

NETWORKING ACUPUNCTURE IN VIETNAM

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This thesis is the original work of the author
except where otherwise stated.

A handwritten signature in blue ink on a light green background. The signature reads "G Dalgetty" in a cursive script.

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*In memory of a dear friend,
Richard Arthur Walsh*

*“we shall never cease from exploration”
– T.S. Elliot*

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Please note that in this thesis, I have anglicised Vietnamese names of persons,
places and books.

Abstract

This thesis proposes that medical anthropologists change the way we think about acupuncture in Vietnam. Acupuncture should not be conceived as a discrete medico-philosophical system as has been acupuncture's textual identity in academic writings to date. Acupuncture is rather a performative network, in the sense used by Bruno Latour, constituted through energetic relationships between science, people, textbooks, classrooms, pedagogic practices, clinical technologies and much more. These come into interaction and their collaborations produce acupuncture in unexpected ways. This conclusion was generated through 15 months of ethnographic fieldwork with acupuncturists in Ho Chi Minh City and catchments from 2007-08. Fieldwork involved observing acupuncturists engage patients, participating in acupuncture classes and volunteering on acupuncture charity teaching and treating missions. A snowballing method was used to generate connections with a mobile and diverse group of medical specialists.

First, it will be shown that in Vietnam, science and tradition were united in the creation of a New Medicine that must be considered on its own terms rather than as a grafting of two different types of medical system. The New Medicine modelled pedagogic and legitimacy-making practices which circulated in the city. Second, local formation of acupuncture objects and shaping of clinical treatment flatten out previously taken for granted hierarchies when describing clinical medical knowledge. The technology of vision was integral to the construction of such knowledge and when interrupted caused acupuncture to grind to a halt. Finally, person networks, after Mark Granovetter, were active in the city generating professional success and legality for practitioners but these will also be analysed using a Latourian approach. Recent ethnographic investigations of science and technology are used to help portray, more faithfully, the interactive dynamic of acupuncture experienced during fieldwork. Such writings extend the scope of what can be investigated as participating in the creation of medical realities in southern Vietnam. I argue that medical knowledge is a reality constructed through continual practices. Knowledge is not a commodity or eternally static entity, knowledge is what we *do*.

Introduction: Medical Knowledge as Network

The recently opened Museum of Traditional Medicine in Ho Chi Minh City (HCMC), southern Vietnam, is unique. To date, it is the only traditional medicine museum and the first privately operated and funded museum in Vietnam. Operated by Fito Pharmaceutical Company, which exports traditional medications to Europe and Russia, it is a luxurious oasis in the chaos of central Saigon¹. When I first visited the Museum, I was met by the scent of rich mahogany wood flooring and the earthy tang of *materia medica*² overflowing their woven sacks. Urns, pots, kettles, scales and grinders were laid out in glass casings to show how plant and animal material might be transformed into medications. An extravagant carving, engraved with the names of one hundred famous scholar-physicians presented traditional medicine as a flourishing tree of knowledge. The carving had taken many years and thousands of dollars to complete my guide informed me, coolly attired in a red *áo dài*, a traditional Vietnamese dress for women. In this Museum, traditional medicine was synonymous with *materia medica* (also suggested for the Peoples Republic of China [PRC], see K. Taylor, 2005; Zhan, 2009b). Some space, however, was allocated in their publication for a short foray into acupuncture, which I very briefly summarise here.

For the Museum of Traditional Medicine, acupuncture pre-dated social memory; its origins were lost in myth. “In our country, acupuncture has a long history. A book called *Linh Nam Chich Quai* notes that in the time of king Hung there was an acupuncturist called An Ky Sinh, who successfully treated the illness of an overlord called Thoi Van Tu by acupuncture” (K. T. Le, 2006:40)³. *Linh Nam Chich Quai* was a 15th century collection of tales circulating at the time of the Hung kings, explained my Vietnamese language teacher. The name meant ‘Strange Stories in the Land of the

¹ I use HCMC and Saigon interchangeably.

² I use *materia medica* rather than ‘herbs’ to better imply the heterogeneity of plant, insect and animal matter harvested to be either fried, boiled, dried, shaved, shredded, burnt and thence applied externally or injected as a medication.

³ The Hung kings are claimed by the current government of Vietnam to be pre-third century BC and the originators of the Vietnamese nation.

South?. In the old days, she explained, the border between China and Vietnam had five high mountains hence Vietnam was called by China, the Hills to the South.

For the Museum, acupuncture had barely changed since its ancient origin. “In the old days, at first stone, ground down to a sharp slim point, was used as acupuncture needles to treat illness. Gradually, according to the development of society, needles of all types like bronze, gold and silver were created” (K. T. Le, 2006:40). Acupuncture’s footprints in history were traced through kings, who marked time and marked change. “In the time of king Thuc An [c.257-207 BC] medical history notes the name and age of a skilled teacher. Thoi Vi used acupuncture to successfully treat the illness of Ung Huyen and Nham Hieu. After Thuc An, came ten centuries of continuing interaction between Chinese medicine and traditional medicine of Viet Nam, especially about material medica and also acupuncture” (*ibid.*). More testimonies to acupuncture’s efficacy followed, detailed for the epochs of Ly, Tran, Ho and Le overlords to Nguyen dynasties who co-operated with French colonial authorities and surrendered to Ho Chi Minh. “So,” the Museum summed up, “Vietnam is a nation having a long history of acupuncture, having organised acupuncture, having acupuncture teachers and having composed talented books about acupuncture as some of the earliest kinds of such works in Asia and the world” (*ibid.*:41).

Acupuncture in the Museum’s discourse is presented as a practice of needling, pursued by famous practitioners, a prestigious therapy consumed by elites and an efficacious treatment whose history was significantly a literary one. Acupuncture at the Museum is authentically Vietnamese rather than sourced from China, unlike many textbooks that have been involved in the “worlding” (Zhan, 2009b:7) of acupuncture in English-speaking regions (for example, Deadman & Al Khafaji, 1998; Kaptchuk, 2000; Maciocia, 1989) and unlike many Vietnamese interlocutors during fieldwork who described acupuncture in speech as *đông y* (eastern medicine or medicine that had its origins in China). Museum discourse translates acupuncture as an enduring Vietnamese entity: change is miniscule, the multiplicity of medical

objects⁴ is excluded, diversity in needling techniques is absent, numerous debates between medical theories are not apparent and variation within clinical practices is invisible. Acupuncture is presented as “a subject which... is transcendental in relation to a field of events [and] runs in its empty sameness throughout the course of history” (Foucault, 1980:117). While I followed needling practices during fieldwork and could find themes of literacy, elitism and fame, I could not find the static acupuncture form so confidently displayed and discussed at the Museum of Traditional Medicine. Acupuncture was never unproblematic for me – I spent a long time being confused about what it was. This problem defines my thesis. Rather than trying to render acupuncture as an ‘it’, I have sought to understand *how* practices came to create, what was called during fieldwork, acupuncture.

This ethnography investigates medical knowledge and how such knowledge comes to be produced. I intend to describe acupuncture practices in HCMC as a proxy for knowledge, using a network theory approach. Knowledge constitutes the reality we live in therefore to investigate knowledge is to question the nature of our reality. At the Museum, acupuncture is very factual, natural and truthful: there seems to be no doubt about acupuncture’s material history and therapeutic effect. Yet in other places, some fundamental objects seemingly required for an acupuncture intervention to exist, such as acupoints and qi, have been questioned. While this can make acupuncture a bemusing subject by which to investigate knowledge, it also ensures that banal practices of knowledge production are rendered legible to an ethnographer. Included in such disjuncture is how circulating stereotypes and fieldwork experiences contradicted each other, especially the inevitable branding that acupuncture *is* Chinese. This label undoubtedly has its own history of production but stereotypes are useful since they create a possibility for disjuncture and make the taken-for-granted, exotic and new. To elaborate on this acupuncture ‘exotica’, I draw significantly on the writings of science and technology researchers who have developed network theory to investigate multiplicity, diversity and movement. I will detail these influences in the next section. Thereafter I will show how acupuncture in

⁴ See Judith Farquhar “bodily *objects* and substances... (e.g., visceral systems, Blood and Qi, circulation tracts), as well as... more abstract *objects* (i.e., the entities that result from extensive analysis such as syndromes and prescriptions)” (1991:370, emphasis added).

Vietnam is usually described as an integrated medico-philosophical knowledge system, which is insufficient for understanding contemporary acupuncture practices. Continuing, I will discuss how my fifteen months of fieldwork in Saigon, with visits to many satellite towns and cities, brought me into contact with a majority of acupuncturists who held a particular credential issued by the Traditional Medicine Institute in central Saigon. Their networked activities can be understood as producing a dynamic that I attempt to portray herein, as a more faithful rendition of what acupuncture might be. Before finishing, I will contextualise technicians in the contemporary dynamics of healthcare in the south of Vietnam. Ultimately, I argue that knowledge is a network of collaborations between humans and things (Latour, 2005), which get together and act.

Thinking Network Not System

As Mei Zhan elegantly described for Traditional Chinese Medicine (TCM), acupuncture is being worlded, meaning undergoing “translocal movements, displacements and reconfigurations” (Zhan, 2009a:168). From China to America, Mexico to Australia and Vietnam to Britain, acupuncture is a treatment of choice for millions of people. Acupuncture can now be paid for through personal health insurance policies in the USA and Australia; doctors practice acupuncture for their patients in the UK; Vietnam exports acupuncture pedagogy and has set up treatment centres in Mexico (see Voice of Vietnam, 2009b). Acupuncture is widely available through public health provision in Vietnam, China and selectively (by medical condition) in Japan. Through private healthcare, it is available in many more countries. Acupuncture is often used as a synergistic treatment for chronic pain and musculoskeletal problems as well as a treatment for addictions to tobacco, heroin and alcohol. Acupuncture has performed strongly in random control trials leading medical research to focus questions on *how* acupuncture works rather than dispute whether acupuncture does, indeed, cause a beneficial therapeutic effect. Acupuncture was a treatment used by the American Red Cross as part of its disaster relief response to the September 11th bombing of the World Trade Centre in New York and

Hurricane Katrina in New Orleans⁵. Finally, the NGO Acupuncturists Without Borders uses acupuncture for post-traumatic stress relief in projects across the USA.

In being worlded, a persistent stereotype is durably reproduced: acupuncture is commonly written as a traditional medical *system* that is radically *different* from its opposite, called biomedicine. Such dualism plays out a story that traditional knowledge is separate and opposed to scientific knowledge. Such approaches can be characterised as treating acupuncture as a CAM (Complementary and/or Alternative Medicine). Medical anthropology is implicated in the creation of this stereotype even though medical anthropologists have worked hard to advocate the rationality of ‘other’ medicines around the world. Ayo Whalberg (2006) argues that decades of work by medical anthropologists, arguing for the rationality of ‘non-western’ medical systems, is one reason why non-indigenous herbal medications are gaining greater legitimacy for medical service provision in the UK. However, conceptualising medicine as a system is problematic because it suggests that medical knowledge is an integrated and coherent set of autonomous traits. These traits are then as identity markers to delineate authenticity and medical purity. Writing medical knowledge in this way means erasing contradictions, multiplicity and change and further, creates a sense of enduring entity, a thing or an ‘it’, which exists external to the actions of others. I must reject this conceptualisation of knowledge because it is not faithful to my fieldwork experience of acupuncture in southern Vietnam. I give four short examples to demonstrate.

Arriving in southern Vietnam with an assumption that traditional medicine was separate and different meant that I was perplexed when relationships between acupuncture and biomedicine seemed to be more about inclusion. When the director of the Traditional Medicine Institute in HCMC noted in passing during an interview that “the mushroom family is useful because it has antioxidants to help cancer and elderly patients” and that research at the Institute was experimenting with the use of acupuncture as an early intervention for stroke victims, she repeated combination as a key metaphor. Dressed in a white coat and trousers, she emphasised that using acupuncture and materia medica together with western medicine was the best way to

⁵ American acupuncturists met in HCMC during fieldwork described these activities to me.

care for a patient. Furthermore, when an acupuncturist complaining of a headache to a colleague-friend was treated with acupressure, massage and two paracetamol, I appreciated the value of fieldwork because I would never have imagined such an event could occur. If medical knowledge is considered to be compartmentalised into different and separate systems, often written as types of medicine, such encounters suggest that one system has overcome or been colonised by another. If medical knowledge is taken to be of different types, we can talk about pluralism (Harrell, 1991; Obermeyer, 2000; Worsley, 1982; Young, 1982; Zhang, 2007). But pluralism continues to assume an internally coherent and independent body of knowledge. There seems to be no room in pluralism to rework different elements into a new and different medical synthesis such as the New People's Medicine on offer at the Traditional Medicine Institute after 1975.

Writing about acupuncture as a naturalised body of coherent medical knowledge would mean that the unsettling presence of blind acupuncturists and American-trained acupuncturists in Saigon, teaching Japanese and American techniques, be erased. I got to know three blind acupuncturists early in fieldwork and since I had little previous experience of acupuncture, I did not 'know' that 'blind acupuncturist' was an oxymoron. The very presence of blind acupuncturists was unsettling for sighted practitioners who often used statements like "but they are blind so how can they... [for example, read printed books in order to learn the standardised acupuncture taught at the Traditional Medicine Institute; needle bodies; know where the points are]." These acts of rejection are also acts of creation, since they produce and reproduce what acupuncture might be. For research purposes, these blind practitioners created "distance" (Latour, 2005:78). They made activities weird and unusual. The presence of blind acupuncturists "disturbed the self evident present" (Bunton & Petersen, 1997:4). The blind indicated "the inherent instability" (*ibid.*) of present configurations of acupuncture. Because I knew blind acupuncturists, I often queried methods of teaching acupuncture. Acupuncture objects (such as acupoints, channels or qi) that appear in other texts as something so orthodox they elide investigation (Birch & Felt, 1999; Kim, 2005, 2006; Lock, 1980; Scheid, 2002; Zhan, 2009b), are questioned in this thesis. Additionally, the annual presence of American-trained and USA resident acupuncturists also participated in acupuncture networks in HCMC: they taught city resident practitioners and lay persons new acupuncture

techniques which were not always taken up. If thinking that acupuncture was an autonomous entity, what should I do with these apparent incongruities when writing an ethnography about a supposedly autonomous and nationalised medical ‘system’?

A persistent stereotype about acupuncture, then, relies on a complementary and/or alternative therapy (CAM) translation. CAM translations of acupuncture persist in medical anthropology/sociology publishing (Pierre, 1989; Shih, Lew-Ting, Chang, & Kuo, 2008; Zhang, 2007). CAM publications describe acupuncture as something complementary *with*/adjunctive *to*. Wahlberg notes that such literature can be divided into three approaches. First, those publications that argue medicine can be separated into radically different meaning systems; second, those which review whether different therapies are available to the public through government and privately operated healthcare services, mainly in industrialised countries and, finally, those publications concerned with the legitimacy and efficacy of a medicine (Wahlberg, 2006a:126-127). These literatures postulate a contrasting relationship between two objects, producing medicine as identity politics mediated by difference. Linda Barnes (2003) describes how acupuncturists in the USA state of Massachusetts campaigned actively to perpetuate such difference. Such framings of CAM are relational, defining difference negatively by what CAM is not, that is, CAM is not ‘biomedicine’.

But do writers know what biomedicine ‘is’? The “idealised biomedicine of tenacious assumptions, formal knowledge, invisible patients and disease as biology is often difficult to reconcile with... physicians in practice” (Good & DeVecchio-Good, 1993:82-83), who act in an “array of institutions, acts and rules”, which often goes unappreciated by observers (Hahn, 1982:216). Previously, medical anthropology neglected to study biomedicine as an ethno-medicine, assuming that since biomedicine was held to be scientific it was therefore beyond culture (Hahn & Atwood, 1982). Assuming that biomedicine is science (and therefore excludes ‘religion’) suggests that medical practices deemed to be biomedical are a-spiritual (c.f. Gaines, 1982). Using biomedicine as a standard to measure other medical rationalities ignores the complex, uncertain and error-ridden nature of medical work (Cassell, 1987; Paget, 1982). Biomedicine is often used as a universal category but it is unlikely that medicine practiced in, say, Tibet under a ‘biomedicine’ rubric would be recognisable as biomedicine anywhere else (V. Adams, 2002:142 n.14). Dutch

researchers on geriatric care argue that “specialists have subsets of diagnostic procedures in common, guided by shared medical [education] but they differ systematically in crucial aspects of their diagnostic approaches... [medical knowledge] will always retain an essentially diverse nature” (Kalf & Spruijt-Metz, 1996:711). Notwithstanding such diversity, other authors suggest that “Chinese medicine” is still “the other of a dominant, even if heterogeneous, bio-medical knowledge and practice” (Napolitano & Flores, 2003:80). However, concerns to demonstrate such an Other-ness obscure the practices by which incommensurability is actually created. This is clear in Sean Lei’s (1999) historical work on how *materia medica* previously enacted as “traditional” came to be disassociated and re-networked into a “socio-technical” network called “science”. He accounts for boundary maintenance, exclusion of competitors and medical dominance without recourse to setting up independent objects that act *on*, contra Foucault, the imagined autonomous bodies of each other.

Rather than ignore incongruities and assume that biomedicine is all-conquering, this thesis argues that medical knowledge is a network and explores the production of knowledge/truth through networks of people and things, their practices and discourses. Networks herein are ecologically constituted, in which co-operation can occur without consensus on meaning (Star & Griesemer, 1989), where different sets of translations (Latour, 2005) abound and in which commitments are required for stability to take place. Such commitments necessitate making effort (Mol, 2002). Medical knowledge is not merely that which is contained in a book, taught in a class or practiced in the clinic. Knowledge is more than a tick-list of attributes which assist recognition and identification of a medical type of system. Medical knowledge is above all practices that are interactively creative of the world in which we live. We are born into a reality and are subject to it; we interact with and yet are implicated in its creation. Network theory focuses on how practices, translations and movements at different sites generate and extend networks which may otherwise be called knowledge. Knowledge is not a thing, knowledge is what we do. Before clarifying what I mean by network, I will explain my use of the word ‘knowledge’.

Most recent publications in medical anthropology and sociology have changed tack on what knowledge might be. Knowledge, argues Zhan, is a “kind of being-in-the-

world” (2009b:24), following Martin Heidegger (1996). Annemarie Mol comes to a similar conclusion from quite different ethnographic sources, arguing that “knowledge is primarily about partaking in a reality” (Mol, 2002:154). Knowledge for Volker Scheid is an “interactive stabilisation”, meaning that knowledge is not only “elements” that come into a “synthesis” but is also the practices of making such a synthesis stable; what these practices are, also changes (2002:45). For these writers, knowledge is not an ephemeral thing that jumps into and out of vessels – such as books, human brains and computers – being therefore separable from those vessels (for example, Craig, 2002; Fuller, 2001; Whyte, Geest, & Hardon, 2002). Such a concept of knowledge has more in common with “knowledge economy” (Machlup, 1962) literature, in which knowledge is a commodity. Knowledge becomes an ‘it’ (Cetina & Preda, 2001) that can take on a monetary value, be traded and put to a use. Knowledge is a thing that is functional and utilitarian (Leadbeater, 1998; Lin, 2007; Powell & Snellman, 2004). That is to say, knowledge takes on a positive value in economic neo-liberalism.

While I will take the position in this thesis that knowledge understood as a fetishised commodity is unhelpful in tracing how realities are constructed, I retain a sense that the word knowledge is one that denotes a positive value. In anthropological as well as economic development literature, knowledge is always positive: truthful, authoritative and real. Foucault (1976, 1980; 1982) uses power/knowledge as a constitutive matrix of the world, shaping our understanding of being *in* the world. Power/knowledge therefore creates reality. Annelise Riles (2004) uses knowledge to talk about that which has form or substance in the world. The word is associated with ‘value’ (Gudeman, 2001; Hansen, 1982; Hobbs, 1988), a foundation for control/domination (power) and out-of-the-ordinary success in hunting-gathering groups (Rushforth, 1992); the word carries ‘weight’ (authority) to create subjects (Anderson, 1996; Ketler, 2000), constitutes a medical habitus (Friedson, 1988; Good & DelVecchio-Good, 1993) and is explanatory (Csordas, 1992). Knowledge is authoritative even if hidden or denied – that is, truth being denied does not cease to be truth in the opinion of the writer (Barnhardt & Angayuqaq, 2005; Wayland, 2003). While ‘knowledge’ can also negate the ability of others to creatively act, this is not what authors emphasise. The word ‘knowledge’ is, then, used asymmetrically (Bloor, 1999; Callon, 1986) in an academic text. Writers flag a positive valuation of data by using

the word knowledge. Actions which in the view of writers might be false, misconstrued or simply lies, are not accorded the word knowledge. I follow this usage, and take the word knowledge to mean that which is truthful and/or real. Therefore the words knowledge, truth and reality are collapsed in meaning and will be used interchangeably in this thesis. Collaborative and conflicting practices, translations and relays, which may be called networks, are how reality is constituted.

The concept of network, as used in this thesis, has been influenced by sociological studies of science and technology writings. Bruno Latour (1999, 2005) posits “*actant resean*”, or actor network theory (ANT), as a sequence of transformations between people and things that collectively constitute lived realities. For Latour, both biological and non-biological actants are shapeful of an outcome that cannot be predetermined. Latour’s later work can be understood through his seminal ethnography of a biochemistry laboratory in the USA, in which he styles himself as an anthropologist visiting an exotic tribe. In laboratory work, inscription, interactions between texts and various experimental devices, scientists’ careers and investments in credibility all collectively produce a reality that comes to be called “fact” (Latour & Woolgar, 1979). His early ethnography of a biochemical laboratory can be read as participation in the ‘strong programme’ associated with David Bloor who asks, “can the sociology of knowledge investigate and explain the very content and nature of scientific knowledge?” (1991:3). The answer is yes and Bloor sets out a method to do so. Hence Latour & Woolgar, in a chapter called *The Construction of a Fact*, detail “how a fact takes on a quality which appears to place it beyond the scope of some kinds of sociological and historical explanation... what processes [they ask] operate to remove the social and historical circumstances on which the construction of a fact depends?” (1979:105). Facts are constructed and come to stability; statements come to demonstrate robustness that the authors call “facticity” (*ibid.*). The constructions of facts emerge from collective endeavour between humans and created technologies, often created for specific experimental objectives.

Network theory as used by science and technology ethnographers must be distinguished from Mark Granovetter’s (1982) argument, and subsequent influence in the literature, on social networks. Consider a model of a hydrocarbon molecule that sits in a high-school laboratory for pupils to play with. Drawing on this analogy,

Granovetter writes about nodes, density of connections and relative strength or weakness of those ties. He argues that middle-class job seekers found employment through weak ties. Weak ties were, employment-wise, more important than close family or close friendships. Granovetter is only interested in how humans connect to each other and how people were able to construct a “social” network. The social, for Granovetter, only concerns humans. In comparison, Latour is adamant that “the social” is hybridised, locating his own work on a pivot between society and nature. For Latour, “the social” is a net of relationships between technologies, practices and active agents. While these two concepts of ‘network’ are very different, they can be usefully brought together and I draw on both. In HCMC, interlocutors framed networking and connections (*người quen*) in a way that can be likened to Granovetter’s model. Fame, or occupational success, was envisaged by practitioners as repetition of their name through distributed person networks. While interlocutors envisaged networks in the sense of Granovetter, I will argue that networks were also active in the sense of Latour in that person networks took on work on behalf of a practitioner and mediated, altered and transported his reputation as an efficacious healer around the city. Person networks helped constitute the realities of medicine in HCMC but persons were not the only active agents involved.

Thinking through knowledge production as a network in the sense of Latour, means focusing on the ethnographic detail of how both humans and non-humans are interactively creative. I therefore attempt to treat humans and non-humans symmetrically (Bloor, 1991; Callon, 1986; Mol, 2002). I treat acupuncturists, textbooks and picture media in the same way, that is, I will explain what they are able to do in the same terms. An acupuncturist, for example, when meeting patients in a treatment room is not said to be ‘representing’ acupuncture but to be doing it. Pain does not have to be only that which can be experienced by a patient but can have a somatic reality of its own. Pain, textbooks, posters and acupuncturists were all “actants” (Latour, 2005), or those things which were able to shape action. When actants collaborated with each other, they produced reality. Collaboration is therefore emphasised. The formation of factual acupuncture objects called acupoints did not rely on only one book or only one practitioner rather the factual existence of acupuncture points was generated when vision collaborated with many textbooks and repeated clinical practices of needling. In this thesis, practitioners with posters and

textbooks are able to figure, perform and construct acupuncture. A network approach emphasises that effort is required to produce reality. By doing so, these writings have some commonalities with social constructionism works and also with performance and embodiment literatures, which I detail below.

Like social constructionism, network literatures assume that the world is manufactured, or constructed, in some way. Medical knowledge does not appear fully made. Work was engaged to create it. That something is constructed, whether it is a biological virus or a development project, does not in any way make it less real and capable of effecting consequences (Haraway, 1991). Social constructionism has been a powerful tool to deconstruct apparently naturalised socio-political orders. Identities, objects and persons are taken to have histories: they come into being through a process that can be described. An exemplar of a social constructionist approach is Stephen McNally's potent thesis on Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome in Vietnam (McNally, 2002). For McNally, HIV/AIDS is an object created by an economic development industry through its paradigms, policies, institutions and people. The globalised discourses operating in the AIDS development industry assumes that AIDS can be understood homogenously and universally. The AIDS industry manufactures identities, such as sex-workers, men-who-have-sex-with-men and intravenous-drug-users, that become internationalised. These are assumed to be the same all over the world. McNally's thesis makes use of Foucault's work on governmentality and disciplinary power to understand a development industry at work in northern Vietnam. However, a key division exists in his work. In assuming a biological reality of a virus, he practices a social-natural divide. Biology – the HIV itself – is natural in his thesis. The natural is not constructed for McNally because the word constructed implies an action that can only pertain to humans. Asserting that something is constructed may suggest that it is false but constructed can also be understood in the sense of requiring work to maintain a reality. The necessity of such work does not make constructions any less real. Network theory extends, therefore, what may be investigated under a rubric of constructivism.

In common with the literature on performance and embodiment, network theory emphasises the productive and ongoing nature of actions. Performance is how

Erving Goffman characterises the social (1959, 1974). Goffman is concerned with authenticity, being interested to know whether individuals are being genuine or not. He uses as scaffolding, as he puts it, dramaturgical metaphor placing the structural-functionalist word 'role' into theatre. "A status, a position, a social place is a pattern of appropriate conduct, coherent, embellished, and well articulated... something that must be enacted and portrayed; something that must be realised" (1959:75). Dramaturgy has value in focusing on how performances come together to produce identities, for example, of gender (Butler, 1990) or ethnicity (Sax, 2004). Identities are then understood as outcomes. In their ethnography of laboratory life, Latour & Woolgar (1979) similarly argue that facts are outcomes of work, they cannot pre-exist action. Performance literatures emphasise that identities are not given but must be continually practiced. Identity (Arendt, 1958), likewise, culture (Tsing, 2005) or the social (Latour, 2005) cannot be autonomously generated. Patchen Markell (2003) argues that since identity is an ongoing work of interactive creation, politics that pursue sovereignty make crucial mistakes about the nature of socio-political realities. Markell's work has proved useful when trying to understand why blind acupuncturists were so problematic to their sighted counterparts in HCMC. The literature on embodiment also shows how continual disciplining constructs gender. Helle Rydstrom's (2003) powerful work on disciplining children into girls and boys in northern Vietnam argues that gender is a habitus acquired through active disciplining of younger children, particularly babies who lacked a penis (girls), by older women. Rydstrom's work rudely disposes any romantic notions of a universal sisterhood opposing male domination since she describes clearly that women constantly discipline the feminine in patriarchy.

However, conceptualising activity as performance or embodiment creates two problems. First, because dramaturgy focuses on performances that persons undertake in the presence of others, it is not clear how persons are able to recognise an authentic performance, when compared to a false performance. There is an implication that this recognition is worked at somewhere else. Rydstrom, for example, posits a pre-existing political mythology – since "body hexis is a political mythology realised, embodied" (Bourdieu, 1977:163) – to be made into bodies. She posits that books, literature and laws become flesh, using Jacques Derrida's work on presence/absence of a penis together with significantly older literatures by Confucius

(see Rystrom, 2003:41-42, 48, 49-50). She makes a very clear case for women disciplining women but her positing of a political mythology that can be read by means of words in paper documents is not convincing. It is not convincing because if the body habitus itself *is* the political mythology, she does not explain why she must use textual sources to manufacture the mythology. Rystrom also cannot account for how these textual sources become translated across space and time into the particular homes she studied in northern Vietnam. What are the vehicles that move “Confucian doctrine” (2003:41) from a pre-colonial period to a post-colonial/post-war present day? These descriptions are absent.

Additionally, in performance and embodiment literatures only adult humans participate in what is social. Adult humans do things like give off impressions, speak, use body language, laugh and recognise humour, reciprocate and have intentions. These are the data that counted for Goffman. Paper qualifications for Goffman would be mere props, ignoring their legal consequences. By bracketing in humans to social analysis and bracketing out other things, performance literature ignores that material things, in different situations, are important for how an identity is able to be realised (Mol, 2002:38-44). Genitalia, for example, are important to doing gender during sexual intercourse and are potently important for passing as ‘male’ or ‘female’ as is made apparent in ethnographic research on transgender⁶. Oxygen is important to existence, more noticeable at high altitude when the body has difficulty carrying out previously unconscious activities like oxidising ingested food. Genitalia and oxygen are not props to doing an identity but material requisites for an identity’s constitution. For this reason, Mol abandons the word performance in favour of enactment (Mol, 2002:49). She uses the word enactment in a sense of ‘doing’ to avoid implications of theatrical performance and questions about authenticity. When I use the word enactment in this thesis, I follow her meaning.

For this thesis, network theory usefully maintains a sense of constant productive action that constructs what is taken to be real. However, network theory additionally challenges ethnographers to engage with assumptions, facts and truths rather than bracket out some aspects of medical knowledge as ethnographically un-investigatable.

⁶ Phoenix Freeman, personal communication.

Network theory also extends action to more actants, which are able to “relay” (Gomart & Hennion, 1999) an activity through numerous relationships between people and things. The ethnographic detail of such activity is then able to reveal how reality is collaboratively constituted.

Acupuncture in Vietnam

Acupuncture in Vietnam has been, to date, described as an autonomous, medico-philosophical system separate and contrastingly different from a foreign and scientific biomedicine. Acupuncture figures as a component of traditional Vietnamese medicine in texts concerned with designating authenticity in terms of an homogenous and nationalised Vietnamese identity. Bao Chau Hoang and colleagues, writing in English, identify acupuncture as traditional medicine, in particular ‘northern’ traditional medicine, “which is Chinese or rather Sino-Vietnamese in origin”, in comparison to southern medicine, which is “genuinely Vietnamese” (1999:1). Hoang et al (1999) is an important source for Whalberg’s comparison of traditional medications regulation in the UK and Vietnam because it is one of very few English language texts on traditional medicine in Vietnam. David Marr argues that traditional medicine can be divided into three categories. These are northern - again using north to mean a Sino-medical ‘tradition’ – southern and an additional system “dealing with harmful spirits, preferably by preventing them from entering the body at all, or failing that, by finding a way to exorcise them and hence regain physical and mental equilibrium”. Marr argues that no single term identifies this last approach to disease and healing (Marr, 1987:170). David Craig (2002) follows Marr when he argues that northern medicine is an institutionalised and publicly reified therapy while southern medicine is the poor man’s medicine: informal, oral, a household treatment, durably ensconced in everyday practice of family life and making use of mnemonics for an “everyday poetic, rhythmic, embodied recitation of recipes” (Craig, 2000:706). Lena Lopez (n.d.) presents northern medicine as a literate medical tradition, making use of *nôm*⁷ ideographic script. In the past, she argues, healers had to be of a particular class to read classic works, make diagnosis and prescribe treatment (an argument also used by Bodecker & Dung, 2001).

⁷ *Nôm* refers to a script only (Marr, 1981; Ominglot, n.d.).

Nelly Krowokski (2007) contends that the distinctions of northern and southern medicine in historical texts were not used to distinguish medico-philosophical systems, rather were used merely to differentiate medications between those prepared from Vietnamese medicinal plants and those imported from China. According to Krowokski, the terms northern and southern are distinctions of plant material medica sources, which she attributes to Tue Tinh's book *The Miraculous Southern Pharmacopoeia* published in 1717⁸. Krowokski's work recounts medical jokes about practitioners written from the 18th century onward. Jokes were told about practitioners of 'our medicine' and 'eastern medicine' while distinctions between northern and southern were not found. Krowokski suggests, then, that medicine was being used to reference national identity. Michelle Thompson also suggests that Vietnamese writers used China as an "oppositional reference" only (2004:4). During my own fieldwork, asking about northern and southern medicine threw up the following definition. A social worker was sure that the difference was cost: northern medicine was more expensive. A social science researcher insisted that northern medications were associated with the soil; they required time for growing and preparation whereas southern medications could be harvested from one's garden, for use at any time. An NGO volunteer turned to me and shrugged. "It's difficult to know the difference," he apologised. Meaning is never definitive and always contingent on context (Hsu, 1999). In my experience, the terms northern or southern medicine were debates: they generated controversy and their meaning was rarely uncontested.

For a thesis about acupuncture, a vocabulary of 'northern' and 'southern' medicine creates difficulties. In the authorship cited above, the word *thuốc* is used to talk about medicine in two senses as both medications and Medicine. In Vietnamese, if we were to discuss medicine as a system, I would use the word *y*, as in the words medical system and medical learning (*y tế, y học*). Monnais & Tousignant (2006), for example, collapse both terms in their discussion of colonial pharmacopeia, arguing that *thuốc* in the colonial period meant both ingested material and a general therapeutic⁹. However, during my fieldwork acupuncture was never referred to as *thuốc*. Rather

⁸ She therefore dates Tue Tinh to the 18th century and not earlier as suggested by Thompson (2004) and the Museum of Traditional Medicine, Saigon.

⁹ Laurence Monnais, personal communication.

acupuncture was labelled as any and all of eastern medicine (*đông y*), traditional medicine (*y học cổ truyền*), classical medicine (*y học cổ đại*) and the people's national medicine (*y học dân tộc*)¹⁰. The ex-director of the Traditional Medicine Institute in HCMC used all these terms in the same book (Truong Thin, 1984). Traditional medicine was the phrase used by my 6 Qi acupuncture teacher to describe his medical practice on his business card. Eastern medicine was the word painted on a wooden board that signposted a pathway to a bhikhu's¹¹ treatment room in Dong Nai, a province neighbouring HCMC. The people's (national) medicine was the title lettered on the Traditional Medicine Institute's name board. Northern and southern medicine did not appear to be vocabularies in use.

Distinguishing acupuncture as being a representative of a northern medical system that was different from southern medicine, as well as science, was not useful during fieldwork. I attended classes on a formulaic acupuncture¹². Vietnamese acupuncture texts demonstrate the use of mnemonic devices hence I could argue that recipes were not features only of Craig's (2002) southern medicine. Numerous schools and techniques of acupuncture abound in HCMC and tying all these to a Sino-Vietnamese 'northern' stream would itself require to be justified. The Traditional Medicine Institute recruited experimentation to validate acupuncture's known therapeutic effect suggesting that science was not excluded. Writing acupuncture as northern-or-not assumes that medicine can be a singularity, identifiable by a tick-list of traits serving as boundary markers. Difference is therefore distributed across genres but ultimately elided. All these approaches "reduce the heterogeneity and evolution of East Asian medicines to a 'representational' single unity... to a single homogenous framework" (Kim, 2006:2968). According to the dynamic of acupuncture that I participated in, singularity was itself a work that had to be undertaken; the radical singularising practises at the Museum of Traditional Medicine, for instance, require to be accounted for to understand how diversity was disposed of (Star, 1989) and to what end (Markell, 2003).

¹⁰ These are the translations I use hereon.

¹¹ Buddhist monk or nun.

¹² See also Deadman & Al-Khafaji: "the majority of acupuncturists in China were itinerant formula doctors who memorised acupuncture prescriptions... the great acupuncture classics... were in part compilations of such acupuncture prescriptions... off course, whenever a practitioner selects a number of points to treat any patient they, by definition, use a prescription of points" (Deadman & Al Khafaji, 1998:61)

Writing medical knowledge in Vietnam as a ‘system’ is an artefact of text construction, in and out of academic settings. However, it is inadequate to reject these texts as misconstruing acupuncture or being simply wrong. If I were to assert as much, I would ignore that texts have a life of their own. Texts circulate. Texts are also included in network activities that constitute knowledge. Through texts, acupuncture takes on particular identities. Acupuncture as Sino-Vietnamese has a textual genealogy: Marr’s (1987) text has influenced a number of writers, as has chapters by Hoang et al (1999) in *Vietnamese Traditional Medicine*. Acupuncture as a northern medicine is circulated through many texts achieving a volume of repetition and so taking on a facticity (Latour & Woolgar, 1979). Textual identities of acupuncture also create consequences. For example, in defining and constructing traditional medicine as an *alternative* rationality, acupuncture can be written as something that is profoundly unscientific and therefore dangerous to the public in biopolitics (see argument in Wahlberg, 2006). Producing acupuncture in Vietnam is not only that which takes place in an ethnographic field-site but is also that which is networked through academic discourses. Networks of relationships between, for instance, books, authors, practitioners and journal publishing change how knowledge production may be conceived. In taking this stance, a field-site and a university are no longer autonomous production locales. A network approach to ethnography captures this sense that researchers are also involved in the work of generating the realities that we not only participate in but also research about.

Network literatures transform what may be investigated ethnographically as well as how medical knowledge might be understood. For acupuncture this means that qi, body Organs and acupuncture points¹³ themselves can be subjected to participant-observation. The construction of these facts can be explored and ‘technologies’ that mediate clinical encounters can be traced in detail. Medicine can be investigated not as fixity but as change; not as stability but as constant efforts to keeping commitments in place (Star, 1989; Star & Griesemer, 1989), so that durability and fixity must be explained. Mol (2002) argues that a medical object called atherosclerosis was multiple in one Dutch hospital: atherosclerosis was done

¹³ I will use acupuncture points, acupoints and points interchangeably.

differently in different spaces, giving rise to potential conflict and confusion. Singularity emerged only at certain times, through the practices of coordination, cooperation and consensus-making. The standardising work engaged at the Traditional Medicine Institute was a network of textbooks, classrooms and teaching practices which sought to make a common acupuncture for post 1975 southern Vietnam. But the “New Medicine” taught at the Institute was unable to dominate acupuncture practices in the city suggesting that the creation of singularity is a complex, and often unfulfilled, ambition.

Contingencies of Fieldwork

Integral to contemporary ethnographies, and particularly ethnographies employing a network approach, is reflection on how relationships between the research topic, the conduct of fieldwork and the construction of texts mutually create an artefact that goes on to additionally participate in the creation of reality. To this end, I will reflect on three activities that shaped my fieldwork and the resulting text. I focus on my decision to work on my Vietnamese language competency, a switch of research topic while in HCMC and finally, that I relied on personal networking to connect with interlocutors. These activities mould what I am now able to write.

Networking was the how-to of personal relationships in “the field” (Bacchiddu, 2004; Passaro, 1997; Perry, 1989). My main contact was Danh¹⁴ who was a networker extraordinaire. He was an overseas Vietnamese, resident in the USA for the previous six years, and very active on his annual return at Lunar New Year. At this time, he distributed acupuncture textbooks, training and networking opportunities for all those caught up in the vortex of his energies. The middle child of five in a middle-class family, he trained as a doctor¹⁵. After his graduation in the year 2000, he hoped to work in heart surgery but did not have “strong *enough*” connections, he described, in government hospitals to do so. Around that time he met a bhikhu friend of his father, who asked him why he wished to study something “so far from traditional Vietnamese culture”. That bhikhu¹⁶ introduced him to the Traditional Medicine

¹⁴ All names are pseudonyms unless stated otherwise.

¹⁵ When I use the word doctor in this thesis I mean someone who has studied for the six year medical degree and was called in Vietnamese, *bác sĩ*.

¹⁶ Buddhist monk or nun.

Institute in central Saigon where he was impressed with a feeling of peace at the place. After another year of trying to “find the path to follow,” as he put it, he retrained in acupuncture for one year at the Institute. He later studied for an acupuncture degree at Tri State College, New York. There he was introduced to diverse acupuncture schools, though he personally favoured Japanese teachings. In New York, he also learnt American Acupuncture, he explained, citing College director Mark Seem’s (1992) characterisation of acupuncture in the USA. Danh was one of my few contacts in Saigon when I arrived for fieldwork. He introduced me to most people in this thesis, directly or indirectly. Because of his activities, I fell in with acupuncturists even though I had initially intended to study patterns of resort by HIV+ sufferers¹⁷.

Networking, in Granovetter’s (1982) sense of the word, was a persistent figuration during my fieldwork in HCMC. While my method could be called snowballing – one person introduced me to that one, who introduced me to another and so on – in Saigon this was described as networking. City residents sought out connections, built relationships and made contacts so that they could get to know each other and to connect to the right job / wife / husband / teacher / friend / business partner / employer and so on; the appropriate contact that could help make the required connection. Thanks to Danh, I met other overseas Vietnamese visiting HCMC to learn acupuncture. Because of him, I was introduced to locally resident acupuncturists. I was hooked up with friends and contacts who visited Danh during his short time in the country. I wandered the city in his entourage watching acupuncture treatment in the back of restaurants, family homes and pagoda compounds. I was left doing moxibustion with unknown patients. I was invited to the cities of Hue, Hanoi and Siem Reap where we pursued acupuncture teaching for the blind. Because of his introductions, I was later able to attend 6 Qi¹⁸ acupuncture classes and finally meet the famous Dr Truong Thin. After Danh’s departure from HCMC, I continued to work with connections made through him. Through those contacts, I was invited to volunteer at an outer city medical charitable project and

¹⁷ Traditional medications are actively taken up by HIV+ sufferers in HCMC and their use promoted by doctors. Acupuncture itself is discouraged because of blood contamination issues and because to date, the HIV+ epidemic has been associated with intravenous heroin use in Vietnam (Government of Vietnam, 2006; McNally, 2002; UNAIDS, 2005)

¹⁸ This is the name of the acupuncture that I learnt during fieldwork.

liaised with acupuncturists who introduced me to charity projects in Dong Nai. I also learnt the NADA (National Acupuncture Detoxification Association) protocol, which was developed to deal with post-traumatic stress and opiate withdrawal symptoms in America.

I was networked through my key contact who pulled together a group of American acupuncturists to teach NADA to Vietnamese technicians¹⁹, doctor-acupuncturists and blind lay²⁰ persons. Danh was a keen follower of Japanese acupuncture techniques. Over 30% of acupuncturists in Japan are blind, he often quoted to us. Therefore during Lunar New Year 2007, I met and worked with two American practitioners during their time in HCMC and during Lunar New Year 2008, met five American acupuncture degree holders and followed their activities. I networked with different people, places and activities through Danh as my significant bond, who was not necessarily the most intimate. I connected with people of the Vietnamese Kinh ethnic group, the majority ethnic category in Vietnam, whose ethnic classification appeared on their identity card. I followed connectivity as in the writings of George Marcus (1995), whose advice was to construct useful new objects while participating in and following people, metaphor or things in motion. Such work made exclusion (where you did *not* go), temporality and movement apparent (Appadurai, 1996; Hannerz, 2003). If I had positioned myself at only one location or in only one institutional site (see Clifford, 1997) such movement, multiplicity and change may have been de-emphasised.

In retrospect, I connected with persons in their occupational rather than personal lives. Some of these decisions were made for me. My 6 Qi teacher, Master Nguyen Phuong²¹ whom I discuss in chapter three, refused to be interviewed by me and rarely invited students into his inner home. I participated in public settings: home-based business spaces, exclusive clinical spaces, staff-rooms of the Traditional Medicine Institute and places in between homes with mobile practitioners. I spent

¹⁹ Being someone who had trained through the technician programme at the Traditional Medicine Institute. Technician programmes were available in many subjects. In this thesis, I specifically mean acupuncture.

²⁰ Lay is taken here simply and strictly as not making a living from acupuncture. No other meanings are implied.

²¹ Master's professional name.

less time in the private spaces of practitioner homes. Possibly this was because I had difficulties establishing intimacy with interlocutors due to language constraints. It may also have been because my stated aim was an interest in acupuncture, rather than *acupuncturists*. However and also, *đi chơi ở nhà* – having fun at home – was considered a northern trait. Northerners, in the words of a Hanotian who had migrated south, liked to invite friends to eat at home with their family but in the south “they” invited friends to eat out in a restaurant or at café. Staying at home was not “comfortable,” argued a Saigonese resident, when I posed the previous statement to him. “What if your friend’s siblings don’t like you. Or their parents don’t like you or you don’t like them... there isn’t space in the house to feel comfortable so it’s better to go out.”

Practices of ethnographic investigation were additionally influenced by research topic switch. Switching topic in the field, after one year of preparation on a different subject, is rather common in anthropology. Initially, I had proposed to follow HIV+ patterns of resort but because I was drawn into Danh’s networking activities, this changed. My supervisor wrote to me that I could pose questions to English-speaking overseas Vietnamese but I had no questions to ask. It was all too new. I had limited contact with acupuncture before fieldwork: I had treatment in Hong Kong before coming to Australia and knew it as a therapeutic for racing horses in England. Much of what I was initially engaged in, I accepted. The “field” was where I set myself to ‘going with the flow’, as advised by a fellow anthropology student also researching in the city. Early experiences became a prototype against which later experiences were compared. However, I could not compare practices with acupuncture anywhere else since I had rarely seen clinical treatment nor, initially, had consulted literature about acupuncture.

I focused on practices because these were the most exotic: the use of long eight inch needles, linking in-sitting needles to electricity or that acupuncture treatment was a public event. These remarkable activities were what I paid attention to. Because I had not read about acupuncture beforehand, I did not ‘know’ about particular configurations: for example, I did not ‘know’ about the so-called Four Examinations that Ted Katpchuck (2000) used to characterise diagnostic practices in China. I did not, therefore, ask about this. I took notes on opinions and actions that seemed

exotic to me and were confusing to the American acupuncturists I came to know. I made notes of scenes, actions and talk²² with my own commentaries of what particular persons did, which allowed to keep track of a mobile group of people who became my key interlocutors. In contrast, when I visited HCMC briefly in February 2009, I was easily able to focus on certain behaviours like consistent personal pronoun use, the use of the word for teacher or the tactility of needling techniques because I was looking out for these practices. Ethnographic note-taking in February 2009 felt much more productive and “hanging out”²³ much more comfortable because I was more confident in doing fieldwork.

Finally, this text took shape through an early decision to improve my Vietnamese language skills. To do so I made sparing use of translators. This meant that, especially early in fieldwork, there were times when I could not understand or communicate verbally as I would have wished. While focusing on practices was a pragmatic solution to fluctuating language ability, I found that without the fetter of talk, I paid closer attention to scenes, activities, colours, sounds and so on. When my language skills improved, when talking with English-speaking interlocutors or when translation was available, I focused on speech therefore talk, at times, distracted my attention away from practices. Learning Vietnamese was almost universally greeted as a positive activity by interlocutors and became part of my field identity: not only someone interested in acupuncture but one who was willing to learn this “difficult” (according to my interlocutors) language. By learning Vietnamese my positionality changed often: from one whose understanding was so-so, to one who was ‘clever and fluent’ (depending on the topic), to one who became a translator for visiting Americans. Axel Borchgrevink (2003) decries the silence in anthropological texts over field-site language competency. He especially takes issue with an unspoken, he asserts, opinion that using translators means that an ethnographer is a second-rate researcher. However, it is may be more likely that ethnographers make use of translators and are committed to learning the field-language so that fieldwork does not need to be construed in such a dualistic manner.

²² Talk is taken to be all forms of words generated through interaction and media – speech, print, tactile, audio (also Holmes & Redmond, 2006:6).

²³ According to Renato Rosaldo, anthropological ethnography is “deep hanging out”, quoted in Clifford (1997:189).

I would agree with Borchgrevink that “understanding a language is a relative concept” (2003:96). For Borchgrevink, the sheer relativity of language means that there can be no unambiguous answer to whether a researcher ‘knows’ a language or not. To know Vietnamese language is a geographic relativity in such a socio-linguistically diverse country. Additionally, Vietnamese is not homogenous in a geography but varies according to one’s actions. By the end of fieldwork, I was comfortable discussing acupuncture but would find discussion about agricultural practices in the western Mekong region challenging. Additionally, I attended acupuncture classes that made extensive use of an older Sino-Vietnamese, which was in spoken use before nationalisation. After 1955 in the north, and 1975 in the south, language was nationalised as a project of mass literacy and modernity (Marr, 1981). Anyone under 30 years of age in contemporary Vietnam would find, and did find in 6 Qi acupuncture classes, extensive use of Sino-Vietnamese difficult. For that class, I relied on recording, transcription and translation of printed texts in conjunction with my Vietnamese teacher who held a PhD in Ancient Vietnamese Literature and therefore recognised many references to earlier time periods.

Reflexively acknowledging the contingencies of field work as part of text production is recognisable in many contemporary ethnographic texts. But, as Donna Haraway argues, “context is fundamental matter not as surrounding information but as co text” (1991:214) focusing attention on the construction of text, rather than making text a problem of representation. Academic writers do not ‘stand outside’, as it were, but collaborate (Sillitoe, 1998) or grapple with infrastructures, people, things and politics. An account such as this thesis cannot *represent* acupuncture practices. It does not re-present an eternal subject. Neither can this text stand in for the understandings of the articulate and lively practitioners who populate it. It cannot stand in the stead of the experience of Nguyen Phuong (chapter three) or Hoa (chapter six) who have practiced acupuncture for over 20 years. Additionally, neither does this text seek to translate *a* culture (Asad, 1986; Beattie, 1964; Geertz, 1973; Paige, 2005), since what is translation, after all? Is it not an inability to express concepts clearly, when no correspondence between ideas can be found, when we know the words but still do not know what the other means? At least, it is a process

of ‘error’ making, selective deletion and referencing words through ongoing yet individualising experiences.

This thesis is constituted interactively through an author and her translators of Vietnamese language and of acupuncture and is therefore additional to their experiences and understandings. For instance, at certain times, the American acupuncturists were instrumental in translating observed acupuncture practices to me. They gave me a means to recognise something about acupuncture practices in HCMC, as much as my lay translators of Vietnamese language did in interviews. When responding to my questions, or sometimes when in rhetorical mode, interlocutors focused explanations for a particular audience: to Gillian, a foreigner who was expressly a layperson, someone who had never trained in acupuncture medicine. Posing these explanations to other interlocutors gave rise to consent or indifference or dissent, so that I arrived at interesting debates. I drew problems and understandings from the relative interplay of these translations. I can therefore argue that in performing treatment, technicians, relatively, avoided touching a patient’s body. But only relative to Japanese trigger point techniques used by a Japanese trained practitioner living in HCMC and Danh, who learnt those techniques in the USA. I will pursue “co text” (Haraway 1991:214) as a subtheme throughout the thesis, making brief note in different chapters of situations when co-construction of ‘data’ were most legible to me. A text can, then, be understood as a ‘quasi object’ as described by Michel Serres in interview with Latour. A quasi object is “like a tracker of the relations in the fluctuating collectivity around it” (Serres & Latour, 1995:108) that “nonetheless remains a useful technical object directed toward the physical world” (*ibid.*:261). A text is a print thing, can be read by seeing eyes, held in feeling hands and can meet an academic purpose yet also trace relations between people and other things that constituted its production. The production of this particular text hinges on acupuncture technicians who worked in a city often called the driver of capitalism in Vietnam. To the crucial presence of technicians, I turn next.

Contemporary Healthcare in HCMC

Technician acupuncturists were key to my research. I engaged with an occupational group during fieldwork and I was interested in what these specialists were doing. Technicians mainly worked in the private sector. Development of private enterprise

in southern Vietnam has entered many accounts in recent years: accounts by health economists, social science and medicine writers, as well as the accounts of city dwellers. The ambiguities generated by private enterprise were a context that interlocutors were implicated in creating, that they responded to and that fashioned contemporary healthcare in HCMC.

Most of my interlocutors had obtained a technician credential or were in the process of doing so. This meant that they had completed three years of study at the Traditional Medicine Institute, in the centre of Ho Chi Minh City. Technician credential holders may also call themselves *huong y*, though not everyone did so. Most of my interlocutors were in their 30s or 40s: some having worked in acupuncture for an extended time while others were retraining after working at a different occupation. Doctor-acupuncturists trained through a one year work-based apprenticeship at the Institute and at the Hospital of Traditional Medicine. One interlocutor trained in Japan so had Japanese credentials. Only one interlocutor held no credentials. It should be noted that even though the majority of my interlocutors held the same qualification, interlocutors had very different school experiences and family relations. The higher educational status of technicians was provided, and recognised, by government so had particular consequences. The existence of a technician credentialing programme enabled certain persons to access medical education, who may otherwise not have been able to do so. But holders of the technician credential were highly unlikely to enter government employment, available because acupuncture medicine was offered through the public healthcare system. Doctor-acupuncturists, rather, were employed in government clinical spaces to oversee the treatment of patients and the work of nurses and *y s²⁴* qualified staff. The greater number of technicians worked in private practice. Their endeavours continue to shape the professionalisation of acupuncture underway in southern Vietnam since the nationalist-orientated Communist Party of Vietnam took government in 1975.

A contemporary dynamic of HCMC has been private sector development. The technicians I came to know operated in the private sector. Through a confluence of reasons, they were unable to practice as employees in government hospitals or clinics.

²⁴ Someone who has studied medicine for four years, in between the two years study required to become a nurse and six years to become a doctor.

Privatisation and the pursuit of profit have been present in many accounts of life and medicine in Vietnam since the 1986 policy shifts called Renovation. Renovation seeks to engineer Vietnam as a socialist-orientated market economy. HCMC has been written as the motor of commercialisation in this new era, using two metaphors. The first is mobility, such as of money, status (Truitt, 2005), widening income differentials (Luong, 2009) and people: embodied in a journeying diaspora²⁵ (Carruthers, 2008; Phong, 2000) and labour migration: manual and sexual (Belanger, 2007; Belanger & Wang, 2008; Thai, 2008). The other is consumption – of consumer goods (Nguyen-Vo, 2004; Vann, 2003), the greatest volume of foreign direct investment monies (Dang, 2008) and the greatest volume of international remittances to resident family members (Niimi, Hung, & Reilly, 2007)²⁶. Martin Gainsborough cautions writers against believing that the state has withdrawn from market activities rather ‘liberalisation’ should be understood as a commercialisation of government that has created, what he calls, a gate-keeping state (2003, 2005).

Since Renovation, health economists have characterised medicine in Vietnam as being on a trajectory of privatisation. Increased private provision of clinical services, authors argue, has moved in tandem with reduced government subsidy for hospital services, increasing individual out-of-pocket expenditures and changed ways of paying for health services such as user fees, health insurance and healthcare funds. Healthcare Funds for the Poor have been reported to allocate less than \$US5 per eligible beneficiary, per year, making the effort of their application unrewarding (B. D. Le, 2005; World Bank, 2001). In HCMC, primary healthcare services can be accessed in each government administrative ward through a local health ‘station’ (*tram y té*). These sites provide doctor consultancy for non-acute cases, gynaecological services, childhood immunisations and are an outlet for public health concerns. For instance, while I was in HCMC, HIV/AIDS prevention was promoted²⁷. Recent changes in government strategy have emphasised illness prevention, grass roots service delivery, expansion of health insurance cover and the active participation of

²⁵ Since July 2009, a legal process for Vietnamese diaspora and expatriates to hold dual citizenship was passed into statute (Thanh Nien News Agency, 2009).

