine physicians argue it is rooted in “The Yellow Emperor’s Inner Cannon” (*huangdi neijing*, 黄帝内经) (Scheid, 2002).

³³ This reflects a very common maxim in Chinese medicine: “Chinese medicine treats the root, Western medicine treats ramifications” (*zhongyizhiben, xiyizhibiao* 中医治本, 西医治标) (Scheid, 2002).

There was no such thing as side-effects in Qiang medicine because all medicines had a “bias” (*pianxing* 偏性). This “bias” referred to an inherent character causing effects in the body that were greatly dependent on the way in which the respective medicine was used. What was needed in these follow ups was to “remedy defects and rectify errors” (*bupian jiubi* 补偏救弊). In this “bias” rectification, a Qiang doctor would, according to Dr Zhang, aim at achieving a *black and white* balance (*heibai pingheng* 黑白平衡), which would bring the patient back to a healthy state. This balance was achieved not only with medicines, but comprehensively with localised treatment and manipulation, “language treatment”, and “psychological intervention”, in order to achieve the best effect. Dr Zhang spoke of “psychotherapy” or “psychological intervention therapy”, in Qiang language *shimizhecheb*, as one of the most important aspects of Qiang medicine. This dimension of Qiang medicine included techniques such as “emotional conditioning” and sleep regulation. Dr Zhang was of the opinion that besides liver disease there were many other diseases that, too, were also related to poor sleeping. These techniques, apart from improving the patient’s sleep, would make the patient digest his food more easily, keep him or her in a good and stable mood, and finally, work on the patient’s immune system, which Qiang medicine designated as *gohotel*. Dr Zhang explained that *gohotel* did not refer to an actual system but to an increase of the patient’s “correct *qi*” and strength. This increase of *qi* resulted in one’s increased resistance. I will now put forward two patient cases that illustrate the connection between theory and practice that Dr Zhang posited.

Two patient cases

The first case that I present here is of a patient with a condition commonly found at the clinic, while the second is a fairly more complex and uncommon one. The treatment and medication offered appeared very similar for both cases. However, that similarity was disputed by Dr Zhang. A lady arrived in the clinic with both neck and left shoulder painful and stiff, feeling discomfort on her left hand while sleeping. She sat in the consultation room facing the back of a chair. Her upper back presented a minor hunch at the base of her neck, and her left hand showed protruding bruised looking blue veins. According to Dr Zhang, this had been caused by the way the patient slept, by the strain of her work, and the strain of carrying and taking care of her children. The patient also mentioned that she worked for many years weaving clothes, always in a bent position.

According to Dr Zhang, it was in the neck that the main problem and obstruction resided. The lack of flowing *mosi, sa, zi, and jina* (*qi*, blood, water, and nutrient substance) stretched down along the *white duct* to the top of her left hand. With *mosi, sa, zi, and jina* blocked up (*beiduzhu* 被堵住), this was a case of *cervical duct obstruction* (*jingzhui guandao bisai* 颈椎管道闭塞) causing *cervical stone disease* (*jingzhui shibing* 颈椎石病), known as *jugedidzie* or *jugeraodzie* in Qiang language.

There were three important points along the patient's neck and shoulder line that were at the center of her illness, these were the main points of obstruction. The first, higher on the patient's neck, the second at the base of the neck, and the third a few inches down along the shoulder line. From the first to the third there was increased pain, stiffness, and *stones* of bigger size. I was instructed to feel, by gently pressing with my fingertips, how these three points felt harder on the left side, when compared to the right side of the patient's neck and shoulder area. Referring to the *ducts*, Dr Zhang exclaimed in an idiomatic way "if it flows it doesn't hurt, if it doesn't flow then it hurts" (*tong butong, butong jiu tong* 通不痛, 不通就痛). The objective of manipulation (*shoufa* 手法) was to unblock the duct and soften the muscle. By pressing hard but not too hard, with an intensity adjusted to the consistency of the muscle, its ultimate objective was to eliminate the pain (*sutong* 肃痛). Because this was a *cold stone disease*, internal and of cold nature, associated to and aggravated by cold, and therefore more common in the winter, he placed the fan-shaped heater behind the patient's back in order to achieve some warming and applied *King Rongtaer* alcoholic solution, to "soften the muscle", while he performed manipulation (Figure 11). In the end, Dr Zhang heated a poultice with *King Rongtaer* paste and placed it on the lowest of the three points. The patient was then given some Chinese proprietary medicines to take home. If this had been a *fire stone disease*, external and of hot nature, instead of the *King Rongtaer* paste the *Ouzizhuazi* paste (欧子瓜子膏) would have been used.



Figure 11: Patient receiving manipulation (*shoufa* 手法)

The second case that I describe is of a patient who arrived at the clinic on her two crutches for her second appointment. Her complaint of knee joint pain was in fact a suffering resulting from several simultaneous medical problems, according to Dr Zhang. Unpacking it from the source of the knee pain, he explained that a while back she had been selling hardware in the winter, she felt cold and because she could not afford to turn on the heater, she decided to jump to stay warm. After a short jump, she suddenly felt pain in her knee. As days went by, the pain continued to aggravate, to the point that she could not walk. After not being able to walk, she developed the pain that she then suffered from at the time of consultation, which had persisted for a long time.

According to Dr Zhang she also suffered from a psychological problem, a “very small heart” (*xin hen xiao* 心很小), a very “fragile thinking” (*sixiang hen cuiruo* 思想很脆弱) and “fragile mind” (*xinli hen cuiruo* 心理很脆弱), with a serious mental illness, the expression of which, at her age of over forty, is called in Qiang language *shekumanedidzie*, that translates as an “emotional disease” (*qingxuhua de jibing* 情绪化的疾病).

In her first visit, together with her swollen and painful knee, she had a “fearful complexion” (*kongjude lianse* 恐惧的脸色), someone had told her that somebody fell ill and died, and she felt as if it was her that had died, afraid that she would get such a

disease. She had visited several clinics and hospitals which had provided little improvement to her condition, so Dr Zhang assured her that Qiang medicine was not the same as other medical treatments. Before the first appointment even a slight touch to the knee would bring pain, at the time of the second consultation, both her knee was less swollen and painful, and her complexion had improved. For Dr Zhang, this was proof that his “differentiation and calculation” method, diagnosis, analysis, and treatment were correct, and that was reflected on his optimism when treating the patient, with his most definite certainty that she would improve.

The specific cause leading to the number of diseases that she then suffered from was requested by Dr Zhang to remain confidential. Through a series of analysis, he arrived at the conclusion that she suffered from gallbladder disease, liver disease, heart disease, and bronchial disease. Taking into account the “six viscera and eight bowels” (*bazang liufu* 六脏八腑) theory, he concluded that the “six viscera were imbalanced and the eight bowels not relieved” (*liuzang bu pingheng, bafu bu tongtai* 六脏不平衡, 八腑不通泰), the core of the problem being at three organs: the heart, liver and kidney. Such problem was expressed in the heart, the liver, and the gallbladder “not being good”, resulting in the patient looking emotionally troubled, with acute sadness, having a quick onset of illness and gradual deterioration. This understanding of organ functioning was something that Dr Zhang again distinguished from that of Western medicine. The idea of looking for an organ to be the main source of an illness was, according to him, the wrong way to see it. This was because it was not the main place where the injury occurred, and there were other places with several joint responsibilities. To illustrate this matter, he gave an example that made a parallel between organs in the body and members in the family, between sickness and worry:

If you are sick, is your mother not worried? Of course, she will worry about you. Your father will worry, your family will be worried, so the same is true of the “six viscera and eight bowels” in our body.

When it came to Chinese and Qiang medicine, the “heart” included one’s thinking, brain (*geni* in Qiang language) and spirit (*shenming* 神明). But in Qiang medicine the “spirit” was not merely the spirit that animated a person, without which the individual would perish, on the contrary, it included a kind of essence-spirit (*jingshen* 精神) and

“awareness” (*ganwu de* 感悟的), that Dr Zhang claimed were both beyond the category of psychology. In Qiang medicine, this patient’s case also denoted an obstruction of “*mosi, sa, zi, and jina*” in the heart, which had led to disease, and a *black and white* imbalance that needed to be worked on.

After such complex diagnosis, I was surprised for having seen the patient being dispensed similar Chinese proprietary medicines to what other patients received, together with the poultice applied to her knee. To my further surprise, Dr Zhang insisted that the patient was instead handed Qiang medicines to boil at home, prepared specifically for her in the pharmacy. This instance has remained a puzzling one. According to him, the medicines dispensed were a mixture of *qianghuo* (羌活 *Notopterygium incisum* K.C.Ting ex H.T.Chang), *baiduhuo* (白独活 *Heracleum candicans* Wall. ex DC.), *xixing* (细辛 *Asarum*), *ciwujia* (刺五加 *Acanthopanax seuticosus* (Rupr. et Maxim.) Harms) and *chonglou* (重楼 *Paridis*). He insisted that these were prescribed according to “Qiang medicine standard” and had the functions of “nourishing the heart” (*yangxin* 养心), to “calm the spirit” (*anshen* 安神), to “soothe the liver” (*shugan* 舒肝) to “tonify *qi*”, (*buqi* 补气), to “regulate the kidney” (*tiaoshen* 调肾) and “nourishing the lung”. Dr Zhang’s way to manage the relationship between organs through medication was again exemplified through family relations:

I will adjust the relationship between many problematic organs, to reconcile them. For example, just like a quarrel at home, you have to find out what the root causes are, and then the two will get along with each other, otherwise they will fight. In the end, if they split up, that is not good, right? That's the reason. The relationship between physical illness and our life is like this.

I will now proceed by describing the relation between the disease inducing *stones* and the use of X-ray diagnosis.

Stones and X-rays

The use of X-rays in bone setting and chiropractic is well documented (Ernst, 1998) and is not an uncommon phenomenon in China (Zhao et al, 2017). As Lambert (2012) found in India, X-rays can often be used by bonesetters as a backup in diagnosis, and even brought in at the initiative of patients. This is a case in which Nguyen (2019) argues that

“hybridity is negotiated”. Such practitioner-patient negotiation contrasts with instances of the mobilisation of instruments that are more practitioner-initiated. This can, to a certain extent, take place for the sake of borrowing legitimacy from biomedicine, such as with the use of injection needles by shamans in South America (Greene, 1998). In the case of Chinese and Qiang medicine, with the ubiquity of such instruments in their hospitals, such a move was rather one of embracing technology and of “development”.

In Dr Zhang’s clinic, the status of the X-ray as a diagnostic backup also existed, and he would often examine X-rays that patients had already taken while visiting hospitals. What I found unique was that in its use, Dr Zhang found support for his Qiang medicine theory of *sanmishashe ducts* and obstructing *stones*. X-rays provided the welcomed “scientific evidence” for the presence of *stones*, showing their material shape, proving that *stone disease* was not a mere theoretical artefact, and so playing an important role in Dr Zhang’s articulation of Qiang medicine and in consolidating its aetiology. This “scientific confirmation” happened only indirectly, given that *stone disease* in the muscle area (the majority of the cases dealt with at the clinic) could be seen and felt as a hard lump but did not show on X-ray or ultrasound. This was due to the minute individual size of these *stones*, according to Dr Zhang. Those that were confirmed through X-ray and ultrasound were gout acidic crystal *stones*, kidney, ureter, and liver (intrahepatic) *stones*, tumours, and those causing cardiovascular blockages. There were still others that escaped the X-ray and ultrasound detection, known as *mengrao*, shapeless *wind stones*, too thin to feel by touching: “like the wind, you feel it, but when you touch it there is nothing”. These reportedly moved in the body, “causing reactions in the organs”. While using X-rays to “prove” *stone disease* theory, Dr Zhang managed to place Qiang medicine in a position that not only made use of, included and embraced a biomedical form of diagnosis, but that superseded it at the same time by showcasing occasions when it failed to detect disease. In the following section, I will move from the clinic setting to that of a large conference, where Dr Zhang took to the stage to display Qiang medicine.

Qiang medicine on stage

This performance took place at the first joint Qiang and Yi medicine conference, among a few hundred participants that included government officials, pharmaceutical industry

representatives, Qiang and Yi doctors. It was there that I observed Dr Zhang performing a short session of Qiang medicine treatment on a female volunteer from the audience (Figure 12).



Figure 12: Volunteer receiving Qiang medicine treatment on stage (photo shared on the WeChat social media platform)

While the volunteer sat on the chair, Dr Zhang placed his fingers on the back of her neck. Upon examination, he signalled that he could clearly feel ten lesions to the cervical muscles and to the left side of her upper back, caused by *stones* compressing the *duct system*, and producing a plate-shaped area. He then proceeded to execute a method of relaxation by “rotating, kneading and pinching”, with both hands on the volunteer’s neck, shoulders, and upper back. As he did so, he explained how his movements varied, from light to heavy, and from heavy to light, according to the patient’s degree of comfort. Because an excess of pressure could cause the hardening of the muscles, the movements should be moderately heavy, and the cervical spine should be released according to the direction of the muscles, while “embodying the unique manipulation of Qiang medicine”. He finished with rapid movements, using the sides of his stretched palms to hack the volunteer’s back up and down, waving his body to the right and to the left, and then lifting his hands up in the end, signalling for the lady to stand up, while finally turning to the crowd. This was followed by applause from the audience. He had acted like a true showman, with the range of his movements amplified for entertainment. This performance contrasted deeply with what I had seen in the clinic thus far. As he reached for the microphone Dr Zhang exclaimed: “This Qiang medicine manipulation is just like our music and dance!”. This performance had managed to place

Qiang medicine in the centre of the spectacle often made of ethnic minorities in China (Rack, 2005), and play into a Han stereotype of ethnic minorities as “happy dancing people” (Rossabi, 2004). Unlike with many ethnic minority performances, performed routinely for the sake of a ticket charge, this did not fit into such model of cultural industry. On the contrary, it was Dr Zhang that mobilised cultural industry for the effect of promoting the enterprise of Qiang medicine, and he did it with medicine overflowing to the area of dance and song³⁴. Overall, this echoed a political slogan spread among the workers in China’s ethnic tourism: “Be a more spectacular version of yourself” (Chio, 2017a).

After the performance, Dr Zhang related the physical action of the treatment he had just executed to the theories of Qiang medicine. He explained that to work on one’s *duct system*, it was not possible to just pinch and stop, it was necessary to “comb” it (*shuna* 梳拿) in a succession of relaxation, loosening, dredging, and ingression, that would unblock the *ducts*, removing the *stones* that were making it impossible for one to breathe normally. The success of the doctor’s “great will” (*dayizhi* 大意志) was in the combing, exerting a direct effect on the congestion of *mosi*, *sa*, *zi*, and *jina*, and guiding these elements inside our body. He then called for the combination of theory and practice, and in a manner of illustration, made a parallel between the *ducts* and the irrigation of the fields:

If our water is not in the duct, or in the channel (literally irrigation ditch, *qudao* 渠道), it will flood the fields, and one will suffer from disasters.

This suggested a connection with the historical figure of Yu the Great (*dayu* 大禹), famed for founding the Xia dynasty (2070–1600 BC) and for flood control, who, according to Dr Zhang, was a Qiang. This parallel with flood control gave a historical tone to the *duct system* theory. By mentioning theories such as the “six organs and eight viscera”, and the unique unity of Heaven, Earth, and Mankind in Qiang medicine, he explained that the treatment of diseases could not be restricted to physical aspects. Indeed, that it needed a combination of humanistic care and psychological experience.

³⁴ He had sung at a different conference after stating that since Chinese medicine included minority medicine, and minority medicine included minority culture, a song would be an appropriate way to end his speech.

This comprehensiveness made for the unique treatment of Qiang medicine that achieved the best results, with satisfactory results in a short time, some of which were immediate. At the same time as praising the uniqueness of Qiang medicine, he likened its manipulation technique to the prescriptions of Chinese medicine. For Dr Zhang, the specific choice and combination of different ways of manipulation in order to achieve a curative effect justified the comparison. He called this: Qiang medicine's "manipulation formula doctrine" (*shoufa peifang miaofa* 手法配方妙法). There was then feedback from the volunteer, who, for having gone through this experience could relate to Dr Zhang's theoretical explanations:

(...) because my neck, right here, because I often use computers, it is a little tight, and then just when teacher Zhang touched it down, then I felt that there are really knots and hard places in this area, and then, right next to it, the flesh is very hard. It is possibly because I often sit for a long time, that in this place the bloodstream is blocked and there are some deposits. Then I felt very relaxed and comfortable after the massage given by Dr Zhang just now. And when he was doing the acupoints, he pressed them on my two arms, and my acupoints got numb. Every time he pressed an acupoint, I felt numb, immediately felt numb, so I felt a very good experience.

Then, facing such distinct (and many influential) spectators, Dr Zhang proceeded in promoting Qiang medicine while positioning his discourse along the current Chinese Medicine Law and its core message of inheritance and development (People's Republic of China Twelfth National People's Congress, 2016). As a side note, he brought up what he saw was Qiang anthropogeny as a new viewpoint for discussion, claiming that many of the scholars present who had studied "Qiang culture" would agree that humans came from the *white stone*, or *big eggshell*, rather than "from the ape as in Darwin's evolution".

He had stated earlier that the spirit was *white stone*, that the *white stone* came from Heaven, and that the *black stone* came from Earth. This was a vision which ultimately gave the sense of a divine origin of mankind. Such a statement is particularly relevant since there is an accepted notion of social evolutionism among the Chinese government when it comes to ethnic minorities, at least since the 1950s with the ethnic minority identification project (McCarthy, 2009). By rejecting evolutionism in a biological sense, and re-dressing an "ancient" human origin concept as a new one worthy of debate, Dr

Zhang was offering a Qiang contribution towards contemporary metaphysical considerations, breaking ethnic barriers, and in a way, through a shared non-evolutionist origin, aligning all Chinese towards the future ahead. The notion that a doctor who embraces all things new would find himself in a scientised public forum, among pharmaceutical representatives, openly denying the theory of evolution, illustrates perfectly what “inherit and develop” means for ethnic minorities in China: to be open to technological change while holding on to one’s “culture”.

The second aspect that Dr Zhang brought forward was a Qiang “thousands of years of old” approach to physical exercise, in what was a form of body cleansing, or of leading an upright life (*jieshen* 洁身). This was based on the three principles of “moderate exercise method”, “regulated life”, and “non-violation of the Heavens” (referring to norms of conduct towards the social and the body). Reputedly, he had been diagnosing cervical spondylosis (he did not refer to it on stage as *cervical stone disease*), in children as young as two years old, which he put down to screen time, while playing games on mobile phones. According to him, there was prevalence of 95% for this condition among the general population. Through this approach, he showed an “ancient Qiang method” to be relevant to a contemporary lifestyle, in countering the nefarious effects of some technology. The speech ended with a metaphorical call to arms³⁵ that was followed by applause: “If we shoot the enemy at once, the common enemy will be defeated!” Next, in order to show a series of very different articulations of Qiang medicine, I will move on to the Qiang medicine clinics up in mountainous Maoxian.

Town clinics

Maoxian (or Mao county) is the county with the largest Qiang population (The Central People’s Government of the People’s Republic of China, 2009), and where 92.4% of the residents are Qiang (Maoxian People’s Government, 2019). Fengyi town (*fengyizhen* 凤仪镇), the county seat, is located 180km northwest of Chengdu, surrounded by mountains, and at an altitude of 1566m. The majority of the town was completely destroyed by the devastating Sichuan earthquake of 2008. Five years later, the town fully embraced ethnic tourism with the opening to the public of its extensive “Ancient

³⁵ War metaphors are a common feature in Chinese political discourse, see Cheng, 2009.

Qiang City of China” (see Figures 13 and 14). *White stones* can be found placed on roofs almost exclusively in touristic areas such as the “Maoxian Pingtuo Qiang village” (*maoxian pingtuo qiangzhai*), built purposefully for tourist accommodation, as well as on other hospitality buildings.



Figures 13 and 14: Ethnic Qiang performance at Fengyi’s “Ancient Qiang City of China”

When interviewing Qiang doctors in the four main “Qiang medicine clinics” (and the only such clinics to my knowledge) in town, the first noticeable detail was the absence of Qiang artefacts. Only one of the clinics had a small and discreet *white stone*, placed below a TV screen. Overall, the efforts to present oneself as “Qiang” were much less apparent than in the clinic in Chengdu. In these Maoxian clinics, with most of the patients being local Qiang people, the need for showcasing alterity and uniqueness was pretty much inexistent, and it was mostly reputation that did the marketing. In a way, even in Chengdu, it was more of a will rather than a need to do so, since it was also

reputation rather than artefacts attracting patients to Dr Zhang's clinic. I will now demonstrate the diversity between the four town clinics, in their approach to medical theory and practice, which runs counter to the centralising efforts made by Dr Zhang in Chengdu and complicates the articulation of a "one" Qiang medicine. This raises the important questions on standardisation that will be approached in Chapter Five.

The "medical society"

A large wooden sign that read "Huiqing Qiang medicine medical society" stood imposing, above the pillars leading to the inner patio of a three-storey complex. This was the biggest space among the four clinics. It housed a clinic, pharmacy, museum, several meeting rooms and living quarters. Apart from working as a clinic, this "medical society" ran several "research centres" (one reputedly with a local university), an "intangible cultural heritage transmitting centre" and a science and technology company. Huiqing was the name of the senior doctor Chen's grandfather. The name now stood not only as the society's name but also as a medicinal product brand. Chen's family had had clinics "in every dynasty", which before the founding of the PRC they also called "medical societies" (*yishe* 医社). They stopped practicing between the "liberation" in 1949 and the 1980s, when they were placed in the "working units" (*danwei* 单位), only to then voluntarily resign during Deng Xiaoping's "reform and opening-up" (*gaige kaifang* 改革开放) policy and to open a "medical society" again. That was "a time of development" as Dr Chen W., the son, put it, that allowed people to come out and open clinics by themselves.

I visited the small clinic that they ran since 1982 back in 2016, which contrasted greatly in size with the newly built one where I interviewed Dr Chen W. in 2018. In 2016, during a consultation with his father, a photo was taken without my noticing, that ended up in their website under the banner: "We are striving to push Qiang medicine to the world" (*women zhengzai nuli jiang qiangyiyao tuixiang shijie* 我们正在努力将羌医药推向世界). That photo was then in 2018 also being used for promotion, in a large poster on an outside wall next to the complex's main gate.

We sat on two small stools by the patio and talked of Qiang medicine. According to Dr Chen W., it was wrong to think of systems and methods as blanket terms, such as bone-setting, or acupuncture. In his view, there was a “historical development process” throughout the centuries, with every Qiang doctor passing down inherited knowledge, constantly improved and refined, generation after generation. Families would be relatively good in a particular field, be it orthopaedics or paediatrics, and in a particular method that they had developed, naturally forming a family’s theoretical system and secret recipes. He considered his own clinic’s practice more comprehensive, systematic, and perfected compared with clinics in rural areas, particularly in terms of diagnosis, pharmacy, and medicine processing, but “not as good as in big hospitals”.

He admitted that the unification of a medical theory was to be accepted by all of the Qiang doctors, and discussions at conferences were heading in this direction, but that it still was not possible to reach such a consensus, with many differences between doctors persisting when it came to diagnosis and treatment. When asked if he had heard of what were presented as the “tenets” of Qiang medicine by Dr Zhang, such as the *duct theory*, he replied:

I heard about it. Doesn’t he talk about it in every meeting? He wants to talk about his *duct theory*. But I personally think, uh... (...) the concept (*guannian* 观念) has not been unified, right? It’s a conceptual problem. (...) It’s not that (his theory) does not exist, just that there has not been a large-scale popularisation, in fact, I also feel that his thing is feasible. But specifically, to what extent is it feasible? (...) In Chengdu university, they are doing research on this subject (...), but this is still in the stage of argumentation (...) it hasn’t really been promoted yet. (...) Feeling the pulse, to see your complexion, the colour of your tongue coating... This is the way that we think diagnosis should be made. That’s what we think we should do. And Dr Zhang, he thinks it’s *stone disease*, *stone accumulation*, right? That’s a theory of his, so we haven’t unified this theory yet.

In his practice, Dr Chen W. thought in terms of meridians, and says they should not be separated from Chinese medicine, which he clearly saw Qiang medicine as part of. When asked about the “six viscera and eight bowels”, it was something that he also did not consider when practicing. He had heard of the concept, but had no idea what the extra organs, when compared to Chinese medicine, were. The only difference between Chinese medicine and Qiang medicine mentioned by Dr Chen W. was in terms of

prescribing. More specifically, in relation to Qiang medicine, he mentioned different interactions between medicines according to each patient's constitution. There was also the use of medicines that were not considered to be of medicinal value in Chinese medicine, as well as different notions of toxicity. This echoed what his father had told me two years prior, that the only difference between Chinese and Qiang medicine came down to medicines.

Family was at the core of what happened in the clinic, and the very work that the young Dr Chen W. did was not the result of a vocational choice, according to him, but the natural progression of someone growing up surrounded by medicine. He related that by growing up in a large family of doctors, one becomes "imperceptibly influenced by what one sees and hears" (*erru muran* 耳濡目染, literally: "immersed ears, dyed eyes"), and acquires a very natural understanding of medical matters, unlike most people who follow "modern medicine's training method". By growing up in such environment, he saw every day how patients were diagnosed, learnt how medicines grew, as well as when and how to process medicines. This was a series of endless learnings that, according to him, made it difficult to recruit outsiders as apprentices, who lacked the "connection to the foundations of this culture", and expect the same results. The father had two apprentices at the time, and these were Dr Chen W.'s two younger sisters, who divided their time between the clinic and outside work. Family training and institutional education became intertwined, given the value generally attributed to formal certifications. The senior Dr Chen had passed his "professional doctor qualification certificate" exam independently, but Dr Chen W. attended the Luzhou Medical College while his sister attended the Sichuan University of Chinese Medicine before both receiving their certificates.

The Chen clinic was famed not only for their skills in treating a variety of conditions, but also for the medicines they produced for external application, aimed at treating injuries. Several of these were patented, and one cream had been listed in 2013 as intangible cultural heritage of the Aba prefecture, with its "ancient handicraft processing". They had also shown their products at an international fair. The main consultation room was also the waiting room. There, I watched Dr Chen senior doing pulse examination with one hand, while holding a cigarette with the other. Half a dozen patients awaited their turn sitting on chairs around the room. Some were local Qiang,

and a few were regular patients coming all the way from Chengdu. He would check the tongues of patients, speak to them at length about “the five phases” (*wuxing* 五行) and Heaven and Earth, while eyeing those sitting down, as someone who knows that he is speaking to an audience. This room was connected to the pharmacy by a long glass window through which I could see Dr Chen W. and his mother busily taking prescriptions written by his father, banging a pestle on the counter to break down some medicines, assembling and wrapping them in newspapers. The walls were covered with red banners, but there were no Qiang artefacts on display. In the afternoon, should a patient come outside clinic hours, at a time when everyone stood chatting, they would promptly be seen outside in the inner patio (see Figure 15).



Figure 15: Dr Chen examining a patient's wrist

The museum's clinic

Located in the Qiang medicine museum, part of the “Ancient Qiang City of China” complex, Dr Yuan's clinic had no sign outside. It was a mere living room with a small table surrounded by three sofas where Dr Yuan and his patients sat and chatted, with a dining table placed behind and a kitchen next door. It had the feeling of someone's living quarters and there were no red banners or Qiang artefacts to be seen. Like Dr Chen, his medical work was not a vocational choice. He was the sixth generation of Qiang doctors in his family, and stated that his love and interest for medicine had been

“genetically transmitted” (*jiyin de chuandi* 基因的传递), handed down in a continuous line, something that he saw as both necessary and inevitable. Dr Yuan claimed that his family name could be found in old local Maoxian health records and took anyone who claimed a long line of family inheritance in medicine, without having such records to support it, as mere “boasters”. However, he conceded that someone could still be a good doctor “regardless of how their potential is induced”. He had an apprentice at the time, and had had others in the past, none of whom were family members.

Like Dr Chen, he described the “immersion” (*erru muran* 耳濡目染) of growing up in a doctor’s family as essential for his dedication to Qiang medicine. However, he added a religious dimension, citing the Buddhist saying: “save one life, build a seven-storied pagoda” (*jiuren yiming shengzao qiji futu* 救人一命胜造七级浮屠). In this way, Dr Yuan lived with the conviction that the two actions had equivalent merit, and that to save a life was the highest appraisal a Qiang doctor could have.

He studied for many years with his father and with a renowned doctor in the region, who had been a former military doctor of the Kuomintang. He blamed policy limitations for not having acquired higher education, and for later not being hired by medical institutions, since he had no certificate. After his father retired from a medical position, he took his job, but because of a personnel department disagreement he was then transferred to another unit where he worked in the construction industry for twenty years. While still holding his engineer certificate, he left that job in the year 2000 to pick up “our ancestral medicine”. He did not take the “medical qualification certificate” exam independently, but instead was able to practice thanks to a change in policy, and through the status of “Qiang medicine inheritor of intangible cultural heritage” (*qiangyiyao feiwuzhi wenhua yichan chuanchengren* 羌医药非物质文化遗产传承人).³⁶ Since then, as well as seeing patients, he spent thirteen years to survey (in Aba Prefecture and beyond), compile and publish a vast collection of Qiang materia medica records, what he called the first “China Qiang pharmacopoeia”, with more than 600 kinds of medicines listed (Li, 2013). He was later writing a “Qiang pharmacy” textbook

³⁶ This is an option that seemed easier in such small towns situated in ethnic minority areas, rather than in big cities like Chongqing, where the apprentice Dr Wang was facing certification problems.

for the Aba Health School to further study “Qiang medicine and pharmacy’s inheritance and the application of its effects”.

Dr Yuan considered Chinese medicine that which used animal, plant, and mineral materials to treat disease. Since minority medicine did so too, he saw no point in separating them, remarking that both constituted a “major Chinese medicine” (*dazhongyi* 大中医). According to him, it all came down to different usage, due to a different “living environment” (*shenghuo huanjing* 生活环境) in each area. As he saw it, if the “living environment” was to be the same, then the usage would be the same as well. At the same time as including Qiang medicine in Chinese medicine he singled the first out, grounding it in pharmacy, for having a “process running from its origin, inheritance, and development that is inseparable from the use of plants, animals, minerals to treat diseases and save people”. He also considered Qiang medicine more “primary” or original, conservative, and “sticking to ancient ways”, in relation to Chinese medicine. When speaking of the theory of Chinese and Qiang medicine, Dr Yuan offered a historicised explanation that, like Dr Zhang’s, placed Qiang medicine at the origin of Chinese medicine, adding that it had given Chinese medicine its “soul” (*linghun* 灵魂) 5000 years ago. However, it differed profoundly in that he did not conceive that Qiang medicine had a theory at all in itself.

In fact, Qiang medicine is a theory that runs through Chinese medicine. It is the earliest theory of Chinese medicine. Why? Because of Qiang medicine's inheritance of *Shennong* (“the Divine Farmer”), The Divine Farmer’s Materia Medica Classic. The Qiang nationality is the earliest, originating from a matrilineal society. Before Yu the Great (*dayu* 大禹), the matrilineal society was of the mother of Emperor Yan (*yandi* 炎帝), called Qiao (*qiaoshi* 乔氏), who was the head of the female tribe. Her son was *Shennong*, the Emperor Yan was called *Shennong*, and *Shennong* tried all kinds of herbs. The earliest system of Chinese medicine was established. In fact, this is what we inherited.

So, Chinese medicine is a branch of Qiang medicine, a branch with a complete system. It developed very fast. Qiang medicine is too closed to form a system. (It) pays attention to medicines. There is no system, no theory in diagnosing patients, Qiang medicine only uses medicines. It asks, “what medicine cures what disease?” (*shenme yao zhi shenme bing* 什么药治什么病), while Chinese medicine asks, “what disease uses what medicine?” (*shenme bing yong shenme yao* 什么病用什么药). The two are inverse.

So, if you want to learn medicine well, you should learn medicines first. If you learn medicines well, then, like in fighting a war, you can use any soldier. If you don't learn medicines well, then, like in fighting a war, you can't use troops.

The main characteristics of Qiang medicine were, according to Dr Yuan, simplicity, convenience, and swiftness. He contrasted the need of Chinese medicine for writing out prescriptions and assembling medicines in the pharmacy, with Qiang medicine, whereby a Qiang doctor would arrive at any place, have a quick look, take a few medicines, assemble them, and would have a formulation right there that could treat diseases.

I'll give you a simple example. Let's take the seahorse, it strengthens *yang* (*zhuangyang* 壮阳), dispels wind (*zhui Feng* 追风) and removes dampness (*chushi* 除湿), so if we don't have seahorse then can we not do it? Can we not treat disease? A Qiang doctor will treat it, and there are many herbal, mineral and animal medicines that can replace the seahorse. This is the brilliance of Qiang medicine.

Chinese medicine is mainly about sitting in the clinic, Qiang medicine is nature-centred (*ziran weizhu* 自然为主), Chinese medicine is about cutting up a number of medicines, processing, putting them there, sit and treat diseases... This is the sitting doctor of Chinese medicine, such as I am now.

Qiang doctors are nature-centred, they go out, go up to villages, as soon as he is ill, he looks, and in the course of his search he immediately understands the medicines of this place, and so he can gather the necessary medicines to make a formulation, and (...) he is able to cure the disease, this is the characteristic of Qiang medicine, which is simple, convenient and fast. Anyone who sits in a hall and picks up the medicine from outside, that is called a sitting Qiang doctor or a sitting Chinese medicine doctor. He is able to accumulate the medicine from all parts of the country into one place, it is a bit more perfected.

The Qiang doctor is different, he is "conveniently available" (*xinshou kede* 信手可得), in harmony with the big nature.

According to Dr Yuan, "witchcraft comes from medicine, and medicine comes from witchcraft (*wu lai yuan yu yi, yi lai yuan yu wu* 巫来源于医, 医来源于巫), and so they are interdependent". One of the treatments inherited in his family, and that he organised in a book (which was not allowed to be photographed), involved drawing seven Daoist symbols on paper, that were then burned and added to a medicinal decoction to be drunk by the patient, something that he claimed showed the "mystery" (*shenmi* 神秘) of Qiang medicine. It also showed that every Qiang doctor had also to be a "witch-doctor" (*wuyi yijia* 巫医一家). Interestingly, he was one of the doctors who insisted the most on "approaching problems scientifically", and standing against what he saw as the "mystification" and "deification" of medicine and medicines. This apparent conflict was dissolved by the fact that, in his view, the efficacy of such treatments justified

“instilling a superstition on the patient”, and the imperative of a scientific stance was only applied to practitioners. Dr Yuan saw the results of such treatments, by making use of incantations when writing certain prescriptions, or giving a massage, as the evidence for the brilliance of Qiang medicine. He equated this to the “Western medicine psychologists”, “making use of consciousness and language to guide, persuade and communicate, in order to achieve the comfort of a patient’s essence-spirit (*jingshen* 精神)”. He described this success in a series of stages: firstly, the patient was convinced that a doctor could cure his or her disease, then the “magnetic field” (*cichang* 磁场) was established, after that the patient’s confidence would rise, and then medicines could treat the disease.

This approach still did not qualify *shibi* as reputable practitioners, since he saw little medicine in their witchcraft, and most important of all, saw them as having other less noble purposes for the “deception” they employed (see Chapter Three). When asked about Dr Zhang’s “core tenets of Qiang medicine”, he dismissed the *ducts* as a copy of the Chinese medicine’s meridians, and *stone disease* as “an adaptation of some modern ideas”. Neither in his hometown, nor throughout his lengthy survey did he come across such ideas among locals.

The signless converted flat

Set a few stories high, in a small and discrete flat deep inside a residential community, was the busiest of the four clinics by far. Even without a sign outside, from the very opening time, a crowd would gather in the waiting room (see Figure 16 for a less crowded instance) to be seen by Dr Jiang, wearing a white coat and hair gel. Unlike in the other four clinics (including Dr Zhang’s in Chengdu), patients had complete privacy in two consultation rooms.



Figure 16: Waiting area at Dr Jiang's clinic

Dr Jiang's father would often sit chatting among patients in the waiting area and occasionally also give consultations in a separate room that also served as storage room, where several massive bags of medicinal herbs were kept. Dr Jiang's son, also wearing a white coat, was only training (reportedly he would take many years until being ready to practice) and was responsible for the waiting system. Among his tasks was to hand out numbered waiting cards to the patients who arrived one after the other up the stairs and through the door. Dr Jiang and his father came down from their village a few years after the earthquake, invited to work at the Maoxian Chinese medicine hospital. Together, at the hospital, they were seeing over fifty patients a day, causing the number of inpatients to increase dramatically during those years there. They successfully cured a few pancreatitis cases that bigger provincial hospitals had reputedly considered terminal, which earned them fame through the attention and news reports of provincial TV stations (Zhang et al., 2014). However, their time in hospital work took its toll, with stressed-related health problems affecting mostly the elderly father, culminating finally in them leaving the hospital and opening the small clinic. The hospital crowds proved to be too much, with the waiting time and availability resulting in quarrels among the patients. The hospital's reluctance in having uncertified doctors also was not making matters easier. In the clinic, crowded as it was, Dr. Jiang took his time in his consultations, and there was always a cordial atmosphere in the waiting area throughout my several visits to the clinic in the space of two weeks. A single surveillance camera

stood up in one corner, and next to a large fish tank by the entrance there was a yellow biohazard bin that patients used to spit inside. These elements, together with the privacy in consultation and the waiting system may be features borrowed from the hospital, although having visited that said hospital (and others in China), privacy is not usually a given.

They were reputedly busy all year round, and so worked on an appointment basis. Dr Jiang did not see patients in the afternoon as he thought it was not propitious for pulse examination. Patients booked their appointments two months beforehand, however, there was time allocated for emergencies. Dr Jiang's son related that almost all of the patients came from outside Fengyi, as "locals don't want to queue for an appointment". Patients usually would have gone to see a doctor in the hospital first. If their health issue was not resolved there, they would then come to the clinic. I met Qiang, Tibetan and Han people coming from all over Aba Prefecture and Chengdu, some driving for many hours to reach the clinic. Among these patients, I met a group of Tibetans who had only realised upon arrival that they would need an appointment. Having driven from a faraway place, they were told to wait instead of being turned back. All the patients that I spoke to reported that they learnt of the clinic by word of mouth.

On display at the clinic was a white brownish stone placed below the flat screen that hung on the wall. There were also red ceremonial scarves, that Dr Jiang called *qianghong* (羌红), left by Qiang patients. Apart from these, there were also white, yellow, and orange ones called *hada* (哈达), which were in turn left by Tibetan patients. I saw several visiting patients leaving ceremonial scarves as they left and so I doubt that they had the room to hold all up on display. The ones hanging were placed around red banners, which were also donated by patients, and below two wooden boards that read "Qiang medicine divine physician" (*qiangyi shengshou* 羌医圣手), and "skill and imparting kindness" (*shuren shide* 术仁施德) (see Figure 17).



Figure 17: Dr Jiang's banners and ceremonial scarves

Dr. Jiang occasionally popped out of the consultation room to the pharmacy room that was located next to it. He wore a blue surgical mask and carried a book under his arm, and there he would assemble the medicines that the patients took home. The pharmacy shelves that surrounded the preparation counter were filled with plastic tubs containing different medicinal herbs, none of which had stickers on indicating their names. All the medicines were collected or cultivated by the family in their hometown, and I was not allowed to photograph any of them. At some point, sitting among a circle of patients by the heater, Dr Jiang's father took a plastic tub with rolls of adhesive tape inside to demonstrate how to boil the medicines at home.

Unlike Dr Yuan, with his interdependence between medicine and witchcraft, Dr Jiang spoke of an ancient division of roles in medical skills (*yishu* 医术), between medicine (*yixue* 医学) and witchcraft (*wushu* 巫术), and spoke of the importance to promote Qiang medicine. His grandfather was a *shibi* and made frequent use of incantations (*zhouyu* 咒语). His father still knew some, but it was with the father's generation that they crossed the mentioned divide, onto medicine, and so made no use of incantations in their clinic. According to Dr Jiang, the work they did in the clinic was not different from what they were doing previously in the village. In their diagnosis, he claimed to consider a lot more factors than Chinese medicine did, including the dreams that patients had. Both father and son also claimed that treatment was highly individualised,

with prescriptions adjusted to body type and constitution. However, for Dr Jiang's father there was no clear division between Chinese medicine and Qiang medicine, and he considered that diversity was in each one and every practitioner instead. In their pulse examination, they both thought in terms of meridians, and the mention of concepts such as *ducts*, *stone disease* and "six organs and eight viscera", was met with amusement and laughter by Dr Jiang's father. They could also treat orthopaedic conditions, but citing the problem of not having enough time for such lengthy treatments, they tended to refer these patients to a renowned doctor in the Chinese medicine hospital, who was trained in biomedicine.

Just like Dr Yuan, Dr Jiang's father put an emphasis on the ability to assemble medicines (*zhuayao* 抓药) as an essential skill in order to be a good doctor. This was something that he considered many doctors did not know how to perform. The other aspect that made a great doctor, according to him, was the realisation that patients were "great professors". This meant that it was through practice and by seeing a large number of patients that one could learn and perfect one's medical skills.

The orthopaedics clinic

The final clinic resembled Dr Zhang's in great measure, in shape and space, with the walls also covered with red banners. However, it was advertised as a "Chinese medicine clinic" and contained no Qiang artefacts. It also had several hospital beds where patients could lie down while receiving the different treatments offered in the clinic, such as acupuncture, moxibustion, manipulation, cupping, cupping with bloodletting, and application of topical medicines. The stickers on the glass door read "bone injury" (*gushang* 骨伤), "acupuncture and moxibustion" (*zhenjiu* 针灸), "healthcare" (*baojian* 保健) and "cupping" (*baguan* 拔罐). Dr Deng studied with Dr Zhang many years prior at the Chengdu University of Chinese Medicine, although Dr Zhang referred to him as his student.

He mentioned that he wrote prescriptions for Chinese medicines, Chinese proprietary medicines, performed pulse examination, and checked face complexion and tongue before prescribing. The only medicines that he stocked were the external medicines that he produced in his clinic in large flasks. He placed great care in the preparation of

medicines for topical application and was very open about how this was done, sharing details of ingredients and the different processing stages. When he spoke of the indications for which those medicines were used, there was no mention of *stone* or *water disease*, but only of fractures, swelling and pain. According to him, in treating his patients he strove to achieve a balance between *black and white*. He also thought the body in terms of *ducts*, but considered the same acupoints (*xuewei* 穴位) as in Chinese medicine. In fact, he claimed that Chinese and Qiang medicine differed in theory but that in practice they were the same.

A disputed articulation

The act of articulating a Qiang medicine, in a material semiotic sense, bringing together the elements that secure its composition as a singular medicine, implies not only a particular vision of Qiang ethnicity, but also that of a distinct academic subject. In this section, I will elaborate on how despite the first being roughly agreed on by practitioners who asserted their Qiangness while claiming the inheritance of ancient knowledge, the second was a disputed one. The very effort of conceiving a theoretical dimension for Qiang medicine, and model it for dissemination in the training of others says a lot not only about what is articulated, but also of the surrounding sociocultural and political environment, expectations, and desired achievements of those involved. At the same time, Qiang medicine cannot be completely treated as a pure academic subject, since it involves family, secrecy, and is considered by practitioners as inherent to, and dependent of one's "culture" (*wenhua* 文化).

Regarding how ethnicity is defined, shaped and portrayed in China, Gladney (1998, p.114) states that "ethnic identity in China (...) is not merely the result of state definition and (...) it cannot be reduced to circumstantial manoeuvring for utilitarian goals by certain groups", and that, as he puts it, it is more of an interaction between notions of descent and socio-political contexts (ibid.). It appears to me that when it comes to the ethnicity in ethnic medicine, this can either be contained in more discreet familial practices, with its associated knowledge and sentiments, or expanded into a broader mode of healthcare, promoting a sort of a "cultural product". Regardless of how vocal one is about what one considers to be his or her "medical inheritance", in China there is ample freedom to define it as one sees fit. It will, inevitably, be situated in a

matrix of what is considered legitimate, noble, and powerful, usually by the ethnic majority. And so, looking at the “medical inheritance” that is portrayed by some as defining the group, one finds plenty that is claimed to be shared and even preceded, relative to the Han majority, while maintaining a distinction between the two.

Moreover, if one shifts the gaze to the boundary rather than to the content that defines the group (Barth, 1969), in this case there is the insistence from the Qiang doctors that I spoke to on a common genealogy and history that permeates that boundary, portraying the majority Han and the minority Qiang the same as well as distinct from each other, in equal measure.

