Special Issue
on the History of Chinese Medicine

Introduction from the Guest Editor

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This issue has been many years coming to fruition, for which I owe my fellow contributors and Hans Ulrich Vogel, as journal editor, many apologies as well as deep gratitude for their patience. The original intent of this special issue was to take aspects of the contributors’ scholarship that shed, in my opinion, new and important light on the history of medicine in China, and get these articles quickly into print. In spite of the various delays that impeded our progress, it is a testament to these scholars that their contributions are just as path-breaking now as they were when we started, even accounting for the substantial updating that they have been kind enough to provide.

Taking these four essays by chronological time period, the first, by TJ Hinrichs, is a truly magisterial study of the ways in which epidemic diseases were understood in China from the Han dynasty (206 BC-220 AD) through the end of the Song (960-1279). Starting from an observation of Paul Unschuld’s, that China always had competing, and coexisting, theories of disease causation, Hinrichs takes the categories of “Warmth” and “Warm Diseases” as a vehicle for investigating this competition. By doing so, she is able to shed new light on a long-standing question in the history of Chinese medicine, which is why Zhang Zhongjing’s 張仲景 Treatise on Cold Damage (Shanghan lun 傷寒論), written towards the end of the Han dynasty, became a canonical medical work only during the Song, nearly a thousand years later.
One major strength of Hinrichs' article is that it engages directly with the western literature of history of medicine, deploying analytic concepts to great effect, and allowing Chinese medical history to be understood according to rubrics applicable to medical history everywhere. For example, social and medical historian Charles Rosenberg wrote influentially about how epidemic diseases could be understood either configurationally—resulting from a disturbance in the normal configuration of climate, environment, and communal life—or as the result of contamination by some disease-causing material substance. Another way of talking about these two modes of disease causation is to say that the first considers disease to be a result of disorders of function, whereas the second understands disease-causing agents to have a real existence independent of their victims. The technical term for this ‘having independent existence’ is ‘ontological reality.’ So in the functional-configurational model, there is no need to imagine a disease-causing thing, as the disease is caused by a disruption to the normal environmental conditions. In the ontological-contaminationist model, disease is caused by real, disease-causing agents.

Three explanatory models for the outbreak of epidemic diseases are found in early and medieval medical texts: the first emphasized the injury that the body sustained from exposure to cold during the winter. This Cold Damage, if it did not immediately cause sickness, might generate a toxin that was stored in the body and that would re-emerge in the spring or summer as an outbreak of disease. These were referred to as Cold Damage Disorders. Another category of epidemic described by Chao Yuanfang巢元方 in his seventh-century *Comprehensive Treatise on the Origins and Symptoms of Diseases* (*Zhubing yuanhou lun 諸病源侯論*) was “Seasonally Spread Disorders.” Unlike Cold Damage, which was caused by the regular climatic conditions of winter, Seasonally Spread Disorders erupted after a spell of uncharacteristically warm weather in winter, cold or dry weather in spring, cold weather in summer, or wet weather in fall. Thus they were disruptions in the proper configuration of climate, and although irregular, were part of larger cosmological patterns that could be prepared for and sometimes even predicted. However, they were also often agreed to be contagious. This distinguished them from Cold Damage Disorders, which might spread around the body, but did not spread from one body to another. Seasonally Spread Disorders overlapped with a more religious understanding of diseases as “Heaven Spread,” a visitation of disease ordered by a displeased Heaven.

The third explanatory model was the one considered least desirable by the administrative elites: Warmth Disorders. Writings on Warmth diseases emphasized a more ontological understanding of epidemic disease, in which infection came from contamination. This understanding of the contagiousness of Warmth Disorders derived from the belief that they were
caused by noxious, pestilential \( qi \), which was demonic in origin and resulted in infestations of the body that could be transmitted from one victim to another. The specific forms of such attacks included demonic strikes, demons lodging in the body (a form of possession), infestation as with supernatural “worms,” and encounters with demons in dreams. Additionally, foul-smelling airs, which Hinrichs renders “effluvia” to emphasize theirphysicality and their differentiation from \( qi \), were also capable of transmitting disease. All of these ontological aspects of Warmth Disorders were able to propagate through contamination, making the Warmth epidemics highly contagious. Such explanations clearly overlapped with Daoist texts on disease, which explicitly discussed the “Five Warmth Demons,” and recommended pharmaceutical formulas that were clearly apotropaic.