²⁶ “In 2008, total overseas remittance to HCMC was estimated at US\$5 billion, to Vietnam in total reached US\$8 billion” (Voice of Vietnam, 2009a).

²⁷ Between January 2008 and June 2009, newspapers sporadically reported increasing lack of doctors staffing these sites due to low pay and improving employment opportunities in the private sector.

the private sector under the government's leadership (S. Adams, 2005). Privatisation includes the charitable sector. Non-governmental provision was organised by private-for-profit practitioners as well as religious organisations, significantly Catholic and Buddhist churches, that were active as private-not-for-profit providers of traditional medical services.

Social science and medicine authors are concerned with equity in this reported era of privatisation. Institutional healthcare access is perceived to be threatened by increased private medical practice (Guldner, 1995; Hien, Ha, Rifkin, & Wright, 1995; Lonroth et al, 1998, 2001, 2003a, 2003b; Lonroth, Thuong, Linh, & Diwan, 1999, 2001; Quy et al, 2003). Lonroth's teams have particularly been interested to understand how privatisation has affected patterns of care seeking in HCMC; whether there is now a lack of control over treatment effectiveness as well as what the impact of pharmacy privatisation has been. Concerns regarding pharmaceutical deregulation (Wolffers, 1995), the lack of so-called 'rational' pharmaceutical use (Lonroth et al, 2000) and popular use of self-medication (Craig, 2002; Duong et al, 1997; Toan et al, 2002) have been raised by authors, alarmed at the implications for pharmaceutical resistance. Researchers also focused on the rising number of retail pharmacies and the role of untrained salespeople advising on pharmaceutical use (Chuc et al, 2002; Chuc & Tomson, 1999). These literatures are ambivalent about privatisation in medicine: characterising privatisation as both parasitic on the national health system (Ladinsky, Nguyen, & Volk, 2000) and as a key player (Ha, Berman, & Larsen, 2002). These authors argue that traditional medicine is given emphasis in government policy by suggesting that all health workers in Vietnam receive some training in traditional medicine and emphasising that doctor students can choose to specialise in traditional medicine. However, in examining Government of Vietnam policy documents, traditional medicine is mentioned but strategies for active implementation of traditional treatments for chronic conditions – the coming epidemic²⁸ – are missing. Given that many circulating definitions of traditional medicine in HCMC was as assistance for non-acute illnesses, this lack is puzzling. Government policy documents focus on training doctors over any other medical occupational category (see Government of Vietnam, 2001).

²⁸ Current World Health Organization (n.d.) messages are that chronic non-communicable diseases are a rising epidemic.

In the accounts of city dwellers, the metropolis was a place where everyone was out to make money. For many, HCMC was a homeland (*quê hương*) usually figured romantically as a rural idyll, such as in the extravagant floral displays laid on by the city People's Committee to celebrate Lunar New Year in 2008. But city dwellers were busy trying to make a living in a cement jungle. One resident called Saigon "a little America" because it attracted naïve university-age students from the countryside, street-smart Hanotians seeking to marry a city resident to gain rights to live in the city and an increasing numbers of tourists so that a new international airport terminal was built and opened during my time there. "Look at all these people," said my Vietnamese teacher gazing down onto the swirling traffic below, "running about all day, poor people and rich people, competing with each other, crazy in the streets looking for work and money." The motivations of others were suspect; strangers were always trying to cheat each other in some way. Connections were the surest protection and the fastest way to make that money. "Does anyone ever win the lottery?" I asked a middle-aged friend, of the lottery tickets sold in the streets by young children, whose families could no longer afford to send them to school, and by wheelchair-bound disabled adults who sat day-long under an umbrella in the hot sun. "I know what you mean," she nodded sagely, "you mean, is it only the friends of the lottery organiser who win it." In the talk of interlocutors, the government was still in control, especially in education. "Opening a business, that's ok, but charity and education are different. If you give some money under the table then anyone can open a business very easily but with charity, lots of anti-government activities might happen [under a charity aegis] so they are suspicious," was the opinion of a middle-aged business woman.

Public and privately funded hospitals were compared and rated by their users. Specialist medical services in the HCMC attracted patients from as far as Siem Reap in northern Cambodia. The private and very expensive X hospital was "like a hotel because the rooms have Wi-Fi". A large central public hospital was "very clean these days, but very crowded," though an interlocutor saw two people in one bed and more patients lying on the floor in corridors "because they do not have enough beds," she thought. Another countered with a more shocking story. "A [government-owned] cancer hospital has four people in one bed and is very, very dirty... the

standard of equipment very low and out of date.” Private medical practices flourished, from sole owner premises to large companies. But private care could not guarantee quality care. The Y private medical centre was not helpful, according to another, “because my mother went there and they did lots of tests but eventually [another] clinic found that she had cancer of the kidney.” The Z diagnosis centre was very famous, an interlocutor explained. “You have to wait there from 3am if you want to see a doctor. It has a lot of famous doctors”²⁹. People talked. People talked about many things including medicine. In the networks that motored HCMC, people, information, suspicion, money, trust and things all circulated. They moved in the service of personal enterprise. In that I create a text about mobility and dynamic connectivity, to write of the city in such a way is very much to write in unison with other accounts.

Before finishing, I wish to draw attention to how I have considered acupuncture in this thesis. In order to focus on a question of knowledge construction, I will not discuss acupuncture’s synergistic interaction with other therapies. Acupuncture was invariably practiced with any of massage, medications, pharmaceuticals, radiology, physiotherapy, chiropractory and various other combinations. It was very common to hear practitioners state that acupuncture was good, that chiropractory or physiotherapy or medications, say, were good but together with acupuncture they were better. Together, they were more efficacious. The most appropriate topic for a thesis about acupuncture in southern Vietnam should concern this synergy. However, I decided to not pursue synergy because as a newcomer to acupuncture, I wished to pursue a deeper understanding of one practice, particularly needling.

More reductively, I followed practices by persons who needled acupoints since I had initially assumed that needling was synonymous with acupuncture. But this was not the case. Cat-gut acupuncture, in which a snippet of surgical catgut was pushed into a syringe needle punctured into an acupoint, was associated in my experience with Catholic charitable provision of traditional medicine in Dong Nai province³⁰. Practitioners said that catgut was not popular because it was too painful. I also heard

²⁹ No appointment system was in use. Also noted in urban Japan (Ohnuki-Tierney, 1984).

³⁰ The majority Catholic population of Dong Nai province originated from southern migration in 1955 when northern and southern Vietnam were created at the 17th parallel.

of laser acupuncture and liquid acupuncture, inserting liquid medication into acupoints or lasering acupoints, but never observed their practice. Like acupressure (*bấm huyệt*), these practices stimulated known acupuncture points. Heat was also used to stimulate points. The Vietnamese word for acupuncture, *châm cứu*, can mean to prick by needle and apply heat through moxibustion. The phrase implied that heat was always used with needling but this was not necessarily the case. Moxibustion or moxa, referred to mugwort root that was burnt over a painful spot, or an acupuncture point, by holding the burning mugwort stick, thick and smoking like a rich Cuban cigar, close to the skin, slowly rotating it. I also saw moxa burnt over a mesh wire stretched inside a metallic box positioned over a portion of the patient's prone body. Alternatively, heat was applied by means of red-light lamps trained over in-sitting needles in a traditional medicine department of a government hospital I visited. Heat was also applied by a hairdryer blowing warmth onto in-sitting needles by a blind practitioner. Outside clinical settings, I have seen a mother carefully warm the back of her child's neck with a moxa stick, singeing the fine neck hairs. Her daughter had a cold but she also invited me to have moxa for relaxation, to feel the dry perfumed heat in the heavy humid air of early rainy season. The use of needling with heat depended on the patient's condition and the practitioner's personal philosophy of medicine. Both technicians and doctor-acupuncturists were as likely to make use of it as not.

All practitioners in this thesis practiced synergistic therapy but one activity that connects them all is that without exception, they all needled acupoints. To a lesser extent I consider stimulation of acupuncture points by other means. This focus on needling practices should not be taken to mean that acupuncture was restricted to needling points. My focus on needling practices in this thesis is a textual device to focus discussion around key threads that I followed throughout fieldwork activities.

Contents

This thesis explores medical knowledge production and asserts that knowledge is a network. Chapter one explores how acupuncture specialists were created through relationships between the Traditional Medicine Institute, which awarded credentials, and the Department of Health, which awarded licences. I will describe how government sought to create a "New Medicine" for post-war southern Vietnam, by

uniting science and the medicine of the ‘old people’ into a new synthesis for a ‘modern’ Vietnam. This medicine was standardising. Pedagogy emphasised comprehensive literacy, mass participation, repeatability and predictability in medical education. In the New Medicine, education was an extension of licensing mechanisms that practiced legality in medicine but in HCMC, credentials and licences were ambiguous in part because personal networks were active in the licence application system at the Department of Health. I focus on how relationships between curricula, pedagogy and licensing created technicians whose acupuncture practices in private clinics around the city generated truths about what acupuncture was and could be.

Chapter two describes how acupuncture objects were constructed in and through relationships between books, qi, acupoints, posters, channels, Organs and patient bodies. The human body, figured as a self-regulating system, was understood to be capable of self-healing. Material for this chapter draws on the published contents of textbooks and posters, as well as discussions with interlocutors. I argue that acupoints were enacted as static, visible and senior in these networked relations. They were senior to corporeal qi, more significant than the passive channels that moved qi and usurped Organs. Qi was the most debated and audible in a realm of discourse, suggesting that its truth was being contested. But points were *über-alles*. To know acupuncture was to know where the points were. These objects were an outcome of relations between print media and practitioner acts so that acupoints gained “facticity” (Latour & Woolgar, 1979). Distributed consensus was how such facticity could arise.

Chapter three describes the realities constructed in the 6 Qi classroom of a local acupuncture Master. A critical dynamic was the efforts undertaken by both students and Master to generate trust. I will describe how a seemingly exotic acupuncture was taught systematically as formulaic relationships between qi, points, Organs, trigrams and the pulse. Systematic relationships were proven through numerical statements derived from myth. Their therapeutic efficacy was measured by a clinical outcome, sitting in our class in the person of a female student. Our teacher sought to simultaneously validate the truth claims he was making about his medicine and convince students that he had kept no secrets by demonstrating completeness. To

mediate a risk that students would disbelieve him, strategies of fun and distinction were also engaged. To mediate the risk that the Master would not teach the complete 6 Qi, students performed hierarchy to entice our teacher to reveal all the 'good stuff'. These created a reality of entangled suspicion and trust, with completeness as a circulating definition of medical efficacy.

Chapter four describes clinical acupuncture encounters through a metaphor of shaping. I concentrate on how many different actants got together to 'do' a clinical acupuncture session. Particularly, I focus on two activities that made action look like treatment – vision and pain. Vision was allocated supremacy in diagnosing problems and in effecting treatment when practitioners needed. Pain was enacted as somatic. The objective of treatment was to exorcise it. When acupuncturists removed a patient's pain quickly, the practitioner was thought to be efficacious and patients returned. Hence patient expectations moulded acupuncturist clinical behaviour even where these went unexpressed. Clinical sessions are often presented as the epitome of medicine, the culmination of learning and licensing procedures. Clinical medicine, I argue here, is a shape: an ecological outcome that created expectations for both practitioners and patients to know that something called treatment occurred. 'Treatment' was the name of activity that met expectation. Treatment was not a passive application of knowledge directly transmitted from classroom-based experiences or cognitive decision-making inside the head of a domineering clinician.

Chapter five considers knowledge as a network in the simultaneous senses of both Granovetter and Latour. Fame cropped up in many explanations of doing medicine. Fame was configured around networks of person connections. Circulation and repetition of one's name in personal networks could obtain patient referral and collegial recognition. Being newsworthy meant that a practitioner would be talked about and therefore a noise was generated about them. Newsworthy acupuncture stories were often stories about successful healing. Data for this chapter focuses on the construction of networks in interlocutor accounts, the creation of connections through introductions and how publicity involving two older practitioners, Chi Ha and Dr Truong Thin circulated. Their names were repeated through many different media, one of which was personal networks. Ultimately networks became active and took on the work of promoting an individual. Fame can be understood as that which

was created by repetition and generated publicity: a publicity that could then translate into different forms of occupational and professional success.

The final chapter is devoted to the experiences of two blind practitioners in Saigon. Blind people were categorised as disabled in Vietnam. Sighted acupuncturists and patients rejected blind persons as incompetent. However, one blind practitioner was particularly successful, making a living for himself and his family, having been in practice for over 20 years. These two blind individuals were in a paradoxical situation of providing care while popular perceptions of disabled persons were that they needed to be cared for. I make use of Markell's (2003) suggestion to engage in a politics of acknowledgement. I will demonstrate that disabled persons were active in medical care provision and were competent in doing so and argue that their rejection highlights how vision was a technology that mediated acupuncture in HCMC. Vision mediated the construction of acupoints as static and minuscule on human bodies and the translation of illness manifestations into meaningful signs. When a blind man needed, a recognised shape of treatment could not occur. However, since the shape of treatment was also that of exorcised pain, efficacy as a clinical outcome meant that success could be generated through personal networks even when vision was absent.

I see this thesis as adding to existing medical ethnography about the production of knowledge in the nationalised medicines of East Asia, complementing texts written by Judith Farquhar, David Craig, Margaret Lock, Emiko Ohnuki-Tierney, Elizabeth Hsu, Paul Unschuld, Stephen Birch and Ayo Whalberg. I have made use of science and technology writings that are also visible in the very recent work of Volker Scheid, Mei Zhang and Jongyoung Kim on nationalised medicine and therefore find myself in a nascent trend. Such writing eschews describing medicine as structural systems, rather considers medicine as dynamic networks. As with Scheid, Zhang and Kim, I have avoided unproductive debates about whether acupuncture might be called either indigenous or scientific. Knowledge here is relational, practiced and contingent.

Publishing on acupuncture in Vietnam is very limited. This thesis is an extended discussion of acupuncture in southern Vietnam therefore contributes significantly to the anthropology of acupuncture in the country. Additionally, since it questions the factual nature of acupuncture objects required to practice such a medicine, this thesis

considers how such medical facts are formed. Finally, I bring in the senses that are key to acupuncture work by highlighting the crucial nature of vision in the construction of acupuncture in HCMC.

This thesis can be a significant contribution to discussion on medicine from the point of view of medical professionals since it details professional-only perspectives. Such perspectives are still uncommon in medical anthropology literature, which tends to focus on patient perspectives and experiences or on relationships between patients and professionals in clinical settings. This dissertation can therefore contribute to a growing interest on how occupational groups are constructed. It also addresses medicine as a political construct and as a participant in southern Vietnam's political situation. Finally, this text can further be read as a history of Ho Chi Minh City, at a particular time and in those aspects is an urban anthropology of a megacity in seeming eternal growth.

1. Making a New Medicine

After 1975, a new ‘people’s medicine’ was promoted by the equally new Communist-nationalist government in southern Vietnam. Government teaching of acupuncture started at the newly created Traditional Medicine Institute in the re-named Ho Chi Minh City. Activities at this location produced acupuncture technicians, the occupational expert group who populate this thesis.

The New Medicine can be understood as a unique arrangement comprising three activities: curricula, pedagogy and licensing arrangements. Elizabeth Hsu (1999) valuably argues that how students of Chinese medicine learn key concepts shape how these medical concepts come to be understood. That is to say, medical education is not only curricula in the sense of a ‘what’ but also pedagogy, in the sense of a ‘how’. These cannot be separated. However, I would add that pedagogy is also an extension of credentialing and licensing networks which control access to legality in medicine. In this way, a monopoly on medical legality can be generated. In the sociology of professions literature, a monopoly on legality is evidenced by credentials which are required to convert a lay person to licensed status (Brint, 2001; Evetts, 2006; Fuller, 2001; Pavlin, Svetlik, & Evetts, 2010). In such writing, credentials and licenses usually stand-in for a person and retrospectively validate participation in a particular pedagogic process. Such activities have been termed professionalisation: the organisation and creation of an occupational group of experts.

The Traditional Medicine Institute in relationship with the Department of Health worked to create a new expert group. Many of my interlocutors had studied or worked at the Institute. The Institute was important in my interlocutors’ experience and envisioning of what acupuncture was. For instance, the Institute enrolled literacy as a key pedagogic hence it was difficult for practitioners to imagine an acupuncture without books. While the Institute’s relationship with the Department of Health was crucial for understanding legality, I was not located in either institution during fieldwork so have little data on this connection and must restrict discussion here to

the Institute. I begin by introducing this focal place. Thereafter I describe how curricula were envisaged as neither an ancient system nor a colonisation of the old by modern biomedicine, rather a new medical synthesis for post-war southern Vietnam. I go on to propose that when citizens entered the gates of the Institute to sign up to a technician training programme, they took part in a new pedagogy that democratised access to medical practice. The new pedagogy emphasised a standardised educational experience. On completion of training, Institute credentials were used to apply for a medical license to practice acupuncture legally. Department of Health regulations clearly set out the paperwork required for a licence application and how long that process should take. But processes of bureaucratisation interacted with personal networking to create a trade in entitlements to legality. To finish, I will describe how this trade changed relationships between credentials, licences and professional training. Credentials and licences became uncertain and ambiguous.

The Traditional Medicine Institute

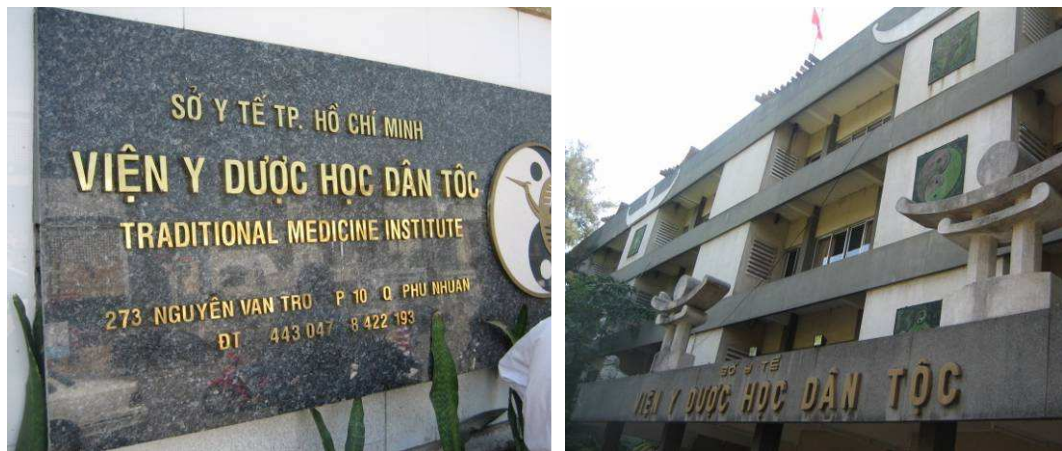


Figure 1: Placing Pedagogy.

The Traditional Medicine Institute (hereon also the Institute) is the government created, managed and mandated organisation for the teaching and popularisation of traditional medicine in the south of Vietnam. The Institute's mission statement declares that the Institute was founded on 24th December 1975, through decision number 43/YTXHTB-TC by the then Minister for Health, Society and Invalids on behalf of the government of the newly unified Socialist Republic of Vietnam. On 2nd March 1985, the then Minister for Health signed decision number 161/BYT-QD handing management of the Institute over to the HCMC People's Committee. The

Institute's remit, according to its own website, is to guide, develop and promote traditional medicine in the south, being the 32 government administrative provinces from central Da Nang city to the southerly tip of peninsular Ca Mau.

The Institute's organisational mission specifically is to:

1. Teach, promote, develop and integrate the modernisation of traditional medicine contributing to the building of a modern eastern medicine.
2. Raise the quality of health and treat illness through the strengths of traditional medicine and cure illnesses of the time and of society.
3. Teach and strengthen training in eastern medicine for staff of the Health Department of the city and the traditional medicine department of the University of Medicine and Pharmacy in HCMC; standardise teaching for all traditional medicine practitioners, pharmacists and doctors of traditional medicine in the south and for foreign students and staff of the Institute.
4. Guide traditional medicine hospitals in the south; build cooperation between the Institute and hospitals, promote traditional medicine inside and outside the country including through international cooperation.
5. Research and develop traditional medicine combining with modern medicine and all different aspects of medicine, culture and art (Traditional Medicine Institute, n.d.)

The organisational mission “conjures” (Tsing, 2005:57) a geographical scale for medical training and treating activities. It describes the Institute as a guide for traditional medicine *in the south*. The south here is geographically specified. It is the 32 provinces ranging from coastal Da Nang city in central region to the distant tip of forested Ca Mau. The Institute guides half a country, in a scale not quite congruent with the former independent State of Vietnam, later the Republic of Vietnam. This geography was integrated with the northern Democratic Republic of Vietnam from 30th April 1975¹, or depending on your point of view, invaded by northern Communist forces to become the Socialist Republic of Vietnam. Additionally, according to the Mission Statement, the Institute is to guide traditional medicine in

¹ At least one of many moments when South Vietnam's complex alliances during the American War failed (detailed by Snepp, 1978).

HCMC itself and for foreigners. Three scales operate in this organisational mission: the city, the south of Vietnam and international spaces, which triangulate the Institute within three possible geographies of action.

The Institute was a peaceful haven in the busy centre of HCMC. Located on the busy airport road, it was enclosed by a high wall that kept out the churning traffic and a folding gate, which was drawn at night and barred entry till early morning. During the day, outpatients were public patients whose barcode on their government medical insurance cards was scanned at an administration booth to sort eligibility for low cost treatment. During the evening, private patients paying higher fees entered the gates. In the local health-station network, doctors and other medical practitioners may rent out space for private practice outside of daytime hours. Inpatient wards sat behind the outpatient rooms and the teaching blocks were entered separately; opposite a courtyard bordered by wavy plants and numerous stone carved busts of long-dead physicians. Students were often found studying under the cooling green shade of labelled trees or moving deliberately around a central plaza in a slow dance of Tai Chi; unimpeded sunshine heating their flowing shoulders. An interlocutor who studied there did so, he explained, because the “vibration” of the place – the feeling he encountered there – was calm. However, when I first visited the Institute in February 2007, the vice-director was annoyed. The Institute had lost space to the airport road upgrade, work that finally finished in late 2008, so they had to rebuild upwards. The Institute was a space to read and learn, enjoy peace and quiet, wait, get treatment and for those lucky few in government employ, enjoy the benefits of guaranteed working hours, salary and future pension benefits.

A shrine to Hai Thuong Lan Ong sat in the centre of this plaza, describing the medical scholar as being alive between 1720-1791. The drifting aroma of incense planted at the shrine might still be caught from burnt out wands, wavering in their ash. Hai Thuong Lan Ong makes an appearance in many accounts as one of the “two greatest representatives of Vietnamese traditional medicine” (Bui, 1999:12) with Tue Tinh (K. T. Le, 2006). His true name is reported to be Le Huu Trac, who was born near Hanoi. He is said to have secluded himself in order to learn his medical trade and went on to become a famous physician (Nguyen, Tran, Nguyen, & Tran, 2003). It is told that he “abandoned” the then common search for titles and fame

and worked according to the values of “humanity and philanthropy” by “curing illness and caring for people’s health” (Anon, 2004:88). He was a “famous man who gave his experience of illness and treatment of sick people in general [not specifically acupuncture]... he is a hero,” a young acupuncturist told me in an interview. His medicine responded to the illnesses of the masses not only those of rich elites. He is described as never having refused difficult cases; as rejecting an idea that illness arose because of predestination and “if a patient died, he carefully examined and checked the clinical records to look for mistakes” (Anon, 2004:89). He was “interested in the clinical study of disease and established a memorandum of paper slips (name of patient, treatment of the disease and result)... he register[ed] the names of medicines, their qualities, preparations and posology”², which Bui summarises as “more scientific” than a Chinese contemporary (1999:22).

In the sources cited above, both Tue Tinh and Hai Thuong Lan Ong figure as the twin fathers of a new and nationalised traditional medicine in Vietnam. Tue Tinh was a Buddhist monk who famously wrote that materia medica of the south (Vietnam) should be used to cure the diseases of southern people (Anon, 2004; Hoang, Pho, & Huu, 1999). He is presented as a literati, who trained physicians and urged people to grow medicinal plants in their own gardens in order to self-medicate. Both Tue Tinh and Hai Thuong Lan Ong can be understood as constructed personalities who flag the conscription of traditional medicine into the creation of an “official” nationalism (Anderson, 1991). Their histories are reworked to meet the needs of the present (Pelley, 2002) for the new nationalist-Communist government of a singular Vietnamese geography. A key need for the new Socialist government was to provide universal healthcare to a voluminous population. Ho Chi Minh declared in a speech as president of Northern Vietnam that Vietnamese people had to “build our own medicine... study means of integrating traditional and modern medicine” (quoted in Wahlberg, 2006:70). This statement, argues Wahlberg, brought traditional medicine back into government provision from the French colonial cold to be moulded as a public health resource by the government.

² Posology is the study of medicine and drug dosages.



Figure 2: Hai Thuong Lan Ong: A Scientific Hero.

The two fathers of traditional medicine can equally be understood as aspirational for the new integrated medicine in the equally new and integrated state called the Socialist Republic of Vietnam. Both Tue Tinh and Hai Thuong Lan Ong are historicised as humanitarian figures, who worked to popularise medical learning and expand health services for the poor. Medicine therefore was to be accessible to the masses. The two fathers of traditional medicine were both literate and composed medical texts, indicating that literacy was a key concern. Reports emphasise that what they learnt was disseminated, rather than maintained secrecy for personal gain. Medicine was, then, idealised through socialism where community good transcends individual gain. Both Tue Tinh and Hai Thuong Lan Ong were “opposed to superstitions which looks for the origins of diseases in supernatural influences” (Bui, 1999:16) and they corrected misapprehensions of earlier generations of physicians to paraphrase Bui. A different theory of causality was to be employed. The new and integrated medicine of the newly integrated state would select from the medical resources on offer in Vietnam and around the world; the past was not to be

completely rejected nor the new to be completely valorised (Marr, 1981; P. Taylor, 2007).

A Modern Medicine for a Modern People

In 1984, the soon-to-be-director of the Traditional Medicine Institute, Dr Truong Thin, wrote that a New Medicine was being created. The New Medicine was not an eastern or a western medicine, not merely the old and not solely the new, rather was a people's medicine (*y học dân tộc hiện đại*) that would meet the needs of the modern Vietnamese. The people of Vietnam would use a Socialist Vietnamese medicine, created through dialectical materialism. *Developing a Methodology for Eastern Medicine and Acupuncture Book 1* was published nine years after the creation of the Institute. Truong Thin remained as director during the different periods that many of my interlocutors studied and worked there and was the most famous practitioner of acupuncture in HCMC that I came to know during my fieldwork. A humanitarian and a modernist, after the example of Hai Thuong Lan Ong, he uniquely used a combination of acupuncture, medicine, poems, music and painting as medical treatment. Truong Thin first trained as a doctor before working in acupuncture and believed that serious illnesses were partly derived from trouble in a person's soul (Thu Huong, 2008). I make use of his significant text to describe how the new people's medicine was envisaged.

The post 1975 medicine in southern Vietnam does not reject past medical philosophies indiscriminately. In the text, a keyword is *thừa kế* or inheritance, in the sense of to inherit, say, property but also to learn, to hold onto and to share something. In other words, "the people's traditional medicine can be turned into a modern people's national medicine without losing the essence of the other's uniqueness" (Truong Thin, 1984:20). However, medicine imperatively must be change³ because in itself, the old philosophies of medicine are insufficient:

The old practices aren't enough (Truong Thin, 1984:10).

We shouldn't stop at classical medicine but go further to form a modern people's medicine (*ibid.*:23).

³ C.f. Hsu (2001:5).

Hai Thuong Lan Ong also warned about this, trying to use the Classic of Changes [*I Ching/Kinh Dich*] to make things mysterious instead of plain and trying to make things spiritual not matter, materialism (*ibid.*:38).

There are many rudimentary and primitive ways of thinking. Very few people dare to innovate, to change (*ibid.*:130).

Writers with excessive belief in the classics only write about matters of history (*ibid.*:131).

Truong Thin emphasises that change is necessary but was to be managed in a particular way. Patricia Pelley notes for northern Vietnam that “revolutionary writers were obviously transfixed by the idea of ‘the new’” in her discussion on post-colonial government thinking in northern Vietnam. She argues that for the post-colonial government, some practices were relabelled as superstitious and wasteful, which then validated government attempts to eradicate them. Other practices were valued and so maintained. Truong Thin uses a similar process of labelling some practices as rudimentary and therefore should be discarded, while others were useful and should be brought in to create a people’s medicine. By doing so Truong Thin renews medicine yet enables the Vietnamese people to hold onto their valued medical inheritance.

Truong Thin renews medicine by recruiting Vietnamese, European, Chinese and Marxist-Leninist text sources out of which he synthesises a unique philosophical arrangement. The ideas of all these philosophers are, then, the inheritance of a modern Vietnamese people:

For the Ancient Greeks, materialism was the search of the smallest indivisible particle, the smallest building block of the universe. Modern materialism dates from the end of the 19th century. Over time, the view of the atom changed (Truong Thin, 1984:30).

Lao Zhu said there is one thing born before the earth, but we don’t know its name so we call it the Tao (*đạo*). In eastern philosophy, qi is concrete matter but because it is so small, like say particles, we can’t see it. We can only see it when it has changed to take a clearer form. These ideas are probably not different from those of Anaximene (*ibid.*:33).

For the Greek Heraclite, everything transforms and changes; time elapses and things change, they move, just as Engels argued. Motion is

eternal and ongoing, there can never be matter without movement. There can never be a time without change. This is what Lao Tzu and Zhuangzi also argued. (*ibid.*:39).

Lenin's dialectical method argues that... each thing has a contrary, each effect has a counter-effect. The Classics only saw a reversing process but modern dialecticalism goes deeper into the structure of real actions. Dialectics lets us keep our traditional theory but to see it in a new way. We appreciate modern dialectical materialism in traditional eastern medicine so that we can further (*thi ra ke*) the development of traditional medical theory (*ibid.*:57).

The Greek, Chinese and Marxist-Lenin sources quoted above are all recruited by Truong Thin to make a new medicine. The New Medicine is imagined as a unique medicine that is unlike any other medicine to date: a bricolage of materialism and dialectics, drawn from ancient Greek, ancient Chinese and recent Marxist-Lenin-Engels writings, which are used to reinterpret each other. Truong Thin traces philosophical relationships between ancient and recent (early 1980s) publications on experimental acupuncture research in the Soviet Union. In doing so, all elements of this bricolage are transformed by being brought into new relationships with each other. Engels is transformed by being linked to Lao Zhu and Thang Zhu by being reinterpreted through Heraclite. The New Medicine is envisaged as neither disjunctivist nor continuous, rather a unique formation in its own right.

Not least for Truong Thin, disciplinary science in an expanded sense of what science might be is also recruited.

We need to bring in the sciences like physics, biology, chemistry and sociology (Truong Thin, 1984:10).

We need to combine science and traditional medicine to find out more deeply about many stages of qi transformation (*ibid.*:42).

Traditional medicine knows biological time, diagnosis and treatment in a refined way. Of course, we need to combine that with all the other individual laws of different branches of science (*ibid.*:43).

Einstein's universe was relative, active, changing... so we don't separate space and time... the medical application of Einstein's spacetime is that if spacetime

isn't separated then the structure and function of Organs must also be unified (*ibid.*:110).

As recent ethnography (Adams, 2002; Hsu, 1999; Kim, 2005) argues, 'science' cannot be understood as having a universal meaning rather I must ask what science means for Truong Thin. The director's use of the word science concerns the "laws" of yinyang, Five Phases and qi transformation – these laws tell about the creation of matter and are "objective principles" (Truong Thin, 1984:31). Understanding the laws of qi transformation would allow a traditional medical practitioner to have greater certainty in medical practice: "without theory we limp, we can't be steady on our legs" (*ibid.*:100). For Truong Thin, science and theory are inextricably linked and theory is his ultimate objective. We must have theory, he argues, "else we only have experience" (*ibid.*:5). The combination of selected philosophy and science would enable contemporary physicians to "see more deeply" into the knowledge of the ancients (*ibid.*:42,46,56). The combination is conceived as synergistic: "thanks to philosophy and science, we can start to glimpse the thinking of eastern traditional medicine" (*ibid.*:114). The combination could help practitioners avoid "wrong" understandings (*ibid.*:97, 114, 135). A selective science does not obliterate the past rather is used to peer more deeply into the truth of eastern medicine. Truong Thin seeks to make use of science as a "vehicle" (*ibid.*:19) that can generate structure, predictability and proof for acupuncture medicine. Science then is brought into the bricolage of socialism, Taoism and Greek philosophy to renew medicine for the medical practitioners of a new government and state in southern Vietnam after 1975.

In his 1984 book, Truong Thin is concerned with synthesising a New Medicine from many sources, imagined as east and west, science and tradition. "Unified medicine is the medicine of a modern people [*y học dân tộc hiện đại*]... dialectical materialism [*đường vật biện chứng*] is the answer to the question of how to create one medicine from two traditions" (Truong Thin, 1984:15). Under a Marxist-Leninist government (Templer, 1998), Dr Truong Thin makes use of dialectical materialism to construct a politically acceptable theory for acupuncture medicine. The citations he uses clearly create a textual genealogy with the works of Lenin, Marx and Engels. His science is particularly the syncretic science of Frederick Engels (1883). Likewise, Volker Scheid describes 'pattern differentiation and syndrome determination' as an ecological effect of 1950s Chinese politics which created, made visible and temporarily erased

practices to constitute a clinical diagnostic tool (2002:200-237) that is described in other sources (Farquhar, 1994; Kim, 2005) as the “one crucial and defining nature of Chinese medicine” (Scheid, 2002:202). As in China, medical theory in Vietnam was built through the political philosophies of groups temporarily heading bureaucratic structures of government.

Structure and systemisation in the New Medicine are seen as solutions to a perceived problem of chaos and incoherence. Through systemisation, Five Phases is rendered a theory which can unify apparent chaos. Systemisation therefore, can help practitioners to ‘see comprehensively’. This is a most important change. Medicine could become integrated; holistic. Unity is the outcome:

If we want to systemise [*bệ thống hoá*] all the different acupoints by their action we must continue to classify by the Five Phases... everything is different from each other and we might wrongly think that they cannot relate to each other at all but they do... they have in common the origins of qi change and qi change in each of the Five Phases (Truong Thin, 1984:97).

This method demands that we investigate each and every subject as one system inclusively... whose parts have determining reciprocal relations, that is to say, they collectively form that system but the character of that system isn't only the sum total of those factors since it can sprout new attributes... this method of having structured systems, of a system being structured of itself and having structured relationships between systems, is quite different from the [old] metaphysical method, which isolates (*ibid.*:112).

We need to have a way of seeing that is both detailed and comprehensive (*ibid.*:130).

Seeing comprehensively is what systemisation can achieve and therefore incoherence and chaos can be deleted. Repeated application of the same principle in the same way means that the smallest aspect like cells, or larger subjects such as humans, could be investigated in the same way. He allays fears that such a repeated application would be stagnant by asserting that systems were generative of more systems. Systematic application of medical principles would transform acupuncture into a modern people's medicine.

Scientific experimentation is recruited to reveal the truth of acupuncture's known efficacy. Truong Thin asserts that this was possible because the machinery of scientific inquiry can see in more detail than was possible in the past:

Because of the issue of acuity, the people of the old days only paid attention to transformation of movement/actions but paid little attention to the concrete foundation of matter... but from the 15th century up till now, technical science has opened wider a way of seeing the world (Truong Thin, 1984:56).

Discussing Soviet experiments into the nature of qi and acupuncture points, which I detail in the next chapter, he argues that:

The issue is that what the ancients thought was un see-able is today become more see-able, science these days can see 10 to the power of 37, so what was unseen is now visible (*ibid.*:46).

By looking at the different methods of research we see that it is rather sophisticated technical work. How could the people of the old days have such handy technical methods to make manifest the channel system? Hence we have not yet been able to satisfactorily understand how the old people discovered channel-points (*ibid.*:141).

A key argument is made here. The old people were correct – the channels along which qi moved, and qi itself, are undisputed truths. That is, acupuncture is not to be put to a scientific test to find out *whether* it works rather science is put to the service of revealing acupuncture's given truth. Through continued scientific research, this truth will be revealed. Science can reveal this truth because its "sophisticated" (*ibid.*) technologies can see more deeply than was possible in the past. Truong Thin assumes that what these technologies can see are, unproblematically, truthful and complete. Research results would not be some disputable vested interest. To accept the truthful nature of research outcomes presupposes that experimental research is in the first place *capable* of producing incontestable truths (Shapin & Schaffer, 1985). This assumption goes without saying. What is at issue is how science is capable of rendering truth. Truong Thin argues that its technologies are able to do so. The visual acuity of new technologies means that the truth is inescapable from a new

powerful seeing eye. Technologies can witness the truth that the ancients had reasoned but which by eyes alone, modern man is unable to perceive.

A changed, modern, systematic and experimental acupuncture at the Traditional Medicine Institute excluded 'folk' remedies. Noticeably, two therapies were excluded from curricula there: cupping and coining. Cupping (*giác hơi*) is when a glass cup is applied to the skin and attaches through the vacuum effect created by suction. In Vietnam, I mainly saw suction created by fire – wiping the inside of a cup with cotton soaked with alcohol and setting the cup alight before placing it on a patient's skin. The suction pulls skin and muscle inside the cup. Discrete abrasion circles appear on the skin and fade over number of days. In HCMC, cupping was associated with *massage dạo*, young men who cycle around in the evenings offering roadside or café-side massage and cupping for relaxation. No classroom learning was associated with *massage dạo*: masseurs learnt techniques from each other. The street masseurs could be dangerous, I was advised, they may not take care and would burn my skin. Coining (*cao giò*) is when a patient's skin is rubbed with a coin or other metallic soft edge in long stroking motions on chest and back and upper arms. Again, red mottled abrasions will result. Many interlocutors had experienced such treatment in the home at the hands of mothers or elder sisters. I saw these practiced by technicians in clinical settings as well as by non-technicians. Cupping and coining were used to extrude wind, where wind was an agent of cold in the body causing flu and flu-like illnesses.

Cupping and coining were not practiced as part of acupuncture medicine taught at the Institute. This was most clear when visiting American acupuncturists comfortably related how, with flu as an example, they might needle certain acupoints or cut those points or rub those points or that they knew others who preferred cupping over particularly acupoints. But for technicians, cupping and coining were separate therapies; they were not ways to stimulate acupoints. Technicians did not study these techniques in classes. These enacted one of the more legible dividing practices between acupuncture technicians in HCMC and American acupuncturists, who had learnt under a TCM rubric and considered such practices as integral to 'acupuncture' (see also Zhan, 2009b). When asked why, interlocutors replied that everyone knew these techniques so why learn them in class. An Institutional doctor

on staff replied that they were of the folk or the people (*nhân dân*) but the school followed the curricula of general scientific practice (*đại khoa*). Her comment emphasised that scientification was valued. But there is another interpretation. In the sociology of professions literature, creation of experts is a product of the division of labour (Johnson, 1972). Specialists are divided from ‘the rest’ by means of exclusive knowledge. When my respondent argued that coining and cupping were of the people, she may also have been arguing that they were ‘common knowledge’ therefore could not practice occupational exclusion.

Becoming a Technician

I propose that the New Medicine taught at the Institute was not only a ‘what’ but very significantly a ‘how’, after Hsu (1999). The newness of acupuncture after 1975 was integrated into how pedagogy proceeded. Because of a technician training programme at the Institute, access to state education in traditional medicine was democratised. Acupuncture training at the Institute enabled a volume of citizens to sign up to classes, learn the same curricula, consult the same textbooks, learn a common acupuncture language and thereafter gain the same credential and apply for the same licence to legally practice medicine through the same application procedures. A volume of students were transformed into experts by the same *modus operandi*. I explore this standardising (Hsu, 1999) *modus operandi* in HCMC by considering some key activities.

Being accepted into the Institute to study for a three-year technician diploma did not require that a citizen was wealthy. “The technician stream is good for those who did not do well at school but who want to care for others,” remarked a doctor-acupuncturist. As I understood it, there was no requirement to sit entry exams to access technician classes, referred to in Nguyen Phuong’s classroom as indicative of a low quality of training (see chapter three). University students in HCMC must complete high school, evidenced by their successful pass in high school examinations. To enter university, students must also sit university entrance exams. This was not required of technicians to enter the Institute, laughed Nguyen Phuong (see chapter three). However, students were required to be literate and to pay an annual fee. Students also required time to attend bi-weekly classes and cash to

photocopy books, eat and live. That is, students required minimal resources to engage in student life.

Along with fees, the most worrisome cost was living in HCMC. Young Anh, who left school in Dong Nai province and came up to HCMC to study, rented a room in outer Thu Duc district for 500,000 Vietnam Dong (VND)⁴ per month. During my fieldwork period (January 2007 – August 2008), speedy inflation had raised prices by 30%. Alternatively, he could have studied at a local school in Dong Nai and attended short courses in HCMC but he felt that wealth creation opportunities were greater in HCMC. Many of his friends finished school and moved to HCMC because it was close. Being a three year part-time programme, the technician's course was shorter than a degree programme and students were not required to have evidence that they had finished high school. For those families with fewer resources, the technician qualification created acupuncture medicine as an attainable education and professional qualification enabling licensing to practice acupuncture medicine.

The Institute was a space of mass medical education, in marked contrast to other acupuncture learning modalities⁵. The Institute was an infrastructure that created classrooms, meeting spaces, eating spaces and libraries, where many teachers taught many students rather than one teacher to one student or one-to-a-few. Class sizes typically were large and classrooms crowded, with over one hundred students reported in some classrooms. Through the technician training programme, numerous students could be trained at the same time. Markus Schlecker (2007) suggests that 'gathering practices' are the actions of a modern bureaucratic state. The state, he argues, is interested in gathering citizens for a purpose. The technician's credential gathered many different individuals from many diverse backgrounds and life experiences and created them as a single category. 'Student' became a classification which gathered many persons into a coherent population. Students engaged in a socialist medical training and, in the main, went on to work in private healthcare provision. Some technicians found work at the Institute and Hospital of

⁴ The exchange rate during fieldwork fluctuated mildly around \$1 US = 17,000 VND. To make these figures meaningful, photocopying a complete textbook cost less than 85,000 VND and a bowl of beef noodle soup cost 11,000 VND in central districts, before inflation.

⁵ Cf Hsu (1999).

Traditional Medicine and others at traditional medicine units within government hospitals around the city. However, the number of posts available in the public sector was low hence private practice was the only option. Whether they could establish themselves in private practice was not a concern that training at the Institute addressed.

Technicians were those who trained only in the eastern tradition, according to a doctor-acupuncturist. Technician curricula included physiology, anatomy and cellular biology; detection techniques such as pulse diagnosis, questioning and taking blood pressures as well as technicalities of acupuncture such as learning location of acupuncture points and channels, how to locate points and how to insert needles. When students learnt to insert acupuncture needles into a human body, they first learnt on themselves. Thereafter they practised on fellow students. In later years, students undertook a practicum, which meant acupuncturing patients under supervision. An American acupuncturist pointed out that acupuncture training in the USA included a course on business essentials. The American training prepared students for post-study life as a private sector acupuncture-business entrepreneur. At the Institute, students learnt technical medical interventions only. Even though the majority of technicians worked in the private sector, there may have been an older socialist economy intent that trained personnel be part of public service.

This classroom-based, mass-teaching method enrolled and valued medical literacy. Textbooks were published and copied for student use hence students had access to more textbooks and to more complete texts rather than passages of text that may be used in private teaching situations (see Hsu, 1999). Medical literacy was therefore not restricted to a small group or a select few. These complete books were active entities in education. Because of books, a student was not required to remember all point locations and point names; books could retain this information for him or her. In being printed to a template and thereafter copied by a photocopier machine, acupoints in textbooks attained statism (see chapter two): they were not subject to individual interpretation as occurs in the act of copying by hand. Hsu (1999) argues that using complete textbooks in classroom-based learning is part of a “standardised” mode of teaching because all students learnt the same key passages of books, heard the same lectures on book contents and that exams measured students’ memory of those contents. For Hsu, classroom work was work associated with

book-learning which was separated from a space where practitioners met their patients, called the clinic. Extended textbook reading, memorising of text passages and taking extensive written notes were not activities associated with clinical practice.

Book-learning was prominent in HCMC but students often desired more experience of meeting patients, looking at illness manifestations and doing needling. A technician who volunteered at an outer city charity project did so, she explained, to gain more experience while concurrently learning from her mother, an overseas Vietnamese healer called Chi Ha who returned to HCMC annually at Lunar New Year. While volunteering at the project, I met seven students who studied at the Institute and worked in the acupuncture room under supervision of the lead acupuncturist. His name licensed the project. If acupuncture students were “weak” in acupuncture – for example, were uncertain on point location – he tutored those students freely but in return he requested that they volunteer on the project for a period of time, from one to three years, twice a week. He did not keep secrets, he insisted. It was difficult, he agreed, to get clinical experience while learning at the Institute so he taught students who wished to learn more.

A medical education which separates classroom from clinic, books from patients, is said to create dissonance in what is learnt in these two spaces. Howard Becker and his ethnographic team describe this dissonance as a theory-practice divide. Their ethnography of a 1950’s USA medical school notes that “a major part of its [clinical experience] meaning lies in its implied polarity with book learning... one does not acquire this knowledge through academic study but by seeing clinical phenomena and dealing with clinical problems at first hand” (Becker, Geer, Hughes, & Strauss, 1961). Book knowledge, the ethnographic team note from the speech of teachers, could be simply wrong or unavailable. Teachers expressed to students that some things should be learnt through the student’s own senses. Books did not account for the difficulties of, say, interpreting a laboratory report or that the administration of tests in the hospital bureaucracy made life difficult. So, “because of all these things it is believed a person must learn much of what he needs to know by *actual* clinical experience. Whether this is true or not, it is probably an important perspective in medical practice” (*ibid.*: emphasis added). The written word was cast by these doctors as subordinate to another authority, being clinical experience. In doing so, teachers

created division between modes of learning; some modes were experiential in a sense of ‘doing it’ and some were cognitive in a sense of ‘reading about it’. Farquhar rejects this dichotomy. She rather argues that ‘practice’ is an epistemological formation with specific historical importance in Chinese medicine. On pulse reading, for instance, “doctors know their specific manifestation can be linked not only with physiological sources but also with a written history of therapies... we need not rise above the level of practice (base, material stuff) into some ontologically distinct realm of the (“immaterial”?) word and idea to trace the complex paths of specific forms” (1994:226 as per original).

Rather than conceive of clinic and classroom – meeting patients and learning books – as dissonant, I suggest that their relationship was envisaged as doing something else in technician training. Texts and universal medical literacy were considered key for the creation of theory in the New Medicine. Dr Truong Thin emphasises the need for theoretical order in the New Medicine, which would *integrate* clinical results with the “laws” of yinyang transformation. Without theory, acupuncture would be chaotic and faith-based, as if it were a religion: “we need theory or else it’s just faith and a number of real results in the clinic” (1984:100). Books were not therefore divided from clinical practice but were the means by which clinical practice would be more comprehensively understood. “If we only know the application of the theory and don’t know the theory itself then we don’t grasp it deeply and we fall into primitive materialism... use inferior reasoning... in an unsophisticated manner” (1984:77).

Likewise, in Hsu’s ethnography book learning was valuable, in the opinion of teachers, because texts were systematic and coherent. Clinical experience was contrasted as chaotic. If a student only learnt through experience, problems would arise when a student encountered the clinically unmet (see Hsu, 1999:189). The student would not know how to treat the patient. The work of reading books introduced students to a how-to of the infinite variety of clinical life. Books should therefore come first, before clinical attendance, not after or never. Because they preceded meeting patients, they could act as “virtual witnesses” (Shapin & Schaffer, 1985:60) to clinical problems on behalf of students who had yet to see them. Texts demonstrate progression. Books comprise a series of parts, chapters and sections,

which together create a sense of a coherent whole. The linearity of textbooks help create this sense of completeness: a book should be read in numerical sequence; chapter one before chapter seven. Therefore books can give a sense that nothing is missing *in the text* (Thornton, 1988). Books and universal literacy, I suggest, were one way in which traditional medicine in southern Vietnam could change from its problematic former guise as a “bit of this and a bit of that” (Truong Thin, 1984:29) into a new and coherent people’s medicine.

Additionally, an expressed intent of pedagogy at the Institute was to be standardisation of teaching for students in the city, the south of Vietnam and for attending internationals (Traditional Medicine Institute, n.d.). Hsu (1999) called college education ‘standardising’ because she understood the practice to be one of monopolisation. An ex-employee of the Institute described teaching during his time there in similar terms: all students learnt the *same*. Dr Truong Thin was director at the time of the speaker’s involvement with Institute. My interlocutor, here, characterised teaching under Dr Truong Thin as a form of monopolisation by the Five Phases style.

Teaching at the Institute was systematic... [Truong Thin’s] technique was very good... but under his administration everyone studied the same technique. Dr Truong Thin likes the Five Phases (*ngũ hành*). Dr Thin’s style links Phase to function. For example, the phase Wood is about emotion: if paralysis exists in the body, it’s a Wood deficiency. The function of Fire phase is heat so if the body is too hot, like a drug addict’s body has too much heat because of the drugs, then Fire is in excess; or if a person is cold all the time then they have a Fire deficiency. The function of Earth phase is sweat or pee or periods or diarrhoea... excretions, so if Earth is in excess you may have diarrhoea or if a patient can’t sweat then Earth is deficient. The phase of Metal absorbs. When we eat and can’t digest and get bloating and gas and so on, then Metal is weak or deficient. Or if someone is hungry all the time, the Metal function is in excess. The Water function is to restore, so if Water is deficient, a person eats but his body can’t restore his strength, or if obese the body holds too much, so Water is said to be in excess. Dr Thin wants to balance five functions in each channel. This method

seems simple. But sometimes a patient comes and you can't differentiate the function issue in the channel. Like chronic fatigue, perhaps we can't find a function. Dr Truong Thin's style is clear for people who come in and, say, are too hot, like hives makes a person too hot. Otherwise we need a different protocol... but maybe I don't know Thin's style deeply enough because I can't use it in all circumstances.

When an ex-Institute employee characterised teaching as a practice of domination by one acupuncture style, he judged singularising practices to be negative. Elizabeth Dunn (2005) similarly argued that standardisation of meat production in post-socialist Poland eliminated diversity. Dunn understood standardisation as a practice of exclusion: the reduction of difference excluded small farmers and valorised industrial food production techniques. At the Institute, only one acupuncture technique was taught but, my interlocutor suggested, knowing only one technique could mean that a practitioner runs out of clinical solutions and patients would therefore leave un-assisted. Negative outcomes were borne inequitably by certain persons. For Dunn (2005), smallholder farmers lost out under standardisation; at the Institute, patients were affected. As in Dunn, one agent dominated. The director's technique, not others, was taught at the Traditional Medicine Institute. Standardisation is often understood in this way, as a singularising practice which ejects diversity in favour of homogeneity (challenged in Lampland & Star, 2009; Latour, 2005).

However, there appeared to be limits on the Institute director's ability to dominate teaching and therefore a limitation on the homogeneity of a 'standard' acupuncture. My interlocutor continued: "at the Institute, the staff didn't train deeply in Dr Thin's style; the staff have their own style and they practice that style at the Institute... so when Dr Thin comes in as the director, the staff don't want necessarily learn something new." Since Institute staff had learnt their own techniques and may not learn those of a new director during senior institutional staff change, there was an implication that at least two techniques were taught: that of the director through

curricula and those of teachers through classroom practices⁶. Standardisation did not homogenise since the director could not unilaterally enforce teaching of his technique. Curricula at the Institute were an attempt to create a common acupuncture for those who studied and worked there but the Institute could not create an homogenous acupuncture in southern Vietnam, as the rest of this thesis will continue to show.

Standardisation can also be understood positively, since by rendering diversity into commonality, standardised curricula can enable communication. In Andrew Lakoff's work (2006), standards reduce diversity locally in the interests of increased mobility and convertibility globally. In the next chapter, I will discuss four acupuncture objects called acupoints, channels, Organs and qi. They are presented in textbooks and posters as unproblematic facts, being stabilised and known. However, I will argue that these were anything but stable. Points were agile, Organs were disputed and qi had many interpretations. In that the Institute sought to standardise teaching for many groups, being "*huong y*, doctors of traditional medicine in the south, foreign students, staff of the Institute" (Traditional Medicine Institute, n.d.), then standardisation could create commonality for communicability. The Institute received French and English speaking foreign students for short-term residencies as part of their acupuncture training in Europe. Students took private classes and toured wards with bilingual or trilingual staff. When two practitioners from different countries met and talked, they could share meaning. If they had both learnt a circulating standard of referring to points as channel-numbers, for example, as Heart-4 or Lung-5, they could understand where certain needling sites were located on a patient body. They could understand an acupoint as, say, Liver-4 and have a vocabulary to talk with each other. They could make an assumption, based on a common acupuncture language, that such an acupoint was located in an expectable place and would know, without having to negotiate at the time of their encounter, whether they were talking about liver anatomical organ, or Liver Organ, or liver organ-channel (see chapter two).

⁶ Hsu also noted that her two teachers instructing at the government college did not teach uniformly (see 1999:169).

However, this form of communication is only possible if an acupuncture language continues to be shared. One evening while on an acupuncture charity mission, I watched two technicians sit over their notebooks and copied textbook pages which listed acupoint names alphabetically. One had finished study two years previous and worked out of her home. One was a student just about to finish his training programme at the Institute. Coming over to sit with me, the more experienced technician started laughing. She laughed that her companion had been studying point names and locations for nearly three years but still could not find many of them. “It’s easy for him to forget them,” she giggled. Practising standardisation was a constant work of keeping up, without which commonality disintegrated.

Trading Legality

Students participating in the technician training programme at the Institute were awarded a credential on completion but the Institute was not the only site of acupuncture learning in HCMC. Attending acupuncture classes at the Institute to obtain an institutional credential was a practice that translated a lay person into a legal professional in the sense of obtaining a government approved training certificate recognised by the Department of Health, who regulated medical practice. However, making a living in acupuncture practice and owning a busy private clinic with a steady stream of patients due to one’s fame (see chapter five) did not require that a practitioner be legal and be educated at the Institute. I met practitioners who had learnt acupuncture in other places and through different methods. One contact learnt with a private teacher, who was the daughter of his father’s close friend. She lectured to him in the mornings and he accompanied her during clinical activities every afternoon. Practitioners were still able to learn within the household (*gia truyền*)⁷ where parents taught sons and daughters their medical secrets, sometimes through hand-written, private books maintained by the family. This mode of learning took place in families who publically offered acupuncture medicine as well as those households who only used the information to assist household members. Acupuncture teaching also took place in Buddhist pagodas by both government

⁷ I emphasise household not family. I came to know family in Vietnam as a genetic construct whereas *gia truyền* could refer to a place where people lived and learnt together not necessarily being genetically related.

certified and uncertified experienced practitioners. Bui suggests that a generic category of 'traditional medicine practitioners' can be disaggregated into three different groups: elder practitioners who had been trained in classical traditional medical techniques with a classical theoretical and philosophical base; those who had received training at traditional medicine faculties of a medical college or a secondary school of traditional medicine and finally, those who had received no formal training but had acquired knowledge and experience through apprenticeships (Bui, 1999:34-36).