Here, I argue that when it comes to the relationship between the state and ethnic minorities in China, there was a shift brought about by Deng Xiaoping’s “reform and opening-up policy” in 1978 and the following years. Such move set the scene not only for the current dynamics of ethnic medicine marketisation, but for the corresponding articulation of ethnic medicine to suit such dynamics as well. It was after the turbulent periods of the Great Leap Forward and the Cultural Revolution (in which a forced policy of assimilation of ethnic minorities was pursued (Heberer, 1989)), that with the Chinese economy in dire need of stimulation, Deng Xiaoping installed the “reform and opening-up policy” (Wang, Q.E. 2013). This was a policy that while giving priority to coastal China, still caused the ethnic minority areas in the interior to experience fast economic growth (Yang, 2012). Still, that same year, a new constitution was issued that fell short of the one of 1954 when it came to ethnic minority rights in these areas (Heberer, 1989). It was the heavy criticisms at the third session of the National People’s Congress in 1980, against the fact that the autonomy of ethnic minority areas had merely existed in theory since the 1950s, that led to the 1982 constitution (*ibid.*). In this document, Chinese ethnic minorities were given more rights than ever before, including self-determination over natural resources and development. This was then translated into law in 1984, was revised in 2001, and is still in effect. However, there are still major restrictions, given that this law applies only to the government, not to the Chinese Communist Party (CCP), which precedes it (Mackerras, 2003). The 1980s and 1990s were also accompanied by healthcare reforms (Ramesh, 2013) that opened small medical clinics such as the one started by Dr Chen in 1982, to a gradually growing, and

now vast healthcare market³⁷. At the same time, in ethnic minority areas there was a revival of customs (Mackerras, 2003), as well as their spectacularisation, which provided for a growing cultural industry, as ethnic tourism poured in through the years that followed (Chio, 2014).

Since then, ethnic minorities have embraced “ethno-preneurialism”, managing and marketing cultural products and practices (Comaroff and Comaroff, 2009) together with the Han majority. These initiatives in ethnic entrepreneurship, studied among the Yi minority (Heberer, 2007), the Hui (Gladney, 1994), the Miao (Chio, 2014) and others, be it in dance, tourism or artwork, draw from an exoticising of ethnic minorities by the Han majority, as the same time as they consolidate an essentialisation of the Han (Gladney, 2004). In this vein, Gladney (1994) remarks that beyond featuring in a simple centre-periphery relation, minorities have contributed to constructing Chinese society and identity. In a sense, they have also played a part in constructing nationalism in an ethnically diverse nation-state (McCarthy, 2009). Specifically, in the case of the Qiang, this construction is particularly visible as it reaffirms an ancient historical unity of people and territory.

Asserting Qiangness

When it comes to articulating Qiang ethnicity, in what Duara (1995) calls “narratives of descent”, it is important to bear in mind that in the Ethnic Classification Project that started in 1954, the Qiang, like other Chinese minorities, were attributed an ethnonym that differed from their autonym. This meant that before the 1950s, most of them had never heard of the term “Qiang” (Wang, M.K. 1999a). The term also came with a historical load, which Qiang doctors have come to use in order to position themselves as the inheritors of “ancient” knowledge, and “the oldest ethnic minority in China”. Accepting this whole ethnic assemblage not only allows Qiang people to access rights and preferential policies, which require that one identifies as such, but also means assuming a role to be played in the nation-state.

If on one hand, this creation of a Qiang ethnicity could be seen as “imagined communities” (Anderson, 1983) and Dr Zhang’s Qiang medicine theory as “invented

³⁷ This phenomenon was ethnographically researched in the north of China by Farquhar (1996).

traditions” (Hobsbawm and Ranger, 1983), on the other, some argue that taking it merely as such, ends up removing authority, disempowering such individuals and undermining their claims to assert themselves in a sphere of rights and identity (Briggs, 1996). These “traditions” have also been called the “weapons of the weak” (Scott, 1985; Lindquist, 2005), and there has also been a reflexive call for anthropologists to position themselves carefully and in a non-offensive manner between analysis and advocacy, when dealing with those who “invent, create, package, and sometimes sell their culture” (Jackson, 1989, p.127). Furthermore, having also conducted fieldwork in Sichuan, Tapp (2002) alerts to the fact that several minorities in the region have never been recognised, and so fail to enjoy privileges afforded to others. The point is, ethnic minorities in China differ a great amount from elsewhere in political terms, considering that apart from the Uyghurs and the Tibetans, they have been pretty much successfully depoliticised³⁸. Therefore, “invented traditions” that reinforce self-determination, do so not at a political rights level, but at the level of the market and in the promotion of products and services. Thus, the case of Qiang medicine is transposable to other regions in the globe in the sphere of the marketisation of ethnicity and medicine, by harnessing a state-defined status to its own advantage, rather than confronting the government in a struggle for political rights.

In drawing legitimacy to Qiang medicine, most doctors referred to its “ancient history and wisdom”. Moreover, Dr Zhang drew in particular from something asserted by Fei Xiaotong (1910-2005), the most renowned Chinese anthropologist. Fei Xiaotong remarked that many ethnic groups in China had, through history, “received blood from the Qiang”, including the Han, (Fei, 1988). This mention was treated by Dr Zhang as authoritative proof of how ancient the Qiang ethnicity and medicine were. In this way, he also considered, paternalistically, other ethnic groups as “the Qiang’s children”.

³⁸ The debate on de-politicisation in China is an ongoing one, with dominant academic voices such as Rong Ma asking for it to be taken further, warning against the mistakes committed by the Soviet Union. In his opinion, the Soviet Union treated ethnic minorities as political units, which fostered later nationalist movements aimed at the independence of their autonomous territories. He gives preference to the United States model, that, as he sees it, because of a framework of “cultural pluralism”, managed to “de-politicize” and “culturalise” their ethnic minorities, successfully creating national identity among them (Ma, 2007). Others retort that matters concerning ethnic minorities and the nation are political in nature. Chen Yuping (2014) argues that “de-politicising” is a distinct political act and that it should not take place.

One of Fei Xiaotong's most influential concepts is that of *zhonghua minzu duoyuan yiti geju* (中华民族多元一体格局) which stands for "configuration of plurality and unity of the Chinese nation", a process of bringing all ethnicities under one national unity (Fei, 1989). In his later years he spoke of "cultural self-awareness" for the Chinese in times of globalisation (Fei, 2015), which Chairman Xi Jinping took further, with his "cultural self-confidence", added years later to the "three self-confidences" (*san ge zixin* 三个自信) that he prescribes to the nation. These are: "self-confidence in the road of socialism with Chinese characteristics", "self-confidence in the (guiding) theories", and "self-confidence in the system" (Chinese Communist Party News Network, 2016). Xi Jinping's "cultural self-confidence" was brought up when I asked Dr Zhang if there were fears of assimilation of Qiang medicine by Chinese medicine with the 2016 Chinese medicine law integrating the first in the latter. He equated assimilation to a "surrender" (*touxiang* 投降), and while endorsing "Chairman Xi's cultural self-confidence", Dr Zhang spoke of a "Qiang medicine cultural self-confidence", and an "ethnic cultural self-confidence" that "comes from inside the bone". According to him, this was what prevented any such assimilation.

This "ethnic cultural self-confidence" stood on a historical legitimacy that as I mentioned previously was voiced by the majority of doctors as they articulated Qiang medicine, and most of all by Dr Zhang. It was, according to him, a legitimacy that stemmed from an uninterrupted line from the ancient Qiang, as their wisdom spread through thousands of years in achievements in the area of medicine (with the Qiang being "one of the first peoples in China to use medicines"), law and astronomy, economy and agriculture. In Dr Zhang's view, this laid the foundation for the development of Chinese culture and Chinese medicine that followed, which was documented in ancient books and archaeological artefacts later plundered and now scattered in museums around the world, from Japan to the UK, Russia, and Germany. It was also a territorial legitimacy, as he remarked that the ancient Qiang included the Tibetans and numerous ethnic groups³⁹ in a region that spread from the Kunlun Mountains to what is now central China, Vietnam, Cambodia, Myanmar, Thailand, and Pakistan. Historical legitimacy is especially important in the practice of a medicine

³⁹ Dr Zhang claimed that people from other Chinese ethnic minorities also recognised the ancient Qiang as their ancestors.

considered “inherited”, therefore, having a lineage and ancient history behind one’s theories and practices is a very powerful tool for promotion. It is with this heavy “medical inheritance” that apprenticeships gain their noble purpose, justification, and legitimacy.

Articulating with and against other “medical systems”

The practice of Qiang medicine in small clinics was positioned favourably by the doctors I interviewed when comparing it to that of hospitals, for having a smaller workload and thus having the ability to provide the “humanistic care” that they claimed lacks in the “working pipeline” of big hospitals. Qiang medicine was also positioned against Western medicine, for being a medicine of “nature” and not of “chemical components”, with medicines that grow naturally and slowly; slow as the long-term process of trial and error that ran through the ages, in which “Qiang culture” was deeply rooted, and that validated Qiang medicine and medicines. Chinese medicine and Qiang medicine diagnosis also stood against that of Western medicine, with “people seeing patients, rather than machines seeing patients”. Overall, Qiang medicine was described by different doctors as being (often concurrently) “cultural”, “inherited”, “dialectical”, and “scientific”. Given the disparities among the different Qiang doctors on their definition of what “Qiang medicine” was, in both theory and practice, articulating it as a singular medical system became a problematic task. That task was, however, not one to shy away from, not for those with such responsibility. After all, the whole Chinese modern history is one of difficult unifications.

With scholars around the world still using a discourse of “medical system” as a tool for advocacy for particular groups (Karunamoorthi et al, 2012), and with a long history in anthropology of affording legitimacy to what are perceived to be “systems of knowledge”, in seminal works such as Leslie’s “*Asian Medical Systems: A Comparative Study*” (1976) and Kleinman’s “*Concepts and a model for the comparison of medical systems as cultural systems*” (1978); with scholars in China referring to the “complete and unique knowledge system of Qiang medicine” (Zhu, W. et al, 2016), and the terms used profusely at Party Committee meetings, it is only natural that systematisation has become a process of legitimisation in itself, with an end result of validation not only in the eyes of the state, but of the market as well.

Although Irwin Press, while recognising the difficulty in delineating medical systems, was attempting to dissect the matter further, distinguishing between ““pluralistic” medical systems; simple and complex medical systems; (...) multisystemic configurations; “sympatric” and “allopatric” systems, dominant and variant medical systems: sub-systems and marginal systems” (Press, 1980, p.45), in 1982 Crick alerted that “anthropological representations of cultural knowledge may really only betray the articulateness which academics feel knowledge should manifest.” (Crick, 1982, p.295). Others have critiqued the concept of “systems of knowledge”, suggesting instead an actor-oriented approach “to clarify how actors attempt to create space for their own 'projects” (Leeuwis, et al, 1990). Additionally, in “How Tibetan medicine in exile became a “Medical system””, Kloos (2013) shows how “even while the concept of medical systems has outlived its analytic usefulness, it continues to be seen as an effective political strategy”. This is something that he verified elsewhere in Asia: “the essentializing function of systematization, especially in the realm of “traditional medicine,” was successfully deployed by Asian nationalists trying to reclaim their “cultural essence” in order to imagine and legitimize their nation” (ibid. p.384).

In the case of China, the systematisation of Chinese medicine has been an endeavour enveloped not only in nationalism but also in scientism (Scheid, 2002; Taylor, 2005). As it gained traction in the 1950s, it was not only being pushed by the Communist Party but also by Western medicine doctors who were made to learn Chinese medicine in the early days of the PRC, and who struggled to make sense of and apply the learnings from the material available (Scheid, 2002). An important concept coming out of this systematisation was “pattern differentiation” (*bianzheng* 辨证). Informed by the party line view of dialectical materialism, according to Scheid, it “permitted physicians to relate objective but decontextualized knowledge of diseases to the concrete specifications of each individual case and thereby to maintain a perspective on the functioning of the whole patient” (2002, p.216). This was an element borrowed by Dr Zhang when as he outlined his “Qiang medicine analysis of pattern differentiation”.

In understanding these nationalist and scientising ambitions, it is important to bear in mind that the essentialisation and systematisation that Dr Zhang and others working with him carried out was done from inside the Chinese political system. More than

affirming an “ethnic cultural self-confidence”, these processes acquired the contours of a cultural product-making technique, with the purpose of competing in a healthcare market. The practical alignment of Qiang medicine with Chinese medicine in terms of systematisation, marketisation and development was merely reinforced with the 2016 Chinese Medicine Law, which, according to Dr Zhang, saw Chairman Xi “clarifying the concept of Chinese medicine”. It was a move in policy that also reinforced the idea of some Qiang doctors that since Qiang medicine was Chinese medicine’s ancestor, they had in fact always existed together, and that it was only natural to make that union official in law. Just like with ethnicity, medicine followed the trend that Qiang and Chinese are the same but different, emphasising an alterity that is tightly, politically tied together.

In other aspects of Qiang medicine theory such as the body’s physiology and pathology, Dr Zhang seemed to go even further than Chinese medicine in its scientisation, mirroring biomedicine in the circulation of matter in the body, using X-rays to make Qiang medicine theory “visible”, while “culturising” it at the same time by incorporating *stone*, with its attributed significance to Qiang people. There is a tight connection established between theory and medicine in China, and so this dimension emerges as central for an ethnic medicine to assert itself (Lai and Farquhar, 2015). In the words of a Lai and Farquhar’s interlocutor, a senior expert working on the development of Zhuang ethnic medicine: “If a minority medicine doesn’t have theory, it can’t gain recognition” (Lai and Farquhar, 2015, p.387).

Lai and Farquhar argue that although in the state-led initiative to “salvage and sort, summarize and elevate” (*fajue zhengli zongjie tigao* 发掘整理总结提高), that is used not only for ethnic medicine but for Chinese medicine in general, there is much of folk healing being lost, this “newly formalized knowledge systems may also generate new forms of charisma, yielding a form of healing that is more heritable, widely embodied, and nationally significant” (2015, p.387). I would argue that apart from folk healers not being included in these discussions of what is salvaged, even among clinic doctors, the articulation of a “system” is highly contentious, and so what gets to be “widely embodied” might already be something that the majority disagrees with.

The very act of essentialising Qiang medicine seemed to mirror a political and organisational dynamics prevalent in the Communist Party, whereby selected individuals were given the voice and the legitimacy to unify under their own terms. When I tried to get Dr Zhang's take on why the tenets of Qiang medicine he proclaimed were not found in clinics elsewhere, he attributed the main reason to other doctors not understanding Qiang language, although I had noticed that some not only understood but also used it. He remarked that "Qiang medicine and culture must be 'local'", and that even the doctors who grew up in Qiang mountain villages (like he did), learned Chinese medicine exclusively, having come in touch with Qiang medicine only later in life. Such later contact was something that he insisted had happened not through academic exchanges but through lessons that they received from him. It was this "late learning" that explained why other practitioners could not fully understand Qiang medicine theories. This lacuna was framed not simply as ignorance, but as an inability to grasp such theories, literally: theories "cannot penetrate" (*shentou buliao* 渗透不了). Such predicament illustrates the manner in which governmental influence is tied to the representativeness of certain Qiang doctors, who consequently articulate Qiang medicine for wider institutional circles.

Apart from theory, when it came to the medical practices in the clinics there was also disagreement on what constituted Qiang medicine, as well as what made it rich and of value. Some doctors insisted that the ability to prescribe was central to Qiang medicine. With Dr Zhang, although he insisted on a high specificity when prescribing to patients, in practice there appeared to be barely any at all in his clinic. As mentioned previously, apart from topical preparations prepared in the clinic, I have only witnessed the same few Chinese proprietary medicines being dispensed.

In terms of deciding what services clinics provide, this seems to be dependent on patient demand, or on the lack of it. At least on paper, in the current Chinese medico-cultural marketplace there is plenty of leeway for new services. The present "Outline of the strategic plan for Chinese medicine development (2016 - 2030) Q&A" specifically calls for an expansion of the scope of ethnic medical services (State Administration of Traditional Chinese Medicine of the People's Republic of China, 2016). In practice, this expansion is not quite as simple. At least from what I gathered in my fieldwork, the appetite for medical alterity (in the form of Qiang medicine) from the Han majority

seemed very minimal, with a small range of services provided in Qiang medicine clinics. Moreover, both in Chengdu and in Fengyi, none of the patients that I spoke with, Han or Qiang, were visiting these clinics in search of ethnic or Qiang medicine.

To conclude, those who benefitted, or aimed to do so, from the articulation of Qiang medicine as a unified form of medicine, ended up playing a part in its making. By contrast, in clinics where the stakes were lower, or the volume of patients was such that there was less focus on external matters, there was a disinterested attitude towards that endeavour. I found this disinterest particularly marked in the villages where I conducted fieldwork, to the extent of calling the concept of “Qiang medicine” into question, and this is a theme that I will explore further in the following chapter.

Ultimately, these findings thoroughly complicate what it means to “integrate” “traditional medicine” in global health. In the case here presented, the very definition and articulation of a particular “traditional medicine” is embedded in nationalism, scientism, and in various struggles for legitimacy, organisation, and promotion, both inherent to marketisation and to a particular socio-political and historical context. The benevolence (at least on paper) delineated in WHO integration strategies of “harnessing the potential contribution of TM (traditional medicine) to health, wellness and people-centred health care” (WHO, 2013, p.11) is here, therefore, surely obfuscated, and likely misguided.

Chapter 3. Qiang medicine as a foreign concept

In this chapter I will explore the absence of Qiang medicine as a concept by partially contrasting and aligning data collected from two Qiang village communities. I will do so by giving an overview of life, health and illness in these villages, while focusing on local afflictions and practitioners, on choice of care, livelihood and ending with insights on the attempts of an ethnic self-definition performed by the members of these communities. With such broad approach, I aim to illustrate how distanced the lives and views in these communities were from any articulation of Qiang medicine.

As mentioned in the introductory chapter, the denomination of a “Chinese medicine” was a conceptual unification that appeared as a reaction to the introduction of “Western medicine” in the country (Croizier, 1976). In the previous chapter I have shown how this discipline was later developed as part of a nation building and nationalist political project (Taylor, 2005) that has in the recent decades been directed by marketising imperatives. I argue that Qiang medicine, too, is part of a political marketising project. It features in the spirit of an all ethnically encompassing *zhonghua minzu* or Chinese nation, and as such, is harnessed by Qiang doctors who navigate China’s social-political system in order to assert themselves as legitimate practitioners. In a way, the manner in which Chinese medicine was pitched against Western medicine in order to assert itself, while concurrently being made in its image, can be reflected in how Qiang medicine is simultaneously defined against (and along) Chinese medicine, having been formally included in the latter by means of policy in the past years.

When it comes to rural communities of Qiang people, these medical, marketising, and political moves seem to lack any relevance. Based on fieldwork conducted in two villages in different counties, Yanwo in Maoxian and Baijiaduo in the village cluster of A’er, in Wenchuan (see Figures 18 and 19), I witnessed a deep pragmatism in healing practices and in choice of healthcare that had barely any reference to “Qiang medicine” or “Qiang medicines”.



Figure 18: Yanwo village



Figure 19: Baijiaduo village

To the exception of the oldest town clinic doctor, all the doctors interviewed in the towns and city had made the distinction between Qiang and Chinese medicine, even if they saw them part of each other. Speaking of “Qiang medicine” was commonplace among doctors who identified themselves as a “Qiang medicine doctor”, since “Qiang medicine” was their trade, and considered by them an academic and practical working field. I did not find such use of the term in the villages, among a local doctor, a *shibi* and a *duangong* (端公)⁴⁰. There was one single mention of “Qiang medicine” by the *shibi* when he referred to medical skills that were passed between different generations of *shibi*, a proficiency that he saw as born out of the remoteness of those mountain villages and the experience that *shibi* accumulated in treating injuries. This centering of Qiang medicine on a generational transmission between *shibi* contrasted with the dismissal of *shibi* in Qiang medicine clinics. It also fit well with the plaque placed outside the *shibi*’s home home that read “Inheritors of *Shibi* Culture”, in Chinese, English, Japanese and Korean. This was one of the very few instances where I found any inscription in a foreign language in both A’er and Yanwo, designating the *shibi* as a cultural artefact for tourists to see (see Figure 20).

⁴⁰ *Duangong* is a term that some equate to *shibi*, but one that was considered derogatory by Dr Zhang. Both stand for “shaman” among Qiang communities.



Figure 20: Plaque outside *shibi*'s home

Both the local doctor and the *shibi* used distinct forms of legitimacy to position themselves as the most medically knowledgeable and authoritative individuals in their villages. Apart from the one mention of the *shibi* regarding Qiang medicine, there was a deep disinterest in the topic among all the villagers that I spoke with. I argue that this disconnect is intimately associated with Qiang medicine institutionalisation (and the absence of it), and to personal and group stakes as well as perceived advantages in the ethnic labelling of “medicine” or “medicines”.

The lack of ethnic significance attributed in these two villages to healing practices, as well as the reliance of villagers on self-care, raises the question of whether the intent of promoting the integration in public health of a particularly “ethnically” packaged form of “traditional medicine” in such communities has any purpose at all. I will now illustrate the living landscapes, and of health and illness, in these two villages. Such description is the product of my attempt at grasping local ethnic and medical significances, only to encounter people leading very pragmatic, straightforward, and adaptable lives. I found out quickly how their day to day practical considerations deeply disregarded any such ethnic and medical attributions.

Local afflictions

The specificity of diseases in a locality, and the solutions that people seek or employ, can be clouded by the very ambiguity of what “disease” means. Elders told me that there were no diseases described in Qiang language that had no Chinese language

equivalent. They insisted that, on the contrary, there were diseases described in Chinese language that had no Qiang language equivalent. Even while using Chinese language, I did not come across names of diseases that were unique to the Qiang. In these villages, the concept of “disease” was something body-centred, something that “one’s body” suffered from. There were, however, a number of afflictions not considered diseases, but attacks from external entities, considered endemic to the area. This presumes a separation between the body (together with the three souls) and an external harmful entity. Such separation denied anything being intrinsically wrong with one’s “self”, apart from the fact that the “self” was under attack, an attack that preceded and superseded the illness that could then develop, and that would show itself in bodily manifestations. To clarify the issue of the “three souls”, Bian (2017), who conducted extensive fieldwork in the first village where I was based, found villagers distinguishing between the three souls of an individual. According to them, after death, one would remain in the tomb, another would wander around and the third would be reincarnated. Other villagers reported that a person only had one soul, which after death would become the ancestor to his or her descendants. The three souls could be scared or taken away by demons or deities and it was incumbent on the shaman to call the souls back to the body. Failure of the souls to return to the body meant that the individual would eventually die as a consequence. The existence of these three souls brought together a concomitant respect for ancestors (since one soul stayed in the grave), for reincarnation, and for the spirits that animated all things⁴¹ (ibid.).

In the second village, I learnt from the village *shibi* of a different take on the “three souls”, an explanation that distinguished them by their position in relation to the body: one soul ran outside, another was always in the human body protecting it, while a third was on the body, and if frightened could not attach itself, leaving one’s essence-spirit (*jingshen* 精神) dejected and apathetic. In this eventuality, it was then up to the *shibi* to bring this soul back to one’s body, “causing the spirit to rise”, without the need of medicines. It is not clear how these three souls might overlap with the ones described in the first village by Bian, if at all. In Yanwo, the demons or evil spirits included the souls of those who died without leaving descendants to perform rituals for them, guiding

⁴¹ A tree could become a tree spirit that was manifested in the human body, and later become a tree god in Heaven (Bian, 2017).

them to the right place of rest, or who died in sudden and tragic circumstances without their body having been cremated (Bian, 2017). In A'er, some of the demons or evil spirits were also "vicious ancestors".

Poison cat (*duyaomao* 毒药猫)

I only met one villager, in Baijiaduo, who reported having been personally attacked by a demonic entity. All the other stories that I came across were quite vague, when it came to place, time, and person affected, which made it difficult to distinguish whether these were mere "stories" or a sign of discomfort in approaching the subject. Among the pernicious entities reported in both villages, the most well documented among the Qiang is the *poison cat* (*duyaomao* 毒药猫, *ddushgvebi* in Qiang language) (Wang, M.K. 1999b; Bian, 2017). In Yanwo I was told that every Qiang village had a *poison cat*, that usually attacked men who did not have a wife, and although they were unable to kill, they could leave one extremely ill and confused, by taking away one's soul. However, it was only in Baijiaduo that, despite many villagers denying knowledge of it, I met someone affected by one. This lady had severe stomach ache (which matches Bian's (2017) description) and had taken "Western medicines" (*xiyao* 西药) as well as an injection, without any visible improvement. Only after seeing the *shibi* and receiving his treatment of *duyaomao cao* (*poison cat herb* 毒药猫草) did she recover, being convinced in the end that it was an attack by *poison cat* that she had suffered from.

The *shibi* in A'er explained to me that the *poison cat* was an ancestral entity who could change shape. It carried a small pouch, a treasure passed on by its mother, that contained different hairs and feathers. It could pull a goat's hair, blow it, and shake itself into a goat, or pull an eagle's feather and be able to fly. Should it lose its pouch, it would "go mad and lose its mind at once". It could follow people who would go up to the mountains, and after having changed shape, could lure them onto a cliff causing their death. If one paid attention carefully, one could distinguish its movements from those of a regular wild goat, for example, and avoid its trap. The ability to be a *poison cat* was passed by a mother to her daughter, few men would get to be a *poison cat*. However, some girls could learn how to become a *poison cat* while others could not. For the first seven days after a baby was born, should one place a few highland barley

seeds around the baby's bellybutton, one could find out whether the baby girl could learn it, for the seeds would open.

The *shibi* claimed that there were many more *poison cats* and other demons before “liberation” (the founding of the PRC). At the time of our meeting, according to him, there were less and less *poison cats*, and they could disappear in one or two generations. He attributed this to two main reasons. The first was family planning, as before there were many more girls, and in a family, should one not be able to learn, then there would be another sister that could. The other reason was the arrival of electricity to the village. One of the ways for the *poison cat* to attack was to blow out the old oil or kerosene lamps and, in this way, producing black smoke, while intruding into someone's home. In this moment, when darkness fell, the individual would be vulnerable to attack. This kind of attack was impossible with the electric lamp, for while the electric light was switched on, the *poison cat* was unable to change shape, something that appeared as essential for the attack to take place. According to the *shibi*, these two factors had resulted in there being very few affected people these days. In the *shibi*'s explanation for the reduction of *poison cats* he invoked a set of physical circumstances that justified the reduction in attacks. For him, it was not a matter of lack of belief or scientisation that explained the reduction, as he added that “if you judge it with science, then you cannot describe it clearly. Science cannot explain this kind of evil encounter.” The reason for the presence of *poison cat* was merely a matter of locality, both according to the *shibi* and to villagers, it was something specific to this region. Wang Ming-ke (1999b) has characterised this phenomenon as a form of scapegoating towards the most vulnerable, usually women, and as he found, more common towards women from outer villages who settled for marriage. He sees it as a form of hostility and differentiation that has the intent of relieving social tensions and unite group identity in a village or family.

Dirty wind (huiqi 秽气)

Another pernicious entity was *dirty wind* (*huiqi* 秽气), equated by some to *evil wind* (*xiefeng* 邪风), or to *evil* (*zhongxie* 中邪). A villager in Yanwo told me of how one could catch *dirty wind* when out in the mountain at evening, causing one to feel dizziness, headaches, and blurred vision. It has been described as a demon that is a “numinous

entity that inhabits the landscape” (Bian, 2017, p. 83). Another villager in Baijiaduo mentioned that *dirty wind* or *evil wind* could be caught not only up in the mountain at evening time, but also when mourning the death of a close one. She also mentioned that a mother after giving birth and not staying indoors for forty days could also catch *dirty wind*⁴². The A'er shibi compared the paralysation that one could suffer from inhaling *dirty wind* to the one suffered from tetanus after a cut, both of which could lead to a state of stupor.

Grass demon (caomo 草魔) and five ghosts (wugui 五鬼)

Two other pernicious entities were the *grass demon* (*caomo* 草魔) and the *five ghosts* (*wugui* 五鬼). According to the *shibi*, should there be “fall and hurt” (*shuaishang* 摔伤) down the mountain, followed by bleeding, then the grass, trees and vines of the mountain would be attached to one’s blood. In this case, human blood could be attached to the *grass demon* and attacked by the *five ghosts*. The *shibi* reiterated that this was not a disease, but an attack, one that could leave an individual depressed, with low essence-spirit. The *dirty wind*, *grass demon* and *five ghosts* were all invisible entities.

Dragon (long 龙)

Finally, there was a visible entity that usually made for a good sign when spotted, but that occasionally could also cause someone to fall ill: that was the *dragon*⁴³. Such sighting was described to me by a Yanwo elder among a group of villagers, at his home, late at night after dinner. He told us how that same year, from the mountain, he had seen a *dragon* made of light flying high above and gesticulated to show us how the *dragon* moved, waving his hands up and down. One of the interlocutors asked if he was drunk at the time, which he denied. He said that it was possible to see a *dragon* there if one was very lucky. Although he was telling us about it, he mentioned that one was not supposed to tell anyone of the sighting, or it could bring misfortune. Those words were followed by a joint laughter that showed these possible consequences to be taken very lightly. The elder referred to the *dragon* and to *pusa* (bodhisattva) interchangeably. This

⁴² In China it is common for new mothers to stay indoors for a full lunar month after the birth of their babies, some Mexican American new mothers also stay indoors for forty days in what is called *la cuarentine* (Horn, 1990).

⁴³ The *dragon* is a widely reported sighting in Tibet (Barker, 2017).

common denomination was explained to me by a villager who remarked that they were one and the same, both god and spirit (*shen* 神). There was also a younger villager who had never seen one. Although he did not believe in its existence initially, he later came to do so. In fact, one of the most important features of the Spring festival period in Yanwo is the parade of the paper *dragon*, purposefully painted for the occasion, and accompanied by percussion. The parade lasts a whole day and involves paying visit to every household in the village, bringing blessings and driving away the “dirty things” (Bian, 2017). In Baijiaduo, at one instance, two local ladies were singing a song about Longchi (龙池), a place in the region which translates as “dragon pool”. I asked at the time whether anyone in the village had seen a dragon and they replied with a matter-of-fact “of course”. However, they claimed that those sightings happened only near Longchi, and that those were the reason the place was given the name.

Common diseases

When it came to disease, the only distinct denomination that I found was a differentiation described by a Yanwo villager between the three different kinds of *delhangde* which stands for a “common cold” in Qiang language, or *ganmao* (感冒), in Chinese. According to him there was one kind caused by “someone not covering oneself well”, another caused by “eating something unclean”, and a third caused by “having sweated too much”. The denominations of other illnesses and symptoms in Yanwo mapped on to generic Chinese language terms, such as diarrhoea or cough. Localised pain, just as in Chinese (and in English), was sometimes named in Qiang language with body part followed by “ache”, such as stomach ache (*paugzhin*) or toothache (*dzegdzhin*). Pain when urinating was called *segerremarre*, while constipation was *rsherremarre*, with *remarre* standing for “that which does not go out”. Regarding the tenets of Qiang medicine presented by Dr Zhang in Chengdu, both the local doctor and the *duangong* in Yanwo had simply heard about *stone disease* and *ducts*, having likely picked the terms indirectly from some Qiang medicine meeting, or related social media. No one else in the villages that I spoke to, including the *shibi* in A’er, had ever heard of those terms.

Local practitioners

The Yanwo doctor

The figure embodying state approved biomedical healthcare in Yanwo was the local doctor, Dr Yu. Well respected by all the villagers that I spoke to, Dr Yu, in his fifties, would usually sit outside his home by the road, praying Buddhist mantras while fingering his prayer beads. He only went to school for five years as a child, back when he was living in a nearby town. At twelve years old he ceased his studies and returned to the village to work. He spoke of that time as a period when the economy was bad, life was hard, and when most people did not study. He proudly claimed that the village had six university graduates, plus four still studying, and that only one had not returned, working at the time in Chengdu. He remarked that unlike Yanwo, many villages still did not send any locals to university. Dr Yu reminisced how when he was a child there was no local shop, that people would need to head to the town to buy supplies. Back in those days, the village had a local barefoot doctor⁴⁴ for a while. A lot had changed since then. At the time of our acquaintance in 2018, Dr Yu multi-tasked between running the local shop, the small health clinic, processing and selling the medicinal herbs collected by Yanwo villagers, as well as dealing with much of the official paperwork that the other villagers needed sorted. Both the shop and the clinic, where he dispensed almost exclusively “Western medicines”, were adjacent to his home.

Inspired by his family, especially by his father and paternal grandmother, who had taught him about local medicinal herbs, health and disease, as well as fueled by the desire to “keep the brain moving”, he started long distance training and opened his clinic in the year 2000. His formal “general practice” (*quanke* 全科) medical training commenced in 2006, covering western and Chinese medicine, and continued till 2013. This training involved spending between three and four months every year (spread over the year, which could consist of a few days or weeks of training at a time), in a medical institute located in a city 300km away into the mountains. Since then, he had yearly training, which lasted for about a week, in Fengyi town. The last such meeting involved

⁴⁴ Barefoot doctors were individuals receiving a very compact medical training from the state (in biomedicine and Chinese medicine) that lasted a few months, to then be dispatched to the countryside, as part of a vast program of rural health coverage initiated in 1968 (Zhang and Unschuld, 2008).

180 village doctors from Aba Prefecture (one per village) and several experts training them in a variety of areas (from techniques in Chinese medicine to CPR). Some of the experts were based in Maoxian, while others were brought in from Beijing. Apart from the training that they would receive, those meetings were also the occasion for village doctors to be briefed in changes of policy and in the latest guidelines.

According to him, only after the 2008 earthquake, did the government take his and other clinics seriously, with regulations and further training. Although there were always limitations on the medicines that he could buy, these were also intensified after 2008, with newly imposed regulations. His impression, after having received his medical training, was that the doctors in the hospital were very lucky for only having to deal with one specialty, and that it was a lot harder to be responsible for general practice and “having to deal with everything”. It was the problem of scope that concerned him as he was aware of the need of being knowledgeable in many distinct areas. Volume was not an issue at all, since his clinic was shut most of the time, only opening very sporadically should a patient come to see him.

Up until 2016 there were many villagers coming to receive antibiotic IV (intravenous) drips⁴⁵. At the time, Dr Yu stocked both penicillin and amoxicillin, which he would not only administer intravenously but also dispense the respective oral forms. He claimed that after 2016 these practices became very strict and meant that he started referring patients a lot more often to different hospitals for these cases, while not keeping antibiotics in stock. All his medicines were bought online, from an online store based in a Chengdu hospital, in what Dr Yu remarked was a very practical manner. The purchases were checked against his qualification and should there be any medicine that he was not allowed to buy, it would just get crossed off the list and would not be shipped. He would then collect all the purchased medicines from a nearby town hospital. From his phone he also had access to several Wechat groups composed of his medical contacts, as well as a company that outsourced medical doctors to answer any medical related question that one could have.

⁴⁵ In China (Reynolds and McKee, 2011), including Tibetan areas (Schrempf, 2010), there is a notion that injections and intra-venous medicine administration, for involving metal piercing the body, have therapeutic value in itself. These were made commonplace in rural areas for being part of the rudimentary arsenal of barefoot doctors, see Lora-Wainwright, 2018.

When it came to patient visits, he claimed that in most instances when a patient would come to see him, he referred them to the town hospital. Among the conditions that Dr Yu treated (none of which were Qiang-specific) there were toothaches, which he divided into what is called literally *fire-tooth* (*huoya* 火牙), describing it as a “pain when eating soup or sweet foods”, and that can be translated as periodontitis, and inflamed tooth⁴⁶ (*yanya* 炎牙), a “pain that appears when eating chillies, smoking or drinking”, which translates as gingivitis. In both cases he would dispense painkillers for a few days, with a later referral to the town hospital should the pain persist. He also treated “common cold” or *ganmao* (which he divided in upper and lower respiratory tract *ganmao*, taking the latter more seriously) but referred cases of “lung inflammation” (or infection) (*feiyan* 肺炎). In his view most cases of diarrhoea just resolved on their own without medicines, but he also treated some, as well as stomach aches, referring cases that he suspected could be appendicitis. In case of fever, he claimed that he recommended drinking hot water and that it usually resolved in a few days. The only case that he mentioned he would recommend a medicinal herb was that of dandelion (*pugongying* 蒲公英) for those presenting pain when urinating. One patient that Dr Yu took to be seen in the clinic had no fever but felt pain all over his body. Dr Yu administered an injection of aminophenazone and barbital (a compound preparation only existent in China to my knowledge), with analgesic, anti-inflammatory, anti-pyretic and sedative properties.

The doctor then mentioned a gentamycin injection, which made me wonder if he did keep antibiotic injections after all, this I wasn’t able to verify, as I understood he was not keen that I would see the small room where he operated the clinic. Overall, there was somewhat of a contradiction that he never fully clarified. Despite him speaking of Chinese and Qiang medicines as being superior, he would dispense almost exclusively “Western medicines”, claiming they were more practical. He would also take “Western medicines” himself, to treat a condition that, as he saw it, “Qiang medicines could not help with anymore”.

⁴⁶ In Chinese language and medicine there is a conflation of inflammation and infection in the term *yan* (炎), in Yanwo Qiang language this is referred to as *papa*.

He dismissed the medicinal herb seller down the road at the next hamlet on account of his lack of medical skills. This particular seller sold much larger quantities than Dr Yu but had no knowledge of what those medicines were used for, a fact that Dr Yu was acutely aware of. I enquired about knowledge regarding the quality of medicines, and Dr Yu explained that identifying quality is complicated, something that was dependent on the season and weather at the time of collection. Dr Yu would assess the quality of medicines by “looking, touching and smelling”. According to him, the other seller only had basic knowledge of quality and could only distinguish between “bad, good or very good”, “like someone selling phones who only knows the difference between prices but can’t explain what each phone can do”.

Given Dr Yu’s background and position in the village, he aligned himself closer to certain official discourses in many discussions and was quick in dismissing medical explanations or categorisations of other villagers. The three kinds of “common cold”, or *delhangde*, that I had heard about from another villager, were swiftly rejected by him, stating that there are only two kinds: *sabei* (hot) *delhangde* and *shti* (cold) *delhangde*. These two categories correspond to those of Chinese medicine, whereby there is *ganmao*, or “common cold”, of the “wind hot type” (*fengre* 风热) and of the “wind cold type” (*fenghan* 风寒) (Wu and Zhang, 2010). While holding on to his prayer beads, he dismissed the phenomenon of the *dragon* as well, stating that “there are many things I don't believe, only in science”. Bian (2017) shows it is easier to align Buddhism with an official PRC stance, rather than other religious practices among the Qiang.

When I asked Dr Yu about *poison cat*, he frowned his face, claiming he neither believed it nor did he understand it. It was something that his grandparents would talk about, but not his parents. He went on to describe it as a fairytale, one in which anyone, be it loved ones, or people one argued with, could turn into anything, a chicken, a cow, a dog or a cat, to then bite people and eat them. “If this is true, then what is the point of having doctors or medicines?”. This statement reinforced his own medical legitimacy, and the purpose of his scientifically minded, professional existence. He retorted, “did you watch TV last night?”, and grabbed his phone to show me the news: “Highlights of today’s AG600 maiden flight on water”. It was a video of the world’s largest amphibious aircraft, made in China, in its maiden flight, taking off and alighting on water. “Look

what our country is doing, if you want to believe in something, believe in this, not in *poison cat*". He was dismissive of both *shibi*, which he struggled to make sense of what they were, and of self-entitled "Qiang medicine doctors", the mention of which he reacted to as if they were part of some grandiose scheme.

The A'er *shibi*

The *shibi* in A'er had a very different way from the Yanwo doctor to assert his medical legitimacy. For example, he recognised that villagers knew how to use simple combinations of medicinal herbs to treat *ganmao*, or common cold. However, he did so in a paternalistic way, being convinced that such knowledge had been passed on to them by his ancestors. Moreover, he always felt cherished by his fellow villagers, and so did his father, claiming that before "liberation" villagers would actually value more what the *shibi* had to say rather than that which would come from the government officials.

The medical aspect of his position was only part of what he did, for as he saw it, the different competences of a *shibi* were divided under the "upper, middle and lower sutra" (*shang tanjing*, *zhong tanjing*, *xia tanjing* 上坛经, 中坛经, 下坛经), and all trained *shibi*, after their apprenticeship, should understand the three of them. The "upper sutra" covered frequent ceremonial work of prayer and incantations, which was especially important in the Qiang new year, and consisted of a celebration of the year's harvest and the "praying for good fortune, respecting the "myriad things" (*jing wanwu* 敬万物)⁴⁷.

This ensured the harmony of all things, from the existence of sunshine, to the growth of crops and livestock, to wild animals being kept at bay from livestock, to the happiness, peace, prosperity, and health of all villagers. The "middle sutra" was a way to "lay foundations" and covered the work of the *shibi* at events such as weddings, funerals, and the building of houses⁴⁸ (when the *shibi* set the "god of the house" (*jiashen* 家神)), assuring prosperity for the generations to come. Finally, the "lower sutra" consisted of dispelling evil, treating disease, removing evil to treat disease, as well as treating and saving people. In this way, he claimed, "the *shibi* is also a doctor". The sacrifices of

⁴⁷ *Wanwu*, literally "ten thousand things" stands for all things in the universe, and is an ever-present term in Chinese thought, see Major, 1993, and Farquhar and Zhang, 2012. Animism in Chinese reads *wanwu you linglun* (万物有灵论) which literally means "the idea that the ten thousand things have soul".

⁴⁸ In Yanwo, these were events commonly directed by elders, who would "invite *pusa*" before a house was built.

chickens, goats, and sheep could happen in all three domains, and so did the beating of the sheepskin drum. The drum would be white, yellow, or black, should it be used for the “upper sutra”, the “middle sutra” (to protect the peace), or the “lower sutra”, respectively.

Since he was a child, the *shibi* had been watching patients coming into his home and being examined and treated by his father. Widely respected in A'er, his father had passed away a few years prior to our first meeting, and so the *shibi* had taken his place. Back when the *shibi* was about seventeen or eighteen, his father began teaching him about the place where, and how, bone fractures happened. Moreover, he taught him of how many bones the human body contained, where these were, and where sprains happened in the body. These teachings happened on a case by case basis, in what the *shibi* described as an easy way to learn, purely based on clinical skills and experience and with no diagnostic instruments.

The *shibi* claimed that simple sprains or dislocations did not require medicinal herbs, nor did these need to have poultices changed regularly. Since he did not give medicinal herbs for those simple cases, he claimed that he did not usually ask for payment for such services. In his view, those cases would be treated in hospitals with a heavy use of medicines and constant change of poultices, and argued that those gave a heavy economic burden to patients. He associated the common need for payment to the performance of an institutional role. In order to distance himself from that, he claimed that he had never been on a “working committee” (*gongwei* 工委), and showed no ambition of treating patients in an institutional position.

Many years prior, should patients be too injured to walk, his father would sometimes put off the farm work and go to their houses, no matter the distance, even if it meant a whole day of walking. In serious cases, the *shibi*'s father would stay away for one or two months, until the patients could get off the bed and resume walking. He attributed this to a medical ethics that was passed down from their ancestors. According to such ethics, doctors should cure illness and help people, to be there when patients needed them, even if it meant putting off their own work. Therefore, as early as the *shibi* can remember, his father was out helping patients. After his father got old and could not walk anymore, then the *shibi* took over from him, going out, visiting patients with feet

injuries, or serious bone fractures, changing splints, changing medicines, liable to leave home in short notice. In not so severe cases, patients came to him instead. The frequency of patient visits would vary, as the *shibi* claimed that sometimes there could be seven or eight patients in one morning, meaning the *shibi* would be unable to finish all treatments until the afternoon. In other times, ten days or more could pass without a single patient coming. In the few visits that I made to his home I did not encounter any.

The length of recovery would depend not only on the severity of the injury but also on the promptness of patients visiting him after injury. According to the *shibi*, after a very simple sprain, if patients came to him immediately, it would be just a matter of resting for one to two hours after the manipulation treatment, and they would be able to walk again as normal. Should the treatment be delayed then it could take a little longer, two to three hours. For more difficult sprains, that did not involve fractures, the recovery could take between one and three weeks. However, should the patient wait for a long time, or if the injury had already happened the previous night, should there be “ligament injury, with capillary invasion of the periosteum” (*rendai lashang, maoxi xueguan qinrule gumo* 韧带拉伤, 毛细血管侵入了骨膜), then there would be inflammation. In that case the healing period would be longer. He went on to explain that with fractures, should the patient be seen within thirty-six hours, the recovery was quite fast. Within one month, he could still connect the bone, but should patients wait for over a month, there would be extensive inflammation, something that the *shibi* considered very dangerous. I was intrigued by his use of biomedical terms and so enquired also whether he had heard of *ducts*, *stone*, and *fire disease*. After lengthy explanations of these concepts, the *shibi* still had no idea of what I was talking about.

His son, who worked in the neighbouring province of Qinghai, a few hundreds of kilometres away, had returned home after a severe injury to his leg and foot caused by construction material having been thrown at him. He considered himself very lucky for having such a knowledgeable father who could treat him. It took one hundred and twenty days after his father’s treatment for him to be fully recovered. The *shibi* mentioned that with that kind of injuries, around one hundred days after treatment one could already carry weighty loads and start heavy physical activities.

The *shibi* did not agree with the use of “anaesthetics” (*mayao* 麻药), a term which I believe he used to cover analgesics as well. According to him, these were stimulants of the “brain nerves” (*danao shenjing* 大脑神经) and so had an impact on recovery. He described the medicines for different conditions such as diarrhoea that were given out at hospitals unnecessarily, and insisted that for those cases herbal medicines were enough. He only used medicinal herbs collected either by himself or by his wife, sometimes from as high as 3000 to 4000m. This collection would usually happen in the summer months and require a trip of a few days. He would then dry and store those medicinal herbs at home so as to have them at hand at all times. He also used medicinal herbs to treat cuts and wounds, only needing to change the medicines once, should it be a small wound, and up to three times, in the case of larger or deeper wounds.