A major preoccupation of the Song dynasty government was creating cultural unity, something that eventually resulted in the extension of [Neo-]Confucian values to the entire population, not just the elites. In medicine, we see the beginnings of this process in the Northern Song (960-1126) with the concern to correct and transform the “southern” customs of avoiding the sick and turning to shamans for supernatural assistance during epidemics. Already in 1066, we see the publication by the newly-established Bureau for Editing Medical Treatises of an authorized version of Zhang Zhongjing’s 張仲景 Shanghan lun 傷寒論 (Treatise on Cold Damage). This book provided empirical analyses of the signs and symptoms of the various manifestations of Cold Damage along a gradient of the three yang and three yin aspects of the body, and recommended herbal formulas for each. Not only was this an entirely secular understanding of disease, but it was also compatible with a newly fashionable way of understanding climatic influences, namely by following the Five Phases and Six Climatic Influences (wu yun liu qi 五蘊六氣). Thus the Han dynasty medical classic, newly interpreted, reinforced the orthodox configurational understanding of epidemic disease causation. Accordingly, officials stationed in regions where the population believed in the powers of shamans to control the Warmth epidemics, or contagious demonic epidemics transmitted by contamination, rounded up the shamans and required them instead to study the Treatise on Cold Damage. Some handed out copies, others had the formulas of the Treatise engraved on stone stelae and displayed in the marketplace, explicitly as measures to reform southern customs.

This new analysis of the reasons for the Song administration’s enthusiasm for Cold Damage adds a great deal to our understanding. Certainly, the Song state was concerned to intervene during disease outbreaks on behalf of the people. But the epidemics themselves do not offer a sufficient explanation for the specific enthusiasm for the Treatise on Cold Damage’s entirely functional-configurational explanations. Rather, its combination
with the theory of Five Phases and Six Climatic Influences provided a
“cosmological framework that conceptually integrated the empire.”

In Che-chia Chang’s study of the Imperial Medical Academy (Taiyi yuan
太醫院), we have another significant contribution to the English-language
 scholarship on the relationship between medicine and government.
 Although the Imperial Medical Academy was the only institution in
 imperial China that examined and certified physicians, there has been very
 little published about it. Chang takes as his starting-point the contradiction
 between the Academy’s traditional dual role as a supervisory institution
 for medicine throughout the nation as well as the source of medical care for
 the palace, and the fact that by the late Qing (1644-1911), it seemed to only
 function as a source for court physicians. How, he wonders, did this
 contraction of the function of the Imperial Medical Academy come about?

In answering this question, Chang takes us on a survey of the activities
 of the Academy through Chinese history, providing much valuable new
 information. It turns out that in every dynasty since China’s medieval
 period, there was an official government office responsible for medical
 education as well as for providing and supervising medical care for the
 imperial family. By the Song dynasty, the central government was stand-
 ardizing and publishing key medical texts (as is also described by TJ
 Hinrichs), and dispatching trained medical officers to the prefectures
 where they supervised local medical schools. The Mongol successor state to
 the Song, the Yuan dynasty (1279-1368), built out this empire-wide system
 significantly, funding a network of medical schools, and sending them
 salaried instructors. During this period, medical practice also became an
 acceptable occupation for Confucian scholars, and officials at the Imperial
 Medical Academy had high rank in the civil service administration.

There was significant contraction in the funding and prestige of the
 Academy during the Ming dynasty (1368-1644), which stopped paying for
 the regional medical schools and instead encouraged the local schools to
 send excellent physicians to the central Academy. The best qualified of the
 Academy physicians would be allowed to serve in the palace, the others
 had other medical and administrative duties. These medical-administrative
 functions explain why the Academy was under the supervision of the
 Ministry of Rites, a position that became anachronistic under the Qing
 when the functions of Academy physicians shrank still further to concen-
 trate only on serving the imperial family.

Here, under the Qing, we find new regulations that prohibited members
 of the Imperial Medical Academy from having a private practice or even
 from attending to court officials without explicit permission. If Academy
 physicians did treat courtiers, they were required to report on their find-
 ings to the emperor. All Academy members were now expected to rotate
 into palace duties. Prescriptions for the emperor had to be agreed by more
than one physician, and at times the emperor allowed Chinese and Jesuit physicians to work together, so that each would be reporting on the activities of the other. Entry to the Academy was drawn from the ranks of the medical students there, who had to pass stiff exams and have a guarantor within the regular staff. This system favored hereditary families of court physicians, whose sons might start studying medicine in their early teens and who, if outstanding, might make the rank of Imperial Physician to the emperor in their fifties. Promotion up the pyramidal structure came only from within, a system which protected the imperial family with a stable service in which the loyalty of the Chinese doctors treating the Manchu rulers was reinforced by their guarantors and by an absence of other career options, as the Qing prohibited retirement of Academy physicians as well as strictly controlling their activities.