Licences, however, divided acupuncturists into two groups: those who were legal and those who were not. Institute attendance rendered a student as a credential holder and therefore, potentially legal. Wahlberg (2003, 2006) argues that credentials, medical schools, licences and government regulations should be considered practices which divided persons. Creation of credentialing and licensing procedures in post-war southern Vietnam produced a division of persons, between those who had obtained a legal right to practice acupuncture and those who had not. Legality was not addressed to acupuncture techniques. After studying government-approved curricula at the Institute, graduate students could take up non-government approved acupuncture training elsewhere without endangering their legal right to practice. A credential and a licence came to have a complex relationship with a person. For Wahlberg (*ibid.*), these were practices, as well as things, which witnessed a named holder as a safe, competent and efficacious practitioner in the service of a public health conceived as biopolitics, which sought to eliminate risks to the lives of a population (Schlecker, 2007) who were ignorant (Gastaldo, 1997) and potentially irrational (Adams, 2002). Without a credential and a licence, no such claims could be made. These pieces of paper exercised division.

These pieces of paper were ambiguous things in HCMC. While I agree with Wahlberg that credentials and licenses did divide, these could not unproblematically validate technical competency and therapeutic efficacy. During lunch with a female doctor-acupuncturist, talk came around to building up a private practice. "It's not polite to ask to see a doctor's qualification in Vietnam," she explained in English, "that's not our culture... if patients get a successful treatment from you, then they will believe in you and refer you to others. They do not look at your qualification."

Certainly practitioners without credentials were considered efficacious and attained durable reputation through patient-to-patient referrals. Yet credentials and licences appeared to confer status. University students explained how their family was very proud of their soon to be *sĩ* status meaning that the holder became an intellectual. Experienced Hoa (see chapter six) styled himself *đông y sĩ* claiming status as an intellectual. People respected a doctor, said doctors, because they had gone to university and obtained a credential. Having a credential appeared to validate attendance at a university and represented wealth and status, or social capital (Bourdieu, 1977), since it takes much resources to get a child to university.

However, intense gossip surrounded the authenticity of such pieces of paper. It was *said to be* easy to bribe a teacher to pass an exam. Stories circulated in personal networks that university students offered money to teachers to ‘pass’ exams regardless of performance. It was easy to ‘rent’ the name of a doctor to apply to the Department of Health to open a private clinic, interlocutors exclaimed. Those who had no credentials and therefore could not legally, in the strict letter of law, apply for a medical licence could alternatively ‘rent’ another’s credential. Such a person, who did have the appropriate piece of paper, was paid to put their name on an application file. Legal regulations explicitly state fines for such activities. It was easy to claim to have been educated but who would know whether the claimant had actually completed an education honestly? An overseas Vietnamese doctor, in HCMC to learn acupuncture, believed that a recent change in acupuncture was the Institute education. Students could now go to a college to learn whereas in the past a genealogy of masters had been important. “In the past, the genealogy acted as a practitioner’s credential,” she suggested, being his or her authority to practice not the government licence. “The more western people in Vietnam become,” this overseas Vietnamese speaker argued, “the more they like certificates – but this does not mean knowledge.” Credentials from the Institute where one pays to learn were suspect because teaching may be incomplete. Patients and prospective patients, she generalised, “would know the old masters. If a practitioner was from a household of practitioners or had been accepted into a household it means that complete knowledge has been taught.” These claims and counterclaims are interesting but even more important is that these rumours circulated in personal networks (*à la* Granovetter) which escalated, translated and transformed circulating content.

Credentials and licences therefore divided as claimed by Wahlberg (2003, 2006) but were controversial. Credentials were translated by interlocutors not as competency or efficacy but as a practice of legality; of taking account of the letter of the law.

Given that credentials were so ambiguous and admittedly not necessary to becoming a successful practitioner, it begs a question of why students bothered to study at the Institute at all. The Institute was access to an acupuncture education, especially required if a student did not have the necessary direct personal connections to teachers or to connections of teachers. Also, in that the Institute provided a common education, this could act as a communication tool for additional training in other places. Additionally, without a licence no Vietnamese citizen or foreigner could practice legally, which could limit success. If a practitioner was mobile, meaning he had no fixed address treatment room, I speculate that a credential and licence were less important since a volume of patients were distributed; the volume of one's success, which could be considerable, was dispersed. However, for a static private clinic address, success coalesced in one place. A licensed interlocutor explained that at some point a clinic's success in attracting patients would irritate the neighbours. "In Vietnam, if you keep a small treatment room for example, around 10 patients a day and don't disturb the neighbours," a practitioner did not have to worry. However, with too many patients, "they block the street with their motorbikes so the neighbours get annoyed." Irritated neighbours would call the local branch of the Department of Health. An official would check out the address and check whether the individual had a current licence and met other regulations. Licence check at that time could become an opportunity to levy bribes on a practitioner, making the need for personal connections in the local health office significant in order to avoid such levies. If you were a practitioner without the appropriate personal connections, uncertainty could be mitigated by schooling at the Institute.

The Department of Health processed and validated licence applications in a process that was to be experienced as homogeneous by all applicants. To register, an applicant was required to submit a file to the local office of the Department of Health in the district ward in which she intended to open a treatment room. This file should include the following:

- The application form;

- Valid copies of professional diploma certificates;
- CV certified by the People's Committees of the ward where the applicant resided;
- A health examination paper certifying good health for professional practice;
- Written certification of having practiced at a traditional medicine establishment;
- Written commitment to strictly observe the Law and relevant professional regulations;
- Copy of personal identity card and right to reside in the city evidenced by a photocopy of their household registration book;
- Two portrait photos.

The regulations also stipulated that files would be processed within 30 days and cash fines from 1 million to 3 million VND would be levied for the use of expired licences and hiring or leasing out of professional credentials (Government of Vietnam, 2003). Licences were valid for up to five years, after which time the applicant may extend or renew. Licence numbers were often, but not always, printed on business cards if the practitioner used them and on outdoor signage above a static clinic entrance. File processing included a site visit by a Department of Health official to check that a site met regulations, for example, on sanitary space, signage and advertisement of treatment costs. Interlocutors expected that if bribes were not offered, since they were never explicitly requested, problems would be 'found' even if there were none. Bribes also provided an opportunity not to have to deal with regulations. Many networks are now visible: local government policing of the population through city residency rights and identity cards; regulation documents and bureaucratic forms; a professional credentialing institution called the Traditional Medicine Institute and person to person networks. These are the networks in which city residents lived.

Applying for a licence was an obligatory point of passage (Callon, 1999) to being legal. Lay citizens were gathered into an institution, rendered as students and, by completing attendance, were awarded a credential which participated thereafter in a person's professional transformation. Particularly, the credential and not the person must get together with other documents to obtain a further piece of paper known as an acupuncture licence. Getting a licence was set out in government regulations as a

process: gather this, obtain that, sign the other, take it here and wait for a short time. Regulations set out a rational and linear process with a start and end point, obligations and expectations and rewards and punishments. Licensing was optional for those who, for whatever reason, did not seek legality. For those who did not have the appropriate credential, were unable to rent a credential or did not wish to train/retrain at the Institute to obtain it, practising illegally was obligatory. For an experienced practitioner in Dong Nai province, licence renewal was no problem, she claimed, because she had undertaken the harder work of first-time application previously. For two blind practitioners, gaining a licence was “difficult”. Hoa, in an interview, glossed the license application process as “the local office made lots of difficulties for me.” When he applied in the late 1980s, he remarked that the government “was making life difficult for everyone not just blind people.” Hoa’s application to the local Department of Health office had taken so long to process, that he studied Vietnamese literature in order to enter teaching but was finally granted a licence as a ‘grandfather right’, that is, he had been doing acupuncture for so long his experience became his licence.

In HCMC, credentials and licences appeared to be acting differently than expected. In many accounts, credentials are witnesses to a person having consumed particular knowledge, knowledge being conceived as a thing (Pavlin, Svetlik, & Evetts, 2010); or permission assigned to a person to do something (Pfadenhauer, 2006). When a licence application was tied to a particular credential, a credential was proof of competency, in the sense of ability to perform certain acts (*ibid.*). Credentials have also been used as metaphor to talk about authenticators of identity within a bureaucratic system (Mitchell, 1994; Morgan, 2003; Schlecker, 2007) with which to make claims on that system. For Didier Fassin and Estelle D’Hallusin (2005), medical certificates were proofs of the highest truth, more truthful than oral narratives by asylum seekers, in part because writing was assumed to be more transparent than speech (Cody, 2009). In these texts, pieces of paper (certificates) with a name on it, is coordinated with a body that also has a name. These accounts create an assemblage between a body which did something, in my case attended a training programme, a piece of paper, a name, and a body which seeks to do something: in my case, practice acupuncture. A name, a piece of paper and bodies are all able to replace each other in different situations. A credential with a name on

it in a medical licence application file in HCMC took the place of an oral testimony that a named person had attended an appropriate training course. But in HCMC, credentials were ‘rented’ for licence applications so that the body which retrospectively experienced training was not the body which prospectively would practice medicine. Additionally, students may be able to bribe their teachers and teachers may not teach the complete course, therefore a credential could stand in-the-stead-of learning. Canh, a committed Catholic in his late thirties who had only recently finished his technician training, complained that students no longer wanted to learn – they just wanted a certificate. They left the Institute but still knew nothing. He complained that credentials took the place of learning: learning was erased, it did not take occur. Credentials appeared.

Credentials and licences appeared as entitlements to legality that were traded. Steve Fuller (2001) argues that credentials split knowledge, figured as freely circulating commodity, from either a person or a social network, that is, knowledge can be disembodied. Like Whalberg (2006), who argues that credentials could stand as a ‘credible witness’ (Shapin & Schaffer, 1985) to knowing, Fuller (2001) suggests that credentials erase a knowing human vessel, which would otherwise have ‘held’ this portable knowledge, out of certain encounters. For Fuller, credentials separate (“alienate”) knowing (“expertise”) from authority/legitimacy (“entitlement”) to do an act. Legitimacy to do acts becomes commodified within an Intellectual Property environment, he suggests. Credentials could not create a split between human and ‘knowledge’ in HCMC because knowledge was never disembodied. Knowledge was a network of interacting bodies, books and practices and was not something prior to their interactive work. However, the creation of a credentialing process did mean that legality itself could be traded. This trade was personalised, which might also be called, corruption.

Licences were traded in person networks. In “Vietnam it was difficult to obtain a licence to open a private clinic as a blind person,” explained Van (see chapter six), “because the blind are classified as invalids so people think we shouldn’t do acupuncture.” Van was a blind woman who was fluent in three languages and often used internet and voice-activated software to connect with online friends around the world. It was because of these fluencies that I met her. In law, there was no

injunction against blind people practicing acupuncture in Vietnam. However, bureaucratic process constituted an impenetrable barrier for her. “If a blind friend opened a treatment room, then it might take one or two years to get permission,” she explained. She did not want to wait that long so she “*châm cứu dạo*,” she laughed, just go around! She visited patients in their home rather than work out of a fixed address treatment room or clinic space. If she wanted to open her own clinic, she could ask her doctor friend B to use his name and if he agreed to ‘lend’, or ‘rent out’, his doctor’s degree she could open a place. B’s name would be the name on the application, so responsibility would belong to B for problems that might arise, such as “the place turns out not to be a clinic but a karaoke joint... so the room doesn’t treat patients but people sing karaoke” *<what other kind of problems might come up?>* “other problems might be that the patient gets a treatment and dies so it means that B takes responsibility” for the possible repercussions but the costs of the business, including having to pay taxes, she would have to take care of these herself. If she opened her own clinic without a licence but was unable to rent a qualification from a doctor, she was sure that she would have to offer cash bribes to the district Department of Health officials and she was opposed to doing that.

An important aspect here is expectation. Van acted on expectation; she could have applied for a licence but she expected problems with the Department of Health because of her un-sightedness therefore she did not try. She felt afraid to approach bureaucracy without personal connections; without friends and contacts on staff to “help” her out in such a jungle. Gainsborough likewise argues that government departments make “life difficult for residents... who had to run the gauntlet of numerous offices to complete simple procedures... it is nearly impossible to determine where bureaucratic interests end and business [personal] interests begin” (2005:375). McNally (2002) concludes in similar vein on his discussion of beer joints (*bia ôm*) in Hanoi. “Help” for Van meant that an official would accept her application without making life difficult for her. Being difficult could entail requesting additional paperwork or leaving her application at the bottom of pile that never reduced. “Help” could mean not delaying an application because the file did not contain cash or not waiting for cash ‘tips’ to grant a licence. She acted in accordance with expectation rather than having experienced directly, rejection or difficulties. Media circulation of stories, in printed press and gossip in personal networks, helped create

these expectations. While cash bribes can be seen as an attempt to reduce presumed high uncertainty in dealing with officialdom, offering cash tips to officials can also be understood as generating such uncertainty in the first place.

Before finishing, I need to emphasise that credentials and licences were multiple. As Mol (2002) points out, things are not always the same, they differ by how they are practiced. In some practices, credentials and licences did act as proofs of attendance at a training course, and the name attached to a body and the name on two pieces of paper coordinated the body which went onto practice medicine on the general public. But this was not always the case and it is the not-quite-knowing which made licences and credentials ambiguous in HCMC.

Conclusion

After 1975 in HCMC, acupuncture changed. A New Medicine was taught at the new Traditional Medicine Institute as a collaborative arrangement between curricula, pedagogy and licensing. This collaboration produced acupuncture technicians in greater numbers, being the shape of what Whalberg (2006) labels, the professionalisation of traditional medicine in Vietnam.

The Traditional Medicine Institute was set up to guide education, training and practice of the new people's medicine in the south of Vietnam. Acupuncture taught at the Institute was characterised as a unification of selected aspects of science with selected truths of the 'old people'. Diagnosing and treating illness could then stand on what was argued to be a proven theoretical foundation. Therapeutic effect was to be validated through neutral experimentation which was revealed by the infallible eye of technologically complex machineries. The new pedagogy valorised medical literacy and book learning as a means by which the New Medicine could be theoretically rigorous and more comprehensively prepare a student for clinical practice. The new pedagogy valued mass participation by students in the same place. Under the New Medicine, no "secrets" would be kept: students could see and hear what other students were learning. As emphasised in accounts of the heroic Hai Thuong Lan Ong, teaching was widely available and not restricted to pagodas or households for localised gain. Notable in Vietnam is how technician training democratised access to

an acupuncture education and professional life in clinical acupuncture when compared to elitist education in South Korea, the USA and Singapore. In these countries, students must enter an expensive university degree programme in order to become an acupuncturist. The Vietnamese people's medicine was also one in which a particular form of credentials and licences appeared. Only credentials issued by the Institute could be used to apply for a licence from the Department of Health to legally offer acupuncture to the public. While licenses are often understood as validations, in HCMC these apparently innocuous pieces of paper appeared as opportunities for trade. Bribes, expectations that bribes were expected and the selling and renting of credentials to assist licence applications meant that credentials and licences could not consistently validate participation in a medical programme at a teaching institution. Licensing appears to have created a bureaucratic point of passage that could be manipulated by personal networks. For acupuncture, such a trade in legality meant that competency and legality were detached from each other. Credentials and licences could speak only to legality. Competent acupuncture techniques were sought elsewhere (see chapter three).

The reality of acupuncture in HCMC was not science *or* tradition, rather these were combined; it was not only curricula but was how teaching was practiced; and was not restricted to pedagogy but integrated licensing as well. Institute teaching made claims to completeness, or more correctly, to a sense that nothing else was required. That claim was rejected by students of a private acupuncture class in HCMC (discussed in chapter three). What is interesting, however, is that teaching methods used at the Institute were also taken up in that classroom. Training at the Institute could be said to model pedagogy so that others could repeat it. I take repetition in the Deleuzian (1994) sense in which each repetition is never an exact duplication. The Institute modelled the use of medical literacy, devalued secrecy and created an acupuncture vocabulary that could generate communicability between practitioners, although commonality had to be worked at. With a common acupuncture vocabulary, agreement may be more likely and through consensus, matters of fact can be generated. I turn next to the construction of acupuncture facts.

2. Constructing Acupuncture Objects

At the Traditional Medicine Institute, a new acupuncture medicine was expressly envisaged as a standard one. Diversity was squeezed so that commonality of understanding could be pursued. Standardisation can look like imposition but, for truth to arise in acupuncture, consensus was required. Four medical objects¹ were taught as fundamental to the work of acupuncture. These were: acupoints, channels, Organs and qi. Treatment was enabled by these medical objects which were empirically on, and interiorised within, a human body conceived as capable of self-regulation. Acupuncturists act *on* these empirical medical objects to intervene in manifestations of illness. In other accounts of acupuncture (for example, Birch & Felt, 1999; Kim, 2006; Scheid, 2002; Zhan, 2009b) these objects appear as extant facts which are unremarkable and unremarked upon. I question this and will show that these objects were variably factual: they were in a kind of “facticity” (Latour & Woolgar, 1979:83) spectrum. I will argue that textbooks, picture media and people were all doing acupuncture and it is only when a consensus between these was generated that medical objects passed as factual.

The relations between these four acupuncture objects produced a particular kind of body. Learning about acupoints, channels, Organs and qi is early work for any aspiring acupuncturist. Students at the Traditional Medicine Institute did not meet patients until later in their studies, so when first approaching acupuncture they approached a technical web of textbooks, oral lectures and diagrammatic representations. A human body was ‘underneath’, it was inscribed with points, channels lined it, Organs were highlighted in it and qi moved autonomously into, around and out of it. Together with these acupuncture objects, a patient and an acupuncturist interact so that treatment takes place.

¹ See also Farquhar (1991:370).

In this chapter, the causes of illness and the nature of diseases are secondary to a technical knowledge required to intervene in manifestations of illness. Practitioners were interested in the *how* of intervention; the techniques and technicalities of therapy. How these four acupuncture objects networked together partly constituted that intervention. In the interests of clarity, I have bracketed out other issues that acupuncturists would consider essential in treatment such as needling technique, needle metal qualities, variation in acupoint stimulation techniques and synergy with other therapies.

Factual Acupoints

“There are around 1800 acupuncture points in the human body,” a technician told me when we first met². “Actually, it’s not possible to remember them all.” He forgot points he used less commonly. Acupoints were named in Sino-Vietnamese³ language. For example, the last point of the Bladder channel on the outer corner of the little toe’s nail is called *Chí Âm* (Guiding Yin) otherwise known as Bladder Channel point number 67. *Dương Cốc* (Yang Ravine) at the side of the inner wrist is named in English, Small Intestine-5. *Khúc Trì* (Pool at the Crook) at the elbow is also known as Large Intestine-11. Sino-Vietnamese point names describe how qi moves at each point location. English nomenclature uses a channel name-point number combination that is quicker and easier to learn but less informative about qi. In Ho Chi Minh City, acupuncture media and textbooks differed in this regard. Acupuncture posters only used names but copied handouts of uncited published texts mapped names to a channel name-point number combination. Technicians were able to use this channel-number convention to discuss points. For example, two practitioners discussed an acupuncture prescription taught by an overseas Vietnamese acupuncturist. “What point was that?” one asked. The other checked his jotter and body location, “*Bang*⁴ 2,” he advised, rather than using its name *Toàn trúc*, waiting for his fellow student to note it down, “*Bang* 9,” he continued rather than using its name *Ngọc Châm*. While points were taught using names, technicians were

² Compare Le Quy Nguu – there are 1,031 points in the body (Le, 1993).

³ Post 1975, Vietnamese language was nationalised in the south of Vietnam, meaning that vocabulary changed and many older Chinese influenced words were discarded. In acupuncture textbooks and teaching discussion, use was made of the older vocabulary hence Sino-Vietnamese can be understood in this thesis as a specialised disciplinary language.

⁴ Short for *Bang Quang*, Bladder.

also used channel-number combinations to refer to points. Points in a channel-number system become servants of a channel. With their own names, points are independent individuals.

In HCMC, acupuncture points, channels and anatomical organs were figured through a series of five acupuncture posters, three of which commonly hung in the private clinics I frequented. These were cheaply available from any bookshop in the city. These posters are dated from 2001 and are copies of Chinese media published in Vietnam. I discuss these posters because they were displayed in numerous clinics and treatment rooms even in clinical spaces where acupuncture was not on offer. A provider of blood-letting, cupping and Classic of Changes (known in English as the *I Ching*) interpretation, paraded these posters on an otherwise bare wall. For those who knew nothing about acupuncture, a first visit to a treatment room would encounter this very visible exhibition of what acupuncture was.

The posters, which I will describe below, were not created in Vietnam thus it could be argued that they figured a particularly Chinese acupuncture. But that these posters were sourced from China (possibly Hong Kong), copied into Vietnamese and circulated throughout the city, was not a problem for interlocutors. Acupuncture media was scarce in HCMC and copying of available materials was a common activity. Interlocutors were keen to get their hands on imported media even if they could not read those languages. Posters were a clear example of copying foreign media that was then circulated for local use. Vietnamese acupuncturists living overseas imported publications that were in either English or Vietnamese language, during their annual return at Lunar New Year. These materials were then copied by machine and not always translated. Students also copied pages from Le Quy Nguu's book (1993), which they circulated by photocopying for fellow students. Photocopy shops were strewn around colleges and universities and can be quickly found in any part of the city. Copied pages of uncited textbooks, copies of complete textbooks and copied and overwritten acupuncture posters were circulated and read, sometimes annotated and then redistributed, so taking on a life of their own. Collectively, with class lectures, discussions between colleagues and experiences in the clinic, they were part of the figuring and imaging of acupuncture in Vietnam. By their ease of circulation, they formed new syntheses with other acupuncture media. These new

configurations were not necessarily beholden to past uses and meanings (Tsing, 2005).

These flat, coloured posters – valuable to the sighted – depict a tall, naked body. The male muscular frame with flaccid penis on display (so gendered but not sexualised) and shaved head draws to mind Kim Taylor’s argument that the Maoist synthesis of a new acupuncture grew out of war (K. Taylor, 2005). This male, fighting fit body poses in triplicate – front, back and side. On his rosy skin are drawn perfectly straight lines, in red and black ink, connecting points by dashed and block parallel lines. Two of these posters present a dual body. On one side of the body, lines march up and down from the toes to the head and from the finger tips to the shoulder over complete skin. The other half shows acupoints over clearly depicted bones and viscera, the bones of the feet, lower leg, thigh, pelvis and spine are coloured, shaded and solid as if on the surface of the body. Under the ribcage, a viewer can clearly make out anatomical organs – lung, kidney and intestines are drawn on one poster and intestines, stomach and liver on the other. In interlocutors’ clinical spaces, these two posters usually hung with a third in which the male model body posed side-on. The bones of the leg and pelvis were traced lightly under rosy coloured skin (see figure three).

These posters are named in Vietnamese as *A Picture of Acupuncture*, under which sit Chinese ideographic characters in complex character, characters in use before the PRC simplified its writing systems in the 1950s⁵, and a translation of those characters into Vietnamese. Acupoint and channel names are dually named in Vietnamese and indistinct ideograph. The ideographic print is intelligible but since none of the acupuncturists I worked with could read any Chinese languages, these scripts created a popular association between acupuncture and China. Vietnamese language in roman scripts (*quốc ngữ*) were legible to the sighted because, while education in Vietnam probably did not reach universality as claimed by the Vietnamese Communist Party, horizontal educational infrastructure ensured that levels of Kinh literacy rocketed in post-war southern Vietnam.

⁵ Daniel Sanderson, personal communication.

Twelve named channels and two named extraordinary vessels are shown by posters as well as textbooks. That is, textbooks and the posters cohere on this point (Q. N. Le, 1993; Pham & Dao, 1992; Truong Thin, 1984). More unusually, discussion of six other extraordinary vessels was taken up by Dr Truong Thin in his philosophical treatise on acupuncture (c.f. Birch & Felt, 1999, the number of extraordinary vessels is debatable). The posters align acupoints cleanly as straight channels. Acupuncture points that stray from channel regimentation, or New Points “discovered under the intellectual horizon of modern medicine” (Q. N. Le, 1993:7), are not figured on these posters. In the often-copied Le text, points are more numerous and are not limited to picking out a linear canal on the body, called a channel. On the posters, all lines representing channels are straight, as if drawn by a ruler thereby “resembling the front lines of an army” (K. Taylor, 2005:22). Dr Truong Thin complains in his 1984 text that thinking of channels as a perpendicular line, which links points, is too simplistic. Although he is not referencing the posters directly, he refers to what the posters were able to convey: a sense of regimented linearity in channel figuration. “Surely channels are not like one simple ‘going-through’ [points] as drawn in almost all acupuncture books, but are complicated routes penetrating many parts of visceral-physiology” (Truong Thin, 1984:151). But the posters did not figure this “complicated route” (*ibid.*) envisaged by Truong Thin. They encourage acupoints and channels to align. Channels link into anatomically located organs creating a particular vision of acupuncture as aligned points and straight channels connecting anatomical organs. I continue discussion on anatomical organs later in the chapter.

Posters perform acupoints as measureable distances between notable body parts. From the ankle to the middle of the back of the knee is measured in 16 sections, asserted by a straight ruler drawn beside the human body model. From below the knee to the ankle is ruled as 13 sections and from the middle of the knee to the top of buttock measured as 19 sections. These rulers also set out lengths from the wrist to the elbow and from the elbow to the armpit. A human, adult body was measured and quantified (see figure three).

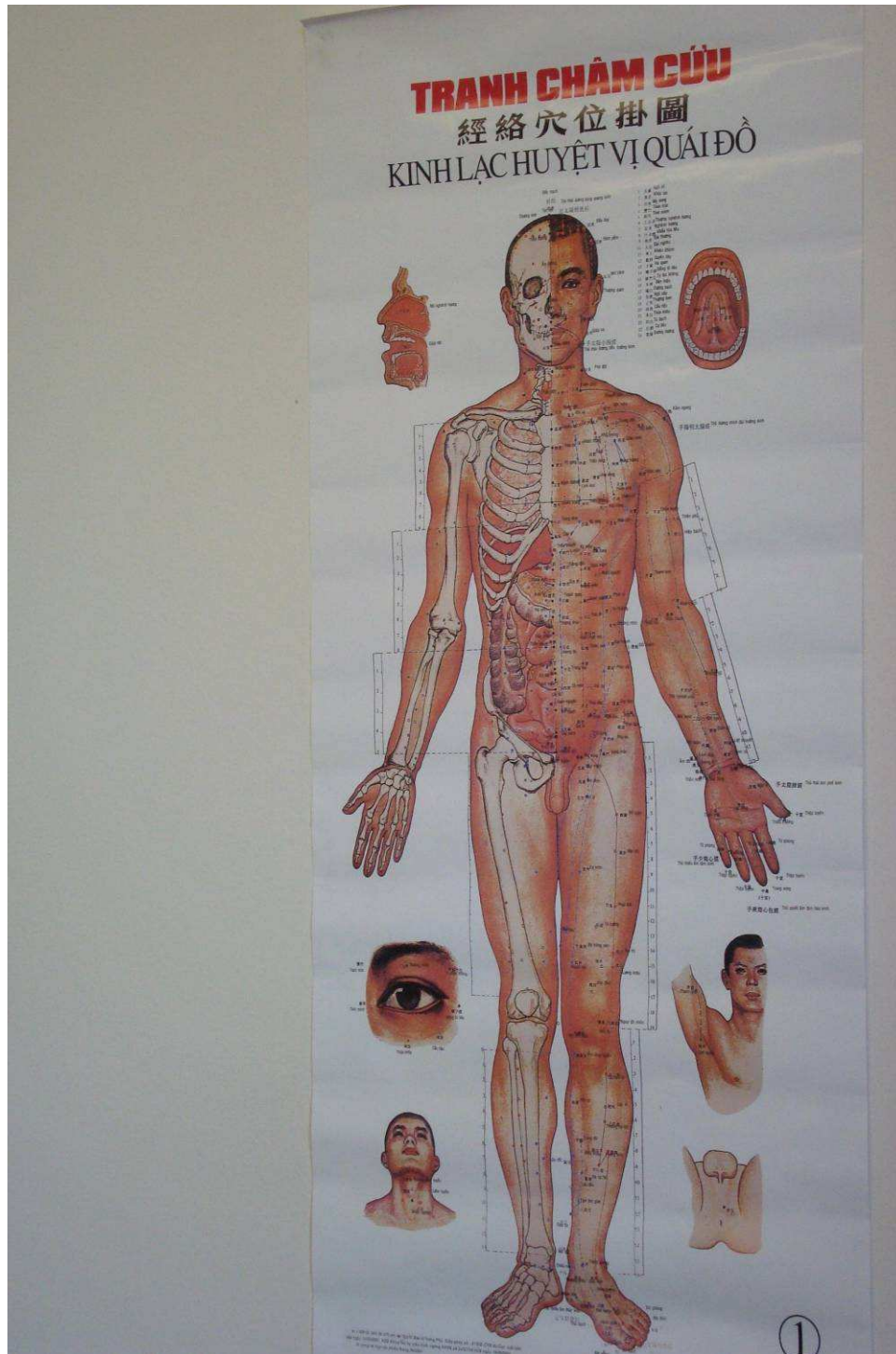


Figure 3: Technicalities in Acupuncture.

In HCMC, when learning to locate points, students triangulated body landmarks. To make measurements on a patient body, technicians could use their own fingers. A practitioner worked out where to treat lumbar pain, for instance, by using four fingers and measuring along a patient's lower spine. This has been described in textbooks as a 'cun' measurement. The width of a practitioner's own thumb was a

‘cun’; four fingers held closed together were three cun (Pham & Dao, 1992:71). Note that by creating a measurement that relies on the practitioner’s body, uniformity in measuring cannot be guaranteed. However, while experienced acupuncturists could quickly find needling locations by measuring with their fingers, sighted practitioners I knew did not seek these points out by measuring rather by looking. Technicians looked at a patient’s body and immediately needled. Acupoints of the main channels were there in the patient body, waiting to be targeted by a competent practitioner – they were not mobile.

Points could be targeted because points were understood as locations that did not move. They were enacted in clinical situations as static and accurate to the tip of an acupuncture needle. This was clarified for me in an incident that occurred during a charity acupuncture training session in 2008. The session was attended by blind and partially-sighted Vietnamese who practiced massage and acupressure for a living, a common profession for such ‘disabled’ people. I was helping out with four experienced technicians. A student had needled Kidney point on my outer ear. I went to ask a Saigon technician to check the needled location. She was near the others and a short argument ensued with the lead trainer, Danh. The argument was about whether the needle had been inserted into the right or wrong place. Had the novice needled the acupoint accurately and correctly? Kidney was taught by the same trainer as the highest point under the ridge of the ear, which was where the technician had first learnt it. But if the needle was a bit “off,” the doctor-acupuncturist explained, it was not a problem since “it’s like trying to find a point with a peanut and we move around the area of a point,” he illustrated by pecking a circle in the air with a sunflower seed he was about to eat. “But it’s the qi we want to move” (I discuss qi later in the chapter; here I focus on points). Danh explained that some points were taught at Tri State College, New York as having a greater (big points) or lesser (small points) diameter of needling. Needling within that greater or smaller location had the same therapeutic effect regardless of needling position within that enlarged point space. That is, points lost exact coordinates.

The loss of needle-tip accuracy of points was an anathema to the Saigon acupuncturists. Technicians learnt in class, could see on posters, read in textbooks and experienced treatment as fixed points with an exact location that could be

pinpointed. A point could be mapped because it was fixed, its location could be predicted. The technician wanted to needle the 'correct' point in the manner she had been taught. For her, there was no margin of error; the needle was either in a correct place or it was not. "Is this Kidney?" I asked another, demonstrating on his ear with an empty guide-tube in the location I had first learnt. "That's it," he agreed vehemently. The technician and the trainer were in conflict, two understandings collided and the technician dismissed (deleted) the trainer's comments. The trainer was wrong. Points were not big or small. They were needle-tip sized and required accuracy for their proper stimulation.

Acupoints were static, always in expectable locations and could be needled accurately by looking. Measuring and mapping point locations did not rely on rulers, be they a thing or a practitioner's fingers. They were enacted as if they were visible on a patient's body. Acupoints in clinical encounters were done as if they were on the superior skin surface. A recently qualified young technician enacted points in this way during a charitable medical mission when treating local patients for free. Voluntary medical service was common among the medical practitioners I knew. The reasons for volunteering were many: volunteering was a way to gain clinical experience; was often said to be a form of marketing for practitioners with a private practice; others who turned up did so 'to help the poor'; while others came along just to have fun. About eight technicians with friends had volunteered that day. Our destination was a local health-station. The place was a collection of featureless concrete buildings inside a spacious, walled compound, although the 'eastern' medical treatment was taking place in a smaller building at the farthest end from the main entrance. Young Anh turned up with a small briefcase in which he had packed a short-sleeved white coat; a stethoscope; tweezers; cotton wool in a small tin and an old vitamin tub that he used to dispose of dirty needles. He used an old cardboard box for dirty cotton-wool. He was the youngest acupuncture volunteer and had only recently gained his technician diploma.

When the volunteers got to the health-station, it was jam-packed with patients hanging around, waiting for checkups from white-coated doctors. A Master of *chích lể* was writing out prescription scripts to patients, who handed them over to his wife, son and daughter-in-law in the treatment room to carry out the cutting. In the largest

room, tonics and packaged medications were dispensed; in the smaller abortion room⁶, two patients were lying down on floor mats with in-sitting needles under a printed sheet of instructions to women on post-procedure care. I helped out Anh. Our room featured the usual three acupuncture posters. A glass cabinet held materia medica glass jars that were nearly empty and a scattering of small metallic boxes. The boxes were labelled with patient names and stored used acupuncture needles, cleaned for future use. Acupuncture needles were recycled until blunt. We did not use those needles, being visitors.

Anh got to work and began by directly asking patients where their pain was being experienced. He always wore rubber gloves while working and wiped the patient's skin with alcohol before inserting needles, using the cheaper, copper-hilted, Vietnamese-manufactured Tue Tinh brand. These needles were in common use. He did not prod around in the patient's body looking for the point of pain, neither did he palpate the patient's body as I have seen practitioners do in other situations and nor did he measure the patient's body with his fingers to triangulate point position. Rather he needled by looking. Moisture ran down his face all day. "It's hot!" he laughed. I followed him around the small space taking needles out, after which he checked the skin and dabbed cotton-wool on any blood that surfaced. We had seven patients. At one point, one patient lay on the bed, one sat on the edge of the bed and two were sitting on plastic stools. Others hung about by the door but since it was acupuncture we had to wait the local standard of 20 minutes for the needles to take effect. The authority of looking in clinical encounters is discussed later (see chapter four), here I wish to emphasise how acupoints as figured in posters and as enacted in clinical encounters cohered. They both agreed. Posters and practitioners "did" (Mol, 2002) points in a particular way. They performed points as if by merely looking at a body, figured on a poster or lying down in a clinical space, a sighted and competent practitioner could see those points.

The empiricism of points may sound innocuous, therefore to emphasise their static enactment, I will compare a technique in which points were slippery and mobile. Two doctor acupuncturists crouched over a prone patient lying on a mat in his

⁶ At time of writing, abortion is part of the government's reproductive health policy.

private rented room. Danh, the experienced trainer, was teaching a female acupuncture novice trigger point technique. Her previous acupuncture lessons had been at the Institute. “*Rather than* estimate that a particular acupoint is, for example, half way up the lower leg,” the male trainer instructed, “a point moves around,” so the female trainee should look for the knot or the obstruction *around* the place where she had been taught that a point ‘was’. That is, he offered a different way to conceive of points. They talked about points as channel-number combinations rather than using names, digging all the while into the groaning patient’s soft tissues to discover where the point was *really*. They spent a long time finding a muscle deep in the under armpit that knotted up “because of carpel tunnel”⁷, Danh explained. The trainer sketched a picture of the arm as if from a medical text book and shaded the muscle they were targeting – “this is what we are trying to hit,” he told her, using his pen to shade the area further, lying like a map on the chest of the prone patient. He said, “you really have to hit the right point or it will laugh at you.”

Stephen Birch (1999) argues that slippery trigger points are different types of points from channel points. Trigger point techniques were developed by Japanese acupuncture schools. What is interesting in the above example is that a Vietnam/American educated trainer enacted a moving point. For this trainer, triggering points meant discovering points anew each time he needed. Point locations were personal to each patient and to each patient at each particular treatment time so that points were always in a slightly different place. For technicians trained at the Traditional Medicine Institute in Saigon, however, stasis was an agreed characteristic of points. Many sources agreed: stasis was figured in posters, trapped in textbooks and enacted by a practice of mapping point location through measurement of anatomical coordinates. In HCMC, acupuncture points neither moved in time nor space.

However, there is nothing natural or given about static acupuncture points: they have to be continually made that way. For instance, in teaching points took on mobility; teachers taught points in slightly different places. Take Spirit Gate point on

⁷ Carpel Tunnel is often experienced as swelling, tingling, pain and numbness inside the wrist; also radiating and referred pain up the arm and into the shoulder.

the outer ear: I experienced under one teacher that its location could be found by imagining an eye of a fish on the outer ear to find the point, while a different teacher described its location as an apex of a triangle. And like that, the point moves, because between teachers, point location varied even if only in millimetres. A static exact location for an acupuncture point has to be continually produced and was done so through textbooks, posters, measurement and eyesight. Standardising point locations in technician training meant that variation in point location was reduced but not eliminated. Measuring bodies made them all, relatively, similar. Relative to a body landmark, or a practitioner's thumb-width, a certain acupoint could be found because points were in precise and unmoving places. Now it does not matter how different the numerous bodies of flesh appear; with regards to acupoint positioning, all adult bodies are the same. I use the word adult advisedly because children's bodies were never figured in textbooks and rarely made appearances as patients in clinics or treatment rooms.

Internationally, when acupuncturists from different educational experiences met, variation in point location became acute. An American acupuncturist made a presentation to the Traditional Medicine Institute staff about an American technique called NADA. She handed out post-cards showing the five point prescription. The staff muttered together about how the figured points seemed out of location and one in particular was in utterly the wrong place. Out and wrong require in and right to be known. The vice-director, after listening to her presentation, pointed out her error. In replying to her invitation for questions, the initial comments were corrections of her postcards: some of your points are in the wrong place. That is, points had taken on mobility – on the American's postcard, points appeared to migrate. Point locations were constantly worked at as absolutes: uncertainty had to be abolished before the staff would listen to the American's claims to know acupuncture. While practitioners also discussed needle insertion techniques and needle insertion/removal order, I have concentrated on points here because points are the point. In HCMC, there can be no knowing acupuncture without accurately knowing where the points are. To figure acupuncture points in an 'incorrect' location was to display a lack of professional technical knowledge.

Variable Channels

Channels focused qi through the body, that is, qi did not suffuse the body as if bathed in sunlight but followed what is termed in Vietnamese, ‘roads’ (Le & Luong, 2003) or in English, ‘channels’ or in French, ‘meridians’ – the lines of longitude that segmented a spherical globe (Lavier, 1966). In Vietnamese, a metaphor of a watercourse is also used. Fourteen regimented ‘watercourses’ are depicted on the poster set introduced in the last section, twelve main or primary channels with two extraordinary vessels. All these channels have their own associated acupuncture points. The posters figure channels as straight and parallel connectors of named acupoints. Lines representing channels on the posters are never horizontal, meaning that the posters do not ‘recognise’ smaller connecting channels networking the body circulating qi, as depicted in a reference text by British acupuncturists Peter Deadman & Mazin Al Khafaji (1998:35) and discussed by Truong Thin (1984). Channels are named for their connecting Organ. Bladder channel is so called because stimulation of that channel creates a corresponding effect in the Organ named Bladder. Textbooks and posters additionally label channels for their correspondence with yinyang and a body part; for example, Hand Lung Channel is a Greater Yin channel. Leg Gallbladder Channel is a Lesser Yang channel; greater yin being the fattest, black, righted-sided yin, which transforms into thinner, white, left-sided yang (see figure four).

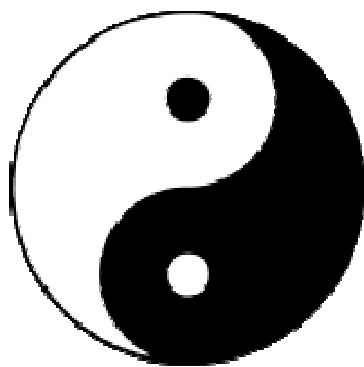


Figure 4: The *Thái Cực*.

Acupuncture channels dissect the human body⁸. Dr Truong Thin, in his 1984 book, draws six yin channels that march on the right side of the body and six yang channels on the left. The three yin channels of the hand are Lung, Pericardium and Heart and the three yin leg channels are Liver, Spleen and Kidney, which are drawn as flowing lines devoid of points. The three yang leg channels flow between the eye over the skull to the lower body are Stomach, Gallbladder and Bladder and three hand yang channels are traced as a line from the fingers to the head being Small Intestine, Triple Burner and Large Intestine (Truong Thin, 1984:149-150). A human body under this nomenclature is cut in half at the waist into upper and lower, and half again into two sides being left and right. The other two main channels always figured on posters and in textbooks are not named roads or courses but take the appellation *mach*, also used to talk about perceiving or taking pulse (*xem mach*). Governing Vessel⁹ is drawn as a line from the very base of the spine along the spinal column to the junction of the upper lip and gum. Conception Vessel, likewise, is drawn as a straight line through the front centre of the body to the chin where it meets with the Governing Vessel when a human mouth closes. “This point is very important in yoga,” nodded a recently qualified technician. Governing and Conception vessels create a complete upper body circle. A body created by channels was in pieces, which coming together made a whole. Two vessels with twelve channels always figured on diagrams and texts as routes that connect points. The other extraordinary vessels, which often disappear in texts, have no personally associated channel points. In HCMC, it was not necessary to know these objects, since points were the locus of therapeutic intervention.

While there was agreement that fourteen independent channels existed, what these channels were was more debateable. Textbooks, posters and teachers agreed that channels were fourteen in number. New Points may not be channel participants but this did not change the fact of 14 channels. Consensus between different sources produced “facticity” (Latour & Woolgar, 1979) about their number. But what were channels? Were they structures that routed qi, or were they the retrospective routes that qi had taken while passing through the body? As qi routes, they were

⁸ Animal acupuncture is increasingly common in Australia, UK and China but my interlocutors claimed they were not aware of acupuncture as a therapeutic for animals in Vietnam.

⁹ Using Deadman & Al Khafaji (1998) translation.

independent of points. However, channels were figured in text and picture media as the outcome of linking points so can also be understood as textual effect of using a ruler to draw a straight line between points on paper. Additionally, however, channels in some teaching texts were constructed as composite organ-channels.

In some places, channels and organs amalgamated. Take as an example, Lung channel. A copied handout from an unnamed text book, which I obtained in 6 Qi private classes, is labelled as Hand Lung Channel of Greater Yin and is drawn as a straight line traversing a dotted, anatomical outline of two lung-bags. Triple Burner channel travels through a sketch of a stomach and curly intestines. The text that tells of Triple Burner channel refers to Triple Burner organ-channel as a linear line intersecting anatomically discrete organs. Triple Burner is interesting because it is said to have no biomedical named equivalent in the way the Lung or Liver organ-channel does (Maciocia, 1989). But in teaching materials circulated by Nguyen Phuong (see chapter three), Triple Burner is figured very clearly as a composite of two organs in the digestive system, the stomach and the intestines. It is interesting that Nguyen Phuong circulated such materials because he was very much aware of the confusion they helped create: between channels as independent entities or as composite organ-channels. He sought to resolve these confusions in early classes.

Points, organ-channels and the body were formed into relationships with each other with points as the fundament. Le Quy Nguu's textbook lists all known and named acupoints in roman alphabetical order, performs acupuncture as knowing and remembering all the points. The contents of the textbook are structured formulaically so that all acupoints can be discussed under the same rubric *viz*:

- Their names printed in Sino-Vietnamese name and handwritten in Chinese characters;
- Other Sino-Vietnamese names;
- Point number of a named organ-channel;
- Special notes;
- Description. 1. Location old days 2. Location nowadays¹⁰;

¹⁰ Again, point mobility is rendered visible.

- Treatment Effects 1. At the acupoint 2. Along the channel 3. General/systemic for the whole body;
- Clinical Applications. 1. Use old days 2. Use nowadays;
- Acupuncture method: 1. Needle angle and depth 2. Heat. 3. Duration of heat.

For example:

Cực Tuyền

Point number one of Heart Channel.

This point was formerly located at the artery of the arm between the tendons. To find the point these days, lift the arm up and trace a line across an armpit then press your finger on the fossa and fold of the arm pit. The point is behind two muscle groups.

(Accompanied by a sketch of bent muscular arm with a dot, representing an acupoint, above the crux of the under arm and armpit).

Treats: 1. Inflammation of articulation of the shoulder; inflammation of peri-articulation of the shoulder. 2. Heart attack (using the word *tim* not *tâm*) smarting pain in the ribs and chest so patient is unable to lift up arm. 3. Glandular tuberculosis.

Clinical use. 1. Combine with Lung-4 to help heart diseases, nausea and dyspepsia. 2. Combine with Conception Vessel-7 and Spleen-7 to manage heart attack; combine with Triple Burner-5 and Gallbladder-34 for side pain¹¹.

Acupuncture: 1. Needle straight to 1-1.5 cm depth, at that point the patient will feel tense or like an electric current has spread to anterior arm. 2. Moxa. 3. For 5-10 minutes. Pay attention! Avoid rolling the needle else the veins, artery and nerve in the armpit will be injured (Q. N. Le, 1993:64-65).

Notable in this textbook is that points and organ-channels are all contained within a body. These two acupuncture objects are always drawn inside an adult body outline. The skin binds a domain of medical intervention, being the human body. Entities

¹¹ The author used point names but I have translated by channel-number combination using the English convention.

that are present in and on the body are of interest. The skin likewise creates a boundary of what is not of interest. A notion that astronomy, for instance, might be important does not make an appearance in this technical medicine (c.f. Marr, 1987).

Analysis of Le's rubric shows how composite organ-channels are created. In the example above, acupuncture point names come first, given in three ways. Points have multiple names but form a single object. One object does not have to go under only one name. The acupoint is numbered as pertaining to an organ-channel. Sequential numbering is a technique that conveys continuity. An organ-channel has an agreed and fixed number of points: these are laid out from number one to the end number¹², collecting the channel into a coherent and holistic entity. This nomenclature form was adopted by the World Health Organization (WHO) Standardisation of Acupuncture Nomenclature working group in 1989. Numbered locations on an organ-channel route are now an international standard using English as the international communicating tool. *Cực Tuyền* can then be translated as HT1, Heart Meridian¹³- point number one. The WHO (1993) has argued that standardisation of acupuncture nomenclature and point locations can render research on clinical outcomes comparable between geographically distant trial locations. The WHO argues, as Lakoff (2006) explores, that even if standards reduce diversity in naming and locating points between countries, standardised points have increased mobility and convertibility for Random Control Trials (RCTs) globally.

In Le's passage above, acupoints are functional medical objects that can be prescriptively activated. The passage details the physiology of the needling vicinity, which is further taken account of in clinical notes. Physiology acts as a landmark to pin slippery points down to a needle-able location, but additionally, veins, muscles, arteries and nerves do not constitute an acupoint. An acupoint is an additional medical object in the human body. Point use attains prescription. For shoulder swelling, anatomical heart pain and glandular bacterial infection, needle the point called *Cực Tuyền*. The existence of these three medical conditions can be ascertained through various diagnostics but more significant is that these manifestations of

¹² It would be interesting to question why there are no acupoints numbered zero.

¹³ WHO Standard Nomenclature talks about meridians rather than channels.

illness are named. Potentially, a provider of this technical acupuncture needs to know the name of an illness manifestation before being able to treat. Naming is powerful, for James Waldrum it is the “power to establish order” (2000:605). Additionally, naming can determine what counts as therapy (Csordas & Kleinman, 1990). Excessive concern for naming, according to Ohnuki-Tierney (1984) writing on patterns of care resort in urban Japan, is a particular form of causation practiced in what she calls biomedicine. In Le’s text, naming triggers an acupuncture point prescription.

However, it should not be assumed that the act of linking a named illness manifestation with an acupoint prescription went uncontested. One doctor-acupuncturist scoffed at such behaviour. “If a person asked me what acupoints to use to treat a migraine, I would know this guy is a doctor and only knows some parts of acupuncture... like [a friend of ours who was in training at that time] and knows a bit of this and a bit of that so if he meets a familiar condition, one that he has met in books or in classes, he would know to needle certain points not others.” Points taking on function created consequences, one of which this interlocutor felt, was transforming medicine into a practice of “just memorising things”. Remembering that a credentialed doctor learning acupuncture at the Institute for the first time was required to undertake only one year of training, he continued, “they think that because they are doctors they know medicine already.” In comparison to such cursory study, another friend who had studied for four years was in a more skilled position to help a patient. “If she met a condition she didn’t know or that she hadn’t seen before, like before HIV had a name, then she would still find a way to treat because she would have a strategy to approach the patient”. Associating points with named conditions has the potential to shape a clinical encounter in a particular way. ‘Name’ could attain ‘cause’ against which therapeutic needling configurations were an ‘effect’. Noticeable is the absence of qi. Qi is not required in this configuration to attain therapeutic effect.

Clinical effect in Le’s text was discussed as a scalar relationship between points, organ-channels and the whole body as a system. The extent of points and organ-channel was constrained by the human body. With no body there could be no points or organ-channels. Needling a point had a local effect, in the immediate vicinity of

the point. Acupoints were figured as tightly localised; stimulating the ‘correct’ site, as discussed earlier, was required to achieve therapeutic effect on the whole system. Note that RCTs also use this analogy. RCTs test for physiological response to particular point stimulation not for activity in the channel per se (Birch & Felt, 1999). Channels in this framing are a technology accounting for why needling has distant effect. Points needled at the toe, for example, may cause sensation at the back of the head. Channels can materially account for why this should be the case. In Le’s excerpt, therapeutic effect refers along this material entity towards a surgical anatomical heart. When discussing what he calls ‘channel’, the author talks about therapeutic effect at an anatomical location; the heart. In this text, channels are not autonomous, independent entities lining the surface of male bodies as figured on acupuncture posters. Channels and organs amalgamate. Finally, the whole body was treatable, in this particular example, through the glandular network system.

An acupoint was part of an organ-channel that was part of a whole body. A sum of these parts made a whole. Parts add up to a whole but their effect differs at different scales. Le’s textual structure conjured scale (Tsing, 2005); it conjures a spatial location of medical intervention. That location was locally, extensively and holistically on and in a human body. Le’s text constructs “a humanist intervention” (Adams, 1998:18). A human body comes into view as component parts which, when whole, are figured as discrete and segregate-able from the world, even while being in it. A body produced here was a closed vessel that contained locations for therapeutic action on itself. Potentially therefore, a patient contained the technologies of his own treatment. “A patient can heal himself,” Dr Truong Thin often told his students.

Unlike points that had one enduring figuration, channels were variably three objects. They were independent entities that moved qi having little to do with acupoints. They were joined-up points and therefore a reason why stimulating points at one site on the body created effect in an entirely different location. And they were organ-channels. However, when channels are organ-channels, points are still significant. Acupoints are where therapeutic intervention immediately and most significantly occurred. Technical acupuncture at the Institute, at its most reductive, was about knowing points. This was not because point naming and locations were the limits of

a bag of acupuncture knowledge, rather because points were the hub of scalar relations from which therapeutic effect radiated.

Debatable 'Organs'

I have argued that posters figured channels as independent entities, while a textbook wrote them as organ-channels: a composite entity. Additionally, 'internal organs' were performed as controversial. Texts have debated whether these words referred to anatomical organs or were names that referenced distributed dynamism within the body vessel. It is a controversy about what names could do. "Doesn't a single name come with a coherent [single] body?" (Mol, 2002:63). Nomenclature with regards to 'internal organs' has been used to identify pure geographies of medicine. This controversy has been pursued in English language texts. "When studying the Chinese theory of the Internal Organs, it is best to rid oneself of the Western concept of internal organs entirely" (Maciocia, 1989:67). English language acupuncture textbooks commonly capitalise acupuncture Organ Names to distinguish between an eastern medicine acupuncture body part and a western medicine anatomical organ, referred to in lower case. Hence **S**pleen and spleen are different (for example Deadman & Al Khafaji, 1998; Maciocia, 1989). Farquhar (1991; 1994) likewise argues against assuming that internal organs in Chinese medicine are the same as Western medicine organs, even though they have the same names under linguistic translation. 'Organs' do not exist in a single place, she argues. 'Organ' is a mistranslation; rather they should be understood as visceral systems. Spleen visceral system, for example, extends throughout the body space with a domain of responsibility intersecting with a time element in diagnosis. However, a problem with this conceptualisation of 'western' organs is that it pertains only to surgery. The authors noted above have understood organs as surgical absolutes. Surgical anatomy teaches internal organs as being in the same place any time a surgeon cuts into tissue of an adult human body. However, surgery is only one of many 'western' medical approaches to internal anatomy; a physiological approach would be very different. Such an approach would rather see the body as interactive systems (see Moore & Dalley, 2005).

A debate about acupuncture 'organs or Organs' is a legible controversy in academia, framed as western thinking versus eastern or, given the lack of translated medical works from any other East Asian country, as western thinking versus Chinese, which

debates medical purity. Chinese medicine is something that is not biomedicine therefore a debate about organs or Organs requires the construction of something alternative, calling it biomedicine and constructing biomedicine surgically, that is, from point of view of one disciplinary practice only. When so constructed in text, a nationalised medicine is contrasted with a particular textual figuration. Writing in 1984, the about-to-be director of the Traditional Medicine Institute in HCMC, Dr Truong Thin, raises the same debate.

Truong Thin discusses a distinction between organs that could be held in the hand of a surgeon as compared with organs that were distributed visceral-physiology. The different nomenclature is set out in the table below. Truong Thin seeks to clarify the nomenclature in use:

These 12 names are for the 12 systems of visceral-physiology. They are names of systems not 12 bodies or places... truly this has created misunderstanding and mistakes in many works of traditional medicine of an eastern direction... many writers have searched for *tâm bào* and *tâm tiêu* saying the former is Pericardium – Pericarde, Envelope du Coeur. They say that the latter starts at its height in the chest area, that its centre is in the stomach higher-abdomen and the lower is the lower abdomen: in the plexus cardiaque; the plexus hypogastrique; plexus solaire. That's an old mistake. The point is that these are all reciprocally interactive systems that unify as a whole body (Truong Thin, 1984:118-122).