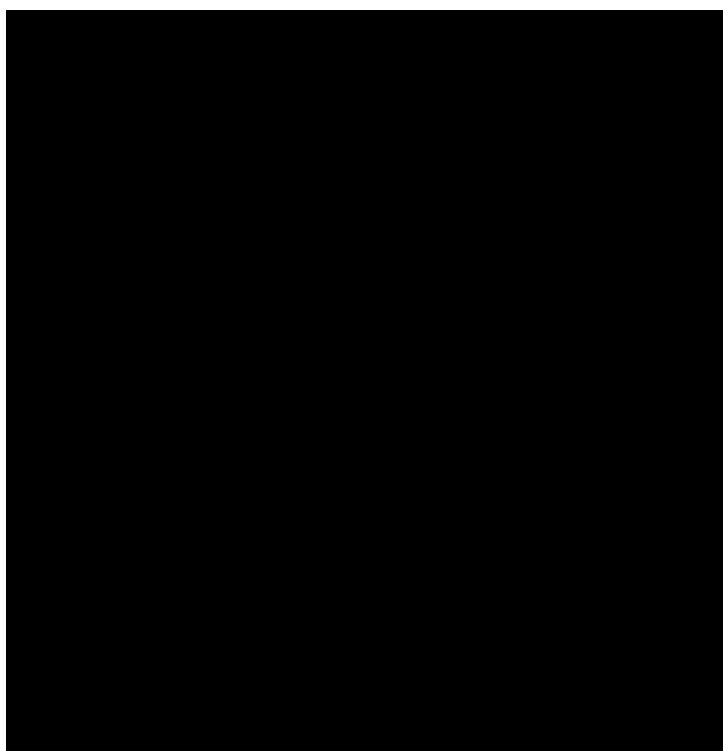
These treatments contrasted profoundly with those that the *shibi* used when dealing with certain local afflictions such as “fall and hurt”. Upon suspecting that someone had been attacked, he would check the “five administrative organs” (*wuguan* 五官)⁴⁹, “look, listen, ask, and touch” (*wang, wen, wen, qie* 望闻问切)⁵⁰, and check the “essence-spirit outlook” (*jingshen mianmao* 精神面貌), since essence-spirit would get depleted by the *grass demon* and the *five ghosts* in the case of “fall and hurt”. Upon confirmation that a patient was suffering from such an attack, the *shibi* would need to sacrifice a chicken (usually black) and use dough to mould the *five ghosts* (producing five figurines), place the *five ghosts* on a bamboo shoot shell, use magic arts through the patient’s body and recite the “*five ghosts* scripture”. Then, the *shibi* would leave the patient’s home and ask the host to close the door shut. After leaving, he would place the dead chicken at the mountain crossroad, place the chicken’s blood on the bodies of the *five ghosts* and burn them. Following this, the *shibi* could not go into the host’s house, not even for the host to thank him. Three days later the patient would be recovered. During those three days, the family would have to place a bench in a visible place outside their door. This bench would be on the left, should the patient be a man, or on the right, in the case of a woman. In this manner, others could know that there was a seriously ill patient inside

⁴⁹ These are the points from which the five viscera in Chinese medicine are observed: nose, eyes, lips, tongue, ears. See Unschuld, 2016.

⁵⁰ Chinese medicine’s four examinations, see Kaptchuk, 1983.

and that they could not go in. Should anyone walk in, then all the procedure would have been in vain.

In order to deal with an attack by *poison cat*, the shibi would use a worn out plough head, or *lihua* (犁铧) [REDACTED], which is commonly used for dispelling evil spirits. Using fire, he would heat up the *lihua* as well as different kinds of stones. He would recite a mantra and turn the patient's essence-spirit from depressed, silent, drowsy, and heavy on the head, into sober and awaken.



Another affliction that he had to deal with was that of patients in a state of stupor induced by *evil wind*. In this case, the shibi would have to resort to the “highest magic arts” and exchange a life for a life, by sacrificing a chicken, a sheep, or a goat at the foundations of the “town god’s temple” (*chenghuang miao* 城隍庙). The person affected would then slowly recover. The structure itself like that of most “town god’s temples” in the region had been destroyed during the Cultural Revolution, in order to give way for building a public canteen.

According to the *shibi*, similar to the stupor induced by *evil wind* was that of tetanus. Although many people would “now get an injection from the hospital for fear of tetanus”, as he saw it, since tetanus consisted in a kind of poison, he just needed to use a herbal medicine and add an ingredient to enhance its efficacy, treating the patient immediately after the wound was inflicted. In this manner, he would “dispel the wind” (*qufeng* 祛风) and so remove the poison. Another way of exchanging life for life, in instances when a patient was extremely sick and dying, was to tie up a strawman, the size of an adult, dress it with the patient’s clothes, recite sutras and chant incantations. Finally, the *shibi* would take the strawman to the crossroad, burn it, and the patient would recover gradually, to then be full of energy again and with his life protected.

The above mentioned medical ethics that was passed through generations, along with the *shibi*’s emphasised statement “I believe in medicine” (*wo xin yi* 我信医) appeared as an attempt to portray himself as a reputable and legitimate practitioner. “I believe in medicine” alludes to the saying attributed to the famous physician Bian Que (5th century BC) that “those who believe in witchcraft instead of medicine” (*xin yi bu xin yi* 信巫不信医) are difficult to cure (Wang, Y. 2009), and involves an ethical stance distancing himself from witchcraft, running counter to such labelling of *shibi* by Dr Jiang in Maoxian. To support his point, the *shibi* explained how every year, on the 28th day of the 4th month of the lunar calendar, the day of the “three gods of the Medicine King” (*yaowang san shen* 药王三神)⁵¹, after coming down from collecting medicinal herbs in the mountains he would burn paper money, sacrifice a rooster, honour the “Medicine King” and wish everyone good health.

I believe in medicine, so there is a “Medicine King” (in the altar), and those who do not believe in medicine do not have a “Medicine King”.

⁵¹ The *shibi* referred interchangeably to the “three gods of the Medicine King” and to the “Medicine King”.

Many years prior, the *shibi* had statues of both the “god of the house”⁵² and the “three gods of the Medicine King”, but these had been destroyed during the Cultural Revolution, and so were instead “written”⁵³ on a divine board at the home’s altar.

The *shibi* worried and felt sorry for his ancestors should his “precious wealth of healing arts” not be passed on. This was something that was imperative to be passed down from generation to generation, in an uninterrupted line. Although he learned everything from his father, and so had his father from his grandfather, the *shibi*’s son worked away and so he hoped to be able to train his nephew. I learnt later from the *shibi*’s son that he eventually took on an apprentice who was not a relative and who went on to study at Tianjin university, a renowned academic institution in the north of China.

In all of the Qiang areas there were no more than thirty *shibi* of his age, so the *shibi* claimed. He did not give much credit to others, as in his opinion, they had only learnt late in life and so were not proficient enough. Along with the role that he played in the village, he had also been recognised by the “State Ministry of Culture for the Protection of Intangible Culture” as a successor of “sheepskin drumming”, reportedly the only one in the Wenchuan county, Maoxian and Lixian. He travelled all over China for joint dancing and drumming performances with other shamans from different ethnic minorities. For these services, he received a subsidy from the government of 10.000RMB in the end of each year. A couple of other villagers accompanied him on these trips. In the most recent one, they had headed to Guangdong, together with other Qiang performers from neighbouring counties, and a couple of choreographers. In a video of the performance showed to me by one of the villagers who had joined the entourage, I saw the *shibi* in the middle, wearing the most elaborate clothing and accessories among the group, while moving the least, contrasting with the dancers surrounding him, who jumped acrobatically on stage.

⁵² Every household that I visited in both villages had an altar with the “god of the house”, that could also be dedicated to the family’s ancestors. At my Yanwo host’s house the kitchen had an altar to the fire god, and there was a separate altar upstairs dedicated to ancestor worshipping, and with statues of both *guanyin pusa* (观音菩萨) (see section on choices of care) and the Jade Emperor (*yuhuang dadi* 玉皇大帝) (see section on livelihood). Only in Yanwo did I witness regular offerings of incense at these altars.

⁵³ Although in China it is common for a deity to be represented in an altar by virtue of its written name, among the Qiang, this could have been a post-Cultural Revolution phenomenon since they had no written language. I found no references of these divine boards being used there before the Cultural Revolution.

The Yanwo *duangong*

In his fifties, and a self-entitled *duangong*, who saw no difference between that term and *shibi*, he, unlike the doctor and the *shibi*, led a very low-profile lifestyle, as an outsider. He had lived in another village further south, and had moved to Yanwo only a few years prior, after his wife tragically passed away in a landslide. He had five sons, one daughter and ten grandchildren. Three of the sons lived in Yanwo, and he split his time between farming, weaving baskets (a self-taught craft), and treating anyone who would come to him for help. The *duangong* was illiterate and had received his training in a different village by a master who had also passed away, leaving many apprentices who were then spread over nearby villages.

When treating someone he would burn *zuma* to invite *pusa* (see Chapter One), and never used or prescribed medicines. He claimed that many of the patients he saw had already been to hospitals, and although doctors would insist the patients were cured, they would still be suffering pain. In these instances, the *duangong* would know that they had not been cured. Such healing knowledge was something that he was not willing to pass on to younger generations as he believed that such ceremonies should be practiced in Qiang language, and that was something he thought young people were not very proficient with. The *duangong* claimed he could grab hot stones, cure mutism (*yaba* 哑巴) and bring dying children back to life.

Choice of care

When it came to villagers navigating the different options of care presented to them, the choice between self-care, local practitioners, clinics and hospitals appeared dependent on the perceived severity and persistence of an illness. Moreover, the kind of affliction often determined a choice that was not exclusive, but that rather often attributed a role to different providers.

Minor ailments such as diarrhoea, coughs, colds and joint pain, toothaches, cuts and bruises were commonly dealt with at home, drinking decoctions of local medicinal

herbs, or applying these medicinal herbs directly to the skin⁵⁴. Those who did not keep medicinal herbs at home would easily get them from other villagers, while people of younger generations preferred to take Chinese proprietary medicines bought in the town or in the city, for considering them more “complete” in their action, although they would often concurrently drink decoctions of local medicinal herbs. However, one older lady seemed to use an excess of amoxicillin prescribed by a town doctor for a variety of ailments, while also concurrently drinking decoctions.

Vedom and Cao (2009) have shown an increase in health clinic utilisation when compared to hospitals among ethnic minorities in south China (although not including Sichuan), between 1989 and 2004, driven by difficulties of access. In the two villages of Yanwo and Baijiaduo (where during my stay a new road was under construction), however, I found an overwhelming preference for, and use of hospitals rather than clinics. Some villagers said outright that they would never go to a “Qiang medicine clinic”, as they claimed to be able to solve everything of minor severity themselves, and that in the case of a serious condition they would go to a large (Western medicine) county hospital. Another villager dismissed even local county hospitals, preferring to take a longer journey and visit the provincial hospital in Chengdu, which “has a much bigger variety of doctors, more highly skilled doctors, everything works very smoothly, it is less crowded, and I get the medicine I need immediately”. He would almost always choose Western medicine, as although he thinks Chinese medicine is “OK”, he found that Western medicine “works quicker”. Also, when it came to medicines, he preferred to buy them in Chengdu, as he claimed the ones in the nearby town as well as in Fengyi town were often expired.⁵⁵ According to him, choice of healthcare also came down to urgency, as he thought only older people, or those who were very ill and preferred not to travel far would go to local county hospitals. Others remarked that going straight to a Chengdu hospital without holding a referral card from a county hospital would be too expensive. One young villager who visited a clinic in Maoxian, did so as this was run by a doctor who used to work at the Maoxian Chinese medicine hospital, which he

⁵⁴ Having metal worn on the skin was also considered therapeutic, I was told by an elder that the silver and golden bracelets that were commonly worn, apart from being decorative had the function of removing “wind wet” (*fengshi* 风湿), which can translate as rheumatism.

⁵⁵ I was not able to confirm this claim on expired medicines, but when it comes to the different problem of counterfeiting, there are reports of a third of biomedical pharmaceuticals dispensed in Chinese rural areas being counterfeit (Vedom and Cao, 2009).

would visit as a child. This doctor would collect and process the herbal medicines that he dispensed, but also prescribe biomedical pharmaceuticals. Another older villager, with chronic back pain, would visit the Maoxian Chinese medicine hospital every year for a period of two weeks to receive the treatment of a Qiang doctor, with daily sessions of acupuncture and cupping with bloodletting. She found that this reduced her pain in half and preferred this to taking “Western medicines”.

Most villagers, however, should they need a long trip to a hospital, they would prefer a quick fix, rather than having to return multiple times, and so privileged Western medicine hospitals over Chinese medicine ones. This hospital division was irrelevant for others, given that they were aware they could receive similar services in a Western, Chinese or Qiang medicine hospital, such as having antibiotics prescribed. Elders who had visited Qiang medicine hospitals equated Qiang medicine to Chinese medicine, and some of them were on biomedical chronic medication, such as antihypertensives.

An elderly couple in Yanwo remembered how there used to be only a narrow road in the village and no county hospital. The wife recalled that when they were seriously ill, they would need to call for a barefoot doctor, or ride a horse to find one. The barefoot doctor would come, do pulse examination, and dispense them either “Western medicines” or Chinese medicines. According to the A'er *shibi*, the lack of hospitals and skilful doctors before “liberation” meant that all patients would come to see his father. Only afterwards did a hospital open in Wenchuan town, and only later was there an orthopaedic hospital. Also, at that time, all the families that had later moved to the foothill were still living up in the mountain. He claimed that it was in the 1990s that locals started to opt for heading to the hospital instead of coming to him. He attributed this to many of those who lived down by the valley finding it easier to reach the hospital than coming up to him along their strenuous road, and to occasionally patients not finding the *shibi* at home, since in recent years they worked mostly on agriculture. However, many patients still preferred to see him or request him to see them, reputedly for the reason that thereby they would not need to be hospitalised, as “at home it goes more smoothly”, and for treatment and recovery being faster than in the hospital. He claimed that there were many other cases when after hospital treatments patients were still not recovered and so came to see him. The cases of the *shibi* referring patients to hospital would only happen

should the treatment be beyond his ability or should the patients be seriously injured, otherwise treating them was a matter of “medical ethics”.

The attitudes of the A'er villagers towards the *shibi* were mixed, and even the same villagers would express contradictory views towards him. This made me think of the changing position of the state towards shamans, with a total dismissal and shunning of their practices as superstitions for decades to only recently incorporating them in China's cultural industry. I felt that especially because of discussing these matters with a foreigner, some villagers were uncertain on how to position themselves. Some dismissed all *shibi* as being fake, cheating people and taking their money. One villager who claimed he only visited the Western medicine county hospital, called the Qiang hospital “fake”, and said he had never visited the present *shibi*. As we talked further, I learned that he had visited the *shibi*'s father about sixty years ago, when he fell as a child, describing the treatment he received with admiration and thankfulness. Another, who also claimed angrily that all *shibi* were fake, the week after, when showing me how to smoke his father's pipe, retorted: "the *shibi* smokes it, and so he is very intelligent, and very healthy. Look, he even went to Guangdong", referring to the *shibi*'s recent state sponsored ethnic performance trip. Other villagers visited the *shibi* exclusively when suffering some injury, while the one who claimed to have been attacked by a *poison cat* was the only villager I met that confessed to have been treated by the *shibi* for a demonic attack.

The attitudes towards the Yanwo *duangong* differed in that a few villagers did not even consider him as one. One lady mentioned that the last time they had a *duangong* in the village was forty years ago, while an elderly couple, puffing at how pointless they thought *duangong* are, said they had never had one. There was however an elderly villager who after having lost her son a few years prior, started having terrible headaches that would not shift. She went on to consult a *duangong* in a village nearby who wrote two pieces of paper for her to hang on each side of her door. Her headaches were reputedly gone for one and a half years. In Yanwo, the two instances I was told for which one should see the *duangong* was for an attack by a *poison cat*, and for cases of *dirty wind*, so that one's soul could be brought back. In the case of *dirty wind*, should the *duangong* not be able to improve the condition, one should then visit a hospital.

I found in A'er that when it came to local afflictions, there was not a monopoly of the *shibi* for their treatment. A villager told me how one could protect oneself from an attack by a *poison cat* when going up the mountain by carrying Sichuan peppercorn (*huajiao* 花椒 *Zanthoxylum*) inside one's pocket. Should one be at home and there be no electricity, throwing Sichuan peppercorn in the fire could offer protection as well. According to her, this was because of the Sichuan pepper's numbing effect (*ma* 麻) that could "counteract evil forces" (*bixie* 辟邪)⁵⁶. The same villager told me if someone had "fall and hurt" (the attack when the *grass demon* attaches itself to one's blood), one could simply throw some of one's own blood onto the fire upon returning home and there would be no further consequences.

When it came to religious practices in both villages, the most common one that would be performed in cases of illness was the offering of incense to *guanyin pusa* (观音菩萨), a bodhisattva associated to compassion (Yu and Chongxin, 2016). A semi-religious practice done frequently in Yanwo was that of fumigation by burning *zuma* from the local mountain. One villager described how it could be used for inviting *pusa*, which "comes to our presence and flies around". *Zuma* was commonly burned in a bowl which was then moved around the body, said to be particularly good for babies, in treating coughs, improving skin conditions, or just for daily use, as a healthy practice.

A fairly recent concept was that of *bupin* (补品), or "tonic", for "tonifying the body" (*bu renti* 补人体) which I was told did not translate well into Qiang language. Although everyone I spoke to had memories of their parents and grandparents preparing medicinal soups or broths that one would drink regularly, back then they did not refer to them in any particular way, and only in the past decades did they start using the term *bupin*. A great majority of the medicinal herbs collected, especially in Yanwo, were destined for sale, and collectors did not attribute to them particular medicinal properties, on the contrary, they used the blanket term of *bupin* to describe their purpose. It is possible that it was a term borrowed from buyers down south, and in more recent years popularised through TV and social media. In A'er, where I found a wider range of medicinal herbs

⁵⁶ A doctor in Fengyi who treated *poison cat* as superstition had offered a different explanation for this role of the Sichuan peppercorn. According to him, it was said to offer protection because of the thorns present in the Sichuan peppercorn plant.

kept at home, and so a wider variety of options for treating any particular minor condition, it was more common for certain herbs to be considered both of a particular medicinal value and a “tonic”. I also found definitions and properties of a particular medicinal herb varying according to the generation describing it. For example, although most villagers I spoke with both in Yanwo and A’er agreed that *wujiapi* (五加皮 *Acanthopanax gracilistylus* W. W. Smith) was used to treat diarrhoea, an elderly couple who was dismissive of the term “tonic”, claimed that diarrhoea was a self-limiting condition that did not require medicines, and that the use of *wujiapi* was instead suitable for help with joint pain. I also met a young villager who dismissed *wujiapi* as having no particular medicinal value at all, and that it was simply a “tonic”.

Among young people, there was the mention of other scientised ideas to justify the consumption of such herbs and fruits. At one point, my Yanwo host prepared sea-buckthorn juice at home, using fruits collected from nearby bushes. Her son referred to it not as a *bupin*, but while explaining that it was not a medicine, he stated that “it is very healthy, vitamins, to help prevent colds”. In a way, the use and definition of medicines (and supplements) in self-care seemed to vary along a relatively different exposure to both biomedical pharmaceuticals and Chinese proprietary medicines.

Livelihood

The deep pragmatism in the lives of the Yanwo people has been found to be tied to a great adaptability to different livelihoods through history, as described by Bian (2017). In parallel with agriculture, people in Yanwo have dedicated their lives, more or less sequentially, to “mining, opium cultivation, herb digging, hunting, logging and yak herding” (Bian, 2017, p.43). The latest shift in the previous two decades, was that towards tourism, linked to the government’s increased boost to a cultural industry of ethnic minorities. These shifts in livelihoods were not frictionless, due to changing relations with the state, in the form of taxes and changes in policy, to relations with neighbours, and to (at least previously) deeply heartfelt animistic notions and practices. From a “lazy tax” in the early days of the Republic imposed on those who refused to grow opium, to a tax on its production (which triggered armed resistance), to the turbulent years that accompanied the opium prosperity when Yanwo was routinely robbed by surrounding neighbours, to a later ban on opium cultivation in the early years

of the PRC (ibid.), these are a few cases of overwhelming shifts affecting the lives of the Yanwo villagers, and only related to one mode of subsistence.

Similar dramatic shifts happened in the state policies towards logging. In Yanwo, trees were considered social beings, and some sacred, the felling of which would bring misfortune to those who practiced it. The first felling of entire trees happened to supply firewood to the communal canteen, built during the fast and extreme collectivisation of the Great Leap Forward. The job of felling trees (some of them sacred) was passed to those descendants of “landlords or rich peasants”, who would bear the resulting misfortune, while still performing propitiation rituals in the attempt to protect themselves (Bian, 2017). In the decades that followed, logging proved very profitable, resulting in fast money when compared to cultivation. Households received timber quotas from the government for the classified collective forests, and villagers competed with each other in the logging rush. Since the late 1990s there has been a full logging ban, along policies to reforest the mountains, and under a language of environmentalism and conservation. Local foresters have been attributed with the task of enforcing the ban, but frequently have turned a blind eye. In the last years, the ban became stricter, which accompanied the growth of “ecological tourism” (ibid.). At the time of my fieldwork the well delimited small groves of sacred trees stood high above the village (see Figure 22).



Figure 22: Sacred trees on a hill above Yanwo

Occasionally some areas were allowed for collection of firewood for domestic use, but that ended the year previous to my arrival, with families having stored enough for three

years. The government's plan was for families to change all stoves and heaters to electric powered ones the following year. All the villagers that I spoke with considered it too expensive and were unsure how that change would pan out. Another thing to consider is the regular power cuts in both villages (and occasional water cuts in A'er)⁵⁷, which if continued could make the full shift to electrical power impractical. Announcements of changes in government incentives would happen sometimes when there were large gatherings, such as the temple festival, when the anniversary of the construction of the Yanwo temple was celebrated (Figures 23 and 24).



Figures 23 and 24: Yanwo temple festival

At the temple festival that I took part in, a middle-aged lady gathered a group of people to let them know, while reading from her phone, that the government was going to pay villagers a subsidy for each *mu*⁵⁸ of planted grassland. The objective was to reduce the heavy yak grazing in the mountains, which were leaving the hills bare. The villagers listened attentively with only one showing his displeasure at hearing the news. Later, a villager told me that the money was quite small, and that it would only pay off for people who owned young yaks or goats, who in this way would have a small convenient space near their homes where the animals could graze.

The relationship to one's environment was framed differently by the A'er shibi, who thought in terms of "respecting" (*jing* 敬):

⁵⁷ Broadband, however, worked perfectly in both villages, and at the temple festival in Yanwo one of the villagers went on a lengthy tirade on how he thought he was being ripped off by the broadband supplier.

⁵⁸ The equivalent to approximately 0.16 acres.

Because we are “passed from generation to generation” (...), every year when the autumn harvest is finished, with a good harvest, people slaughter sheep and cattle, they pray to show respect to Heaven and earth, to the “myriad things” (*wanwu* 万物) and live in harmony with the “myriad things”. They do this to protect the ecology, to respect the “myriad things”. Why respect the “myriad things”? Because they live off the mountains and rivers. When they live in the mountain, they respect the mountain god, when they rely on the river, they respect the water god, when they rely on the mountain forest, they protect the ecology and respect the tree god, (they respect) the “myriad of things”, when they raise chickens, they have the chicken god, when they herd sheep, they have the sheep god, when they raise cows they have the cow god, when they raise horses they have the horse god. They believe in the “myriad things”, live in harmony with the “myriad things”, everyone and everything complements each other, are inseparably interconnected (*xiangfu xiangcheng* 相辅相成), and protect the ecology.

The idea of “respecting” (*jing* 敬), while reportedly involving religious practices and a “respectful” attitude, did not exclude the sacrifice of the entity that was respected. From my experience, the “respect” itself was visible in ceremonial contexts, but not in others, for the one killing of the pig that I witnessed, in the attitude of the participants, was indistinguishable from other killings of the pig that I have witnessed elsewhere. I also imagine that the term “protecting the ecology” was a fairly recent addition to the *shibi*’s vocabulary, in line with recent state priorities in the area. When attempting to understand whether there was any sacredness imparted to medicinal herbs, in the same vein as that attributed to some trees, this was dismissed by not only the *shibi*, but by all villagers that I spoke with in both A’er and Yanwo. Their own complaint that the numbers of several kinds of medicinal herbs were decreasing on a yearly basis and could only be found higher and higher up on the hills was followed by an indifference and stark pragmatism that reflected the speed at which villagers turned to different resources available. In terms of the switch and choice between the collection of different medicinal herbs, this was something connected, at least in recent years, to the swings in their respective market prices (see Chapter Five). The collection of medicinal herbs by the *shibi* did have a sacred element, but an anthropocentric one. Upon arrival at the mountain and before collecting, he would offer incense to the “Medicine King” and ask for protection when walking among mountain cliffs: “We are serving the people, we are going to collect herbs. I hope I will meet you when I go East, and that I will meet you when I go West. Don’t let me end empty handed”.

The *shibi* related that before setting off to the mountain it was common for other people to offer their good wishes and their assistance. He would always refuse the latter since many of the medicines that he collected were to be kept secret and therefore he did not wish any company. The exception to this was his nephew whom he trained to recognise the medicinal herbs that he used, as well to assemble these for treatments. When trying to understand whether the mountain god could be offended by excessive collection, as it could be the case when it came to felling sacred trees, the *shibi* made it clear that it did not matter at all and that there was no connection between the mountain god and medicinal herbs: “medicines can’t help but be less and less, and it is normal for you to go from near to far”. This was an attitude that placed a noble connotation on the very act of collecting medicinal herbs, for the sake of treatment, and so did not seem to contemplate, or be concerned with, possibilities of commercial excesses or waste. Punishment and worship, although not linked with medicinal herbs, was associated with the “ecology” in general:

We can't live without water, so we worship the water god. The water is precious, and so we worship the water god. We believe in the “myriad things”. The Qiang people are quite harmonious with the “myriad things” and want to live in harmony. If you destroy the “myriad things”, destroy the ecology, they (“myriad things”) will punish you, with landslides and such, you know? This is the reason we worship the tree god.

The protection that trees offered from landslides was well recognised in Yanwo, and villagers would treat it as the reason for the 2008 earthquake not to have brought severe damage to the buildings nor casualties. However, older villagers claimed that the lack of destruction had been due to protection from the *pusa* instead. A’er differed from Yanwo very visibly on account of the impact of that same earthquake. Unlike in Yanwo, several villagers had died, and many of those living in Baijiaduo had moved down from their destroyed hillside village homes. Those ruins and rubble stood above Baijiaduo as a tragic reminder of a past life (see Figure 25).



Figure 25: Ruins of the destroyed village above Baijiaduo

According to villagers who grew up in them, those houses had been built two centuries prior. That land was still used for cultivation, and Baijiaduo villagers would climb up and down on a daily basis to tend to and collect vegetables. In Yanwo, at the time of my fieldwork, people divided their time between agriculture, yak herding, and digging medicinal herbs and fungi, with caterpillar fungus (*Cordyceps sinensis* (BerK.) Sacc., *dongchong xiaocao* 冬虫夏草) being the most profitable. The Songping valley, where Yanwo is located, was well-known in Fengyi town for its diversity in medicinal herbs. There were no restrictions on its collection, and the only problem were occasional conflicts with villagers from surrounding areas who would come to collect, which was against customary law. There were a few ways in which locals dealt with the issue, sometimes calling the “trespassers” out and instructing them to move away, and occasionally charging them a fee, or collecting one tenth of what medicinal herbs they had.

The botanic diversity also attracted several enterprises for the cultivation of medicinal herbs in the area. All but one had failed, and the *Fritillaria* (*beimu* 贝母) base that was running had changed managerial hands many times, something that locals resented (see Chapter Four). Tourism had kicked off with a sizeable guesthouse, run by local Yanwo villagers, but built and owned by a company based on a touristic area near Chengdu.

Thanks to the guesthouse, other locals were also making extra money, taking tourists on horse trips to the surrounding hills. Drinking *zhajiu* (炸酒)⁵⁹ from a large pot through long straws, by two or more people standing around it, was an activity that I saw only in Yanwo, and performed especially to coincide with the arrival of a big tourist group. In this occasion, there were lengthy prayers recited in Qiang language before the drinking, and then singing and dancing afterwards. Along with developing tourism, the Yanwo villagers developed the idea that they had the “most authentic Qiang minority culture” (Bian, 2017, p.221), while not making claims when it came to any “Qiang medicine”.

At the Yanwo government culture office there were a few photos on exhibit, mostly of village festivities, but with one that is very telling of the fraternal relationship envisioned by the Chinese government of the Han and Qiang ethnicities. That was of a large statue on a Henan province hilltop of Emperor Yan (*yandi* 炎帝) and Emperor Huang (*huangdi* 皇帝), in China widely taken as brothers and respective ancestors of the Han and the Qiang (see Figure 26).

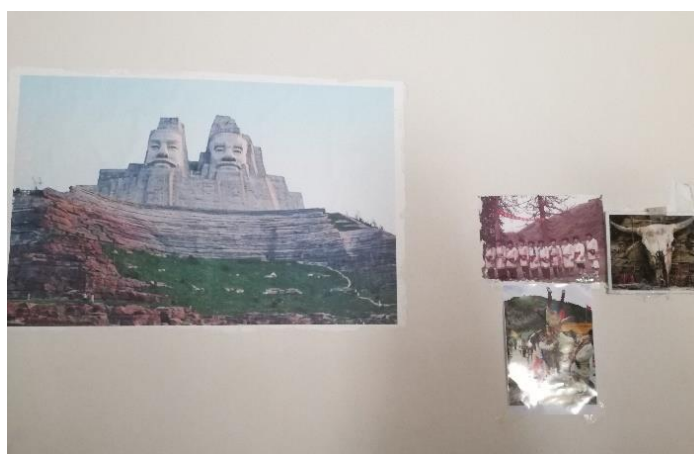


Figure 26: Emperor Yan (on the left) and Emperor Huang at the Yanwo culture office

In A'er, the government presence was more visible, with numerous PRC flags, and some of the Communist Party as well, flapping with the wind, tied to posts dangling on the roof of each house. The locals told me that they were brought by the workers building the new road, and that after the roadworks were complete the flags were likely to stay. The prolonged roadworks also meant that in the winter would be the first time ever without communal Qiang new year celebrations, since it would not be practical for

⁵⁹ A strong alcoholic drink made of wheat or highland barley.

all the visitors to get to A'er. Therefore, each family would celebrate at home instead. At the bottom of Baijiaduo, by the roadworks, another construction was taking place, one that produced banging and drilling noises through every waking hour. Such construction was for the future guesthouse, which just like Yanwo's was being built by outsider investors and destined to accommodate tourists coming to A'er. The plans for the changes coming to the village were well displayed further up the road, near the *shibi*'s home, and spelled a complete make-over for the village, with shops, outlets, and Starbucks included (see Figure 27). Locals told me that this was a mere possible design, that those works in particular could start the following year and it was not certain which stores would be opening there.



Figure 27: Plans for A'er

Most of the A'er villagers dedicated their time to agriculture, and herding cows. Some were working in the guesthouse construction, and many were employed by the army and drafted elsewhere in China (one had frequent placements in Russia), visiting the village occasionally. It was especially during these visits that conversations would get considerably heated, alcohol-fuelled, and very nationalistic in nature. There were many patriotic outbursts, and in one particular evening constant and effusive praise for the “reform and opening-up” (*gaige kaifang* 改革开放) policy:

It is all thanks to Deng Xiaoping and Xi Jinping, who attracted investment and allowed communication and exchange with other countries. And if it wasn't for that

then you couldn't be here. It is thanks to them that there is “harmonious society” (*hexie shehui* 和谐社会).

Seemingly, the army jobs, together with the financial support for reconstruction of homes after the earthquake provided enough “harmony” for some to eclipse that of the “myriad things”. Almost none of the houses built after the earthquake had white stones placed on the corners of their roofs (as the old ones had before), something that the *shibi*'s son attributed to a “lack of faith” (*xinnian queshi* 信念缺失). My host, the son, who had built his house down in the valley after the earthquake wrecked the one he had grown up in, did not include any white stone on his roof. He told me that some people still did it, to “respect the mountain god”, and in the hope that it would bring them protection. When asked why he did not do the same his answer was simple: “I don't believe it”. The reason to have white stones placed on the four corners of a roof was given in an evolutionist manner by the *shibi*:

The white stone comes from primitive society, said to have been brought down from the sky, it's from primitive evolution.

Human beings originally ate raw meat and had no fire. At last, by rubbing the white stone they made fire. Then we began to eat cooked food. The oldest “ape man” (*yuanren* 猿人) of the Qiang nationality then worshipped the white stone. He said it was a kind of god. Why does he worship it on the roof of the home? Because he worships it as a god. The white stone is called the white stone god. The white stone has a kind of auspiciousness for the Qiang nationality, it has the meaning that everything will go smoothly (*baishi baishun* 百事百顺). I will do a hundred things, and all will go well. So, it is worshipped in this way, you know? That's why it's been continuously worshipped for thousands of years.

(...) Originally, before the earthquake, on the old homes, every household had it. In the earthquake reconstruction, some people built it and others did not. The Qiang people have rules. They usually build it on the third floor, you know? When Qiang people build houses, the first floor is for cattle, sheep and livestock. Pigs, cows, horses, chickens, sheep, and so on, they are closed there. The second floor is for people to live in. The third floor is for the harvested crops, for the grains. The white stones go on the top. It's like the Jade Emperor (*yuhuang dadi* 玉皇大帝)⁶⁰ in heaven being given tribute. It is the head of the family. The other thing is to keep the people safe, you know? Every year on the first day of the 10th month in the Qiang year, you have to respect it. You can only kill white chickens, white sheep, none of other colours, those are not allowed. All must be white.

⁶⁰ An important Daoist deity, referred to as the most important one for the Qiang by my host in Yanwo, who kept several Daoist books at home.

Before the Cultural Revolution reached A'er, societal "harmony" was established differently, customary law had a heavier weight. According to the *shibi*, rules and regulations were formulated over time and accepted by each household in front of the gods at the "town god's temple", which were present in all the villages around. These rules covered "the protection of women and children, safety, the safeguarding against the violation of all village rules, and against telling the village secrets to outsiders". Those accused of any crime who refused to admit their guilt would have to go and swear their innocence at the "town god's temple", "shouting it to heaven and earth", the tragic consequences to one's life for lying to the gods were deterrent enough for one to abstain from doing so, a very effective method, as the *shibi* saw it. Although the "town god's temple" was destroyed during the Cultural Revolution, the "foundations and the gods are still there" at its original location, and he claimed rituals were still performed at the location. One villager told me how he still remembered seeing and hearing people shouting, swearing their innocence at the Baijiaduo "town god's temple" a few decades prior. Another related how all the three temples in Baijiaduo were destroyed during the Cultural Revolution, both by locals and outsiders, "because they didn't believe in ghosts, and were against feudal society", he spoke of those times as extremely arduous, when there was just "no food to eat".

"What are we?"

Having given an overview of the changes to the livelihoods of villagers in Yanwo and A'er, I will now focus on how the self-definition of being a "Qiang" is performed in these settings. In this way, I will show the tentative efforts of villagers to articulate ethnicity and argue that the expression of Qiangness is one that, to a large degree, is enacted to meet an outside-generated categorisation. Again, articulating "Qiang medicine" is absent in such efforts.

In "Economies of ethnicity", Eriksen (2005) distinguishes between "ethnic *identity*" which he connects to a "sense of belonging" and defines as a contributor to ethnic cohesion, and "ethnic *organisation*", relating it to "the mundane interests of its members (or at least its leadership)". In a place such as China, with rapid social transformations, and with ethnic labelling being an instrument of the state as much as of the ethnic minorities themselves, "identity" and "organisation" can become too blurred

to tease apart. It can be on occasions when a definition or a categorisation is asked, that that which is many-sided and nameless struggles to come into a unified verbal expression. This, in a way, may require one to stand from some foreign viewpoint in order to attempt it.

It was after dinner in Yanwo, in a friendly and homely chat between some tourists and the locals running the guesthouse that the topic of local religion came about, two brothers wrestled with a definition to no avail. Both with little certainty, one hinted “we are Buddhist... or Daoist”, while the other wondered, before reticently disagreeing: “what are we...? We are *wanwu*”, referring to animism. Bian (2017) described the Yanwo community as having an animistic cosmology tied to an open religion that incorporates various elements from several religious or value backgrounds. It is this *mélange* of elements that makes it difficult for one to produce an articulation, that which might seem necessary, if one is to take ethnicity as a “cultural resource” in a tourism marketplace. Articulating ethnicity visually might be easier than in the form of explanations, even if still not fully natural. At home in Yanwo it was common to hear jokes and subsequent joint laughter when a girl would dress up with a very elaborate dress and accessories to receive a big group of tourists in the guesthouse: “Are you having your wedding today?”

Without (at least immediate) stakes in the promotion of a “Qiang medicine” industry, and without a sign of attributing ethnic significance to their healing practices (save for the one instance by the *shibi*), the two villages gave me a glimpse of daily instances of health and illness, practices of self-care, and the navigation of therapeutic and healing options for the resolution of local afflictions and general diseases. For those who recognised the former, these seemed to coexist with diseases without explanatory conflict, and villagers saw a role for not only self-care, but also local practitioners and hospitals in their treatment.

The overwhelming preference for hospitals rather than clinics in these two villages contrasted with the presence of Qiang and Tibetan people who would travel far from rural areas to see Dr Jiang and his father in their Fengyi clinic. None of the doctors working at the Fengyi clinics reported having had patients complaining of the local

afflictions described in Yanwo and A'er⁶¹, save for one single case reported by Dr Yuan. He spoke of the attack by *poison cat* as a “disease of redness and swelling” (*hongzhongbing* 红肿病), easily solved by one of the medicinal herbs commonly designated as “*poison cat herb*”. According to him, the legend of the *poison cat* said that every village should have a *poison cat*, that otherwise the village water would be poisonous. He claimed that some people in Qiang villages had mastered this treatment through the years and used it, wrongly, as a way to achieve “the highly centralised system of the tribe”. In what he saw as pure manipulation, he accused them of making use of the “things of our natural sciences to control people”. Dr Yuan added: “us modern people should look at this problem scientifically”.

However, the A'er lady that reported having been attacked by *poison cat* claimed she could identify the “*poison cat herb*” herself, but that the treatment still required the intervention of the *shibi*. Such treatments described in this chapter were spoken of as local solutions for local problems. These local afflictions were never treated as something that was specific to Qiang people, only specific to location, present in the landscape. There is something to be said regarding location. While Dr Yuan described Qiang doctors in bucolic terms, as “nature-centred”, contrasting them with the sitting doctors of the clinics, and claiming medicine to be a product of the “living environment”, he clearly saw *poison cat* and *shibi* as a product of deception instead. In this, he did not admit *shibi* to be doctors. Furthermore, he claimed “nature” to be inherent to the domain of the “natural sciences”, which would then simply be manipulated by some for ulterior motives. Such dynamics can be understood as the “nature-centred” against the “nature-manipulator”.

In what seemed an effort to deny such image, the way and the language used by the *shibi* to position himself as a legitimate practitioner, rather than articulate an ethnic medicine, appeared to have been repeated through the years. Indeed, these were identical to our conversation two years prior, as he spoke of his medical ethics, of evolution, and the *white stones* dating back to the “ape man”. He talked of these matters

⁶¹ One of the doctors referred to people who would think in such manner as “ideologically backward people”. Another explained the symptoms attributed to *dirty wind* in the villages, as dizziness caused either by a lack of physical fitness and *qi* (in this case avoided by gradual acclimatisation), or by high blood pressure.

while Mao Zedong looked down on us from a poster on his living room wall. Why were we discussing the “ape man” in a shaman’s home, in the mountains up in the middle of Aba, when Dr Zhang had refuted its existence in a packed medical conference in the large auditorium of a hotel in Chengdu?

The turbulent times of Cultural Revolution had left behind more than destroyed temples, but a semi-domesticated explanatory mindset of how the world and society worked. Semi because the gods were alive and well, for those who respected them, but a materialist tone pervaded even the *shibi*’s explanation of how electricity and family planning had induced a reduction in cases of attack by *poison cat*. Although part of the cultural industry, by means of his performances over the country, the *shibi* was not actively involved in the promotion of an ethnic Qiang industry, he was rather occasionally employed in it. And in that he might have missed the recent turn on harnessing certain (now) acceptable elements that merely gave an exotic spin to a deeply rooted in Chinese medicine (as well as biomedicine) articulation of Qiang medicine. That was a Qiang medicine that dismissed completely his contribution as well as the local afflictions he dealt with.

Although A’er villagers had conflicting views regarding the *shibi*, they seemed to pay more attention to his individual achievement of travelling the country, rather than to any particular group representation that could be derived from it. These dancing shows might also be a contributing factor for Qiang doctors to want to distance themselves from *shibi*, keeping their medically entertaining performances to conference stages and their participating volunteers. Individual achievements and entrepreneurship in Yanwo and A’er were highly valued and life there revolved around the different livelihoods and prospects available to bring prosperity to one’s family, while running parallel to immediate considerations on dealing with disease and affliction. The past decade since the tragic earthquake had shaken some of the belief and hope of many, and to an extent pushed the pragmatism and adaptability these communities had lived by even further.

In Yanwo, elder villagers spoke of bigger freedom than when compared with the days of feudal society, of the development brought by the Han, among which writing was seen by one elder as the most valuable. In turn, younger villagers were more focused on attuning to business opportunities. There was a recognised ethnic interdependence that

catered for Han needs through tourism, sale of yak meat, and medicinal herb collection, barely using any of the latter at home and predominantly selling. Activities themselves were interrelated, as my host told me of how the guesthouse business opportunity arose from connections that he had with yak meat buyers near Chengdu. Therefore, ideas of disruption of community networks need to be contended not only with the historical adaptability of these communities, but with an interdependence that has been running at least since the late Qing dynasty, with the collection of medicinal herbs in Yanwo for barter and sale at markets (Bian, 2017). However, relations with corporate entities in Yanwo were by no means frictionless, both with the guesthouse owner company, and towards the *Fritillaria* cultivation base.

Nevertheless, I did not find any traces of political dissent in both villages. Even the mentions of the hard times of the Cultural Revolution were in the context of a country and government that had surpassed its dark times and faced a prosperous road ahead. The visibility given to the Qiang, especially post-earthquake, had been a platform for inclusion in larger markets and networks, with the Han as main customers, and from where to attempt at strategically achieve one's goal of prosperity. Young people also did not demonstrate any interest in politics, and their focus was completely on how to get ahead, while navigating a system seen as filled with opportunities, and so with little reason to contest. There was, therefore, a quiet resilience, by which villagers made use of these changes and opportunities to prosper.

Ethnicity became something to trade in. Turning oneself into a touristic artefact was something that one would just get on with, laughing it off along the way. Discussions of ethnicity brought the topic to action and livelihoods, equating "what we are" to "what we do": "we raise yaks", "we collect herbs", "we now take in tourists", "we organise the festival in the temple", etc. This is a localised approach to ethnicity that points right at the Qiang autonym *Rma*, "we", and that is not concerned with the Qiang at large, amidst all their diversity; in language, religion, and livelihoods, often with disputed claims such as on the "right way" to make a particular dish. Competing claims from the two villages of being the "real" or the "authentic" Qiang ran parallel with a continued state effort of unification, one that especially when it came to a Qiang medicine was thoroughly ignored in these rural areas.

Chapter 4. The contested ethnicity of Qiang medicines

After having discussed the articulation of Qiang medicine as well as its absence in the previous chapters, in this chapter I will move on to a different articulation, that of Qiang medicines. In doing so, I will steer away from the attributions of Qiang ethnicity to humans to the one directed at non-humans, by focusing on a disputed materialisation of ethnicity in marketable products.

It was at a national forum of the China Medical Association of Minorities (CMAM) in Chengdu that I witnessed first-hand the (collaborative) race among ethnic minorities for the production of proprietary medicines. This was the “6th National Ethnic Medicine Inheritance and Innovation Development Forum” and the theme was the pervasive “One Belt One Road” (*yidai yilu* 一帶一路) initiative⁶². Han as well as ethnic minority doctors and academics took the stage to showcase their achievements on the research and development of different medicinal products. Mongol, Yi, Dai and Qiang medicine came into focus. A few spoke of the theory behind their “system of ethnic medicine”, the Mongols boasted of the “dialectical and logic thinking methods” in their “medical system”, others tried to sum up the current challenges (such as lack of funding) and opportunities for development. However, the majority of the speakers developed at length on biomedical aetiology and pathology, compound prescriptions, the extraction of active ingredients, Crohn’s disease and interferons, the use of HPLC (High Performance Liquid Chromatography), MS (Mass Spectrometry), and PCR (Polymerase Chain Reaction) in their research, as well as the large investments secured thus far. In the spirit of “One Belt One Road” their gaze was also fixed abroad, with partnerships

⁶² The “One Belt One Road” or the “Belt Road” initiative refers to China’s grand strategy on foreign policy and trade put forth in 2012 (Callahan, 2016) with the first policies associated to the concept appearing in 2015 (Aoyama, 2016). This strategy has been described on one hand as the means of “promoting China’s new vision of global governance” (Callahan, 2016). On the other, it has been taken as merely a new name for the solidification of international cooperation efforts that have run since the 1990s (Aoyama, 2016). The initiative has a particular focus on relations with the rest of Asia, Europe, Middle East and Pacific Islands while still pushing for a global influence with the international community.

being developed with Southeast Asian countries such as Thailand, Vietnam, Laos, and Cambodia.