Chang interprets these restrictions on the Qing Medical Academy’s functions as reflecting the Manchu rulers concerns for their own safety. Doctors could not treat courtiers without permission in order to limit their ability to participate in court politics. Acupuncture was banned at court in 1822, likely out of concern that the stout acupuncture instruments of the day might be used to assassinate the emperor. The closed and hierarchical system of promotion meant that by the time an Academy physician was admitted to treat the emperor directly, he would be older, very experienced, and always working as a member of a team, never alone. This stability came at the cost of lack of flexibility, however, a situation that was becoming painfully apparent by the end of the dynasty.

From Chang Che-chia’s study of medicine at court, we turn to Henrietta Harrison’s paper on the medical history of a relatively poor but educated man living in rural Shanxi. Liu Dapeng 劉大鵬 (1857-1942), whose diary was written daily between 1892 and the day before his death in 1942, records many aspects of his own and his family’s health, beliefs about illness, and methods of treatment. This fascinating source, described by Harrison with expert attention to context, gives us a rare insight into everyday health and healing practices at a time of great social and medical change.

The most striking thing to emerge from Liu Dapeng’s accounts is the way health, disease, and therapy were an inextricable part of the moral order of late Qing and Republican China (1912-1949). When Liu gets sick, he usually ascribes the cause to his own failure to uphold Confucian values, such as failing to mourn his father’s death properly, and when a neighbor’s wife falls ill and dies, he describes this as a punishment for the sins of the husband. When he recovers from painful sores, he is gratified that the cure must have been a reward for his own virtuous thoughts. When epidemics broke out, Liu saw this as punishment for the moral failings of the community, for which community responses such as sacrifices to the
Plague God were appropriate. Health, like the Confucian world-order, was first a family matter, then a community concern, and lastly the domain of the state.

Within the family, illness was treated first with self-medication, then by appealing for help from the expertise of friends and neighbors, and lastly by paying for professional services. Liu’s self-medication generally started with commercial preparations whose main function was to purge, and adjusted the severity of the purging with opium-containing drugs. He used vacuum bowls in a process known as cupping to bring infected blood and pus to the surface of boils, which could then be drawn out with poultices or lanced directly in a form of acupuncture that was performed by a neighbor who knew how to use needles but was not educated enough to know the classical acupuncture points. Liu himself gave out his own favorite medications when they were requested by neighbors, underlining the community relations that were fundamental to health care. Harrison notes that these relations included women acting as healers, and not only in obstetrical/gynecological matters. At other times an educated friend visited sick family members and wrote out classical-style prescriptions to be filled at the pharmacy. All such acts of kindness were recompensed within the moral economy of the village, but rarely in cash, more often in return favors, in kind, or with a celebratory meal.

This kind of community response to disease was far preferable to calling in the professional doctors, whose reliance on patient fees made their motives morally questionable, and whose professional distance made their therapies incommensurable with the moral causes of ill-health. Harrison argues that it was to try to reconcile this contradiction that doctors, when called in, were treated as honored friends, even though the financial relationship stretched the fiction sometimes to breaking-point. When Liu’s family members were seriously ill, the medical fees he paid were significant, in a couple of cases enough to put him into debt for the year. Less wealthy families could be reduced to bankruptcy by medical fees in cases of serious illness.

Additionally, it is notable that even an educated man like Liu was not above praying for cures and taking temple remedies by a divinatory process as late as the 1940s at the local Daoist temple. Earlier, in 1901, his parents had also sent him a diagnosis and prescription for his neck pain that had been obtained from a spirit medium via planchette writing. The prescription involved buying drugs that were combined and ingested in much the same way as classical formulas.

During Liu Dapeng’s lifetime, the institutions of western medicine were slowly being established in Shanxi, but few of them registered in the central Shanxi village where he lived. The exceptions were vaccination against smallpox, which was successfully integrated into local medical
culture, and the use and promotion of milk products for the very young or the sick. Milk powder and lactose products were widely advertised as medical panaceas, and Liu records that his neighbor injected his wife with lactose when she fell sick after childbirth. Milk products featured alongside a wide array of western-style medical products that began to be advertised in newspapers and sold in pharmacies, with injected preparations, in particular, signaling a new medical modernity.

The institutions of medical modernity originated with the central authorities, which during the political chaos of the Republican era generally meant the provincial capital of Taiyuan rather than the national capital, and were intended to be disseminated in a descending hierarchy towards the villages. As Harrison’s insightful analysis of Liu Dapeng’s community reminds us, this top-down promotion of modern medical institutions and new models of healthcare violated the moral order that was at the core of village life.