English	Sino-Vietnamese	Nationalised Vietnamese
Lung	<i>phế đản</i>	<i>phổi</i>
Liver	<i>can</i>	<i>gan</i>
Spleen	<i>tỳ tỳ</i>	<i>lá lách</i>
Kidney	<i>thận đẩu</i>	<i>thận</i>
Heart	<i>tâm ngọ</i>	<i>trái tim</i>
Pericardium	<i>tâm bào</i>	<i>màng ngoài tim</i>
Gallbladder	<i>tỳ đờm</i>	<i>mật</i>
Small intestine	<i>tiểu trường</i>	<i>ruột non</i>
Large Intestine	<i>dại trường</i>	<i>ruột già</i>

Bladder	<i>thân bàng</i>	<i>bàng quang</i>
Stomach	<i>vị thìn cung</i>	<i>dạ dày</i>
Triple Burner	<i>tam tiêu</i>	<i>No single anatomical equivalent</i>

This passage appears to concur with Farquhar's descriptions of visceral-physiology as a dynamic system. To make his point, Truong Thin plays on words to emphasise that different nomenclature enacts utterly different objects. These are separate and exclusive. Sino-Vietnamese nomenclature references visceral-physiology in space-time while nationalised vocabularies discuss internal organs seen by surgeons. If I agree with Truong Thin, Le Quy Nguu was able to enact a composite object, an organ-channel, by using both nomenclatures since he uses Sino-Vietnamese to name the channel and nationalised Vietnamese to talk about location of therapeutic effect. In other words, he could make a composite entity by compositing nomenclature. However, I argue that Le creates an amalgamated object not only through vocabulary use but also by referring to a fixed location of an entity and by creating scalar relationships between static entities. An organ-channel is unique; it is neither visceral-physiology nor a surgical organ.

One of Truong Thin's own students likewise had a different concept of Organ from his teacher. Canh was a technician acupuncturist whom I met through a mutual friend. Our third meeting was set up specifically so that he could help me 'understand something about acupuncture'. Our conversation continued all afternoon but at one point we talked about anatomy. He often spoke rhetorically, positioning his white skinned listener – me – as a westerner against which to bounce 'eastern medicine', to say what a thing is by what it is not. He did this by making statements like "westerners want to know" as answers to questions I had not asked (for example that "westerners always want to know what qi is.") "We must know anatomy and western medicine because if we needle the head say, we have to avoid the brain," he told me, "some points are very dangerous to needle." Knowing surgical anatomy was related to danger and safety raised as a matter of concern (see Wahlberg, 2006). He then drew a picture of the human lungs with an oesophagus pipe connected to a mouth and a line to represent skin with pores. "In western medicine, pores are in the skin to let the skin breathe. We can say that the lungs are the pipe, the bags of air, the bronchial tubes and the nose. But in eastern medicine

lung also has the meaning Metal Phase¹⁴ and also includes the pores of the body. If the pores are tightly closed then you will be sick because you can't sweat, but if your pores are open too widely then you will also get sick. So it's not just the lung bag itself but the creation of it; all the organs that support it. That's Lung."

By making use of Phase logic, Canh could construct a different kind of Organ. Phases were classificatory principles. Things that were similar were grouped around a principle and were made similar by being so grouped. The principle of Metal was absorption as taught by Dr Truong Thin (see chapter one). Because of Phase classification, Canh could expand a notion of lungs as more than merely a lung-bag and a pipe. He had to define a reductive notion of lung and ascribed this figuration a western character. Then he could describe an expansive Lung so that Lung became a physiological system, anatomically distributed even if still surgically defined. These he talked about as systems. Many bits worked together to make a coherent unit. We must think of this unit – Lung – as coordinated work between these many bits. Pores, tubes, bags and skin all get together and do Lung. Unlike the organ-channels of Le, this Lung does not have a channel.

The nomenclature of outer ear acupuncture reinforces a relationship between nationalised language and surgical internal organs. Sino-Vietnamese nomenclature on acupuncture posters and in textbooks is used to talk about points and channels in the body including the head. Outer ear acupuncture points are a different object from body – including the head – points. According to the posters, ears are not connected to the 14 main channels. Over 160 ear acupoints were taught at the Institute, named according to their corresponding surgical organ. Ear acupuncture point names are neither qi descriptions nor channel numbers but surgical organs using nationalised language.

Outer ear points are imaged as directly related to a thing a pathologist can hold in her hand after dissecting a dead body. A poster pasted on the door of the staffroom at the Institute's Inpatient Oncology department referred to the points of needling

¹⁴ Actually, he used the word Element but there is enough controversy about the Five Elements already so I will continue to write these as Phases (see also Hsu, 1999).

the ear in three languages: Vietnamese, Chinese ideograph and English (see figure five). It is interesting that even though ear acupuncture is described as a technique developed by the French (Hsu, 1996; Le & Luong, 2003) such posters made no use of French vocabularies. The ear is represented as a foetus curled up as if in the womb, head down: a miniature body.



Figure 5: A Miniature Body.

Stimulating Heart point on the ear, for example, is akin to directly stimulating the heart in one's body. On the ear acupuncture poster, pictures reinforce a link with surgical organs. They cooperate with surgical nomenclature to create homological understanding of ear point stimulation. For instance, Heart on the ear is labelled with

a picture of a heart nestled between the demi-orbs of lung connected by a rose coloured tube. This implies that stimulation by needling or pressure on the correct location induces effect in this organ located close to the lungs. Since each ear point is named for an organ, an ear acupuncture point was made homological¹⁵ with a surgical organ rather than having an independent name describing qi movement. My interlocutors were negative about the desirability, use and effects of ear acupuncture, arguing that it was ineffective. Hsu, on the other hand, described ear acupuncture as a “lucrative” practice in Yunnan, southern China (1996:429).

In HCMC, Organs were the most textually legible and discursively audible debate in constructing acupuncture. Nomenclature with picture media created confusion – not only for me but also for students in a private class and was noted by teachers when commenting on their students. Nomenclature was particularly confusing when thinking about internal anatomy. From two vocabularies at least four organ objects can be identified: composite organ-channels, visceral-physiology, distributed anatomical systems and surgical organs. These all coexisted together making use of the same vocabularies and often did not clash, since they were “distributed” (Mol, 2002) in different media forms such as textbooks, posters as well as persons. It was noticeable however, that perpetrators of an organ controversy in talk, did so rhetorically. Debate about organs was coordinated by geography: the east was different and westerners did not understand. Surgically isolated organs were compared with distributed physiology and these were said to cohere with two homogenous spatial directions.

The dualist nature of the Organ debate was perpetuated through orientalist and occidentalist stereotypes. Edward Said (1978) argues that the Orient exists heterogeneously as a domain, a boundary and a commentary on the occident. Therefore to understand one requires knowing the other. Understanding and identity formation arises through the relationship between the two (Carrier, 1995). They form a comparative framework that set up the possibility of comparison, even if the framework enables essentialised identities (Spencer, 1995). These identities can be then put to a use (Markell, 2003). In HCMC, an orientalist framework served to

¹⁵ Korean hand and feet acupuncture also operates on the basis of homology (see Kim, 2005, 2006).

separate by creating mirror images. Two comparably different domains were created, featured as a gulf in understanding. However, Canh and Truong Thin created mirrors differently: Canh created a discursive boundary whereas Truong Thin spent his book mapping an eastern medical domain. These discourses were concerned about systemicity. Rhetorically, Truong Thin argues that authors did not understand the true nature of visceral-physiology and hence *comprehensive* understanding was blocked. He suggests that distinction was a concern when seeking correct understanding of eastern medicine; of clearly grasping medical theory so that practitioners could stand strong and with confidence: “we must develop zealously while throwing out the erroneous/obscure information” (Truong Thin, 1984:100). Systematic understanding can enable comprehensive understanding. Canh argued that eastern medicine was expansive, distributed and systematic and therefore not its mirror; chaotic, reductive, and localised. He was interested to create medicine as structured. Le Quy Nguu (1993) is interested in relationships between organ-channels, localised points and a human body that was a system in which these medical objects interacted. Organ-channels and points interacted predictably; relations between different scales were harmonious not unsure or unclear. A legible and audible debate about organs was a debate that worked at a matter of concern in acupuncture – the systemicity of medicine practiced¹⁶.

Multiple Qi

One hot and sunny afternoon, late in dry season 2008, I was in a doctor-acupuncturist’s house in central Saigon. Five technicians and a graduate of a Japanese college crowded around a student-playing-patient. They were learning a new acupuncture technique. The atmosphere was calm, concentrated and occasionally rippled by soft jokes. The ‘patient’ was needled near her elbow with a 4.5 cm long, nickel needle-stem, pushed deep into her flesh, up to the copper hilt. I asked in English, because this practitioner was comfortable with English, “why are you needling so deeply?” “This is an arm point,” she told me, “we can needle deeply yet safely here”. I asked again and she repeated herself. “It isn’t dangerous to needle the

¹⁶ I will continue to write Organs with a capital O in this thesis to hold a sense that Organs were debates.

top of lower arm so deeply.” But I was not satisfied so asked again. “For the qi,” she replied but did not expand. I felt she was wondering what answer I was expecting.

Qi or *khí* / *khí huyét*¹⁷, was a word often uttered by American acupuncturists visiting HCMC. I was interested in American usage because qi seemed to be readily available as a clinical explanation. In a meeting with doctors at the Traditional Medicine Institute Cancer Department to demonstrate the NADA technique, the senior American acupuncturist talked about the calming effect of the five points of NADA. “Anger in the qi is from the Liver,” she stated, “when we do the Liver point we can see that patients calm down.” After watching acupuncture analgesia for a goitre surgery with Professor Nguyen Tai Thu in Hanoi, our group dissected what we had just seen. “Sedating needle technique,” said one American, “was used rather than tonifying (strengthening) to stagnate blood and qi in the goitre area.” Danh argued that acupoint size did not matter because it was the qi that should move. He also used qi as a personal metaphor. On his study in USA, he reflected “I worked really hard that year, my Spleen qi was low.” I was interested in their speech patterns because at that time I was also spending time with Chi Ha (see chapters four and five) and her daughter, who always referenced “blood”. That is, blood was their clinical explanation, never qi. Canh argued with me that the word qi included blood: *khí huyét* was qi-blood therefore qi can also imply blood. However, he clarified, blood so referred was “not exactly like blood in the body”. However, I understood Chi Ha as referencing blood exactly like in the body.

Qi has been subject to much debate and the word often appears untranslatable. Many publications have emphasised the polysemy of qi. “Qi is the common denominator of all things... the substratum of the cosmos... [it] does not ‘cause’ change [being] present before, during and after any metamorphosis” (Kaptchuk, 2000:44). Paul Unschuld notes that in the Chinese period of the later Han (AD 25-220), acupuncture points were named as caves or holes where demons, spirits and the wind could lodge. They were “holes in which the so called *ch’i* is able to penetrate into the body”, as well as flow out again. The written character for *ch’i* in AD100 was

¹⁷ Pronounced with a hard k, as in Japanese language, ki or kee. In Mandarin, the word is pronounced with a soft ch, hence sounds like chee (Lim, 2009).

“vapour rising off food” that could float through air; together with blood this vapour could move through the organism (Unschuld, 1985:71-72; 2009:39). Farquhar (1994) argues that qi is multiple, both a manifestation and a condition that multiplies and changes. Qi therefore is unitary and multiple; both structure and function and a configurative force. English translations of qi as energy, she attacks, are weak and mono-dimensional. The pressure during Maoist times to ‘scientific’ language by defining a term and demonstrating its objective reality has distorted the historic idea of qi. Giovanni Maciocia argues, however, that “most modern physicists would agree [that]... qi may be termed ‘energy’ since qi expresses the continuum of matter and energy as it is now understood by modern particle physics” (1989:36). Trying to understand what qi is cannot start from freefall definition. Words are references to a temporary synthesis of experiences therefore meanings cannot be homogenous or universal (Hsu, 1999). This section will explore how qi was understood in HCMC acupuncture networks.

“Truly traditional acupuncturists,” an overseas Vietnamese acupuncture student told me making the issue a matter of authenticity, “believe in qi moving between the patient and the practitioner through the needle. They wouldn’t use laser or a guide-tube because they would want to induce change in a patient through their personal movement of qi.” She was in the city undertaking introductory training at the Institute. “Some say it doesn’t matter where you put the needle,” she continued, “the needling itself has a placebo effect but placebo, that’s not coincidence, that’s qi.” She questioned the qi of a blood-letting (*chích lê*) teacher whose treatment room we had visited previously. He had been teaching and treating for over 25 years but smoked while teaching and his wife brought out beer and salty nibbles after our first meeting. “How can anyone could go to a practitioner with such poor qi from smoking and drinking alcohol,” she wondered rhetorically, “can I trust him to heal me?” Qi for the speaker was material. It was stored in the practitioner’s body; it could degrade or be improved by particular actions – not smoking or drinking alcohol, living the speaker’s notion of a pure life. I found these comments ironic because the blood-letting teacher made no claims to qi. Rather, he talked about blood. But the overseas student took blood to be part of qi-blood even though I understand the teacher as not doing so. He did not teach blood-letting using acupuncture points and channel tracts. He was not interested in Organs. Pricked points used to let blood were in

different locations compared to acupoints used to stimulate qi and relied on a different logic.

When “we do acupuncture,” explained Japanese-trained, Saigon located, Van (see chapter six), “it means” passing one’s own energy to the patient, which helps that person to come out of illness. In Japan, she received no advice about not drinking beer or smoking but she felt that it was appropriate for a practitioner to abstain. Abstinence would give rise to “good energy” that was “better” for the patient who inevitably received it. Energy moved from the acupuncturist through the needle. When doing acupuncture, a patient recovered slowly if the practitioner’s energy was negative. But the patient, Van noted, could not know whether a practitioner had good or bad energy before receiving treatment. Committed vegetarian and active meditator Danh, believed that qi flowed along the needle between bodies. This was noticeable to the patient, he claimed. He treated a friend in Saigon who told him his qi was much stronger than five years previous when he had just started practising acupuncture. Again qi could be morally imprinted; it could be stored, depleted and replenished as a stock. It could be transferred between bodies through touch when therapeutic intervention occurred. This transfer could not be prevented, it was inevitable. All a practitioner could do was to ensure that his or her qi was positive and moral so that a patient would not be harmed by an acupuncture intervention.

“Certainly a patient can deplete my energy,” an older practitioner agreed. He considered acupressure particularly draining since his bare hands were laid flat on the bare skin of a patient. Acupressure also required that a practitioner dig into the body of the patient. Both these actions could quickly spend his ‘power’, which was better controlled by using an acupuncture needle. Meditation “takes power out of the universe and funnels it into the patient so that I don’t have to use only my own power,” described Canh. He described a movement between practitioner and patient as “the patient’s disease rushed into my body.” At first he did not believe that would happen but after working with patients he became tired. “You need to know how to push the disease away from you through meditation, like yoga and zen meditation,” he explained, though he also used a special set of breathing exercises to help restore his strength.

Hoa (see chapter six) treated all his patients with an additional method called “*phương pháp nhân điện*”. This was explained by him as breathing in fresh air through seven points in the body such as between the eyebrows, top of the head, back of the neck and so on all the way down the spine. This was similar to yoga but not the same, he clarified on my question. He pulled out his certificate of course completion from the Mankind of Enlightenment Love that had taught him this technique. The Method Of Healing By Using Universal Energy required practitioners to exercise calmness and be free from worry; to bring happiness to patients; to accept the trials of society the quicker to settle their karma; to love everyone equally; during treatment to focus on the patient and not be distracted and finally, to relinquish personal interests so as to be able to open the vital points in the body (Mankind Enlightenment Love, n.d.). Hoa retrieved energy from the universe, which entered his body. This made him feel stronger so that he could then “inspire” (my translator’s word) this energy for others to improve his acupuncture practice. A friend introduced him to the course, which was offered to him for free. He practiced this breathing every day. He did not practice vegetarianism nor refrained from smoking and drinking alcohol in the interests of pure energy. Eating meat was not a problem, he reckoned. “I need to make my mind clear, not my body.”

These practitioners agreed that something moved between a practitioner and patient during clinical treatment. They disagreed about what to call this movement – it could be qi, morality, illness or energy. This movement was empirical, material and tangible therefore sense-able. By being empirical, all these could participate in medicine. Kim Taylor notes that early Communist China texts sought a “scientification” of acupuncture medicine as a political requirement (Taylor, 2005:25), a requirement of Chairman Mao, whose sense of science was as a Marxist search for truth, which could be found in any and all academic disciplines. Acupuncture under Mao was to be based on a politically acceptable and ‘truthful’ theory of how therapeutic effect was enabled. Qi, yinyang and Five Phases were considered intangible because they could not be seen using scientific methods. Qi, yinyang and the Five Phases were understood as not material objects so could not explain therapeutic effect. Therefore in a 1949 textbook and continuing into the new TCM curricula from 1956, theories of disease were based on Soviet science. Ivan Pavlov’s work on neuro-pathology and physiological regulation of the body through stimulus of “nerves by injection of

fluids or electrical stimulation”, was taken up (Taylor, 2005:26). Works based on Pavlov’s research on neural control of blood circulation, heartbeat and pancreas regulation “considered cerebral cortical control of the nerves to rely on the processes of inhibition or excitation” (*ibid.*:27). In HCMC, theory development for acupuncture was also translated through Soviet science. I will make use of my own translation of a text by Dr Truong Thin who used Soviet experimentation on the efficacy of acupuncture to demonstrate the empiricism of qi for generations of acupuncturists in southern Vietnam. Since acupuncture histories about southern Vietnam are rare, particularly so in English, I rely significantly on Truong Thin’s work to describe a short account of qi.

In HCMC, qi was material. In the PRC, Taylor (2005) argues that qi was intangible and therefore could not engage with the empirical science of the Communist government from 1949. For Truong Thin this was not the case:

The [book called] Classic of Changes has a sentence: Matter without form is the Tao; Matter with form, being tangible, is qi. True qi is something concrete. Things having form are qi. Many authors said that qi was air. But if we don’t have air we die. However, qi seems formless but can still be perceived such as we can perceive wind, cold, heat, and so on, which have no form. But if we have no food, and food makes blood, we still die, so both qi and blood are important, they are strongly attached to each other. Qi and blood like this give rise to many expressions of life, being now energie, bioenergie, prana (Truong Thin, 1984:32-35).

Qi also includes the idea of a charged electromagnetic field; plasma, and bioplasma. Objective knowledge of the structure of the universe today is the nucleus and the electromagnetic field. These are the two shapes of things. So if we think about qi like that, then we don’t have to throw out the viewpoint of the old people. But we don’t have to understand qi in the old way anymore, rather can raise qi as a philosophical principal like matter in dialectical materialism philosophy: qi is no longer mysterious and unseen (*ibid.*:40).

Matter was the essence. Manifest qi, having form was investigate-able. As Gerald Bodecker¹⁸ has pointed out, understanding “traditional” medicine in Vietnam requires rethinking disciplinary focus. A fundamental assumption habituated through the phrase ‘biomedicine’ is that medicine is shaped through disciplinary biology. But Truong Thin enacted medicine across the disciplinary boundaries of physics, biology and chemistry. Together these would reveal the physicality of life. “To speak about qi... is to talk about mass [or volume or quantity], to talk about transformation is to talk about energy. They always have a strong attachment as Einstein showed in his formula $E=mc^2$ ” (Truong Thin, 1984:43). Hence heat and cold, gas and electromagnetic fields are physical matter that may be rendered visible by experimental techniques. For Truong Thin, since qi was form, all of these were manifestations of qi changes.

A multi-disciplinary medicine revealed a truth known since old times: that of an internally regulated equilibrium in the human body:

The old people had used yinyang to predict much matter and actions... we now discover antigens, antibodies, in our immune systems, everyday we verify the value of yinyang theory or the law of unification and struggle between contrasts... All phenomena inside the body have two aspects: excitation or yang and inhibition or yin, which oppose and bind each other. If either impacts the other too strongly or too weakly, then yinyang will lose physiological equilibrium and will bring forth a state of pathology; something we see clearly in the sympathetic nervous system and para-sympathetic. For example: our heart beats at around 70 beats per minute. This occurs because one “side” is the sympathetic nervous system stimulating the cadence of the heart, promoting the heart to make it beat faster; and on one side is the parasympathetic, inhibiting the cadence to beat slower! One side excited, one side inhibited. One side yang, one side yin, independent but tied together in order to regulate the heart so that a normal condition arises (Truong Thin, 1984:58-59).

¹⁸ In an interview for the Australian Broadcasting Corporation Radio (Mitchell, 2002).

In this passage, Truong Thin focuses on bodily homeostasis. The vocabulary here does indeed sound like Pavlov's work on conditioned response (Taylor, 2005). However, I want to focus on the argument that a human body tends to internal homeostasis, or internal dynamic balance. Homeostasis can be read in physiology, which is where Truong Thin executes *Organs: visceral-systems not surgical organs*, he insists (see earlier). Homeostasis is the "constant conditions in the internal environment. Essentially all the organs and tissues of the body perform functions that help maintain these constant conditions", argues Guyton (1981:3) a textbook that the trained medical doctor Truong Thin cites often. In the body, homeostatic regulation operated through feedback. An organism can quickly change its internal dynamic to biochemically function in fluctuating environmental conditions. Both Guyton and Truong Thin argue that this occurs through a dual process of positive and negative feedback. Positive feedback mechanisms accelerate/enhance internal action, or push activity out of normal ranges. Negative feedback mechanisms regulate, maintain and reduce activity, an act of coming back into range. Thus for Guyton the body has an overall organisation, an order: "parts operate in harmony... continuous interplay provides continuous automaticity of the body" (*ibid.*:7). The body for both Guyton and Truong Thin is a system.

Homeostasis figures a broad optimal range of physiological function, which the body actively seeks to remain within. The body, without intervention, seeks to correct itself; help itself. The human body in Truong Thin's book knows itself; it knows the limits of its own physiological functioning. This, for Truong Thin, was very important because acupuncture was therefore assistance to help the body help itself. "The body can manufacture all the medicine it needs," he told me. One of his ex-students repeated the doctor's teaching of "modern medicine interrupts the body's own process... but acupuncture helps the body *nội sinh* (heal itself)." Acupuncture medicine for Truong Thin was an interiorised medicine. Things outside the body in this technical medicine were of reduced relevance. When wind, cold, heat and qi were outside the body, their behaviour was irrelevant to the health of the interior. They only became relevant when they breached the skin barrier. This medicine is an individualising medicine: an individual skin-flesh-bone frame is figured in textbooks and posters as the subject of acupuncture. Sickness in this technical medicine is internally derived and treatable. Illness arises internally and

acupuncture points, which are in and on a human body, were the object on which intervention occurred.

In his 1984 book, Truong Thin seeks experimental evidence for how acupuncture is able to assist the body help itself. Results from the Soviet Union and the Eastern Bloc countries, the PRC and France are recruited. “Many authors reckoned the mechanism of acupuncture was a reflex mechanism of the nervous system” (Truong Thin, 1984:138) citing *Acupuncture: The Ancient Art of Chinese Healing and How it Works Scientifically*, an English language publication from China, dated to 1973. That acupuncture had a positive trial outcome was not in question. Research questions focused on how acupuncture achieved this. He disagrees with researchers who thought that effect arose through the stimulation of nerve endings, citing *Peripheral Afferent Pathway for Acupuncture Anaesthesia in China*, an English publication dated to 1973 and two authors from the Soviet Union, in a Vietnamese publication called *Acupuncture Study 2* from 1979. Acupuncture’s “mechanism of conquering pain” (Truong Thin, 1984:138) is not a Gate Control mechanism, he asserts, disagreeing with a text called *The Scientific Basis for Acupuncture*, a French publication dated to 1981 and *A Mechanism of Acupuncture Anaesthesia*, an English publication from China dated to 1972. Rather Soviet experiments with bioelectricity are used to animate Truong Thin’s formulation of acupuncture effect. Particularly, Truong Thin focuses on Kirlian photography, a technique that photographed the electrical discharge from an object impressed with a high voltage field. Electromagnetic fields generated by living plants, animals and things were photographed in Soviet research.

For Truong Thin, life is electrical. Citing Soviet and Chinese authors from a Vietnamese publication *Acupuncture Study 2* dated to 1979, he points out that:

On the skin there are a number of points with more organic electrical potential compared to others. These coincide with acupuncture points. These change according to states of pathology, illness, psychology, whether full or hungry, awake or sleeping, Earth’s electromagnetic field (Truong Thin, 1984:140).

Citing Soviet and Romanian authors from the Vietnamese publication, *Acupuncture Study 2*, he continues:

Acupuncture channels are paths of lesser electrical resistance compared to different portions of the skin. Points have less resistance again. From this, researchers have detected points and diagnosed illness in the channels. Resistance changes according to many factors, such as warmth, heat of atmosphere, state of biology, pathology, illness of patient; day and night; earths electromagnetic field; solar explosions on the sun (*ibid.*:145)

Truong Thin lists a number of factors that might shape bioelectrical resistance. But he does not pursue them, because he was only interested how these might pertain to the human body. “The lack of resistance is important because these are places that have least power to obstruct therefore smoothly exchange energy between the electromagnetic field and the nucleus and the universe and people. That is, one information system” (Truong Thin, 1984:141) citing *On the Biological Essence of the Kirilian Effect - The Concept of Biological Plasma*, an English publication from the Soviet Union, dated to 1968.

Dr Truong Thin was trilingual in Vietnamese, English and French and so could access publications that otherwise relied on provision of translated Vietnamese versions. He did not make any citation of original writings in Chinese or Russian. The Chinese sources were accessed through English language. Taylor notes that the PRC started publishing acupuncture research in English from 1956 as part of Chinese Communist Party work to “reflect the best of China in every possible way” (2005:67) to the rest of the world, which here included Vietnam. The Soviet sources were translated into Vietnamese. Communications between science communities between different countries were facilitated by China’s face-west policy at a time when Hanoi-Beijing relations were “in continued tension” significantly over what Ramses Amer called “the Soviet factor”¹⁹ (2004:337). That is to say, at that time, Vietnam was part of the ‘west’ China was facing.

Truong Thin argues that channels are routes of lesser bioelectrical resistance and points are the places of least impediment. Channels are retrospective flows of energy

¹⁹ A Treaty of Friendship and Cooperation was signed between unified Vietnam and USSR in 1978 which facilitated development aid and trade flows becoming less significant on reconciliation with China (see Pike, 1987).

from the universe, through the body and out again, into the surrounding universe. Points are places that are most susceptible to energy transfer since points were places of least impediment to such exchange. Energy (using a word from disciplinary physics, *năng lượng*) could enter the internal – divided away from the external by skin – and move throughout, not diffusely but in what might retrospectively be seen as paths, or routes of lesser impediment to movement. Energy could “exchange with the outside of the body” (Truong Thin, 1984:155). An electromagnetic field, being an electrically charged domain, is made analogous with the universe. The nucleus is likened to a human. A particle is referred as a collective of a neutron, a proton and an electron, each being dually charged. These interact, representing a dynamic and internally interactive body. Two separate entities are envisaged: an interactive and affective domain through which moves an internally dynamic, mainly sealed, unit. They interact because they are separate bodies. Skin binds qi movement *within* a body because only on acupoints, the places of least electrical resistance, can the universe and a human body exchange qi²⁰. Truong Thin’s text worked to establish a ‘theoretical’ (literate exegesis) explanation for how acupuncture’s known therapeutic effect occurred. In this technical medicine, the potency of the healer appears limited. Acupuncture therapy for Truong Thin was about helping out rather than curing. A practitioner’s role was limited to helping the body help itself.

For all my interlocutors, qi was a fundament of the physical world hence a human body, Organs, channels, energy, needles, a treatment room, electricity needle stimulator units, all these and more were qi manifested. Qi was also interiorised. Qi entered and left the human body through acupoints, which again enacted points as essential. Needling excited or inhibited the movement of qi inside the body so a language of sedation and tonification, turn up/turn down, was used to talk about needling actions (though Nguyen Phuong dismissed needle stimulation as ineffective). Qi movements inside a mainly sealed human unit could retrospectively be seen as routes taken and be called channels. In the Le Quy Nguu (1993) text, the naming of an illness manifestation triggered a point prescription. Strictly speaking, a named manifestation did not require qi since therapeutic effect is enacted on three

²⁰ Also noted by Chee-Han Lim researching Qigong in Singapore: points are thoroughfares (Lim, 2009:56).

scales. Those scales were points, organ-channels and the body system which do not require a practitioner to refer to, explain, talk about or raise in discourse, qi. Qi temporarily disappeared from the speech of technicians in HCMC. Incidentally, qi also disappeared from government regulations. “Guiding the Implementation of the Ordinance On Private Medical and Pharmaceutical Practice and Decree” (Government of Vietnam, 1994), for example, discusses treatment space, credential requirements and authorised medical actions. Government regulations, which were selectively adhered to, did not see qi (Lim, 2009:94). However, qi was not their concern, rather the activities of human bodies and their spatial locations were.

Conclusion

In HCMC, medical objects were constructed through greater or lesser consensus-making between people and things. For acupuncture technicians, four acupuncture objects existed empirically – they were visible or touchable. They formed required medical knowledge – that which was necessary to intervene in the manifestations of illness.

The most durable object was acupoints. There was no doubt about what they were. They were static, small and visible to competent needlers. Such was the singularity of points that any alternative notions were immediately erased. Channels, Organs and qi have been shown to be multiple. Channels were qi movement routes or acupoint coordinators or a composite entity with organs. Organs themselves were debated as a dividing line between east and west and what an ordered and systematic medicine should look like. The very definition of qi was multiplicity; discussion about qi was legible and audible. A human body delineated the limits of technical acupuncture. Points, channels and Organs were in the body and ended at the skin barrier. Therapeutic effect was considered to operate internally by manipulating medical objects within this system. Since these were inside a body, the body could potentially heal itself. Practitioners therefore could not cure, merely assist the body in its own medical work. Qi, notably, was not limited by human skin and bone. But for technicians, qi was not a relevant explanation for needling configurations. Mobile and multiple qi could not explain practitioner decision-making since accurate needling into needle-tip sized acupoints was how therapy was created in an interactive system called the human body. Qi could not be pinned down as a causal

agent, which possibly made qi unmanageable in clinical situations. Perhaps qi was too chaotic so was less likely to appear as a mediator of medical intervention than the other medical objects discussed.

I have suggested that medical objects, as much as medical practitioners, can be subjected to ethnographic study. I have done so by treating people, books and posters symmetrically. They have all been understood as participants in making acupuncture. An acupuncture that could not be pictured would be very different. Without pictures, acupoints may be more mobile; channels more contoured to the shape of a human body and potentially the Organ debate would not exist. I speculate that acupuncture training would require more observation and *hands-on* in clinical situations. That is, a more tactile acupuncture might result. An acupuncture that could not be written would be very different. Greater emphasis may be put on mnemonic devices like formulas and rote-learning. Pictures and texts therefore have been understood not as representatives of acupuncture but rather as being acupuncture itself.

Something which is 'factual' is supposedly 'neutral', as if separate from a contested and constructed social sphere (for example, McNally, 2002). However, since facts arise through consensus this cannot be the case. Acupoints were singular objects in HCMC. Consensus about what they were was overwhelming. The consensus about points meant that they were a key way of knowing acupuncture. When debates become facts they become assumed and unremarkable. They also become intensely shapeful since they can shape the terms of future engagement. Factual and unremarkable points, for example, shaped how assessments of professional competencies were made and therefore who may be called 'an acupuncturist'. Points formed a bedrock for communication between acupuncturists. They were *the* assumption on which teaching in a private classroom could proceed. In the next chapter, I will describe how Nguyen Phuong challenged his students to rethink their notions of qi, Organs and channels but never points. An operating consensus allowed him to do this. Facts are, therefore, always consequential.

3. Trust before Truth

Gilbert Lewis suggests that histories of medicine are mainly about “does the treatment work?”; trust is required when asking this question, he argues, because we cannot always put a therapy to the test (1993:192). In medicine, perhaps nothing is more valuable than knowing what ‘works’ but distinguishing claims to knowing may be difficult. How can a medical student be sure he is not learning ‘quackery’ (Wahlberg, 2006a)? In a teaching situation, how can a student tell what is ‘true’ or not? This chapter contends that for knowledge (the what-is rather than the what-is-not) to emerge, trust is essential.

As described in chapter one, media – including personal networks – passed around stories of bribery, corruption and incomplete teaching. Ambiguities about credentials colluded with circulating myths that *hông y* kept secrets. It seemed to me that there were difficulties validating truth claims in Ho Chi Minh City during 2007/08. Such difficulties made distinguishing who to believe risky, in the sense of being uncertain. A teacher in a private acupuncture class claimed to teach a technique that assured healing. He had empirical proofs that his medicine worked. But a question vexing students was how they could guarantee he would teach them *all* of his ‘secrets’? Only complete knowledge was efficacious. The teacher had a problem of how to ensure that his students believed him when he claimed to be doing so. Intimacy, argues Anthony Giddens (1990), is required for revelation of the authentic in such circumstances. Mutual trust enables intimacy and disclosure but trust is a practice: it must be maintained. Trust must be continually worked at by the parties involved since without continual performance, trust ceases. I will describe how trust was worked at in the 6 Qi classroom by both teacher and students in order to generate efficacious medical knowledge.

I will first introduce a locally resident master, Nguyen Phuong, who taught 6 Qi acupuncture to a small class of acupuncture technicians who had trained, or were about to finish training, at the Traditional Medicine Institute. During fieldwork, I

also attended this class. The class was described by our teacher as one in which students learnt efficacy. He assured us that he would teach an acupuncture technique of proven therapeutic benefit. I recorded classes so am able to quote Nguyen Phuong verbatim and detail the acupuncture he taught, focusing on how he systematically demonstrated that his information was complete. Thereafter I will describe how twin strategies of fun and hierarchy worked at making intimacy in the classroom. An intimate relationship was desired so that students could judge the quality of information being taught. Finally, I describe how our teacher distinguished himself from the Institute, which figured in his discourse as a source of both competition and cooperation. These descriptions will detail how trust emerged collaboratively.

Master (thầy)

Just before 2pm on any Sunday between March and June 2008, seven students arrived for an acupuncture class. Pulling up haphazardly but not late, we pushed our bikes into a corner of a narrow, bumpy walkway in the residential compound. Lanh¹ and I cycled because we lived close by but the others motor-biked from their homes, up to 40 minutes away depending on traffic conditions. Without a motorbike, attending private classes in the city centre would have been much more inconvenient. Four women and three men attended this class; the youngest was 30 years old and the oldest of late 40's. All had trained at the Institute; the youngest woman was still in training while the two oldest practitioners had been practising for over 15 years. Five students practiced acupuncture out of their home-based, private clinics and one worked at the Hospital of Traditional Medicine. I did not have a private clinic and neither did the youngest woman. We were there because of Lanh, who had told us about the class. Students gave up their Sunday afternoon over a period of some months, to travel to our teacher's home and learn an acupuncture that had proven its efficacy.

We knew this acupuncture was efficacious because of Lanh's testimony to the fact. Six years previous, Lanh had suffered back pain and had gone first to the Institute for acupuncture, which had failed, meaning she still lived with pain after her

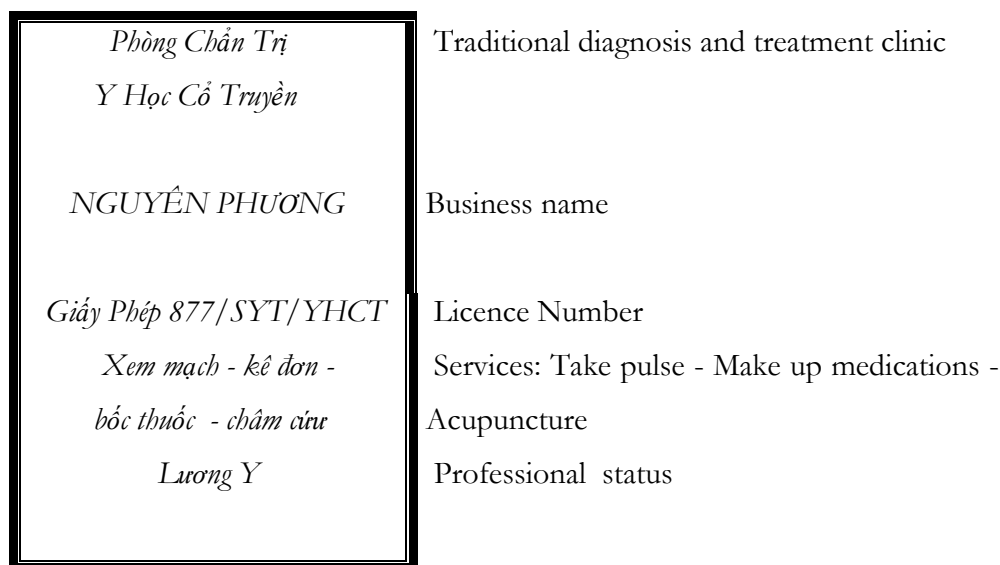
¹ Student names are pseudonyms.

treatment programme finished. She heard about Nguyen Phuong and came to his clinic where she had been successfully treated. After such a victory, whenever she was ill she came back to Nguyen Phuong. Six years later, she wished to change her occupation to acupuncture and requested that Nguyen Phuong teach her but he recommended that she first go to the Institute and obtained a credential. After that, she could develop her acupuncture studies with him. We all knew her personally, therefore could trust in the truthfulness of her story. While all the students had trained, or were in-training, at the Institute they were not certain they could obtain such beneficial results from the teaching there. A common complaint was that teachers at the Institute taught “just a few acupoints” or students might “just pay and learn a little but the teachers don’t want to tell you everything because they might want to do ‘extra’ tuition for an additional charge.” While the Institute with the Department of Health, by means of credentials and licences, could be said to monopolise medical legality, the Institute did not monopolise acupuncture training partly because that teaching was thought to be incomplete.

Lanh was the physical measure of Nguyen Phuong’s medical efficacy or his *hiệu quả* (a positive result). She was a walking, talking and personally known, therefore trustworthy, statistic. In HCMC, patients determined *whether* a treatment worked. Acupuncturists, on the other hand, may say *why* it worked. In the eyes of acupuncturists, patient presence at a treatment room was a quantitative assessment of how much their medicine worked. One professional assessment of Nguyen Phuong used this empirical verification. “Look at *thầy* Nguyen Phuong,” pointed out an acupuncturist who had been running his own treatment room for five years, “he has between 40 and 50 patients a day. That proves his techniques. If methods work the patient will always tell you because they will always come back.” Clinical outcomes could be measured by counting patient numbers. Counting in this way relied on ‘a patient’ being an individual body as discussed in chapter two. When a practitioner’s name circulated and attained ‘noise’ in personal networks (see chapter five), he was able to generate a patient load. Healing was proven empirically, confirmed by events that were explainable (Young, 1979). This reasoning could be described as a patient-perceived approach to efficacy (for example, Finkler, 1985; McGuire, 1991) being concerned with how a patient experienced clinical activities and how such patients assessed results. However, assessing efficacy according to

patient volume is also a free market logic; the customer is always right. Regardless, it is likely important that I was not doing fieldwork in an institution, since practitioners in private practice were concerned about generating patient footfall so as to continue in their occupation. By counting patient numbers, Nguyen Phuong's students could measure his medical efficacy. In so counting, they were sure his acupuncture had *hiệu quả*. Students turned up to 6 Qi acupuncture classes to get the 'good stuff', as one interlocutor put it.

We knew Nguyen Phuong as our teacher rather than in a personal capacity; we met him in his clinical space while he was in teacher mode. The ground floor front room of our teacher's home was his clinic space. The heavy metal shutters were thrown open, showing six wooden benches in a line, a wooden dresser stuffed with materia medica and our teacher, sitting behind his consulting desk, leafing through printed papers. A small rack by his elbow held his business card, which he used to advertise his sole trader practice.



A whiteboard was propped against the sidewall, resting on the back of his parked Honda motorbike. Kicking off our shoes at the house entrance, we entered and bowed slightly to our teacher, greeting him with the words *chào thầy* thereby naming him Master. He returned our greeting without using personal pronouns or names and made small talk while we pushed two wooden benches together to form a table. These benches were unusual in HCMC since most private clinics used lower standing hospital beds to lie out their patients for acupuncture treatments. He passed

out printed crib-sheets, drafted by a young man at the photocopier shop close by his home who had helped diagram the work on Photoshop software. Apart from one handwritten handout, all his papers were printed.

“Ok!” he exclaimed, moving out of his chair to stand by the whiteboard to indicate that the class had started. “This must be strange for you,” he told us, “but in this class you have to accept Six Phases, not Five.” He drew out 12 circles and labelled them Organs, through which ran straight lines being channels. On some days, he produced a ruler to make sure the representative lines were perfectly straight. He never reinterpreted his own work in ‘lecture’ mode – his drawings on the small whiteboard mimicked those on his crib-sheets. At those times, he was the only older, grey-haired person standing up so that his head was higher than ours. We sat calmly, until the late sun refracted bright light into our eyes through the unmoving blade of the overhead fan.

Our teacher was dressed in what I came to think of as a male ‘uniform’ in HCMC: coloured slacks, shirt with sleeves carefully folded to the elbow, a white T-shirt peeking at the v at his neck and shoeless, being inside. He did not wear his clinical uniform of white cross-style top with black slacks, nor did he present himself to us without a shirt, going bare-chested in the privacy of his home in the heat of the day. The class was not private space. We never ventured from this cool, shady space into other parts of his residence. James Clifford suggests that space is “discursively mapped and corporeally practiced” (1997:186). One space can be corporeally practiced as three places: a classroom, a clinical treatment room and a private space.

In this chapter, there will be no details of Nguyen Phuong’s ‘private’ life. I was very keen to interview my teacher. I was fascinated by his medical logic and his potential life story. He was 59 years old in 2008 and had grown up during the war of independence with France and the civil war between northern and southern Vietnam, culminating in the creation of a one Vietnam in 1975. He had lived through the time of subsidy and continuing Marxist-Leninist inspired government policies into Renovation policies from 1986. He refused to be interviewed by me, citing that he was too busy; he had no time, it was not possible. His clinic was open every day of the week, morning and evening and he taught on Sunday afternoons the only

period of the week that he was free. “Don’t try to interview your teacher,” my redoubtable translator advised, “if you are a student in his class.” Being student and teacher meant acknowledging each other particularly that could not substitute for other identities, such as if I had been, say, a journalist or a biographer or a professional peer. I had not met him before I became his student, therefore we did not have any other relationship outside of the classroom and he was not interested in changing that. An anthropologist does not have relations with interlocutors in general. Rather, we have particular relations with different people. I thought I was an apprentice on a PhD anthropology programme (see also Bacchiddu, 2004) but in the 6 Qi classroom I was a student, getting acupuncture schooling. I always struggled against being connected as ‘just his student’, which erased my identity as an aspiring ethnographer.

Demonstrating Completeness Systematically

6 Qi acupuncture was derived through the Classic of Changes (*Kim Dich*). In English language, the Classic of Changes, or the *I Ching*, is associated with a quintessential Taoist philosophy of the universe as constant and endless change. Such philosophy has historically influenced philosophies of medicine, meteorology, sociology, psychology, mathematics and prophecy in East Asia. This last subject, prophecy, was a popular perception of the meaning of the word ‘Classical Medicine’ in HCMC. At the Institute, scientific experimentation was authoritative – experimental science became the “modern” (Truong Thin, 1984) obligatory point of passage (Callon, 1999) through which clinical efficacy was to be evidenced. But at this different learning site, authority was derived from the Classic of Changes. Vietnamese acupuncture texts make little comment about the Classic of Changes, perceiving the Classic as illusory and largely irrelevant for a number of reasons that possibly include Communist rejection of perceived feudalistic elements in favour of sustained focus on a systematic and structured acupuncture. A book called *Vietnamese Traditional Medicine* (Hoang, Pho, & Huu, 1999) devotes 11 pages out of 285 to history and never mentions the Classic of Changes; *An Outline of Chinese Acupuncture* translated into Vietnamese (Pham & Dao, 1992) devotes two pages to detailing acupuncture publications during Imperial dynasties before rushing into acupuncture technicalities; Dr Truong Thin selectively makes use of sentences to support his argument that qi was scientifically objective, not mysterious and unseen (Truong Thin, 1984).

Additionally however the *Nội Kinh*, which I have taken to be *The Yellow Emperors Inner Canon*², was claimed by interlocutors to be the earliest compilation on acupuncture (see also Unschuld, 1985). The Classic never figured as an equally influential source with interlocutors who had not studied 6 Qi.

The first three 6 Qi lessons were spent listening to our teacher's monologue on the historical and philosophical origins of this technique. He handed out a printed crib-sheet and went on to discuss it. The origin of the universe was Eternal Infinity, he lectured, out of Eternity arose the Ultimate, or the yinyang symbol, which spontaneously gave birth to yinyang duality and thence to four phenomena symbolised by four, double-lined, diagrams. These gave rise to eight, triple-lined, trigrams called the *bát quái*. These manifestations of yinyang duality thereafter gave rise to countless other natural forms, one of which was Man. Man was a mini universe in himself as well as being connected to greater space-time. The nature of that connection was unspecified. At this point, no teacher from the Institute would find this reasoning problematic, although the one-two-four-eight theory of change was only one of many. Numbers were used to describe theories of qi change. One Ultimate becomes Two YinYang became, here, Four Phenomena that became Eight Trigrams. The lectures then went on to elaborate on two pre-literate origin myths called the *Ha Do* and *Lac Thu*. The Classic of Changes, he explained, never had letters but was expressed only by signs; signs made through continuous and broken lines called trigrams. "Thanks to the appearance of two works called the *Ha Do* and *Lac Thu*, the contents of the Classic have become clearer. These two myths can help us understand that most famous work of Eastern philosophy: the Classic of Changes," our teacher continued. For this reason we studied the legends. Here, I am not interested in myth structure but how they were used.

Nguyen Phuong used these two mythical narratives as a systematic proof of the source of 6 Qi's efficacy. The first narrative told that a king, called Phuc Hy,³ saw a dragon-horse rise out of the Manh Ha river and on its back was a pattern of black and white spots, arranged in four concentric circles (see figure six).

² A book composed of two texts: the *Spiritual Pivot and Basic Questions*, c.3rd century BC – 1st century AD. It is often taken as one of the earliest compilations on medicine in China.

³ The two kings named here were noted in Chou dynasty literature (Dawson, 1978:6).

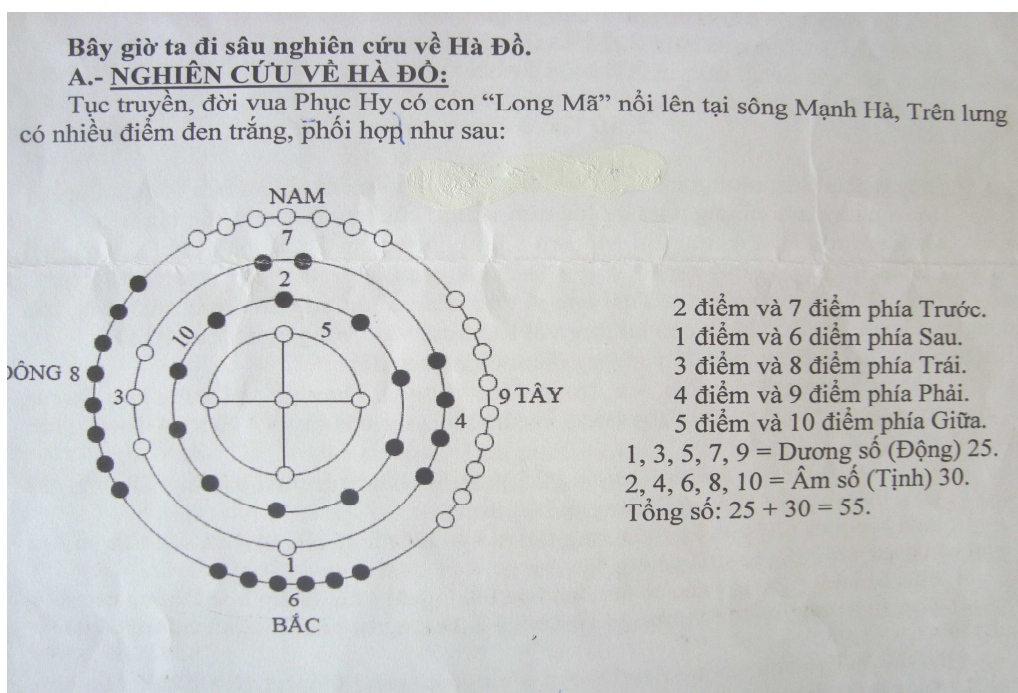


Figure 6: What the Dragon-horse Told. ©Nguyen Phuong

The description of these circles was presented to us numerically:

1 inner white spot and 6 outer black spots were located in the direction of north from the perspective of the king (see figure six). North is always at the bottom of an acupuncture compass).

2 inner black spots and 7 outer white spots were on the dragon-horse's back in the southerly direction.

3 inner white and 8 outer black spots were on the left or the easterly direction.

4 inner black and 9 outer white spots were on the right or westerly direction.

5 inner white and 10 outer black spots were in the centre.

The numbers 1, 3, 5, 7 and 9 were the numbers of yang or Heaven, we were taught.

The yin or Earth numbers were 2, 4, 6, 8 and 10. The numbers 1 to 5 were those of the formless. The numbers 6 to 10 were the numbers signifying form, or more precisely post the-act-of-formation and now having form, were a thing: matter. The numbers signified that both Heaven and Earth colluded in the creation of countless forms of matter and energy over time.

Numerology was correlated with a Phase and with a direction:

The numbers 1 and 6 represented the Water Phase in the northern direction.

- 2 and 7 represented Fire Phase in the southern direction.
- 3 and 8 represented Wood Phase in the easterly direction.
- 4 and 9 represented Metal Phase in the western direction.
- 5 and 10 represented Earth Phase in the Centre.

The second narrative described how a king called Dai Vu, after managing the water level of Lac Ha River to prevent a flood, saw a great turtle rise up out of the water and on its shell were line-patterns corresponding to the directions of north, south, east, west, south-west, south-east, north-west and north-east (respectively). Together these formed a square:

- 9 lines were drawn on the shell at the head of the turtle.
- 1 line was at the bottom of the shell.
- 3 lines were on its left ribs.
- 7 lines were on its right ribs.
- 2 lines were on the shell by its right shoulder.
- 4 lines were on its left shoulder.
- 6 lines were on the shell by its right foot.
- 8 lines were by its left foot.
- 5 lines were in the middle of the shell.

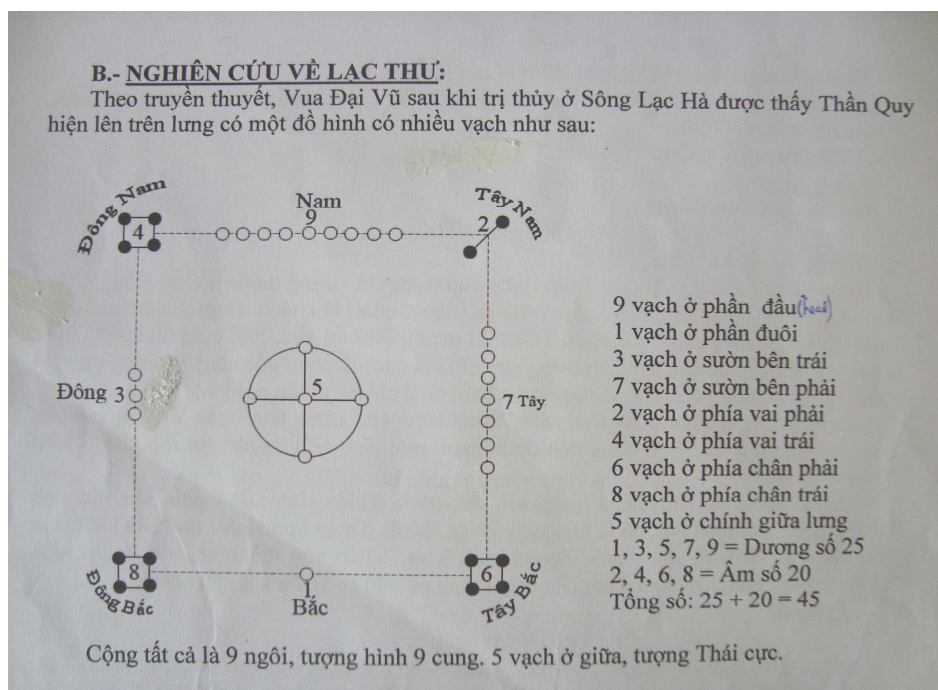


Figure 7: What the Turtle Told. ©Nguyen Phuong

The two myths integrated to form one understanding. The symbols on the turtle's shell formed a geometric square. The spots on the back of the dragon-horse were circular. A square symbolised Earth while a circle was taught to us as the symbol of Heaven. When these two geometric patterns, circle and square, combined they formed a synthesised symbol of transformation and told a story. They told that the formless Eternal Infinity agitated through which matter formed. Trigrams corresponded with directions on the basis of their personality. For example, the trigram for Water Phase was North, at the bottom of an acupuncture compass because Water sinks. Heat rises so Fire was Southerly, at the top. A trigram, number and direction all collaborated to indicate their proper position. A number does nothing in itself – to create meaning a number must exist in relationships with other phenomena (Holmberg, 2005). When patterns created by both narratives were unified, they “revealed,” argued Nguyen Phuong, the mutual anticlockwise and clockwise movement of yinyang. “This event is very important to the people who have mastered the Tao in practising its work,” our teacher pointed out to us.

“Teaching at the Institute,” elucidated our teacher, did not reveal this important event. “Dr Truong Thin,” he specified, “didn’t know about this, [he] didn’t know that in the symbol of the Tao, yinyang wax and wane but they don’t move together in one direction. Usually,” Nguyen Phuong continued, reducing all other teachings to one interpretation, yinyang was taught as moving in one direction, as in the often given example of one day. Over the course of one day, all life passed through various states of yinyang in a forward continuous movement (also for example, Maciocia, 1989 and 'lay' perceptions in Saigon). But those books and those teachers ignore the complexity at the heart of the Ultimate, argued Nguyen Phuong. Yang moves anticlockwise and yin moves clockwise, so in effect they ‘kicked’ each other. At this point, he carefully scored the coloured margins on the yinyang symbol, where black became white and white, black. “It’s the opposition to each other” that gives rise to movement and change, he explained. This kicking, as it were, was where the 6 Qi method arose; out of the very essence of the Tao.

The two myths of the Ha Do and Lac Thu were centrally important for 6 Qi. The myths described symbols on the backs of animals. These were stories that drew our attention to numbering. We were not directed to interpret the animal itself, how it

came to be there, nor the elite personage who saw these animals, how he came to be there and what happened thereafter. The potency of the narratives lay in those things that were recognised as not-words. Counting marks and circles gave rise to numbers. Each number corresponded with yin or yang, a Phase and a direction. Numbers were laid out geometrically. Our teacher explicated meaning by synthesising numbers, trigrams, directions and geometric shapes. Our attention was drawn to numerical and geometrical accounts. David Bloor argues that it “seems that mathematics embodies truth which has a quite compelling nature” so that it seems there is a clear right and wrong: either numbers add up or they do not (1991:85). In the *Lac Thu* myth, the odd numbers of 1, 3, 5, 7 and 9 were the yang numbers adding up to 25, our teacher told us. The yin and even numbers were 2, 4, 6 and 8 that all added up to 20. Altogether, 25+20 totalled 45. All the totalled numbers in the *Ha Do* myth added up to 55. Added together, these numbers arrived at 100. The number 100 symbolised the 10,000 things in existence over time, our teacher argued. Numerical accounts appear to “describe a reality” (Bloor, 1991:86), one that is beyond words.