Most of the ethnic medicines at the CMAM conference were displayed as, or on course to become, proprietary medicines and presented as “the result of development”. However, at the time there were still no Qiang medicines that had achieved the “national medicine registration number” (*guoyao zhunzi hao* 国药准字号), meaning that they could not be sold nationwide. This was a “delay in development” due to missed opportunities in the 1980s and 1990s, according to Dr Zhang (see Chapter Five). Therefore, in a market without a literal “ethnic label” on the packaging of compound proprietary medicines, Qiang ethnicity was mobilised mostly for raw materials, in processing, marketing, and in a wider relational aspect between Qiang people and medicines at the point of use.

In order to understand what made a medicine Qiang, I approached the subject with a variety of people, from villagers and doctors, to corporate staff and university researchers. What developed was a discussion of a variety of contested ethnic markers, with little agreement on which should stand as the defining feature of Qiang medicines. There was also a spectrum running between a far-reaching inclusiveness to a narrow specificity of what constituted Qiang medicines. I argue that this variability is characteristic of an aspirational setup for the creation of a pharmaceutical sector, with varying articulations situated along different stakes on a prospective ethnic pharmaceutical industry, even with the ethnic label being used sometimes indiscriminatorily, for marketing purposes, while viewing them privately as strictly ethnicity-free botanical products.

What I will present in the following section is merely a heuristic device that helps to organise the different ways in which the ethnicity of Qiang medicines was spoken of as well as contested. As with the articulation of a “Qiang medicine”, I treat “Qiang medicines”, both plants and preparations, as constructed artefacts rather than things-in-themselves. They, too, are articulated by virtue of drawing from a particular socio-political environment in a multitude of ways. Apart from general ethnic label attributions, there were two specific cases where, respectively, a species and a variety

were allocated the ethnic Qiang label by some. The first case was *qianghuo* (羌活 *Notopterygium incisum* K.C.Ting ex H.T.Chang), the name of which has been used for at least 2000 years, and the second to *wabu beimu* (瓦布贝母 *Fritillaria unibracteata* var. *wabuensis* (S.Y.Tang & S.C.Yueh) Z.D.Liu, Shu Wang & S.C.Chen). In the case of the latter, this was given the name *qiang beimu* (羌贝母) by a pharmaceutical company in the two years prior to my interview with their representative. The variety itself had already been “discovered” over thirty years before. These two cases of ethnic label attribution raised several issues, which I will explore in their respective two sections. These sections will not attempt to form an ethnobotanical treatise, but rather show how among several features, morphological ones are drawn to assert or deny the Qiang ethnicity of medicines, and in this way articulate or refute articulations of Qiang medicines.

Four domains of articulation

Those who elaborated on Qiang medicines articulated these under one or more of the following three domains of activity. The first was through contact with Qiang people, in collection or by being passed on from one’s ancestors. The second was in the processing (*paozhi* 炮制) and transmission of secret formulas (*mifang* 秘方). Finally, the third was in a particular therapeutic usage, described as a “cultural” usage by Dr Zhang.

A fourth domain that was often, but not always, disconnected from human activity of the Qiang, was the place of origin. This was particularly relevant when describing cultivated medicines, using the label of “authentic” (*daodi* 道地, occasionally *didao* 地道), or “authentic Qiang medicine” (*daodi qiangyao* 道地羌药), which would be associated simply with factors such as soil and climate of a Qiang region, or at times to a history of usage in the area. Finally, there was also an outright denial by some interlocutors of such a thing as a Qiang ethnicity of medicines, while others subordinated it to the category of Chinese medicines.

Contact

From the four domains that I mentioned, the first covered Qiang medicines as those that were collected by Qiang people, or shown how to collect by one's Qiang ancestors, with one interlocutor mentioning particular harvesting times specific to different ethnicities.

Processing

The second domain was concerned with processing, which for some meant that by employing a certain “Qiang processing” even medicinal materials from distant places could be turned into “Qiang medicines”. This “Qiang processing” was described by Dr Zhang as involving religious elements. In contrast, Dr Yu in Yanwo village described it simply as a better one than that used by the Han, since it involved a singled stage of extraction, instead of two, which meant that the medicine would be “better and more concentrated”. This was a method dismissed by Dr Yuan, at the museum clinic, as he claimed that very few people knew how to do “real *paozhi*”. Apart from dismissing the method, he dismissed such way of attributing Qiang ethnicity to medicines. According to him, the reason *paozhi* was irrelevant in defining a medicine as Qiang was anchored in the past:

As for processing, under very special circumstances it (medicines) can be processed... (But) A Qiang doctor couldn't carry the processed medicines with him. If you carry it with you, your tribe will need a lot of means to carry it (...). This is unrealistic. In the past, there was no transport or communication. You couldn't just take some animals, such as cattle and horses, to help you carry the medicines. So how did he treat disease? He used medicines that would grow in the local area. His greatest advantage is that he can replace medicines (the medicines he needs according to what he has available).

Others spoke of different processing methods as altering not only the efficacy of a medicine but also their indication and even toxicity. Dr Chen spoke of different processing methods among the Qiang when it came to handling the toxicity of aconite⁶³, arsenic and that of mercury. Regarding the latter, he mentioned how Tibetans used a method that involved reciting religious scriptures while preparing it⁶⁴, something he dismissed while equating it to the methods of *shibi*. Mercury was used rarely although more often in Qiang medicines than in Chinese medicines, according to Dr Chen. Dr

⁶³ See van der Valk, 2019, for a discussion on aconite detoxification and formulation in Tibetan medicine.

⁶⁴ See Gerke, 2013, for the ritual and material aspects of mercury processing in Tibetan pharmacies.

Jiang, although referring to Chinese medicine as a generic term, used the scale of processing as a distinction between Chinese and Qiang medicines, the first being “dug for money, sent to the pharmaceutical factory in large quantities”, while when it came to Qiang medicines, these existed in “small quantities, with low productivity”, often from a “secret formula”. However, he still saw, in a favorable manner, Qiang medicines as slowly entering a stage of large-scale production.

Usage

The third domain covered usage as a determinant for Qiang medicines, and interlocutors predominantly used an anthropocentric language of “attitude towards medicines” or “understanding of medicines”. This was often done together with an evolutionist take on “a long-term process of trial and error realising the properties of a medicine, its benefits to the body” or “feeling one’s way through accumulated clinical experience”. Such a take was supported by a university researcher’s approach to efficacy as matter of fact, referring to Qiang people as not concerned with how a medicine worked, only with the fact that it worked, and thereby having persisted using it through time.

The different “attitude towards medicines” between the Qiang and the Han was explained by Dr Yu in Yanwo as Qiang people being more single-minded (*zhuanyi* 专一), and therefore treating an illness directly for its symptom, usually using a single medicine, while the Han would have more complex solutions. I was curious whether this “single-mindedness” could be also a target of the accusation commonly made to Western medicine, under the Chinese mantra: “Chinese medicine treats the root, Western medicine treats ramifications (*zhongyi zhi ben, xiyi zhi biao* 中医治本, 西医治标)” (Scheid, 2002). This was a possibility that he outright rejected, stating that Qiang medicines were still much better than “Western medicines”, for although they took longer to treat an illness, they still treated its root, not the ramification, due to its “thousand years of experience”.

Such simplicity was, according to Dr Yuan at the museum clinic, due to the fact that in the past, Qiang doctors were not dispensing formulations or compound drugs. In his view, they were dispensing mainly single drugs instead, which would be used in

succession, treating different symptoms that would appear along the course of an illness. As Dr Yuan saw it, several of these therapies were later used by Chinese medicine and for some of the proprietary medicines that circulated in the market. In this way he, again, attributed to the Qiang the ancestry, through practice and not theory, of the therapeutic aspects of Chinese medicine.

Dr Zhang referred to this usage of medicines as deeply “cultural” and therefore inseparable from Qiang culture, for “Qiang culture is a deep vein that runs between Qiang people and Qiang medicines.” This “cultural specificity” implied different forms of administration. It also determined that some medicines considered valuable in Qiang medicine were deemed useless in Chinese medicine, or only partially useful in the conditions that they treated. It was this specificity that made water one of the most important medicines among the Qiang, according to him.

In regard to the categorisation of medicines, only Dr Zhang and Dr Deng at the orthopaedics clinic referred to this being done differently in Qiang medicine, in which there was an extra “flavour” to the “five flavours” (*wuwei* 五味) of Chinese medicine (Unschuld, 2016). The extra flavour was “numbing” (*ma* 麻), added to “bitter, sour, sweet, salty, and acrid”. Dr Zhang also referred to the addition of fire and ice to the four thermo-influences described in Chinese medicines: “cold, cool, warm and hot” (Unschuld, 1986). There were also two extra properties that Qiang medicine attributed to medicines: “removing the ice” and “breaking the water”.

Instead of thinking in terms of properties, Dr Chen, of the medical society, on the other hand, pointed towards different contraindications and incompatibilities between medicines when he prescribed Qiang medicines, compared to Chinese medicines. This position would support Dr Zhang’s view of Qiang medicines needing to be used under a Qiang medicine theory, albeit contradictorily, given his stance on an all-pervading “Qiang culture” determining their use. Two academics were also of the opinion that the theoretical background on which one stood (whether this was Qiang medicine theory, Yi medicine theory, etc.) for the use of a particular medicine determined its ethnicity in the particular instance of therapeutic use.

Place of origin

Regarding the domain of location, although two academics and a hospital director referred to the Qiang ethnicity of medicines as contingent on being collected and used in Qiang areas, as opposed to Han areas, in general, the idea of a medicine being an “authentic Qiang medicine” by virtue of location, was widely disputed. Dr Zhang made a distinction between “local” (*dangdi* 当地), meaning “a medicine that grew locally”, and “authentic” (*daodi* 道地) which stood for “a medicine characteristic of a location”. He gave the example of *jiaotianma* (角天麻 *Dobinea delavayi* (Baillon) Baillon)⁶⁵ as being *daodi*, or “authentic”, with similar indications to that of *tianma* (天麻 *Gastrodia elata* Bl.), on helping with dizziness and blurred vision. The two correspond to different species, with *jiaotianma* in China taken to fall under one of the four categories of fake or counterfeit *tianma* (Yang et al., 2017).

For Dr Zhang, the authenticity that he claimed was historically documented, since he took all the medicines described in the “Divine Farmer’s Materia Medica Classic” as being from Qiang areas and growing in the mountains of the region. According to him, even if these days one could also find these medicines down by the foothills, they were different in nature, given the different altitude at which they grew, making the ones growing in Qiang areas “ethnic medicines”. Others in academia and in industry attributed the label of *daodi* to “high quality” and “best efficacy”. They insisted that although certain medicinal materials could be seen growing in other places, these had grown originally in a specific place. Therefore, medicines originating from such location would have the best efficacy in comparison. Springer (2015) found that among Sichuan collectors and traders, of Han and Tibetan ethnicities, common denominations were used that employed the prefix *chuan* (川), of Sichuan, standing for the region, rather than making any mention of ethnicity when communicating with each other. Among my interlocutors, collectors would not only disregard ethnicity in such denominations, but also the notion of *daodi*, while still acknowledging that the medicines growing locally, and wild, were better than those elsewhere. On the other hand, academics and doctors would mention these often, and would frequently instrumentalise such labels. Teacher Ling elaborated:

⁶⁵ *Jiaotianma* does not feature in the Chinese Pharmacopoeia and so I have used the Latin denomination of Wu and Raven, 2008 and present in Yang et al., 2017.

It's like *chuanxiong* (川芎 *Ligusticum chuanxiong* Hort.) in Dujiangyan, the quality of *chuanxiong* growing out of the soil in Dujiangyan is the best. This is authentic medicinal material, that is to say, it has a long history, the quality of its medicinal materials is good. (...) our “red soil environment”, this soil, this water, this climate cannot be replicated (...), the altitude, latitude, longitude and so on, all is unreplaceable natural environment. Because only in this soil does it grow best. This is the authenticity of history. *Di* (地) refers to this place, *dao* (道), was an administrative division in the Tang Dynasty, just like there is “province” now. (...) that is how these two characters got combined to form *daodi*.⁶⁶

So nowadays, authenticity represents good quality, that the variety is the correct one, it tells “this is the authentic medicinal material and you do not need to doubt it”, its efficacy is absolutely the best, it is a synonym for “high quality and good efficacy” (*zhiyou xiaojia* 质优效佳), that is what it means.

Then one who says “authentic Qiang medicine”, it must be of their Qiang nationality, in their history, maybe in a process of inheritance of Qiang medicine, they really used it locally (...).

Daodi was often treated as a seal of quality by those in the academia and the industry, a mark of “honesty” and trust. This was presented as the product of a highly specific combination of soil elements, sunshine, water, and ecological environment that had proved through history, often together with local processing methods to result in a medicine of outstanding quality. Transplanting this species elsewhere would, according to some, always result in a loss of quality.

While some detached the plant material from human action and took *daodi* as exclusively a mark of quality, not of ethnicity, other institutional interlocutors spoke of medicines produced and used exclusively by Qiang people as being “special medicines of Qiang medicine” and “authentic medicines of Qiang nationality”. These were medicines that could make their way to the Chinese pharmacopeia in the future, once they had the appropriate standards. According to this view, this nomenclature could not, however, be applied to the majority of medicines which had an overlap in that they were used by dozens of ethnic minorities. There was also a concern by some of a possible abuse of this “seal of quality”, with an academic interlocutor asking for a more meticulous criteria to evaluate this “authenticity”.

⁶⁶ For a take on the conceptual history of *daodi* medicinal materials see Zhao et al, 2012.

Refutation

The discussions of ethnic authenticity and location were starkly disregarded by Dr Yuan, at the museum's clinic. He called it a superficial understanding of these matters, stating that "real Qiang medicine can be produced anywhere", "the main origin is its use". Placing practitioners and lay Qiang people at the centre of the argument, he declared confidently: "Qiang medicines are called Qiang medicines when Qiang medicine uses it." This outright denial, or at least undifferentiation of the ethnicity of raw materials was shared by many. One interlocutor, working in the pharmaceutical industry, insisted on how the theories of Chinese, Qiang and Tibetan medicine were all very close to each other, and all medicines could be said to be Chinese medicines. With a very pragmatic attitude, and seeing medicines strictly as industrial products, for him, an overall denomination was justifiable by the fact that in the end "it's all plant medicines, there's no difference."

An academic involved in a project for the standardisation of Qiang medicine, probably referring to the Chinese medicine law of 2016 (People's Republic of China Twelfth National People's Congress, 2016), invoked a "rule" that stated that, according to him, all medicines in the country, Chinese or of minorities, were to be called Chinese medicines. Since many medicines were composed by mixtures of raw materials produced by different nationalities, in his view this simply reinforced the idea that Qiang, Chinese or Tibetan medicinal materials were all the same. It was only different theories in their use that could bring any posterior differentiation.

In the two villages, with the lack of such theories, although people always referred to the medicinal herbs growing in the surrounding mountains simply as "medicines", the question of whether these were Chinese or Qiang would either not make sense or be replied with "Chinese", or "all the same". In A'er, my host, the son, who would sell medicinal herbs to buyers in the town, would just refer to the nearby growing medicinal herbs as "medicines", making the distinction sometimes between "the medicines used in Chinese medicine" and "the medicines that we use (locally)", while commonly placing them under both categories. In contrast, when approaching the subject with Dr Yu in Yanwo I realised that he saw the ethnicity of medicines as something changing along the route of collection, processing, and preparation. He took all raw medicinal materials to be Chinese medicines, later becoming Qiang medicines after his initial processing.

However, should the medicines that he sold end up in the hospital in Fengyi, they would be prepared according to Chinese medicine prescriptions and so become Chinese medicines again before being administered to patients. His wife confirmed that they called it Chinese medicines there in the hospital, and so argued that perhaps they were “Chinese Qiang medicines” (*zhongqiangyao* 中羌药). I later realised, through contradictory accounts from a pharmacist and a hospital director, that the supply of medicinal herbs to the Maoxian Chinese medicine hospital pharmacy was shrouded in mystery, amidst regulations and standards (see the following chapter).

If the ethnicity of Qiang medicines was involved in multiple disputes by different parties, in the thick of conflicting descriptions, there was one occasion when I witnessed a medicinal liquor being articulated as Qiang medicine in a totally different and proactive way. At a late 2018 meeting of the CMAM, when the professional committee of Qiang and Yi medicine was first established, one of the items in a goody bag distributed to each participant was a bottle of medicinal liquor. Later in a speech, a Han doctor who lived most of his life in a Qiang area where he directed a large hospital, announced how the medicinal liquor that everyone held had been produced. According to him, it had been the result of a large survey of “all the centenarians living in Qiang areas”. This hospital’s research had aimed to find out the reason for their longevity, and so investigated the medicines they took, the liquors they drank, and the food they ate. These were all fused together and sorted, removing “certain toxic substances” that they identified, and assuring its safety, to finally produce *qianghong* (羌弘 literally “Qiang magnificent”) liquor, to “regulate immune function and benefit mankind”.

It seemed clear that the discussion of ethnicity became a lot more straightforward when there were products marketed under an ethnic label and the process to achieve such products could be demonstrated, such as in this case, by unequivocally encapsulating “ethnicity” in a bottle for the audience to witness. In such circles, attributing ethnicity to raw materials was rarely embraced and it was rather placed on the result of manufacturing and industrial processes, associating it with “progress” and “development”. I argue that this was a way of avoiding claims of ownership towards raw materials and of limiting it to registered products. In the case of the Qiang, with the absence of registered medicines, and with only “medicinal liquors” in the market, the

two cases that I will now describe go against that wave, taking individual medicinal herbs, and producing an articulation of Qiang medicines that in the first case is anchored in a shared imagined past, and in the second is malleable and exploited for marketing purposes.

Qianghuo – The weight of “history” and legends (*chuanshuo* 传说)

Among a group of participants encircling a large round dinner table in a hotel, while at one of the conferences of the Qiang medicine branch of CMAM, a discussion ensued: “is *qianghuo* a Chinese medicine or a Qiang medicine?”. Dr Zhang was convinced that it was Qiang but a few colleagues working in the pharmaceutical industry were not. The discussion was finally wrapped up by Guang De, the development strategist: “it is both Chinese and Qiang”.

Endemic to Qiang and Tibetan areas, and with the name literally meaning “Qiang life”, the medicinal use of *qianghuo* in China dates back at least to the time of the “Divine Farmer’s Materia Medica Classic”, appearing later in the “Compendium of Materia Medica” (*bencao gangmu* 本草纲目) written in the 16th century Ming dynasty (Zhang and Unschuld, 2014), and still nowadays prescribed and sold commonly all over the country. Guang De’s way of settling the argument echoed not only the commonplace use of *qianghuo* in China, but also the recent changes in policy that had established minority medicine as part of Chinese medicine. However, for Dr Zhang this was no ordinary medicine, but “a very famous medicine among Qiang medicines”. The mention in the “Divine Farmer’s Materia Medica Classic” of *qianghuo* as the “protector of the Qiang envoy” and “protector of the Qiang king” (Sun and Sun, 2010) made him consider “the core medicine” in this medical canon of over 300 medicines. According to him, there was no other medicine with such early and minute detailed literary recording as *qianghuo*.

Dr Chen, of the medical society, who was not as familiar with the “Divine Farmer’s Materia Medica Classic” as Dr Zhang, instead explained the connection between the Qiang nationality and *qianghuo* by means of a “beautiful legend” (*meihao de chuanshuo* 美好的传说):

A tribal leader was seriously ill and then we had a doctor here who told him that if he took this medicine then he would be cured. Then at that time there was no name for this medicine, it was many years ago, a few hundreds of years ago, we did not know how to call this medicine. But he asked the doctor what the medicine was called. He said he didn't know, and then the leader told him to call it *qianghuo*, because he was the king of the Qiang. The king of the Qiang, who took this medicine to survive, and so he called it *qianghuo*. It's a legend, a beautiful legend. (...) How does the “Divine Farmer’s Materia Medica Classic” explain this? Is that the same way?

Dr Chen considered *qianghuo* “a representative of the Qiang nationality” and stated that anyone inside the industry would know that the best *qianghuo* was that growing in Qiang areas, the “silkworm Qiang” (*canqiang* 蚕羌). According to Dr Chen, “it is very expensive in the market”, and only existed in the wild as it could not be cultivated. He explained that it received the name for the appearance of this rhizome resembling that of silkworms, and that it “has the highest content” and “its effect is the best”. “Silkworm Qiang” consists of the rhizome of the *qianghuo* that grows at higher altitudes than most. Its very high price was also attested by an academic who worked on *qianghuo* cultivation.

Dr Yuan, of the museum’s clinic, although recognising the different name in Qiang language for *qianghuo*, that of *sigea*, insisted that the connection between the Qiang nationality and *qianghuo* can be established if one looked into its “historical origins”. According to him, at the time when China had 50 million people, and 30 million of them were Qiang, they spread over a wide area that stretched from Tibet in the West to Xinjiang in the North, to Shanxi in the East and Yunnan and Guizhou in the South. In those days, the Qiang lived a nomadic and hunting life, before turning to farming, and because of life in the open fields, it was easy for them to catch cold (*ganmao* 感冒) and so they “conveniently collected *qianghuo*”.

Because of the wind and cold attack (*fenghan de qinxi* 风寒的侵袭), it was very easy to get headaches, body aches, to develop dampness (*chuansheng shiqi* 产生湿气), so *qianghuo* would be the first medicine to use, and because Qiang people were the first to use it, this endowed it with the name *qianghuo*. Because this medicine has solved most of the pain and hardship of the Qiang people, made them active and allowed them to survive, so it is named *qianghuo*. Its name originated this way.

In contemporary medical texts, the uses for *qianghuo* appear diversified when described in a context of a medicine used by the Qiang, or as a “Qiang medicine”, comparing to

those of Chinese medicine. In Chinese medicine it is described as inducing sweating, relieving pain, “dispersing wind” (*sanfeng* 散风) and “draining dampness” (*qushi* 祛湿), and so used to treat colds and “wind wet” (*fengshi* 风湿) or rheumatism (Li, 2010). In Qiang medicine, however, it is described as also being used for numbness caused by “cold and dampness”, and specifically for cough, headaches, throat pain, oedema, and skin ulcers (Qi et al, 2000; Li, 2013).

The way in which *qianghuo* cured the Qiang king was described to me by a pharmacist of the Maoxian Chinese medicine hospital, of Han nationality, from a Chinese medicine perspective. He was convinced it received its name for having originated in Qiang areas, and went on to relate how the king of the Qiang suffered from a “wind-cold disease” (*fenghan bing* 风寒病) in the winter and used *qianghuo* for its “acid, warm and great heat properties” (*xin wen da re* 辛温大热). After sweating, and with a miraculous effect, the disease was cured. However, for Dr Zhang, *qianghuo* did not just simply cure a disease, but saved the Qiang king by bringing him back from the dead. And within this life-saving action lay its biggest difference in properties when compared to Chinese medicine. According to Dr Zhang, it did not only remove the wind and dampness as well as stop the pain, but “disperses the coldness”, raises the *qi*, “breaks the water”, “removes the ice”, “adjusts the soul” (*zhenghun* 整魂) and “saves the heart”. “Saving the heart” stood for “inducing resuscitation”, a capacity of *qianghuo* to which Dr Yuan also subscribed. “Breaking the water” and “removing the ice” were described by Dr Zhang as properties exclusive to Qiang medicine. While stating that these were difficult to translate from Qiang language, he elaborated:

It (*qianghuo*) has “warm”, “hot”, “dispersion”, and “untying” (properties). It possesses these aspects and so has the use of “melting ice”, and of “rising cold to hot”. Do you not think that someone after dying will turn into a piece of ice? *Qianghuo* can melt it and then pull life back from the line of death. It can achieve this effect.

The only town doctor to dispute the ethnicity of *qianghuo* was the senior Dr Jiang, at the signless Maoxian clinic. According to him, there was no ethnic relevance to *qianghuo*, since in Qiang language it was called *sigea*. In regard to the academic interlocutors at the Qiang branch of CMAM, all of which were of Han nationality, two viewed the ethnicity of *qianghuo* as relative and dependent on whatever ethnic medical

theory was used while employing it therapeutically, and one made a distinction between “medicine” and “medicinal material”. The latter was teacher Zhou, who had authenticated the apprenticeship ceremony. She appeared to be concerned with ownership, for while stating that the Qiang people were the first to use *qianghuo*, and that among Qiang people *qianghuo* was the “most representative medicine”, according to her, it could be called “Qiang medicine”, but not “Qiang medicinal material” or a “special medicine of Qiang medicine”. This was due to the fact that there was no exclusive use by the Qiang nationality, but an overlapping use instead among various nationalities, which made it a “multi-ethnic cross-use medicinal material”. Her preferred way to describe *qianghuo* was as an “authentic medicinal material of Sichuan” that “hasn’t had the *chuan* character added to it”⁶⁷. In terms of its action, she confirmed the properties widely described in Chinese medicine but added that in rapidly inducing sweat, *qianghuo* could make one’s pores “carry away the viruses and bacteria”.

The other two interlocutors argued that because of there not being exclusive use of *qianghuo* by the Qiang, its ethnicity was something mobile. One of them mentioned that in Chinese medicine it was also called “black medicine” (*heiyao* 黑药), and then referring to medical texts “from ancient times to the present” spoke of *qianghuo* as “the emissary that protects the Qiang people” and offered a different story for its name attribution:

An emperor of the Qiang nationality had a terrible headache during the war. He grabbed a herb under a horse and ate it, his head stopped hurting, and his body felt better. So, he gave it a beautiful name, *qianghuo*.

Although he considered *qianghuo* a “medicine representative of the Qiang nationality”, he viewed it as a “Qiang medicine” only relatively, by virtue of a particular Qiang use or processing method. I will now move on from articulations of *qianghuo* as a Qiang medicine coming from institutional actors to the actual encounter between *qianghuo* and Yanwo village collectors.

⁶⁷ The construction of a Sichuan authentic medicine certification service is one of the objectives of the *Sichuan Province Chinese Medicine Industry Development Plan (2018-2025)* (State Administration of Traditional Chinese Medicine of the People’s Republic of China, 2019). Regional denomination for the creation of brands is also a central feature of the European Union’s Common Agricultural Policy (CAP) and its Protected Designations of Origin (PDO). See Higgins, 2018.

Collecting *qianghuo*

In the second time that I accompanied Yanwo collectors, we climbed to about 3100m, passing the grazing yaks from a distance, while eagles hovered above us, and I carried on following the three ladies (see Figures 28 and 29), in their forties, who moved up the mountains, through mud and thorny bushes, at an impressive speed, clearing the way with their adzes.



Figure 28: Collector carrying adze



Figure 29: Collectors having a lunch break

The collection of *qianghuo* and *foshoucan* (佛手参 *Gymnadenia conopsea*) lasted from dawn to dusk, an extremely difficult work that the three collectors made seem easy, with their many songs, chatter and laughter. When, after being asked if I was tired, I asked the same question, a lady replied, “can’t do anything about it, need to make money”.

Only the roots were collected. They would dig the soil with one to three strokes of their adzes, grab the plant by the root with earth still attached to it, snap the root and smack it on the adze's handle to lose the earth, before getting it in a bag or apron pouch, all done in a repetitive motion and a very automatic fashion. Some other collectors had told me that *qianghuo* is best when flowering. However, in all occasions both the plants with flower and without it would be dug up (see Figures 30, 31 and 32). The collectors could easily spot both, even when these were hiding among other foliage or under trees.



Figure 30: Uprooted *qianghuo*



Figure 31: *Qianghuo* flowers



Figure 32: *Qianghuo* roots

They would always spread apart in the mountain, not too far from each other. In order to keep track of where each one was, they would occasionally let out a sort of a "woow" shout, and to know whether it was worth getting any closer to where another was collecting, a shout of *you meidei?! (有没得)*, meaning "is there any?!" They would regularly check on how much each had collected as a means of comparison. This particular day, before lunch, one of the ladies upon realising she had collected a lot less than the others, did not stop to eat like everyone else until she had collected what she thought was a fair amount. The other ladies moved the roots to plastic bags and then into bigger bags so that they were kept dry. We sat, and they then broke some twigs, to be used as makeshift chopsticks, and we had lunch. Along with the food that we had brought, they handed me small flowers that they had just picked, we then smacked some on the back of our hands in order to remove the bugs first, then ate the bitter flower heads.

"Today we got less than usual", one said. They could sell each jin⁶⁸ of both *qianghuo* or *foshoucan* for a few dozen RMB (see Figure 33). As we continued eating, they would occasionally call for the third lady to join us for lunch, shouting "our bellies are full!" Eventually, she returned and there was a light-hearted atmosphere that continued. They spoke often in Qiang language between them, especially when joking with each other. At one point, one of them interrupted her singing to laugh, and they all laughed heartily till they cried, in a contagious manner that broke language barriers and got us to laugh together.

⁶⁸ One jin is approximately equivalent to 1.1lb.



Figure 33: *Qianghuo* for sale down the road from Yanwo

In the villages, the “representativeness” that I mentioned in the previous section seemed very much an external representational device in itself. Dr Yu in Yanwo told me bluntly that people there did not see any relation between *qianghuo* and Qiang people and, like Dr Jiang, added that the Qiang name for it was *sigea*. However, the Yanwo villagers that I accompanied collecting *qianghuo* referred to it as to every other medicinal herb they collected by their Chinese names, while speaking Qiang language. Other villagers told me that they did not know the Qiang name for *qianghuo* or that such name did not exist. This, together with the fact that very few medicinal herbs were kept at home, suggests that the use of Chinese names suited a collection predominantly destined for sale to Han people, at least since the late Qing dynasty (Bian, 2017). In one instance, when I asked Yanwo collectors whether there was a relation between *qianghuo* and Qiang people there was an indifferent silence in return, as I elicited the question “do you think it’s your medicine?” one laughed and in a joking manner replied “sure, it’s our thing”.

One thing that all interlocutors agreed on was that every year in the summer months of collection there was less and less *qianghuo*, and that it was necessary to climb higher

and higher to find it. My host in A'er, the son, told me how that year was the first that he was not collecting *qianghuo* for there being “too few, and too far away”. He told me later that *qianghuo* was often the only medicinal herb that the villagers in Yanwo would keep at home, given its use in treating common colds. One lady in particular told me that apart from being brewed it could also be smoked, which is consistent with the description of its uses in the book *Collection of Chinese minorities medicine* (Qi et al, 2000). In one particular evening, I saw *qianghuo* being brewed together with ginger in a pot on the stove at home, to treat the cough of my host's youngest son (see Figure 34). Unlike with the thorough listing of the effects of *qianghuo* by Dr Zhang and town doctors, in the two villages, discussions of the effects of *qianghuo* were absent, as were for most other medicines. The question of “what does the medicine do” would not make sense. Instead, it was “what do you use it for” that would get interlocutors to elaborate on how they related to the medicines that surrounded them.



Figure 34: *Qianghuo* and ginger brewing on a stove

Cultivating “fake” and “real” *qianghuo*

Down in the valley, and growing alongside the Yanwo villagers, often by the side of the road, was “broad-leaved *qianghuo*” (*kuanye qianghuo* 宽叶羌活 *Notopterygium franchetii* H.Boissieu), referred to locally as *luyazi* (see Figure 35). Known to germinate very easily and therefore easy to cultivate, some villagers in Yanwo and in nearby towns grew it themselves, unable to do the same with “real” *qianghuo*. Many in Yanwo called it “fake *qianghuo*”, and argued that *luyazi* was a totally different plant, “with a very different flavour”. Its particular aroma also earned it the name of “stinky Qiang” (*chouqiang* 臭羌), and they did not consider it medicine, while a university researcher insisted that it was merely a different species of *qianghuo*, and that it was also used in pharmacies of Chinese medicine, “not fake medicine”. However, Dr Zhang did not consider it to be medicine either, and villagers insisted that it was far inferior to the one growing high in the mountain, an inferiority confirmed by the fact that they were only able to sell it for a third of the price. The association between cultivated and “fake” was, for most villagers, overarching.



Figure 35: *Luyazi*

This original inability to transplant the mountain *qianghuo* to low altitudes, and the falling numbers of the species in the wild had led the “*Qianghuo* research group” at the Sichuan College of Chinese Medicine to spend the past twenty years working on a way to grow a particular cultivar of *Notopterygium incisum* K.C.Ting ex H.T.Chang. Bringing biologists, pharmacists, and soil specialists together, they had conducted dozens of cultivation projects to then train villagers to cultivate it themselves, all over Aba prefecture. While they insisted that in terms of chemical composition the plants

were identical, their biggest obstacle was correcting morphological differences of the cultivar they worked with, which meant that its value in the market was still much lower than its wild counterpart. Instead of individualised long roots, their cultivar of *qianghuo* presented a large mass of fibrous roots (see Figures 36 and 37).



Figure 36: *Qianghuo* at a cultivation base

Figure 37: Cultivation base uprooted *Qianghuo*

In the attempt of solving this particular problem, which they considered the most important one, the university researcher who headed the research group drew a different distinction between “medicine” and “medicinal material” than that which had been defined by other academics when it came to *qianghuo*. As he saw it, although the quality of their *qianghuo* as “medicine” was identical to that of the wild, its quality as “medicinal material” was not. There were two main reasons for this. Firstly, that its morphological differences could be too large to be consistent with the current description of the Chinese Pharmacopoeia. Secondly, that pharmaceutical enterprises could encounter some troubles when using this raw material for processing. This clarified a variety of different motivations surrounding these cultivation initiatives that I will be exploring in the following chapter, on development and sustainability. Apart from the morphological differences, there was also the lower price and the lack of any previous satisfactory consumption in the self-care of villagers. All of these were likely

to make such cultivars retain the label of “fake”, of “not as good”, or of that which “doesn’t work”, at least by most villagers who could not, or would not cultivate it.

One of the bases in which the “*Qianghuo* research group” had carried their work was outside Yanwo, which before having been completely dedicated to the production of *wabu beimu* (瓦布贝母 *Fritillaria unibracteata* var. *wabuensis* (S.Y.Tang & S.C.Yueh) Z.D.Liu, Shu Wang & S.C.Chen) for a large Chengdu company, had been involved in diverse cultivation initiatives. In one of the many changes of hands, the owner had sold it, and the new bosses did not approve their staying. In that Yanwo base they told me that the company had no interest in growing *qianghuo* there since its value was too low to sell. The “*Qianghuo* research group” had bases in five different Sichuan counties, most in Aba Prefecture, but none in villages where Qiang people lived. Their main base, and the biggest such *qianghuo* base in China, was located in a village in Xiaojin county, 3200m high. Although this county’s population is registered as 52% of Tibetan ethnicity, and 48% Qiang (Xiaojin People’s Government, 2019), in this particular village, which I visited with two of the researchers from the research group, locals told me that despite many still having “Qiang nationality” on their identification documents, all of those who spoke Qiang language or “knew Qiang culture” had passed away or left the village. Still, one local guesthouse had four white quartz stones distributed by the four corners of its roof, a common feature in buildings dedicated to tourism in Qiang areas. The base was run by two young men, trained by the “*Qianghuo* research group”.

We unloaded the gear upon our arrival, which consisted of a regular electronic scale, an airtight electronic scale, a liquid nitrogen tank, a chlorophyll measuring device and tagging material. In the following day, an older villager helped the two researchers I was with uprooting nine bundles of *qianghuo* plants, seemingly at random, and placing them into individually tagged bags, so that they could later collect the samples they needed. Upon arriving at the first floor of the building that they used for their work, the plants were firstly washed, in order to remove the dirt, and then their roots sliced with a blade, small enough to fit the sample ampoules. They then used the electronic scale to make sure that each piece weighed 0.5g, before using the airtight electronic scale to weigh two root pieces of 0.2g (sliced from the 0.5g fragment) and a portion of clean leaves weighing 0.2g, in a total of 0.4g that would fill each previously tagged ampoule. All the ampoules were swiftly placed inside the liquid nitrogen tank, which would later

be taken to Chengdu for sample analysis at the research centre. Finally, they used the chlorophyll measuring device to measure the chlorophyll of the different batches of *qianghuo* plants that grew in pots, placed in rows by the first-floor rail (see Figure 38), while recording all the data in a notepad.



Figure 38: Freshly collected and older batches of *Qianghuo* behind

An old man, who seemed to live there, approached, looked at a few of the plants, touched some of their minuscule dry flowers and then stood behind the researchers looking curiously at all the apparatus. This all took place while the villager who had helped to dig the plants sat quietly in the corner smoking his cigar, while three Tibetan ladies sat around chatting and embroidering shoe insoles with floral patterns.

At night, while chatting with a local in the guesthouse who collected *qianghuo* from the mountains, he told me how they considered the wild *qianghuo* better, and used it in their self-care for stomach and bowel problems, as well as for common colds. He attributed this superiority to the fact of it having a long single root, rather than short ones. No one there that I spoke with established any relation between *qianghuo* and Qiang people.

Qiang Beimu – New ethnic possibilities

I will now move on to the case of *qiang beimu*. Commonly used in China in the treatment of coughs, *beimu* (贝母 *Fritillaria*) earned its name, which also means “mother-of-pearl”, for the morphological resemblance of the bulbs to white shells (Cunningham et al., 2018). In Qiang language it is called *gvubgea*. Like with *qianghuo*, there were widespread concerns regarding morphology and content when defining its authenticity. However, rather than drawing from “historical” features to justify the attribution of ethnicity to a medicine, the name of which contained the character *qiang* (羌), in this case the character was added in recent years, as part of a marketing move by a particular pharmaceutical company, and this *wabu* variety was not recognised as Qiang among others. Since I came across it after spending time in Yanwo and having visited the cultivation base nearby where they grew the same variety, I decided to follow *wabu beimu*, between the Yanwo cultivation base, a Chengdu pharmaceutical company, and universities.

The ethnic attribution to this variety of *beimu* led me to explore the different views, responsibilities, justifications, and contradictions surrounding such labelling, among several interlocutors. This turned out to be wrapped in intricacies and served as a very valuable cue in order to approach the articulation of Qiang medicines, and understand the political and marketing workings of ethnic attribution to medicines in China.

Outside the conference auditoriums that would host CMAM’s Qiang branch meetings there would always be a couple of stalls promoting products, either medicinal materials or herbal extracts, of enterprises associated with the organisation. It was in one of these stalls that I found *beimu* in its raw material state, labelled as “Qiang medicinal material label, *wabu guobuge, qiang beimu*”, a label ornamented with “Qiang writing” (see Figure 39). *Wabu* stood for the variety *wabu beimu* (*Fritillaria unibracteata* var. *wabuensis* (S.Y.Tang & S.C.Yueh) Z.D.Liu, Shu Wang & S.C.Chen), and *guobuge* for the Chinese transliteration of the Qiang *gvubgea*. Next to it, long sachets sat on display, containing a powder preparation of *qiang beimu* that was easy to drink, and could be swallowed directly as well (see Figure 40).



Figure 39: *Qiang beimu* medicinal material



Figure 40: *Qiang beimu* drinking powder

After chatting with the pharmaceutical representative that stood behind the stall, Mr Luo, we had lunch together. An acquaintance of Dr Zhang, he had originally graduated in Chinese pharmacy, and had for the past twenty years been working in the pharmaceutical industry, most of those years being in Quality Management. I used the opportunity to show him what the *wabu beimu* that grew in the base outside Yanwo looked like. After looking carefully at the photo, he replied that it looked “fake”, that the bulb did not open as it should, with the cloves staying close together (see Figures 41 and 42). According to him, even at one year of age, the bulbs that he grew would already be opened. Another difference between them was that his *beimu* did not grow in a greenhouse, but outdoors, and despite the soil freezing in the winter they carried on growing fine. Each bulb took a minimum of three years before it could be sold, being at its best at five years of age, although he also had seven-year-old ones on display. When I asked why they had decided to name it *qiang beimu*, I was told that it had been the idea of teacher Zhou, the teacher who had authenticated the apprenticeship, and who he claimed had been working with them.



Figure 41: Greenhouse outside Yanwo



Figure 42: *Wabu beimu* growing in the greenhouse outside Yanwo

In order to understand how this variety became (or attempted to become) *qiang beimu*, I will give a brief explanation of its background. Its bulb is considerably larger to those other *beimu* most commonly collected and consumed in China, it was first registered as a new and independent species in the early 1980s (Tang and Yueh, 1983), and in the 1990s recognised as a variety of *Fritillaria unibracteata* (Liu et al, 2009). The variety received the name *wabu beimu* since it was “first found” in the mountains of Waboliangzi (瓦钵梁子) located in Heishui, one of Maoxian’s neighbouring counties⁶⁹. Reportedly, Professor Tang Xinyao, who had named *wabu beimu*, had worked in the domestication of this variety since the 1980s, and so had other experts in the field, one of them renowned for publishing a vast compilation of morphological characteristics on the different species and varieties of *beimu*. It was also in the 1980s that Dr Yuan’s brother, who like him gave the odd consultation at the Maoxian museum clinic, started working in *wabu beimu* cultivation in the base outside Yanwo, where he went on doing so for almost the following thirty years. He was well respected in Yanwo, and Dr Yu in the village blamed the constant change of companies in charge of the cultivation base for his departure. The last take-over had happened two years prior to my visit of 2018. Apart from the *wabu beimu* cultivation, Dr Yuan’s brother also had a project nearby growing about one hundred different medicines, attempting to replicate their natural conditions of growth in the wild, and so advertising them as “authentic Qiang

⁶⁹ Heishui presents a special case, being a county with the majority of its population speaking Qiang language but identified as Tibetan by the government (Heishui People’s Government, 2010) given the widespread practice of Tibetan-style Buddhism (Huang, 2004).

medicines” (*daodi qiangyao* 道地羌药) (Bian, 2018, personal communication 10 August).

The manager running the cultivation base when I visited, producing the *wabu beimu* that Mr Luo considered to be “fake”, had only been there working for the past two years, since the new pharmaceutical company took charge of the premises, employing around eight Qiang people who, like the manager, were from a village nearby. The workers in the base were in charge of different tasks in the greenhouses throughout the year (see Figure 43), with special care paid to watering the earth weekly, and weeding constantly, during the designated months. Weeding had special importance, for in the case that weeds would grow large enough, these could damage the *beimu* bulbs.

	Dormant	Germinating	Remove weeds	Fertilise	Plant	Collect
Jan.						
Feb.						
Mar.						
Apr.						
May						
Jun						
Jul.						
Aug.						
Sep.						
Oct.						
Nov.						
Dec.						

Figure 43: Different cultivation stages at *beimu* base outside Yanwo

Like with Mr Luo’s *beimu*, the bulbs in the base were shipped to be processed in the city. This particular company advertised in their website that they were the first in China achieving GMP (Good Manufacturing Practice) standards for medicinal herbs and that their products were “sold to excellent proprietary Chinese medicine factories, hospitals and chain drugstores nationwide and exported to countries and regions such as Korea, Japan, the US, Singapore, Hong Kong and Taiwan, etc.” There was no ethnic mention in any of the products advertised. Additionally, no one at the base mentioned

the *beimu* they grew as being a Qiang medicine. In case this company was planning to run the cultivation base long term, at least the manager on the ground was not, as he told me that he planned to start growing *wabu beimu* and *qianghuo* (which he had mentioned the company had no interest in cultivating) by himself two years later. In order to do this, he would not be buying a greenhouse, a decision that he put down to the high cost of 30.000RMB each. Instead, he would cultivate his medicines in his family's plot up in the mountain.

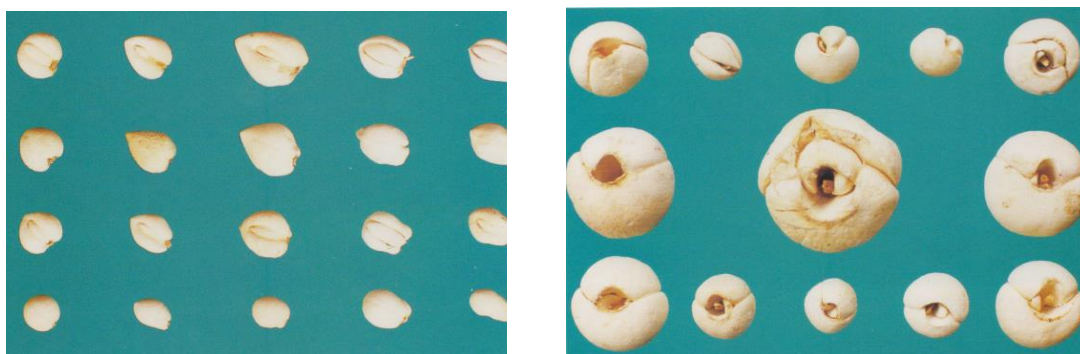
In regard to Mr Luo's company, the reason that in the past two years it had become involved in the production and cultivation research of *wabu beimu*, or as they called it, *qiang beimu*, and the reason that he was personally responsible for the supervision and development of their cultivation base in Maoxian county, was, according to him, all to do with "opportunity". He went on to explain how before *wabu beimu* entered the pharmaceutical factories that this was merely an "agricultural by-product" (*nongfu chanpin* 农副产品), planted by farmers, who accumulated vast experience in the process. One of these farmers was Mr Fei, a Qiang villager who had been domesticating local *wabu beimu* for thirty years, and "making Qiang medicines". Given his experience as well as the success of his cultivation methods, with very high germination rates and "best quality", he was invited to be the company's technical expert for its cultivation, "the technical consultant who guides the company to grow *beimu*".