Finally, we come to my own article on the medical career of Ding Fubao (1874-1952) Here, we see several of the themes in our previous articles rearticulated in the medical marketplace of Republican era Shanghai. As a young man Ding Fubao, like so many Confucian-educated scholars of previous dynasties, was hoping for an official position within the civil service. During the upheavals of the last decade of the Qing, it seemed for a while that his success in the first ever qualifying examination in medicine, held in Nanjing in 1908, would lead to such an official position. These hopes were dashed by the Xinhai Revolution of 1911, an event that spelled potential disaster for Ding as a well-connected supporter of the Qing.

In response to these upheavals and his own recurring financial embarrassment, Ding became a capitalist medical entrepreneur. He set up his own publishing company to publish his many medical translations from Japanese, opened a medical clinic in Shanghai specializing in lung diseases (he and his family battled tuberculosis for many years), and even briefly went into the drugs business, producing two proprietary medicines and marketing them aggressively in the Shanghai press, particularly the Shenbao 申报. These activities were highly successful: Ding’s translations of Japanese medical works quickly made Japanese medical terminology dominant in Chinese, overtaking the many years of effort that English-speaking missionary doctors had put into creating a new medical terminology in Chinese.

Ding’s activity as a creator and seller of proprietary remedies has received little attention from historians of medicine, but I argue here that it is key to understanding this period in the assimilation of western medicine. Ding’s remedies were expensive, marketed in western-style bottles, but were in fact based on inexpensive Chinese herbal remedies. Like many
other preparations at this time, both western and Chinese in origin, they borrowed the allure of modernity without having to specify their actual contents. In the end, Ding came to be disgusted with this aspect of his medical enterprise. In 1914, and after he had already become wealthy, he stopped producing the drugs, and rededicated himself to only those medical activities that were befitting a junzi 君子, a Confucian-style gentleman.

The timing of Ding’s retreat from the pharmacy business also coincided with the development of the western-style medical profession in China. In July of 1914, the editorial pages of the China Medical Journal lambasted both Chinese and western drug companies for their “indiscriminate selling of drugs in China,” and in 1915, Chinese doctors with western medical degrees launched the National Medical Association of China. Because Ding had no such degree, having based his practice on only his success in a 1908 hybrid Chinese-western medical examination of the New Policies era, he was not eligible to become a regular member of this association, even though he was awarded honorary membership. Ding was clearly aware of both these deficits: in addition to ending his drug manufacturing, he also sent his son, Ding Huikang 丁惠康 (1904-1979), to get a western medical degree in Germany.

Picking up on Henrietta Harrison’s observation that Liu Dapeng frequently interpreted illnesses as punishment for his own or family members’ moral transgressions, we find, perhaps surprisingly, that Ding Fubao was also convinced that he bore a great deal of blame for his own and his family’s ill-health. This seems to have co-existed easily with his commitment to the germ theory of disease causation. In several places he voices his guilt for passing on tuberculosis to family members, which he interprets as a sin that requires atonement. The fact that his eldest son suffered from a debilitating mental illness was later interpreted in the Shanghai press as a commentary on Ding’s bad karma. Ding’s conversion to Buddhism and his extensive philanthropic activities, including medical philanthropy, were fueled by this idea of disease as moral retribution.

Historians of medicine have often treated medicine as an index of cultural change, according to which the increasing acceptance of western medicine in China has become a marker of China’s transition to modernity. Yet the persistence of the moral economy of health that we see in the cases of both Liu Dapeng and Ding Fubao suggests that medical change does not necessarily indicate acceptance of the values of a secular, governmental modernity. On the contrary, Ding’s enthusiastic promotion of western medicine was part of his commitment to a Chinese moral culture that transcended the commercial modernity of republican-era Shanghai.

Taken together, these papers underscore the importance of medical orthodoxy to the state, both during the expansion of Confucian culture
during the Song dynasty, and again in the modern period. Historically, the Chinese state has exerted itself many times to define acceptable forms of spiritual activity. This is not the same as secularization: some religious activities were always approved, while officials attempted to eradicate others because they threatened the state’s power and authority. During the Song, concerns about social and economic stability led the state to promote the empirical remedies of the Treatise on Cold Damage and deemphasize the dangers of contagion, because contagion was acknowledged to be caused by supernatural forces beyond the control of the state administrators. During the Qing and republican eras, efforts to define medical orthodoxy were defined by ethnic (Han-Manchu) and international relations, rather than a primary commitment to a transcendent scientific “truth.” These papers may be taken as a reminder that all truth-claims need to be regarded with skepticism and investigated with an eye to the power relationships involved.