Through the use of myth, our teacher argued that truth was illiterate – truth was derived from the language of mathematics and symbols. The truth was that qi flow was dual and contradictory: “where Heaven and Earth meet as one, there must be an extreme change, or an inversion, where yinyang and yangyin each change position with the other,” Nguyen Phuong taught. 6 Qi acupuncture was a formula that created an alternative flow of qi around the body to mimic this place and time of yinyang inversion at the heart of the Tao. He used myth to derive a numerical proof, which generated an acupuncture formula that would guarantee healing because, he claimed, the formula was based on the essence of universal formation and change. Our teacher asserted that 6 Qi was a more accurate, systematic and logical translation of Nature than anything taught at the Institute. But he did not ask us to take his word for it; he worked through a proof in the sense of an empirical demonstration. 6 Qi discovered a truth; a truth that was always there, waiting to be found and understood.

Latour (1993) would argue that these two narratives, used to prove the efficacy of 6 Qi, were the ultimate statement of modernity because humans were purified out of true knowledge. Purification and re-blending are the practices of modernity for

Latour. For Nguyen Phuong, Nature was transcendent; it surpassed humans therefore truth did not lie in humanity rather in nature, symbols and numbers. The myths purified out humans and transcended any words belonging to any nation, race or people. While Nguyen Phuong proved truth using myth, the use of myth itself followed a particular rationality. Demonstrations laid out in text crib-sheets, imaged in lines and circles, using familiar rules of Phase transformation that students learnt in classes at the Institute, obeyed repetitive rules. The relational logic of these rules was reliable; it did not suddenly and inexplicably change. Myths were taught as something structured and methodical (see also Levi-Strauss, 1969), which has been the pedagogy in use at the Traditional Medicine Institute (described in chapter one).

Myths were proofs of the unique and significant nature of 6 Qi teaching:

So, [there are] six aspects of qi, insufficiencies and excesses... before you may have heard of the 6 Qi but you didn't know the meaning. Other teachers just follow the four phenomena and the eight trigrams but they did not know the name of the two spots on the Ultimate, the least yin and the least yang. Before now, a number of people recognised too much yin, too much yang, insufficient yin and insufficient yang but did not understand these two points. They only saw that the picture of yinyang (*thái cực*) had four aspects. There are many books that haven't yet brought out the significance of these two aspects.

Eight forms of qi may be described in symbols called trigrams (see figure eight). A broken line symbolised yin while an unbroken line represented yang. The two trigrams of only yin and only yang were not used because they represented impossible states. As Nguyen Phuong often emphasised, there is never a time when yin has no yang and yang has no yin (also emphasised by Farquhar, 1994; Truong Thin, 1984). Since two trigrams were dropped, six were left that represented various combinations of yinyang. Each represented a Phase (discussed in more detail in chapter one). 6 Qi introduced a Sixth Phase called Nourishing Warmth (*thư*) together with the familiar Fire, Earth, Metal, Water and Wood. In 6 Qi, Phases transformed by means of two distinct relationships: generative and draining. In the generative sequence, Nourishing Warmth was generated by Water Phase and went on to support Wood. In Five Phases, Water generated Wood directly. In the draining

relationship, Nourishing Warmth drained Earth directly. These two relationships, supportive and draining, mimicked the movement of qi in the symbol of the Ultimate.



Figure 8: Eight Trigrams.

The Phase logic of progressive draining and generative relationships was brought into pulse diagnosis. Students at the Institute learnt pulse as three pulse locations on two wrists and that within each pulse were three depths. Many pulse types including floating, sinking, slipper, empty, slow, rapid, long, short, moderate may be identified (see Kaptchuk, 2000 for extended discussion). Learning to read an eastern pulse was difficult because of the subtleties required. In Institute teaching, pulse location never changed. The practitioner's finger-pads fell lightly onto three pulse locations on a patient's wrist where he 'perceived' (*xem mach*) the activity of an Organ. Fingers and Organs communicated directly with each other. A total of six pulse locations were used. How an Organ was understood was temporarily not relevant: touching the patient's left wrist at the first pulse location for either heart understood as surgical anatomy, heart distributed or heart visceral-physiology, did not matter because the practitioner would read 'Heart' and feel the activity of Heart. However, this static reading of Organ location on a patient's wrist was not enacted in 6 Qi acupuncture: rather Organ locations read on a patient's wrists changed places.

6 Qi relied on differentiating a normal from an abnormal pulse. The work of treatment was to 'normalise' the pulse. An Organ pairing could be read as a dynamic state of qi represented by a trigram. When a practitioner's finger-pads fell onto a patient's wrist, she would feel either a normal or an abnormal pulse. These were figured on our teacher's whiteboard in tabular form, with each column corresponding to a patient's wrist. Pulse was read on both the left and the right wrist of a patient. Each cell corresponded with an Organ pairing at each of three locations on a wrist.

A Normal Pulse, read on the:		An Abnormal Pulse, read on the:	
Left Wrist	Right Wrist	Left Wrist	Right Wrist
Large Intestine & Spleen Organs pair Earth trigram	Stomach & Pericardium Fire trigram	Gallbladder & Heart Nourishing Warmth trigram	Small Intestine & Kidney Water trigram
Triple Burner & Liver Wood trigram	Bladder & Lung Metal trigram	Bladder & Lung Metal trigram	Triple Burner & Liver Wood trigram
Small Intestine & Kidney Water trigram	Gallbladder & Heart Nourishing Warmth trigram	Stomach & Pericardium Fire trigram	Large Intestine & Spleen Earth trigram

A normal and an abnormal pulse were in an inverted relationship with each other. An acupuncturist using 6 Qi pulse diagnosis must consider the dynamic interchange of yinyang under each seeing finger-pad and compare what was happening at opposing and contrasting locations between the pulses. Pulse activity at each patient wrist location had to be understood relative to each other. An abnormal pulse was weakness. Students had to learn to recognise an abnormal pulse: we were urged to learn this.

Take your own pulse when you feel well... take the pulse of the healthiest people you know so you can get to know the difference between wellness and illness, learn the pulses when someone is ill... women especially can do this by checking how your pulse is different on the days of your menses... you don't need to know the names of illness, you just need to know activity at the three levels of each of the six pulses.

Knowing the name of an illness was not necessary to move a patient out of weakness rather a practitioner needed to understand the pulse. When diagnosing a patient, Nguyen Phuong often asked questions, read the pulse and checked blood pressure with an aneroid sphygmomanometer (familiar device used by doctors to check blood pressure). However, what the patient might indicate as their chief complaint through

speech was less valuable than what the pulse told his fingers directly. “The patient will tell you many things but the practitioner needs to find out the root,” he told us. The root was in the interpretation of the pulse.

Each pulse location was, then, an Organ-pairing that was linked with a trigram. The symbol was more important than a name; names were only required when we talked about the trigrams without drawing them. Usually however, our teacher turned to the whiteboard and scribed out a trigram rather than worry about names. A normal pulse could then be described in a language of trigrams. A normal pulse followed a mono-linear logic of supportive Phase generation (*trong sinh*). This supportive relationship meant that Fire supported, or gave rise to, Earth, Earth to Metal, Metal to Water, Water to Nourishing Warmth, Nourishing Warmth to Wood, Wood to Fire and continuing. A double bellied 8 figured as a sequence, when drawn out as a sinuous line through the boxes penned on his whiteboard, represented the pulses. Illness was a contrary pulse. The tabular form that he used to explain illness graphically figured an opposing and inverted ‘flow’ or sinuous line. Illness was understood as a draining sequence (*trong khac*). This opposing mono-linear flow of qi through the Organs was represented as being contrary to generative Phase logic. An ill pulse was therefore figured as a detrimental flow through trigrams from Fire to Wood to Nourishing Warmth, to Water, to Metal and to Earth. Students learnt Five Phases logic at the Institute. They were familiar with these sequences of support and drainage. Even though 6 Qi introduced an additional Phase, the mono-linear sequencing of generation and drainage flows did not change.

Table 3: Qi Flow through the Pulse

A Normal Pulse was a flow:		An Abnormal Pulse was a flow:	
Read on Patient's			
Left Wrist	Right Wrist	Left Wrist	Right Wrist
Trigram Earth 2	Fire 1	Nourishing Warmth 3	Water 4
Wood 6	Metal 3	Metal 5	Wood 2
Water 4	Nourishing Warmth 5	Fire 1	Earth 6

6 Qi treatment was an act on the pulse. This act was what our teacher called a “formula” (*công thức*). It was an inversion of point types correlated with the same six trigrams that were used to describe Organ location, read at pulse sites. Six acupoint *types* were used. These were Calming (*tĩnh*), Spring (*vinh*), Stream (*du*), Origin (*nguyên*), River (*kinh*) and Meeting points (*hợp*). In an un-cited copy of part of an old textbook that he handed out in early classes, each point type above was annotated on each of the twelve main channels. These point types inverted with each other according to a never-varying rule. The formula on yin and yang channels was slightly different because Origin and Stream points were the same on yin channels. The set of point types were repetitively used and became predictable: they never varied. Points from the Conception and Governing Vessels were used as additional points. The formula stated how these point types should be inverted. These points were indicated for treatment. I will not describe the formula here since I wish to draw attention to the systemicity in operation in this teaching. The formula dictated point transposition. These created what I have translated as a spirit channel (*mạch nguyên thần*). The spirit channel was used to effect needling configurations. When a spirit channel was created it was not a single channel ‘entity’ but a net of points crisscrossing the body and so recruited all the channels for any one treatment event. All points used were channel participants. New Points (Q. N. Le, 1993), for example, were absent in 6 Qi. In later classes, our teacher demonstrated how the formula operated, discussing each of the twelve main channels methodically.

Needling locations were determined through a logic of opposition and inversion of trigrams. Through a repetitively applied formula, three lined trigrams were transformed into six lined hexagrams (since they represented an Organ pair). When hexagrams of needling locations were drawn, on the white board or printed on crib-sheets, diagrammatically they were seen to be inverted. The diagrams called hexagrams looked opposing and inverted (see figure nine). Inversion then was located in hexagrams rather than points, channels or Organs. Our teacher explained:

In applying this method of inversion in treatment, we verify the area of pain, in terms of the main channels and what their trigrammatic representation would be. Then we invert these points to find out where to needle. These inverted points lie on the net called the spirit. Points lying in the field of pain are contraindicated. We do not needle points in

the field of pain but we can treat pain by following these formulaic principles. We compose the spirit in order to treat the main channel, where pain has arisen because of blockage [qi is stuck, it can't move]. We use the spirit to treat the main channel though in reality we are treating the internal Organs... Medications are made to a script and acupuncture is the same: acupuncture can be discussed completely like a prescription. It's not at all that we have a prescription ready to needle; it's just that we resolve the patient's issue by using a set of principles.

HUYỆT THÔNG (Chống Chỉ Định)	HUYỆT CHÂM (Chỉ Định)	— PHỐI HỢP +
Côn	Thương	Thương Dương
Lôn	Dương	Xích Trạch
Kinh	Nội	Nội Đỉnh
Cốt	Đỉnh	Kinh Cừ
Thái	Trung	Trung Chử
Uyên	Chử	Thái Xung
Thông	Khuru	Khuru Khur
Cốc	Khur	Ngư Tế
Chí	Dương	Dương Cốc
Âm	Cốc	Thiếu Thương

Figure 9: Contraindicated Points (left) and Indicated points (centre) Invert to give a Point Prescription (right). ©Nguyen Phuong

The formula, methodically worked through, concluded with a needling prescription. This prescription dictated needling points in locations distant from where a patient verbally indicated pain was being experienced. “Ignore pain, obey the trigrams,” the Master counselled us. I argue in chapter five that acupuncture was enacted clinically in HCMC as a treatment of pain. Somatic pain indications were an important determinant of needling locations. But in 6 Qi, uniquely our teacher claimed, points lying in the field of pain on a patient's body were contraindicated for treatment. An expectable acupuncture treatment in HCMC was 20 minutes of electrical acupuncture needled into the field of pain indicated by the patient. This was utterly

not a 6 Qi treatment. In 6 Qi, all channels were recruited to enable qi movement. Needling into the field of pain was contraindicated because the field of pain indicated blockage. In 6 Qi acupuncture, blockage was removed by going around, for example, in the way that a roadblock might be eased, not by removing the problem at the point of block but by rerouting traffic onto other roads that are freely moving. The mode of unblocking was in the translation of trigrams. Needling configurations were deduced from trigrams and hexagrams.

The pulse was imaged in tabular form. Our teacher drew tables to image Organs. Organs were represented as boxes, six Organs in relationship with all other Organ boxes. The tabular form in which this information was delivered was predictable: it never changed. 6 Qi always treated both sides of the body, left to right and front to back, so created a needling pattern that mimicked 'movement' figured on tabular 'maps' of pulse locations handed out to us as explanations. Qi was directed between the right and left of the body and between the upper and lower body. Needling configurations looked balanced. As Lanh explained one time, laughing about needling herself to treat a 'flu she had, "I couldn't do 6 Qi because we must needle two legs, two arms, so how could I needle the opposite arm with an in-sitting needle!" She needled Bladder points in her feet instead. In a sense, the body and a printed table of pulses, in print or scribed on the whiteboard, mimicked each other. They could stand in for each other with respect to figuration of qi flow.

Teaching in 6 Qi class had a reliable and repetitive order. Classes were progressive: we started with philosophy; proceeded through proof; deduced from narratives the essence of a formula; took note of relationships between familiar acupuncture objects; used familiar nomenclatures for these objects and arrived at indicated needling configurations. Each channel was graphically represented in a tabular form, which related to all other channels using the same tabular form. These forms did not vary and therefore were predictable in a complex learning situation. While 6 Qi was experienced as difficult by all in the class, tabulation created regularity. Tables raise clarity and reduce uncertainty, argues Star (1989). Representing channels as predictable and dependable tables meant that each channel became the same: channels did not have unique eccentric habits; they were standardised into systematic relationships.

I argue that a significant concern in 6 Qi class was completeness. Our teacher was very clear that we should attend all classes and take hold of all handouts to ensure that we lost nothing of this method that assured therapeutic effect. These verbal injunctions chivvied students to take responsibility to ensure that our learning was complete; that nothing was left out. Also, continual provision of printed materials was notable. The first handout was a printed six-page text on the philosophical origins of 6 Qi. In the second class, he handed out seven pages of hand-drawn diagrams describing the different relationships between Organs. Thereafter we focused on one Organ pairing individually and sequentially so that each class was accompanied by a formulaic printed text. He later handed out an un-cited photocopy of all point names arranged alphabetically from Le's (Q. N. Le, 1993) text. Copying was rife and intellectual property was not an issue. These papers were copied as desired and handed around to friends and interested colleagues. I did the same myself, with Nguyen Phuong's own papers. As discussed earlier, acupuncture teaching resources were in poor supply so these papers were very valuable. Printed handouts were physical, mobile signifiers of holism.

Completeness was also demonstrated in Nguyen Phuong's teaching style: explanation in textual exegesis, in symbolic numerical proofs, in tabulated deductions of point prescriptions and verbally in direct response to his students was systematically pursued. One afternoon, the youngest student Tan was bothered. He had a headache; this method was too difficult to understand. Rather than mimicking notes, Nguyen Phuong darted to his whiteboard and dashed off a set of trigrams with a linear drawing of the pulse – three lines indicating three levels – using arrows to indicate a pulse rising and falling, setting up an explanatory diagram that had not been in the printed handouts. We must pay attention, he told Tan, to the four corners of the pulse. If one corner of the pulse was rising, the other may be falling and vice versa. He signed his own pulse. "This location is Lung, is it right?" he queried Tan rhetorically, "that's easy, but this 6 Qi is more difficult."

6 Qi was difficult but it was not mysterious; our teacher answered questions with diagrammatic explanation or an experience referent. He did not leave questions unexplained, as Hsu's personal teacher in 1980s Yunnan did. Hsu describes a

moment of non-comprehension in her classes with a private practitioner of Chinese medicine that is worth detailing because it is so different from the teaching stance in 6 Qi class and so reveals something about Nguyen Phuong's style. With five other students, Hsu had been studying older Chinese texts in a private class. The texts were difficult to understand because of metaphor and linguistic change that had since occurred. One passage was so obscure that the students looked to the teacher for some direction. He took off his glasses, breathed on them and let the condensation thereon evaporate. No words were spoken and the class dispersed. Hsu writes that "instead of providing clear definitions of the words... [he] left us to decide which aspects of them were relevant. This shows how much room he left for personal assessment of his indirect interpretation" (Hsu, 1999:108-116). Nothing so mysterious happened in 6 Qi class. Our teacher directly presented and explicitly explained, ensuring that we understood; satisfying himself that he had given us the whole of the 6 Qi.

The whole of the 6 Qi was mythical origins; numerical proofs; illiterate deduction of truth and a truth presented as revelation (see Haraway, 1991). The all of 6 Qi was the generative and destructive laws that acted at pulse locations that were figured in tabular form and a formula of point types that never changed. Such progressive explanation, continual provision of materials and the urging to attend classes were all practices that did systemisation. Classes were envisaged as progressive; tabular handouts were repetitive and reliable. Nguyen Phuong used systemisation as pedagogy, which was a model of truth production also used at the Traditional Medicine Institute. Both loci of learning modelled truth production as literate, predictable and explanatory, making use of a common vocabulary. That vocabulary was of factual points, variable channels with Organs and qi in a familiar form as multiple objects and debates.

Notably, Nguyen Phuong set out a formula of proven efficacy at predictable class times. In contrast, he himself had learnt 6 Qi from a bhikhu⁴ over a much longer period of time because his teacher would never set dates and times for teaching, kept changing the curricula and would not write anything down. Change was the

⁴ A Buddhist monk or nun.

fundamental essence of all action, the bhikhu had argued, which students had to grasp in a fundamental way. Teaching in Nguyen Phuong's private classroom was modelled differently; handouts, class times and a place of learning were all reliable. His teaching used a method of truth production that all his students were familiar with. Use of this method, I suggest, may be understood as geared towards generating trust in his teaching, in a context of problems validating the truth claims he also made.

Creating Intimacy

While our teacher was systematically working at doing completeness, students were concerned about distinguishing it. '*Lương y* keep secrets' was a repeated caricature of traditional medicine in HCMC (see Scheid, 2002; Hsu, 1999 on secrets in Chinese medicine). Personalised learning was how true and complete understanding might be attained. "Practitioners didn't write their secrets down in a book, all their effective cures were taught within the household (*gia truyền*) so the practitioner needs to be with a family or a Master or else how can they learn the techniques that really work?" explained an avid materia medica and acupuncture user. Credentials and licences did not stand in the stead of efficacy: truly efficacious techniques were kept for those within trusted relationships. All students had heard this. Secrets raised the possibility of secrecy: no one knows what they could or should know. In Hsu's ethnography, secrets were information that should not be shared widely; others might use it for their own monetary or prestige profit at a later time (1999:35-36). While secret teachings are "marked by uncertainty", suggests Hsu (*ibid.*:50), secrets also secure the authority of a practitioner and can be considered a personal adornment (citing Simmel, 1950, secrecy adds value), creating a practitioner as outstanding. 6 Qi class could be interpreted as work that set out to demonstrate that secrets were *not* being kept. In order to demonstrate the not-secret nature of the class, much giving was engaged by our teacher. Our master handed out texts, explanation, details, ensuring we all got the printed papers, chastising us if we had to miss a class saying we would not be able to catch up and reviewing previous classes because one of the small group had been absent the previous week, together with the 'little secrets' he told.

However, complete teaching came to us because we paid for the class. The first three classes were free, after which a fee of 1,200,000 VND was levied for the rest of the

course⁵. For this, our teacher assured us, we would learn everything: he would teach us everything that he knew with regards to the 6 Qi; nothing would be left out. Notice that by so emphasising, our teacher raised an anxiety that he might actually be keeping secrets. Concerns about secrets, completeness and resulting efficacy of the teaching were brought into the classroom by students who had heard these stories elsewhere. The requirement of assurance is the “expression of mistrust”, argues Annemarie Berg (2003). Uncertainty was generated anew in the classroom. Students did find the price expensive: Tan whistled when he heard the price; Lanh was concerned that I would find the price excessive because I was a student. Acupuncturists charged between 40,000-80,000 VND for a private treatment depending on their personal estimate of what a patient could afford to pay, so this teaching could be crudely equated to attaining an extra twenty patients. Nguyen Phuong had empirical measures of the efficacy of his healing. If students used his methods, which had proven their effectiveness, then talk would circulate and those twenty extra patients would be obtainable. But students wished to be certain that classes would not turn out as at the Institute where they might “just pay and learn a little but the teachers don’t want to tell you everything,” as one student described.

Intimacy, generated through fun and story-telling was how interlocutors could judge a relationship and therefore the quality of information. I argue that our teacher sought to build trust in a context of uncertainty by demonstrating completeness. He also used fun (*vui*): talking, listening and togetherness. In such activities, people could come to know the “heart” of another, as one interlocutor described. We could get intimate. Nguyen Phuong was an older, successful and experienced Master teaching to mostly active practitioners. He was a joyful storyteller of his clinical experiences. Many narratives drew on the shared experience of being a practitioner and occasioned laughter from students who never reciprocated by telling their own. We were in a discursively constituted teaching space, participating in interaction between unequals. In these stories, our teacher presented himself as a successful practitioner to younger aspiring peers. Those stories often caused students biking home together to remark, *đi học vui, phải không* (learning was fun). I present three of Nguyen Phuong’s short stories to indicate their variety.

⁵ It would be interesting to study unpaid teaching to understand how cash mediates trust-making situations.

One time someone called me to help a patient suffering his fourth stroke. The arms of the patient were in seizure; he lay curled up like a prawn. But when the patient is like that, how can we accept money for treating the patient? It seemed that there was no-one at home to care for this patient. No-one wants to accept the responsibility of care, so the illness drags on for many years. That's a hard case to treat.

There was once a patient, the husband of a hospital worker, lying in the Intestinal department. He lay there for one week and lost five kilos and after that time he still had pain; he couldn't eat and couldn't sleep. In the late afternoon, someone took the patient to see me and I took his pulse and 'perceived' a flu pulse. I needled into the flu and gave him materia medica for his flu so that his chronic stomach pain was relieved. When faced with acute and chronic symptoms together, we put the chronic aside for the time being and treat the acute. A week later his stomach pain was gone and he was discharged from hospital.

Really, we need to be careful to send people to be treated in the right place, to be treated well and then we can receive payment. There was a woman who was driving her motorbike and was taking her parents along. Dad, the eldest, sat on the back and dad fell off the bike and chipped his shoulder blade. He came here to get acupuncture. I needled him twice. But then I could see that I couldn't cure him; I wasn't sure if he had suffered a chip in his bone or not so I called for an x-ray and he went to the hospital for an operation. He doesn't have shoulder pain now.

Story-telling worked at many things: they were fun to hear, they gave advice couched in humour and they were opportunities for students to ask about their own patient. Classes were in monologue – questioning by a teacher and coerced answering of students was not employed to check the understanding of a lesson. Our teacher advised how to approach a complex case: we put the chronic aside and treat the acute. He suggested taking care when estimating one's own abilities as medical practitioners: we must be careful. He told us that he was willing to refer patients to a

hospital if a patient could not come out of illness, making medicine a function of healing not of one's professional ego. When he was telling these stories, he looked around at us all, smiling, cheerful, animated, giving cadence and shape to the narrative. He did not boast that his methods always produced a positive result: he would just as easily note that a patient died suddenly and no-one knew why. Possibly the nature of his students prevented excessive boasting; he was talking to fellow practitioners. Further, his medical ethic (*y dao*) was to "tell the advantages and the disadvantages, tell all three sides of a story." These narratives presented both positive and negative cases, showing that not every illness could be healed. By doing so, these narratives worked at developing a close personal relationship between this teacher and this particular set of students at that time⁶ as students and teachers.

Additionally, in the 6 Qi classroom hierarchy was used to get intimate. Students particularly used and performed the word *thầy*. In and outside of the clinic-classroom, Nguyen Phuong was always addressed or referred to as Master. Students did not follow up the word for teacher with a qualifier indicating the teacher's speciality as Didier Bertrand noted in Hue city (1996). Students self-referenced themselves as *em*, the same pronoun used by those of younger age when interacting with older persons and by a wife in relation to her husband regardless of age. Nguyen Phuong's other title was *huong y* but no student used this title nor, as I have done here, used his name. Neither did the youngest students call him *bác*, senior uncle on the male line, nor older brother *anh*, which Lanh could possibly have used being only slightly younger than the Master. We all used *thầy*. *Thầy*, however, called us by our first names or refrained from differentiating between us with a personal pronoun. Neither did he use *ừ*, a word of informal agreement made by seniors towards juniors, such as between grandparent and grandchild. *Thầy* use was most marked when students raised their own patient cases with Nguyen Phuong. The tone of the petitioner's voice lowered and slowed, indicating hesitancy, while they asked his opinion of their treatment method or advice on how to continue with a complex case: women and the youngest male present made greatest use of this style of asking.

⁶ Nguyen Phuong gave classes every year to different students.

The male gendered honorific of *thầy* conveys respect and connotations of mastery of a particular skill, argues Rystrom, “a teacher is expected to teach the inferior who, in turn, demonstrates respect by obediently taking the superior’s good advice into account” (2003:122). According to Rystrom, a body habitus of superior-inferior is developed through disciplining at home and in school. The raw material of child is shaped into an adult, hierarchically-conscious, gender through disciplining by women in the home and teachers at school. Both male and female teachers in primary schools are active in the transformation of a child through their own moral example and by teaching curricula using methods such as rote learning, a “tool that does not brook dissent or discussion... adhering to strict well established conventions” (Rystrom, 2003:126). A teacher in Rystrom’s ethnography is a hard social structure against which children have their inferiority formed. However, Dr Truong Thin (1984) negatively refers to shamans, witchdoctors and sorcerers in his 1984 book even while continuing to use the honorific *thầy*. Truong Thin argues that those ‘teachers’ practice a medicine that is chaotic and at a low level of literate education but even so, continues to use the word ‘master’ suggesting that the title does not automatically ‘make’ a superior person.

Rystrom’s conclusion was “only one way to think about teachers,” a practitioner explained. I had brought up Rystrom’s book in a discussion one morning, while sitting around in mutual friend’s clinic. There were two types of teachers, my interlocutor continued; school teachers and teachers of medicine were not the same. An acupuncture teacher was someone who changed his lifestyle and the life of others. Teacher Nguyen Phuong, my interlocutor pointed out, meditated, was a vegetarian, had long clinical experience and always worked for the benefit of the patient. Consider the leader of a free traditional medicine clinic we had met, he continued. He was a *bhikhu*⁷ (I often overheard male *bhikhu* get called *thầy* in greetings) who dispensed acupuncture and medications and used acupuncture techniques that required a patient to be treated only once a week, instead of two or three times per week. Such a practitioner potentially loses money, if the clinic was for-profit, but this was not a concern compared to the welfare of the patient. The speaker used his own schema of what made a superior personage but he talked about

⁷ Buddhist monk or nun.

teacher as one who worked on himself so that he transformed himself, as in the *đi tu* (become a bhikhu) metaphor. When a person *đi tu*, s/he transformed the way she lived as was evidenced by external behaviours. Hence outward signs of inner morality can be read. As in Rystrom, the moral guidance of a teacher was required, though in Rystrom a teacher was someone who punished and enticed obedience to a gender norm.

An acupuncture teacher was one who had engaged voluntarily in self-transformation and led by example. In our first handout from Nguyen Phuong was a phrase: “*tu thân, tề gia, trị quốc, bình thiên hạ*”: a man should work first to change himself; then learn to manage his household; thereafter learn to manage the country and thence the world. A human self was at the centre of concentric scales from which world change was possible. The use of the word Master in a different situation is instructive. While Danh was not usually addressed as *thầy*, during a memorable occasion he was so referred. The event was a short visit to a government-supported project that housed blind people and provided paid work of making toothpicks, broom brushes and offering massage. The work was laborious and boring. We turned up one afternoon to ask if the residents were interested to learn an auricular acupuncture technique (NADA) to supplement their massage work. Most were generally interested but one young man particularly so. He was excited by our presence and the potential we offered to him to learn and change his life. He repeatedly called Danh ‘master/teacher’ when questioning whether he had found the correct ear acupoints, when seeking answers to questions about what would happen if he needled in the ‘wrong’ place and when seeking assurances about future learning. “Master” for this young man was an exhilarating potential that could effect change in his own life.

Ester Goody suggests a “consistency across cultures with which teachers insist on being given respect and obedience” (1978:41) however in 6 Qi class, it seemed that the students were more conspicuous in hierarchy creation, in both utterance and body postures. Rather than individual vortexes of learning interacting with each other, students were concerned to create a relationship of one teacher to many students. During class hours, our teacher sat at the table with us. If he stood up to mark on his whiteboard he invariably sat down afterwards, not seeking to maintain a

head height differential between himself and his students. A senior person's head should be higher than an hierarchically junior person, suggests Andy Kipnis (1997) on hierarchy making in rural China. Hot herbal tea, rather than the ubiquitous iced green tea, was served at each acupuncture class. Lanh would take care to serve our teacher first, bowing her head slightly and offering the plastic disposable cup double-handed to him. We waited for our teacher to take a first sip before we reached for our cups. As noted above, listening to treatment stories never triggered reciprocal stories from the other adult practitioners in the classroom. Students lingered a while after class, to chat and joke with each other or to ask our teacher some particular questions, either about the class or their own health. While students could turn their back on our teacher when walking out of his house, they rather wandered out avoiding a direct turn near his face. The front of the body was here a zone of respect, while the back of the body was a zone of non-respect (Dinh, 1998). On entering the clinic-classroom students would make a quick shallow body bow to the teacher: this was most marked in the older men. If mobile phones rang during class, students moved quietly away from the teaching table to answer it before switching it off since they had forgotten to do so beforehand. Like iced green tea, answering the mobile phone while in the middle of meetings was a ubiquitous hobby in HCMC. By turning their phone off, students were demonstrating that their teacher was more important during that time period than anyone else seeking to contact them.

The 6 Qi students desired the hierarchical relationship which their address performed, not necessarily in deference to a given but in the hope that our teacher would live up to the title. Arjun Appadurai calls this behaviour "coercive subordination" in India; giving deference entitles the giver to kindness and compassion (1990:108). However, students in the 6 Qi classroom were not interested in kindness, rather secrets. Becker and colleagues (1961) argue that the questions medical students ask, and what they write down, indicate what they want to know. In HCMC, student questions revolved around the content of the 6 Qi formula and the Master's experience, flagged by questions about what to do with a particular patient a student had encountered. Towards the end of the first block of classes, Nguyen Phuong spent class time telling us stories of his clinical experience, still in monologue. Particularly, he talked about a treatment that had proved successful for him in the past and drew the needle positioning he had used on the whiteboard. This

was a secret that only he knew, he told us, only he and now we students knew it. Now we could use it in our own practice. Point locations were carefully drawn and copied out into student jotters, along with the teachers accompanying experience of when and how often he had used it. Students were interested in secrets. 6 Qi was the biggest secret since it was not taught at the Institute and relied on finding the appropriately knowledgeable teacher willing to take in students. Intimate relations between people were used to mediate a risk that never disappeared: that perhaps he was not telling us all the 6 Qi secrets. In this particular clinic-classroom, familiarity was engaged by making relations of seniority between one to many: we were students, inferior, and we silently urged Nguyen Phuong to *be* a teacher and guide us. As students we desired asymmetry. Asymmetry was not negative in terms of obtaining the desired completeness of teaching.

Distinction

In talk, Nguyen Phuong actively distinguished between his acupuncture and all others. He flagged this work using statements like “there isn’t a method around like the 6 Qi for being so scrupulously detailed like this”; “my advantage described in these diagrams”; “my specialty”; “my formula is deep acupuncture”; “thanks to this method of the 6 Qi we needle and the patient doesn’t feel shock or fear”; “there have only been four masters of 6 Qi in the last 1,000 years.” 6 Qi, he claimed, was valuable. He would prove its uniqueness by comprehensive explanation and ample provision of learning resources. These would fully evidence a method of efficacious healing. Noticeable however, was that 6 Qi was always additional to teaching at the Traditional Medicine Institute teaching, never in place of it.

The Institute was used to set up a distinction with 6 Qi. The Institute was the Other, standing for all other sites that could locate acupuncture learning in HCMC such as households, pagodas and private teachers. Mirror reasoning was employed. 6 Qi could be understood in relationship with what it was not. 6 Qi, our teacher told us, was truly Vietnamese not Chinese: “the Chinese do not bring yinyang into the heart of medicine the way 6 Qi does”. At the Institute, “they” just teach Chinese techniques. Before, a student learning should learn medicine of the Classic of Changes (*học y, thì phải học dịch y*) but “not any more.” At the Institute, pulse was taught as a set of static locations. This was not the true pulse, rather pulse was

dynamic. Learning at the Institute was easy but if a student learnt easy it would not be easy to practice, rather it would be difficult. “If we learn the hard way, it will be easy to practice.” Particularly, 6 Qi was made to be difficult. Chatting about the class, I remarked to fellow students that *y dich* was logical and very interesting. “Yes, interesting,” laughed Lanh, “but it gives me a sore head!” The oldest male student agreed: it was harder to learn but that meant it would be easier to practice once understood. Certainly, they all agreed with our teacher, it was much “deeper” teaching than they would get at the Institute.

Two acu punctures were distinguished from each other, one difficult and one easy. In this hierarchy of learning, one acupuncture gained greater value. Our teacher figured himself as providing the higher. His clinic-classroom was a progressive place of learning since at the Institute students learnt ‘low’ (*thấp*). “Go to the Institute,” he suggested to me waving his arm at the open doorway of his home where sunlight glared outside, “go there and learn low and then come back here and learn high.” All the other students in this class had studied at the Institute and had gone on to practice. I should follow suit, he advised. Lanh had gone there for sciatica treatment many times, he continued, but she felt better with just one treatment of 6 Qi. He personalised a measure of his efficacy by referencing someone I knew therefore implying that I could trust him because of her. “You won’t need to sit exams there,” he laughed. He gave knowledge, he emphasised, not credentials. Attendance at his class went un-certificated. Credentials were for the Institute, he reckoned.

Difficulty was made by employing and requiring translation between three languages: nationalised Vietnamese, Sino-Vietnamese and trigrams. Trigrams were used to describe acupoints, Phase sequence and temporary states of the pulse. Classes that lectured on the 6 Qi formula were conducted in Sino-Vietnamese while classes that discussed treatment experience were conducted in nationalised Vietnamese. Point types, formula and pulse-taking method should all be memorised. Treatment points were spread across the body rather than being localised. The class was experienced as difficult because it was a class of what Nguyen Phuong called higher learning. This higher, progressive class was experienced as difficult with efficacy as the final outcome.

6 Qi class was phrased as a progression up from Institute learning and so was not intended to replace it. Points maintained their facticity. All students were assumed to know where the points *were* (see chapter two) as well as know their names, since our teacher named point locations. Points remained static – they had not suddenly become slippery, individual objects. Points were still accurate to the point of a needle tip. Acupoints maintained their primacy in medical reasoning: point types constituted the formula. We were challenged to rethink channels and our teacher re-engaged in the Organ debate. Look at this diagram I have given you, he told us during an early lesson,

You might have learnt that when needling the Kidney channel we needle for the Kidney Organ. When we needle Heart channel, then by doing so we needle to help the Heart. No! It's not like that. We needle to help Heart by needling points that run through all the different channels... it's not that points on one channel treat that channel only or treats that Organ only. The most important thing is for the acupoint that we needle to have value. It's not that we tonify blood for the channel and then use points for the Heart. It isn't like that. The channels and organs have a relationship like a net. It isn't that 12 channels are 12 parallel channels and that's it. The channels link up all the points and all the points interconnect with each other.

Elaboration about Organs was somewhat sidestepped in favour of clarification about an assumption that we would consider Organs as organ-channels.

Equally, a Sixth Phase interacted with Five others, changing the order of supporting and draining Phase relations but the logic of support and drainage did not change. When constructing the spirit net by using all other channel pairings to treat one pair, he continually emphasised that this was based on the main channels and that he was not inventing a new channel. All acupoints indicated for treatment lay on the main channels and were never outside of those. The centrality of both qi and blood was unchallenged. "Qi goes up and blood goes down. One is the root and the other is the branch. We need to have both up and down, rising and falling," he insisted. His claim was to a more effective acupuncture prescription, which was manifested in the logic of the trigrams from Classical medicine. This alone was efficacious hence

disagreed with any and all needle stimulation techniques and disagreed that particular acupoints had in themselves curative properties for named diseases.

A hierarchy of value was implicated in geographies of learning. First go to the classrooms at the Institute, he urged me, and listen to the teachers employed there. Thereafter, bike over 'here' to his clinic-classroom. He generously allowed me to study in his classes but I was an anomaly, as he pointed out to me. I should not be in a class of higher learning first, or before, the lower. This was a progressive hierarchy: Institute first, then his classroom. Nguyen Phuong did not give credentials, he gave knowledge, he asserted. However, as pointed out earlier, even if he did give credentials the Department of Health would not recognise these as evidence of acupuncture training for a medical licence application. He argued, however, that he was not in the business of teaching students in order to obtain legality rather he was teaching students how to heal. Learning to heal would be more difficult. Nguyen Phuong's hand gestures made a relationship between two different pedagogical loci. The Institute was referenced as a basic infrastructure, without it learning high would be impossible. Go there and learn the basics, he urged, go there and obtain a language with which to talk, listen, read and think about acupuncture. This was possible because standardising work creates a common language with which to engage difference (Lakoff, 2006; Latour, 2005). This does not mean that everyone who studied at the Institute will understand acupuncture objects in the same way. Lanh, for example, was in her late forties and entered the Institute after being treated by Nguyen Phuong for many years. She therefore translated Institute acupuncture language through that of 6 Qi.

By making a hierarchy of value, our teacher also seemed to flatten out difference. He made his sole trader business equal to a network of numerous classrooms and mass student participation, book publishing machinery, multiple treatment rooms and inpatient wards at the Institute and its monopolising relationship with the Department of Health. However, he was not required to deal with organisational uncertainties such as the extent of institutional budgets nor staff politics. Rather, he had to deal with more immediate monetary uncertainties like generating future income through teaching and treating in private practice. Nguyen Phuong created the Institute as a fundament of acupuncture when he referred students to learn there

and when he collapsed all other acupunctures available in HCMC into a category of technician training at the Institute. He assumed this education when making 6 Qi coherent for students. He acknowledged that he could not provide legality. But he claimed efficacy. Thereby efficacy and legality were separated. By networking himself with the Institute, he claimed face with the Institute. Kipnis describes face as dynamic relationship negotiation. Having enough face is to sit opposite, as an equal, a senior in a banquet or a guest entering the home. To do so is to assert that self and the other are of parity. Face is not only the superiority of another but having sufficient superiority of one's own to be able to sit together-with, to face another (Kipnis, 1997:43). By acknowledging the legality-making network of the Institute, with its credentials and the Department of Health, with its licences, Nguyen Phuong could also raise his own face by asserting that he was in parity with this network.

Distinction was a means by which students were invited to judge the value and completeness of their teaching. Nguyen Phuong placed himself in relationship with a network that his students were already familiar with. Students had rejected the Institute's claims to an holistic education and were concerned about possible 'incompleteness' of their teaching there. But the teaching and the credential of the Institute had brought them into a medical profession, in which they were assiduously working with aspirations of being successful. In other words, they had commitments to their Institute education. Nguyen Phuong assured them that this education was useful but colluded in their anxiety about its comprehensiveness. It was basic but not sufficient to therapeutically transform patients, he implied. He brought this up by quoting an expression: "people say that eastern medicine is like the saying 'deaf to the sound of the gun'. If you don't know what a gun is, you don't know that you should be scared." A practitioner who just knew a little was ignorant. Such a person did not know when to be scared, even when they should be. With insufficient, or incomplete, knowledge a practitioner might harm a patient. All students who came to his classes gained 'higher' understanding, he assured us. But by distinguishing between his own teaching and that of the Institute, he also created a sense that this 6 Qi was little known since it could not be found in any other classroom or any book. This teaching was rare and it was only through his personal classes and through hard work that efficacious knowledge was so rendered. Because we all knew that the

'good stuff' was secret, he used distinction to assure us that 6 Qi was not 'common knowledge'.

Conclusion

This chapter has been about how trust works to create truth, taken in a positive sense of the what-is rather than the what-is-not. Student-practitioners in a private acupuncture class sought to learn an efficacious acupuncture technique but for this technique to be called 'knowledge', students required the *all* of the 6 Qi and getting the all required the generation of trust. As Foucault (1976, 1980; 1982) points out, the question is not whether something is true or not, but how truths are made.

I have described how a teacher and his students worked at creating trust so that efficacious knowledge might emerge. They worked in a context of doubt about credentials and circulating stories of bribery and corruption but they also generated anxieties about incomplete knowledge in the classroom itself. 6 Qi was a complex acupuncture formula taught as a class of higher learning to Institute graduates. Our teacher used a teaching model that was familiar to students from their Institute education: he emphasised literate comprehension, repeatability, predictability, a common vocabulary and systematic explanation. Both teacher and students sought to become intimate with each other, *as* students and teacher, through strategies of fun and hierarchy-making. A circulating narrative was that traditional medicine practitioners kept secrets: a student had to get close to his Master to learn the truly efficacious techniques. Additionally, 6 Qi was distinguished from Institute teaching. Students were assured that they needed to learn the 6 Qi since their Institute education was insufficient but also, since all the 'good stuff' was in secrets, they were confident that not everyone knew it.

Trust was required to attain an outcome called 'efficacious knowledge' or else a student of medicine could end up with class-notes on superstition and lies. Our teacher validated a truth claim to teaching the complete 6 Qi by using a familiar pedagogic model. The quality of that information was judged through the quality of personal relationships developed within the classroom. Such relationship-building employed strategies that were made use of elsewhere in the work of creating connections and personal networks in HCMC (see chapter five). Hierarchy between

persons and pedagogic sites was mutually produced in the classroom as an ongoing work. It was not 'established' after which it could be forgotten about. The work of trust making in 6 Qi was legible through contexts of doubt and cynicism so that completeness was uncertain. Truth claims were questionable. These fears about the incompleteness of teaching suggest that one circulating definition of efficacy for acupuncturists in HCMC was holism itself – a pedagogy which allows for incompleteness potentially loses therapeutic efficacy. The efforts made in the 6 Qi classroom also raise an interesting consideration about situations when we trust without question. For example, how and in which situations is trust in Randomised Control Trial procedures (RCT) and outcomes produced, especially since RCT is taken as a 'gold standard' against which to measure the clinical efficacy of acupuncture (Kaptchuk, 2000; Rhodes, 1996; Waldram, 2000)? The pursuit of efficacy in acupuncture was to successfully treat patients in pain. I will consider clinical encounters more fully in the next chapter.

4. Shaping the Clinical

There is often an unspoken assumption that medical education is unilaterally geared towards clinical encounters and that the memorised contents of lectures and textbooks are transferred, via the medium of a human practitioner, from one site (such as an Institute) to another (a treatment room). But must we consider clinical truth as only that which is generated within a reflexive and authoritarian clinician (Davenport, 2000; Higgs & Andersen, 2001; Higgs, Titchen, & Neville, 2001) who gains experience that is transformative? Reality making in clinical encounters can be re-conceived.

Patients attending an acupuncture clinic or treatment room in Ho Chi Minh City did not ask about a practitioner's training or to see their credentials and licences; these pieces of paper were rarely displayed. They appeared unimportant to clinical encounters. In this chapter, I investigate what did take on relevance when acupuncturists met their patients. Clinical encounters have been described in terms of a mono-linear phase: first diagnosis and then treatment. But there are problems with this conceptualisation, which I review first. During fieldwork acupuncturists did not appear to dictate treatment events. Therefore rather than thinking of such encounters as phases, I will make use of Mol's suggestion on shape. She commented in *The Body Multiple: Ontology in Medical Practice* that things – chairs, tables, letters and clothing – give shape to clinical encounters (see Mol, 2002:27). For Mol, these do something; they act and in doing so collectively form an encounter that looks-like an event called 'getting treatment'. That treatment has a shape, I would add, has consequences. Expectations emerge and recognition can arise. A patient could then know what an acupuncture treatment was, and to the contrary, what it was not.

The shape of acupuncture treatment in HCMC was dominated by vision and pain. Descriptions of these two practices will divide the rest of this chapter. I will describe how the act of looking and the presence of pain participated in the clinical activities of three practitioners, Chi Ha, Nguyen Phuong and Canh. Before finishing, I will also make minor note of how patient clothing, needle metal qualities, electrical

acupuncture units and care were all implicated in creating a shape for acupuncture treatment, to emphasise that while looking and pain were important, they were not the only mediators active in clinical situations.

During fieldwork, I was interested in what an occupational group called acupuncturists were doing and working at. The sufferings, perceptions and behaviours of patients were matters of concern for acupuncturists, so come into this chapter through practitioners themselves. Even though I do not raise patient perspectives or opinions in this chapter, patients will be shown to actively shape the medicine they participated in through the expectations they brought to clinical encounters.

Diagnosis and then Treatment

Diagnosis and treatment has been idealised as a lineal, causal and homogenous process, presented as a series of stages that move through pre-diagnosis, diagnosis and treatment, which result in ongoing treatment or cure (for example, Markovic, Manderson, & Quinn, 2004; Stewart & Sullivan, 1982). For Talcott Parsons (1951), a discrete stage model structured clinical encounters, each stage designating a function for the sick-patient and the physician-healer roles thereby legitimating actions for both participants in the process. Taking issue with such a linear idealisation, Csordas & Kleinman (1990) suggest that a search for diagnosis can itself be a response to illness or that diagnosis itself can be seen as therapeutic or, again, that healers may not necessarily diagnose patients. Nonetheless, “producing the truth was obliged to pass through this relationship if it was to be scientifically validated”, Foucault argues (1976:66). Because illness manifestations are required to pass through diagnosis, they can be ascribed a characteristic: normal or pathological. Thus the physician is in a powerful position to create an identity for a subordinated patient. Diagnosis, in this literature, is a time of uncertainty and waiting, of refutation of illness or ‘wrong’ diagnoses, or having no diagnosis (Nettleton, 2006). That is, “historical information and examination results... are seen as ‘facts’ which the physician only needs to ‘lay bare’... medical criteria and disposal [as in how to dispose of a medical problem] are seen as... fixed ‘givens’ against which the obtained data have to be matched” (Berg, 1992:154). For medically unexplainable phenomena, sufferers “developed a set of narrative strategies that are intended to reduce the risk of being classed as

‘psychological cases’” (May, 2000:225). Diagnosis by a domineering physician is a pronouncement that concludes a period of uncertainty: ‘a-what’s-the-matter’ is *named*.

For this literature, the primary purpose of diagnosis is considered to be to name the afflicting condition. Naming is considered to be causal. Naming legitimates an experience of illness, which gains acknowledgement as genuine by friends, family and medical practitioners (Glenton, 2003; Nettleton, 2006). A name triggers a therapy prescription, for example, anti-retroviral pharmaceuticals for those classified as HIV+ or appropriate ritual to remove the sufferings of an oracle client who was “being afflicted by the deity Bhairav” (Sax, 2004:295). Naming defines a medical practitioner’s professional and expert status (Jutel, 2009). Naming, as a practice of classifying, creates identifications that are put to uses such as to access state welfare supports where available (Cranea, Quirkb, & van der Straten, 2002); support groups (Lyttleton, 2004) and may overwhelm other identifications of person – extensively discussed in literature on a positive HIV test (Farmer, 1992, 2005; McNally, 2002). That diagnosis is able to produce politicised identities means it has been considered a strategy of power by these writers interested in how authority has been constructed and pursued.

However, characterising clinical encounters as a phased encounter consisting of stages has been critiqued. Marc Berg argues that this notion is only found in textbooks and is therefore a textual artefact. “Physicians [in a Dutch hospital] do not first search for a diagnosis and then, subsequently, decide upon a therapy. This phased, two-step motion does not characterise medical problem solving. On the contrary, from the outset, the transformation process is uni-directionally geared towards the construction of a [solution]” (Berg, 1992:169). The uncomfortable actions of placebo challenge linear causality in thinking about clinical procedures because efficacy precedes an authorised or known cause (see Appendix E, Kaptchuk, 2000), therefore clinical trials must show greater-than-placebo effect to claim efficacy (Wahlberg, 2003). Diagnosis has also been shown as highly variable; the same patient will receive a different diagnosis from different specialists and from different practitioners within the same specialism (Kalf & Spruijt-Metz, 1996). ‘Social’ factors such as ethnicity (Baskin et al, 2006), gender (Bertakis et al, 2004; Lewis et al, 2006)

and language competencies (Mol, 2002) are now seen as intrinsic to medical problem solving. Patients often undertake multiple treatments simultaneously, a complaint in HIV literature by individual practitioners unable to account for synergistic interaction of polypharmacy (Crone & Wise, 1998; Ernst, 2002; Furler et al, 2004). A treatment stage may not manifest itself: it is known that patients may not follow treatment plans and some diagnoses have, as yet, no orthodox treatment. This worried physicians at a Dutch hospital “as they watch their colleagues using diagnostic techniques to little purpose if this does not help in the treatment of the patient” (Mol & Elsmann, 1996:612). Diagnosis without treatment may be construed as a ‘good’ but these Dutch physicians worried that too many details could be a burden, risked the patient’s life and wellbeing as well as being a waste of money (*ibid.*). Further decisions to make use of tests such as MRI, blood tests and x-rays need not be used for the benefit of a patient but rather deployed by a practitioner to gain authority and trust (noted during fieldwork in HCMC; also noted in Kim 2005). The NADA detox acupuncture formula is a five point protocol that is applied regardless of patient condition. For this reason, NADA is labelled a protocol because it is supposedly homogenous (Smith, 1999; Valois, n.d), but American NADA practitioners I met in HCMC classified the five points as a treatment. NADA was a treatment without a diagnosis.

Nonetheless, even if a meeting with a patient in a clinical setting cannot not be said to be causally phased, the question remains whether acupuncturists in HCMC engaged ‘problem detection techniques’ (Mol & Elsmann, 1996)? They did. But in comparison with Jongyoung Kim’s descriptions of problem detection by materia medica experts, acupuncturist activities seem almost unrecognisable. Kim (2005) provides thick detail of a key interlocutor, a Professor of Korean (eastern) medicine, which allows for some interesting comparison. Kim details what he called syndrome differentiation and therapy determination (following Farquhar, 1994) at the East West Stroke Centre in Seoul, South Korea. There, two doctors - one medical doctor (MD) and one oriental medical doctor (OMD), Professor Moon - both meet patients in a private consultation. Each have their own detection techniques; each have a computer to which test results like MRI and x-ray are relayed for reading and interpretation (though in 2005, OMD were not legally able to prescribe such tests without MD approval). The East West Centre is the only place in South Korea

where one patient met two doctors. Kim describes how, at the first visit, a patient is greeted with rigorous medical interviews by both doctors. The MD always interviews first so the OMD has heard a treatment plan before starting his own interview. Moon makes written notes elicited from questions; takes pulse, looks at the patient's tongue; asks about location of pain, bowel movements; body temperature and sweating. In Professor Moon's private clinic, patients may be companioned by family members while meeting the physician. First, a nurse takes blood pressure and registers patients; a resident undertakes a preliminary interview and asks about current symptoms, history, chief complaints, asks the patient whether they suffered from diabetes, hypertension, hyperlipidemia (those explicit questions), then asks about preference for cold or heat, takes pulse, asks for details of urine and stools, height, weight, menstruation and diet. Thereafter Professor Moon undertakes an interview, which may repeat some of the earlier questions. One patient returned three times. On each occasion, she gained a diagnostic conclusion and a *materia medica* formula was reached (Kim, 2005:116-135). These asking-testing activities also took place when acupuncture was used as a treatment¹.

Kim's descriptions maintain a circular linearity between detection, syndrome differentiation and treatment determination. On each occasion, the patient is made legible to the practitioner through practices of looking and questioning – MRI scan is taken here as a practice of looking. Fascinating in Kim's work is the sheer volume of detecting events; they seem to pile up, one on top of another. They are reminiscent of Foucault's essay on confession, for in these consultations the body seems to confess itself. The body is made to take account of itself and its behaviours. Confession, notes Foucault, takes many forms. Foucault argues that in medicine, the clinical exam has changed from a perception of signs to an interrogation, "the exacting questionnaire" as if in a confessional, where the one who listens is the person who is powerful (Foucault, 1976:61-66). Similarly, by chance I met a Swiss acupuncturist in HCMC, who was undertaking a short internship to complement his OMD degree in Switzerland². He described his consultation method in Switzerland

¹ Jongyung Kim, personal communication.

² He had done a five-week practicum at the National Hospital of Acupuncture in Hanoi, as part of his three-year Oriental Medical Doctor degree. His Swiss training college and the Hospital had institutional relationships.

for me. He talked to his patients for at least 30 minutes to find out what was *really* wrong with them, where the pain was truly, that is, additional to where they had told him where it was. “Is it this spot? Is it the spot next to it? Or just next to that?” he asked his patients. And in that process of asking rather than merely noting pain in a generalised area, the process *of itself*, he felt, could help reduce the pain. “Vietnamese acupuncturists,” he compared, used a single question to generate a generalised indication of pain from patients and on that basis, needled. Verbiage in clinical acupuncture situations in Vietnam was reduced.

Verbal confession was not how clinical acupunctures attained shape in HCMC. Rather three non-verbal factors were more fundamental: minimal questioning, a commitment to treatment and treating patients in public view. Detecting how to treat illness was variably actioned by looking over the patient, using minimal questions about where patients felt pain and listening to their complaint. A practitioner may or may not take pulse, may or may not measure blood pressure with an sphygmomanometer (or blood pressure meter) and stethoscope, all of which could last up to five minutes. While technicians were familiar with tongue diagnosis, I never saw it engaged. Looking and questioning were consistently practiced. In very busy situations, patients indicated the location of suffered pain, at which place their body would be immediately and quickly needled. Most importantly, however, a knowledgeable practitioner told the patient what was wrong with her: told her, for example, if she was suffering anxiety, that her hair was falling out, that she was experiencing heat in her stomach or that she dreamt a lot. The patient was not induced to verbally confess. Practitioners looked at the patient’s body, read it and thereafter translated non-verbal manifestations into signs (also noted in Marr, 1987: asking lots of questions would be considered incompetent). Acupuncturists kept their conclusions to themselves. They rarely explained their deductions since “a principle”, a senior acupuncturist noted in interview, was not to make the patient worry.

Second, expectations to treat were decisive for acupuncture treatment in HCMC. Farquhar’s (1994) study of TCM notes that “no patient leaves the doctor without a formula that has been produced in response to his complaint... [a] small but eloquent detail” (Farquhar, 1994:176). Farquhar and I both agree that practitioners

did not decide *whether* to treat, merely *how* to treat. There was no possibility that a patient would be sent home and told to rest or otherwise not participate immediately in a needling experience. I observed numerous acupuncture treatments in both private and charity clinical settings. In these situations, practitioners had both a financial incentive to provide treatment and no incentive since they were not paid for their work and patients were treated for free. In all of these, I only ever saw one acupuncturist refuse to needle a patient. That event was in Master Nguyen Phuong's treatment room. He argued with his patient that needling would have no effect and taught her a standing meditation technique instead, which she was advised to practice daily. He did not request any form of payment for the consultation. However, it was unusual that any patient be refused treatment. In practical terms, a decision to initiate treatment had been made by the patient, before her arrival at the place of treatment. A patient's very presence was testament that a treatment would be performed. Practitioners used detection techniques to generate information geared towards an immediacy of performing treatment. Farquhar notes that this means a "patient, not the doctor, determines that she *is* ill. The reality of the illness is not at issue... there are no 'malingerers' simply by virtue of the fact that all illnesses are treatable as reported" (Farquhar, 1994:176).