According to Mr Luo, the domestication of *chuan beimu* (which includes *wabu* and several other species of *beimu* growing mostly in the Sichuan province) had not been successful for many years. However, at a later stage, with the Chinese Pharmacopoeia introducing *wabu beimu* in 2010 (China Pharmacopoeia Committee, 2010), with the wild resources of *beimu* being gradually exhausted (and *wabu beimu* very rare in the wild), with its demand far from being met, and with encountering Mr Fei, all these factors provided the perfect opportunity for his company to start operations, as others had already done. The main reason for *wabu beimu* being chosen, and not a different variety, was that, as Mr Luo saw it, although its "medicinal value is basically the same as that of (the other) *chuan beimu*", *wabu beimu*'s production was larger, with a bigger output and a "more mature planting technology". Mr Luo saw beneficence in his actions since in this way they could "continue *chuan beimu*'s life and develop the industry of authentic medicinal materials in Sichuan". While remarking that there were no

chemicals used in the process of planting, he explained how its growth conditions were equivalent to the *wabu beimu* growing in the wild. His cultivation base was at its early stage of development, still with only 15 *mu*⁷⁰ of area and 15 workers, but it was set to increase its size in the future. There, only the managers were appointed by the company, the specific planting operations in the base were all done by local Qiang people.

The morphology of authenticity

In the attempt to clarify why Mr Luo thought that the bulbs in the base outside Yanwo were not the “real” *wabu beimu*, he pulled a large book compiled by a Sichuan expert on the matter, who reputedly provided the first data on production locations and domestication of *wabu beimu*. He flicked through the many pages filled with photos of *beimu* bulbs of different varieties and species and then explained that the many forms of *wabu beimu* could vary according to their different age, environment, and growth conditions (see Figures 44 and 45). Among these, he pointed to the ones he claimed matched the *beimu* that he grew, while stating that after having come across many different samples, not once did he see the unseparated bulb shape that my photo displayed.



Figures 44 and 45: Different forms of *wabu beimu* (Li and Lao, 2001)

In his stake in promotion and development, he was treating the fact that his product matched previously documented morphological descriptions as a token for authenticity and quality, showing superiority in relation to others that did not. A few days after Mr Luo showed me around his company’s facilities and the production of their different

⁷⁰ One *mu* is the equivalent to approximately 0.16 acres.

medicines, he contacted a professor with whom he consulted occasionally, and this confirmed that the photo I had given him was in fact of *wabu beimu*, despite not offering further explanations.

When I asked three different university researchers their opinion, one told me that it was likely *wabu beimu*. However, he could not assess it clearly from the photo. Another researcher also said that she had not come across a closed bulb example and that it would be necessary for the plant to blossom in order to be sure. The third stated that it was *wabu beimu* and that an open or closed bulb was irrelevant in defining it as such. With several different domesticated cultivars appearing in the past twenty years, it is likely that individual variations abound (although Mr Luo claimed that there were only imperceptible differences between his product and the wild *wabu beimu* of the region), and morphological details can be used as a way to affirm authenticity by certain producers. What most of the *wabu beimu* have in common is the bigger size when compared to the most commonly collected and used *anzi beimu* (暗紫贝母 *Fritillaria unibracteata* P.K.Hsiao & K.C.Hsia) (see Figure 46), and that makes it a lot less popularly accepted.

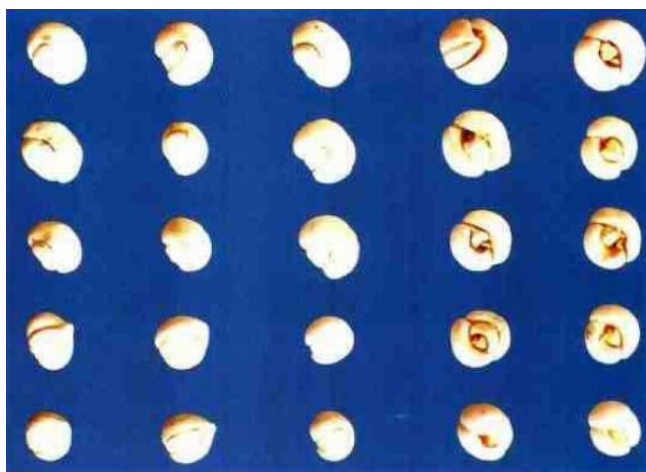


Figure 46: Different forms of *anzi beimu* (Li and Lao, 2001)

If one researcher praised the efficacy and the augmented biomass as reasons for *wabu beimu* consumption to be adopted, another drew on the particular morphological feature of *anzi beimu*, “embracing the moon” (*huaizhong baoyue* 怀中抱月) as a mark of quality. According to him, this meant that there was a bigger half that “embraced” a

smaller half. “It should be smaller than this (pointing at his fingertip), but *wabu beimu* is as big as garlic”. In his view the difference in shape meant that it was difficult for people who used Chinese medicine to accept it. The fact that *wabu beimu* was recognised in the Chinese Pharmacopoeia had opened the doors of the market to it. However, there were very different reasons for its use. He told me that although tests had shown there was no difference in efficacy between the two, patients preferred the small *beimu* to take home to boil, and Chinese medicine doctors considered the small *anzi beimu* to be more effective. This had in turn generated great controversy between doctors and certain academics, the latter who thought they were both the same in terms of efficacy. For pharmaceutical producers, who would charge a lot more for finished proprietary medicines such as the “*chuanbei* and loquat cough syrup” (*chuanbei pipa tangjiang* 川贝枇杷糖浆), it was not a point for debate, as they would choose to use the bigger and cheaper *wabu beimu*.

Nonetheless, through breeding, cultivators were achieving sizes that superseded the requirements defined in the Pharmacopoeia. This was a problem that led to many Sichuan enterprises, with a high output of their artificially cultivated product, struggling to find a market for their enlarged *wabu beimu*. That did not seem to affect Mr Luo, since he claimed that his *wabu beimu* was in line with the legal requirements of the Pharmacopoeia. Among my Qiang interlocutors, doctors did not seem to mind either way, should it be *anzi* or *wabu beimu*. Indeed, Dr Yuan at the museum clinic remarked that “morphological teachers and doctors” think that only “the small one” is *beimu* and can be used as medicine, not “the big one”. Still, none of them referred to the large variety as being *qiang beimu*.

In regard to the Yanwo village, there was widespread scepticism about the bigger *wabu beimu*, with many stating that its efficacy (*gongxiao* 功效) was not as good as that of *anzi beimu* both in the relief of coughs and as an alcoholic solution to stop bleeding and healing wounds. Dr Yu in Yanwo explained that there were many kinds of *beimu* but that the one found growing on their mountain was the “normal” one and also the best. In his view, there was a distinction, not only of morphology, but between that which was wild and that which was cultivated and “abnormal” in its size, and this was so also because *wabu beimu* did not grow in the wild on the mountains around Yanwo.

The marketing of *qiang beimu*

Mr Luo's company was the only one, to my knowledge, using the name *qiang beimu* in his product labelling, and he was the only interlocutor referring to it as such. According to him, the idea to name *wabu beimu* as *qiang beimu*, came after they had started growing it in Maoxian county, when through meeting teacher Zhou, they "discovered that *wabu beimu* is actually *qiang beimu*", and realised "the Qiang people in Maoxian historically used this variety". He claimed they used it externally with "the best curative effect" to draw out poison, treat swelling caused by insect bites, as well as painful boils, tumours and some cancers, while in Chinese medicine it was mainly used for "moistening the lung and stop the cough" (*runfei zhike* 润肺止咳). The alternative and "historical use" that he had identified justified the attribution of the *qiang* labelling, in his view, which was also reflected in the indications section of his *qiang beimu* drinking powder sachets. This, apart from mentioning the "moistening of the lung", included the reduction of abscesses (*sanjie xiaoyong* 散结消痈), such as "breast abscess" and "lung abscess".

While at the same time as considering Qiang medicines the same as Chinese medicines, and only spoken of differently by virtue of different therapeutic uses, Mr Luo harnessed an ethnic label that gave a unique feature to his product and reinforced its list of indications. Coincidentally, the reduction of abscesses is also mentioned in the pharmacopoeia, so it is not novel in Chinese medicine, however, external application is. According to him, this "long historic use" in the particular location where they grew their *qiang beimu* also allowed him to label his product as an "authentic medicine".

Mr Luo's enthusiasm with the labelling of *wabu beimu* as *qiang beimu* was not shared by teacher Zhou. When I asked her of this collaboration with Mr Luo's company, she dismissed it as a few meetings at conferences, and that "deep level cooperation" had not yet begun. She did not seem aware of the labelling of the product as *qiang beimu*, despite of the fact that she had also been in the conference where this product was being promoted. She also claimed that she had no knowledge of *wabu beimu* being used in the treatment of cancer, only of coughs and throat ailments, by villagers in the area where it was first "discovered".

It's like this. If they gave it this name, the country will not recognise it. The Chinese government would not say that one medicine material... It is originally a “multi-ethnic species” (*duo minzu de jiaocha pinzhong* 多民族的交叉品种). Han, Tibetan, Yi... At least in Sichuan many nationalities use *beimu*. (...) but it must be included in the Pharmacopoeia, so it can't be called like that. (...) because after you call it, you just want to highlight its own characteristics, but if no one agrees, then you can't. The government will not recognise it. Because it just states that it has the characteristics of the Qiang minority. Once so unified by the state, you can't have Tibetans calling it Tibetan *beimu*, Han calling it whatever, the Yi minority calling it whatever kind of *beimu*, this is impossible.

While I was unable to verify what had taken place in the meetings between teacher Zhou and Mr Luo, it was clear that teacher Zhou wanted to distance herself from such ethnic attribution to a medicinal material, and by invoking the unfeasibility of such labelling in the eyes of the government placed herself on the safe side of any ethnic or legal disputes. When I spoke with two other researchers who had no stakes (either admitted or refuted) in this marketing move, they painted a picture that was not a stark one of governmental rejection. Instead, this was one that saw benefits in a labelling directed at the market, while not recognising *wabu beimu* as *qiang beimu* themselves.

The first researcher, while acknowledging the lack of a particular connection between Qiang people and *wabu beimu*, did not see a problem with some calling it *qiang beimu*. The second, was especially relaxed about the ethnic labelling of medicines. On one hand, she remarked that everyone knew that *qianghuo* had the character *qiang* (羌). On the other, since that everyone “of all different ethnic medical disciplines” used it, it did not mean that it could be used only by the Qiang. After repeating the name *qiang beimu* twice out loud, as if to get a feel of how the words resounded, she continued:

How to look at it... If someone wants to promote our brand of Qiang medicine, to find some special entry points, to add some colour to the medicine behind our nationality culture, I think this is not a bad thing, it's very good.

Although this was simply a raw material in the powder form, sold alongside with the whole bulbs, the creation, development and promotion of such an “ethnic product” was designed to enter the market of proprietary medicines, and be available in pharmacy chains all over China. This was an established extended commercial network that Mr Luo took pride in. Such “reformulation regime” (Pordié and Gaudillière, 2014b) was

using place of origin, the fact that it was cultivated by a Qiang person and an assumed “historical use” in order to materialise Qiang ethnicity in a medicine. In this way he articulated *qiang beimu* as a Qiang medicine, for marketing purposes.

Such marketing approach was one that met the format of a direct-to-consumer advertising that bypassed the role of doctors. Although most Qiang doctors were still enthusiastic with the prospect of Qiang proprietary medicines being developed, of which single medicine preparations appeared as a first step, the feeling was not shared by all. Dr Yuan at the museum clinic rejected materialising ethnicity in medicines in such way. He articulated Qiang medicines differently, for in his view “real Qiang medicines can be produced anywhere”, and it all came down to how these were used. He gave his example precisely with *chuan beimu*, not distinguishing between any particular varieties, to explain how in Chinese medicine it could only be used to “moisten the lung, promote secretion and stop cough”, while in Qiang medicine it could also be used for injuries, “having the function of constriction, of thickening and generating muscle”. While rejecting any value to proprietary medicines in general, as well as to single-medicine preparations such as powders and granules that did not require people to boil their medicines, he centred ethnicity in the role of Qiang medicine among practitioners and lay Qiang people alike and claimed that one could only call medicines “Qiang medicines”, if they were used by “Qiang medicine”. Having a label crystallising a medicine as “Qiang”, regardless of how it was going to be used, ran counter to that.

Competing in Sichuan and beyond

Wabu beimu was considered a medicine that constituted an “alternative second wave” medicine for clinicians, when compared to the smaller *anzi beimu*, by teacher Zhou. According to her, clinicians and the industry were attempting to turn it into a “food product” (*shipin* 食品), a “medicinal food” (*yaoshi tongyuan* 药食同源), which she resented, as she thought keeping it as a medicinal material was the best outcome, even if she agreed that it was inferior in medicinal quality to the *anzi beimu*. With demand far outweighing the supply, and with each *beimu* bulb taking years of growth before entering the market, teacher Zhou saw “saving *beimu*” as a lost cause, even if, as she claimed, the government had given it its highest priority designating it a “heritage

authentic Sichuan medicinal material” (*chuancheng daodi yaocai* 传承道地药材)⁷¹. She saw the wild *anzi beimu* as having a very low output, and growing under a fragile ecological environment, both factors “very difficult for human beings to influence in a short time”. For teacher Zhou, here lay the great advantage of *wabu beimu*. Not only could it be grown at lower altitudes, but both its output and size were very large. Therefore, the fact that the Pharmacopeia had still not changed its legal description to accommodate the *beimu* of bigger sizes that were being produced was a contradiction that had not yet been solved.

After my arrival in Yanwo in the month of August, although villagers had told me that the season for *beimu* had passed, one lady remarked how she was surprised she could not find any *beimu* by then, that it must have been the many yaks grazing the hills that had eaten the remaining bulbs. Having an opposite opinion, the manager at the *beimu* cultivation base had dismissed this, insisting that yaks only ate herbs and not bulbs. Regardless of the cause, the falling numbers of *beimu* bulbs in the wild imbued corporate initiatives of cultivation and production with a particular tone of benevolence and care for the environment as well as the local population. Mr Luo spoke of his and other companies producing *wabu beimu* in the region as developing high quality medicines, with no counterfeiting issues, all in areas free of pollution, with good soil quality, only differing in the management technology of the planting process, and in the harvest that different companies executed. Although Mr Luo’s company was at a very early stage in production, he spoke of opening more cultivation bases in the future and of the prospect of solving local unemployment and combining their operations with the poverty alleviation policy (*fuping zhengci* 扶贫政策) in China.

This clean high output and production ethics of the companies with cultivation bases in Maoxian county was later put into question when a patient at a Maoxian clinic joined a conversation on *beimu* that I was having with one of the doctors. According to him, in a particular Maoxian base they were using hormone fertilisers indiscriminately in order to increase production by two and three-fold, and “eating up resources from local people”, as well as “eating up millions in (destined for) targeted poverty alleviation efforts

⁷¹ For the list of Chinese medicinal material resources monitored under the *Sichuan Province Chinese Medicine Industry Development Plan (2018-2025)*, see State Administration of Traditional Chinese Medicine of the People’s Republic of China, 2019.

(*jingzhun fuping* 精准扶贫)”. He referred to this as a practice that was not exclusive to *beimu* but being used commonly with large-scale vegetable growing in the area.

With dwindling numbers of *beimu* in the wild, *wabu beimu* was not the only emergent *beimu* being chosen for cultivation. Although of a different species than *wabu beimu* and *anzi beimu*, *taibai beimu* (太白贝母 *Fritillaria taipaiensis* P.Y.Li) also fell under the category of *chuan beimu* in the Chinese Pharmacopoeia (China Pharmacopoeia Committee, 2010). Despite the name *taibai* originating in the Taibai county of the Shaanxi province, it could also be found in the wild in Wanyuan county, in the northeast of the Sichuan province. The head researcher of the “*Qianghuo* research group”, who was also heading a separate project for the cultivation of *taibai beimu* explained to me that among experts there was disagreement on whether the species found in Wanyuan was in fact *taibai beimu*, since its flower morphology “differs from the traits described of the *taibai beimu*”. According to him, although the size of *taibai beimu* is not as large as that of *wabu beimu*, it has the advantage of growing at around 1000m of altitude, unlike *anzi beimu* and *wabu beimu*, which required land at around 3000m high. The research group was building a base in collaboration with a company, working on their *taibai beimu* cultivation, but it would still take a few years before they could have seeds ready.

There was one thing that all interlocutors agreed on, and that was a *beimu* regional superiority, the conviction that *chuan beimu*, with all its different species and varieties was far superior to its historical “competitor” *zhe beimu* (浙贝母 *Fritillaria thunbergii*), originally from the eastern coastal province of Zhejiang. Doctors and academics all mentioned the latter’s “poor antitussive effect”, and its much lower price in the market. With the *beimu* resources in the wild at risk of disappearing, the domestication of different varieties of *beimu* accompanied very concrete prospects of profit and of starting enterprises facing an enormous demand for their products, as long as they kept to the morphological features described in the Pharmacopoeia. Other considerations went hand-in-hand, of ecological protection and care for local populations, however, with each base employing only a handful of people, and with possibly dubious practices running in the background, the benefits are so far hard to tease out. Ethnic labelling appeared in such process, at Mr Luo’s company, with him claiming this was based on a

“realisation” rather than in a concrete marketing effort. This was a “realisation” that stayed at odds with most Qiang people’s preference for the smaller *beimu*. Still, among many, it was instrumentalised as an unofficial ethnic attribution, and justified as a beneficial marketing move for the promotion of Qiang medicine.

Articulating Qiang medicines for a growing market

The ethnic contestation of raw materials that I have explored in this chapter is likely to be simplified in the future. In line with the growing importance given to proprietary medicines as this industry grows (Hsu, 2009), with China’s fourfold economic contribution of proprietary medicines (*zhongchengyao* 中成药) over herbal pieces (*yin pian* 饮片) for 2014 (Di Tommaso et al, 2017), in ethnic medicine conferences there was a marked focus on the former. Such priority was framed under a “natural” developmental progression of medicines, with their pinnacle at industrial pharmaceutical production and entering the market. I argue that the predominance given to proprietary medicines simplifies issues around ethnicity by delineating industrially designed marketable products. In this way, ethnic medicines are articulated as compound preparations labeled as ethnic on their commercial packaging, distancing them from questions around the ethnicity of raw materials. Furthermore, materialising ethnicity on the result of an industrial design embraces tropes of “advancement” and “development”, while feeding into an inter-ethnic competition for the registration of pharmaceutical products.

Such reformulation, like the industrial articulation of Qiang medicine, turned out to be an issue very much exclusively relevant for the stakeholders of such enterprises. The regret described by those who would like to see “Qiang medicines” sold nationwide, but were being hampered to do so by regulations, was in fact not shared by all. Although Dr Zhang and Dr Chen at the medical society kept such dreams for the external application solutions they produced, with the former also hoping in the future to dispense Qiang proprietary medicines rather than the Chinese ones that he stocked, and with the latter speaking of their spray bottles as the condensation of “centuries of efficacy”, the other Maoxian doctors did not share this vision for the future of the medicines they used in their clinics. Dr Jiang senior dismissed the sprays produced by Dr Chen, and Dr Deng at his Maoxian orthopaedics clinic associated unfavourably the development of mass-

produced proprietary medicines, what he called *gao dan wan san* (膏丹丸散 literally meaning “ointment, pellet, pill, powder”) to something brought by the Japanese in the 1980s, and so inherently non-Qiang.⁷² Dr Deng claimed that medicines had originally a much lengthier processing when compared to contemporary industrial procedures, which conferred it much better quality.

In regard to the attitude of villagers towards possible future Qiang proprietary medicines, although one spoke of being open to the idea of buying in the future, should these become available, Dr Yu in Yanwo was very sceptical and insisted he would not. This was because, according to him, these medicines gave no guarantees, as “they are not established yet”.

While the reality of Qiang proprietary medicines did not come to be, the articulation of Qiang medicines was restricted to preparations to sell in the clinic, such as those of Dr Zhang and Dr Chen. It was also performed in relation to raw materials deemed by some to have a “historical” connection to the Qiang such as *qianghuo*, to “authentic Qiang medicines” like *qiang beimu* and to those growing in Qiang areas. These raw materials were, among some, also seen as promising a bright future for possible Qiang proprietary medicines, with Dr Zhang claiming that “the charm of *qianghuo*” lay in its versatility.⁷³ Still, villagers were very suspicious of the medicinal herbs cultivated to meet the demand that faced the producers of proprietary medicines, and clearly did not consider them “authentic Qiang medicines”. They were quick on dismissing these as “fake”, in contrast to the ones growing in the mountains, without attributing ethnicity to either of them. In this manner, I argue that the “authenticity” of medicinal materials that appeared in institutional circles was not only the product of specific environmental conditions, that stakeholders would draw from, but also of socio-political-economic ones.

⁷² *Gaodanwansan*, also described with the inverted characters *wansangaodan* (丸散膏丹) is not a recent concept. Despite the characters having appeared isolated throughout history in medical canons (Sun and Sun, 2010; Li, 2010), they appeared together and associated with pharmaceutical technology already in the late Qing dynasty (Jin, 2017). The connection with Japan is explained by the Japanese influences that the medical reformist Yu Yan brought into his pharmaceutical production in the first half of the twentieth century (see Background section), with these products becoming more popular after the 1980s with China’s economic reform (Chee, 2015).

⁷³ The proof he offered was the fact that it featured in the famous “nine flavours *qianghuo* pill” (*jiu wei qianghuo wan* 九味羌活丸), used to treat such different conditions as “cold, arthritis, pain, stomach-ache and headache”.

Therefore, the articulation of *qianghuo* and *qiang beimu* as Qiang medicines, the first using the legitimacy of “history”, the second contemporary marketing, appeared highly manipulated among academics, some practitioners, and people in the pharmaceutical industry. In relation to the first, the widespread use of *qianghuo* in the region by villagers, also in places such as Xiaojin, where the “*Qianghuo* research group” cultivated it, and where people neither self-identified as Qiang nor referred to *qianghuo* with any ethnic connotations, also confirmed that designating it an ethnic medicine was a recent phenomenon, harnessed by people living elsewhere. Regular use through time in any of these villages did not translate into an ethnic affinity coming from any sort of a unified group, not at the village level, and especially not under the Qiang, with its unification as a single nationality being seven decades old, and engineered by the state. This ethnic unification was also not visible in other areas such as language, touristic displays, or even culinary practices, with competing claims of who is “truly Qiang” in the latter two.

In regard to the second medicine, *qiang beimu*, the new possibilities of ethnic denomination did not reflect on the Qiang who were not directly involved in such enterprise. It did not draw from the majority of the contemporary Qiang, either in their practices, uses or preferences. Such articulation shines a light on how materiality, properties, and “history”, are derived by singling out certain geographic areas, and then further designating certain individuals, to speak for the whole ethnic group. In this way, who and what speaks for the Qiang gets mobilised for standardising and marketing purposes. The workings of such generalisations are very practically minded, and the outcome is completely dependent on a possible future acceptance by the market, and on how well promotion is carried out. In this sort of ethnic labelling, the end justified the means, and interlocutors moved quickly between abstract and historical arguments, to reject or approve certain labels, towards very pragmatic ones, easily accepting that the promotion of Qiang medicine justified such attributions. Finally, under the guise of poverty alleviation and job creation, the motor for such workings was the prospect of entering the vast Chinese and international markets of materia medica, medicines and supplements, with tremendous efforts employed in the push for a Qiang medical industry, which I explore in the following chapter.

In marketing these products and services, catering for the imagination both of the Han majority, and of that of foreigners, is paramount. Interestingly, the category of Qiang, by virtue of being a historically Han-defined “other” (Wang, M.K. 1999a), sheds light on the majority itself. It does so by virtue of being an external group definition and construction that loops back into the Han majority in the form of “ethnic medicines”, “ethnic clothing”, and “ethnic places”. For those individuals defined as such, the distinction seemed to lie between those who had stakes in specific enterprises and those who did not, be it related to medicines, or to tourism. They then defined themselves along contingent lines as they navigated the socio-political-economic system in their daily lives, and when looking at future prospects did so with either hope or suspicion, depending on where they stood. Not only is self-definition done in this way, but also the definition of other elements in this environment, in the case presented drawing from location, process and therapeutic use to articulate Qiang medicines. Medicines which, in particular, offer an excellent cue to engage not only in discussions of ethnicity, but also of livelihoods, medico-healing practices, resources, and industry.

Chapter 5. Pushing for a Qiang medical industry

In the previous chapters I have unpacked the attempted articulations of Qiang medicine and medicines, showing both to be fraught with friction: the first being tentatively assembled amidst a disputed unifying theory as well as the interests of different practitioners, the second through a contested materialisation of ethnicity in medicines, both endeavors ignored in the two villages where I conducted fieldwork. I have in this way set the foundation for what I will explore in this final chapter. Here, I demonstrate how in institutional circles of academia, government, industry, and stakeholder practitioners emerges a mutual reinforcement between Qiang medicine and medicines. Laying the ground for the establishment of a prospective Qiang medical industry, the articulations of both Qiang medicine and medicines featured in a widely shared vision of an imperative, rarely questioned, linear development of industrial change and economic growth. If such vision was passionately argued for by those with stakes in the enterprise of ethnic medicine, with undertones of not wanting to “lag behind” nor to be considered “a backward minority”, it was nevertheless doubted by those at the margins of such project.

I will begin by picking up from what I have elaborated on earlier in the methodology section and give an overview of temporal and atemporal anthropological approaches to the study of development, modernity, and industrialism. These are relevant when positioning China in the world, as well as the Qiang in China, both in relation to the Han majority and to other minorities. Then, I will put forth the local arguments, justifications, and proposed ways for what is a central feature of these industrial development efforts: standardisation and scaling up. This will be done firstly in relation to Qiang medicine, and secondly to Qiang medicines. Thirdly, I will show how the development of the latter, deemed extremely important to that of the former, is articulated along the current problems and prospective solutions for its supply chain sustainability, couched in a discourse of environmental protection. Finally, I will focus on how the WHO, with its current “Traditional Medicine” strategy, arguably designed

with Chinese economic interests at heart, encourages such production and consumption cycles, whilst ignoring many of the communities that it claims to care for.

“Latecomers” and the anthropological approaches to industrialism

In the research on modernity and industrial realities there has been a rift between the approaches of those working with material semiotic ethnographic methods, attending to what has been defined as the agency of nonhumans in constituting practices and social configurations (Callon, 1984; Latour, 2005; Law and Mol, 2001), and those more interested in a political approach that investigates the externalities responsible for inequality through history (Fortun, 2014; Landecker, 2016). There have also been those attempting to bridge the two fields, arguing that the methods of the former can be harnessed for the investigations of the latter (Anderson, 2002; Kipnis, 2015; Fitz-Henry, 2017).

Latour starts with the premise that “we have never been modern”, that modernity entails a work of purification, a separation between the “natural” and the “cultural” that never really succeeds (Latour, 1993), and so he vouches for a research that “follows the actors” in such attempts (Latour, 2005). As I mentioned previously (see Methodology section), the criticism given to those working with material semiotics in such way is that they are not only being apolitical but also ahistorical (Fortun, 2014). In the words of Fortun: “even if we have never really been modern, we still have a modernist mess on our hands, a concrete mess, produced (in part) by what could be called an industrial theory of meaning and value, an industrial language ideology” (2014, p.312). The temporal aspect of such approach is visible in the definition of the current age as “late industrialism”⁷⁴, which according to Fortun consists of “deteriorating industrial infrastructure, landscapes dotted with toxic waste ponds, climate instability, incredible imbrication of commercial interest in knowledge production, in legal decisions, in governance at all scales” (2014, p.310). Ironically, while borrowing a similar temporality, it is also a “lateness” that which gains very aspirational contours in China (and East Asia), a region that has been continuously referred to as a “latecomer” in a

⁷⁴ This term has roots in the work of the sociologist Ulrich Beck with “risk society” (1992) who referred to epochal distinctions of pre-, early, and late industrialism.

modernising and industrial sense (Wang, F.L. 2016). This phenomenon has been explored by STS scholars working in East Asia who paraphrased Latour with “we have never been latecomers” (Chen, 2015; Lin and Law, 2015), in the attempt to detect alternative knowledge spaces for local technosocial practices (Lin and Law, 2015)⁷⁵. It has been the conjoining of such modernist discourses, both from without and from within, that has produced “modern China” (Yang, M.M.H. 1994). However, this sense of deficiency has not been reflected in a completely one-sided push for copying the West, nor hostility towards what is considered to be Chinese, it has instead allowed “for shifting and contested positions toward traditions, ranging from projects that would entirely destroy the “old” to those that would preserve or even invent traditions as sources of modernization” (Meinhof, 2017, p.53). I argue that the project of Chinese and ethnic medicine in China is one of the latter. In this case, reaction and compliance to external rules and standards can be found both in China when facing the rest of the world, and in minorities facing Chinese institutions. In relation to Chinese medicine, the minorities “developing” their own ethnic medicine are considered the “latecomers”, and among these, blaming missed opportunities for not (yet) having registered proprietary medicines, are the Qiang, further “latecomers” down the road. It is in this context that encounters in conferences between Qiang practitioners and those of other ethnicities showcase the weight of questions such as “you don’t have written language, right?”

The way in which Latour described the “moderns” as abolishing the past (Latour, 1993), however, bears no resemblance to this project of ethnic medicine, which constantly draws from the “ancient times” for legitimacy (as Dr Zhang invokes what he takes to be “Qiang writing”), following the contemporary Chinese medicine maxim of “inheriting and developing”. Very occasionally there was a mention of a “modern traditional” hybridity (Marsland, 2007), or of “modern inheritance”. However, what was visible overall was an ingrained technosocial evolutionism that ran without the ambition of arriving at a modern stage, or to be “modern”, but instead with a taken-for-granted impetus of simply moving forward while carrying one’s inheritance along, and thus avoiding being “backward” (*luohou* 落后). Even among those displaying their use of

⁷⁵ Liu (2011) argues with dismay that many STS scholars in China think of the main task of the discipline as advancing technological innovation and developing production, while Li and Lu (2018) defend the uniqueness of STS in China, having been “deeply influenced by the tradition of Marxist ideology”.

high end technology for the extraction of active ingredients, there was a sense of transmission of some form of legacy.

Therefore, Qiang medicine was in general portrayed as being purified, but not modern, which among most Qiang practitioners gained the previously mentioned connotation of that which disregards the past. Instead, the past was re-fashioned while engendering Qiang medicine as systematic, having a method, ethnic, unique, *youtese* (有特色 with special characteristics), inherited over a long line, and in development. Those at the forefront of Qiang medicine as a discipline vouched for it to be ready for the market and industry, among efforts to show and prove why it deserved to be so, as they attempted to meet the necessary standards. Standardisation then came as a process of tailoring and adjusting practices, materials, and theories, within this circle, so that Qiang medicine was fit for the market. Qiang medicine practitioners would team up with government officials, academics and business leaders, the latter three labelled “the key formulators of triumphalist Chinese capitalism” by Ong and Nonini (1997), in the struggle to agree to a way for standardisation. These individuals were united by a notion of “lateness” and by the prospective rewards that awaited. They were also united in disregarding many village healing practices as non-transferable, condemned as misguided, as in the case of those performed by *shibi*, despite occasional calls for their “scientific investigation”. Still, some other therapeutic practices were merely harnessed as promotion for medicinal materials.

In regard to the positioning of Qiang medicine practitioners in relation to those of other ethnic minorities, I witnessed a hospital director (who developed a “Qiang medicinal wine”, see previous chapter) speaking at a conference, calling for Qiang medicine practitioners to avoid receiving the label of a “backward minority” by combining their practices with “present technology”. In these circles, the Mongols, Miao, and the Tibetans were occasionally praised for doing so. The latter, however, had had a preferential economic treatment since the post-Mao era from the Chinese government, under the banner of “Saving Tibet”, contingent on the problem of “lagging behind” (Saxer, 2013).

Standardising Qiang medicine

Before arriving at the discussion of how and why there is the attempt to standardise Qiang medicine, I will start with the question of what exactly is being standardised. As I have shown in Chapter One and Two, through the inheriting and articulation at his clinic and public forums, that which the most influential Qiang medicine doctor at the government level aimed to standardise was already a carefully crafted articulation. Furthermore, it was directed through efforts of unification and wider acceptance, with a personal investment in wanting to speak for all Qiang practitioners, and thus defining a benchmark against which others should measure up.

Defining what it is that medicine consists of then boils down to the question of who gets to define it, among legitimacy and knowledge claims, and with both divisions, that between “folk” and “official”, and between shaman and doctor, running deep throughout Chinese history. In fact, folk customs were already officially labelled as ignorant and shamans as illicit in their ritual healing in the Song dynasty (960-1279) (Hinrichs, 2015), both having fallen in and out of favour with the state through history (Hinrichs, 2015; Lampton, 1974; Thomas and Humphrey, 1996). Therefore, these divisions are not new. In China, medicine defined as a transmitted body of theory and practice has often run hand-in-hand with medical institutions and with some sort of standardisation (Hsu, 1999), with the legitimacy of medicine also tied with the legitimacy of those same institutions. What is fairly recent in comparison, is an ethnic attribution to medicine under the wing of a scientised and systematised Chinese medicine, a literate academic discipline in the making (Andrews, 2014), and its standardisation aimed for the nationwide healthcare market, as well as towards a global one. In this aspect, a difference that appears between Qiang and Tibetan medicine is that the latter, given its wealth of medical texts and the fact of having been widely practiced in Tibetan institutions before “liberation”, as well as having been left to its own devices in the 1950s, always displayed a degree of divergence from Chinese medicine (Saxer, 2013). Conversely, among those spearheading the prospective Qiang medical industry, the ambition was scale, not divergence. Hence, in their discourse, Qiang medicine slipped perfectly into a Chinese medicine framework as its “ancestor”.

The articulation of Qiang medicine as an academic discipline appeared tied to the production of school manuals by Dr Zhang and the attempt to develop courses at Sichuan educational institutions. The promotion of this “doctoring” enacted in academic and medicine conference circles gave great importance to written language and medical theory, in an effort to demarcate the discipline from “folk”. In contrast, among the villagers with whom I conducted fieldwork there was no mention of either a Qiang or a “folk” medicine, which leads me to think of medicine in this case as a category invoked by practitioners and institutions, even if to describe what “the folk” (*minjian* 民间) do, but not relevant in the context of the problems and solutions that emerge in village daily life. In a similar way to what Das (2015) describes, local afflictions in the village context were shown as events embedded in everyday life. Their solving through self-care, or by visiting the *shibi* (who accumulated several functions besides those he claimed to be medical) was not framed as constituting medicine.

When I asked an academic who worked in the organisation of the Qiang medicine conferences whether they would ever consider inviting *shibi* to participate, her vision of what Qiang medicine and Chinese medicine together should aspire to achieve completely excluded that possibility. She did not see the *shibi* as being fully dedicated to medicine, having “many interests”, describing them as lacking in knowledge and mistransmitting what they knew, as they passed it orally. The best, in her view, was to have a foundation in Chinese medicine theory, and then, on the top of that, to also have “the family heritage of Qiang medicine”. Taking this into account, she spoke highly of Dr Zhang not only for his strengths in the theory of Chinese medicine, but for having first-hand experience of the medicine and therapeutics of the Qiang nationality, in what she called “folk herbal medicine” (*minjian caoyiyao* 民间草医药) and that by integrating the two he could use “the thinking of Chinese medicine theory to sort out the theory and experience of Qiang medicine”. She considered this a “very good process for us to carry forward Qiang medicine”, that such a solid backing, while being inherited, was “the main force and source of development of Qiang medicine”. Interestingly enough, while she conceived Qiang medicine as Chinese medicine peppered with some “Qiang characteristics”, a work conducted primarily in a Chinese medicine framework, Dr Zhang always performed it as if putting forward something completely unique and distinct, with any similarities with Chinese medicine only due to the fact that Qiang

medicine had predated it as its ancestor, not to mention the fact that he always distanced himself from any “folk medicine”. This apparently opposite but complementary stances suggest a kind of organisational symbiosis that suited both individuals.

“Being simply a lonesome folk doctor is not enough”

The scaling up associated with standardisation was often not only associated with development but with competence. Achieving that level of competence was then coupled with striving to establish an educational structure, through which Qiang medicine could be inherited and transmitted, in China and beyond, in a harmonisation of formal education, apprenticeships and clinical experience. Dr Zhang spoke of his ancestors as famous folk doctors, but that the insufficiency of the “folk” status lay in the small group of people that they could serve, and his concern was about how to expand this “service group”. He took himself to be a pioneer who by coming down from the mountains to the capital had brought Qiang medicine, where it could “take root”, and be “developed and carried forward”. He insisted that despite his clinic being relatively small, their “connotation building”⁷⁶ (*neihan jianshe* 内涵建设) was quite good, and they had mastered their techniques perfectly with visible results and benefits in curing their patients.

This “taking root” in the city, as a precondition for the discipline to flourish, sheds light on a sort of selective standardisation, that is not about an all-encompassing adjustment of practices, but instead of a dismissal of those not willing or unable to “make it big”. Therefore, I argue that this kind of standardisation starts where there is a body of theory and practice to be replicated and uniformised, and that dismissing “folk” is not standardising but rather consolidating a group of doctors and a medicine, in this case under a socio-political imperative of development. That which is left behind is then taken as not worthy of being standardised in the first place, or to be called medicine for that matter. What is “carried forward” is then a “developed inheritance”, an ancient wisdom that has embraced technology. A contradiction then emerges in Dr Zhang’s discourse, that is of a conflicting claim of Qiang medicine as a medicine that speaks for the whole ethnic group, ubiquitous among the people, while at the same time remarking

⁷⁶ “Connotation building” stands for innovation, development of strength and competitiveness, a term used among players in China’s healthcare market.

the group's ignorance of it, and that folk doctors or *shibi* even when taught are unable to grasp Qiang medicine core concepts, the theory they possess not being "deep enough". Qiang medicine is in this way portrayed both as pervasive and vast, and as precious and concentrated, worth protecting and developing.

Such distancing from "folk" accompanied a disinterest of villagers towards the services of such doctors. Rather than any sort of ethnic affinity when choosing medical care outside the village, what I found was a pervasive preference for large Western medicine hospitals. In fact, any doctor dispensing exclusively medicinal herbs was unpopular in these villages, as these medicines seemed within reach, something that villagers could sort out themselves, and so associated to solving minor conditions that they felt capable of treating. Confronted with this preference of care, Dr Zhang insisted that patients would find a variety of choice suited to their particular condition when entering these large hospitals, with "modern medicine", Chinese medicine, Qiang medicine and that of other minorities available and complementing each other. However, the kind of choice that he described was more of a distant reality, since such "melange" did not happen at the time in Chengdu hospitals, with only a few Qiang doctors practicing out of the city in county hospitals. And that was, in fact, a distant reality that was not ambited by villagers anyway. Hence, Dr Zhang's idea of expanding the "service group" consisted mainly in gearing Qiang medicine to the Han majority, by facing China's large healthcare market.

While taking this dynamics into account, in Fengyi's unassuming Qiang clinics I saw many patients that were locals to the town, and others that were of Han ethnicity who had travelled from Chengdu. Also, Dr Jiang, with his widespread fame for having appeared on regional TV, had Tibetan patients who had travelled from afar. Coincidentally, it was in these Maoxian clinics that there was more value attributed to "folk" practices. Still, all doctors dismissed *shibi* and their incantations, and village local afflictions were taken as "ideologically backward", or a result of deception by *shibi*. This rejection could be understood as a conflict of what Kleinman has described as "explanatory models" (1978), but rather than seeing these as different explanations for a phenomenon that does not affect both parties equally, I take the case of *poison cat*, as an example, to be an entity that is simply not present in urban areas, and so is excluded in those explanations as even existing. Under a material semiotic prism,

explanations draw from networks, and as Latour observes: “accounts of agency will constantly add new entities while withdrawing others as illegitimate” (Latour 2005, p.56).

The dismissal of incantations was something that I also found while investigating “folk medicine” in Russia. These were on one occasion made redundant by an interlocutor shifting their healing agency, when used together with medicinal herbs, towards the vitamins present in the latter, which had been placed in them by God (Campinas, 2013). When Dr Yuan called for cases of *poison cat* to be investigated scientifically, he too was shifting agency from *poison cat* towards natural elements that just lay there waiting to be identified by science. These were in his view being manipulated by the *shibi* for the sake of controlling his fellow villagers, a view that consolidated the legitimacy of practitioners such as him.

The so called attack by *poison cat* that Dr Yuan called a “disease of redness and swelling” (*hongzhongbing* 红肿病) was according to him solved easily by one of the medicinal herbs commonly designated as “*poison cat* herb”. These would act as “detoxifiers” and cause diarrhoea so that the poison could pass through one’s stools. The reason that one should ingest it at night and not during the day was simply for it matching “our *yin* and *yang* of Chinese medicines, as well as our natural *yin* and *yang* of human beings”, with Dr Yuan adding that “it’s not a mysterious thing but people deify it (*shenhua* 神化)”. This “deification” and “mystification” (*shenmihua* 神秘化), which Dr Yuan blamed for “separating ourselves from natural science” and “losing many opportunities” was compatible with the reverence that he claimed Qiang people had for mountain gods and fire gods, with the latter translating into what he saw as protecting “nature” and respecting its laws. In his view, “(as practitioners) we should respect realistic science and not revere what is unscientific”. However, it was acceptable for him to “instil a superstition into someone”, when writing a prescription, or giving a massage, and reciting an incantation while doing so. Superstition and science featured in a fluid balance that depended on how and by whom they were used, as he drew from both while rejecting what he saw were the manipulating intents of *shibi* as well as the misguided practices of “Western medicine”. Therefore, while denouncing the *shibi*’s deception, he praised the “persuasion” that came with his own incantations and his soup

made out of the ashes of Daoist symbols. The latter, apart from comforting a patient's essence-spirit (*jingshen* 精神), could “enliven and activate some positive energy dormant cells in your body, fight against your disease cells, achieve a balance, and then the disease will be cured, according to its natural tendency”. At the same time as calling to “respect nature and break away from superstition”, he praised such healing methods, at least when performed by him, under his benevolent intents. Hence, with Dr Yuan there was no stark divide in excluded elements of a network of healing, but rather an exclusion of individuals performing them, as in this case the *shibi*, with what he considered were his dubious intentions. Dr Yuan's enthusiasm for scientific enquiry ran along with his pseudo-scientific discourse, drawing from scientised entities that he framed in an environment of balance. These featured in his treatment, which he qualified as “discharging” and “unravelling”, and contrasted it with the “cruel, sterilising and disinfecting” practices of “Western medicine”. Rather than taking such practices as led by malicious intent, he framed them as misguided, and as being set on blind destruction that resulted in self-harm. He saw microorganisms reproducing faster along the development of stronger antibiotics and equated this situation to two countries locked in an arms race. The solution was to use compassion and the “concepts of Chinese and Qiang medicine” in order to appease the microorganisms, a simple matter of “abiding by the law of nature”.

One can spot from Dr Yuan's position firstly the notion of balance and non-interference, characteristic in the Daoist underpinnings of Chinese medicine, secondly, scientisation, and thirdly, the rejection of the methods of “Western medicine”, as he articulated Qiang medicine in a manner distinct from other practitioners. Such manipulation of “dormant cells” through incantations was exclusive to Dr Yuan, in fact, he was the only doctor I met who admitted to using incantations, justifying deception as an instrument to bring about positive changes in a patient's health, and contrasting it with *shibi* who he claimed would do it for power. All other doctors discarded incantations altogether, while still referring to “psychological action” through their practices.

When it came to disputed entities, if in clinics *poison cat* was completely discarded, the gods were somehow transposed. With *shen* (神) standing both for “god” and “spirit” in

Chinese, Dr Zhang spoke of the “heaven gods” (*tianshen* 天神) as referring to “natural law” (*ziran guilü* 自然规律), and of *shen* as one’s “spirit”. Therefore, in his view, “offending the gods” stood for offending the “natural law”, as well as one’s spirit and body. One could execute such offence for example by staying up late and not getting enough sleep, which would then be followed by consequences arising in one’s health. This take reflects a human-centred reframing of morality that fits well within the so called “dialectical” thinking to which practitioners claimed to subscribe. By thinking in this manner, the focus is on an individual responsibility for one’s actions, rather than responsibility being attributed to external entities. In *‘Just some spirits’: The erosion of spirit possession and the rise of ‘tension’ in South India*, Halliburton (2005) develops on what he calls “the ascendance of universal categories”, with the proliferation of psychological idioms centring distress on the self, and away from spirits, a phenomenon that bears similarity to Dr Zhang’s notion of “offending the self”.

Overall, in the articulation of Qiang medicine as a discipline, I found three most commonly agreed on divisions that gave the first glimpse of agreed standards among practitioners. Those were: between “official” and “folk”, between doctor and *shibi*, and between medicine (*yixue* 医学) and witchcraft (*wushu* 巫术). Regarding the latter, every practitioner saw this division having been maintained in their families for at least two generations, only Dr Yuan treated the two as “mutually reinforcing”. Qiang medicine was thus generally articulated along these lines. The dismissal of *shibi* is important for understanding standardisation especially for drawing a line on what is worthy of being standardised. Finally, in this standardising drive, folk doctors were urged to supersede that status in a move imbued with the beneficence of serving a wider base of patients. The future tendency is, for one to become an “official” Qiang medicine doctor, training on a (not yet) unified Qiang medicine to be essential (see Dr Wang’s case in Chapter One).

Standardising as “making it more legal”

Having shown how Qiang medicine practitioners demarcate what and who is eligible to constitute Qiang medicine as it is “carried forward”, I will now discuss the criteria, objectives and obstacles facing these practitioners as standardisation is broadly taken as a necessary step towards developing an industry of health services. This is a step not

only deeply linked to legality, but often equated to it. In *Market magic: getting rich and getting personal in medicine after Mao*, Farquhar (1996) elaborated on individual strategies that practitioners in the North of China engaged in, navigating small entrepreneurship while striving to achieve wealth. She showed the distancing from the state slogan “Serve the people” and the embracing of “To get rich is glorious”, while still warning that this move should be read against the backdrop of previous deprivations during the famine of the Great Leap Forward and the pervasive asceticism of the Mao years. These were individual practitioners operating alone in small retail businesses, and what I will show here is the scaling up and organisation (but also conflict) between practitioners, attempting to find a common ground in the form of standards in order to take up their Qiang medicine enterprise to China’s healthcare market. Here, with this being a group endeavour, despite the omnipresent promise of riches, the altruism behind “Serve the people” lingered on, but under the premise of serving through the wide reach of the market.

The state effort to spur marketisation can be seen in Chinese policy, and is advocated by Chinese-born scholars at home and abroad, such as Fei-Ling Wang, a professor of international affairs, who argues: “a state-led route and a strategy of guided marketization are more appropriate for modernising efforts of "latecomer" nations” (Wang, F.L. 2016, p.7). These efforts have only intensified and diversified since the Deng Xiaoping years to different areas of commercial life, such as the healthcare market of minority medicine and medicines. Policies in this context feed a cycle of guidance and conformity, as they indicate in what areas funding might be available and provide new openings and the possibility of certifications. In this way, they afford stepping stones for the complying enterprises towards a wider market reach. Nevertheless, there is a difference in the nature of regulations issued for medicine, when compared with those for medicines, the latter taken to be too restrictive among practitioners, academics and the industry, something that I will explore in the following section.

With the Chinese medicine strategy asking simultaneously for standardisation and diversification of services (State Administration of Traditional Chinese Medicine of the People’s Republic of China, 2016), in practice, Qiang medicine doctors were left to their own devices regarding what services they decided to provide. The lack of a

“doctor qualification certificate” proved to be a problem especially if one was to practice in a hospital, in small clinics it was a matter of having the minimal documentation required in order to keep an establishment open, even if this was under a masseur (*anmo*) certificate. Dr Wang at the apprenticeship ceremony (see Chapter One) was the only case I came across of someone facing certificate issues while working in a small clinic, and his hassle was coming from customers rather than inspectors.

Therefore, in clinics there was then a fine balance between firstly, the boldness attributed to the Zhuang minority (see also in Chapter One) for having pushed the boundary on legality and achieving posterior state recognition, and secondly, a wish to comply with the law in order to establish Qiang medicine further. This discretionary compliance and grey area legality were evident when practitioners referred to the advantage of certificates as “making things more legal”. In regard to hospitals, the father and the son practitioners who came down from their village invited to work at the Maoxian Chinese medicine hospital, did so while the hospital director who had invited them took personal responsibility for any medical conduct issue that could arise, given that they were not certified. Despite them having vastly increased the patient demand, this director argued that once he left his position at the hospital, there was anxiety among the other directors, regarding the possibility of them not being covered in the case of a medical accident, and that so they removed the two practitioners eventually. When speaking to both father and son, both admitted they far preferred practicing in their own clinic to their previous job, on account of having a more pleasant working environment.

Most practitioners mentioned the policies on ethnic medicine, including those of 2016 (that included it as part of Chinese medicine) (People's Republic of China Twelfth National People's Congress, 2016), as protective of doctors. Some saw them also as supportive to the growth of the industry, with one practitioner who received help from the government in setting up his company mentioning an “emotional treasuring of this industry” (*ganqinghua de aihu zhe ge xingye* 感情化的爱护这个行业) by the state. Guang De, the development strategist, argued that there should be more policies and stronger ones in place, in order to speed up training and accreditation of Qiang doctors. He saw the importance of policies running alongside that of market recognition. Others equated having more policies with development. The question that I placed among

practitioners as well as academics and industry leaders, of whether they were having the opportunity to influence policy in the many meetings and conferences that they took part in was predominantly reframed not as “influencing” but as “advice”, “providing reference”, or of the “political-industrial-academic (*zhengzhi chanye xueshu* 政治产业学术) working together”. However, one interlocutor felt that his suggestions were ignored, while another gave evidence of small achievements that he claimed proved that the government “listened to the views of the “grassroots level” (*jiceng* 基层)”. Some, however, complained that the state paid attention but did not take concrete action nor provided funding for projects.

The stepping aside of the government on such implementations and letting the market do its work can be explained by recent changes on the structure and funding of organisations who mobilise the “political-industrial-academic”, such as the, at the time, newly founded “Sichuan Provincial Research Association of TCM Appropriate Technology”. One of its leaders explained to me how such organisations had become self-sufficient, by organising “business activities”, selling advisory services and working with projects entrusted by the government. In this way they had overcome the direct dependency on government funding:

In the past, Chinese social organisations were funded by the government. But in the last few years, the government has allowed social organisations to operate independently. Because before when the government allocated funds, there were advantages and disadvantages. The advantage was that it ensured the normal operation of these social organisations who would carry out their activities, but sometimes there were disadvantages that bred some inertia, such as the lack of independent innovation or initiative, so now our national government adjusted to the international standards, it is called “alignment” (*jiegui* 接轨).

Therefore, what was seen by some as lack of government engagement, was seen by others as the spurring of innovation, meeting “international standards”, by letting the market pick what was worth developing and to raise funds through that pathway. The abundance of platforms provided by the numerous organisations was occasionally met with frustration, for practitioners not seeing concrete results in the promotion of their own companies, while realising that this kind of endorsement was also not forthcoming from the state. Some founded companies under the activity of “research

and development of products and services”. These allowed practitioners and their associates to operate as “legal” or “corporate” entities, rather than as individuals, reportedly facilitating dealings with other entities. Such companies competed with each other as they tried to assert themselves, and there was at one point accusations of one being a “shell company” (*kongke* 空壳), with no content of their own, simply plagiarising another.

For Dr Zhang’s company, one of the priorities was establishing a chain dedicated to “well-being recuperation” (*kangyang* 康养), or “recuperation of suboptimal health” (*tiaoli yajiankang* 调理亚健康) (see Chapter One), following the model of other existing Chinese medicine chains in the country. The development strategist argued that they had the resources but not the personnel to make it happen. And that is why such importance was given to collaboration with academics who were lobbying to get a certification procedure accepted for vocational schools and beyond. This push was seen not just as a form of developing the industry and reaching more consumers, but also benevolently as a way to “solve unemployment”. Therefore, if standardisation was of minimal practical relevance for clinics, save for the question of practitioner certification, I argue that the brunt of standardisation impact is on how Qiang medicine might be practiced in the future, should the wish for en masse training of practitioners be fulfilled.

The academic material that would support such training was being developed by Dr Zhang and would feature highly disputed theories among Qiang doctors such as those of *stone disease* and *sanmisashe ducts*. If Guang De, the development strategist, dismissed “Western medicine” treatments (except in the treatment of cancer) and considered them useless in prevention and recovering, he praised what he saw was a unification in its theory: “is there not only one theory of Western medicine?”. He saw this unification also in Chinese medicine, and so vouched for following its scientised and systematised approach that the discipline has carried since the 1950s (Taylor, 2005). For him, the standardisation, or “principlification” (*yuanzehua* 原则化) that he envisioned for Qiang medicine was imperative for doctors to follow in order to have a framework, a core theory to work with, which they could then build on as well as translate it into different treatments in practice. This imperative was therefore justified by the need of a

systematic education central to scaling up, for “if there is no unification of standards, then how do you teach? How do you test?”. He saw no issues nor obstacles to such push, given that according to him, the Qiang nationality was a “small population minority”. However, even in a “small population minority”, having an individual speak for the whole ethnic group is not a frictionless matter. While reflecting the fact that a single “Qiang nationality” is a fairly recent phenomenon, Dr Zhang’s “unifying” voice was criticised by one practitioner who claimed that using the small scope of what was characteristic of his hometown to guide an academic field would result in problems, a “frog at the bottom of the well” (*jingdi zhiwa* 井底之蛙)⁷⁷.

Among those academics and practitioners linked to the Chinese Medical Association of Minorities it was frequent to hear a call for the unification of practices and theories, that by each one “doing their own thing” it was being difficult to combine efforts that would push the industry forward, which a few insisted was stuck in a “bottleneck” (*pingjing* 瓶颈). This was framed as an obstacle caused by practitioners putting their own interests above those of the cause of Qiang medicine, and the contradiction in this came down to the very obvious stakes of those determining standards. The “Association of TCM Appropriate Technology” called for the implementation of therapeutic pathways and guidelines, and Dr Zhang in particular called for sweeping standardisation of practices to take place immediately and at once, rather than later and in small increments. However, like all the other practitioners, he agreed that there were areas that could not be standardised and like almost all of the others gave the same example of pulse examination to justify his point, an impossibility tied to each individual patient’s unique constitution.

The possible conflict between providing services that were reportedly tailored to an individual patient, and between offering standardised solutions was apparently inexistent for Dr Chen at the “medical society” (see Chapter Two)⁷⁸. Because his family was invested in both fields, he did not see it as a matter of having to choose

⁷⁷ The “frog at the bottom of the well” is a Chinese idiom that relates the encounter between a frog boasting of his home at the bottom of a well to a turtle who had travelled the ocean. It is commonly used to refer to someone seen as being of limited outlook.

⁷⁸ Dr Jiang and his father at the signless converted flat had not long before adopted a similar position, starting to distribute the same “foundation medicine” (*jichuyao* 基础药) to all patients in recent years. This was a tonic prepared from a secret recipe and would be taken alongside individual medication.

between one or the other and therefore conciliated the two. He agreed with standardisation for the production of medicinal products, but not for clinical practice, since “you are not a standardised person (...) his disease is not a standardised disease”. For him, engaging in industry and development were not optional but rather necessary, for as he saw it, “after surviving, one must develop”. Like others, he saw a twofold benevolence for the industrialised medicinal products that he developed. Firstly, they could accomplish something that he could not do alone, by the number of patients that they could reach and treat (even if without the specificity inherent to his consultation), and secondly, he could stimulate not only the Qiang medical industry but also others related to it, and bring prosperity to the “common people” involved in their supply. The lucrative market of medicinal products proved to be an ambitious but difficult area for practitioners to access, while standing at the core of what many thought would propel Qiang medical industry and bring prosperity to those involved. The profits from the pharmaceutical industry could even be used to build your own Qiang medicine hospital, the development strategist claimed. Entering such path required first of all for a doctor to be registered, and that was also why many saw certification as paramount.

Standardising Qiang medicines

“If minority medicine wants to develop, it is medicines, not medicine, that will really contribute the most to its development. (...) One doctor sees a few patients, but medicines are different, (...) the one that circulates in the market, the one that has a registration number, is targeting a group of more than a billion people in China.”

Guang De, interlocutor working on “Qiang medicine development strategy”

While among many working in this circle, arriving at a product suitable for such vast market appeared to be the epitome of the development of minority medicine, it is worth understanding that any such product draws from several different areas and industries, as well as from informal markets. In this section I will discuss not only the efforts and views on the standardisation of raw materials but on that of processed compound preparations, the latter more easily articulated in stakeholder circles as “Qiang medicines” than the former (see Chapter Four). I argue that the contrast between the two offers the perfect cue to rethink who are the beneficiaries of such standardisation.

It is worth mentioning that the essentialisation of medicinal substances and preparations in China for a formatted production, even if accelerated and scaled up in the past century, dates back to the Ming dynasty. At the time, pharmacies in China would bottle pills and powders that were prepared based on secret recipes and classic prescriptions, adorned with images and slogans for sale (Andrews, 2014). Later in the Qing dynasty, the educated elite was also bypassing doctors and their personalised treatments (Unschuld, 2010b), by turning to “folk medication” that consisted of a single medicinal herb for the treatment of their ailments, and away from the services of physicians who would charge heftily for prescribing complex prescriptions. Therefore, although Saxer (2013) argues that Tibetan medicine, for focusing on ready-made pills rather than individual prescribing is more suitable for industrial production than contemporary Chinese medicine, I would say that in China, set prescriptions and individually tailored ones have still coexisted for long enough for the transition to mass production (Chee, 2015) to be one easily embraced, at least from the side of the consumers of such medicinal products.

This transition has been described as one of “re-networking” by Lei (1999) in the case of the isolation of an anti-malarial compound in the 1940s, with Chinese medicine doctors giving way to scientists in its production. As Lei elaborates, there was a patriotic push to develop and consume domestic products under the pretence of benefitting the national economy. This nationalist fervour continued in the decades that followed, as another anti-malarial compound, artemisinin, was isolated by Tu Youyou from *Artemisia annua* (Hsu, 2006), an achievement that later granted her with the Nobel prize for Physiology or Medicine. Even the A'er *shibi*, who due to the secrecy in his medicinal herb collection would refuse to be accompanied by other villagers, vouched for the “collection and identification of specimens”, so that these “inheritances” would not be lost, a stance which echoes the choice “integration or erasure?” invoked by Adams and Li (2008).

When it comes to raw medicinal materials and compound preparations, I found standardisation to take a form that appeared at an intersection of the state and the market, while defying common assumptions of how their agendas operate. Based on her research with refugees from Southeast Asia picking matsutake mushrooms in Oregon for exporting to the Japanese market, Tsing warned against working with an

anthropology of governmentality that “too often knows the answers in advance” (2009, p.363) using ethnography only to illustrate them. She argues that it was the post-WWII development programs, in which economies of scale were taken as bringing the “greatest good to the greatest number of people”, through standardising labour and ecology management, that defined the way we frame changing economies (Tsing, 2009). In fact, in my fieldwork I found this “beneficence through scaling up” to be a common trope, with “altruistic” nationalist and communist undertones, portrayed as a necessary step to bring prosperity both to the nation and to the masses. However, upon looking closer at how standards for doing so were defined, debated, and used to guide action, by examining their unintended consequences, a richer picture emerges, one of fragmented interests pulling apart at whatever standardisation had to offer. If Latour (1993) has encouraged an ethnographic look behind the scenes at the workings of purification that take place in modernisation projects involving non-humans, Tsing has done that for the standardisation of products (Tsing, 2009, 2015). I will now develop on the standardisation of raw materials, starting with the aspect of the transliteration of Qiang names of medicines into Chinese. Although the use of these Chinese words was restricted to an academic compendium, their production sheds a light on how, to a certain extent, one arrives to the “Chineseness” of medicines.

“Instilling a soul” into a standard name

In the lengthy ethnobotanical survey that he compiled, Dr Yuan at the museum clinic saw immense responsibility when transliterating the Qiang names given to different medicines into Chinese. Firstly, he made sure to use the dialect of *quguhexi* (曲谷河西) area, which he claimed the state had designated for official transliterations into Chinese back in 1986. This made sure that his work had the country’s recognition, and not just his “own recognition”. As he saw it, in academia, names should be highly unified, as “we can’t make a hundred flowers blossom” (*bu neng gao baihua qifang* 不能搞百花齐放)⁷⁹. Secondly, because there were many Chinese characters to choose from that would be homophones, he saw it as an imperative that when borrowing a Chinese name, a

⁷⁹ This refers to the Chinese idiom “let a hundred flowers blossom and a hundred schools of thought contend” (*baihua qifang, baijia zhengming* 百花齐放百家争鸣) used by Mao Zedong. It was invoked during a brief period known as the “hundred flowers campaign” when restrictions were lifted on intellectuals, who were afforded considerably more freedom of speech and thought, for about one year (Bruckermann and Feuchtwang, 2016). Dr Yuan’s remarks on the contrary insisted that academia required unification rather than diversity, at least in the question of name attribution.

positive meaning should be used, and that the name should be endowed with the “highest cultural and positive things”, precisely for the Qiang not having an original written script. Should it be negative, he thought the medicine would be rendered worthless. To give an example of how he arrived on a final name, I will take the title of the compendium that he published, which simply meant “Qiang medicines”. In Chinese, it was called *ermasibai* (尔玛思柏). As I mentioned previously, *erma* is the common Chinese transliteration of the Qiang autonym *Rma*. The word “medicines”, however, for its Qiang sound resembling *shiber*, was transliterated as *sibai* (思柏). Dr Yuan’s choice of characters was due to the fact that *si* (思) stands for “thought”, and its loftiness “instilled a soul” into it. A more obvious option would have been to use *si* (斯), which stands merely for “this”. That would have been a mistake according to him, for it would come across as “the work done by a low person”, showing basically that “you know something about medicine, but you are illiterate in Chinese” and so “inviting to one’s own humiliation”. The second character *bai* (柏) stood for “cypress”, having the meaning of evergreen.

Interestingly, by insisting on what he saw was excellence in name standardisation, Dr Yuan seemed to be concerned more with his own personal image, rather than with how the Qiang as an ethnic group was to be perceived. This was likely related to him being aware that his work would be predominantly read by fellow academics, practitioners, and individuals at the government level, and so a priority was given to how he positioned himself among that circle.

Wild and cultivated medicinal materials

The graciousness and nobility afforded to the standardisation of Qiang names of medicines into Chinese contrasted starkly with how Dr Yuan saw the standardisation of raw materials. He was firmly convinced that firstly, it was impossible to fully grasp the complexity of a crude medicine through analysing samples, and secondly, that the very effort to agree on a standard for components of a medicine, borrowing from “Western medicine”, was misguided and counterproductive.

It is not easy to solve the mystery of nature, why do you have to fight against nature? Right? Cleverness may overreach itself (*congming fanbei congmingwu* 聪

明反被聪明误) (...) So how do we standardise it? How to standardise Chinese medicine? By form or by ingredients? Shape or composition? What is standard? How to define a standard? (...) a single medicine, with its different seasons of collection, different altitudes, different collection times, both the composition and the form will undergo changes, all can be used as medicine, how to standardise it?

Dr Yuan's concerns on the narrow scope of what was admitted as "standard medicine" referred to the criteria established in the Chinese Pharmacopoeia for identification of medicinal materials, expanded from the edition of 2010 (which already contained standards for testing chemical components) to the one currently in vigour, of 2015, by including PCR DNA identification among other procedures (China Pharmacopoeia Committee, 2010, 2015). These are standards that act as market modulators, determining what is allowed to proceed onto industrial production and eventually enter the market as finished products. And here it is important to make a distinction between collected and cultivated medicines, because the fact is medicinal herb collectors would get paid either way for the medicines they collected, unaffected (and actually protected) by these standards, given that the pharmacopoeia parameters were based on wild medicinal materials. For the head of the "*Qianghuo* research group", while developing a *qianghuo* cultivar, the concern was not on the basic components defined by the pharmacopoeia, which were assured in the *qianghuo* they worked with, but on the difficulty to tease out which other components were at work, a recurrent theme in Chinese medicine drug discovery (Lin et al, 2012).

For example, your Western medicine is different. With Western medicine it's monomers. The structure of a single ingredient is definite, and it can be purified for clinical use. Everything is very clear, but Chinese medicines are different. There are too many ingredients in it. There are many ingredients in a plant. We don't know exactly what ingredients are at work, or in what form they are working in, whether they are metabolites, or a primary structure.

Another university researcher also complained that Chinese medicines or *Qiang* medicines were unfairly being subjected to criteria that simply did not fit into how they worked.

As I often say, I clearly have big feet, you give me a small shoe on purpose to put on, then I certainly cannot put it on, ah... I am very miserable, very lame, so I wobble when I walk the street, (...) this is the most serious problem in the modern inheritance of Chinese medicine and the further development in

combination with modern science and technology (...) there is no better solution at present.

And so, in the case of the *qianghuo* cultivar, standardisation appeared as a way to produce “stable quality”, and by standardising planting and management technologies the aim was to avoid fluctuations, rather than relying on a single component’s efficacy. As I was told, by clinically testing the medicines, and finding a way for medicine parameter fluctuations to fall under a basic norm that the research group formulated, they believed the medicine was able to retain constant efficacy.

The conditions of growth were also extremely important. Apart from altitude and soil, the slope inclination and the water supply, there was one factor that a practitioner had told me was only considered among “folk”, but that they too took into account, that was the *yang* (sunny) or *yin* (shady) side of the mountain. According to the head of the research group this was very important as the *yang* side would be too dry or dense, and so the *yin* side would be the best, also for usually having a mixed forest. The knowledge that they valued from the locals that they trained in their cultivation projects regarded their climate, land, environment, natural disasters, and farming habits. All these elements would come together in assuring that certain components were present in a consistent manner.

The standardisation of Chinese medicine raw material cultivation is ensured by China’s Good Agricultural Practice (GAP), which was developed along the lines of WHO’s Good Agricultural and Collection Practices (GACP), but that does not constitute a binding standard, not now, nor back when Saxer elaborated on it in the context of Tibetan medicines (2013). Zhang et al (2010) argue that GAP is still dependent on producers and farmers for its popularisation. Mr Luo, the pharmaceutical representative, was of the opinion that the early stage of Chinese medicine cultivation should be standardised, to make sure that pesticides, fertilisers and “rotten medicines” were controlled, and that the composition of the soil was suitable for a certain medicinal material. However, his company was not GAP certified, and he did not see a need for it to be so. Despite supporting such standardisation, he was against strict standard controls for final products. He was convinced of a hierarchy within the industry that set level standards of production, and which determined the price of a medicine, rather than this

being decided by whether it had a high content of a particular component. Therefore, he saw raising the bar on the latter to be pointless.

In the distinction between wild and cultivated raw materials, almost all interlocutors, including all villagers, and also Mr Luo, the pharmaceutical representative, agreed that the wild had superior quality to the cultivated. Only Dr Yuan at the museum clinic argued against making such sweeping generalisations, and a university researcher working on the standardisation of Qiang medicines preferred to think of clinical efficacy and claimed that research showed that the wild were not necessarily more effective. He also thought that the cultivated medicines by virtue of having “more scientific and standardised” planting techniques could and should “grow better”. One of the leaders of the “Association of TCM Appropriate Technology” was also of the opinion that some cultivated medicinal materials could have better quality than their wild counterparts.

For the pharmacopoeia parameters being based on wild medicinal materials, standardisation took a dimension that protected the interests of collectors, and forced cultivation initiatives to emulate those same parameters, both in morphology as in chemical composition. If on one hand this created problems for those developing cultivars that did not match the pharmacopoeia description for their enlarged size such as with *wabu beimu*, or for their fibrous roots such as with *qianghuo*, on the other hand it guarded against pollution and the use of pesticides, despite the abuse of fertilisers still being hard to control on finished products. This abuse of pesticides and fertilisers is a problem recognised by the Chinese government in the “National authentic medicine production base construction plan (2018-2025)” (State Administration of Traditional Chinese Medicine of the People’s Republic of China, 2018), but as long as GAP is an optional requirement this problem is likely to persist, even with the flash inspections that teacher Zhou claimed were now routinely performed by the government. Regarding the safeguarding aspects of standardisation towards the industry, Tsing has a point when she asks bitinglly “why not live for the moment and throw away all our plans? Who needs standards when the prizes are so close to hand?” (2009).

However, when it comes to the clinical aspects of assessing active chemical components, this essentialisation is still fraught with contradictions. Aside from those destined for industrial production, the supply of raw medicinal materials to hospitals

was in theory required to be done through a certified company that performed quality control on either collected or cultivated medicines, and not directly from individuals buying from collectors. One of the Maoxian Chinese medicine hospital directors referred to it as “sunshine procurement” (*yangguang caigou* 阳光采购), calling it a “standard form of obtaining materials, products and services in an open, transparent and scientific manner”. When I contacted the company that was said to supply the hospital, they claimed they had never supplied raw medicinal materials to them. Upon asking the hospital pharmacist about this, he simply stated that he could not discuss it. The mystery shrouding this particular supply of raw medicinal materials illustrates well the loose grip of standardising procedures in this part of China. I will now turn to the standardisation of compound preparations.

Processing and production

The dream of producing Qiang proprietary medicines with a “national medicine registration number” from original family secret prescriptions was shared by Dr Zhang, Dr Chen at the “medical society”, and many of those in the academic-industrial circle, while at the time those medicines were only allowed to be sold in their individuals clinics as I mentioned previously (see Figures 47 and 48). The motivation for doing so was generally one of unquestioned necessity, reflecting on the shared desire among these stakeholders for the Qiang as a group to overcome what they saw as the unfortunate condition of being a “latecomer”. This was also a motivation spoken by Dr Chen as linked to a notion of benevolence, by the possibility of their medicines reaching a large number of people. By others, this was spoken of as a way to publicise their minority medicine, imbued with a sense of pride, with one interlocutor making the parallel between these practitioners and a proud Sichuan chef who hopes that his dishes will feature among the famous cuisine of the nation. Another reason pointed out was the sheer profit that it could bring, which could then be invested in developing Qiang medicine. If one interlocutor mentioned how the government encouraged ethnic minorities to develop their own products, another complained that despite the encouragement, there was no government attention paid to it, and without concrete state efforts, the development or demise of such ambitions was left to the market.



Figure 47: Dr Zhang's alcoholic solution for external application



Figure 48: Dr Chen senior applying his family branded muscle pain spray solution to a patient's back

Among those working in and with the pharmaceutical industry, who were trained in Chinese medicine, the enthusiasm for proprietary medicines came firstly with the idea of a better and faster absorption by the human body of these medicines when in the powder form, when compared with herbal piece decoctions. Secondly, it came with the antithesis of the personalised care that many imagine is integral to Chinese medicine, that by embracing a fixed formula, process, and standard, medicines aimed at specific patients would have a “very good curative effect, as long as the quality is guaranteed”. However, in regard to an assured quality, a university researcher argued that this is already reduced at the point of R&D, for the requirements of using lower dosages in clinical trials, and that therefore the herbal pieces individually prescribed by a Chinese medicine doctor would be “more potent” and “work faster”. This notion of potency was also in a way echoed by the pharmacist at the Maoxian Chinese medicine hospital who considered that decoctions were more appropriate for acute conditions, while proprietary medicines suited chronic conditions better.

In regard to the tension between the secrecy of a family's prescription and the wish to scale-up, I came across a case that contrasts with what Saxer (2013) has described in Tibet. In the case that he related, after a very successful patient treatment, an *amchi* (practitioner of Sowa Rigpa or Tibetan medicine), had several doctors coming to ask him for the prescription that he had used. This knowledge was only transmitted from

father to son and his ancestors had warned that breaking the prescription secrecy would cause the medicine to become ineffective. Eventually the *amchi* consented, for the sake of helping many people, in what Saxer argues were economic and moral reasons for doing so (Saxer, 2013). In the case that I came across, two of Dr Chen's prescriptions happened to catch the interest of teacher Zhou, who was proposing to have them produced at different medical institutions. She insisted that the property rights would still belong to Dr Chen, that she "wanted to help", but Dr Chen eventually refused to disclose the prescription, reportedly for fears of being seen as not caring for his family skills. In this balance between benevolence and profit, beyond those moral and economic reasons, it is important to also consider the terms under which such disclosure is made, and the perceived consequences for doing so.

The leverage that a family could have on disclosing a family prescription and in this way possibly setting the terms on which scaling up was done, was intertwined with the absence of standardisation when it came to processing and production, something that was pointed out as one of the several obstacles that had caused Qiang medicines to not have "national medicine registration numbers" yet. The main reason brought up to explain that absence was the one I mentioned previously of missed opportunities in the 1980s and 1990s, at a time when the registration of medicinal products was more straightforward. This was a time at which, according to Dr Zhang, the state would approve and register one prescription after another as long as a practitioner's prescription was declared "to have very good effect". He claimed that unlike among other minorities like the Miao (Yang and Peng, 2015), the Qiang did not receive timely information on this, due to poor coordination between grassroots workers and the government. Dr Zhang saw the present regulatory requirements as one of the bottlenecks hindering the development of Qiang medicine and complained that even if the government was supportive there were simply too many restrictions in place.

The 1980s and the 1990s was the period that preceded the implementation of a centralised system for drug registration in 2002 by the SFDA (State Food and Drug Administration), later named NMPA (National Medical Products Administration), which brought extensive requirements including scientific studies of safety and efficacy (Saxer, 2013). Drugs registered locally before 1997 were exempt and passed onto the new system, but the ones registered later required re-registration according to the then

new protocol (ibid.). This new registration called for pre-clinical (animal testing), and three phases of clinical trials (Craig, 2012). Apart from the issues of registration for Qiang medicines, there was the issue of complying with China's production GMPs (Good Manufacturing Practices), made mandatory in 2003 (Li and Hamblin, 2016). According to the university researcher working on the standardisation of Qiang medicine the inability to do so was due to "history, technology, personnel, resources and funding". The future ability to comply was dependent on a long process of constructing factories, training personnel, and attracting investment that was under way and that would, according to him, come into fruition at some point in the future.

The question of scaling up always appeared tied to standards, and if complying with drug registration and GMP requirements seemed far in the distance, there were talks of initial efforts to reach some consensus on what was to constitute "standards of Qiang medicines" (like the Tibetans (Saxer, 2013), the Mongol and Uyghur minorities had done), which could be a first step to further unification. In Qiang medicine conferences this work was only spoken of vaguely without concrete steps taking place, with one former hospital director speaking of having plenty of plans but no people or money to make them happen. In the meantime, there was university research done with a standardisation (based on national and international standards) of particular treatments and preparations identified as Qiang, while individuals such as Dr Zhang and Dr Chen continued using their own separate channels for sourcing and preparing the medicines that they produced. Among practitioners who did not have such proprietary ambitions, Dr Yuan at the museum clinic was convinced that by virtue of processing, granules and other pharmaceutical forms (with or without "western ingredients" added to them) were shedding a lot of the efficacy that could be found in decoctions. According to him "Chinese medicine uses crude medicine to treat diseases, which is low in cost and has no side effects, (...) our industrialisation and standardisation of Chinese medicine harms Chinese medicine and Chinese medicines". In this he alluded to the "nonscalability" (Tsing, 2012) of a discipline and medicines in an articulation of these that defied the one generally put forward by stakeholders.

For Mr Luo, the industrialisation and wide distribution of his *qiang beimu* powder form meant that he had to fully comply with Chinese GMPs, which he claimed had been extensively aligned with those of the West after the GMP revision of 2010 (National

Medical Products Association, 2019). He resented the high requirements his company was subjected to, given what he saw were deep differences between Chinese medicines and “Western medicines” in its “essence, technology, historical conditions, environment and production needs”, something that he considered was restricting the development of the industry and limiting that of Chinese medicine. As Saxer (2013) argues, although Chinese GMPs were directly inspired in Euro-American experiences of pharmaceutical production, and put in place after a European Commission complaint with the WTO (World Trade Organisation) for unfair competition, the striving for GMP implementation cannot be seen merely as a product of international pressure, but falling in line with China’s policies towards a scientised and modernised Chinese medicine.

Overall, it is very difficult to think of these developments as an orchestrated standardisation of Qiang medicines, both in terms of wild and cultivated medicinal materials, as in processed, small scale and mass-produced medicines. Depending on whether one refers to raw medicinal materials such as *qianghuo*, processed powders of *qiang beimu*, the national registration of family recipes, or the implementation of GMPs, orchestration, resistance and benefits are distributed in uneven configurations, of present execution and of future prospects. Therefore, as one looks closer, the standardisation of medicines loses an inherently positive or negative connotation, as pharmaceutical companies complain of regulatory hurdles, medicinal herb collectors have an edge over cultivation initiatives, and some Qiang practitioners hope for investment so their family recipes can go onto nationwide distribution. However, the advantage of medicinal herb collectors is a fragile one, since they collect very finite resources and therefore work on a thin line of possibilities. They are also dependent on unstable market prices that spur rushes for whatever raw material is suddenly profitable to collect. Cultivation initiatives then appear as eco-saviours, catering for pharmaceutical companies, while collectors are accused of wrecking the environment, an issue that I will explore in the following section.

Sustainability and paternalism in the service of the market

Having explored how the attempted standardisations of Qiang medicine and medicines connect to the push for a Qiang medical industry, with the predominant importance given to pharmaceutical expansion, I will now focus on a fragile dimension that emerges as a major hindrance to that endeavour, that of sustainability. The concern and initiatives on environmental sustainability in Sichuan can be framed under China's "Western Development Plan" (*xibu da kaifa* 西部大开发), the largest regional development plan in the country so far (Jeong, 2015). It was first launched in 1999 (Lai, 2002) and its long-term planning was divided in three stages, the "Laying the foundation stage", from 2001 to 2010, the "Accelerating development stage", from 2010 to 2030, and the "Comprehensively promote modernisation stage", from 2031 to 2050 (National History Network of the People's Republic of China, 2009). This plan was designed as a way to deal with the economic gap between coastal China and the interior that appeared with the post-Mao market reforms, but the state economic funding that it supplies, Jeong (2015) argues, acts as a control mechanism for ethnic unrest, in the way that it distributes resources to selected minority areas. Issues of possible outbreaks of civil unrest are not something visible in Qiang areas, but arguably relevant in Tibet and Xinjiang.

The "Western Development Plan" was not only meant to act on regional income inequalities, but to provide the industrialised coast with resources, while attempting to tackle the social and environmental problems that emerged from those economic transformations (Flower, 2009). In the process, it has strengthened both market penetration as well as state capacity, and carried on expanding regulatory infrastructures (McNally, 2004). One of the environmental consequences of such acceleration, in the case of the opening up to supply a growing domestic and international industry of medicinal herb materials, is that several botanical species are now considered endangered and are being monitored, such as *qianghuo* and those classified under *chuan beimu* (State Administration of Traditional Chinese Medicine of the People's Republic of China, 2019). Research conducted in several Sichuan and Tibet sites has shown that the bulbs of one of the *chuan beimu* species, *Fritillaria Cirrhosae*, are reducing in size and growing deeper underground, with these changes having been induced by heavy collecting (Li et al, 2017). Coincidentally, this change makes for even more desirable

chuan beimu, given the wide preference for smaller bulbs. Human induced dwarfing has also been documented with the Himalayan snow lotus (*Saussurea laniceps*) in Tibet, however, in this case it is the appreciation for the large sized plant that is behind such artificial selection. As Landecker (2016) has pointed out, political and industrial shifts can produce very visible and often lasting biological manifestations and material outcomes.

The political solution for this problem has been proposed as the “Plan for the Protection and Development of Chinese Medicinal Materials (2015-2020)” (Central Committee of the Communist Party of China and the State Council, 2015a), hailed as the “first national special plan to alleviate the supply and demand conflict of endangered Chinese herbal medicines within five years” (Central Committee of the Communist Party of China and the State Council, 2015b). It is not simply a conservation plan, but rather one that takes the premise of “protection through development” (Central Committee of the Communist Party of China and the State Council, 2015a) to justify massive expansion of cultivation initiatives, focusing on the “construction of standardised, large-scale, and industrialised production bases” of Chinese medicinal materials for “innovative Chinese medicine and medicines with ethnic characteristics” (ibid.). Such conviction on a “rational” economic-ecological efficiency shows that it is never the excessive demand that is put into question, but instead, the “disorderly development of authentic medicinal materials”, blamed for affecting the “sustainable and healthy development of Chinese medicine” (SATCM, 2018).

Particularly in Sichuan, the “orderly development” proposed under the “Sichuan Province Chinese Medicine Industry Development Plan (2018-2025)” (SATCM, 2019) included initiatives specifically directed at Tibetan and Yi medicine, as well as the “research on the transformation of wild varieties and the industrialisation of artificial planting” of “four to six representative Qiang medicines” with the further creation of a regional brand of Qiang medicines. If on one hand there is the mention of sustainability and ecological protection in such plans, on the other what is stressed is the profits awaiting such expansion. Through “vigorously promoting standardised and large-scale production bases”, the development targets for the province were of 7 million planted acres and an annual output of medicinal materials exceeding 20 billion RMB for 2020, and respectively 8.5 million acres and 30 billion RMB for 2025. These targets

accompanied goals such as the “deepening of industrial integration” and the “internationalisation of industrial brands” (SATCM, 2019). What these national and regional plans show is that conservation, in this case equated to cultivation, is instrumental to the growth and reproduction of industrialisation. Such solutions to a crisis of scarcity prove that environmental impediments can constitute the source of novel forms of accumulation (Brockington and Duffy, 2010; Brockington, Duffy and Igoe, 2012). In this manner, by focusing both on large scale cultivation and the creation of brands, the aim is to simultaneously increase supply and foster demand (Blaikie, 2009).

In practice, Yanwo and the surrounding villages saw a few cultivation initiatives in the early days of the “Plan for the Protection and Development of Chinese Medicinal Materials (2015-2020)”, but the only base that continued to operate changed hands many times, something that the locals resented. Other bases (of much smaller dimensions than those described in the government plan) all failed, with locals pointing out that with some of them individuals took the government initiative money but then did not cultivate at all, as in the case of a small field supposedly designated for growing *dangshen* (*Codonopsis* 党参) (see Figure 49). This is a phenomenon also described in Tibet by Saxer (2013).



Figure 49: Field designated for *dangshen* cultivation

There were three formats of cultivation that I came across, the first were individual farmers who cultivated their own land, the second were local cooperatives that worked with companies that would buy their produce, the third were companies that employed workers in their compounds (such as the company outside Yanwo with their greenhouses). The “*Qianghuo* research group” trained people working in the three

formats, with some being independent individuals without farming knowledge but who would find a way to grow *qianghuo* in forest soil. Mr Luo, the pharmaceutical representative, in turn, spoke highly of the second format. The model he worked with was a cooperative set up by local farmers who supplied land and labour, while his company was in charge of the central management, “expanding the market and solving the problem of marketing the local agricultural products”. He saw this as a great model for “solving the problem with idle land, the problem of unemployment, and increasing the farmers’ labour income”. In general, the question of who benefited the most from such initiatives was answered very confidently by most non-villager interlocutors as a “win-win situation” (*shuangying* 双赢).

Brockington and Duffy (2010) warn caution with the overly positive win-win rhetoric of market solutions and “saved nature”, and I argue that in the case of medicinal herbs, the benevolence attached to such work is accentuated by the nobility that is attributed to the final consuming act, that of healing. When referring to the local “Min river lily” (*Lilium regale* E.H.Wilson, *minjiang baihe* 岷江百合)⁸⁰, Dr Yuan, at the museum clinic, illustrated perfectly what it meant to have industrial solutions to “solve” industrial problems:

If we make good use of local varieties and develop industries, planting in the original ecology of the “common people” then it will benefit the people. The benefit for the country is in treating the lung diseases of many people. If our lungs are healthy, there will be more genes resisting smog, and our immunity will be improved. As a result, many medical costs will be reduced for the country, which will benefit the country. In this way, a company also develops and achieves win-win results.

In his statement, despite being critical of industrialisation when it came to processing medicines, Dr Yuan viewed that of the cultivation of medicinal herbs in good light, as long as they were planted in the “original ecology”. Instead of questioning the causes for industrial pollution, he had already interiorised the problem of smog as a country’s reality that would not go away any time soon, distant as it was since that smog was not a problem in hilly Maoxian. Therefore, industrialising the “Min river lily” for the sake of “multiplying smog resistant genes” was a feasible solution against the impact on health

⁸⁰ *Minjiang baihe* does not feature in the Chinese Pharmacopoeia and so I have used the Latin denomination of eFloras (2008).

caused by industrial pollution, while reducing medical costs nationwide. When it came to conservation, he also believed that the state should introduce policies to protect certain medicinal herbs like the *qianghuo* in the same manner as it had done with the panda.

One academic researcher, working in pharmaceutical technology, stood out as the only researcher who was not as enthusiastic about private cultivation initiatives. He echoed the concerns with the abuse of fertiliser that I had witnessed elsewhere. In his view, many cultivators and cultivating companies would pursue economic benefits, and that if they saw that the price per weight was not moving, they then would use planting technology to increase production and reduce planting time, causing quality degradation. He was also of the opinion that the benefits of such initiatives were unequally in favour of companies, to the detriment of locals, be it employees or independent cultivators. However, the question of whether there was such an imbalance frustrated one of the leaders at the “*Qianghuo* research group”. For her, a farmer was simply dealing with a commodity from the moment that he planted, selling at a price that was contingent to the market demand.

On the one hand, he sells it as a commodity to respect the market demand. On the other hand, he is at a relatively backward agricultural level, so the government has many supporting policies to help him, one is to help him learn (planting) technology, the other is to help him with costs. For example, give him seeds of medicinal materials, then give him some inputs needed for agriculture, and then help him to develop this. It's meaningful for the industry, and it's also good for farmers so as to improve their living conditions. So, is China not helping the poor? In this aspect it is the best in the world doing it.

According to her, benefits should not be seen in a polarised winner and loser perspective, since each individual would earn one's due portion in the business process, adding that “a company is not a welfare institution”. Overall, among those working with cultivation initiatives there was a mixed attitude towards collectors, consisting of both blame, and of a willingness to “help”. The social responsibility that companies claimed to enact was often linked to their involvement in the government's poverty alleviation programme. This was named as “Targeted Poverty Alleviation” in 2013 (Liu et al, 2018) but has run since the mid-1980, with its priorities shifting gradually from relief provision to income generation (Croll, 1994). Companies participating can receive tax

relief, land transfers, and financial support from the government if they invest in an area of the country, usually rural, deemed to be poor by the state (Yan, 2015). They can also be involved in “social responsibility” activities.

In relation to Qiang communities, claiming to be involved in the programme constituted a marketing effort, the more so after the 2008 Sichuan earthquake, when donations poured in from all over the country to help the survivors. The state alike gave funds and resources into post-earthquake reconstruction projects, which resulted in the Qiang being regarded as a “fortunate” state rescued ethnic minority, whose living conditions and “traditional culture” were immediately advanced and promoted (Zhang, 2016). The “cause of Qiang medicine” also received plenty of attention after the earthquake, as Zhang et al (2014) illustrate with the particularly paternalistic Chinese idiom: “a child who can cry has milk to drink” (*hui ku de haizi you nai chi*, 会哭的孩子有奶吃). They argue that minority medicine had been “a child who wasn’t able to cry”, and that for the Qiang that situation changed after the earthquake.

As many pushed for a Qiang medical industry, one particularly established and large pharmaceutical company was invited to join the CMAM Qiang branch in that effort by the Sichuan Administration of Chinese Medicine. This company found a way to capitalise from that “cry” in the marketing of the medicinal herb extracts that they produced, more specifically in a promotional video that portrays a rescue worker with a company badge saving Qiang villagers from the 2008 earthquake rubble (see Figure 50).



Figure 50: Screenshot of a pharmaceutical company’s promotional video (LYYonline, 2017)

Upon meeting two of their representatives, they claimed to have cultivation bases in Qiang areas and to also participate in the government's poverty alleviation programme, but did not disclose any details of "social responsibility" activities⁸¹. In fact, I am positive that they did not have a rescue team at the earthquake site, and that the advert enactment is instead a purely paternalistic allegorical portrayal of "saving the Qiang".

I have shown here how the onus of responsibility for the environmental depletion of medicinal herbs is placed on collectors, and how state and corporate scaling-up initiatives are portrayed as the solution for the respective sustainability problem. In the following and last section, I will discuss how the growing global demand for such products instead of being put into question is, on the contrary, stimulated by the WHO global health strategy.

The WHO and the harmonisation of consumption

China's ethnic minorities have been included in the most recent WHO reports, which display the state of both ethnic medicine and medicines in the country. The 2015's WHO "People's Republic of China health system review" (Meng et al, 2015) purports to show the far reach of medical institutions providing ethnomedicine services in China. From what they claim are ethnomedicine services provided in ethnomedicine hospitals, at temples, clinics and at home, there is a cross-cutting and homogenising notion of what ethnomedicine, or the medicine attributed to a particular ethnic group is. It states that "The knowledge and skills of ethnomedicine have always been inherited and passed on by personal example and verbal instruction, or even ancestrally" and that "this approach has enabled many specific techniques and remedies to be preserved, but restricted the diffusion of ethnomedicine" (Meng et al, 2015, p.153). Therefore, the creation of platforms for diffusion, in the form of medical institutions, and supported also in Chinese development plans (Qionglai People's government, 2017), is seen as a mere vehicle for propagation of something that is supposed to be inherently representative of a particular ethnic minority and applicable across the board.

⁸¹ For anthropological approaches to corporate social responsibility see Rajak, 2011 and Dolan and Rajak, 2016.

This position clearly ignores the articulation in the systematisation of practices and theories, alongside the efforts at standardisation that appear in medical institutions, and that I have developed upon along this thesis, not to mention local afflictions cast aside as superstition, all part and parcel of defining what “medicine” is. The creation of ethnic medicine is thus portrayed as something simply inherited and developed, void of the context and requirements that makes it operational and transmissible in Chinese institutional circles, and most of all, appealing to the decision making ethnic majority.