This commitment to treatment meant that questions on who should make the final decision about accepting treatment or decide between different options were irrelevant. By presenting himself, the patient has decided already: treatment *will* be accepted. By inviting patients into his space, the acupuncturist has already decided to perform treatment. Even when practitioners referred patients to a hospital when their patient could not seem to recover, referral occurred after a practitioner strived to treat. Verbal or expressed 'consent' did not enter clinical settings. The doctrine of informed consent, argues Caroline Kaufman, is part of "a long history of concern over the appropriate way for physicians to communicate with patients" (1983:1661) and positions the legal profession as a "guardian of patient rights in the face of claims by the medical profession to thoroughgoing autonomy" (*ibid.*:1659). While in HCMC it was not unheard of that a patient had sued a medical doctor, a greater worry for practitioners was to be the subject of negative talk or even worse, no talk at all.

Last, clinical encounters in HCMC were public events. In Kim's (2005) account of clinical encounters between a physician and patient, consultations take place in private. Patients enter an enclosed space so that techniques of obtaining a confession from the body, such as by speech, scans and tests, take place as a one-to-one activity. In Vietnam, no such privacy materialised. Treatment encounters in a practitioner's home, in clinics or during charitable acupuncture missions were all public affairs. The patient was the presenting body³. Anyone entering a treatment room during opening hours could overhear the answers a patient gave to the brief questions a practitioner posed; patients might chat with each other while waiting for their in-sitting acupuncture needles to take effect; waiting patients took up residency on available chairs or stools so were able to watch treatment in progress. Other accounts (Farquhar 1994; Hsu 2000; Scheid 2002) suggest that privacy differed by practitioner.



Figure 10: In the Public Eye.

³ Surrogate patients were described in urban Japan, where colleagues or relatives attended on behalf of an ill person. These surrogates described illness symptoms, took possession of medications, paid bills and picked up medication prescriptions or test results (Ohnuki-Tierney, 1984:179-180).

Further, in HCMC patient clothing was never removed entirely and the body draped in clinically specific alternatives, such as surgical gowns. Trouser legs were rolled up (unfortunately, I had not noted if women wore skirts when visiting an acupuncturist) and shirt sleeves were folded up. Men may remove their shirt though some kept on their undervest. Everyday clothing over the chest region for women and pelvic/upper thighs for both men and women were never removed. This suggests that a patient body was still a sexual body, even in clinical settings and that privacy was maintained through clothing. The patient lay down in front of an upright acupuncturist. Sitting, community-style, acupuncture discussed by the American acupuncturists was very rarely practised. Sitting treatments allow for a greater number of patients to be treated in one clinical space. A patient body lying down was how treatment was performed in almost all cases that I saw. A body lying down in front of a practitioner with trouser legs and shirt sleeves rolled up was one of the ways an acupuncturist ‘recognised’ a patient and an act that helped turn an encounter between two or more people into a therapeutic one.

Incidentally, although Berg (1992) argues that clinical encounters as phases are a textual artefact, such an artefact is also an identification available to be put to a use (Markell, 2003). I can elucidate this point through the experiences of an American acupuncturist during two treatments she had at a government acupuncture facility in HCMC. The female acupuncturist told her Vietnamese counterpart, in English, that she had pain in her shoulder and that her shoulder movements were restricted. Later, she recounted that “they needled the... channel and the local area [shoulder points] but didn’t balance the treatment using other body points” as she would have done but her key complaint was that “there was no diagnosis.” She had been trained in a private TCM college in America; she had been introduced to, and taught to use in her private practice, detection techniques such as looking at the tongue, pulse taking and extended questioning. “They just listened to me and needled the local area. They spoke excellent English,” she finished, that is, lack of speech communication was not why she could not understand her treatment. With another American acupuncturist colleague, who also had been treated at the Institute, an apparent lack of diagnosis – or more precisely, what they would recognise as a ‘diagnosis stage’ – was used to conclude that a lower therapeutic effect had taken place. Treatment had lost its shape and therefore was evaluated as being of lesser impact. The Americans sought a

recognisable performance of diagnosis, which must be time ordered. A recognisable diagnosis should precede inserting needles. Inserting needles meant that a prior stage had ended and a treatment stage had started, since the dictum states that a practitioner must diagnose and must do so before treating. Recognising diagnosis means it had to be learnt, or as Latour (2005) puts it, downloaded from somewhere. When behaviour was unrecognisable, a judgement was made that something was missing: there was a lack. The American's expectations helped shape the clinical encounter that she participated in.

Occularism

How looking "gave shape" (Mol, 2002:27) to therapeutic intervention is especially important for this thesis because blind interlocutors forced me to focus on sightedness or its absence as a material element in the creation of a recognisable entity called treatment. For acupuncture encounters, looking was the primary mode of detection; detecting what the problem with the patient was. "When a patient comes toward me," an experienced acupuncturist explained, "I look over the patient; at the way she walks, whether say she might be stiff on one side or limp slightly or bend a little with a bad back, perhaps she can't turn on one side" so he could speculate that perhaps the patient was stiff on that side. There were always illness manifestations in the body of a patient that may be translated into signs meaningful to practitioners by the act of looking. The often stated importance of experience was explained as learning to look. By treating many patients, a practitioner started to see signs "without thinking any more." A patient enters an acupuncturist's treatment room. Because she presents herself, the practitioner already knows she has come with a problem. Before asking, touching the pulse or listening to the patient's complaint, from the first moment an acupuncturist's seeing eye fell on his patient, he was trying to find out what the problem was. Treatment was an encounter identified as vision prominent.

Farquhar (1994) and Kaptchuk (2000) argue that the Four Examinations of looking, listening/smelling, asking and palpating are intrinsic to TCM syndrome identification. Arguably, these practices occur in any clinical situation regardless of what 'type' of medicine is in focus. As discussed, asking was less relevant for acupuncturists in HCMC, palpating was passive when compared to active use of

palpation in Japanese acupuncture techniques such as Hara diagnosis or trigger point needling and smelling never came up. Smell, as in the Vietnamese word *mùi* or in translated conversations was never talked about, pointed out or referenced to me. Since I was not tracing the Four Examinations, I did not ask specifically about smell. During my fieldwork, looking, asking, listening to answers – as both conversational content and how the patient answered - perceiving the pulse and palpating points in the field of pain were raised as methods of rendering illness manifestation into meaningful signs. But looking was paramount.

“When patients come to my mother,” Huong told me, “they don’t talk about their illness; mother tells them about it, she looks and sees a person and can tell them how it is.” At that time Huong was finishing up her technician studies at the Traditional Medicine Institute. Huong’s mother was called by all Chi Ha, an overseas Vietnamese living in the USA who made an annual return to Saigon at Lunar New Year. Chi Ha had no credentials and on her business card did not assign herself a medical title but subsumed herself into an organisational name. I detail more about Chi Ha in the next chapter to focus on her work of becoming famous. She was a spirit medium of Ba Den, Chi Ha’s authority to treat. Chi Ha was the only spirit medium practitioner I was networked with, a surprise to an anthropology colleague in HCMC who assumed that since I was studying ‘traditional medicine’, spiritualism would be my daily work. Possibly this was because my main connection was a doctor-acupuncturist and ex-employee of the Traditional Medicine Institute, so I networked with credentialed practitioners whose standardised education had excluded spiritual elements.

I describe here how looking gained authority in treatment encounters with Chi Ha. I was in Chi Ha’s house with her daughter, her patient-turned-friend and an American friend of mine called Dario. Medical doctor Sau had popped in for a short time. Sau had uterine problems; Chi Ha had told her so, without the use of questioning, a couple of days previous when they had met for the first time on a social outing. The patient was amazed and came to the house for treatment. Sau had had an ultrasound that showed a tumour in her uterus, about two or three centimetres long, which had been operated on. However, she continued to suffer dizzy spells, anaemia and for a while could not urinate. Another tumour was found, which was pressing on her

bladder. This was also removed. But she had recently found out that she had another two tumours in her uterus. As a doctor, Sau only recently became interested in traditional medicine and thought that doctors, in the main, were not interested in traditional medicine. Her statement ignores that the Traditional Medicine Institute employed doctors, nurses and nurse-practitioners who trained in ‘western medicine’ to practice ‘eastern’. Sau sat and chatted mainly to Chi Ha, intermittently translating into English for me. She always addressed me in English; Chi Ha addressed me in Vietnamese. On this occasion, Chi Ha’s friend called Eve, who was more fluent in English than Chi Ha, also helped me with translation.

Chi Ha explained how she engaged with a patient. She took Sau’s pulse using the three fingered positions and then pressed a point in the apex of the palm, which induced a feeling of nausea in Sau. She did the same to me but to no effect. “That’s because you aren’t sick,” she reasoned. Next, she pressed points in my shoulder and neck and on my response replied that I was hot and that next week I would develop flu – I developed flu symptoms two days later. She stroked my face and explained she could also tell from my face because the skin was dry. She urged me to feel her face in comparison, which felt moister and fuller, and then called Huong over and stroked the facial skin noting that it was also dryer than her own. She called her friend over for further comparison, since she had suffered cancer. “Traditional’ medicine reflected Sau, had an “advantage over ‘western’ because it intervened earlier in the patient’s condition.” The patient could take some preventative medications and not have to suffer. With Dario also present, and without touching him, Chi Ha told the noticeably overweight male that he had high levels of blood-sugar and blood-cholesterol. He confirmed her observation. Chi Ha told him that his liver was not balanced, that his stomach had not been working well but on the day we met it was working better than before. All this he agreed with. She would give medicine for his diabetes – he did not have diabetes, he told me later, but it was present in his family – and this would also cause him to loose his belly, she observed directly of his obesity. She gave Dario the medicine “for nothing, it is a gift” but if he felt better, he should tell his friends that it was Chi Ha who had treated him and made him well.

Chi Ha used her sight to match outward manifestations to a synthesis of past signs she had encountered when meeting patients. Specialists in western medicine also had

this advantage, a doctor in HCMC agreed. A specialist had seen many similar conditions before so could immediately interpret illness manifestations as meaningful, including manifestations which a generalist doctor may not notice. The specialist would appear to ‘know’ what the matter was, even if it seemed she would know mysteriously so. Part of that also meant failure. Chi Ha wrongly stated, for example, that Dario had diabetes and that I had had a serious illness in my childhood. In privileging looking at illness to find signs of treatable conditions, potential for failure exists each time. Potential for failure exists in all detection methods. Failure is called a false or a mis-diagnosis when clinical encounters are considered as stages, resulting in a treatment that cannot help a patient and potentially cause harm.

Practitioners, I suggest, recognised streams of signs flowing through a treatment space. Such recognition enabled by looking could seem mysterious. Sau was amazed that Chi Ha could seem to recognise her problem without asking; without her having to confess her problem. Looking had recognised a hidden problem, a tumour inside the body, in the absence of other detection techniques. The naked eye had divined the hidden. The seeing eye of Chi Ha gained competency from correctly, as determined by the patient, divining a somatic reality; by telling a patient how *it is*. Chi Ha built on this sense of wonder by telling patients about events of the past and future. On a different occasion, she told my young translator about her parents and speaking about her destiny. My translator was very surprised that Chi Ha told her correct characteristics of her parents, for example, that nearly two years ago she had nearly died but for her mother. She was very keen to meet her again. An ability to so mysteriously divine medical secrets could generate name fame that was important for generating ongoing patient referrals in private practice.

“The assessment of the patient... is considered difficult to write about and capture”, notes Kaptchuk (2000:179). However, taking notice of illness manifestations and rendering these meaningful as signs of conditions, as Chi Ha explained above, was quite prosaically about comparing patients as they passed through clinical encounters with her. She was busy comparing, skin moistness for example, on the basis of which she could make other ‘predictions’ about how illness might emerge and change. These were taken with other signs, such as what happened when particular points

were pressed and absence or presence of pain. Looking was not used in isolation. “To know something was not to behold the optical singularity of an object but to apprehend its fuller phenomenal identity simultaneously with its position [in] an ordered field”, argues Jonathan Crary (1990:62) speaking about a 19th century western European notion that vision was touch. For Chi Ha, vision was not isolated from other ways of detecting and examining but colluded to divine disease realities even into a predictable future. Collective detection techniques could predict an illness course in its movement through time. An edge may then be gained: treat illness before it happened (see also Zhan, 2009a, 2009b). The authority of looking was not constrained by delineated moments when signs presented themselves to a naked knowing eye.

The identity of a pulse “within an ordered field of signs” (Crary, 1990:62) was what Nguyen Phuong was looking for when he met patients. Patients presenting to Nguyen Phuong walked into the same room where classes took place. He was always busy during working hours. Any observer entering the now-treatment room, would see patients lying down on the unforgiving wooden tables, head resting face up or down on compact heavy cushions covered by some flagrant floral design in nylon. On one visit to his treatment room, I found patients on all four tables and portable screens between the two patients lying nearest the awning, for privacy from the street. Four young teenagers, all girls, sat on the unfolded chairs along the side wall where his motorbike was usually parked; waiting. Only two of his patients were men. His wife calmly moved between tables, training a glowing moxa stick around in-sitting needles smoke swirling around her, the warm earthy aroma filling the room⁴. One patient had red spots around the in-sitting needle, indicating that she was having a very mild allergic reaction to the inserted metal.

Nguyen Phuong invited a new patient, a middle-aged woman, to sit across from him at his desk. His eyes worked over her face and skin as she spoke, looking for skin irritations and pallor, watching out for coughing and general demeanour of a patient. He questioned her complaint – how long she had suffered it, her sleep and eating patterns and listened to how the patient spoke and breathed. He did not make notes.

⁴ His wife also made up unprocessed materia medica (*thuốc nam/cây thuốc*) packages.

He listened patiently, muttering “*ừ, ừ*” a familiar affirmative from a senior to a junior, as for example grandparents may use with grandchildren, to indicate that he was paying attention. “The patient will tell you many things,” he taught us, “but you must pay attention to the pulse.” He ‘perceived’ the pulse (*xem mạch*) through his first three fingers, which sat lightly on the patients inner wrist, resting on a small pulse cushion. His fingers saw each pulse on each wrist in turn, each finger using delicate pressure to divine activity at each of three pulse depths, contrasting pulses in each location considering whether mirrored locations were strong or weak or strong and weak. “A floating pulse has the symptoms of nervous breakdown, high blood pressure, tired, hard to breathe and a stuffy feeling because Pericardium is tired,” he explained in one class. After these performances of looking, he brought out his stethoscope and sphygmomanometer (blood pressure meter) and strapped it around the patient’s bicep to check her blood pressure.

Collectively, these detection methods generated a confession from the body with little words. A patient body communicated directly with the practitioner. Nguyen Phuong perceived the pulse because he was treating the pulse. He sought to classify what pulse he was looking at, in collaboration with other visible manifestations in the patient body. Those manifestations were not symptoms of disease in the body but a state of the pulse. Usually pulse-taking is understood to be a method of detecting illness. “Disharmonies in the human landscape leave a imprint on the pulse”, writes Kaptchuk, noting that “codifications and discussion variously cite 24, 27, 28 or 32 pulses” (2000:196) that may be signs of a condition named Deficient Yin or an Excess Yang pattern and so on. That is, varying states of the pulse were a manifestation of an underlying syndrome that was nameable. In 6 Qi acupuncture, the pulse itself was not a detection method. The detection methods were pressure of the Master’s fingers on a patient wrist, the sphygmomanometer and stethoscope checking blood pressure and looking at illness manifestations, which were all acts he used to identify which pulse he was seeing. He identified a pulse and used acupuncture to correct that pulse. “We don’t need to name an illness in order to treat the patient,” this Master advised endlessly in class. Illness did not need a name for a

patient to be treated and come back to wellness. Names were not causal in Nguyen Phuong's treatment room⁵.

Looking was authoritative not only in practitioner interpretation of illness manifestations but also in needling practice. As if the patient was a poster, an acupuncturist read point locations that were empirically on a patient body. As argued in chapter two, acupoints did not move; their location was expectable. For an experienced practitioner, acupoints did not need to be recognised, a present body did not need to be compared with past bodies to synthesise a correct acupoint location, a location could be read because it existed at the same place on every body. In Nguyen Phuong's treatment room, a patient was invited to lie down for needling. At first, four points were needled on the patient's outer ears to help her relax⁶. When he needled, he used his eyes to locate points. First, he looked at the bare skin, available because trousers and shirt sleeves had been rolled up, and swiped some alcohol-soaked cotton wool, held by forceps in his left hand, on the skin spot to be needled. He lightly touched the place where he would needle with his 3rd finger before swiftly inserting. No other point location technologies or techniques were used. Seeing eyes acted here as an intermediary (Latour, 2005) or can be likened to a technology which enabled points to be read on the patient body; points that were done as visible (also see chapter two). Needles were inserted to shallow depths so did not stand upright, rather fell over. His motions were swift and sure, always watching the body, not shifting his eyes between body and the poised needle in his waiting hand. He left needles in-sitting for variable periods of time, depending on the patient, but after this period he would remove the needles and ask them to turn over so that he could needle the other side of the body. 6 Qi was a symmetrical treatment.

Treatment time was longer in Nguyen Phuong's treatment room than the more commonly practiced 20 minutes of electrical acupuncture operating at an outer city charitable practice. After removing needles, he tapped them into clear tubes, swaddling them in cotton-wool. Each tube was labelled with an individual's name and stored in his treatment room. Looking gained authority by reading known

⁵ Not naming can also mean that a practitioner's diagnosis is less likely to be scrutinised by other practitioners or doctors. Richard Eves, personal communication.

⁶ He had attended classes on ear acupuncture at an inner city pagoda.

points. Acupoints in always stable and expectable locations were needled with fleeting touch. The practitioner seemed to mysteriously know where they were without having to search for them on the patient body. Looking was able to distinguish therapeutic loci that were invisible to patients.

Resolving Pain

“Patients will come back if I cure their pain,” Hoa (see chapter six) explained. If patients felt relaxed and he reduced their pain during an acupuncture session, Hoa was confident they would return. Acupuncturists asserted that patients most commonly came to an acupuncturist with pain, in the hope that therapy would remove it. While patients presented with other problems, for example, insomnia, pain was a constant theme in practitioner’s rationale on why their patients came to them. For this reason, I will focus on pain in this section. Acupuncture was a *relatively* painful therapeutic intervention. More painful, say, than drinking down pharmaceuticals that a growing social science and medicine literature has worried about in recent years (see introduction chapter) though the pain felt during needling depended on the practitioner’s personal technique. Pain in clinical encounters has been written around concerns of how pain is perceived and experienced by patients and their search for a cure (Aldrich & Eccleston, 2000; Bendelow & Williams, 1995; Csordas & Clark, 1992; Husuma et al, 2002; Kugelmann, 1999); about what causes pain, latterly including political-economy causes (Baszanger, 1992; Bendelow & Williams, 1996; Wilkin, 2009) and how contrary medical personnel and patient assessments of pain determine patient satisfaction with treatment (Bates, Rankin-Hill, & Sanchezayendez, 1997; Harrison, 1993). Pain is often taken as symptomatic of underlying syndromes but pain can be both symptomatic and the object of intervention. In HCMC, pain’s manifestation was not the only concern for acupuncturists in private practice. If the “patient is patient,” Hoa described, he could affect their underlying condition but often this was not the case. The patient sought more immediate exorcising. For practitioners, patient expectations about immediate change in their pain were formative of the clinical treatment they participated in when they laid down in front of a practitioner.

“When a patient comes to me,” Chi Ha maintained, “they need to see a change before they leave.” Acupuncturists were “afraid to needle in Vietnam,” she opined

“because the patient feels pain, so they insert needles to a shallow depth because they don’t want the patient to feel pain.” Practitioners know that if the patient feels too much pain they might not like to return. “But with shallow needling, the needle cannot go deep inside the body and make a difference,” so to have an effect, acupuncture needed some “power.” She preferred to use electrical acupuncture. Chi Ha argued that efficacy of therapy, indicated by a change in patient’s perceived pain, had to be noticed immediately.

For Chi Ha, pain was all of the problem, her detection method as well as her technique of intervention. Locating problems meant locating blockages. As noted earlier, ‘channels’ were allocated a metaphor as channels of water or as roads along which qi flowed. A problem became very simply a blockage. Qi was stuck, when it could not run, acupoints whose militarily precise alignment referenced a channel, were needled to make qi flow again. Many acupuncturists needed to not only stimulate the place of pain with more pain but to also ‘open’ the appropriate channel. Channels were how points related to each other but only channels could get blocked, points did not have this quality. Blockage in a channel was detectable by pain. The location of pain was the location of blockage.

According to Chi Ha, qi was not blocked, rather blood was. Qi and blood have been conceived as entangled partners (see chapter two). However, if words have no intrinsic meaning and their significance is derived from how they are used (Hsu, 1999), then Chi Ha used blood as the red stuff that swirls about the body, which mottles the skin after accidents and is devoid of an expressive partner called qi. Since I wanted to be sure how Chi Ha was using the word, I asked for direct explanation. Her patient-turned-friend helped with translation.

You know! Circulation right in your body, blood moves around your body; blood moves in the vein but it gets stuck, (*máu không chạy nhiên*), its stuck say in the arm or neck; there is no movement, no circulation any more like after an accident. When the blood is stagnant it becomes black. To get new blood, we need to get rid of the older black blood, the spoilt blood (*máu bị hư*). The place of the blockage is really sore so we can find the blockage and there we can get acupuncture or acupressure or let blood to break the clot; this gets the blood moving again.

All techniques to remove a blockage were equally valid, no one was intrinsically better than another and their use depended on the patient's condition. Pressure, cutting or needling targeted stagnation. "When blood isn't moving then an abscess forms." For Chi Ha, lack of circulation was the reason for illness or injury or pain. "Veins run all over the body, but blood can clog or get stuck [cannot run], so you need to remove the obstruction... like clearing a plug hole." To emphasise, Chi Ha nodded to her daughter. Huong had a slightly swollen left eye, which she had had for about three months. Chi Ha asked me what the problem was. After a couple of my wrong guesses, they explained that the blood circulation through the thyroid was poor. Blood goes up (*đi lên*) but does not go down (*đi xuống*) and she traced a line of a vein over Huong's head. The blood got stuck (*tắc*), which caused the swelling of the eye.

Clearing that plug, or that block, was likely to be painful. She used me as an example. I had been hit by a motorbike the day before and limped into her house. In my case, she told me that my ankle was bruised and painful because the vein was twisted so the blood could not move properly; it could not circulate. She pressed around my ankle searching out places of acute pain, checking these by pressing harder to stimulate more pain and then treated, in this case, by rubbing (*cao giã*) with a large, brass smooth edged, square holed coin. She used the wide rounded edge – "not painful," she advised, running her finger over the smoothed edge – with Chinese characters on one side and trigrams on the other. Her friend explained that rubbing the skin opened the pores, in the way that some might have a warm bath to open the skin pores (or, as I heard from non-acupuncturists, induce sweating through sport or steam bath). This allowed the skin to breathe. "When patients see their skin red and mottled they think its bad but actually it goes away quickly," Chi Ha continued. It did; the redness reduced quickly and by end of eating lunch, the mottling on ankle was gone. Chi Ha pointed out the change to me. For Chi Ha pain was positive. Pain could identify an underlying problem – a blockage – and through pain, an unblocking could take place to enable circulation again.

During our conversation it came up that I had visited a doctor, so she urged me to compare my two treatments.

Table 4: Two Treatments.

Chi Ha	Doctor
I told her that I got hit by a bike at a red light in town and that my ankle hurt when I walked. As described above, she dug into the ankle and rubbed the location of pain, asking after some minutes into this whether I could still feel pain, and if so, where it was. Then, she told me to get up and walk around and asked me how it felt. I answered that it felt looser and lighter. She agreed and then asked me to dash my foot against the floor, which caused pain, so she did more rubbing, again asking where the pain was and if I still felt it. When I told her there was no more pain, she urged me to get up and walk then jog on the spot. She kept asking, “how do you feel?”	I told the doctor my ankle was sore when I walked and he asked me to hold it up so he could look. There was a slight bruise. I told him the pain was inside the ankle. He prodded around the ankle asking which places were sore or not. He suggested I might have a fracture but that there were a number of bones in the ankle area, which were not fractured so I could go and get an x-ray. Even if it was fractured, I would not get a cast, so, he concluded, I should rest for a while. “Today and tomorrow,” I suggested. He disagreed, advising that I rest for two weeks and not to cycle or walk around.

Chi Ha used pain to treat pain and was continually concerned about my noting a change. The doctor seemed concerned to identify a cause and to offer a remedy: rest. After relating the story above, Chi Ha was satisfied and explained her reasoning: wasn't her treatment more practical because who can sit around at home when there is work to do? Immediate resolution of pain was not only therapeutic for a suffering patient but practical in the daily life of people who were active.

The change sought during a clinical encounter was a change in the patient's experience of pain. Somatic pain was an empirical truth. Patients described where the pain was in the public presence of other patients. Pain reference on a patient's directive was taken as true: there was no contestation. Pain was what the patient tells you where it is. There was no questioning of where the pain was 'truly', in the way a Swiss acupuncturist described to me. Medical authority was not played out as an expert legitimiser of pain, one who must locate, visualise and mandate a discursive

pain for an ignorant patient (compare Rhodes et al, 1999; Tait & Chibnall, 1997). Pain was inside the body, it was knowable by looking at exterior manifestations when a patient walked, sat, moved and talked. Pain was undeniably ‘there’. Mariet Vrancken called this a “somatic-technical approach... pain is seen as something inside the body that has to be eradicated, as an agent of suffering... everything outside the scope of well-defined somatic pathology is outside the [medical] agent’s field of activity” (1989:443), meaning sensation alone was taken to be pain. There were no techniques to render psychosocial dimensions of pain relevant to this clinical encounter. Even in Nguyen Phuong’s 6 Qi acupuncture of “going around”, true pain continued to frame treatment performance. Moving the needle, such as pecking needle stimulation in Japanese trigger acupuncture techniques, or right/left twisting of the needle for tonification or sedation taught at the Institute were rejected. These actions were not important, he claimed. More important for him was that the needled points were valuable. Instead of stimulating pain to resolve itself, Nguyen Phuong averted stimulation, so that pain was performed as negation, a contraindication. But pain itself was never in doubt.

The practice of technician Canh can show how pain was networked into treatment. Canh worked out of a whitewashed two-roomed and low-roofed building, sitting inside a health-station compound. Eight women and two men were his patients one morning when I accompanied him. They were all between 40 and 60 years of age. He was late. They sat waiting for him on folding chairs in the small treatment room and in the outer administration/materia medica storage room. Four women were lying on the two available beds. “Vietnamese women love acupuncture, much more than men,” he answered my question later, “men are afraid of the needles; they think needling is too painful.” Canh greeted them as he came in. His student-friend, retraining out of electronics, was doing acupressure on a sitting woman, an acupressure publication curled up on the table beside him. Shrugging on a white medical coat, Canh got to work. At his clinic, asking was again minimised. If the patient was new, he would ask what medications she was taking but he had treated all the waiting patients before, so he did not ask⁷. He checked blood pressure in older

⁷ Different practitioners asked different questions. Some asked about the occupation of the patient, where the pain was being experienced and whether the patient was married or single, since this also affected health, those practitioners asserted.

patients because “some patients faint away under the needles so I take their blood pressure to know how strong they are for needling.” Before touching a patient, Canh dribbled alcohol through his fingers, rubbing it off with cotton wool and used more to clean the Tue Tinh branded needles, pointing out to me that he needed to be careful of hepatitis, HIV and other infectious diseases. “Maybe I should wear plastic gloves,” he reasoned to me, but he wanted to feel the needle enter the body so that he could feel through the needle what was happening in the body at that acupoint. “If I wore gloves or used guide-tubes to insert needles like they do in Korea, I couldn’t feel the needle.”

The waiting patients had not brought a medical note-book and none were held in the clinic. No note-taking occurred as referenced by Kim’s (2006) and Farquhar’s (1994) work on *materia medica*. I noticed the same while volunteering for an outer city charitable project providing medications and acupuncture. Note-taking was present only during the work of detecting pulse in the *materia medica* room. Note-taking and patient confession may only be involved with *materia medica* rather than needling, possibly because of their different performance of treatment. Drinking brewed *materia medica* was an act undertaken at home hence performing treatment in *materia medica* may have been about performing a looking-at-illness, whereas performing treatment in acupuncture was about doing needle insertion. Note-taking might also be more prominent when acupuncturists are under greater surveillance such as when working in government institutions (see Scheid, 2002).

All patients had a little metal box of Tue Tinh needles nestled in cotton-wool. These were changed after ten treatments and trashed in the medical waste bin of the health station just next door. These locally manufactured needles were the cheapest and most readily available in various lengths. Prices varied slightly between sellers. Packets of 10 x 11.6 cm long cost 10,000 VND; 20 x 7 cm long needles were the same price. 60 x 4.5 cm needles were 12,000 VND. Chinese imported needles were sold in packets of 100 x 4.5 cm for 100,000 VND though could also be purchased in sets of 10. During the rampant inflation of later 2008, which ratcheted up prices by 30% measured in terms of relative change in food and rent prices paid by interlocutors, the price of acupuncture needles went up “just 200 or 300 VND,” a seller agreed, “not as much as other prices.” Tue Tinh needles were characterised as

having poor metallurgical quality, an overseas Vietnamese acupuncturist who drew a sketch to explain, depicting the Tue Tinh needles saw-like, ‘ragged’, hence were more painful to be needled with.

Because Canh used electrical acupuncture, his needle insertion technique was deeper than Nguyen Phuong’s. He inserted needles into a field of indicated pain, which was an act that generated additional pain. He darted the needle into flesh, which punctured the patient’s skin and then threaded the needle through his fingers into the flesh. The point was needled to depth before being turned clockwise, “for tonnification,” he explained, two or four times⁸. With the needles rooted in flesh, they stood upright according to the angle of entry. Electrical leads were then easily clipped to the metallic hilts. In this particular clinic, 20 minutes of electrical acupuncture was a ‘quasi-standard’ (Latour, 2005): more likely to occur than not. Electricity stimulated the field of pain faster than human hands twirling needles were able to do, giving quick, even at times, instantaneous pain resolution. The units were locally manufactured, small and portable and had three knobs to control tonnifying treatments and three to control dispersion or sedating treatments. Canh claimed that the direction of needle-turning (when done by hand) was either a tonnifying, stimulating action or a sedating, calming action. By attaching leads to either tonnifying or sedating knobs the practitioner again makes a decision on what the effect of needle insertion should be. However, it would be difficult to evidence whether the released electrical current mimicked hand turning in this way. Note that Nguyen Phuong completely disagreed with needle stimulation techniques so would have disagreed with Canh’s assertions.

Each knob on the unit had a double lead, meaning that the number of needles that could link to an electrical unit was limited – unless more than one unit was present. Canh used one unit per patient. Attaching the clipped cords plugged into a small electrical unit to the upright needles, he turned the machine on and opened a current into the needles. Separate knobs controlled the current frequency, from a minimum of 0.5 Hertz up to a maximum of 30. “How do you know how many volts to give,” I

⁸ Compare a photograph of acupuncture treatment in Japan: skin wells up around a gouging thumb, entitled. See “A paramedic determines pressure points and inserts acupuncture needles, 4 to 8cm long” in Ohnuki-Tierney (1984:115).

wondered. “Guess!” he laughed, but as he turned up the voltage he kept asking patients if they could accept the irritating *nhic-nhic* of the needles and when they could not, when it was too painful, he turned the current down slightly. Electrical acupuncture stimulators (*điện châm*) carried out the work of stimulating needles so that neither Canh nor his student had to sit beside a prone patient twisting needles for stimulation. They were then free to greet other patients. Electrical units meant that more patients could be seen by any one practitioner at any time therefore could form what treatment came to look like.

Like Chi Ha, Canh used multiple techniques together to seek pain removal. Before needling the next patient, he worked aromatic oil into her lower back, especially massaging and ‘pulling’ on her lower spine and pushing the skin and bones in opposite directions, making the patient grunt in discomfort. He used a pressure-roller along the upper spinal area for a few minutes before going back to using his hands. After these exertions, he needled into the field of indicated pain. The patients on that day were repeat patients; they had been a couple of days previous. He told them to return four days later, on Monday. He only had two beds so could treat only two patients at any one time. Waiting patients sat around in the same room chatting to each other and the patient undergoing treatment, if she had not dozed off. Today he was rushing, but if he had time he liked to tell jokes and stories so that, he said, the patients could relax and enjoy their time in the clinic more, because that was also part of the treatment. On a later visit, I found that pictures of Hai Thuong Lan Ong and Tue Tinh had been hung up on the wall and classical music playing quietly so that his patients would enjoy the experience more. In Canh’s treatment room, needling with massage, joking and relaxation were all participants in clinical acupuncture.

Clothing was never removed during treatment and was implicated in directing therapy. Canh commented that he liked to needle a point in the right side of the right buttock but his mainly female patients sometimes wore trousers whose material was too heavy, so he was unable to needle through it. He would not pull down the trousers to reveal bare buttock and needle as he had wished. If the cloth was the cheaper, thinner, floralised nylon, he would be able to needle through the trousers. Thicker cloth averted where he was able to insert needles. Instead, he used points at

the back of the knee and outer ankle to ‘open’ the (in this case, Bladder) channel. These points had a quality of enabling movement, he described. They were also publically accessible points in open-access clinical situations. Clothing was not merely a prop (Goffman, 1959) but in acupuncture treatment altered a practitioner’s choice of needling locations. That is, clothing altered the choice of loci that were thought to collectively generate scalar therapeutic effect (as described in chapter two).



Figure 11: A Shape of Treatment.

Treatment was also about caring. Uncommonly, the last patient of the day was 18 months old. Canh narrated her story to me in English. “She was born through a ring womb or failure of the cervix to dilate. The mother went to her local district hospital – not the city centre – at 9pm and was seen by a doctor at 2am.” In Canh’s opinion, the staff on duty at that time had little experience: they were just “nurses and newly qualified doctors,” he explained. “The staff forced the birth [did not seek caesarean surgery] even though the baby was stuck for a long time.” The baby’s head was distorted and bulged at the forehead. Her fists were clenched, feet and legs seeking to rise and open. Canh laughed and pulled them straight saying, “you are a girl, not a boy!” Her eyes “don’t recognise anything, that’s where you can really see there is

something wrong,” Canh pointed out to me. The baby’s mother had gone to many doctors in the local area and in the city centre but they refused to treat the baby. Finally, she came to him. He saw her and thought “I can’t help her, but I believe in God, so I accepted it.” God was the last resort. Mother and baby came regularly for acupressure and advice. Canh demonstrated points to the mother that she should massage at home, such as on the outside ankle bone. Pressure on this point caused the baby to align her foot in a normal angular position rather than vertical following the shin. The baby did not crawl or cry. The older women fussed over her, saying she was pretty: her mother had pleated her hair into bunches. Canh felt there had been a change in the baby in the last month; that the baby was more active than before. He pressured the baby for about 15 minutes and burnt moxa over points in her spine and chest using sliced ginger to prevent the heat burning the patient’s skin.

The baby and her disabled condition made her an unusual patient. Babies and children were rare patients in the treatment rooms of acupuncturists I knew. More likely, patients were middle-aged and significantly female. Further, disability as a presenting problem was very rare; much more common was that treatment was shaped by pain. Pain was the spoken problem and pain was part of its own resolution – with semi-blunt needles; because of fingers pressured into fields of experienced pain; through the throbbing *nhic-nhic* of electrical voltage stimulating a painful region; by pushing and pulling flesh and bones to gouge out pain. An acupuncturist, needles, electrical units and the thickness of clothes as well as jokes and God, performed treatment in Canh’s clinical space. These networked a shape of care. That care has been characterised in a Sino-Vietnamese expression occasionally seen stylised on clinic walls as “to treat as if from mother” (*hương y như từ mẫu*): to treat without concern for profit but for what would be in the best interests of the patient.

Before concluding, it is necessary to briefly mention government regulation of traditional medicine. It is likely that government regulations were involved in fashioning clinical encounters but I am unable to indicate how they did so. Wahlberg (2006) has argued that since the unification of Vietnam, traditional medicine is being professionalised and that this may be evidenced through increasing government regulation, measured by increasing number of government guidance and sanctions

literature. Wahlberg interprets these as dividing practices in the interests of a safe and efficacious medicine that guides public health policy in both Vietnam and the United Kingdom.

In HCMC, the government regulated medical persons, their places of treatment and their medical practices. According to article 18, section 2 of the *Ordinance on Private Medical and Pharmaceutical Practice*, all private medical practitioners – individuals or organisations – are “obliged” to transfer patients to “appropriate medical establishments” when a patient’s condition falls beyond their “scope” of therapy. According to the same Ordinance, practitioners are to engage in primary healthcare actions including contemporary public health campaigns such as HIV/AIDS prevention (for acupuncturists this meant ensuring needles were sterile). They are not allowed to apply “new professional techniques... when not yet so permitted by the Health Ministry”. Traditional medicine practitioners were singled out as strictly forbidden to employ “superstitious practices” (Government of Vietnam, 2003). What the Committee considered to be superstitious went unspecified. Practitioners of “traditional national medicine” were allowed the following actions: to feel the pulse, to write prescriptions, to prepare medicine and to give medication and treat diseases by non-medication methods of traditional national medicine, which had already been approved by the Ministry of Public Health. An acupuncturist should have an appropriate qualification and two years of experience before opening their own treatment room (*ibid.*). Clinical spaces should have “sanitary condition” for example and sanctions were set out for giving the wrong address, having no credentials, “having no signboard... conducting medical practice beyond one’s professional capability... allowing another person to use diplomas... or the certificate of qualification” and “failing to observe the regulations on sterilisation and bacteria-killing in the course of acupuncture, injection, pricking, surgery and other methods used for medical examination and treatment” (Government of Vietnam, 1996).

In thinking about how treatment was shaped, the disciplining of persons, places and practices by government is implicated. Indeed, interlocutors appeared to be in consensus with the law at times, for example on issues of patient referral and hygiene. An interesting question, however, which I cannot answer, is how regulations

were translated and enforced. Dunn (2005) argues that enforcement measures gives power to regulatory standards. According to Dunn, without policing regulatory standards cannot actively shape practices. The question is, then, how did medical regulations move from government offices in Hanoi to treatment spaces at these different sites in HCMC? And what happened along the way? It seems for instance, that a document did not move wholly and completely. From reading these regulations, I realise that at various times, and in different ways, the practices of my core interlocutors might contravene one particular article of a legal document while cooperating with others. I speculate that regulations would be required to pass through personalised networks that 'translated' their contents differently for different persons, depending on their connections within networks. Personal networks generated uncertainty when dealing with government bureaucracy even though such networks might also be considered a response to the risks of dealing with a cumbersome and Byzantine bureaucracy in the first place.

Conclusion

Rather than conceiving of the clinical as an 'application' of so-called formalised, written and theorised knowledge, I have argued that treatment can be considered to have shape. This implies that a model of patient-practitioner, as two isolated subjects moving through stages of diagnosis and then treatment, is only one of many shapes that clinical encounters may take.

I have argued that shape arises because interacting practices corroborate and compete. Ocularism was the means by which a patient body could be read, in the sense of retrieving meaning. A practitioner retrieved the meaning of illness manifestations before asking a patient what the matter was. Asking became irrelevant. A performance of looking was how a patient knew that competent needling was being performed. Looking was an act by which acupoints were read on the body so that therapeutic effect could be stimulated. Thereafter, I discussed how pain was a key factor. Pain was the problem that patients brought to their acupuncturist; pain was a diagnostic to locate that problem and was intrinsic to treatment experience when needled with blunt needles and not least, pain's absence indicated that a patient had come out of illness. Practitioners in non-institutional settings felt that patients sought fast pain removal and noticeable change after a

treatment event. Because practitioners tried to meet their patient's expectations, patients could shape clinical encounters even when they were not verbally active. Pain and ocularism created recognition of treatment itself; of how a patient would know she was being treated and how an acupuncturist knew he was engaging in work that might be later termed therapeutic.

In this chapter, classifying and naming illness appears not to define clinical encounters. There is a possibility that disease naming was under performed in clinical acupuncture in HCMC. However, during fieldwork I did not focus questions with acupuncturists on practitioner decision-making, so the reported absence of naming and classifying illness may be an outcome of methodology. The density of questioning noted in other accounts (for example, Kim, 2005) was derived from research with materia medica practitioners. If I had focused on herbalists, rather than needlers, possibly naming would have been more significant. Alternatively, naming may be unimportant against the imperatives of removing somatised pain. Certainly the very successful Nguyen Phuong thought naming was a distraction to the work of helping patients. However, naming in different clinical settings does help to shape an encounter. When naming is absent, for example, in chronic pain conditions, this state of affairs is taken to be a negation: without names, diagnosis is said to be incomplete and curative treatment cannot commence (for example, Nettleton, 2006). But this situation can only arise because of a prior recognition of what clinical events *should* look like. In acupuncture in HCMC, an absence of naming did not, it seems, create such a crisis for treatment.

Considering clinical treatment as that which is shaped, challenges assumptions about what may be considered relevant in treatment situations. To describe treatment in terms of shape means not to delete the ability of clothing to compete with an acupuncturist's intended needling configurations. It means not excluding the work of electrical units, which freed up a clinician to meet more patients. These two items acted and, in doing so, created treatment. Without them, treatment would look very different. Shape is important as a mechanism of recognition. Thinking treatment through 'shape' emphasises how expectations and evaluations arise. For the American acupuncturists, when diagnosis lost its shape, they feared there had been none. For many Vietnamese when looking was necessarily absent, as in the case of

blind acupuncturists, treatment could not occur but when pain was resolved, a practitioner was considered efficacious. Ensuring that validations of efficacy moved through trusted person networks was essential for occupational survival and I detail these in the next chapter.

5. Generating Noise

This chapter is based on an assumption that without patients, clinical treatment cannot take place. Because most of my interlocutors were not institutionally based, the work of finding patients was intrinsic to their medical practice. Finding patients cannot be considered in this thesis as an add-on to clinical practice but a necessity to stay in medicine. In order to be able to greet patients in their clinical spaces, acupuncture practitioners sought fame or *sự nổi tiếng* (literally, raising noise). Noise about a person was understood as essential to continuing in the occupation and to attaining status within it. But generating noise was not an act that practitioners could undertake by themselves, rather personal networks took on this labour and the vigour of one's networks determined the volume of a practitioner's success.

I will describe how person networks were figured as a way of life in the city and argue that to be talked about in these networks required that a practitioner be newsworthy. Thereafter much of the ethnographic detail in this chapter will illustrate how success has been attained by two very different practitioners – Chi Ha and Dr Truong Thin. These acupuncturists seemed to be complete opposites: one had no formal training and the other had been the director of the Traditional Medicine Institute. However, both were successful and relied on networks to move talk about them. First, I will describe three ways in which newsworthiness was enacted about Chi Ha – through healed patients, through herself and through additional digital media. However, the more successful acupuncturist was Dr Truong Thin: he was described as “famous” without need for further explanation. I will show how his name circulated in multiple media forms transforming him into a symbol for traditional medicine in Ho Chi Minh City. Nonetheless, fame was rendered through similar practices so that even though these two practitioners seem very different, they are actually comparable.

Fame, name recognition and talk were often raised by my interlocutors as important in medical work. Most of my interlocutors were in private practice and so were required to generate their own patients. Word-of-mouth was an important marketing

tool in a competitive therapeutic market-place. The costs of acupuncture treatment, the time taken to change a patient's condition and available alternatives were all evaluated. These were understood by practitioners as part of patient decision-making. By way of background to the work of generating fame, I will discuss this first.

Acupuncture in a Competitive Market

Patients are required for clinical encounters to take place but acupuncture was often more expensive than other therapeutic interventions. Acupuncture had to compete. For example, consider how a sufferer of chronic head aches might relieve his pain. Treatments were many and could be taken up simultaneously. A sufferer could visit a pagoda or temple. He could swallow western pharmaceuticals (*thuốc tây*) purchased cheaply from any pharmacy by a white-coated seller, who pulls out a large urn of aspirin pills to ask how many pills he wants to buy. In early 2007, ten pills cost 20,000 VND in district 1, HCMC. Chance discussion in a daily marketplace could result in the offer of a small package of unidentified, instruction-less, differently shaped and coloured pills from a non-credentialed seller, all wrapped in coloured magazine paper for 7000 VND. To gain a doctor's opinion, consultations cost around 40,000 VND outside central districts. Medications sourced from the PRC, Taiwan, Hong Kong or South Korea, which may be termed *thuốc bắc*¹, were the most expensive; a course of treatment could cost up to 200,000 VND. Massage might help; a 50 minute full-body massage at the Nguyen Dinh Chieu School for the Blind cost 40,000 VND (all prices current at time of fieldwork).

Institutional and non-institutional acupuncture provision varied on cost. Depending on a patient's ability to pay, two payment rates were available at the Traditional Medicine Institute; private and public. Holders of government health-insurance cards for low-income earners could obtain a single 20 minute acupuncture treatment for 15,000 VND; after public daylight treatment hours, private patients were treated at higher cost. If acupuncture was desired, institutions with religious affiliations, such as Catholic traditional medicine hospitals or Buddhist affiliated projects, offered free treatment for 'poor patients' and reduced fee treatments for those unable to pay. A

¹ Northern medications. What is *thuốc bắc* was always a source of argument (see introduction chapter). Here, I highlight monetary expense.

single acupuncture session cost between 10,000-20,000 VND at Tan Dinh Catholic Hospital in district 1. Van and Hoa (see chapter six) charged around 70,000 VND to a new acupuncture patient but also charged reduced fees for repeat patients or those who found it difficult to pay. Nguyen Phuong charged 40,000 VND for a repeat visit. Canh was treating for free as part of his Catholic commitments. To make these numbers meaningful, during the time of my fieldwork a meal of pork, rice & vegetables cost 15,000 VND in a street-side eatery, district 1, HCMC; a glass of sweet milk coffee purchased street-side, was between 5-10,000 VND; renting a small room outside central districts cost less than 1million VND. A single acupuncture session could be expensive and there were numerous other therapeutic options available.

Acupuncture could not only be more expensive than many other therapeutic interventions but also took longer and was more painful. Acupuncture as a therapy required time to generate effect. In any one session, acupuncture could take at least 20 minutes with in-sitting needles in some places; in the treatment rooms of Van and Nguyen Phuong, much longer. Repeat visits were inevitable, which meant that a patient had to suffer longer and practitioners worried about their patience to return. Pharmaceuticals were considered popular, according to medication sellers and users I talked to, because they worked quickly. But the same users also argued that pharmaceuticals could not exorcise the underlying problem. For this reason, other remedies were sought. Acupuncture was relatively more painful than swallowing pharmaceuticals or other medications. However, cheaper unprocessed materia medica (*thuốc nam*) can be unpalatable, leading some patients to say they could not take it (*không uống được*) and hence they sought acupuncture.

Medical practitioners working in an institutional setting were not the same as those working in small independent clinics and treatment rooms. Salaried practitioners in hospitals were not required to ensure a patient arrived or returned. A potential patient arrived; work to attract the patient had been done somewhere else. But in sole trader treatment rooms, an acupuncturist was a medical practitioner, a marketer and an accountant, all rolled into one. If I frame acupuncture as an intervention on

offer to an idealised rational chooser (Wilk, 1996)² of therapeutic interventions where price, treatment time and comfort were evaluated and compared with other therapeutic resorts, I may point out that for any sole trader acupuncturist in private practice and seeking to continue therein, competition was stiff.

Generating customers was essential for success in the private sector. A form of marketing was required. Word-of-mouth has been discussed as highly effective marketing and advertising in business literature (for example, Buttle, 1998). Such literature presumes that an outcome of marketing is sales, which generates profit. In business literature, word-of-mouth in person networks can generate customers. How do you find patients I asked my interlocutors? “I don’t find patients, patients find me,” answered Canh. “For example,” Van replied, “the way you found me; a mutual friend introduced us by email sharing our phone numbers and you called me – through friends and word-of-mouth.” “By referral,” answered Anh, in interview through a translator, “one person tells another that I did a good job. In Vietnam, patients find the doctor not like in foreign countries where the doctor finds the patient.” “Only rich people would have a constant doctor,” chipped in my university student translator. Medicine moves by word-of-mouth, summed up an interlocutor, who has since retired from medicine. “People talk and *phát ra*” (radiate/send out, for example, the sun *phát ra* light). By word-of-mouth, people could find each other – patients could find an efficacious practitioner and students could find a knowledgeable teacher. I asked Nguyen Phuong how he came to know 6 Qi. He replied, “the same way as you. Lanh came here for treatment. She is a friend of Trung. You know Trung and he brought you here. Lanh called you to tell when classes started. And here we are,” illustrating those personal connections that were instrumental in me finding him. He also implied that personal connections were necessary to finding someone or something. All speakers framed medicine as network.

Life is Network

A problem facing patients, an interlocutor argued, was how to know if treatment by a particular practitioner would be effective. How could they know a treatment would

² The framing was used by patterns of resort literature (for example, Romanucci-Ross, 1969; Schwartz, 1969).

effectively exorcise their pain? Chi Ha treated many patients but some did not return. “If the patient does not have their pain reduced immediately, they want to know why not,” she explained. “One patient even wanted to make a contract with me that after so many days he had to be *bết bệnh* (illness ended).” “The habit of patients is that they don’t know where to go,” Nguyen Phuong argued, “so they just go and lie on their bed. One patient I knew had knee pain. He got needled [got acupuncture] in his knees only. But how can this help? Accept that we have to work hard for a short time and then we can learn how to truly help the patient.” The problem for practitioners, as I understood from their talk, was that patients did not need to find *any* acupuncturist or *any* treatment room but one that could truly help, that is, the one belonging to the speaker. How, then, could a patient come to know about a practitioner?

The most intimate vehicle of moving a name was that of personal connections (*người quen*). Talk of relationships, connections and networks permeated many conversations I had in HCMC. ‘Connection’ was the figuration of a person, always a person, who could ‘help’ obtain an unspecified or particular benefit. The idiom of help was much used. Connection was also talked about as a necessity. “I make a connection for you,” Danh shouted from the back of a speeding motorbike, throwing out an arm to his friend who was driving me along a busy night-time main-street. I should contact this friend if I needed help after he had left Vietnam. Van felt that her lack of connections was detrimental when seeking a practice license at the Department of Health. Charity medical work was used by both western and eastern medical practitioners to make new connections and develop existing relationships. Danh himself was sometimes called *ông mai* by his friends, which can be translated as a romantic matchmaker but can also refer more generally to someone who brought people together so that they might get acquainted and form useful relationships.

Talk of connections, their necessity and their figuring of relationships as a network was so repeated that they took on a “facticity” (Latour & Woolgar, 1979:83) for me, un-reflected upon until I returned to University. High-school students wishing to enter medicine, for instance, explained that they would need a connection in a city hospital to enter their preferred medical speciality or to avoid a rural placement. University students practising their English sought work in the private sector rather

than government because to work in government required connections, they clarified. To engage with bureaucracy required money or connections, elucidated middle-aged business men and women. A friend was surprised to hear my degree grades because he had assumed that since I was on scholarship, I had good connections. An acquaintance introduced me to her American teacher who commented that when she first came to Vietnam our mutual contact had introduced her to many people and now she was doing the same for me. Our mutual friend commented (of me), “she has her own networks.” A friend, on visiting a pub-style bar that was open past midnight, commented that it could do so “because they had good connections.”

Even karma³ was talked about as personal relationships enduring in time. A friend and I got on well, he reflected, because our friendship was an outcome of having “good karma with each other,” meaning a good (fair/balanced) relationship with each other in previous lives. Relationships persisted from the last life, into this life and onto the next. The relative balance in relationships between parents and children, between friends or between married couples in this life, could be understood by reference to how these relationships had panned out in the last life. Children, for example, were the unpaid debts of past lives since parents provided so much to their children in this life. Or if one person had left a debt unpaid to another in the last life, they would marry each other in this life. When acupuncturists described building their patient base as a work of connecting to connections, they used a circulating framing of ‘how life is’ in Saigon. Even the originality of Nguyen Phuong’s net of acupuncture channels can be reinterpreted through daily repetition of the importance of nets of connections: people who could connect people in different locations.

Networks were, then, ubiquitous and this led to their being ambiguous. In Saigon, everyone, it seems, was networking. The *need* for networks was pervasively talked about. Connections were required to connect to benefits, which might be an introduction to the right person or information about an application deadline. Because ‘everyone knows’ that a connection was required to obtain a benefit,

³ I was interested in *ngiệp* (an outcome, which Vietnamese English speakers might call their karma); *nhân-quả* (causality) and *duyên số*, of which my own translation would be serendipity. Committed Catholics were conversant with *nhân-quả* since the result of actions was heaven or hell.

suspicion and cynicism about networking were also omnipresent. Motivations for participating in networking could be friendly; but equally, other people could seek to take advantage of another's employment position and resources. At such a time, suspicion about the motives and fear of future obligation-making would result in resistance to connection-making. Resisting could be as simple as not participating in activities by remarking that "I'm working," or "I don't have a vehicle (*xe*)." Interlocutors could refuse to answer their ringing mobile phone. Valuably, mobile phones have the facility of caller-identification meaning one could potentially ignore calls, depending on the caller. Keeping secrets could prevent relationship development. Covert resistance (Scott, 1985) was also used. Doctors, for instance, were pressured by family and close friends to 'speak to' the consultant on a ward in which a loved one found him or herself and passively agreed to do so but engaged in no efforts to pressure that colleague towards a presumed higher standard of care than otherwise might be the case. This presumption was on the part of the family, who assumed that when a loved one fell outside a net of personally related connections, lack of care and assistance would result⁴.

Familiar people were everywhere; at school, work, funerals, death day remembrances, wedding parties and New Year celebrations. Because of, and through, such events friends and strangers could participate in crucibles of connection. At one wedding dinner party I attended with a male friend, we sat at a table with his primary school friends. They had grown up together in a small town in the Mekong Delta and later migrated at different times to HCMC. They were variously a journalist, an under-manager of a central hotel, a yoga teacher, a policeman and a customs officer working at the airport who met together at the wedding party after a gap of some months: the wedding was that of another age mate from the same 'homeland'. The Traditional Medicine Institute held a celebratory banquet for the Lunar New Year in its gardens, inviting over 100 guests – staff, former staff and their connections, with food, gossip and singing as the order of the evening. Familiar people were also students. Nguyen Phuong exhorted his students to give him their mobile number so that if any patients should call him from a distant district he could refer them to a more local acupuncturist. He

⁴ Also urban Japan: "personal introductions often ensure much greater attention by the doctor" (Ohnuki-Tierney, 1984:177).

simultaneously implied that his name had travelled out of his local district and invited students into a reciprocal patient referral system. Relationships generated more connections that generated benefits and ultimately more relationships. Connections, an interlocutor described, were like the phrase “*tiền để tiền để tiền.*” This phrase can be translated as ‘money is required in order to make money’ or that ‘money gives birth to money’ since the word *để* can also be used to describe a woman “sprouting out” a baby. Relationships gave birth to more relationships that are required to make more relationships. In this way, a net of personal connections was born.

Networks were spoken of as essential, even though they were not always so. For instance, interlocutors agreed that entering study at the Traditional Medicine Institute was unproblematic; no connection was required to apply and enter. But connections and relationships were required when dealing with the Department of Health. In those instances, relationships figured negatively, as sources of corruption. Corruption, described an older female businesswoman, *was* network. “It’s like this,” she described, “I have my network and you have yours. But I need your signature on something, for which I get x dollars so I say to you, I will give you y% of that. Then if I get caught you have to protect me because you will also be caught. So two networks are joined” and become more intense. Personalised networks between staff working in marketing, hospitals and pharmaceutical providers were implicated in anti-retroviral treatment price inflation for HIV+ persons (Nguyen & Tran, 2005). These narratives emphasise the fundament of network in accounts of ‘how it is’. Talking about networks and their essentiality created a context where network was all. And because of that, expectations were generated that without connections an applicant could not negotiate bureaucracy (see discussion on credentials and licensing in chapter one). Repeating in talk that connections had been used and were needed to obtain a benefit was itself an activity that created believability in the necessity of connections. Repetition was an additional activity; additional to the practical successes of obtaining a material benefit through existing relationships.

Personal networks developed trust through nets of familiarity. Developing relationships implied building trust and the simplest means to assess the claim of a stranger was through a known person (see Ashwill & Thai, 2005). Trust, as I

understood from fieldwork, was generated by participating in relationships; by participating familiarity could arise. People could get to know the “heart” of a stranger. By participation in relationships, familiar persons came to participate in endless reciprocal exchanges (*nhân đi, quả về*). Therefore to be in a relationship was simultaneously to be a participant, an obligate and a recipient of many exchanges: care, friendship, love, money, support, food, schooling and so on. Introducing two strangers to each other through a mutual familiar person meant that each stranger relied on a known relationship and assessed a stranger through the known. The known person acted as a guarantor for the not-yet known (Ashwill & Thai, 2005). Giddens (1990:80, 119) suggests that such trust, founded on social connections and co-presence, is pre-modern, whereas Alison Truitt (2005) researching money and banking systems in southern Vietnam, where currencies have repeatedly lost value after regime change and commercial failures, argues that failure to trust ‘systems’ is only rational. As argued in chapter one, a lack of trust similarly existed about credentials. Credentials could not validate or warrant (Rushforth, 1994) expert knowledge in the shape of efficacious clinical outcomes. Therefore the problem of finding a truly efficacious practitioner was solved by relying on personal networks of familiarity and trust.

Practitioners sought to take advantage of the ‘fact’ that patient referral took place through a trusted person to generate more publicity. Scheid (2002) suggests that scholar-doctors use relationships to insert themselves into an ‘infrastructure’, like a teaching school or a research institute or a discipleship. Reflecting the fact that I did not undertake an institutional ethnography, I would suggest that in Saigon, relationships for acupuncturists in private practice were geared towards inserting themselves into additional personal networks. To this end, Nguyen Phuong employed a friendly disposition towards patients and students. He commented on his own behaviour one day in class.

My medicine means that patients come and go many times... but when coming in front of the doctor, many people don’t dare speak openly about their concerns... with regards to me, people see me as a neighbour, that we are folksy [having the common touch] with each other, so they dare. They dare to ask me how many times they will need to get needled

and take how many measures of medication they must take before coming out of their illness. I'm busy in that.

Nguyen Phuong prided himself on his approachability, something he was 'busy' with in efforts to maintain and develop his private medical practice. The empathy that developed in relationships between a practitioner and his patients and between a teacher and his students was important. He affirmed a sense that these relationships could, and perhaps should, be friendly encounters. Networks of connections in familiar and friendly relationships could take on the work of publicising a practitioner rather than being dependent on numerous one-to-one relationships. For practitioners, this was essential. Networks became a vehicle, or as Latour (2005) puts it, they were mediators. They took over activity and changed it. Myriad networks moving one's name independently of one's own publicity efforts was how practitioners envisaged success.

Connections were made through personal introduction. In February 2009, an interlocutor opened a luxurious new clinic. The clinic was substantial, employing seven staff to offer acupuncture, massage and medications. To publicise her new enterprise, the owner introduced all her contacts to the new clinic meaning she told them about it in conversation, face to face or on the telephone and invited them to visit the newly opened premises. These contacts were her family members and their contacts, colleagues from previous employment and acquaintances made through other contacts all of whose telephone numbers she had saved in her mobile telephone. These people did not visit the new clinic alone but with, at very least, one other person such as their husband or wife, another family member or a friend. For example, a former colleague of the clinic owner brought his sister and fiancée, his sister obtaining a treatment that was gifted free on the first occasion. I was there with another friend who had accompanied me. That the first treatment was free during these opening weeks was never spoken about. It was free even though the owner was paying her staff a basic salary plus commission and had to meet ongoing business costs such as rent and electricity. The very first treatment was free as an 'introduction' to the service, an interlocutor later explained. We sat together in an open space outside the separate treatment rooms, chatting over small cups of warm green tea and a small bowl of sweets. On other occasions of introduction, fruit was

offered. We, a mix of familiar and strange persons, sat together and drank tea and talked; discussing the new clinic, the work involved in getting to its opening, joked with the owner about her single status and chatted about family and work circumstances. The conversation seeming to meander for a time, before the acquaintance with their friends or family left.

During an introduction, two strangers are not required to step through a doorway into unfamiliar territory, to meet alone and unmediated. During this time, business cards can be exchanged formally but more often 'phone numbers were entered into the ubiquitous mobile telephones. I also received a free massage 'to introduce' me to the new service and was initially unsure about payment. Afterwards, I sat down with the owner and a different set of her connections for more talk. I intimated that I was about to leave at least three times, therefore taking at least another hour to make my exit, thinking that hinting at my leaving would induce a request for payment. Highly uncomfortable, I left without paying, appreciating Michael Callon's (1999) description of business as practices in which the calculative nature of market transactions are deliberately entangled with other kinds of relations. After the opening period for the new clinic, new and existing patients met their acupuncturist directly and were not offered tea or extended conversation with the owner.

Networks were a form of media that translated a practitioner's work into many different auditoriums of talk. Unsurprisingly, I was also instrumental in connecting connections. At my first 6 Qi lesson with Nguyen Phuong, I invited a bilingual friend of mine to translate. I found that it was not practical to have two persons talking in class instead of one (the teacher). Also, my friend was fascinated with what our teacher was saying and did not, in fact, translate. Instead, I relied on transcription and translation. But that meeting between my translator and Nguyen Phuong, functioned as an introduction. She later returned to seek treatment for back pain, which Nguyen Phuong treated through standing meditation. He advised her to stand in posture for an increasing period of time each day. She reported that she undertook this remedy daily while listening to music and watching TV. She lived with a relative in a different district and discussed Nguyen Phuong with him. Subsequently both returned to his treatment room. Her relative, she reported, also practiced the standing meditation daily. Additionally, she told a friend of hers who was interested

in meditation but that friend felt, I was told one evening, that this particular practice was repressive of emotions and not helpful. The publicity of happy patients can be accepted or rejected by others. When talk moved through networks, what 'is' got translated. What I considered to be a meditative practice, which Nguyen Phuong used as a clinical solution, got translated into an emotionally repressive act as well as a daily beneficial event. Through networks, acupuncturists could generate talk that would lead to more patients sitting on her waiting bench or calling his mobile number seeking treatment.

In trying to understand why interlocutors considered fame so very important, acupuncture framed solely as autonomous clinical encounters or textual and teaching debates is not helpful. Being a successful practitioner meant keeping patients and attracting more because without patients, clinical experience could not develop, learning could not evolve and a graduate student of any education, credentialed or otherwise, could not become successful. Publicity, in acupuncture as in any other business, was intrinsic to success since it maintained a person in the occupation. For a number of interlocutors acupuncture was a business, it generated income so that fame-making for those was aligned with marketing and publicity. Acts of producing publicity, however indirectly, fed into sales so that the work of developing name-fame can be ultimately reduced to a sales pitch. Scheid notes in Beijing 1994-99 that "increasingly what counts for [Chinese medicine] physicians is personal fame, which *translates* into personal wealth" (2002:194 emphasis added). Personal cash wealth did count for some of my interlocutors. But for others, fame translated into something else.

Becoming Newsworthy

Fame for my interlocutors was to be talked about. To be talked about meant to generate publicity through networks. Celebrity literature has often defined celebrity in this way. Celebrity literature has been useful when trying to understand what my interlocutors were doing when engaging in particular discursive activities. Leo Braudy (1997) argues that fame is the immortality of a name over time, more so than the person who occupied that name. Writer efforts to find out who a famous person is authentically, misses the point. A name is more important because that name can take on a personality, separate from the person who creates and inhabits it. Likewise,

my interlocutors emphasised that one's name, like Chi Ha or Truong Thin, should circulate, rather than details about 'who' that person was. A name and person were therefore separable. For Braudy, fame-making throughout history comprises conscious acts characterised by "attitudes individuals have towards themselves" (1997:15). Graeme Turner (2004) argues that whether investigating fame or celebrity, both require publicity, promotion and advertising for their existence. These activities need not be understood as the means to an end but rather can be taken as 'rational' goals in themselves. Neil Jamieson argues that prestige and social hierarchy have always been important in Vietnam: "traditional Vietnamese" competed for social hierarchy and "cared passionately about face and relative status" (1993:31). Fame can be also understood as endeavours undertaken to attain such status and need not be a servant of monetary accumulation.

Fame as a rational goal of itself was the explanation by a technician who could not understand the actions of a US acupuncturist. The young acupuncturist, who had travelled with a small group of practitioners out of HCMC to teach acupuncture protocols for free to blind and partially sighted practitioner of massage and acupressure, wondered about the leader's activities. The main question was why. Why was a sighted US-resident Vietnamese acupuncturist so keen to develop acupuncture for the blind in Vietnam? It was a big question, puzzled my fellow volunteer, who drew a big question mark with his finger on the table between us. The only reason, he argued, was fame for the family in their homeland – to become renowned in the homeland – that must be why they were doing it. Fame was the goal in itself. He used a word that I did not understand so he changed it to one I did know, *nổi tiếng*. When other avenues of reason could not be found, fame was the most likely, for him, explanation. Fame, for this young man, was success that might be accumulated even if not in the form of money (also Bourdieu, 1977; Rystrom, 2003).

Fame depends on publicity and generating publicity is labour in the world that can be investigated and documented. Generating celebrity in the arenas of sports, films and television and business in the UK, USA and Australia, argues P. David Marshall (2006), is dependent on the work of publicists, agents, managers and public relations occupations. For Marshall, labour is expended in an industry of celebrity

construction. In his writing, celebrity is an adjective for activities calculated to generate talk – when a person, a name, an event, an institution, a practice or a technology – becomes a discursive event. Celebrity is traceable in and through vehicles such as TV and radio (Turner, 2004), newspapers, blogs and internet sites. Publicity is measurable in a volume of press clippings (Boorstin, 1961) or column inches or screen space, all being vehicles of carrying talk through space and time. But such publicity relies on appearing newsworthy (Turner, Bonner, & Marshall, 2006). To be talked about is to be newsworthy, that is to say, the act of talking about another enacts that person as ‘news’. Talk by patients and practitioners ‘did’ newsworthiness in acupuncture. The most newsworthy acupuncture events were quick pain removal or a miraculous cure. To explore newsworthiness in acupuncture, I focus on successful healing talk emanating from and about one particular practitioner, Chi Ha. First, I detail a story of a miracle she performed for a patient, later friend, called Eve. The theme of miraculous healing will then be followed into the talk of Chi Ha herself. Last, I will follow the theme of successful healing through another vehicle of moving talk: TV and DVD film. These will show how person networks and other media forms moved a practitioner’s medical reputation in the newsworthy form of ‘cure’.

The first narrative about Chi Ha comes from a grateful patient of a proven healer. I met Eve in February 2008. We met in the house of Huong, a technician I had come to know while volunteering at an outer city charitable project, freely providing acupuncture and materia medica packages to any patient who presented for treatment. Huong was the daughter of Chi Ha. Eve had once been a patient of Chi Ha and was now a close friend and her very vocal publicist. Both Eve and Chi Ha were overseas residing Vietnamese who lived near each other in the USA. They had left southern Vietnam in the 1980s, called the time of subsidy by Ken MacLean (2007), a time of post-war hardship, shortage and ‘re-education’ of southern government sympathisers and ex-ARVN (Army of the Republic of Vietnam). Chi Ha and Eve visited Vietnam annually after obtaining their American passports. Eve had met Chi Ha six years previous, in 2002, at a time when she was very ill with cancer. She told me her story in a mix of Vietnamese and English over two different occasions.

My sister-in-law heard about a woman called Chi Ha who helped people walk again and cured their illness. She advised me to meet her. At that time, I had cancer of the lungs and uterus and when they operated, they left some cotton wool inside my bladder that I eventually passed as urine. At that time I was really ill; my skin and my lips turned black, I couldn't see out of my left eye and was going blind in the right one. I was ready to die and that's when I went to Chi Ha because I thought 'this is the last chance'... Chi Ha treated me with blood-letting, medications and acupuncture. I had small lumps on my skin the size of a small grapefruit and soft to touch, like a balloon. I had them behind my ears and on my arms. That was because of the bacteria in the cotton wool inside me... that bacteria passed into my blood and then the bacteria tried to come out of my body. When Chi Ha did blood-letting, inside the lumps was all full of white stuff, not red blood. Can you believe that, my blood wasn't even red any more because of the bacteria in the cotton wool! Chi Ha really helped me. If it wasn't for Chi Ha, I would be dead. Back then, my lungs, heart, liver and stomach were all failing. I couldn't see in one eye for all the black specs in-front of my vision, my hair was falling out and my fingers were going like this [tensing her fingers into a claw]. The doctor thought I had arthritis. I couldn't sit or lie comfortably because of problem in my coxes, I was permanently bent over and the doctor wanted to operate... So I went to Chi Ha. Chi Ha told me that if I trusted Ba Den and Buddha, together they would help me. [The Black Lady/Goddess was a popular cult in the western Mekong Delta. On the ancestor alter inside the home, an engraving depicted Ba Den with Khmer facial features, round face and eyes. She was dressed golden, black-haired standing demure with arms trailing⁵.]

Actually, at first I didn't believe but after that Ba Den came into Chi Ha's body and she used the body of Chi Ha to treat me. The swelling in my fingers reduced [she raised her hand, demonstrating that her fingers had

⁵ Philip Taylor notes that the Black Lady has different names in different ethnic religious traditions. Petitioners visit her shrine, located just inside the southwestern Cambodian-Vietnam border, to appeal to her powers as "provider of children, healer, relationship adviser, business consultant". She is "one of a group of goddesses that have been ascendant since mid-1980's" (P. Taylor, 2004:4).

been double normal size]. Ba Den came to Chi Ha again even though I still didn't believe in Ba Den. You know, the face of Chi Ha is different when Ba Den is in her body. They clicked my tailbone – that was very painful – and used blood letting over the coxes three times, pushing out the stagnant black blood using a bamboo stick in hot water to draw out the blood. After that I could lie and sit comfortably. Nowadays, I am 80% well but I still take herbs [materia medica] for this blood infection I've had for about two years. I don't think I will ever be 100% well but the change is so great.

On a different occasion she observed:

It's a miracle that Chi Ha knows medicine. It's magical. Maybe in the day time she doesn't know how to treat a patient but in the night it came to her, what to do and what method to use. *Dinh hương* [the name of Chi Ha's charitable organisation] is another name for Ba Den. Ba Den comes into her body when Chi Ha can't decide how to help people. But it's Ba Den's decision, she doesn't come into just anyone's body or on Chi Ha's invitation. Ba Den will only enter the body of someone with a good heart. When Ba Den comes into Chi Ha's body, Chi Ha can write out the name of medicinal plants to use in medical recipes <how does Ba Den know medicine?> I don't know, she just knows. Ba Den treats patients through the body of Chi Ha, like when Chi Ha treated your ankle the other day Ba Den came into the arm of Chi Ha when she was doing acupressure and directed the arm of Chi Ha to cure your ankle.

The organisation *Dinh hương* is an organisation of ex-patients like me. I help out one day a week because I don't live close to Chi Ha's house [in their adopted city]. But those living closer to her house help out more. <What kind of things do you do there> I attach the electric cables to needles for electrical acupuncture or insert needles into the body of a patient always following Chi Ha's instructions about where to needle and how... or take out the needles after a certain time... make up materia medica packages like boil the leaves or grind or smash *cây thuốc* [medicinal parts of different plants such as roots or stems]... whatever Chi Ha asks me to

do, I do it. Others might do other things like donate time or money. Some of the patients she treated pay her rent. She has around 50 patients every day and only has two assistants to help her... she's very busy.

Obtaining a quick change in pain will make an acupuncturist newsworthy but taking a patient from the brink of death was much more so. Eve's account is full of drama and incident. It demands to be told and retold. She first told me how she found Chi Ha. Eve found Chi Ha because her name was already noisy. She told me, in effect, that Chi Ha was already famous. She told me of her great need for assistance, her shocking condition and the gruesome and empathy-generating details of her suffering. She set up a scene by which transformation seemed unlikely. She then detailed what Chi Ha did, the various sources of her assistance and her eventual change into her current state of health. That is, she detailed an unlikely conclusion: that she could be well. Interestingly, she developed her narrative within a contemporary time frame, linking her experience and mine, so that Chi Ha was shown not to have 'lost her touch' (see Weber, 1946) or been deserted by the Black Lady. An otherworldly source of healing was named as a source of medical knowledge. A warm-hearted helping source compared to the nameless and faceless Others, who figure as protagonists in the form of "they" or "doctors". These others were feeble in the face of her illness and worse, harmed their patient through their interventions so that even her blood changed colour. Chi Ha figures as a last resort caused by the malpractice of the ineffective and inept, nameless doctors.

But not only Chi Ha healed. It took the cooperative work of at least three agents (Harrell, 1991) to undo harm and restore Eve's health. That is to say, so awful was her condition that she was not easily and quickly transformed into a healthy person. The sanctity of Chi Ha and her humility were put forward. That the Black Lady entered Chi Ha's body evidenced Chi Ha's genuineness of heart, someone who cared for others rather than profit. Chi Ha did not seek cash payments for healing. Her work was organised under a charitable institution where costs like medical supplies, rent, water, electricity were met through donation. All labour was also donated. Methodical accumulation of money was rejected. Finally, belief was rejected as rationale for her cure. There was no 'placebo' operating here. Eve did not believe but was helped regardless. There was no doubt about the cause of her transformation. It

was in the relationships between Chi Ha, the Black Lady and the Buddha, though Buddha got less coverage.

A patient's advocacy on behalf of an efficacious healer enacted that healer as newsworthy. Eve was very vocal. She silenced and erased some authorities, named and revealed others (see Saris, 1995:68). She made a verbal testimony to someone who was not familiar with the healer, about that healer's therapeutic efficacy arguing, in effect, that 'it worked for me, I am the living proof'. Among the many interesting facets of this account is how Eve promoted access to Chi Ha for me. She assisted me by using English and Vietnamese so that I could understand without needing an additional translator and verbally introduced Chi Ha's qualities and proofs as a healer. Talk in her home city brought her to Chi Ha and through talk she brought Chi Ha to me. By writing about Chi Ha, I continue to circulate her name in a talk form (Holmes & Redmond, 2006). Stories moved and talk was the agent of that movement. Eve was like an events manager, someone who brought people together so that "they go away and they talk about it forever" (Turner et al., 2006:782).

Incidentally, there is a key difference between Eve's perspective and my own. While both Eve and I frame Chi Ha as famous, I am following the practices of story-telling in talk to understand how fame was generated. I argue that Eve used talk and a successful healing story to raise noise (awareness) about Chi Ha. Eve, however, was interested in persuading me of Chi Ha's authenticity as a healer. Fame for Eve was attached to Chi Ha. Even though she was requested to believe in the Black Lady and the Buddha, it was Chi Ha's name that moved around networks in Eve's home city as the efficacious medical practitioner. Eve was not interested in the Black Lady, rather that Chi Ha communed with the Black Lady to enable miraculous healing. Chi Ha's authority to treat was not in paper credentials or in attendance at a government Institute, rather located very personally in her 'good heart', which purified her to commune with an otherworldly agency. Taking a patient from death into life was a "miracle" so in Eve's interpretation of her escape from death, Chi Ha figured as the genuine article. For Eve, her death at that time was inevitable. In averting the inevitable, Chi Ha with the Black Lady had become divine. Chi Ha's authority to act was not of this world (Weber, 1946). Eve was in a very intimate relationship of hope, support and healing with Chi Ha and the Black Lady. While Eve's reasons for

circulating the story of her ‘miracle’ were likely numerous, its effect was to generate noise about a healer whom, in this instance, was not engaged in self-promotion of any kind.

Next, I follow the telling of successful healing stories, this time by Chi Ha herself. To generate ‘noise’ in networks required newsworthiness. Successful healing stories were how newsworthiness was done. Eve told her own story to me and Chi Ha did not rework it. Chi Ha told different stories and I report them here in the third person. Chi Ha’s first therapeutic success was herself. After an accident, her knees were so painful she was unable to walk. She visited many doctors but they could not remove the pain. The pain in her knees was great, she remembered, so she self treated with materia medica and a method based on the Five Phases (see discussion on Five Phases in chapter two). Four years later, when her friends got sick she suggested this method to them. When they took her advice, they recovered. During that time, she was still earning a living as a seamstress. She started full-time clinical practice in 2002, after a male plumber, who suffered paralysis on the left side of his body through stroke, came to her for help having heard about her work in their home city. After his successful cure, she quit work as a seamstress and worked full time in charitable medical practice. She treated a doctor who had 25 years experience of medicine: he came to her because “he couldn’t move his arms, couldn’t hold breath in his lungs,” she described. She treated him with a combination of pressure and needling. After the treatment he could move and hold his breath, she claimed.

Successful healing stories entered our early conversations after her questions of me – where was I living and what were my family circumstances. She told me initially that she knew medicine through her family, though later she told me directly that she had never studied medicine in any form either at a government school, through a pagoda or temple or through a family apprenticeship. The first story she told me was about the doctor, while the story of her own successful treatment she told me because I asked how she got into medicine. These stories identified a particular patient, condition, therapeutic method and an outcome, which were always positive for the patient. By contrast, Nguyen Phuong, who also loved to tell healing stories to his students, spoke of both successful and unsuccessful outcomes, that “when we speak of positives must also speak of negatives,” as he put it. Telling successful healing

stories was a practice engaged by practitioners who had licences and credentials as well as those who did not. More interesting is that the Black Lady did not enter Chi Ha's talk as it did in the patient story told by Eve. Rather the Black Lady entered her body while I was present. Chi Ha sought out a digital film clip zooming to a scene where the Black Lady entered her body. She introduced me to the Black Lady while in the body of Chi Ha. I will come back to this later.

Narratives, the enactment of a practitioner's newsworthiness, moved through repetition. I take repetition here to have a sense of variation with continuity, rather than as an exact copy (after Deleuze, 1994). Chi Ha repeated the plumber and doctor story to Danh on a jaunt to a bhikhu friend's charitable clinic in Dong Nai province. The vehicle of circulation was networking. During the Lunar New Year period, while Chi Ha was visiting her family with Eve and Danh visiting his with American acupuncturist friends, we arranged to visit the clinic, a two hour bus ride from the city. Four American visitors, with two doctor-acupuncturists, myself, another friend of a friend, Eve, Chi Ha, Huong, her uncle who was also an acupuncturist and her brother piled into the minibus. As usual, one turned up late but after that short delay, our small crowd got on the road. The visit was for fun (*cho vui*), no patients were attending clinics because of the New Year holidays. Friends, family and their connections attended: we went as a group not in solitary ones or twos. One outing served a number of functions: I wanted to meet the bhikhu again, Chi Ha wanted to meet Danh and the outing was fun for those who were bored. We bounced along in the minibus, chatting, stopped for iced-coffees and sugared sweets and arrived in time for an 11am lunch. After eating, the acupuncturists moved over to a new hospital wing that had been resourced through local and international donations. Practitioners asked each other for a treatment of acupuncture, cupping or coining to "know what it feels like, to become a better practitioner" and to show "a little secret, just enough so that you think there must be more."⁶ As Chi Ha and Danh got down to finding out more about each other, I heard her repeat the plumber and doctor stories.

In HCMC, it was noticeable that repetition often turned up in talk. When I was learning 6 Qi acupuncture, I gave an article handed out in class to Canh because I

⁶ Answers to my suggestion that when practitioners get together they must show of their treatments.

was sure he would be interested to read it. His student told me later, while we were all lazing in a café over iced coffee one hot afternoon, that “in the old days, when learning medicine one had to learn the Classic of Changes.” I excitedly asked him why he thought so. He replied that Canh had told him, which Canh had read from the article I copied for him. Similarly, during an interview with an acupuncturist who subsequently changed occupations, opinions were given which, I realised, were repeats that we had both heard from a common source, a teacher of blood-letting and the Classic of Changes. Asked what ‘eastern medicine’ was, my interviewee replied that it was whatever came from China; Vietnam had been a colony of China for over 1000 years so was influenced by China. Eastern medicine, he elaborated, was acupuncture and ‘northern’ medications but blood-letting was particularly Vietnamese. Cupping and coining were not eastern medicine either, those belonged to Vietnam. Our teacher had “said so,” he reminded me, telling me in talk about the talk of another used as an authority. We had both visited the teacher together with other friends during Lunar New Year 2007. Talk was repeated, enabling movement.

A successful healing story was repeated in networks of familiarity. During the Dong Nai journey, stories travelled to Vietnamese listeners and two just-met doctor-acupuncturists. Chi Ha gave an upper body coining treatment to one doctor and they sat together at length discussing, among other things, where she had learnt medicine, at which school, in which language as well as discussing certain acupoints and their effects. The doctor-acupuncturists were generally respectful towards her, calling her older sister, using a friendly intimate pronoun without variation and continuously self-styled using the inferior pronoun. This was proper, since Chi Ha was noticeably older than the other two. However, in different situations with others who were older, these doctors did not always so self-refer⁷, so their consistency in pronoun use was noteworthy. I was surprised by the warmth in their encounter wrongly thinking that they would have been more distant due to Chi Ha’s lack of formal education. They later agreed that Chi Ha’s medical language was not like other acupuncturists so wondered where she had been schooled. “She doesn’t have a licence, right,” one stated in lieu of a question. I replied that she was self-taught. “It doesn’t matter,” he replied, “what’s important is that she is a [good] healer and has lots of patients who

⁷ For example, when angry or tired, one ‘forgot’ and referred to himself as older, instead of younger, even if not going so far as to call an older woman inferior. In that situation, the personal pronoun for the older woman was momentarily dropped from speech.

like to come to her clinic.” These credentialed licensed practitioners, having obtained pieces of paper from regulating authorities validating their ability and right to practice medicine, framed medical practice as being ultimately authorised by patients.

Finally, an additional media was used to deploy Chi Ha’s fame as a miracle healer. In Dong Nai, stories were repeated though talk in personal networks so enacting newsworthiness. Personal networks were a form of media. Repeating stories through this media created circulation. Stories about Chi Ha circulated in other media. For the benefit of any new visitor to the family home, Chi Ha played a short documentary that was filmed in the USA. The film was run repeatedly over the period she was in the city. Those relatives and friends, who were at home more often, saw the film frequently. The film was created by an overseas Vietnamese TV channel called “Vietnamese TV in (her resident American state)” and copied onto DVD for her by the TV company. The film started out by showing some clips of various overseas Vietnamese community activities and celebrations and then switched to a suited, young, female presenter who introduced the viewer to Chi Ha and her work. The camera moved into Chi Ha’s home. In the film, Chi Ha wears white; white trousers and a white, half-sleeve top, working in her consulting room. The film shows a large front room of her home that has been converted into a clinic space. A hospital bed is the treatment bench, complete with a prone patient and stainless steel medical tools held on a trolley. The ubiquitous posters (see chapter two) are pinned up on the wall. A grand, ornate alter to the Black Lady dominates one end of the clinic space.

In the TV clip, the main focus is a white American patient called Cindy who is Chi Ha’s second white patient. All her other patients are from the Vietnamese community. Before 2002, Cindy tells the TV camera in English, she had led a normal life but suddenly could not move, could not speak clearly and had to live in a wheelchair. She was diagnosed with multiple sclerosis and had been told by doctors that she would die after four or five years. She came to Chi Ha *<how did she know about Chi Ha? Rumour, answered Eve>* and after three months of treatment, she could move her hands and legs and move her face muscles more easily though still with stiffness in her speech. She lauded Chi Ha to the TV presenter, saying no-one could help her until she met Chi Ha. Cindy could not believe the change after such a short

time. Chi Ha argued later that belief was very important. “If the patient believes the doctor can heal them, then it’s easier to treat.”⁸ “Right,” nodded Eve, contradicting her own testimony that she had not believed yet was healed regardless.

As much as talking about Chi Ha in personal networks performed her as newsworthy, Chi Ha’s very presence on TV enacted her as worthy of being talked about. Through electronic media, different patients gave verbal testimony to the efficacy of Chi Ha’s treatment. They repeated on camera what Eve had done in person. The media itself – a TV show – testified that Chi Ha was newsworthy since it showed her on a media platform that extended word-of-mouth in space and time. She was, literally, the news; being authenticated by TV.

TV was not the only digital media engaged. Chi Ha undertook charity work while on annual return to the homeland, gifting food and free treatments to residents of a village in Dong Thap province, bordering Cambodia *<why there? Lots of poor people there, Chi Ha answered. One of her contacts had arranged it all, she didn’t have time to arrange it herself>*. The giving had been filmed on a handheld digital camera by her son-in-law. When I visited her on a different occasion, she linked the camera to the TV so that she could zoom through the uncut footage to a particular segment. Listening to her comment on the film as it played and by watching film, I could see that she was talking to a woman who at the time was being possessed by a Chinese spirit but Chi Ha was able to remove the spirit with the help of the Black Lady. Switching to the TV news segment filmed in the USA, she replayed the interview with Cindy, allowing those present in the room to watch the TV interviewer ask about her qualifications (none) and how she afforded to run the clinic since she did not charge for treatment (donations). This time, she allowed the film to run on into a series of short interviews with patients who had been successfully cured by Chi Ha. Through testimonies, Chi Ha accrued a volume of coverage. But these repeated stories circulated separately. These stories moved through different media that were able to move her name in different ways. TV extended the noise of her name in her home state, over a geography potentially more extensive than person networks. Her happy patients went away and talked about her in their own person networks, moving her

⁸ During fieldwork, a Swiss acupuncturist remarked that he also thought his patients needed to “believe in the voodoo” of acupuncture. Vietnamese doctors told me that they “can’t treat patients who don’t believe in me.”

name by word-of-mouth. Her fame was dependent on constant talk to keep her name circulating. Her own self-affirming healing stories were addressed to those she met. Different media forms could take on the work of moving a medical name so that the name holder did not always need to engage in publicity herself. The media spoke for her.

However, Chi Ha had not yet broken free from her labour in the world. In all of these stories, it is interesting that Chi Ha was active; she was always working. Eve recounted the treatments that Chi Ha undertook for her, digital film showed Chi Ha at work and in Chi Ha's own accounts she tells us what she did – I needed him there or I did blood-letting here. Her efficacy was constantly being proved (Weber, 1946), she was still 'famous for...' unlike doctor Truong Thin who had been described to me simply as famous, without recourse to his accomplishments. Truong Thin appeared to be famous for being himself. He seemed to epitomise Daniel Boorstin's quip that the famous were famous for being famous, arguing that a famous person was no longer required to accomplish great deeds and that he was a 'pseudo event' (see 1961:57). It is to this epitome of fame in acupuncture that I now turn.

"Famous"

On a return field trip to HCMC in March of 2009, I had the great fortune to personally meet Dr Truong Thin. I had first encountered his name some 18 months previous in an interview, when it had meant nothing to me. On that occasion my translator was Canh, together with a mutual friend of ours. My interviewee had learnt *nắn đốt sống cổ*⁹ (difficult to translate; massage on the neck bone, suggested our friend). Unsure I asked our interviewee whether it was a 'western' or 'eastern' technique. He replied with the source of his learning, Dr Truong Thin. "Who's he?" I asked since at that time I had not heard of him. "A very famous doctor... very famous... this technique came from him," replied Canh. My translator gave no further explanation about who Dr Truong Thin was. The 'fact' of his name should have been sufficient.

I met this famous doctor-acupuncturist at his private medical partnership called the Centre of Modernised Traditional Medicine. Six doctors and two technicians worked

⁹ Chiropractory.

there. Truong Thin treated patients by acupuncture and its other rooms hosted high-oxygen chambers in which patients could lie for various periods of time for rejuvenation. The literature, all in Vietnamese, presented the familiar successful healing stories, this time in print. Pictures of the transformation accompanied the stories for added dramatic effect. I met Truong Thin through Danh, who worked under the famous doctor at the Traditional Medicine Institute. When I met Dr Truong Thin, he was sitting at a varnished mahogany table with empty chairs in his large treatment room. Three hospital beds were partly hidden behind rattan screens. We sat on chairs by the wall so that about three metres of floor space separated us from the doctor, sitting at the table, inking buff coloured paper sheets. When finished, he laid down his calligraphy pen. Looking up, he asked who I was, which prompted Danh to introduce me. The doctor's first question was "who guides you [in your research]?" and he then invited me to sit beside him at the table. "What is traditional medicine of Vietnam?" he asked but French visitors entered and interrupted. He addressed them in French speaking quietly; seemingly very tired (I was told later that he was seriously ill). A white-coated practitioner came in and turned on the TV positioned behind the doctor, so that we could watch a clip of him singing a song on his locally published music DVD. Guitars and a piano organ were set up for play at any time. The DVD played a song about *một bước tới rồi, một giờ tới rồi* – 'in one step I have arrived, in one hour I have arrived' as in Zen Buddhist Thich Nhat Han's injunction to meditate to the mantra "I have arrived, I am home", each step brings me into the present. Still addressing the French visitors, Truong Thin stood by his electronic piano and closed his eyes listening to himself singing on the TV, saying that he was listening to the sound of nature. His pot belly perched out, his grey hair was careless to his shoulders but his brown eyes were clearly lit from within.

Up to this point, the doctor had said very little but began to speak slowly and quietly, saying that traditional medicine was three things. The first was humanism, which meant that first and last, was the patient. Second, the patient was a colleague of the doctor. Patients and doctors should look at each other as equals, not as monetary ends. Third, the body can manufacture all the medicine it needs. The body can make insulin or adrenaline so traditional medicine was used only to help the body

manufacture what it needs¹⁰. His talk rambled between many topics. Traditional medicine, he described was a *đạo* (a religion, in the sense of a ‘path’ of life). He hesitated and changed tack. Patients always want a very clever doctor to help them, he told us, they want to know that the doctor who is treating them is really clever and will treat them well, that he is like an angel. Vietnamese people follow traditional medicine very much in HCMC, he explained to us all, because western medicine is foreign to them; traditional medicine *is* culture. He rested before continuing. Man was nature and vice versa – man and nature were interconnected; man was nature and nature was man. When he finished talking, there was a short silence. He asked me how I felt about this interaction, waving his hand to indicate himself and me. Since it was a relief to be in the presence of someone who did not talk all the time, compared with Eve, Chi Ha and all the teachers I had met up to that point I answered so. “It’s peaceful,” I replied, “you talk less.” He replied slowly, “there is nothing to say.”

Dr Truong Thin does not need to say anything: it has all been said already. His words have been circulated through many different media forms over the last 25 years. His books, for instance deliberate on man’s relationship with his environment, only one of which (1984) I was able to translate for this thesis. Even when he did not write a book but merely wrote forewords for colleagues’ books (for example, to Pham & Dao, 1992) his name was again activated. There is no information in a foreword as to ‘who is Truong Thin’ but because he wrote the foreword advocating a book be read, his name was again circulated. His reflections on humanism can be found incarnated in polished stone at the Hai Thuong Lan Ong shrine, in the forecourt of the Traditional Medicine Institute. In Mandarin, French, English, and Vietnamese the different aspects of medicine are depicted as:

- *y lý*: medical science, which could also be translated as medical theory;
- *y đạo*: medical philosophy or a ‘path’ of medicine;
- *y đức*: medical ethics or medicine as ethics;
- *y kỹ thuật*: medical technology or medicine as a technology;
- *y nghệ thuật*: medical art or medicine as art;
to serve *nhân bản* or humanity.

¹⁰ Compare Unschuld’s canter through history of medicine in China: he inferred acupuncture as having a moral dimension. Acupuncture differed from medications in that it was only able to reinforce the body while medications could sort out a problem regardless of whether a person had lived the ‘right life’ or not (1985:99).



Figure 12a: Humanitarian Medicine.



Figure 12b: Humanitarian Medicine.

Unlike Chi Ha, Dr Truong Thin's fame was produced institutionally. Truong Thin studied for his medical degree during the 1960s and later became director of the Traditional Medicine Institute, suggesting at the very least that his family was supportive of the Communists during the American War (see, for example, Templer, 1998 on the post-war difficulties of ex-Southern Vietnam government and army personnel). Explanations were made by interlocutors on Truong Thin's ability to achieve institutional position. Here are some of them. Truong Thin was in the medical corps for the Viet Minh during the war so was "well placed" to be promoted during peace time; he was "connected" to the Party, to the government; he "knows" people in the Party and in senior government. I cannot make a judgement about his personal/professional network but in Saigon, since life was figured as network,

connections were explanations for success when a trail of accomplishment was invisible.

Because of his institutional position, Truong Thin could influence a volume of students and colleagues within the Institute. As director, he has been able to shape teaching curricula and acupuncture practice for numerous generations of students who have read his books. Ex-colleagues worked at maintaining their connection with him; Danh met with the famous doctor on his return visits to Saigon. On occasion, he relayed some words that the doctor had “shared” with him at meetings I was not present at. Some of these comments included topics discussed above. That is to say, the doctor repeated himself in talk much like Chi Ha repeated her stories of successful healing. Others invited to such meetings with the doctor included Danh’s uncle who was learning acupuncture at the Institute. Sometimes his uncle would chip into conversation with “Dr Truong Thin says...” As discussed in earlier chapters, Truong Thin’s fame was a foil for Nguyen Phuong’s elaboration of 6 Qi, Hoa in chapter six names him as his teacher and an experienced technician considered Truong Thin’s name sufficient to indicate what he had been learning. His name was repeated in many different places.

Achieving position made Truong Thin quotable by online and print news media. For example, the press of the HCMC People’s Committee quoted Truong Thin as the chairman of the HCMC Oriental Medicine Association on the opening of the Fito Museum of Traditional Medicine. “Truong Thin... *said* this was the first traditional medicine museum in Vietnam, similar to those countries with advanced traditional medicine industries like China and Japan” (HCMC People’s Committee, n.d. emphasis added). The press release described a comment but more important was that the doctor’s name was put into an association with the Museum. Truong Thin’s philosophy of complete medicine was discussed at length by Vietnamnet (Thu Huong, 2008), similar to a piece that surfaced two years previously in ‘society’ pages of Vietbao online (Viet Bao, 2006) typed up from a print newspaper (the Thanh Nien). His participation in an online question and answer session (Viet Bao, 2005), in celebration of the then upcoming Doctor Day¹¹, was published in Tuoi Tre newspaper, popular with my interlocutors for its perceived attempts to seek distance

¹¹ An annual celebratory day when doctors may be presented with flowers or other gifts.

from government messaging. But since Vietnam government media is surveilled, these articles also suggest that Truong Thin and traditional medicine were considered safe subjects of media discourse. Dr Truong Thin also participated in a 2002 Australia Broadcasting Commission radio broadcast on the challenges of integrating western and eastern medicine, opening the programme with his quote that traditional medicine is culture (Mitchell, 2002). Dr Truong Thin does not need to say anything. His name and his words have been repeated and circulated through multiple forms, which moved his name into many additional networks. Here I am doing it again, through this thesis. Doing fame means not being “restricted to a single media form” (Holmes & Redmond, 2006:11). In this way, the name of Truong Thin became a symbol of institutional traditional medicine in the city.

A name only appears to break free from a person’s labour in the world because it circulates - but circulation continues to rely on the labour of numerous media. In the moment when Canh described Truong Thin as famous, such work was temporarily rendered invisible by the speaker. But Truong Thin’s accomplishments were not forgotten; rather the greatest accomplishment was that of networks, which took on work. Truong Thin appeared to be famous for being famous; his newsworthiness seemed to depend on being Truong Thin. This effect was generated by many different media, labouring on his behalf. His fame had acquired durability through repetition through these different media networks. But a name circulated particularly, not homogenously, since not everyone talked about Truong Thin. My field-notes of discussions with younger Anh and Huong, who graduated after Truong Thin had left the Institute and were not intimate with those connected to Truong Thin, make no note of his name. Neither did discussions with a practitioner educated in Japan. These omissions suggest that the doctor’s fame is temporary; temporary to the persons he was able to personally connect with. Giles Deleuze (1994) argues that repetition is the means by which temporary stability can arise. Attaining a state of fame, as Dr Truong Thin had at time of writing this thesis, meant attaining only a temporary status, which will disintegrate when the personal connections that hold it in place dissolve.

Conclusion

While city residents figured life in the sense of Granovetter's personal networks, I have applied a Latourian network analysis to demonstrate how such networks were able to move fame, considered essential by practitioners, in the work of making medicine in HCMC.

Person networks mediated occupational success. Without these networks, an efficacious healer would not become known. Networks of people took on the work of extending a medical reputation. Fame was therefore a means and an end. It was how to stay in the occupation and how to gain status within it. Word-of-mouth generated talk in personal networks so that networks can be understood as a form of media. Successful healing stories moved through this media by means of repetition and so gave rise to a 'noise' about a practitioner. Both Chi Ha and Dr Truong Thin were engaged in repetition; he of his philosophies of medicine as art-full and she of her clinical successes. They both became discourse makers: they shaped what came to be repeated. They were successful because they engaged additional media – TV and digital forms, as well as books and institutional position. Success was attained when all these networks became active and took on the work of publicising practitioners. They moved a 'name' independently of the body attached to that name, located at a particular address.

Haraway (1991) points out that researchers and interlocutors are co-dependent, therefore academic texts should be understood as collaborative constructions. This chapter has focused on talk and, as I mentioned in the introduction, my fluency in Vietnamese was variable. Significantly, this meant that I could not understand third party conversations, which I realised were an important tool to help find out 'what's going on'. I depended on asking directly about activities but could not overhear others discuss such activities and hear their opinions about them, independently from those persons having to interact with me. Therefore talk, as written in field-notes and refashioned here, was an outcome of these interactions. Such talk was an outcome of English language interviews and of translated Vietnamese language discussion. Vietnamese citizens also modified their language so that we could communicate. Interlocutors who were familiar with my strange style of speaking Vietnamese sometimes translated my speech into Vietnamese-Vietnamese for others

who were less accustomed to my speaking style. We were all mutual mediators making changes and adaptations to ensure communicability with each other. Those outcomes have become part of this text. I and my interlocutors created context, or as Haraway puts it, “context is fundamental matter not as surrounding information but as co text” (1991:214): we jointly created what is written up in this thesis.

Fame generated by active networks could be variously translated. For Chi Ha, the circulation of third party testimonials to her efficacy validated her status as a genuine healer. The actions of multiple media forms moving Truong Thin’s name, created a sense that the doctor was disinterested in fame; that he was merely famous without doing anything. For a sole practitioner in private practice, fame could mean very simply publicity, which was essential to occupational survival. Hoa, whom I will describe in the next chapter, used the generative potential of networks to continue in his chosen occupation and overcome negative assessments of his competency.

6. Vision Interrupted

That the production of truth/knowledge involves exclusion and deletion is well known from studies on identity (Baumann, 1992; Pelley, 2002; Smith, 1986; Wicker, 1997). Research on the creation of scientific facts has come to the same conclusion (see Star, 1989). Deletion in Susan Leigh Star's work occurs because of numerous commitments to an operating consensus: to accept some information as truthful would destabilise other working arrangements. In respect of acupuncture in Ho Chi Minh City, there were multiple commitments to vision. To show this, I will describe the professional experiences of two blind acupuncturists that I came to know during fieldwork. I will call them Van and Hoa. These two practitioners rendered taken-for-granted relationships in the work of making acupuncture more legible. They drew my attention to vision and made me mindful of what happened when vision was interrupted. Blind acupuncturists interrupted naturalised relationships between acupuncture objects and treatment shapes and between reputation, personal networks and efficacy. Some of these relationships were mediated by vision but some were not, hence a somewhat paradoxical situation could arise that a blind practitioner was both professionally rejected and successful.

My discussion will focus on acknowledgement as well as recognition of identity. Markell (2003) argues that a politics of acknowledgement should be engaged when dealing with identity politics. To be recognised, she argues, is ultimately detrimental and what is required is rather to acknowledge some basic conditions of social and political life. After considering Markell's argument in more detail, I will describe a short history of Van and Hoa through four themes: how they came to be doing acupuncture in the first place; the reactions of their fellow practitioners to their presence; how and why patients rejected their competency; and, how they might, after all, become successful. Thereafter I consider what a blind identity meant in HCMC and how lack of sightedness was perceived. However, an identity as a blind person is insufficient to explain the professional rejection of Van and Hoa. Blind

acupuncturists were considered unusual, remarkable and problematic. To understand why, requires understanding what made blindness a problem for acupuncture itself.

A Politics of Acknowledgement

Van made a speech in February, 2008 in which she complained that her acupuncture skills were not recognised in Vietnam. But in *Bound by Recognition*, Markell (2003) argues that framing identity around a politics of recognition has a number of fundamental problems, which makes it ineffective in analysing the injustices it seeks to change. Lack of recognition has been taken as a negative, she argues. Not extending or exchanging respect with another is understood as a systematic refusal to extend a benefit. To conceive of recognition in this way is analogous to thinking about recognition as a maldistribution of wealth. Recognition in such a framing becomes commodified and its relations of production obscured. Additionally, identity is taken as prior to action, such as the action of obtaining a benefit called recognition. To obtain a benefit, a group seeks a fixed identity, with which to be recognised. Groups seeking recognition therefore tend to focus on the consequences of maldistribution rather than the mechanisms of misrecognition itself. Appealing for recognition is misleading, she maintains. The ideal of mutual recognition is impossible and “in pursuing it we misunderstand certain crucial conditions of social and political life” (Markell, 2003:4).

Markell’s argument zeroes in on recognition as the pursuit of temporal sovereignty. The problem, she diagnoses, is not lack with regards to an identity but more about bringing identity to bear on action; using identity to “establish connections in an agent’s past, present and future” as an ongoing effort (Markell, 2003:5). Drawing on *The Human Condition* (1958), she explores Arendt’s proposition that history takes the form of identity; a given set of facts about who we are, which both precedes and governs our actions and tells us what ‘authentic’ is. For Arendt (also Butler, 1990), identities are *results* of action; action is where people disclose/make-up/try on/suggest who they are. But we do not act in isolation; we interact. Outcomes are not up to any one individual; they are unpredictable. The outcome of intersecting unpredictabilities is who we are hence identity is only ever available in retrospect. For Arendt, to wish for recognition of an identity is to wish for death. Recognition politics, suggests Markell, is a response to an experience of uncertainty, “part of what

we are is dependent on unpredictable others and... [a] politics of recognition responds to this by demanding that others recognize us for who we already are” (Markell, 2003:14).

Sovereignty in recognition politics is often understood as autonomy of an identity, Markell continues. The sort of sovereignty envisaged by James Scott (1998) did not sweep away autonomy but measured and mapped it, thereby rendering it legible for the state to read. By doing so, difference was transformed and identity undermined. Policies that tie the distribution of rights and resources to identities are “dependent upon one’s recognisability as the bearer of an identity” (Markell, 2003:175), which risks binding a person more closely to a temporary notion of who they are or might be. Identity is stabilised and outcomes become predictable. Identity so rendered has been ‘formed’ or as Arendt might say, is dead already. Markell’s argument then addresses the *desire* for sovereignty understood as autonomy but here I will pay attention to her call for acknowledgment. A politics of acknowledgements is about relations that create misrecognition rather than focusing on the characteristics of a temporary identity.

The government of Vietnam recognised a particular corporeal aspect of some citizens’ bodies: their unsightedness. This lack was rendered critical through state practices of gathering the unsighted into institutions that provided education and vocational learning, deemed suitable for the new corporeally based identity of such persons. Unseeing eyes and obscured irises marked out a body which, on that basis, was shaped through the government’s ability to recognise the unsighted. Producing persons as a finished identity of blind “heighten[ed] hostility or indifference to what they might become” (Markell, 2003:175), for example, to become an acupuncturist. Responses to this identity *fait-accompl*i produced many practices of discrimination and prejudice that were experienced by Van and Hoa. Being unable to see and categorised as disabled became the most important disposition certain people brought to interaction with these two practitioners. Investments in sightedness in acupuncture meant that a temporary subordination of some was possible (Markell, 2003). Vision was a matter of concern in the ongoing construction of what acupuncture might yet turn out to be.

Van

An acupuncture treatment by Van was very active. She would begin by setting out her two stainless steel kidney trays, one to hold clean needles and one to hold dirty needles, checking their identity by tracing their outline with her fore-finger. She manhandled an aluminium tin that held cotton wool out of a noisy plastic bag, gripping the lid, hearing the scrape of metal on metal as the cap came off. New sterile needles were opened in front of the patient, twisting the plastic-blanketed needle to discriminate the paper strip, which was ripped off to reach the lightweight, plastic-handled, Japanese-manufactured needle. When she had her equipment set out around her, she plucked on the cotton wool and dipped it with medical alcohol to carefully wipe her fingers, balling it into a separate plastic bag, found by its crunchy crackle at her side. Teasing out another cotton ball, she rubbed the patient's skin with the cooling liquid in the area to be needled. Ready, she asked the patient where the pain was. This particular patient suffered knee pain. Before needling, she palpated around the field of pain, poking strong fingers into sensitive reaction points searching for the acute points of pain that made the patient cry out. The patient lay on her back, clothed but with trousers rolled up so that the bare skin of her legs was vacant to the air.

Van began to tap needles into the body of the patient using a guide-tube. A guide-tube was a narrow plastic tube slightly shorter than the needle length. Van held the needle slightly inside the tube, so that her fingers manipulated both tube and needle. When she sat the tube on patient's skin over the pain (trigger) points that she had previously discovered, the tube made first contact with skin, followed by the needle. She tapped the fallen needle lightly using her forefinger, pushing the needle into the body to desired depth. Unlike acupuncturists who had learnt acupuncture at the Institute, she stimulated needles by hand using continuous push-in-pull-out-push in (pecking) technique. The needle plunged and rose causing sensation in the needled area. She constantly stimulated the needle not allowing the needle to sit still but worked around the field of pain with (in this particular treatment for knee pain) five needles, inserting, removing and reinserting the same needles in different points around the knee, lower leg and around the ankle. The patient mentioned that one point near the ankle was very sore. "That's the ill point," she explained, "if you are not well that point will be sore." There were many techniques to make stimulation

she explained later, but Vietnamese people were weak in their body so did not like strong stimulation. When treating patients in Saigon, she could not use as many stimulation techniques at the same time as she might do in Japan; she could only use one, preferring the pecking needle technique. When she finished needling points, she massaged around and under the knee cap and down the outer lower leg. She collected the dirty needles accumulated in the kidney tray and disposed of them in the patient's rubbish bin. Van was blind.

Van learnt acupuncture in Japan on scholarship when she was 24 years old and returned to HCMC five years later in 2004. Blind acupuncture was a Japanese innovation that motivated a medicine emphasising touch and palpation instead of reading and remembering. Consequently, the shape of treatments using Japanese schools of acupuncture differed from treatments by technicians who had graduated from the Traditional Medicine Institute. Van's hands, for example, made greater contact with a patient's skin when she was seeking needling locations and she was very familiar with guide-tube use, perceiving it to be ordinary; unlike Hoa's response to learning guide-tube which I detail later. That Van learnt acupuncture in Japan raised a language problem when discussing her training and talking about acupuncture practice: she often found it difficult to translate her acupuncture training into either English¹ or Vietnamese. I realised later that I should have used a Japanese/English translator since she had not acquired a Vietnamese language of acupuncture.

Van had been blind since two years of age, having suffered measles in childhood. Her eyes were clouded blue and she often wore fashionable tinted sunglasses to distract attention from them. She could, however, differentiate light and dark and preferred to be in bright places. She graduated from Nguyen Dinh Chieu High School for the Blind, inner HCMC, at 15 years old. She continued learning school-year 12 at a community college, which accepted sighted and blind students. There, she also studied English and improved her Japanese. A small but manageable fee was paid. She had been learning Japanese for six months before gaining a scholarship from the International Association for the Visually Impaired in Tokyo, Japan, with

¹ All state schools teach English as a foreign language: Nguyen Dinh Chieu school was no exception.

some assistance from the Japanese government, to study overseas for five years. The teaching programme in Japan instructed students in acupuncture, acumoxa, amma (Japanese massage) and shiatsu. Staff at Nguyen Dinh Chieu school were familiar with the programme and encouraged her, she said, to learn Japanese while still in school and further encouraged her to go forward for the open interview in Japanese language. She had no previous inclination to study acupuncture medicine. She had no history of medical learning in her family. The Japanese grant was a route into a particular professional life that she otherwise would not have had.

A story circulating during fieldwork dated blind acupuncture in Japan from the early Edo period (1603-1867). The story was originally published in Tokyo Time Out in English, lifted from a website and circulated by email through personal networks. The story went that during the Edo period of rampant sexuality, a national gonorrhoea epidemic left many children blind. The government of the time developed massage schools as a means for the blind to support themselves. In the 16th century, a blind person named Waichi Sugiyama decided to practice acupuncture. He studied from 18 years of age with a sighted acupuncturist teacher. After five years, his teacher threw him out saying that he was unlikely to ever become accomplished in acupuncture. He continued studying under another teacher. However, still having difficulties, the legend was that he travelled to an underground cavern and prayed for divine inspiration for 21 days. He finally gave up and stumbled back into the light of day, poking his hand on a pine needle. He picked it up and, realising it was sticking out of a bamboo reed, was inspired to create a needle insertion guide-tube. Waichi Sugiyama went onto to cure Shogun Tsunayoshi Tokugawa of a serious illness, organise institutional acupuncture training for blind students and made simplified versions of older medical texts available to the blind (More, n.d.). By 2007, guide-tube insertion was said to be used by 90% of all acupuncturists working in Japan (Japan Society of Acupuncture and Moxabustion, n.d.).



Figure 13: The Guide-tube Innovation.