In the most recent “WHO global report on traditional and complementary medicine” (WHO, 2019), there is mention of an established “rural traditional Chinese medicine medical care network” in China that includes ethnic minority medicine and integrated Chinese and Western medicine, and that spreads from county-level Chinese medicine hospitals to township-level health centres and village clinics. The agglomeration of all these settings under the definition of “rural” lays bare a common issue with the discourse of development in China. On one hand, as Chio (2014) warns, what is defined as “rural” in China can include suburban communities close to major metropolitan centres, on the other hand, with the post-2006 “Build a New Socialist Countryside” campaign and with the 1990 “Urban Planning Law” turned into the “Urban and Rural Planning Law” in 2007 (Chio, 2017b), there has been rapid urbanisation of the countryside with rural towns turned into small cities (Bray, 2013; Hillman, 2013). Therefore, the significance of ethnic medicine institutions, as well as of Chinese medicine services, in villages such as those where I conducted fieldwork, is substantially misrepresented.

In regard to ethnic medicines, the 2019 report mentions that among Chinese medicines and ethnic minority medicines, at the end of 2017 there were more than 60.000 nationally approved medicines, with 4424 pharmaceutical enterprises having passed GMP inspections, and with 177 GAP approved sites in China (WHO, 2019). The report speaks of “a modern Chinese pharmaceutical industry, held together by commerce” having been established, with an output value of 786.6 billion RMB relative to Chinese medicines, 28.55% of the total output by China’s pharmaceutical industry (ibid.).

The WHO’s efforts in this area are not only related to what they call “Traditional and Complementary Medicine” (T&CM) services, but with “self-health care”, the latter

which they state to have increased as “consumers choose to be more proactive about their own health” (WHO, 2013). This is then interpreted as showing the need to develop documents and tools for consumer education and “self-health care”, such as the “WHO guidelines on developing consumer information on proper use of traditional, complementary and alternative medicine” (WHO, 2004). What the WHO defines as the promotion of “proper”, “rational”, or “therapeutically sound” use of appropriate “traditional medicine” by practitioners and consumers, demonstrates that their efforts are focused on the consuming end of a healthcare industry, predominantly urban, and not on those consuming herbal medicines prepared at rural homes, often the collectors that supply such industry. At least among those villagers with whom I conducted fieldwork, their self-care and local afflictions seem miles apart from the “self-health care” that the WHO purports to educate on. This predicament undermines the very core of what the WHO’s strategy claims to stand for, that is the care for those whom “herbal medicines, traditional treatments, and traditional practitioners are the main source of health care, and sometimes the only source of care (...) close to homes, accessible and affordable” (WHO, 2013).

Their pledge of “strengthening safety, quality and effectiveness through regulation” falls into an assessment of the non-biomedical by biomedical expertise, which has been critiqued by Kadetz (2015), and pointed out by an academic interlocutor who referred to Chinese drug trial centres for verification of compounds to be run by those with a “background on Western medicines”. It is a quantification of compounds that another university researcher argued was rendered meaningless by the indications, length of a treatment, as well as the “patient’s state”, that Chinese medicine would take into consideration, thus maximising efficacy and avoiding toxicity. The people-centredness that the WHO champions, in the end translates into a quantification and regulation of what is to circulate in the market, and is thereby uniformised to a vast group of consumers. Such a dynamic is something that clearly suits the industry, which coincidentally hammers on the message of their efforts being people-centred at heart. This harmonisation is rendered visible by the recent relationship between the Chinese Pharmacopoeia Commission and the International Committee for Harmonisation (ICH). In 2017 the CFDA (Chinese Food and Drug Administration) was elected a member of the ICH management committee (Zhang, 2018). Presently, the Chinese Pharmacopoeia Commission is working on “improving the Chinese Pharmacopoeia related test

methods” in line with the ICH international standards (Chinese Pharmacopoeia Commission, 2018), and in time for the 2020 edition of the Chinese Pharmacopoeia (Zhang, 2018).

The aimed expansion of consumption is not merely one across borders but also onto rural areas, where the harmonisation of consumption happens through the form of marketing, rather than regulation. Croll (2006) argues that large major rural development programmes in central and western Chinese provinces have been framed by the necessity to boost consumption, and increase the demand of domestic products and services in the countryside. In a way, rural consumers become viewed as “latecomers” by those like Guang De, the Qiang medicine development strategist, who wanted to include rural areas in the later, post-urban phase of Qiang medicine clinics chain expansion, for “there will be many elderly people in rural areas who need some old-age care, recuperation health services”. The aim of such expansion reveals an acute awareness to the future business opportunities afforded by China’s fast population ageing (Wang and Chen, 2014).

With all the coordination and pervading win-win outlook involved in the push for a Qiang medical industry, speaking of standardising Qiang medicine or Qiang medicines tells very little of what health and illness means for Qiang communities. That is because the healing practices, be it by a *shibi* or of self-care in Qiang villages, as well as their local afflictions, are all largely absent from such considerations. Standardisation then works under the format that if an individual wishes to continue production or practice in small scale, they are free to do so under their own terms, but should they want to make use of a vast healthcare market then they are required to conform to (some) standards. Among the circles where that transition is encouraged, and where money and reputation are promised, there is also a steering of what Qiang medicine and medicines should look like and consist of, in short, of how these should be articulated in order to succeed in their dissemination.

Conclusion

In this thesis, I have attempted to show how, drawing from a variety of entities, rare and mundane, appreciated and discarded, Qiang medicine and medicines are articulated and take shape in clinics and academic-industrial circles. Additionally, I have brought forth an array of entities that compose the daily life of Qiang villagers, from which Qiang medicine was absent. Here, I illustrate this core thread of the interrelation between medicines, spirits, and the market in rural Aba, amidst a regional and national industrialising trend, through the example of *zhuling* (猪苓 *Polyporus umbellatus* (Pers.) Fries).

As we sat one evening, my A'er host showed me several bags of the medicines he collected. Some of the medicines were dried herbs, some were fungi. The fungi made me recall the mention of *zhuling* from Yanwo village and so I enquired him whether he kept any. His eyes brightened, and instead of reaching for one of his bags, he sprang to his feet and reached up to his family altar. Adorned with a ceremonial red ribbon, the *zhuling* stood before me (see Figure 51).



Figure 51: *Zhuling*

Scientifically, it is described as a stage in the lifecycle of the fungus *Polyporus umbellatus*, characterised by a hardened mass of fungal mycelia, or sclerotium (Zhao, 2013). Could it have been its medicinal value that had elevated *zhuling* to the altar, I wondered. According to my host, *zhuling* was used to treat diarrhoea, and was not even a valued solution to the ailment. It was its uniqueness and rareness, I was told, that gave *zhuling* its place on the altar, for its unusual shape resembled that of *pusa*, or bodhisattva. Also, it was the fact that it had “no root, no seedling” (*meidei gen, meidei miao* 没得根, 没得苗) that added to its unusualness. Most of all, the reason for it to be there was that given its size, it had been worth a lot of money, and so had made for a good “offering” (*gongpin* 供品) to the spirits of his ancestors.

The price of *zhuling* had fallen sharply from years ago. Back then, the price peak led to a rush for *zhuling* in the mountains, and to subsequent cultivation initiatives. Later, the fungus was hard to find. It was also not worth the trouble looking for, since with cultivation initiatives came a price drop and subsequently little reward for collecting it. This was a problem described not only by my A'er host, but also by villagers in Yanwo. Still, the *zhuling* kept its place on the family altar, a sight that I have not found elsewhere. The A'er *shibi* dismissed the importance that my host gave to it, stating that “it can be put anywhere”. Such situated rareness and importance that *zhuling* evokes reminds one to be careful when making claims of ethnic affinity, be it towards medicines, or medical disciplines.

And so, what happens in a different configuration of extensive reproducibility, of mass cultivation of medicines? What happens in a configuration of academic transmission of theories and practices? Facing such setup, this particular *zhuling*'s uniqueness of shape was probably reinforced, even if its monetary value decreased. The diluted features of the mass-produced require uniqueness too, so that there is something of value for production and transmission. As I have shown in the first chapter, “Inheriting Qiang medicine”, ritual and secrecy are mobilised in order to condense what is taken to be an ancient essence that must be passed on. Consequentially, these aspects become spectacularised and exoticised as they are enacted for an ethnic majority-dominated audience and customer base.

In medicine as in medicines, by acting in the realm of the institutional and the organisational, one deals with concerted targets, political and economic goals. Transmission and production need an articulated uniformisation and that is where “systems” come into the picture.

Situating the legitimacy of "medical systems"

More established industries, such as that of Tibetan medicines, by drawing from a vast network of techno-social entities of individuals, technologies, and institutions, give a more solid shape to what has been described as “pharmaceutical assemblages” (Kloos, 2017). Moreover, the industry of Tibetan medicines does so by connecting to Sowa Rigpa, also known as Tibetan medicine, making use of what is deemed to be a long institutional history and a wealth of written records. In this way, both fields enjoy an apparent coherence that in global health invites little questioning of their and others’ existence as “systems”, industrial and medical (WHO, 2013, 2019). In WHO documents these appear described individually not only as “indigenous medical systems” (WHO, 2019), but as “traditional systems of medicine” (WHO, 1976, 2013). Dr Margaret Chan, former Director-General of WHO at one point grouped all these into one large “system of traditional medicine”, as opposed to a “system of Western medicine” (WHO, 2013). However, this standalone, or grouped, portrayal of medical systems has been criticised in anthropology in the past decades (Alter, 2008; Cohen, 1995; Langford 2002; Scheid, 2002), and it has been shown that medical systems exist by virtue of conceptualisation and interplay between politics and medicine (Kloos, 2017).

In the case of Qiang medicine, by thinking of such system as a an “articulation” (Latour, 1999; Harris, 2005), a very tentative and disputed one, I have sought to demonstrate the situated work that goes into its making. By doing so, I have revealed different groundings for the validity of classifications (Foucault, 1970), as well as a diverse “ordering of things” (Harris, 2005). When considering this order-making for institutional circulation (Farquhar and Lai, 2014) I cannot help but notice a mirroring of political orderliness, and to some extent a tone of devotion to the arrangements of institutional and governmental networks in which these stakeholders navigated. Such necessity of order and rules was illustrated to me by one interlocutor, a Maoxian

hospital pharmacist who quoted Mencius (fourth century BC) in a colloquial manner: “without rules, nothing can be accomplished” (*meiyou gui ju bucheng fangyuan* 没有规矩不成方圆, literally “without rules one cannot draw square and circle”). This popular old quote reinforces the idea that along the attempts of joining efforts and unifying theories follows a constantly hammered state message, of a harmonious and unified state-nation built around centralised decision making.

If for the WHO the theories of the “medical systems” they claim to support seem to take second stage to their focus on materia medica (WHO, 2013), in China, theory and orderliness are important, at least among the circles forging ethnic medical disciplines, and so spell domestic acceptance. In Chinese language, the two words that refer to system are *tixi* (体系) and *xitong* (系统), the first considered less rigorously conceived than the second which has a more scientific connotation (Lai and Farquhar, 2015). They can refer to theoretical and practical systems, and simultaneously to a physical setup or infrastructure. Also, scientific texts refer to the digestive system as *xitong*, and so Dr Zhang’s *duct system*, with its stone blockages, was also described as such. With these denominations there was a variation among Qiang doctors for the way they made use of *tixi* and *xitong* that mapped onto where they stood in the formal task of articulating Qiang medicine. For Dr Zhang, who took centre stage in that endeavour, Qiang medicine was a *xitong*, or a “complete *tixi*”. Others used *xitong* to qualify their practice in showing that they were “systematic” and while refusing to agree on an overarching Qiang medicine theory, referred to the existence of different “family theoretical systems” as *tixi* (*jia zu lilun tixi* 家族理论体系) instead. Such particularly systematic and unifying articulation of the discipline by what often seemed a solitary albeit highly connected individual, seemed to elevate his status as the true inheritor of something that would otherwise be lost. Moreover, it framed him within academic-industrial circles as an expert of a subject that others frequently seemed not to be able to grasp. From this position, he could assert the simultaneous universality and hiddenness among the Qiang of the tenets he proclaimed.

Not only does this carving of an authoritative standpoint, by means of a system articulation, relates to the legitimacy and marginalisation of non-professional expertise (Lambert, 2012), but such dynamics say a lot about medical and scholarly legitimacy, in

the sense of consensus within a particular institutional milieu (Latour, 2005). I therefore argue that it begs anthropology to situate the legitimacy of “medical systems”.

Surrounding Dr Zhang was the approval of a wide circle of academics, industry and government figures that supported wholeheartedly what they saw was a strong foundation of Chinese medicine being used to “sort out” ethnic medicine, in an articulation filled with exotic elements. The legitimacy and charisma that he drew from this support needs in fact to be situated as tied to a particular circle, since among other doctors the enthusiasm towards those “tenets of Qiang medicine” was absent.

However, if a unified theoretical and practical system had still not been agreed on, the mere gathering around the idea of Qiang medicine (*qiangyi* 羌医) voiced by most practitioners, enacted, and reinforced the unification of the Qiang as an ethnic group in that circle. The fact that the only denomination used is the Chinese one of *qiangyi* shows how the discipline is defined through and through within a Chinese framework.

In the eyes of the state, despite the latest policies stipulating that all ethnic medical disciplines fall under one Chinese medicine, a sense of inferiority has continuously been present. “Ethnic” continues to only refer to minorities and not to the Han majority, with the latter intrinsically linked to the large category of Chinese medicine (Glover, 2005). I argue that this has driven Qiang medicine practitioners to find a way to harness the historicity of the Qiang as an ancient ethnic group, in order to position themselves as the ancestors of Chinese medicine. Through this move, Qiang medicine appears framed as an original essence of the contemporary Chinese medicine and in this way operates and promotes itself within the state framework, not opposed to it. It sits on what is deemed to be an ancient legacy, which is particularly important, since the normative value of medical inheritance is well established in the field of Chinese medicine, as well as consecrated in law (People's Republic of China Twelfth National People's Congress, 2016).

Beyond situating the legitimacy of medical systems in institutional circles, is the matter of doing so among the population at large. When dealing with so called ethnic medicine, it is essential to understand how it features among the respective ethnic populations, not only at institutional sites of care, but within communities. In sum, who is it legitimate for? Firstly, even at clinics, I did not meet one patient who was visiting in search of “Qiang medicine”, all had arrived by virtue of the personal recommendation

of relatives, friends, or neighbours. Most of all, in this research, what transpired was how far removed from such considerations of a disputed system of Qiang medicine was life in Qiang villages. In their healing practices and local afflictions, no villager that I spoke with even conceived “Qiang medicine”. In their choice of care, there was generally a clear disconnect and disregard for any clinic or hospital offering “Qiang medicine”, with the few that had used those hospitals equating it to Chinese medicine. Moreover, there was no conception of discrete medical systems that villagers were drawn to. Instead, they were drawn to biomedical doctors, to *shibi*, and rarely to Chinese medicine doctors, by virtue of what they conceived as individual expertise.

Although in Yanwo village the *duangong* yielded little appreciation and respect from the villagers, in A'er village people were divided in how they valued their *shibi*. As the *shibi* spoke, it was noticeable the nostalgia of a time when local law was to a certain extent devised and enforced right there in the village. By resorting to the appropriate ceremonies, the *shibi*'s father and grandfather would make villagers “face the gods”, in a plea to prove their innocence. Alongside this eroded political authority was his conviction that a lot of what the A'er villagers knew in terms of healing and self-care had been passed to them by his own ancestors.

Things had changed. The interconnectedness of the last generations to institutions outside meant unprecedented access of villagers to hospitals. The afflictions and demons that the *shibi* dealt with were dismissed as fruit of his own manipulation by all Qiang medicine clinic-based practitioners. Moreover, by taking on responsibilities in “sheepskin drumming” performances all over China, he contributed to the growing view inside and outside the village of *shibi* as mere cultural artefacts. Such shifting legitimacy of healers was reflective of a growing desire among urban practitioners for accreditation. Theory as the backbone of medicine appeared connected to an intellectualisation that privileged quasi-shared explanations over action, and dismissed a variety of afflictions as simple “superstition”. All of this took place under the benevolence of creating jobs, producing wealth, and bringing fame to a medicine that was articulated in the direction of producing a transmissible textual body. The wish for the proliferation of accredited practitioners ran side by side with that of the scaling up of pharmaceutical production, in a symbiosis of Qiang medicine and medicines that awaited more investment in order to grow. Overall, investment, infrastructure, and

regulations, all meant tagging along, in a large degree, to what the existing industry of Chinese medicines already had in place. In this sense, “medical systems” constitute an important part of branding, drawing legitimacy to the industrial enterprise as it is disseminated in institutional circles.

An industrial push at home and abroad

Despite these being the early days of a Qiang medical industry, the push for such industry was done while acknowledging the unsustainability of present supply chains for Chinese medicines. My research participants regularly pointed out how the demand far outweighed the supply, which followed an intensified depletion of endangered species. Government plans call this issue a “contradiction between supply and demand” (Central Committee of the Communist Party of China and the State Council, 2015a), which provided the justification for a faster scaling up of production, in a bid for “protection through development” (ibid.). The massive cultivation initiatives planned for Sichuan (see Chapter Five) happened in coordination with national and international laws and strategies (WHO, 2002, 2013), all of which stressed the beneficence of such enterprise, as well as the increase of the safety and quality of products.

China’s impetus for the WHO’s steering in this area is visible not only domestically but abroad. Interestingly, for China, this is not only a matter of exporting Chinese materia medica and medicines. In the country’s relation to Tanzania, for example, apart from the latter having become a market for Chinese medicines (Hsu, 2015), Tanzania has also been the recipient of Chinese investment and contracts for the development and industrialisation of its own medicinal materials (Langwick, 2011). The purpose of China’s “One Belt One Road” or “Belt and Road Initiative” is not limited to expanding its market of exports. It is also dedicated to exploring local resources abroad for new products, much of it under a guise of aid and development, as well as searching international political endorsement (Callahan, 2016).⁸²

Again, this dynamic fits well with the priorities of the WHO’s “Traditional Medicine Strategy 2014-2023”, which are geared towards the development and harmonisation of

⁸² Such kind of foreign policy strategy is, of course, not exclusive to China but enacted elsewhere around the world, see Peluso, 1995 and Black, 2018.

materia medica's industry around the world, as well as the "education of consumers". In my fieldwork, the last point is one that resonated in particular with the Maoxian Chinese medicine hospital pharmacist who was of the opinion that the general public lacked pharmaceutical knowledge, and that this should be popularised.

Amongst the institutional circles in this research, the assumption of the beneficence of the market and industry in reaching more consumers was pervasive. By crossing borders, the enterprise of Chinese medicine was viewed as benefitting everyone along its production chain, in a ubiquitous win-win scenario that faced little questioning overall. Interestingly, the WHO's "empowerment" that is apparently given to consumers in their self-care seems to ignore the circumstances of producers, both cultivators and collectors. For them, in the A'er and Yanwo villages at least, such proprietary products were of minimal relevance, from the consumer's point of view.

Concluding remarks

In this thesis I have made substantive contributions to both the field of medical anthropology and of the anthropology of pharmaceuticals. I have explicated three empirical sets of findings: first, that Qiang medicine and medicines are articulated differently by different groups. Second, that entrepreneurship can be entangled in ethnic medicine projects. Third, that ideas of "medical systems" can be deployed to legitimatise ethnic medicine in certain academic, medical, and industrial circles, while those systems, medicine, and medicines, remain predominantly unheard of outside of such circles. I have also made contributions to the discipline of anthropology. By focusing on institutions and the making of theory, I have thus invited an awareness of our own institutional weight when conducting research, as well as of our own theorisations, and their situated importance.

By grounding this research in material aspects of health and healing, and while crossing the bridge between consumers and producers, institutions, and communities, I have shown Qiang medicine and medicines to be constituted by virtue of disputed articulations. In a broad sense, three groups emerged. The first were stakeholders, individuals with present or prospective gains relative to a Qiang medical industry, who articulated Qiang medicine and medicines, albeit differently, along industrial, market and governmental

imperatives of development. The second were non-stakeholder practitioners, who articulated Qiang medicine and medicines, while sceptical of such industrial enterprise. The third were Qiang villagers, puzzled by such articulations, for whom Qiang medicine and medicines appeared as foreign concepts. Hence, city and town dwellers with their institutional affiliations mobilised ethnic identity in a particular way, for the establishment of an ethnic medicine. This was irrelevant to villagers, who in turn enacted ethnic identity differently for purposes such as ethnic tourism.

Additionally, in this thesis, by focusing on the materiality of medicines, I have added to discussions on ethnicity and entrepreneurship, of others who have investigated the marketisation of ethnicity (Comaroff and Comaroff, 2009), ethnicity as organisational routines (Brubaker, 2004) and as the entrepreneurial mobilisation of groups (Barth, 1994). More specifically, in the field of the anthropology of China, I have brought forward an in-depth look into a singular ethnic minority and an ethnic medical enterprise that builds on the research done among other Chinese ethnic minorities, in the medical field (Farquhar and Lai, 2014; Lai and Farquhar, 2015) and others (Heberer, 2007; Gladney, 1994; Chio, 2014). I am convinced that given the aspirational setup for a Qiang medical industry, I have rendered visible the negotiations and conflicts central to this endeavour.

Above all, I have shed light on the situated relevance and legitimacy of “medical systems”, and how these appear embroiled in political and marketising considerations in the very way they are conceived. I have also tried to challenge assumptions of ethnic affinity towards medicines and healing practices in the field of global health. In a global sense, I am wary of initiatives for the promotion of integrated medical services, as well as the increased output of “traditional” medicinal materials, suspecting these to ultimately cater for urban populations and middle class, instead of small communities.

The value of this in-depth ethnographic research across sites, in explicating the ways Qiang medicine is articulated and situated, begs for further similar research amongst other communities envisaged to benefit from initiatives and strategies on “traditional medicine”. My research has shown the value of focusing such investigations on local self-care practices, afflictions, and choice of care, and how these feature with or against different practitioners or healers, as well as notions of “medical systems”. By replicating

my approach elsewhere, it will become possible to see whether my findings and interpretations resonate in other settings.

In regard to my contribution to the discipline of anthropology, I would like to make two points. The first is that, as a Qiang medicine apprentice, having investigated institutions, their genesis as well as their absence, I urge an awareness in ethnographic research to the weight that the institutions we represent might have. If on one hand our institutional presence opens doors when navigating institutional circles, it is important to understand the degree of promotion and endorsement that our interlocutors can harness from that same presence, in what might be the very reason for those doors to open. The second point regards our theory-generating drive in research. At times accused of constituting the building blocks of ivory towers, at times deemed important for the sake of relevance and the guidance of practical efforts, I find that it can, in fact, be very distinctive of institutions. There is a sense of unification in the production of theories that somehow mirrors the unification of institutions as singular bodies, as I have shown with the articulation of Qiang medicine theory. Whether it is the use of a common lens, of a shared tool, or of an organised collective, there is an institutional streak in this making sense of, and changing the world. In ethnography, investigating questions around modernity through material semiotics remains appealing to me for its purpose as a tool rather than a theory, however, there is an unescapable degree of prescriptiveness to both of these that only by being in the field and allowing oneself to be corrected can be evened out.

As I conclude writing this thesis, I hear that life in the Yanwo and A'er villages goes well. The families who hosted me are in good health and the children are growing fast. In Chengdu, Dr Zhang has built a flashy and "ethnically" designed new clinic. A crowd gathered for the opening ceremony which included "ethnic" performances as well as speeches outside, on a busy commercial street. The clinic then took its time to operate fully, as COVID-19 hit the city. Opening a new clinic meant moving away from the small residential community, albeit not completely. The Qiang medicine museum remained there, since the new clinic did not have the space to accommodate it. Dr Zhang has also started a new healthcare company that gives training and advice to other institutions on diagnosis and treatment. In Fengyi, soon Dr Chen will not be the only practitioner with a newly built clinic. Dr Jiang and his father will leave the signless

converted flat and move their busy practice to a more visible and accessible location by the roadside. Aspirations fulfilled.

Bibliography

- Adams V., 2001. Particularizing Modernity: Tibetan Medical Theorizing of Women's Health in Lhasa Tibet. In: Connor, L. and Samuel, G. eds. *Healing Powers and Modernity: Traditional Medicine, Shamanism and Science in Asian Societies*. Westport, CT: Bergin & Garvey.
- Adams, V. and Li, F., 2008. Integration or Erasure? Modernizing Medicine at Lhasa's Mentsikhang. In: Pordié, L. ed. *Tibetan medicine in the contemporary world: global politics of medical knowledge and practice*. London: Routledge.
- Adams, J., Hollenberg, D., Lui, C. W., and Broom, A., 2009. Contextualizing Integration: A Critical Social Science Approach to Integrative Health Care. *Journal of Manipulative and Physiological Therapeutics*, 32(9), pp.792–798.
- Ai, J., 2012. ‘Selecting the refined and discarding the dross’: the post-1990 Chinese leadership’s attitude towards cultural tradition. In *Routledge handbook of heritage in Asia* (pp. 142-151). Routledge.
- Albert, S. and Porter, J., 2015. Is “mainstreaming AYUSH” the right policy for Meghalaya, northeast India?. *BMC complementary and alternative medicine*, 15(1), p.288-300.
- Alford, W.P., 1995. *To steal a book is an elegant offense: Intellectual property law in Chinese civilization*. Stanford University Press.
- Alter, J.S., 2008. Rethinking the history of medicine in Asia: Hakim Mohammed Said and the Society for the Promotion of Eastern Medicine. *The Journal of Asian Studies*, 67(4), pp.1165-1186.
- Anderson, B., 1983. *Imagined communities: Reflections on the origin and spread of nationalism*. Verso books.
- Anderson, W., 2002. Introduction: postcolonial technoscience. *Social Studies of Science* 32(5–6), pp.643–658.
- Andrews, B., 2014. *The making of modern Chinese medicine, 1850-1960*. UBC Press.
- Aoyama, R., 2016. “One belt, one road”: China's new global strategy. *Journal of Contemporary East Asia Studies*, 5(2), pp.3-22.

- Appadurai, A., 1986. Introduction: Commodities and the Politics of Value in The Social Life of Things: Commodities in Cultural Perspective, ed. Arjun Appadurai.
- Association of Social Anthropologists of the UK and Commonwealth, 2011. *Ethical guidelines for good research practice*. Available at: <http://theasa.org/downloads/ASA%20ethics%20guidelines%202011.pdf>
- Baer, H., 2004. Medical Pluralism. In: Ember, C. and Ember, M. eds. *Encyclopedia of medical anthropology. health and illness in the world's cultures*. New York: Kluwer Academic/Plenum Publishers. pp.109-116.
- Baer, H., 2011. Medical Pluralism: An evolving and contested concept in Medical Anthropology. In: Singer, M. ed. *A companion to medical anthropology*. Chichester: Wiley-Blackwell. pp.405-424.
- Barker, D., 2017. Dragons, Drokpa and a Drukpa Kargyu Master. [ONLINE] Available at: <https://www.moowon.com/stories/dragons-drokpa-and-a-drukpa-kargyu-master>. [Accessed 16 October 2019]
- Barth, F., 1969. Ethnic groups and ethnic boundaries. *The Social Organization of Culture Difference*. Scandinavian University Books, Oslo.
- Barth, F., 1994. Enduring and Emerging Issues in the Analysis of Ethnicity. In *H. Vermeulen and C. Govers (eds) The Anthropology of Ethnicity*. Amsterdam: Het Spinhuis.
- Beck, U., 1992. *Risk society: towards a new modernity*. London, Sage Publications.
- Bentley, C.G., 1987. Ethnicity and Practice. *Society and History*, 29(1), pp.24–55.
- Bernard, H. 2006. *Research methods in anthropology: qualitative and quantitative approaches*. Lanham, MD: AltaMira Press.
- Bian, S., 2017. *Mountains, Gods and Modernity – Resilience and adaptations in the Sino-Tibetan borderland of Northwest Sichuan*. Unpublished PhD thesis. University of Oslo, Norway.
- Black, M., 2018. *The global interior: Mineral frontiers and American power*. Harvard University Press.
- Blaikie, C., 2009. Critically Endangered? Medicinal Plant Cultivation and the Reconfiguration of Sowa Rigpa in Ladakh. *Asian Medicine*, 5(2), pp.243-272.
- Blaikie, C., 2015. Wish-fulfilling jewel pills: Tibetan medicines from exclusivity to ubiquity. *Anthropology & Medicine* 22(1), pp.7-22.

- Bodeker, G., 2001. Lessons on integration from the developing world's experience. *BMJ (Clinical Research Ed.)*, 322(7279), pp.164–167.
- Bodeker, G. and Ong, C.K., 2005. *WHO global atlas of traditional, complementary and alternative medicine* (Vol. 1). World Health Organization.
- Boston, J., 1971. Medicines and fetishes in Igala. *Africa: Journal of the International African Institute*, 41(3), pp.200-207.
- Bray, D., 2013. Urban Planning Goes Rural. Conceptualising the “New Village”. *China Perspectives*, 2013(2013/3), pp.53-62.
- Briggs, C., 1996. The Politics of Discursive Authority in Research on the “Invention of Tradition”. *Cultural Anthropology*. Vol. 11, No. 4:435-469.
- Brockington, D. and Duffy, R., 2010. Capitalism and conservation: the production and reproduction of biodiversity conservation. *Antipode*, 42(3), pp.469-484.
- Brockington, D., Duffy, R. and Igoe, J., 2012. *Nature unbound: conservation, capitalism and the future of protected areas*. Routledge.
- Brubaker, R., 2004. *Ethnicity without groups*. Harvard University Press.
- Bruckermann, C. and Feuchtwang, S., 2016. *The anthropology of China: China as ethnographic and theoretical critique*. World Scientific Publishing Company.
- Calhoun, C., 1993. Nationalism and Ethnicity. *Annual Review of Sociology*, 19(1), pp.211–239.
- Callahan, W.A., 2016. China's “Asia Dream” the belt road initiative and the new regional order. *Asian Journal of Comparative Politics*, 1(3), pp.226-243.
- Callon, M., 1984. Some elements of a sociology of translation: domestication of the scallops and the fishermen of St Brieuc Bay. *The sociological review*, 32(1_suppl), pp.196-233.
- Campinas, M., 2013. *Dynamics and Kinetics in human-medicinal relations: how should anthropology explore the materiality of medicines?*. Unpublished MSc thesis. University of Edinburgh.
- Cant, S. and Sharma, U., 1999. *A new medical pluralism? Alternative medicine, doctors, patients and the state*. London, New York: Routledge.
- Central Committee of the Communist Party of China and the State Council, 2006. *Ministry of Health: 15 ethnic groups in China have hospitals using their own medicine*. http://www.gov.cn/jrzg/2006-12/26/content_479954.htm

- Central Committee of the Communist Party of China and the State Council, 2015a. *Plan for the Protection and Development of Chinese Medicinal Materials (2015-2020)*. http://www.gov.cn/zhengce/content/2015-04/27/content_9662.htm
- Central Committee of the Communist Party of China and the State Council, 2015b. *Endangered Chinese medicinal materials supply and demand conflicts ease within 5 years*. http://www.gov.cn/zhengce/2015-04/28/content_2853867.htm
- Central Committee of the Communist Party of China and the State Council, 2016. *Outline of the "Healthy China 2030" Plan*. In Chinese. Available at: http://www.gov.cn/zhengce/2016-10/25/content_5124174.htm
- Ceppek, M.L., 2019. Theory, ethnography, and ethics in an indigenous phenomenology of oil. *HAU: Journal of Ethnographic Theory*, 9(3), pp.673-679.
- Chan, M., 2014. Supporting the integration and modernization of traditional medicine. *Science*, 346(6216).
- Chang, R., 2014. Making Theoretical Principles for New Chinese Medicine. *Health and History*, 16(1), pp.66–86.
- Chao, Y.L., 2000. The ideal physician in Late Imperial China: The question of sanshi 三世. *East Asian Science, Technology, and Medicine*, (17), pp.66-93.
- Chee, L.P., 2015. Re-formulations: *How pharmaceuticals and animal-based drugs changed Chinese medicine, 1950-1990*. Unpublished PhD thesis. National University of Singapore - University of Edinburgh.
- Chen, D.S., 2015. We have never been latecomers: A critical review of high-tech industry and social studies of technology in Taiwan. *East Asian Science, Technology and Society: An International Journal*, 9(4), pp.381-396.
- Chen W., Lester, P., and Lester, M. 2000. *Will the Qiang Language Survive?*. In The 33rd International Conference on Sino-Tibetan Languages and, pp. 220-234. Bangkok, Thailand: Ramkhamhaeng University.
- Chen, Y., 2014. My views on “depoliticizing” national issues. In *De-Politicization of Ethnic Questions in China*, pp.137-153.
- Cheng, X., 2009. Chinese metaphors in political discourse: how the government of the People’s Republic of China criticizes the independence of Taiwan. Unpublished PhD thesis. Ball State University, Indiana.
- China Internet Information Center, 2008. *The county with the largest population of Qiang people-Maoxian*.

- http://www.china.com.cn/aboutchina/zhuanti/scdzzq/2008-05/17/content_15289991.htm
- Chinese Pharmacopoeia Committee, 2010. *Chinese Pharmacopoeia*. 2010 ed. *Beijing: Traditional Chinese Medicine Science and Technology Press of China*.
- Chinese Pharmacopoeia Committee, 2015. *Chinese Pharmacopoeia*. 2015 ed. *Beijing: Traditional Chinese Medicine Science and Technology Press of China*.
- Chinese Pharmacopoeia Commission, 2018. *Adoption of the ICH Q4 Pharmacopoeial Test Method Workshop was held in Beijing*. 17 November.
<http://wp.chp.org.cn/en/content.html?id=ff80808166e8124b016776dea6160182>
- Chinese Communist Party News Network, 2016. *From the “three self-confidences” to the “four self-confidences”— On General Secretary Xi Jinping's Cultural Construction of Socialism with Chinese Characteristics*.
<http://theory.people.com.cn/n1/2016/0707/c49150-28532466.html>.
- Chio, J., 2014. *A landscape of travel: the work of tourism in rural ethnic China*. University of Washington Press.
- Chio, J., 2017a, *Colloquium: Archetypes of Ethnicity: Architecture and Expectations in China's Ethnic Tourism*, lecture notes, SOAS, delivered 14 March 2017.
- Chio, J., 2017b. Rendering rural modernity: Spectacle and power in a Chinese ethnic tourism village. *Critique of Anthropology*, 37(4), pp.418-439.
- Chirkova, K., 2007. Between Tibetan and Chinese: Identity and Language in the Chinese Southwest. *Journal of South Asian Studies*, 20(3), p. 405-417.
- Chow, K.B. and Kramer, I., 1990. *All the tea in China*. China Books.
- Coderey, C., 2020. Myanmar Traditional Medicine: The making of a national heritage. *Modern Asian Studies*, pp.1-38.
- Cohen, R., 1978. Ethnicity: Problem and Focus in Anthropology. *Annual Review of Anthropology*, 7(1), pp.379-403.
- Cohen, L., 1995. The Epistemological Carnival: Meditations on Disciplinary Intentionality and Ayurveda. In *Knowledge and the Scholarly Medical Traditions*, edited by Donald Bates, 320-43. Cambridge: Cambridge University Press.
- Comaroff, J.L. and Comaroff, J., 2009. *Ethnicity, Inc*. University of Chicago Press.
- Companion, M. and Chaiken, M. S., 2017. *Responses to disasters and climate change: Understanding vulnerability and fostering resilience*. New York: CRC Press.

- Craig, S.R., 2012. *Healing elements: efficacy and the social ecologies of Tibetan medicine*. Univ of California Press.
- Crick, M.R., 1982. Anthropology of knowledge. *Annual Review of Anthropology*, 11(1), pp.287-313.
- Croizier, R. 1965. *Traditional medicine in Communist China: science, communism and cultural nationalism*. New York: Maud Russell.
- Croizier, R., 1976. The Ideology of Medical Revivalism in Modern China. In: Leslie, C. ed. *Asian medical systems: a comparative study*. Berkeley: University of California Press.
- Croll, E., 1994. *From heaven to earth: Images and experiences of development in China*. Psychology Press.
- Croll, E., 2006. *China's new consumers: social development and domestic demand*. Routledge.
- Cunningham, A.B., Brinckmann, J.A., Pei, S.J., Luo, P., Schippmann, U., Long, X. and Bi, Y.F., 2018. High altitude species, high profits: Can the trade in wild harvested *Fritillaria cirrhosa* (Liliaceae) be sustained?. *Journal of ethnopharmacology*, 223, pp.142-151.
- Dang, H., Wang, Q., Wang, H., Yan, M. and Liu, X., 2016. The integration of Chinese material medica into the Chinese Health Care Delivery System, an update. *Phytotherapy research*, 30(2), pp.292-297.
- Das, V., 2015. *Affliction: health, disease, poverty*. Fordham University Press.
- Dauskardt, R.P.A., 1990. Traditional medicine perspectives and policies in health care development. *Development Southern Africa*, 7(3), pp.351-358.
- Dean, K., 2003. Local communal religion in contemporary South-east China. *The China Quarterly*, 174, pp.338-358.
- Desjarlais, R., 1989. Healing through images: The Magical Flight and Healing Geography of Nepali Shamans. *Ethos*, 17, pp. 289-307.
- Desjarlais, R., 1992. *Body and emotion: The aesthetics of illness and healing in the Nepal Himalayas*. University of Pennsylvania Press.
- DeWalt, K. and DeWalt, B., 1998. Participant observation. In H. Russell Bernard (Ed.), *Handbook of methods in cultural anthropology*, pp.259-300. Walnut Creek: AltaMira Press.

- Di Tommaso, M.R., Huang, M., Yue, Q. and Pollio, C., 2017. The Chinese TCM Industry: Growth, Changes, and Policies. *Healthcare Policies And Systems In Europe And China: Comparisons And Synergies*, pp.37-57.
- Dobler, G., 2019. Who defines the new? A plea for ethnographic humility. *HAU: Journal of Ethnographic Theory*, 9(1), pp.195-199.
- Dolan, C. and Rajak, D. eds., 2016. *The anthropology of corporate social responsibility* (Vol. 18). Berghahn Books.
- Dreyer, J.T., 1993. China's minority peoples. *Humboldt Journal of Social Relations*, 19(2), pp.331–358.
- Duara, P., 1995. Rescuing history from the nation: Questioning narratives of modern China. University of Chicago Press.
- Dunlop, D.W., 1975. Alternatives to “modern” health delivery systems in Africa: public policy issues of traditional health systems. *Social Science and Medicine*, 9(11–12), pp.581–586.
- Dunn, E., 2007. Escherichia coli, corporate discipline and the failure of the sewer state. *Space and Polity*, 11(1), pp.35-53.
- Ecks, S., 2013. *Eating Drugs: Psychopharmaceutical Pluralism in India*. New York: NYU Press.
- eFloras, 2008. Published on the Internet <http://www.efloras.org>. Missouri Botanical Garden, St. Louis, MO & Harvard University Herbaria, Cambridge, MA
- Englund, H. and Leach, J., 2000. Ethnography and the Meta-Narratives of Modernity. *Current Anthropology*, 41(2), pp. 225-48.
- Eriksen, T. H., 1993. *Ethnicity and nationalism: anthropological perspectives*. London: Pluto Press.
- Eriksen, T.H., 2005. Economies of ethnicity. In: Carrier, J.G. ed. *A handbook of economic anthropology*. Edward Elgar Publishing.
- Eriksen, T.H. and Jakoubek, M., 2018. Introduction: Ethnic groups, boundaries and beyond. In *Ethnic Groups and Boundaries Today* (pp. 1-19). Routledge.
- Ernst, E., 1998. Chiropractors' use of X-rays. *The British journal of radiology*, 71(843), pp.249-251.
- Ernst, W., 2002. *Plural Medicine, Tradition and Modernity*. London: Routledge.
- Farquhar, J., 1994. Knowing practice: The clinical encounter of Chinese medicine. *Boulder, CO: Westview*.

- Farquhar, J., 1996. Market magic: getting rich and getting personal in medicine after Mao. *American ethnologist*, 23(2), pp.239-257.
- Farquhar, J., 2017. STS, TCM, and Other Shi 勢 (Situated Dispositions of Power/Knowledge). *East Asian Science, Technology and Society: An International Journal*, 11(2), pp.235-238.
- Farquhar, J., 2020. *A Way of Life: Things, Thought, and Action in Chinese Medicine*. Yale University Press.
- Farquhar, J. and Lai, L., 2014. Information and Its Practical Other: Crafting Zhuang Nationality Medicine. *East Asian Science, Technology and Society*, 8(4), pp. 417–437
- Farquhar, J. and Zhang, Q., 2012. *Ten thousand things: Nurturing life in contemporary Beijing*. MIT Press.
- Fei, X., 1988. Plurality and Unity in the Configuration of the Chinese People. *Tanner Lecture, Chinese University of Hong Kong*.
- Fei, X., 1989. *Zhonghua minzu duoyuan yiti geju (Configuration of Plurality and Unity of the Chinese Nation)*. Beijing: Zhongyang minzu xueyuan chubanshe.
- Fei, X., 2015. *Globalization and cultural self-awareness*. Springer Berlin Heidelberg. Available at:
http://apps.who.int/iris/bitstream/10665/92455/1/9789241506090_eng.pdf?ua=1
- Fenton, S., 2003. *Ethnicity*. Cambridge: Polity.
- Fitz-Henry, E., 2017. Multiple temporalities and the nonhuman other. *Environmental Humanities*, 9(1), pp.1-17.
- Flower, J., 2009. Ecological engineering on the Sichuan frontier: Socialism as development policy, local practice, and contested ideology 1. *Social Anthropology*, 17(1), pp.40-55.
- Foran, B.J., 2007. *Medical Pluralism and Global Health Policy: The Integration of Traditional Medicine in Health Care Systems*. Unpublished PhD thesis. University of Western Sydney.
- Fortun, K., 2014. From Latour to late industrialism. *Hau: Journal of Ethnographic Theory* 4(1), pp.309–329.
- Foucault, M., 1970. *The order of things: an archaeology of the human sciences*. London: Tavistock Publications.

- Geertz, C., 1963. The integrative revolution: primordial sentiments and civil politics in the new states. In: Geertz, C. ed. *Old Societies and New States*. New York: Free Press.
- Geissler, P.W. and Prince, R. J. 2010. Persons, plants and relations: treating childhood illness in a western Kenyan village. In: Hsu, E. and Harris, S. eds. *Plants, health and healing: on the interface of ethnobotany and medical anthropology*. New York: Berghahn Books.
- Gerke, B., 2013. The social life of tsotel: processing mercury in contemporary Tibetan medicine. *Asian Medicine*, 8(1), pp.120-152.
- Gladney, D.C., 1994. Representing nationality in China: Refiguring majority/minority identities. *The Journal of Asian Studies*, 53(1), pp.92-123.
- Gladney, D. C., 1996. *Muslim Chinese: ethnic nationalism in the People's Republic*. Cambridge, MA: Harvard University Press.
- Gladney, D.C., 1998. Clashed civilizations. Muslim and Chinese identities in the PRC. In: Gladney, D., ed. *Making majorities: Constituting the nation in Japan, Korea, China, Malaysia, Fiji, Turkey and the United States*. Stanford University Press, California.
- Gladney, D.C., 2004. *Dislocating China: Muslims, minorities, and other subaltern subjects*. University of Chicago Press.
- Glover, D.M., 2005. Tibetan Medicine in Gyalthang. *The Tibet Journal*, 30(4/1), pp.31-54.
- Graeber, D., 2015. Radical alterity is just another way of saying “reality” A reply to Eduardo Viveiros de Castro. *HAU: journal of ethnographic theory*, 5(2), pp.1-41.
- Graham, D., 1958. *The Customs and Religion of the Ch'iang (Qiang)*. City of Washington: The Smithsonian Institution.
- Graham, H., 2012. *Real Qualities*. CRiSAP Research Series 0.01.
- Grasseni, Cristina. 2014. Of Cheese and Ecomuseums: Food as Cultural Heritage in the Northern Italian Alps. In Ronda L. Brulotte and Michael A. Di Giovine (Eds.), *Edible Identities: Food as Cultural Heritage* (pp. 77-92). Farnham, Surrey: Ashgate.
- Greene, S., 1998. The shaman's needle: development, shamanic agency, and intermediality in Aguaruna Lands, Peru. *American Ethnologist*, 25(4), pp.634-658.