While Japanese schools used classical acupuncture texts imported from China so that channels, acupoints and philosophies of qi would be recognisable, Japanese schools differed technically and stylistically. For example, thinner needles were developed that led to ‘no-pain acupuncture’; active stimulation techniques were popular; non-inserted needle techniques were used; there was greater appreciation of “subtle energy movements in the body” (Weinstein, 2007) and greater promotion of tactility in treatment. Learning acupuncture in Japan meant fingering an extensive Braille library and life-size anatomical models. Rather than flat diagrams of a body on paper, raised lines representing channels were created on body models so that students could feel the location of a channel moving up the body through their fingertips. Life-size anatomically precise models manufactured with acupoints raised meant that students could not only memorise acupoints but play with the anatomical features of a body, to mark point location. Life-sized and over-sized models of body structures and organs were groped so that a blind student in Japan could know in her hands the shape and sense of anatomical liver as an entity or nerves stringing the body down the spine or the urethra of the kidneys moving into the penis. She knew through touch not by reading flat pictures in a book. American acupuncturists argued that Japanese training, with its focus on palpitation techniques and a “deeper”

understanding of qi, body fluids and blood meant training was very sophisticated and experiential. Sighted people did not get such a three dimensional learning experience in New York colleges. It was all flat; in books; all 2D, they reckoned.



Figure 14: Anatomical Models Used by Blind Students in Japan.

“It was challenging,” Van said, to learn everything – physiology, anatomy and acupuncture – in Japanese. We had met to drink coffee, chat and hang out. She flipped the hinged lid on her tactile watch so that her finger-pad could feel around the circle to locate pointers and numbers and tell the time. Van first stayed in a rural province to improve her Japanese before moving to a Tokyo school for the blind and begin her medical studies. During this time, she received an annual living allowance. She was the only foreigner in her class in Japan and spent the first two years improving her language skills and learning Japanese massage, amma and shiatsu – considered medical treatments in Japan. The next three years were spent working

towards a certificate in Acupuncture and Moxabustion obtained under national examination approved by the Ministry of Health, Labour and Welfare, which enabled her to be apply for a licence to be employed, or open her own private clinic, as an acupuncturist. Any applicant for the licence must have graduated from an acupuncture and moxabustion school, university or college, or in the case of the visually impaired, from a school for the blind or a centre for the visually impaired, recognised by the Ministry for Health, Labour and Welfare (Japan Society of Acupuncture and Moxabustion, n.d.). Since only Japanese schools are on that list, any person who studied outside Japan will not be able to gain permission to practice acupuncture legally and publically in Japan.

Van's training included classes on anatomy, pathology and "a little western medicine," she described, such as taking blood pressure and what she called "rehabilitation" – a form of physiotherapy with massage and electrical acupuncture. The Japanese Acupuncture and Moxabustion Association website laid out the three-year diploma in more detail. First-year courses comprised elementary scientific thought and social studies. Later field-specific studies included learning the structure and function of the human body – anatomy and physiology; advances in disease prevention and recovery – pathology, sanitation, rehabilitation medicine, introduction to clinical medicine and particulars of clinical medicine; philosophy of acupuncture and moxabustion in relation to health, medical treatment and welfare with general medical treatment and related legislation. Field-specific studies comprised 'basic' acupuncture; clinical acupuncture; acupuncture in society and hands-on clinical experience with general studies. Van noted that she did not learn ear acupuncture in Japan. Nor did she ever hear her teachers talk about ear acupuncture; the core focus of her training was on body acupuncture. She studied for the same length of time as her *huong y* peers did in HCMC but unlike them, had to sit programme exit exams.

When I met Van, her acupuncture practice was of middling success. Her patients found her by word-of-mouth referral: she did not use any advertising or a business card. For a 1.5 hour acupuncture and massage session, she charged 80,000 VND though for massage alone taking up one hour, she might charge less. She was never as busy as older, male, Vietnam-trained and licensed Hoa. Her acupuncture practice

was always “so-so,” she described ambiguously; her case load was neither numerous nor absent. Unlike Hoa, she did not link meditative practices to her acupuncture. She often listened to Buddhist sermons by CD and liked to practise meditation but this was for purely personal reasons. Occasionally, she visited a pagoda with friends to listen to a sermon and meditate. She was vegetarian four days a month but could not do so all month because she worked and “needed to eat meat to get strength for teaching and doing acupuncture” in patient’s homes. Being vegetarian was not a practice she used to ‘purify’ her qi as other practitioners might understand it (see chapter two). For her, these were not practices that could affect therapeutic outcomes and therefore patient volume.

By February 2009, when I last met her, she was still working in private practice, teaching at Nguyen Dinh Chieu School but had also taken up part-time work at a private traditional medicine clinic. She had been offered the work by a doctor entrepreneur whom she met during charity acupuncture missions undertaken in HCMC during 2008. The entrepreneur had been planning the clinic for at least one year. Difficulties in setting up and finding clients had been a subject of open discussion at lunch times during the charity work. Van worked at that private clinic giving shiatsu and Japanese massage for a percentage of the client fee. She told me that she could also do Japanese acupuncture but since at that time the clinic was still new and there were very few acupuncture clients, the male, Traditional Medicine Institute-trained and legally licensed practitioner carried out that work. Acupuncture was only a part of Van’s livelihood making and it would be interesting to know if in the future, she did treat in a Vietnamese clinic using Japanese acupuncture.

Van could not open her own clinic in Japan unless she had permission to reside in Japan, which her professional diploma did not award. Residency in Japan, she felt, would give her the opportunity to practice her training, otherwise it was wasted. She could never make full use of her training in Vietnam because of problems with red-tape and lack of trust by patients in blind acupuncturists. Practising in Japan would also enable her to improve her technique, she thought, which she felt she could not do in Vietnam since she had few patients and little opportunities to develop professionally. Her phone vibrated on the table between us, bleeping and lighting up in a message alert. She picked up the slim model and held it to her ear to hear the

screen reader software read the SMS aloud in a tinny, male voice. She tapped a quick reply, the software repeating orally the letters she had just typed in. Not least, she finished, setting the phone back on the table, her status in Japan would also “give me the chance to help blind people in Vietnam” (similar rationale given in Vasiljev, 2003).

Van experienced collegial rejection of her occupational identity. At the same event in which she had given her speech, the director of the Hue Acupuncture Association noted his surprise at acupuncture training for the blind. There was both fear and curiosity about blind acupuncture in Vietnam, he suggested. “These days we have consensus that acupuncturists should learn point location, physiology and anatomy. But how could the blind learn all this?” The Acupuncture Association in Hue worked with a retired local acupuncturist, Uncle Phuoc to help train blind students “even though it was easier to train sighted students. Now, students and teachers had finished one year of training.” The director was not sure about government policy on acupuncture training for the blind and asked in the course of his presentation for Uncle Phuoc to write to the Department of Health and ask for advice in this matter. Were blind acupuncturists legal, he was querying.

These sentiments were also found at the School for the Blind, where Van worked. On one occasion, the headmaster had wanted to find out about acupuncture teaching in Japan and asked a sighted office worker to do some preliminary research into it. He did not ask her, she complained. “He did not want to ask me nor accept my opinion even though I have lived in Japan and studied acupuncture there!” Being blind and therefore disabled, Van felt that her experienced understanding of acupuncture was erased.

Hoa

Hoa was an older, more experienced and more successful acupuncturist than Van. Acupuncture was his sole occupation when I met him. We met very early in my fieldwork and learnt ear acupuncture together through our association with Danh. We travelled to Hue and Hanoi on acupuncture training missions, together with other volunteers and bumped into each other through mutual friends. I also interviewed him formally through an unfamiliar, to him, translator. I had seen Hoa

do acupuncture many times but one memorable occasion was when we visited and treated a friend of his after a charity mission, organised by an outer city charitable association I had been volunteering with. The organiser was a volunteer of the materia medica room at the association; no acupuncturists working or volunteering there attended this particular trip. The charity mission had been set up to gift notebooks, pens, crayons and sweets to children of three rural primary schools and clothes and rice to women selected by the local district People's Committee. The volunteers comprised four materia medica volunteers together with retired Saigonese, all contacts of the organiser. Hoa attended on that day, a fun day trip to a rural province to help the needy poor (compare Nguyen-Marshall, 2008).



Figure 15: Needling Through a Guide-tube.

The demonstration of Hoa's therapeutic efficacy came at the end of the trip, which culminated in a visit to a friend of his who had been unable to make the journey. The bus ride had been long, hot and sweaty. We arrived back into the city by early evening, as the sun was sinking into gold-red, and swung by the plush district 7 to drop in on Miss Li, still at work in a district hotel. She had not come along because she had felt unwell for the previous two days. After being made welcome, Hoa took her blood pressure without asking; his friend willingly opened out her folded arm to him. We all sat around on available chairs, drying out since we had been caught in a

heavy thunder storm earlier in the day. Instead of taking three-fingered eastern pulse, which I had seen him do countless times in the past, he wrapped a talking sphygmomanometer (blood pressure meter), manufactured in the USA, around her arm which spoke aloud in English and told us what her blood pressure was at that time. Conveniently for the sighted and those who could not understand English, the monitor had a digital face. When we peered over his shoulder – Miss Li lying on a coat on the floor, Hoa cross legged beside her – we could read the blue typeset. Unstrapping the aid, he asked if she had eaten since it was now near 6pm. She had not, so a friend found some milk for the patient to take first: needling on an empty stomach may induce fainting.

Before needling the patient body, Hoa needled five points in her ears. That may have been for my benefit, since as I mentioned, we had met through a NADA ear acupuncture training course. He told me later that this particular point combination had no efficacy and that he rarely used it. Leaving those needles passively sitting in the outer ears of the patient, he took up longer, new, sterile needles to insert into acupoints on the top of the patient's head, the outside of each knee and inside of her ankles. He used a guide-tube for insertion, again, possibly for the benefit of the audience, which included me. He told me later that the guide-tube wasted a lot of time. Leaving those needles sitting in, without stimulating by either pecking technique or by twisting, he drew out a small hairdryer from his backpack to heat the needles and through the needle, the acupoints. Sighted practitioners may apply heat by holding burning moxa over in-sitting needles, which Nguyen Phuong was fond of using. Hoa had brought his own extension cord in his backpack of acupuncture equipment. After ten minutes of low heat, he switched off the dryer and pulled out his electric massage tool, an electric powered pressure tool. Using this, he 'massaged' the same points after I had taken the needles out. I only removed the needles after being urged quietly by the elder organising volunteer. She motioned that I should help Hoa: that is, someone who was not an acupuncturist urged another non-acupuncturist to assist. I had made no move to remove needles. I had assumed that Hoa was capable of removing acupuncture needles since he had been practising for over 20 years. Hoa vibrated the points on the patient that he had just needled as well as pressured points on the patient's hands, head, and back of the neck, knees and feet. Because the tool was electric, it moved much faster than human hands and set

up vibrations in the patient's body, which give an incredible sensation of being shaken around all the while not moving.

The materia medica volunteers, meanwhile, were joking and giggling at the performance, especially when the electric massage tool made an appearance. Treatment finished, Hoa re-strapped the velcro band of the speaking sphygmomanometer to the patient's wrist. The joking stopped and a brief silence ensued to await the result. Impressively, Miss Li's blood pressure had lowered. Everyone crowded over his shoulder, chattering noisily so that it was difficult to hear the electronic voice tell exactly what the number was. The acupuncturist advised his patient not to work so hard and to rest. Hoa made use of a range of electronic and electrical tools to create an acupuncture practice that suited his particular style of doing business – mobile and synergistic. He used heat, as well as acupressure, with needling. The blood pressure monitor had the added value of being a visible, independent verifier of his efficacy as a healer. As well as a medical tool, it was a very useful marketing assistant. In this encounter, the digital blood pressure monitor generated noise about Hoa's healing potential.

Hoa had practiced acupuncture for 22 years and learnt, he told me in interview, simply because he always loved it. He lived with his mother and three of eight siblings: an older blind brother who was a keyboard player at a local club and two sighted sisters. He lost his father in late 2007. He was the youngest child in his family and at that time had not yet married. His neighbours knew him as blind-Hoa, which I found out when visiting his home and asked for acupuncture-Hoa; a stumped neighbour wondered who I was talking about until she cried, "oh! Blind-Hoa!" He had been blind since birth, as were two of his siblings and a cousin. He was the only member of his wider family who knew acupuncture. In 1983, he began a three-year technician course with the Traditional Medicine Institute. On my question, he replied that it had been easy to apply to study there; he did not encounter any obstacles at that time. Hoa used a cassette recorder with concentrated listening to remember class lectures. His sighted friends read textbooks aloud to him so that he could rewrite them into Braille. His class had had over 30 students but by 2008 only Hoa was still practicing. "Perhaps they didn't like acupuncture after learning it or they

didn't have a talent or ability with it," he speculated. He found acupuncture easy to learn.

Translating spoken word into written Braille is labourious work, requiring strong fingers and long hours of concentration. If a blind learner has no access to voice recognition software to read print, then he will be dependent on Braille. To write Braille, a pitted stencil plate is overlaid with thick paper – thicker than print paper so that it will hold impressions – and a covering stencil, sorted into cells. Imprint is punched out with a metal stylus in reverse so that when the work is finished the page can be turned over to be read through finger-tips flowing right to left. Braille technology was devised in 1821 by Louis Braille. It uses a six raised/non-raised dot combination to create characters and punctuation. These are arranged in cells, each cell being two columns of three dots each. Braille does not transcribe one cell per linguistic character but rather uses a unique grammar. Since Vietnamese is romanised, minor adaptations were included to transcribe tone and diacritics. In Japanese Braille, signs for a consonant and vowel were combined into a single syllabic block. Braille was difficult to learn, Van told me, because each point was very small and the punched codes were difficult to distinguish clearly. She could read Braille in Japanese, English and Vietnamese but preferred to listen to either of those languages on the internet on her home PC using screen-reader software, where she could access greater variety of resources than were available to her in printed Braille. There were relatively few books translated into Braille.

Standardised teaching at the Institute used a technology called print literacy. Books, articles, written notes, circulated photocopies and posters were all 2D and could be read by any person being sighted and who had been taught to interpret the letter-symbols. By not providing alternative reading technologies, such as Braille or anatomical models or audio resources, standardised teaching can be understood as a diversity filter, deleting other pedagogical technologies. Any individual which then enters a standardised pedagogical infrastructure and cannot adapt to restricted technologies in use, inequitably bears a burden to create his or her own resources as Hoa did here.

Hoa gained his technician credential within the standard three years and requested to study further at the higher level but could not obtain permission from the Institute. At that time, he also found the fee costly. Dr Truong Thin taught him for half a year, he told me, before he became director of the newly independent Traditional Medicine Institute in 1985. At that time, said Hoa, *y sĩ* and *y tá* were the same level (we were trying to decide if his qualification was equivalent to what might be called nurse-practitioner in UK or a nurse). The government did not “appreciate” his qualification, he described, by which he meant that he could not work in a government facility. “It was difficult for technician acupuncturists to get a hospital job [in the public sector]” after graduation, therefore he went to work for himself, meeting private patients in their homes (*làm tư*) rather than opening his own clinic. If he applied to work in a hospital, he felt that the government would not rate his qualification as equivalent to a sighted person. This thinking had not changed in the last 20 years, he pointed out, and like so many other endeavours in Vietnam, healthcare was difficult. “People could get a government health card,” chipped in our translator, “which lowers the cost of treatment but its so difficult to get it that people don’t bother; they just use their own money” (see also Adams, 2005; World Bank, 2001).

Hoa was able to generate a living in acupuncture because of personal networks. A blind acupuncturist was hard for people to accept, he explained. “People think blind people won’t know where the points are *really*.” So to gain trust, first he practiced on his family, then on his neighbours and they referred him on to their friends and family. “Its simple math,” he explained, “2x2 is 4, 4x4 is 16 and so on.” His busiest time was the last few weeks before the Lunar New Year, at which time he could meet around 10 patients per day, averaging a payment of 60/70,000 VND per patient. He practiced hand simulation acupuncture – not the popular electrical – with acupressure, massage, physiotherapy and *duỡng sinh*. He learnt these at the same time as acupuncture. *Duỡng sinh* was a series of gentle movements for old people to practice early in the morning: soft slow movements to stay healthy, he explained for me. Hoa could advise old people on such movements as well as diet if they did not feel well. His business card (below) proclaimed him as a *đông y sĩ*, an eastern medical specialist and intellectual.

During a treatment he sought to reduce a patient's nominated pain and for them to "feel healthier afterwards." Psychology was important of course, he agreed. Psychology supported the patient's soul and the actual treatment supported their body, he argued, in the way that a prescription from a medical doctor was for the body while advice from a physician was a form of encouragement.

<i>châm cứu, xoa bóp; vật lý trị liệu</i>	Acupuncture, massage, physiotherapy
Đông y sĩ	Eastern medicine Intellectual
Hoa...	Full name of Hoa
• <i>trúng phong; bán thân bất toại</i>	Treating: Stroke; hemiplegia
• <i>viêm; thần kinh tọa</i>	Swelling or inflammation; sciatica
• <i>đau nhức; các chứng về thần kinh</i>	Acute pain; illnesses of the nervous system
• <i>bệnh phụ nữ; đàn ông và trẻ em</i>	Women's, men's, children's illnesses
❖ <i>Phương pháp nhân điện</i>	Particularly using the method of <i>nhân điện</i> (discussed in chapter two).
<i>Address / Telephone Numbers</i>	Contact details

Hoa also treated patients who did not believe he could heal them. For example, one patient suffered numerous headaches and just wanted to try acupuncture for the first time – to find out if it could 'work' for her. If patients felt relaxed and he reduced their pain during an acupuncture session, they would return, Hoa asserted. He felt that if a patient believed in a healer she would come back, else she would not. Around 30% of his patients did not return, that is, 30% left in the middle of a course of treatment because they felt that the treatment was not working. Hoa characterised this as the patient did not wish to wait for therapeutic effect to occur. When a patient had pain he could superficially remove that pain, but deep rooted problems would take longer to heal – he was confident that if a patient was patient, he could cure the root of their problem so that the patient was 100% pain-free.

Hoa had a high percentage of repeat patients. He knew his patients very well, since they were mainly from his residential district in the city and had known them over a long period of time. He got around by motorbike taxi. Sometimes the cost of the taxi was higher than the fee for treatment. He offered treatments for free to very poor

patients which, he guessed, constituted about 20 or 30% of his patient load. He rarely used the guide-tube, which Danh had introduced to him the previous year. Using the guide-tube wasted a lot of time, he felt and explained his reasoning. First, he must manipulate the needle into the tube. Second, he had to find the acupuncture point. Third, tap the needle into the patient's body. Fourth, control the depth of the needle and last, *riút kim*, remove the needles. He preferred not to use it.

It also mattered whether a blind practitioner *appeared* to be blind. Another male practitioner I got to know through an internet introduction became blind at 20 years of age. But by this time, he had learnt the body postures of sighted people. His brown eyes were clear and unclouded. Such a blind student was able to do practicum in an acupuncture training college with patients who were unaware that he was blind. He depended on assistance from sighted friends who told him whether a patient was lying face up or face down or how the clinic was set up; such as where the bed was, where the table with cotton wool, alcohol and so on were, so that he could navigate the clinical space without bumping into anything. His friends handed him needles and accepted back the dirty needles for medical waste. They worked *ăn ý*, very close together he described, so that by the end of a treatment a patient would be surprised to find out that he was blind. His clear eyes gave him time to convince patients that he was a competent practitioner instead of being *a priori* recognised as someone who should not be needling. Hoa eyes were always shut and even though Van's eyes were open, her obscured irises were a visible sign of her disability. When looking at both Hoa and Van, prospective patients could never doubt that they were blind.

While Hoa had become successful through personal networks, strangers were suspicious of his professional ability. On one occasion while sitting in the home of a friend with Hoa and a young acupuncturist in training, the youth's aunt came in and complained of back pain. Hoa offered to treat her. He needled points in her arm and leg – as usual her trousers and shirt were rolled up, her clothes not removed. He sat on the floor to insert needles, the patient sitting comfortably above him at the edge of a knee-high sleeping platform. After insertion, he waited beside the patient for the treatment to take effect, occasionally stimulating the needles by hand-twisting them three turns. The patient twitched a leg out to her nephew, motioning him closer and murmured that he should check whether the points had been correctly needled. The

youth had been learning for three months, Hoa practising for over 20 years. Hoa's experience became negligible beside his inability to participate in an expected treatment shape.

Likewise, prospective patients often rejected his medical services. Knowing acupuncturists, I often referred connections to their treatment rooms. One evening, a friend mentioned that her mother suffered pain, weakness and numbness in her hands and wrists, which moved up her arm. I suggested she try acupuncture and offered to introduce her to my charismatic 6 Qi teacher. His house was too far away, she replied. I offered to introduce her to Hoa who lived in the same ward of the same district as the prospective patient. Her mother would not like to go to him because he was blind, she explained, "that's what people are like in Vietnam. Did you know that at the ear acupuncture training [carried out by visiting American volunteers in the city], a poor, old woman had refused to allow Hoa to treat her for free just because he was blind?"

Recognised

Finally, I decided to tackle the issue of blindness and trust directly. I discussed the question with a close friend who was an experienced user of traditional medicines. Were patients afraid of blind acupuncturists? I asked. No, she replied, that was not the case, "but blind people can't go around the city by themselves, they need someone to care for them." She thought it unexceptional that a prospective patient refused to be introduced to a blind acupuncturist for treatment. Patients could not know for sure that the blind acupuncturist was inserting the needle in the correct location, she reasoned. Perhaps they inserted it in the 'wrong' place, even just a little bit. "A good acupuncturist needs to know the disease and where the points are and what points to use for what disease." That is to say, a good acupuncturist needed to know where the points were exactly because only when the exact point was needed, could acupuncture have an effect on the disease.

My interlocutor continued her explanation: to know the points and diseases, the acupuncturist "needs to read many books, but it isn't possible to remember them all," so while blind people might learn by memory, they might not remember all the points and all the diseases, so were liable to make mistakes. For the speaker, books

were the means by which a full and complete knowledge was possible. Humans were fallible, books were not. My interlocutor echoes concerns manifested at the Traditional Medicine Institute and in Nguyen Phuong's classroom about comprehensiveness. To know acupuncture, a practitioner needed experience of treating many patients. She thought blind practitioners would not get experience because patients were afraid to go to them. I suggested that blind people were illiterate, running with the idiom to be 'blind about'. *Người mù* was a person who could not see. An illiterate was one who was literally blind to the letter, *mù chữ*. *Mù* also indicated that a person had no knowledge about a subject. For example, if I did not know anything about music, I would be blind about music. However, my interlocutor strongly resisted that. Braille was a language and blind people could read and write in Braille, "but there aren't many books in Braille," she finished.

In Vietnam, "it is said that 'disability means useless' and disability comes from the sin [or karmic consequences] of the parents or the disabled individual's previous life, so it needs to be hidden" (International Council for Education for People with Visual Impairment, 2006). Tine Gammeltoft (2007) points out that disability is the karma not only of an individual but a whole kin group, and it is the morality of the kin group that will be discussed by neighbours and strangers. Van explained further. "My being blind is my *số mạng* (fate; destiny), my *ngiệp* (karma; result; consequence) and it means that in my last life I must have been a criminal." Because of a sense that it is better to meet one's karmic consequences in the present life than carry karmic debts into the next, "people are not necessarily interested in educating visually disabled persons to be independent and [may] prevent them from enhancing their potential... this point of view makes blind individuals sit down and expect help and lose their self-confidence" (International Council for Education for People with Visual Impairment, 2006).

The number of people classified as blind in Vietnam is not reliably known at time of writing. There may be around 900,000 persons with visual impairments, guessed a teacher from Nguyen Dinh Chieu School for the Blind in Saigon, using a national definition of blindness from the Vietnamese Association of the Blind issued in 2003. This definition stated that membership of the association was open to "anyone who can only count fingers at less than three meters" (D. B. Le, 2006). Such a definition

gathers those who are irreparably blind and those with visual impairments, which the World Health Organization (2009) believe can be corrected with appropriate lenses, into one category. Such a classification does not differentiate between those like Van who can perceive light and those like Hoa who cannot. Nor does the definition take note of the condition of the eye itself. A blue-white iris for example, is visible to the seeing population, whereas someone who became blind in later life may have clear irises. Visual impairment was heterogeneously experienced and a category of blind was not an homogenous one.

Gathering unseeing persons into categories with particular predicates, is itself a creative work of identification, “an act that brings something new into being or that transforms the world in some way” (Markell, 2003:40). Through the work of the Blind Association, a person was gathered and recognised, that is, made to be visible through and to particular structures of governance. This new identification was put to a purpose (*ibid*). In Saigon, government work of recognising blind was put to a purpose of care.

Blind people needed someone to care for them, my interlocutor had explained. Van and Hoa moved around by motorbike taxi (*xe ôm*) or were taxied by a family member. They did not use a white cane when walking in the streets but relied on other persons guiding them. I did not ask why this was the case but Bach Dan Le comments that “although they have been trained in its use, some of our blind students do not use the long cane because they feel that people do not regard a blind person with a white cane as normal” (D. B. Le, 2006). In school, students had been taught to stand slightly to the rear and right of the lead person, gripping that person’s dangling arm around the bicep from which they could sense direction change (left, right, stop, go, up and down) and also initiate a direction change themselves. Unsighted persons were those who did not move independently of others, a puzzling comparison with Japan, where diverse teaching resources, canes, architectural design, street furniture and legal injunction were used to meet a desire for autonomy and independence. However, in HCMC pitted pavements, crowded sidewalks, footpaths taken over for business space – public space was often privatised – and choking traffic meant that using a sighted guide may have been more practical than using a cane.

Un sighted people were guided across train tracks to mount a waiting train, waited at meal times for others to put food in their bowl or ask for certain foods to be put there, they waited at the table until others finished eating before leaving with their assistance. Blind people were those who, at ear acupuncture training sessions run by Danh during his annual return at New Year, sat impatiently waiting to be called on to speak, to demonstrate or to discuss a method with other blind or visually impaired persons who were learning it. They were those who, when called to the lectern to discuss their acupuncture experience, waited for guidance from that location back to their seat. A blind acupuncturist was in a paradoxical situation of offering care to a patient who thought the healer should be cared for himself.

The principal place of care for Van and Hoa had been the government owned and operated, with foreign aid donation, Nguyen Dinh Chieu School. It was a residential facility for city and city catchment citizens, named after 19th century poet from southern Vietnam who opposed the ruling Nguyen dynasty collaboration with French colonial powers. He wrote many poetic elegies for those who died resisting the French. It is said that he contracted an eye infection and became blind from his mid-20s but still opened a small school, working as a teacher and a medical practitioner². Nguyen Dinh Chieu School prepared Braille teaching materials (graded textbooks on History, French, English and Geography) for outlying schools in rural provinces as well as being a site of education for blind children in the city and nearby provinces. The School advertised on the radio and in newspapers for applications for entry, permissible from the age of two up to 15 years old. Van got to Nguyen Dinh Chieu School because a teacher visited her parent's home and advised them to send their only blind child there. Formal classes first started when a pupil reached six years of age. A child who entered at two years of age would enter kindergarten, start to learn Braille and begin to be shaped by school life. Eventually, she might graduate high-school there. The School was self-contained with living quarters for pupils, canteen and staff room, classrooms, a Braille print room and massage training rooms. In 2007-08, the School had around 200 students, Van guessed, of varying ages between primary and secondary school pupils.

² Philip Taylor, personal communication.

Blind students at Nguyen Dinh Chieu School learnt acupoint locations in massage training. The School had received development assistance from the Christian Blind Mission as well as the Japanese and Australian governments to supply occupational training materials. Van taught Japanese and Vietnamese massage together with basic pressure points, anatomy and pathology. Blind students who had attended massage classes would therefore be familiar with the location and names of around 60 acupoints on the body. Students learnt massage by feeling and handling anatomically correct models of the body, including a full skeleton and life-size models of the body, legs and arms with the muscles, ligaments and fatty tissues apparent and clearly defined. Such models were used to learn anatomy but when learning acupoint location students learnt by touch and reading. Four series of Braille books from the Ounkai Association for Social Welfare for the Blind in Japan were reproduced at Nguyen Dinh Chieu School, teaching students about medical ethics, hygiene, biology, acupuncture channels and points, Japanese massage, *duong sinh*, surgical techniques and disease. Point location was taught after anatomy courses. Anatomical features on a body were used to triangulate a point source. For example, to find a point on Bladder channel in the mid back area, a student would take a pointer from the corner of the shoulder blade, follow a line to the third rib, then trace across to the spine to count the correct number of vertebrae before measuring by using fingers, in this case two, from spine to the point. Van wandered around the class correcting point location by touch. Like most other teachers I met in Saigon, she was very talkative in pedagogic situations. Pupils were the ones who listened.

The School prepared blind students for an occupation in massage. The School also functioned as a massage centre, offering male only and female only massage to the public at lower cost than in a private spa. In 2008, 40,000 VND was charged for a body massage under a fan – not using an air conditioned room – though tipping was widespread. “Women don’t tip as much as men,” Van laughed. The massage rooms were popular with businesswomen, Van told me, because they were cleaner and more reputable than either untrained masseuse who cycle around the city (*massage dao*) or sex-shops with massage frontage. *Massage dao* was cheaper than massage at the School but had a negative reputation. “With massage you have to lie down, if you just sit in the café and get a massage that’s no good, there’s no effect you have to lie

down and take your clothes off. But if you invite these people to your house, it is not safe because they will steal your stuff and could hurt you... don't use them!" advised an older female interlocutor. Massage-going-around also offered cupping (*giác hơi*), associated with acupuncture by American practitioners but not for Saigon residents. After graduation, students could work in massage either in the School's public massage rooms or by setting up their own business. Massage was a well accepted profession for the blind – the others being music and manual labour. Masseuses working in either the government school or private clinics may massage seven or eight clients for one hour each, in one day. Such work could lead to repetitive strain syndromes since massage is hard manual labour. With massage, a practitioner could work with one client per one hour, whereas an acupuncturist could treat many more in that hour, depending on the available clinical space for patients to lie out. Massage was an occupation at which you could make a living but was not respected. "Blind masseuses don't get called Master," a doctor-acupuncturist framed bluntly.

In sum, being identified as blind meant being recognised as someone who had to be cared for. A blind person was a person who was guided, shepherded, dealt food and who waited for assistance. Van, after her independent life in Japan, sometimes found these actions irritating. Being recognised as blind meant depending on others and suffering restricted income opportunities. Wandering city streets under a hot sun as a mobile singer, working on manual labour projects³ or toiling at massage were all occupations that meant sweating, which rarely made enough to live on. A blind child was therefore a burden to parents. Being recognised as blind meant a life if not in poverty at least in difficulty, which could be expressed by citing karma. Being institutionally cared for prevented destitution and early death for blind children and adults in very poor families but it also meant being directed into a limited number of low-income occupations.

However, understanding the presence, rejection and success of Hoa, particularly, cannot be found in how only exploring how blind persons were identified. Learning massage entailed learning a small number of points but they were the same points

³ For example, shaving bamboo sticks to make brushes or toothpicks. Note that for acupuncturists acupressure was considered harder labour than needling (see chapter two).

used by acupuncturists. Learning to locate these points used the same methods that technicians used. The Nguyen Dinh Chieu Blind School was able to make use of additional teaching technologies, resourced through international relationships. Potentially, that anatomical education was more precise. These practices did not give rise to a sense that ‘blind acupuncturists’ were a reasonable proposition. The rejection and success experienced by blind acupuncturists requires acknowledgment of existing acupuncture constructions as the contexts in which all my interlocutors worked. What is required is acknowledgement about how these constructions got together and created consequences for vision.

Acknowledging Acupuncture

The topics I posed at the start of this chapter have been engaged with throughout the thesis. The thesis itself can be additionally read as an attempt to account for blind practitioners and the paradoxes they generated for sighted persons. Let me summarise the answers.

How did blind persons come to be doing acupuncture in the first place? The simplest answer is because of the presence and activities of a democratic and standardising pedagogy at government institutions. The Nguyen Dinh Chieu School for the Blind was aware of Japanese teaching scholarships and encouraged their students to learn Japanese in order to apply. A very small number are awarded globally each year, so Van’s own aptitudes for language were also important. For Hoa, the existence of a technician diploma and the Traditional Medicine Institute meant that he could participate in acupuncture medicine. He suffered no harassments in seeking and starting study at the Institute but he also told me that he had no family connections in acupuncture. Without the Institute and the technician credential, he would have had to rely on personal connections to source a private teacher or a private household willing to teach him. I am not sure how difficult that would have been. Certainly presenting himself for classes at the Institute meant that having the appropriate connections were less relevant to access training. The supposedly systematic licensing process would suggest that he should have been able to gain a licence because his file was complete: he had all the correct papers as it were. However, due to a trade in legality he found it difficult to get licensed because he argued, he was blind. That is to say, he did not have the appropriate connections

to overcome this hurdle. This suggests that without the existence of the New Medicine, he may not have been able to train. He did eventually get licensed and worked, as many technicians do, in the private sector.

Why did fellow practitioners reject the existence of blind acupuncturists? Relations between qi, points and channels and Organs were networked particularly. Acupoints were the most factual objects in the acupuncture taught at the Institute, responsible for the training and supply of a mass of technicians and a lesser number of doctor-acupuncturists. Therefore Hoa, with his fellow students, learnt an acupuncture vocabulary and were shaped as practitioners through a particular pedagogy. Knowing point location was equivalent to knowing acupuncture. Arguments over point location were used to challenge professional competency. A technical knowledge of acupuncture required accuracy to the tip of a needle. Needling the 'correct' place accurately stimulated scalar effect in the body, constructed as a system. Points were performed as static, in expectable locations and lurking in a patient's body, waiting for a needle to stimulate them through the hand of a competent knower. Points became determinants of practitioner knowledge and in this regard they overwhelmed qi, Organs and the channels. Measureable, locatable, static, surveyable, quantifiable points, which were accurate to a sharp needle point. If the hand that held the needle did not hit a needle-tip sized point exactly, therapeutic efficacy could not result.

A key problematic, therefore, was point location. While students were taught, and I have seen practitioners use, measurement of a patient body with practitioner body parts – fingers, thumbs, finger spans – textbooks, posters and printed handouts imaged acupoints as self-evident. They enacted points as empirically visible on the patient model. When a sighted practitioner needled, he read the body as if it were an acupuncture poster. Being unsighted meant being unable to read point locations or recognise signs of illness. For reading, vision is required. Lack of vision interrupted a taken for granted "relay" (Gomart & Hennion, 1999). Vision was the mode by which factual objects were translated into therapeutic intervention sites. Vision was also the mode by which manifestations of illness in a patient body were rendered as signs of treatable conditions. A practitioner meets a patient. The practitioner 'knows' that factual acupuncture objects exist in and on that body. She has to find them. Only when she has found them can she needle. Compared to Japanese schools,

acupuncture techniques I came to know in HCMC were less tactile. Without touch, the mode of translation was vision. An inability to read factual objects on patients' bodies meant that colleagues did not only doubt blind competency, they found their very existence an anathema. The words 'blind acupuncturist' were an oxymoron. Without vision, the whole project of technical acupuncture was interrupted.

Why did patients reject the competency of blind practitioners? Treatment, I have argued in an earlier chapter, had a shape. That shape was moulded by the acts of looking and the acts of pain removal. Both of these directed activity so that it could be called retrospectively, efficacious treatment. These shapes created expectations of what treatment should look like. Without looking or pain removal, treatment did not occur. A blind person cannot see therefore the translation of illness manifestations into meaningful signs was interrupted. Vision was not participating as expected therefore acupuncture ground to a halt. Other modes of translation were inactive; questioning was little used because a seeing practitioner relied on a mode of translation that did not require speech. Indeed, listening to a patient could be misleading, argued Nguyen Phuong. Needling the body required that an acupuncturist needle with accuracy into needle-tip sized points. A practitioner performed those points as if they could be seen on the body, he read them when he needled because he did not search for them in the patient's body or dig into muscle and tendons as in trigger point acupuncture. A patient's experience was that practitioners eschewed touching skin; groping on the body in search of an acupoint was not acupuncture as had been previously experienced. Additionally, comprehensive knowing was called for. A "good" acupuncturist, quoting my interlocutor (see earlier), knew all the points and many diseases, not merely a few. Knowing a little bit of this and that, as Dr Truong Thin (1984:29) scoffed, was insufficient in a modern medicine. There were numerous points in the body, it was difficult to remember them all, a technician noted. Print technologies were mnemonic devices that participated in providing comprehensive treatment. Comprehensiveness was a consistent problematic at different pedagogical sites in HCMC. Without access to such books, patients believed that comprehensive knowledge of points and illnesses was unlikely.

Given rejection, why was it that I knew a successful blind acupuncturist? Hoa was successful by connecting to personal networks. People knew people who knew people. They were connected in what Granovetter has called social networks (1982). I have called these personal networks. People talked; going to an acupuncturist who exorcised pain meant that a satisfied patient went away and talked about it. A name could then circulate in personal networks, which would take on the work of generating noise or fame. In personal networks, initial guarantees of effect were not so much about the practitioner but the personal relationships that introduced a prospective patient to an unknown acupuncturist. Trusting a familiar person was more dependable than trusting strangers, whose motivations could not be accounted for. When Hoa treated, he treated those close to him: family, friends and their connections. Those who felt a change during treatment came back so that he was able to build a practice with numerous return patients. However, he did have patients who never came back. Meeting patient expectations was crucial and a patient's key expectation was quick removal of pain. Patients often were not patient, practitioners noted. These expectations were part of a shape of clinical acupuncture. That shape was acupuncture as a treatment for and of pain. Coming to a treatment room with pain, and leaving without it – pain being performed somatically – meant the practitioner was effective; that a treatment 'worked' as was evidenced by a patient's opinion. A shape of treatment was able to deny competency but also to award it. In that clinical efficacy was measured in patient volume, this particular shape of treatment could also result in an incompetent inferior being revalued as a successful acupuncturist.

Conclusion

Vision was a key technology that constituted the acupuncture practiced in HCMC. A new and modern medicine was rendered empirical through ocularism: this was a truth of acupuncture. When challenges to such truth arose, in the person of a blind practitioner, truth was maintained by exclusion. Commitments to vision were such that blind practitioners were significantly rejected. Vision could only remain essential to acupuncture if something was deleted: that something was the paradoxical presence of blind acupuncturists.

I came to know two blind acupuncturists, who were institutionally trained, credentialed and competent. They experienced, concurrently, professional rejection and success. That their competency and occupational identity could be rejected while at the same time they could become successful, demands an explanation. I have described that blind people were recognised as requiring care. But this in itself cannot account for their professional experiences. Acknowledging acupuncture means acknowledging when vision mediated relationships and when it did not. Vision was a mode of translation in acupuncture in HCMC. It was the means by which signs and therapeutic sites could arise. Vision translated illness manifestations into meaningful treatment signs and factual acupoint objects into needling sites. For my interlocutors, such was the facticity of acupoints that rather than destabilise a consensus about them, blind acupuncturists were denied an occupational identity. Additionally, acupuncture contexts were shaped by personal networks, which created success through trusted familiar patient referrals. These referrals told of successful and quick pain removal and a volume of patients waiting in a practitioner's treatment room, thereby measuring a practitioner's efficacy. Patient referral was not an activity translated by vision but by talk. Trust was not created through vision but through familiarity. As much as living and working in HCMC and in Vietnam, acupuncturists worked in contexts that took shape as classrooms and treatment rooms. These were extended in personal networks and arose out of relations between printed books, copied poster media and patient expectations. The acupuncturist in the phrase 'blind acupuncturist' grappled with and was formed through these interactions. The blind in the phrase 'blind acupuncturist' was recognised as requiring care and suitable for only a limited number of occupational activities. Accounting for blind persons in acupuncture requires acknowledging all of these practices.

Out of this conclusion, arises an implication for advocacy. Van argued that Vietnam did not "recognise" her skills and achievements. This was possibly in error. "Vietnam" did recognise her. "Vietnam" recognised her as something and categorised her as blind. Recognition is not what she should seek, rather acknowledgement. Advocacy for blind acupuncturists in Vietnam cannot be successful in gaining benefits – training, credentials, licences, patient base – if that advocacy cannot engage with the very particular 'how' of acupuncture as networked vision.

Conclusion

This thesis is titled *Networking Acupuncture in Vietnam* for three reasons. First, this ethnographic study makes use of a network approach. A network approach is common to writers investigating science and technology, where scientific knowledge is taken not to be revelation of natural realities but rather ongoing and hybridic constructions that nonetheless can be very real (Haraway, 1991). This approach is useful because change rather than stasis is assumed; knowledge is understood as performative rather than something accrued and technologies are included as participants in creating realities that come about through collaboration. In network approaches, objects become multiple and singularity becomes curious. Network investigations have been significant in anthropology since the 1990s and have extended the boundaries of what may be investigated ethnographically. In this thesis, the construction of acupuncture objects in Vietnam is scrutinised. Other texts have investigated, to name but a few, the biological ‘facts’ of kinship and gender in the UK (Strathern, 1992a, 1992b) and chromosomal information in genetic screening of pregnant mothers in the USA (Rapp, 2000). Network has been a particularly useful concept for those studying East Asian medicine (Kim, 2005; Scheid, 2002; Zhan, 2009b) because it has enabled exploration of irrepressible diversity in medical practice.

Second, my focus is on acupuncture not acupuncturists, where acupuncture is a proxy for thinking about medical knowledge. Because I switched thesis topic during fieldwork, a key problem for me has been to find a way to conceive of acupuncture that was congruent with my field experiences. Previous writings on traditional medical knowledge in Vietnam could not help me navigate the diverse and dynamic acupuncture scenes I was involved with. Knowledge is a word that has overtones of commodity and writers who take this stance are therefore able to write about knowledge as “bodies”, “systems”, “forms” or “different types” (for example, Garro, 1986; Rasmussen, 2000; Wayland, 2003) which may be co-present and therefore be a “heterogeneous mixture of knowledge” (Ketler, 2000:139), be additional to performative actions in the world, as in the phrase “knowledge and practice” (Craig,

2002; Obermeyer, 2000), may be “acquired” (Sesia, 1996), lost (Quinlan & Quinlan, 2007) or ‘transmitted’ (Hansen, 1982; Hsu, 1999). Scheid expressly rejects the phrase “knowledge transmission” because it has a “cognitivist bias” and “mystifying notions of internalisation” (Scheid, 2002:164). Since this thesis has taken knowledge to be the many practices of constructing reality, in effect collapsing the meaning of knowledge and reality, I have not framed knowledge as types, be they different systems or something experienced compared with something intellectualised.

Third, this thesis investigates medical knowledge in Ho Chi Minh City, a place at the intersection of transnational networks. During fieldwork, I came into contact with numerous and active *Việt Kiều* (overseas residing Vietnamese) personal networks. These were maintained by annual visits to family; charitable giving; the import of medical textbooks (in both English and Vietnamese language); the provision of training in Japanese and American schools of acupuncture as well as export of Vietnamese medical techniques. Institutional relationships between government Schools for the Blind meant that Vietnamese nationals, resident in their native city, could practice an acupuncture that was, in many ways, utterly foreign to many of their professional compatriots. Vietnam in this thesis is a transnational space, a country whose philosophical inheritance, as some argued, is as much from the ancient Greeks and other European thinkers as indigenous activists, Chinese writers and Soviet scientists (also Pelley, 2002:43). Therefore, a study on acupuncture in Vietnam is unlikely to find that acupuncture is ‘just like Chinese’, as visiting European college students commented of their reasons to choose a non-China country to do their overseas acupuncture practicum. Such comments merely indicate how durable the stereotype of acupuncture as a quintessential Chinese object can be. Because traditional medicine has been colonised as a national object by nationalist governments in China, Vietnam and other places, nationalism has re-networked acupuncture as part of a coherent national identity, whether that’s a Japanese (Japan Society of Acupuncture and Moxabustion, n.d.), Korean (Kim, 2005, 2006), Vietnamese (Hoang, Pho, & Huu, 1999; Truong Thin, 1984) Chinese (K. Taylor, 2005; Zhan, 2009b) or an American (Seem, 1992) one.

The presentation of acupuncture as a national medico-philosophical system, on view at the Museum of Traditional Medicine in Saigon, has been rejected in this thesis.

This is a common conceptualisation of acupuncture in Vietnam (Bodecker & Dung, 2001; Bui, 1999; Craig, 2000; Craig, 2002; Hoang, Pho, & Huu, 1999; K.T. Le, 2006; Marr, 1987; Wahlberg, 2006). A key problem is that these writers rely on a sense that science and tradition are systemic medical *alternatives*. I have described how, in HCMC, a New Medicine was contemplated – one that winnowed out elements construed as backward and brought in other techniques, such as experimentation that could meet the needs of a modern and unified Vietnamese people. I proposed that this new synthesis should be understood on its own terms since it was and is explicitly a politico-medical project in which dialectical materialism was used to generate a new philosophy for ‘traditional medicine’, now called the people’s medicine. Hence when Master Nguyen Phuong took three fingered pulse and checked blood-pressure with a sphygmomanometer or advocated that a patient go to the hospital for an x-ray to check for a bone fracture, he was enacting a medicine that was neither western nor eastern but a government mandated practice in which technologies were brought into interaction so that their meaning and effect were transformed.

I argue that acupuncture in Vietnam can instead be understood as a performative network. It is how acupuncture was enacted and done that has been important here. Therefore in clinical situations, taken as encounters when practitioners meet patients, I paid attention to what was made relevant. Chi Ha clearly explained how looking, comparing and categorising manifestations of illness used a technology of vision. This was important for her reputation as a healer who recognised a problem without needing to ask what the matter was. When points were needled on patient bodies they were performed as static, predictable and small. Likewise, textbooks and posters enacted points and channels as static objects that were precisely locatable by measuring patient bodies or by triangulating body parts. By focusing on practices, change and difference were highlighted. Electrical acupuncture was used in some clinics and never in others; acupuncture guide-tubes were used variably. When similarity occurred, it was intriguing. Two senior practitioners, working in very different clinical settings, insisted that they did not keep secrets from their students; many different people figured life in the city as a network. Focusing on practices prevents essentialisation of an identity since no ‘grand logic’ (Kim, 2005) is either assumed or shown to be acting during participant-observation fieldwork. We do not

need to call this difference ‘fragmentation’ or ‘disjuncture’ (for example, Tsing, 2000; 2005; Zhan, 2009a, 2009b) because as noted, systematic unity and coherence is not taken to be prior.

Network includes things and humans as active doers, detailed in ethnography by Latour (1999, 2005) and Mol (1999, 2002; Mol & Elsmann, 1996). I have extended the insights of these authors into a study of acupuncture. An acupuncture poster does acupuncture as much as an acupuncturist; clothing did something in clinical situations as much as practitioners who were needling; trigrams were how Nguyen Phuong could construct a normal and abnormal qi flows through the pulses; textbooks were active in the creation of acupuncture as much as patients who went away and talked about a successful or unhelpful treatment. By doing so, acupuncture has been dehumanised somewhat in this text which is in contra-distinction to the very humanist medicine practiced at the Traditional Medicine Institute. Bringing in a multitude of things as capable of changing action decentres an investigation so that no authoritative source appears to be operating. Network approaches build on Foucauldian constructivist ideas and this text furthers that work by showing that networks with no centres are still capable of generating shape in the world: shapes of treatment and notions of authenticity.

Since a network approach focuses attention on practices, apparently singular objects become multiple. I have described how the acupuncture objects known as channels, Organs and qi were never singular. Channels had at least three identities; Organs were audible and legible *as* debates and qi was too dynamic to be contained. Likewise, even a brief examination of credentials has shown how a seemingly innocuous piece of paper was ambiguous in HCMC, when an extension of pedagogy into licensing created trading opportunities through personal networks. I have also demonstrated how a topic called ‘acupuncture in Vietnam’ can be said to be multiple. From the standardised techniques taught at the Institute to the seeming exotica of 6 Qi; the variable performance of acupuncture as one of electricity (or not) and use of Japanese techniques, acupuncture in Vietnam was never singular. This work is then closely aligned with Kim’s recent work, who showed that even the notion of an individual grand self as a “coherent and unified version of identity” (2005:241) was untenable, emphasising that incoherence and fluidity are normative states of

existence for any 'object'. The multiplicity of objects presents a "threat of incommensurability" for Mol (2002:85), who focuses her research on strategies used to create an object as singular and therefore, commensurable. She is concerned about incommensurability and maintenance of coherence. However, multiplicity need not be a problem. That objects are multiple is only problematic at certain times and the question is rather *when* does this problem arise and for *whom*?

Since a network approach focuses on practices, in which objects become multiple, situations when singularity arises are surprising and demand explanation. For acupuncture in HCMC, the factuality of acupoints was durable, distributed and unshakeable. Points were done in books, in clinical settings, discussed and taught as: static, small and locatable. Such was the factual value of this figuration of points that an alternative of 'big' points was instantly deleted. Multiplicity was not tolerated. Because of their facticity, points could shape acupuncture; for instance, knowing 'where the points are' was used to determine professional competency. But how did points come to be so singular? Repetition was a key practice of distributing consensus. Points were repeated in many places as the same thing; books, clinical performances, picture media all concurred. Repetition was active in creating another fact of life, that of personal networks. That life was a network and connections were needed to make a living in HCMC was repeated by many different people in the city. To make this truth, however, practices of exclusion took place. The occasions when personal connections were not necessary, for example to sign up to technician training at the Institute, were rarely discussed. Likewise the particular factual representation of acupuncture points was also maintained through erasure. Blind practitioners were excluded from professional competency since without a mediating technology of vision, points would change. However, since even factual acupoints could lose their pinpoint accuracy between different teachers, it may be that an absolutely homogeneous acupuncture does not exist.

In this regard, working in fieldwork situations where diversity appeared to be everywhere meant that I paid less attention to tracking situations when multiplicity was a problem. However, one instance that requires more research is when acupuncture is enrolled to construct a national identity, as for example on very prominent display at the Museum of Traditional Medicine. In those displays,

acupuncture was presented as intrinsic to an enduring Vietnamese “ethnie” (Smith, 1986) but to arrive at such displays much has to be deleted. Not least, the post-colonial renewing of traditional medicine was missing from Museum displays. The appropriate questions are how and why multiplicity was a problem. Pelley convincingly argues that post-war chaos and confusion in northern Vietnam made unity a “piety” (2002:144) for the nationalist-communist government but this requires investigation in a southern Vietnam context.

Network approaches emphasise that a multiplicity of practices and objects come into interaction. Collaboration is transformative. I have described how in the 6 Qi classroom, students and teachers collaborated to produce completeness which transformed information into knowledge. Strategies of distinction, fun and hierarchy were deployed to create intimacy and a familiar pedagogic model was used to demonstrate comprehensiveness. In an environment of cynicism, believing in completeness put trust in a key position of influence. This implies that trust is required for any information to take on a truth value. Likewise, talk, moving through personal networks motored by relationships of familiarity in which trust could be nurtured, transformed Hoa from anathema into a competent practitioner who could successfully remove somatic pain. His newsworthiness circulated a reality of his practice; that despite being blind he could heal. Important to Hoa was the net of familiarity: patients who did not know him were shown to distrust him. Collaboration was able to produce a reality that overcame another truth of acupuncture in HCMC – that acupuncture was networked vision. If acupuncture was a system this last sentence appears incoherent: I assert that vision was a key technology of acupuncture yet Hoa was successful. However, as stated earlier, practices bring actants into interaction so that what these technologies and practices can mean and do are mutually transformative; meaning is created anew each time.

A focus on collaboration means that relationships between classroom and clinic based learning in medicine need not be one of presumed disjuncture (for example, Becker, Geer, Hughes, & Strauss, 1961; Hsu, 1999). Relationships between the clinic and the classroom may be more complex and networked than a ‘gap’ approach suggests. I described how the collaboration between texts and American practitioners’ pedagogic and subsequent clinical experiences gave rise to a particular

recognition of treatment. Because these practitioners recognised treatment in a particular way, in HCMC they could complain that ‘diagnosis was missing’. That is, texts were active in determining what treatment *should be*, so that in this situation we cannot dismiss a textbook as being ‘wrong’ and the clinical ‘correct’, as doctors did in Becker and colleagues (1961) seminal ethnography. For the American acupuncturists in HCMC, an experience of treatment failed to agree with a previous consensus. The American acupuncturists experienced ‘mis’ recognition, treatment did not occur as expected, therefore treatment potentially had not taken place. Rather than comprehending book learning and clinic learning as oppositional and in conflict, medical anthropology may need to return to Farquhar’s (1994) suggestion that books and clinical practice should be jointly understood as a coherent epistemological formation.

Texts are, productively, problems of construction: they are collaborative works that are able to constitute the world in some way. This includes relationships between researchers, interlocutors and academic texts. I have made repeated mention of “co text” (Haraway, 1991), in the sense of mutual creation of field-notes between interlocutors and investigator. From being networked with Danh, who significantly determined the persons I met; appearing as the Other for Canh; being straitjacketed as an acupuncture student getting schooling in Nguyen Phuong’s classroom; appearing as a relay of fame for Chi Ha as well as a foreigner for whom talk was altered to ensure communicability and one who had the ‘wrong’ language fluencies to communicate with a Japanese-trained acupuncturist, “co text” (*ibid.*) has been important. Interlocutors and I were mutually dependent. My subsequent writings arose out of these interactions and these very particular relationships. Like Zhan (2009b), I envisage this thesis as therefore co-imagining, with my interlocutors, what acupuncture in Vietnam is and could be.

Networking Acupuncture in Vietnam suggests that investigations in the southern capital can be somehow applicable to the whole country. However, it is likely that the acupuncture presented here may have a ‘southern’ flavour. Many interlocutors figured contemporary Vietnam in talk as one state with two geographies. It was common to hear during fieldwork that southerners were friendlier and easier to get to know than northerners; that northerners liked plain foods whereas southerner

liked salty or northerners wanted their children to get a good education but southerners just cared about making money. But a regional comparison about acupuncture was very rare. Was there an assumption of a nationally homogenous acupuncture as sought by the Institute? One rare suggestion was that acupuncture techniques used in the Saigon-based Traditional Medicine Institute did not make use of acupuncture anaesthesia, which was associated in northern Vietnam with the famous Professor Nguyen Tai Thu. It would be interesting to understand how acupuncture varied regionally even though this question did not stimulate the curiosity of those I worked with. Given the different histories of these two geographies, future research on acupuncture – and traditional medicine in general – could benefit from investigating southern medical records of the 1954-75 period which may reveal a reason for this seeming regional indifference. My ethnographic experience was of acupuncture intensively networked with America, Japan, Cambodia and central Vietnam in a way that may not be possible in Hanoi's or Haiphong's translocal acupuncture networks. Given the nature of network, the lack of differentiation would be remarkable and raise questions about which singularising practices enabled homogeneity to arise.

This then is the appropriate place to unbracket acupuncture. In the introduction, I pointed out that I would separate acupuncture away from its synergistic interaction with other therapies. But such bracketing is now a problem. I argue that acupuncture is a network and that network includes practices of massage, giving pharmaceuticals and the use of sphygmomanometers, manipulation by physiotherapy and much more. I described how Canh included music, art and fun as required therapeutic practices. Nguyen Phuong included a standing meditative practice. By bracketing acupuncture, I have in one sense bracketed out therapeutic efficacy since practitioners located *hiệu quả* in this interaction. I have constructed acupuncture as a needling therapy, which is how acupuncture has been measured in random control trials and often decried in literature. Synergy is rather the best place for a study of medicine since no therapy is mono-applicative. Collaboration is required to cause changes in illness manifestations, some of which are desirable, and called cure or healing, and some of which are not, and may be called failure or side-effects.

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