- Gregory, C., 2014. On religiosity and commercial life: Toward a critique of cultural economy and posthumanist value theory. *HAU: Journal of Ethnographic Theory*, 4(3), pp.45-68.
- Håklev, S., 2005. Chinese barefoot doctors, a viable model today? *Working paper IDSC11*.
- Halliburton, M., 2005. "Just some spirits": The erosion of spirit possession and the rise of "tension" in South India. *Medical Anthropology*, 24(2), pp.111-144.
- Haraway, D.J., 2003. *The companion species manifesto: Dogs, people, and significant otherness* (Vol. 1, pp. 3-17). Chicago: Prickly Paradigm Press.
- Hardon, A. and Sanabria, E., 2017. Fluid drugs: Revisiting the anthropology of pharmaceuticals. *Annual review of anthropology*, 46, pp.117-132.
- Harman, G., 2012. Real qualities. *CRiSAP Research Series 0.01*
- Harrell, S., 2001. *Ways of being ethnic in Southwest China*. University of Washington Press.
- Harris, J., 2005. The ordering of things: Organization in Bruno Latour. *The Sociological Review*, 53(1_suppl), pp.163-177.
- Heberer, T., 1989. *China and Its National Minorities: Autonomy or Assimilation: Autonomy or Assimilation*. Routledge.
- Heberer, T., 2007. *Doing business in rural China: Liangshan's new ethnic entrepreneurs*. University of Washington Press.
- Heishui People's Government, 2010. *Heishuixian gaikuang*.
http://hs.abazhou.gov.cn/zjhs/jbxqzjhs/201407/t20140710_963345.html
- Higgins, D.M., 2018. *Brands, Geographical Origin, and the Global Economy: A History from the Nineteenth Century to the Present*. Cambridge University Press.
- Hillman, B., 2013. The causes and consequences of rapid urbanisation in an ethnically diverse region: Case study of a county town in Yunnan. *China perspectives*, (3), p.25.
- Hinrichs, T.J., 2015. The Catchy Epidemic: Theorization and its Limits in Han to Song Period Medicine. *East Asian Science, Technology & Medicine*, (41).
- Hirsch, E., 2004. Environment and economy: Mutual connections and diverse perspectives. *Anthropological Theory*, 4(4), pp.435-453.
- Hobsbawm, E. and Ranger, T. eds., 1983. *The invention of tradition*. Cambridge University Press.

- Holbraad, M., Pedersen, M., and De Castro, E.V., 2014. "The Politics of Ontology: Anthropological Positions." *Theorizing the Contemporary, Fieldsights*, January 13. <https://culanth.org/fieldsights/the-politics-of-ontology-anthropological-positions>
- Holliday, I., 2003. Traditional medicines in modern societies: an exploration of integrationist options through East Asian experience. *The Journal of medicine and philosophy*, 28(3), pp.373-389.
- Horn, B. M., 1990. Cultural Concepts and Postpartal Care, *Journal of Transcultural Nursing*, 2(1), pp. 48–51.
- Hsu, E., 1999. *The transmission of Chinese medicine*. Cambridge University Press.
- Hsu, E., 2006. Reflections on the ‘discovery’ of the antimalarial qinghao. *British journal of clinical pharmacology*, 61(6), pp.666-670.
- Hsu, E., 2008. Medical Pluralism. In: Heggenhougen, K. and Quah, S. eds. *International Encyclopedia of Public Health*. First Edition, vol. 4. Amsterdam: Elsevier. pp. 316-321.
- Hsu, E., 2009. Chinese propriety medicines: An “alternative modernity?” The case of the anti-malarial substance artemisinin in East Africa. *Medical Anthropology*, 28(2), pp.111-140.
- Hsu, E., 2015. From social lives to playing fields: ‘the Chinese antimalarial’ as artemisinin monotherapy, artemisinin combination therapy and qinghao juice. *Anthropology & medicine*, 22(1), pp.75-86.
- Hsu, E. and Harris, S. eds., 2010. *Plants, health and healing: On the interface of ethnobotany and medical anthropology*(Vol. 6). Berghahn Books.
- Hu, D., 2010. Marx in china. *Socialism and Democracy*, 24(3), pp.193-197.
- Huang, C., 2004. *A reference grammar of the Puxi variety of Qiang*. Unpublished Doctoral dissertation. University of Hong Kong.
- Ingold, T., 2008. When ANT meets SPIDER: Social theory for arthropods. In *Material agency* (pp. 209-215). Springer, Boston, MA.
- Islam, M.N., 2017. *Chinese and Indian Medicine Today: Branding Asia*. Springer.
- Jackson, J., 1989. Is there a way to talk about making culture without making enemies?. *Dialectical Anthropology*, 14(2), pp.127-143.
- Jenkins, R., 1997. *Rethinking Ethnicity: Arguments and Explorations*. London: Sage.
- Jensen, C.B., 2012. Anthropology as a following science: Humanity and sociality in continuous variation. *Nature Culture*, 1, pp.1-24.

- Jeong, J., 2015. Ethnic Minorities in China's Western Development Plan. *Journal of International and Area Studies*, pp.1-18.
- Jiao, H.S., 2007. High in the clouds A'er village (云端的阿尔村). Chongqing, Chongqing Press.
- Jin, J., 2017. *Huqingyuyang jiusangaodan quanji* (胡庆余堂丸散膏丹全集). Beijing, China Traditional Chinese Medicine Press.
- Kadetz, P., 2011. Assumptions of global beneficence: Health-care disparity, the WHO and the outcomes of integrative health-care policy at local levels in the Philippines. *BioSocieties*, 6(1), pp.88–105.
- Kadetz, P., 2012. Endangered practices: challenging the discourse of healthcare integration. In: Scheid, V., and MacPherson, H. eds. *Integrating East Asian medicine into contemporary healthcare: authenticity, best practice, and the evidence mosaic*. Edinburgh: Elsevier Churchill Livingstone
- Kadetz, P., 2013. Challenging a universal approach to health care integration: China, Cuba, and the Philippines. *European Journal of Integrative Medicine*, 5(1), pp.54–61.
- Kadetz, P., 2015. Safety Net—The Construction of Biomedical Safety in the Global ‘Traditional Medicine’ Discourse. *Asian Medicine*, 10(1-2), pp.121-151.
- Kaptschuk, T. J., 1983. *The web that has no weaver: understanding Chinese medicine*. New York, Congdon & Weed.
- Karunamoorthi, K., Jegajeevanram, K., Xavier, J., Vijayalakshmi, J. and Melita, L., 2012. Tamil traditional medicinal system-siddha: an indigenous health practice in the international perspectives. *TANG [HUMANITAS MEDICINE]*, 2(2), pp.1-11.
- Keith, M., Lash, S., Arnoldi, J. and Rooker, T., 2013. *China constructing capitalism: Economic life and urban change*. Routledge.
- Kipnis, A.B., 2015. Agency between humanism and posthumanism: Latour and his opponents. *HAU: Journal of Ethnographic Theory*, 5(2), pp.43-58.
- Kirksey, S.E. and Helmreich, S., 2010. The emergence of multispecies ethnography. *Cultural anthropology*, 25(4), pp.545-576.
- Klein, J.A., 2018. Heritagizing local cheese in China: Opportunities, challenges, and inequalities. *Food and Foodways*, 26(1), pp.63-83.

- Kleinman, A., 1978. Concepts and a model for the comparison of medical systems as cultural systems. *Social Science & Medicine. Part B: Medical Anthropology*, 12, pp.85-93.
- Kleinman, A., 1980. *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry*. Berkeley: University of California Press.
- Kloos, S., 2013. How Tibetan medicine in exile became a “Medical system”. *East Asian Science, Technology and Society: An International Journal*, 7(3), pp.381-395.
- Kloos, S., 2017. The pharmaceutical assemblage: Rethinking Sowa Rigpa and the herbal pharmaceutical industry in Asia. *Current anthropology: A world journal of the sciences of man*, (6), pp.693-717.
- Kloos, S., and Blaikie, C. (Eds.) (forthcoming). *Asian Medical Industries: Contemporary Perspectives on Traditional Pharmaceuticals*. London: Routledge
- Kohn, E., 2013. *How forests think: Toward an anthropology beyond the human*. Univ of California Press.
- Kohn, E., 2015. Anthropology of ontologies. *Annual Review of Anthropology*, 44, pp.311-327.
- Kolas, A., 2005. *On the margins of Tibet: cultural survival on the Sino-Tibetan frontier*. Seattle: University of Washington Press.
- Krause, K., Alex, G., and Parkin, D., 2012. Medical knowledge, therapeutic practice and processes of diversification. *MMG Working Paper 12–11*.
- Kuriyama, S., 1999. The expressiveness of the body and the divergence of Greek and Chinese medicine.
- Lai, H., 2002. China’s western development program: Its rationale, implementation, and prospects. *Modern China*, 28(4), pp.432-466.
- Lai, H., 2009. China’s ethnic policies and challenges. *East Asian Policy*, 1(2), pp.5–13.
- Lai, L. and Farquhar, J., 2015. Nationality medicines in China: institutional rationality and healing charisma. *Comparative Studies in Society and History*, 57(2), pp.381-406.
- Laidlaw, James. 2010. “Agency and responsibility: Perhaps you can have too much of a good thing.” In *Ordinary ethics: Anthropology, language and action*, edited by Michael Lambeck, 143–64. New York: Fordham University Press.

- Lambert, H., 2012. Medical pluralism and medical marginality: bone doctors and the selective legitimation of therapeutic expertise in India. *Soc. Sci. Med.* 74(7), pp.1029–1036.
- Lampton, D.M., 1974. Health policy during the great leap forward. *The China Quarterly*, 60, pp.668-698.
- Landecker, H., 2016. Antibiotic resistance and the biology of history. *Body & Society*, 22(4), pp.19-52.
- Langford, Jean M. 2002. *Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance*. Durham, NC: Duke University Press.
- Langwick, S.A., 2011. *Bodies, politics, and African healing: The matter of maladies in Tanzania*. Indiana University Press.
- Latour, B., 1993. *We have never been modern*. Harvard university press.
- Latour, B., 1996a. On actor-network theory: a few clarifications. *Soziale Welt*, 47(4), p.369–381.
- Latour, B., 1996b. On interobjectivity. *Mind, culture, and activity*, 3(4), pp.228-245.
- Latour, B., 1999. *Pandora's hope: essays on the reality of science studies*. Harvard university press.
- Latour, B., 2000. When things strike back: a possible contribution of ‘science studies’ to the social sciences. *The British journal of sociology*, 51(1), pp.107-123.
- Latour, B., 2004. Why Has Critique Run out of Steam? From Matters of Fact to Matters of Concern. *Critical Inquiry*, 30(2), pp.225–248.
- Latour, B., 2005. *Reassembling the Social: An Introduction to Actor-Network Theory*. Oxford: Oxford University Press.
- Latour, B., 2007a. Can we get our materialism back, please?. *Isis*, 98(1), pp.138-142.
- Latour, B., 2007b. The recall of modernity: Anthropological approaches. *Cultural studies review*, 13(1), pp.11-30.
- Law, J., 2009. Actor network theory and material semiotics. In: Turner B. S. (ed). *The new Blackwell companion to social theory* (pp.141-158). Chichester, West Sussex, United Kingdom, Wiley-Blackwell.
- Law, J. and Mol, A., 1995. Notes on materiality and sociality. *The sociological review*, 43(2), pp.274-294.
- Law, J. and Mol, A., 2001. Situating technoscience: an inquiry into spatialities. *Environment and planning D: society and space*, 19(5), pp.609-621.

- Leach, E. R., 1965. *Political systems of Highland Burma: a study of Kachin social structure*. Boston: Beacon Press.
- Leeuwis, C., Long, N. and Villarreal, M., 1990. Equivocations on knowledge systems theory: An actor-oriented critique. *Knowledge, Technology and Policy*, 3(3), pp.19-27.
- Lei, S.H.L., 1999. From Changshan to a new anti-malarial drug: re-networking Chinese drugs and excluding Chinese doctors. *Social Studies of Science*, 29(3), pp.323-358.
- Lei, S.H.L., 2014. *Neither donkey nor horse: medicine in the struggle over China's modernity*. University of Chicago Press.
- Leslie, C., ed. 1976. *Asian Medical Systems: A Comparative Study*. Berkeley: University of California Press.
- Leslie, C., 1980. Medical pluralism in world perspective. *Social Science & Medicine. Medical Anthropology*, 14 B(4), 191–195.
- Leslie, C. and Young, A., eds. 1992. *Paths to Asian medical knowledge*. Berkeley: University of California Press.
- Li, C. M., 2016. The annual sales value exceeds 800 million yuan. The annual output value of Mongolian medicines is far from that of Tibetan medicines. Shanxi News Portal, 20.08.2016. <http://www.sxjin.cn/zixun/1608/474.html>
- Li, R.G., ed. 2013. *Ermasibai: Guidebook of China's Qiang medicines (尔玛思柏: 中国羌药谱)*. Beijing, China Agricultural Publishing House.
- Li, S., 2010. *Bencao gangmu: Chinese Classic Collection Edition (本草纲目: 中国古典名著珍藏版)*. Jilin, Time Art Publishing House.
- Li, V., 1975. Politics and Health Care in China: The Barefoot Doctors. *Stanford Law Review*, 27(3), pp.827–840.
- Li, X. and Hamblin, D., 2016. Factors impacting on cleaner production: case studies of Chinese pharmaceutical manufacturers in Tianjin, China. *Journal of Cleaner Production*, 131, pp.121-132.
- Li, Y. and Lao, J., eds. 2001. *Illustrated compendium of authentic and local standard medicines (道地药和地方标准药原色图谱)*. Chengdu, Sichuan Science and Technology Press.
- Li, X., Liu, L., Gu, X. and Xiang, J., 2017. Heavy collecting induces smaller and deeper *Fritillariae Cirrhosae Bulbus* in the wild. *Plant diversity*, 39(4), pp.208-213.

- Li, Z. and Lu, X., 2018. Reflections on STS in Mainland China: A Historical Review. *East Asian Science, Technology and Society: An International Journal*, 12(2), pp.185-196.
- Lin, W.Y., 2017. Shi (勢), STS, and Theory: Or What Can We Learn from Chinese Medicine?. *Science, Technology, & Human Values*, 42(3), pp.405-428.
- Lin, W. and Law, J., 2014. A correlative STS: Lessons from a Chinese medical practice. *Social Studies of Science*, 44(6), pp.801–824.
- Lin, W.Y. and Law, J., 2015. We have never been latecomers!?! Making knowledge spaces for East Asian technosocial practices. *East Asian Science, Technology and Society*, 9(2), pp.117-126.
- Lin, Y., Betz, J.M., Bindra, J.S. and Bobzin, S.C. eds., 2012. *Drug Discovery and Traditional Chinese Medicine: Science, Regulation, and Globalization*. Springer Science & Business Media.
- Lindquist, G. 2005. Healers, Leaders and Entrepreneurs: Shamanic Revival in Southern Siberia. *Culture and Religion: An Interdisciplinary Journal*, 6(2), pp.263-285.
- Liu, H., 2011. The Big-Bag Tradition of Science Studies in Mainland China. *East Asian Science, Technology and Society: An International Journal*, 5(1), pp.73-78.
- Liu, Y., Guo, Y. and Zhou, Y., 2018. Poverty alleviation in rural China: policy changes, future challenges and policy implications. *China Agricultural Economic Review*.
- Liu, Z.D., Wang, S. and Chen, S.C., 2009. A taxonomic note of *Fritillaria wabuensis* (Liliaceae). *Acta Botanica Yunnanica*, 31(2), p.182.
- Lock, M., 1984. *East Asian medicine in urban Japan: varieties of medical experience*. Berkeley: University of California Press.
- Lock, M., 1990. Rationalization of Japanese herbal medication: the hegemony of orchestrated pluralism. *Human Organization*, 49(1), pp.41-47.
- Lora-Wainwright, A., 2018. Using Local Resources: Barefoot Doctors and Bone Manipulation in Rural Langzhong, Sichuan Province, PRC. *Asian Medicine*, 1(2), pp.470-489.
- Luesink, D., 2015. State power, governmentality, and the (mis) remembrance of Chinese medicine. In *Historical epistemology and the making of modern Chinese medicine*. Manchester University Press.
- LYYonline, 2017., *Zhongyang dianshitai xinluse yaoye guanggao aide xinluse*. [online video] Available at: <https://www.bilibili.com/video/av16362218/>

- Ma, E., 2015. Join or be excluded from biomedicine? JOINS and Post-colonial Korea. *Anthropology & medicine*, 22(1), pp.64-74.
- Ma, R., 2007. A new perspective in guiding ethnic relations in the twenty-first century: 'De-politicization' of ethnicity in China. *Asian Ethnicity*, 8(3), pp.199-217.
- Mackerras, C., 1994. *China's minorities: Integration and modernization in the twentieth century*. Hong Kong: Oxford University Press.
- Mackerras, C., 2003. *China's ethnic minorities and globalisation*. Routledge.
- Major, J.S., 1993. *Heaven and earth in early Han thought: Chapters three, four, and five of the Huainanzi*. SUNY Press.
- Maoxian People's Government, 2019. *Xianyu gaikuang*.
http://www.maoxian.gov.cn/zjmx_mx/mx_xygk/201710/t20171017_1295884.html
- Marcus, G.E., 1995. Ethnography in/of the world system: The emergence of multi-sited ethnography. *Annual review of anthropology*, 24(1), pp.95-117.
- Marsland, R., 2007. The modern traditional healer: Locating 'hybridity' in modern traditional medicine, southern Tanzania. *Journal of Southern African Studies*, 33(4), pp.751-765.
- Martin, Kier. 2014. "Afterword: Knot-work not networks, or, anti-anti-fetishism and the ANTipolitics Machine." *Hau: Journal of Ethnographic Theory* 4 (3): 99–115.
- Marx, K., 1998. written 1845, first published 1924. *Theses on Feuerbach', The German Ideology*. New York: Prometheus Books, pp.569-71.
- McCarthy, S., 2009. *Communist multiculturalism: ethnic revival in southwest China*. University of Washington Press. medicine, southern Tanzania. *Journal of Southern African Studies*, 33(4), pp.751-765.
- McNally, C.A., 2004. Sichuan: driving capitalist development westward. *The China Quarterly*, 178, pp.426-447.
- Meinhof, M., 2017. Colonial temporality and Chinese national modernization discourses. *InterDisciplines. Journal of History and Sociology*, 8(1).
- Meng, Q., Yang, H., Chen, W., Sun, Q. and Liu, X., 2015. People's Republic of China health system review. *Health Systems in Transition*, 5(7), pp.2-3.
- Mol, A., 2002. *The body multiple: Ontology in medical practice*. Duke University Press.
- Mol, A. and Law, J., 1994. Regions, networks and fluids: anaemia and social topology. *Social studies of science*, 24(4), pp.641-671.
http://www.hprc.org.cn/gsgl/dsnb/zdsj/200908/t20090820_28292_2.html

- Mueggler, E., 2001. *The age of wild ghosts: memory, violence, and place in Southwest China*. Univ of California Press.
- Mullaney, T., 2011. *Coming to Terms with the Nation: Ethnic Classification in Modern China*. Berkeley: University of California Press.
- National Bureau of Statistics of China (NBS), n.d.. *Tabulation on the 2010 Population Census of the People's Republic of China. Distribution by age, sex, and ethnic groups*. In Chinese. Available at:
<http://www.stats.gov.cn/tjsj/pcsj/rkpc/6rp/excel/A0201.xls>
- National History Network of the People's Republic of China, 2009. *Great Western Development*. In Chinese. Available at:
http://www.hprc.org.cn/gsgl/dsnb/zdsj/200908/t20090820_28292_2.html
- National Medical Products Association 2019, Good Manufacturing Practice for Drugs (2010 Revision), http://english.nmpa.gov.cn/2019-07/25/c_390577.htm
- Neumann, A. K., and Lauro, P., 1982. Ethnomedicine and biomedicine linking. *Social Science and Medicine*, 16(21), pp.1817–1824.
- Nguyen, D., 2019. Mapping knowledge domains of non-biomedical modalities: A large-scale co-word analysis of literature 1987–2017. *Social Science & Medicine*, 233, pp.1-12.
- NVivo qualitative data analysis Software, QSR International Pty Ltd. Version 12, 2018
- Ong, A. and Nonini, D. eds., 1997. *Ungrounded empires: The cultural politics of modern Chinese transnationalism*. Routledge.
- Oppitz, M., 2011. Qiang shaman ritual objects. *Anthropology and Aesthetics*, 39(38), pp.18–33.
- Oppitz, M. and Hsu, E., eds. 1998. *Naxi and Moso Ethnography: Kin, Rites, Pictographs*. Zürich: Völkerkundemuseum Zürich
- Paxson, H., 2008. Post-Pasteurian Cultures: The Microbiopolitics of Raw-Milk Cheese in the United States. *Cultural Anthropology* 23(1), pp.15–47.
- Peluso, N.L., 1995. Whose woods are these? Counter-mapping forest territories in Kalimantan, Indonesia. *Antipode*, 27(4), pp.383-406.
- Penkala-Gawęcka, D., and Rajtar, M., 2016. Introduction to the special issue “medical pluralism and beyond.” *Anthropology & Medicine*, 23(2), pp.129–134.
- People's Republic of China Twelfth National People's Congress, 2016. *People's Republic of China traditional Chinese medicine law*. Promulgated December 25.

- In Chinese. Available at:
<http://www.satcm.gov.cn/e/action/ShowInfo.php?classid=140&id=23573>
- Permanent Mission of the People's Republic of China to the UN, 1999. *White Paper 1999: Ethnic minorities policy in China*. Available at: <http://www.china-un.org/eng/gyzg/xizang/t420274.htm>
- Pickering, A., 2010. *The mangle of practice: Time, agency, and science*. University of Chicago Press.
- Pieke, F.N., 2014. Anthropology, China, and the Chinese century. *Annual Review of Anthropology*, 43, pp.123-138.
- Pillsbury, B., 1982. Policy and evaluation perspectives on traditional health practitioners in national health care systems. *Social Science & Medicine*, 16(21), pp.1825–1834.
- Ping, H.E., 2007. On the phenomenon of “return to Marx” in China. *Frontiers of Philosophy in China*, 2(2), pp.219-229.
- PITAHC, 2015. Guidelines Implementing R.A. 8423 IRR on the National Certification of Hilot Practitioners and Accreditation of Hilot Training Centers and Hilot Healing Centers. Circular No. 01 series of 2015.
- Pordié, L. and Gaudillière, J.P., 2014a. Introduction: Industrial Ayurveda: Drug Discovery, Reformulation and the Market. *Asian Medicine*, 9(1-2), pp.1-11.
- Pordié, L. and Gaudillière, J.P., 2014b. The reformulation regime in drug discovery: Revisiting polyherbals and property rights in the ayurvedic industry. *East Asian Science, Technology and Society: An International Journal*, 8(1), pp.57-79.
- Porkert, M., 1976. The intellectual and social impulses behind the evolution of traditional Chinese Medicine. In: Leslie, C. ed. *Asian medical systems: a comparative study*. Berkeley: University of California Press. pp.63-76.
- Press, I., 1980. Problems in the definition and classification of medical systems. *Social Science & Medicine. Part B: Medical Anthropology*, 14(1), pp.45-57.
- Prout, A., 1996. Actor-network theory, technology and medical sociology: an illustrative analysis of the metered dose inhaler. *Sociology of Health & Illness*, 18(2), pp.198–219.
- Qi, L., Luo, D.S. and Zhu, B., 2000. *Collection of Chinese minorities medicine (中国少数民族传统医药大系)*, National Science and Technology Publication Inner Mongolia Science and Technology Press.

- Qionglai People's government, 2017. *"Thirteenth Five-Year Plan" for the Development of the Traditional Chinese Medicine Health Industry in Sichuan Province*.
http://www.qionglai.gov.cn/qlsgzxxw/szfwzzyxxzz/2017-05/09/content_d110fe0a3a584e448efcb7488a650f65.shtml
- Rack, M., 2005. *Ethnic distinctions, local meanings: Negotiating cultural identities in China*. Pluto Pr.
- Rajak, D., 2011. *In good company: An anatomy of corporate social responsibility*. Stanford University Press.
- Ramesh, M., Wu, X. and He, A.J., 2013. Health governance and healthcare reforms in China. *Health policy and planning*, 29(6), pp.663-672.
- Rees, T., 2018. *After ethnos*. Duke University Press.
- Reynolds, L. and McKee, M., 2011. Serve the people or close the sale? Profit-driven overuse of injections and infusions in China's market-based healthcare system. *The International journal of health planning and management*, 26(4), pp.449-470.
- Robertson, J., 2002. Reflexivity redux: A pithy polemic on positionality". *Anthropological Quarterly*, 75(4), pp.785-792.
- Robinson, N., 2006. Integrated traditional Chinese medicine. *Complementary Therapies in Clinical Practice*, 12(2), pp.132-140.
- Rossabi, M. ed., 2004. *Governing China's multiethnic frontiers*. University of Washington Press.
- Samuel, G., 2013. Revisiting the problem of Bon identity: Bon priests and ritual practitioners in the Himalayas. *The Journal of the International Association for Bon Research*, 1, pp.77-98.
- Saxer, M., 2013. *Manufacturing Tibetan Medicine. The Creation of An Industry and the Moral Economy of Tibetanness*. New York, Oxford: Berghahn.
- Scheid, V., 2002. *Chinese medicine in contemporary China: plurality and synthesis*. Durham, NC: Duke University Press.
- Scheid, V. and Lei, S.H.L. 2014. The institutionalization of Chinese medicine. in: Andrews, B. and Brown Bullock, M. (ed.) *Medical Transitions in Twentieth-Century China* Bloomington Indiana University Press. pp.244-266.
- Schrempf, M., 2006. Hwa shang at the Border: Transformations of History and Reconstructions of Identity in Modern Amdo. *Journal of the International Association of Tibetan Studies*, 2, pp.1-32.

- Schrempf, M., 2010. Between mantra and syringe: Healing and health-seeking behaviour in contemporary Amdo. *Medicine Between Science and Religion: Explorations on Tibetan Grounds*, pp.157-184.
- Scott, J.C., 1985. *Weapons of the weak: Everyday forms of peasant resistance*. Yale university Press.
- Seol, B., 2008. A Critical Review of Approaches to Ethnicity. *International Area Studies Review*, 11(2), pp.333–364.
- Springer, L., 2015. Collectors, Producers, and Circulators of Tibetan and Chinese Medicines in Sichuan Province. *Asian Medicine*, 10(1-2), pp.177-220.
- Stanford, J.N. and Evans, J.P., 2012. The influence of Mandarin Chinese on minority languages in rural southwest China: a sociolinguistic study of tones in contact. *International Journal of the Sociology of Language*, 215, pp.79-100.
- Staub, P.O., Geck, M.S. and Weckerle, C.S., 2011. Incense and ritual plant use in Southwest China: a case study among the Bai in Shaxi. *Journal of ethnobiology and ethnomedicine*, 7(1), pp.43.
- State Administration of Traditional Chinese Medicine of the People’s Republic of China, 2016. “*Outline of the strategic plan for Chinese medicine development (2016 - 2030)*” Q&A.
<http://www.satcm.gov.cn/fajiansi/zhengcewenjian/2018-03-24/2474.html>
- State Administration of Traditional Chinese Medicine of the People’s Republic of China, 2018. *National authentic medicine production base construction plan (2018-2025)*. <http://bgs.satcm.gov.cn/zhengcewenjian/2018-12-24/8631.html>
- State Administration of Traditional Chinese Medicine of the People’s Republic of China, 2019. *Sichuan Province Chinese Medicine Industry Development Plan (2018-2025)*. <http://www.satcm.gov.cn/d/file/p/2019/07-22/5c3acdc7b2eea7e7e58e88fda4c39e0e.pdf###15635076197432c740cfc38600c9e11589d9d23633ec51563507595.pdf###1.32%20MB>
- Sun, X.Y. and Sun, F. Y., 2010. *Shennong bencaojing (神农本草经)*. Taiyuan, Shanxi science and Technology Press.
- Tan, G., 2013. An ethnography of life and changes among Tibetan nomads of Minyag Dora Karmo, Ganzi Tibetan Autonomous Prefecture, Sichuan. *Études mongoles et sibériennes, centrasiatiques et tibétaines*, 43, pp.1-18.

- Tang, S. and Yueh, S., 1983. Three new species of *Fritillaria* Linn. *Acta Acad Med Sichuan*, 14, pp.327-34.
- Tapp, N., 2002. In Defence of the Archaic: A Reconsideration of the 1950s Ethnic Classification Project in China. *Asian Ethnicity*, 3(1), pp.63–84.
- Taylor, K., 2005. *Chinese medicine in early communist China 1945-1963: a medicine of revolution*. New York: RoutledgeCurzon.
- The Central People's Government of the People's Republic of China, 2009. *Woguoweiyi qianzubowuguan kaishi chongjian zailiangniannei jiancheng*. http://www.gov.cn/jrzg/2009-05/12/content_1311934.htm
- Thomas, N. and Humphrey, C. eds., 1996. *Shamanism, history, and the state*. University of Michigan Press.
- Tilburt, J.C. and Kaptchuk, T.J., 2008. Herbal medicine research and global health: An ethical analysis. *Bulletin of the World Health Organization*, 86(8), pp.594–599.
- Tiqia, R., 2012. The 1911 Revolution in China, the Chinese Calendar, the Imaginary Qi and Healing: Translating Li Fa into an Australian Chinese Calendar and into an English Edition of the Northern Hemispherical Chinese Calendar. *Chinese Studies*, 1(3), pp.23-36.
- Torrance, T., 1920. *The History, Customs and Religion of the Ch'iang (Qiang)*. Shanghai: Shanghai Mercury Press.
- Tsing, A. L., 2009. Beyond economic and ecological standardisation. *The Australian Journal of Anthropology*, 20(3), pp.347–368.
- Tsing, A.L., 2012. On Nonscalability. The Living World Is Not Amenable to Precision-Nested Scales. *Common Knowledge*, 18(3), pp.505-524.
- Tsing, A.L., 2015. *The mushroom at the end of the world: On the possibility of life in capitalist ruins*. Princeton University Press.
- Turner, V. W., 1967. *The forest of symbols: aspects of Ndembu ritual*. Ithaca: Cornell University Press.
- Unschuld, P., 1979. *Medical ethics in Imperial China: a study in historical anthropology*. Berkeley, University of California Press.
- Unschuld, P. U. 1985. *Medicine in China: a history of ideas*. Berkeley, University of California Press.
- Unschuld, P., 1986. *A history of pharmaceuticals*. Berkeley, University of California Press.

- Unschuld, P., 2003. *Huang Di nei jing su wen: nature, knowledge, imagery in an ancient Chinese medical text, with an appendix, the doctrine of the five periods and six qi in the Huang Di nei jing su wen*. Berkeley, University of California Press.
- Unschuld, P., 2010a. *Medicine in China: a history of ideas*. Berkeley: University of California Press.
- Unschuld, P.U., 2010b. The Berlin Collections of Chinese Medical Manuscripts: Rural Authors, Rural Contents. *Monumenta serica*, 58(1), pp.281-293.
- Unschuld, P., 2016. *Huang Di Nei Jing Ling Shu: The Ancient Classic on Needle Therapy*. University of California Press.
- van der Geest, S., 1985. Discussion: Integration or Fatal Embrace? The Uneasy Relationship between Indigenous and Western medicine. *Curare* 8(1), pp.9-14.
- van der Valk, J., 2019. Garuda 5 (khyung lnga): Ecologies of Potency and the Poison-Medicine Spectrum of Sowa Rigpa's Renowned 'Black Aconite' Formula. *HIMALAYA, the Journal of the Association for Nepal and Himalayan Studies*, 39(1), p.111-128.
- Vedom, J. and Cao, H., 2009. Patterns of the Use and the Choice of Health Care Facilities among the Han and Minority Populations in China. In: Cao, H., ed. *Ethnic minorities and regional development in Asia: Reality and challenges*. Amsterdam: Amsterdam University Press.
- Velimirovic, B., 1984. Traditional Medicine is not Primary Health Care: A Polemic. *Curare Saarbrücken*, 7(1), pp.61–79.
- Wahlberg, A., 2014. Herbs, laboratories, and revolution: on the making of a national medicine in Vietnam. *East Asian Science, Technology and Society: an International Journal*, 8(1), pp.43-56.
- Wang, F.L., 2016. *Institutions and institutional change in China: Premodernity and modernization*. Springer.
- Wang, G., 2015. Ethnic multilingual education in China: A critical observation. *Working Papers in Educational Linguistics (WPEL)*, 30(2), pp.35-47.
- Wang, M., 2010. The Intermediate Circle. *Chinese Sociology & Anthropology*, 42(4), pp.62–77.

- Wang, M.K., 1999a. From the Qiang Barbarians to the Qiang Nationality: The Making of a New Chinese Boundary. In: Huang, S. and Hsu, C. ed. *Imagining China: Regional Division and National Unity*. Taipei: Institute of Ethnology.
- Wang, M.K., 1999b. Nuren, bujie yu cunzhai rentong: minjiangshangyoude duyaomao gushi [Women, Pollution and Village Identity: Stories of Poison Cats in the Upper Min River Valley]. *Zhongyang yanjiuyuan lishi yuyan yanjiusuo jikan*, 70(3), p.699-738.
- Wang, M.K., 2002. Searching for Qiang culture in the first half of the twentieth century. *Inner Asia*, 4(1), pp.131–148.
- Wang, Q.E., 2013. Capitalism for China? Editor's Introduction. *Chinese Studies in History*, 47(2), pp.3-6.
- Wang, Y., 2009. A Simple Exploration of the Medical Ethics Thoughts in Pre-Qin, Qin and Han Dynasties. *Chinese Medical Ethics*, (3), p.52.
- Wang, X.Q. and Chen, P.J., 2014. Population ageing challenges health care in China. *The Lancet*, 383(9920), p.870.
- Wang, J. and Farquhar, J., 2009. ‘Knowing the Why but not the How’: A dilemma in Contemporary Chinese Medicine. *Asian Medicine*, 5(1), pp.57-79.
- Wang, Y.X. and Prott, L., 2016. Cultural revitalisation after catastrophe: the Qiang culture in A’er. *International Journal of Heritage Studies*, 22(1), pp.26-42.
- Wang, W. and Yan, Y., 2012. Suboptimal health: a new health dimension for translational medicine. *Clinical and translational medicine*, 1(1), p.28.
- Weckerle, C.S., Yang, Y., Huber, F.K. and Li, Q., 2010. People, money, and protected areas: the collection of the caterpillar mushroom *Ophiocordyceps sinensis* in the Baima Xueshan Nature Reserve, Southwest China. *Biodiversity and conservation*, 19(9), pp.2685-2698.
- Wellens, K., 2010. *Religious revival in the Tibetan borderlands: The Premi of southwest China*. Seattle: University of Washington Press.
- White, S., 1999. Deciphering “integrated Chinese and Western medicine” in the rural Lijiang basin: State policy and local practice(s) in socialist China. *Social Science and Medicine*, 49(10), pp.1333–1347.
- WHO, 1976. *SEA/RC29/R11-Traditional Systems of Medicine* (No. SEA/RC29/R11). WHO Regional Office for South-East Asia.
- WHO, 1978a. Declaration of Alma Ata. Geneva: WHO.

- WHO, 1978b. *The promotion and development of traditional medicine: report of a WHO meeting [held in Geneva from 28 November to 2 December 1977]*. World Health Organization.
- WHO, 2001. Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review. *Essential Medicines and Health Products Information Portal: A World Health Organization resource*. Available at: <http://apps.who.int/medicinedocs/en/d/Jh2943e/9.9.html>. [Accessed January 25, 2017]
- WHO, 2002. WHO Traditional Medicine Strategy 2002-2005. *World Health Organisation Geneva*, pp.1–74. Available at: http://www.wpro.who.int/health_technology/book_who_traditional_medicine_strategy_2002_2005.pdf. [Accessed January 25, 2017]
- WHO, 2004. *WHO guidelines on developing consumer information on proper use of traditional, complementary and alternative medicine*. World Health Organization.
- WHO, 2005. *WHO global atlas of traditional, complementary and alternative medicine*. Kobe, Japan: WHO Centre for Health Development.
- WHO, 2009. Report of WHO interregional workshop on the use of traditional medicine in primary health care, Ulaanbaatar, Mongolia, 23-26 August 2007.
- WHO, 2013. WHO Traditional Medicine Strategy 2014-2023. *Alternative and Integrative Medicine*, pp.1–76. Available at: <http://apps.who.int/iris/bitstream/>
- WHO, 2015. People's Republic of China health system review. *Health Systems in Transition*, 5(7).
- WHO, 2019. *WHO global report on traditional and complementary medicine 2019*. World Health Organization.
- Whyte, S.R., van der Geest, S. and Hardon, A., 2002. *Social Lives of Medicines*. Cambridge: Cambridge University Press.
- Winner, L., 1980. Do artifacts have politics? *Daedalus*, pp.121-136.
- Wright, S. and Shore, C., 1997. Policy: A new field of anthropology. In *Anthropology of Policy* (pp. 3-39). Routledge.
- Wu, X., 2014. The farmhouse joy (nongjiale) movement in China's ethnic minority villages. *The Asia Pacific Journal of Anthropology*, 15(2), pp.158-177.
- Wu, Z. and Raven, P.H., eds. 2008. *Flora of China 11: 1-622*. Science Press (Beijing) & Missouri Botanical Garden Press (St. Louis).

- Wu, J.R. and Zhang, B., 2010. Experience of Professor YAN Zheng-hua in treating cold. *China Journal of Traditional Chinese Medicine and Pharmacy*, (5), p.22.
- Xiaojin People's Government, 2019. *Renkou minzu*.
<http://www.xiaojin.gov.cn/xjxrmzf/c100127/201909/b6b3fa8c86f54188b58cd122f5723fea.shtml>
- Xu, Q. et al., 2013. The quest for modernisation of traditional Chinese medicine. *BMC complementary and alternative medicine*, 13, pp.132-143.
- Yan, K., 2015. *Poverty Alleviation in China: A Theoretical and Empirical Study*. Berlin: Springer.
- Yang, D.L., 2012. *Beyond Beijing: Liberalization and the regions in China*. Routledge.
- Yang, M.M.H., 1994. *Gifts, favors, and banquets: The art of social relationships in China*. Cornell University Press.
- Yang, S., 1998. *The divine farmer's materia medica: a translation of the Shen Nong Ben Cao Jing*. Blue Poppy Enterprises, Inc.
- Yang, J. and Peng, Y., 2015. Traditional Miao cures to boost health of Guizhou's economy. *China Daily*, 18.03.2015. https://www.chinadaily.com.cn/china/2015-03/18/content_19839959.htm
- Yang, S.N., Dai, B., Wo, A.X., and Lei L.M., 2017. Study on characteristic spectrum of *Gastrodia elata* based on cross response, *Shipin gongye keji* 38(19), pp.227-230.
- Young, A. 1983. The relevance of traditional medical cultures to modern primary health care. *Social Science & Medicine*, 17(16), pp.1205–1211.
- Yu, C.F. and Chongxin, Y., 2016. Guanyin and Dizang: The Creation of a Chinese Buddhist Pantheon. *Asiatische Studien-Études Asiatiques*, 70(3), pp.757-796.
- Yu, E. and Amri, H., 2016. China's Other Medical Systems: Recognizing Uyghur, Tibetan, and Mongolian Traditional Medicines. *Global Advances in Health and Medicine*, 5(1), pp.79–86.
- Zevik, E., 2002. First Look: The Qiang People of Sichuan. *Asian Anthropology*, 1(1), pp.195–206.
- Zhan, M., 2011. Human oriented? Angels and monsters in China's health-care reform. *East Asian Science, Technology and Society: An International Journal*, 5(3), pp.291-311.
- Zhang D.F., 2015. Export of Chinese material medicine products reached 3.2 billion dollars in 2014. *J Tradit Chin Med Manag*, 23(3), p.125.

- Zhang, P., 2008. Zhongguo Qiangzu renkou chao changgui zengzhang de yinsu fenxi [Analysis of the factors behind the supernormal growth of the Chinese Qiang population]. *Renkou yu jingji zazhi*, 4, pp.51-55.
- Zhang, Q., 2016. *Making disaster zones into “scenic sites”, homelands into “gardens”, and peasants into “grateful survivors”: the Chinese state in Qiang village earthquake recovery*. Unpublished PhD thesis. Tulane University.
- Zhang, W., 2018. Chinese Pharmacopoeia and Progress in the Compilation of Chinese Pharmacopoeia 2020. *ChP-EDQM Workshop on Pharmaceutical Excipients*. https://www.edqm.eu/sites/default/files/presentation-workshop_excipients-chinese_pharmacopoeia_and_chp_2020-september2018-zhang_wei.pdf
- Zhang, D. and Unschuld, P.U., 2008. China's barefoot doctor: past, present, and future. *The Lancet*, 372(9653), pp.1865-1867.
- Zhang, Z. and Unschuld, P.U., 2014. *Dictionary of the Ben cao gang mu, Volume 1: Chinese Historical Illness Terminology (Vol. 1)*. Univ of California Press.
- Zhang, D., Zhang, J. and Zhang, Y. 2014. Analysis on the Institutionalization of Ethnic Civilian medicine: A Case Study on the Institutionalized Veteran Qiang Doctors. *Journal of Guangxi University for Nationalities*. 36(6), pp.17-20.
- Zhang, B., Peng, Y., Zhang, Z., Liu, H., Qi, Y., Liu, S. and Xiao, P., 2010. GAP production of TCM herbs in China. *Planta medica*, 76(17), pp.1948-1955.
- Zhao, Y.Y., 2013. Traditional uses, phytochemistry, pharmacology, pharmacokinetics and quality control of *Polyporus umbellatus* (Pers.) Fries: a review. *Journal of ethnopharmacology*, 149(1), pp.35-48.
- Zhao, Z., Guo, P. and Brand, E., 2012. The formation of daodi medicinal materials. *Journal of ethnopharmacology*, 140(3), pp.476-481.
- Zhao, J.F., Zhang, T.J., Gao, Q.Y., Zhao, C.F., Han, L.L. and Chen, G., 2017. Bone setting manipulative reduction for the treatment of children's distal radioulnar fracture and dorsal dislocation. *Zhongguo gu shang - China journal of orthopaedics and traumatology*, 30(7), pp.664-668.
- Zheng, Z., 2018. Within two or three years, will 60% of the drugs be removed from shelves? Replacement with healthcare products? Be wary of the “master plan” behind it. *Shanghai Observer*, 20 February. In Chinese. Available at: <https://www.shobserver.com/news/detail?id=122916>

Zhu, W., Ma, X., Wei G., Tang, X., Tian X., and Zhang X., 2016. Qiantan qiangyiyao chanye fazhan sikao [Discussion on the development of the Qiang pharmaceutical industry]. *Zhongguo minzu yiyao zazhi*, 22(6), p.55-56.

Zhu, Z., Wang, T., Fu, D., Gui, Y., Wang, J. and Cui, T., 2016. Innovative development path of ethnomedicines: an overview of ethnomedicines in China. *Frontiers of medicine*, 10(2), pp.166-177.

Appendix: Diagnostic criteria for *knee stone disease*

Western medicine criteria:

- The disease occurs predominantly in middle-aged or elderly adults. Women after menopause are more likely to develop unilateral joint knee burden.
- Chronic cumulative joint injury with slow onset.
- Joints may have a clear history of trauma, with the disease developing gradually thereafter.
- Possible to present syringomyelia with neurotrophic disorders, Kashin-Beck disease affecting epiphyseal development, rickets, or other congenital, developmental osteoarthritis.
- Early arthralgia, exercise stiffness, severe symptoms in the morning, improvement after exercise, but worsening symptoms after overwork.
- At its early stage there is no swelling of joints, muscle atrophy or muscle spasm.
- Hinderance to joint movement is mild and rough frictional sounds may occur during movement.
- There may be tenderness in the fissures of the affected joint, and sometimes proliferative protrusions at the edge of the joints may be palpable.
- Interlocking or touching of intra-articular loose bodies may occur.
- Late joint swelling, aggravation of pain, limited movement, joint deformation, sometimes joint effusion, positive patellar tap test in patients with more effusion.
- X-ray examination: sharp joint edges, spur formation of varying degrees, narrowing of joint space, sclerosis of subchondral articular surface, and cavity formation in cancellous bone. In the late stage, the articular surface may be irregular, the bone extremity may be deformed, and there are loose bodies in the joint.
- Blood tests are normal and erythrocyte sedimentation rate (ESR) is not fast.
- Differentiation from gout and rheumatoid arthritis at an early stage.
- Differentiation from joint tuberculosis or syphilis in the elderly at a late stage.

Chinese medicine criteria:

- Joint pain due to blood deficiency and wind invasion, inadequate movement, lack of breath, laziness, fatigue, spontaneous sweating, palpitation, insomnia, thick and tender tongue, white tongue coating, and slow pulse.
- Joint pain resulting from strain is not severe but persistent, and the soreness of affected joints is more painful. Clear pain often related to occupation. Dizziness, fatigue, spontaneous sweating and other symptoms of Qi deficiency, yellow complexion, white lips, palpitation, clouded vision and other symptoms, pale tongue, feeble pulse.
- Pins-and-needles or stabbing pain is present in the joint due to Yang deficiency and blood congealing. The painful area can be slightly swollen, the skin is darker, there is fear of cold, frail walking, the tongue is swollen, there may be bruises, and the pulse is weak and astringent.

Qiang medicine criteria:

- *Knee stone disease* in the joint (*sanmishashe*) duct.
- *Mosi, sa, zi, and jina* (*qi*, blood, water, and nutrient substance) out of balance.
- Nutritional imbalance of the knee joint, failure to moisten the various tissues and organs of the knee joint, resulting in the impaired operation of the knee joint (*sanmishashe*) duct, which is blocked, resulting in the bone rarefaction of the knee joint, accretion and softening.
- Tissue aging leading to various *knee stone diseases*.

Western, Chinese, and Qiang medicine diagnostic criteria table presented by Dr Zhang at a Qiang medicine conference