國立政治大學國際傳播英語碩士學程
International Master's Program in International Communication Studies
College of Communication
National Chengchi University

碩士論文
Master's Thesis

論文題目
Chinese at Heart, Western Where Appropriate: An Exploration of Professional Identity in a Chinese Medical Clinic

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中華民國 99 年 3 月
March 2010

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A Thesis

Submitted to International Master's Program in International Communication Studies

National Chengchi University

In partial fulfillment of the Requirement

For the degree of Master in International Communication Studies

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Acknowledgement

In the first place, I deeply thank to my advisor, Prof. Mei-ling Hsu, whose help, advice and supervision were invaluable not only for accomplishing this Master's degree but also for my overall academic development. I would also like to record my gratitude to the evaluation committee members, Prof. Leonardo Chu and Prof. Wen-ying Liu, for their precious insights and interesting discussions.

My sincere thanks go to Huiting Yu, our academic angel, for her patience and assistance with a thousand and one things. I am also grateful to all IMICS community members (both professors and students) for their company, making my experience in Taiwan unforgettable.

I would also like to thank my family and friends (you know who you are!) for their constant support and for boosting my optimism in hard moments.

Last but not least, I want to express my special gratitude to Dr. Chen-yu Lee and all the members of Yusheng Chinese Medical Clinic who introduced me to the world of Chinese medicine and made this research possible.

Abstract

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By

Viktorija Laurinaityte

Studies in medical anthropology and health sociology have shown the intensification of the exchanges between Chinese and Western medicine. However, there is a lack of literature exploring this phenomenon from the human communication perspective. To fill this gap, this study aims to analyze patterns and processes taking place in the interaction between Chinese and Western medicine by inquiring into professional identity of the Chinese medical practitioners. To implement this goal, a qualitative exploratory research was conducted in the Yusheng Chinese Medical Clinic, employing the methods of participant observation and interviewing.

Drawing on the communication theory of identity and applying positioning as an analytical tool, it was found that professional ideology, adherence to Chinese medical theory, and sociohistorical situatedness were the most salient factors determining positional shifts in the discourses with Western medicine. In some discursive practices, the relationship between the two medical systems was dichotomized. In other ones, it was perceived in terms of partnership or even unification. Accordingly, the complex and dynamic picture of professional identity was captured. The shift from emphases on being a good physician to being a good Chinese medical physician, as well as discrepancies between perceived professional self and enacted professional self, were observed. Based on the findings, this study calls for the discussions on the relevance of the yin-yang mode in interpreting the interaction between Chinese and Western medicine in the context of globalization.

Keywords: Chinese medicine; Western medicine; professional identity; communication theory of identity, positioning; globalization; yin and yang

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1. Introduction

Communication between the East and the West has been taking place for ages, from Silk Road trade in the Middle Ages to exchanges of bits and bytes through digital highways in the Information Age. The world has witnessed tightening relationships and increasing interaction which have deepened both understanding and misunderstanding between the two regions. Chinese medicine has been one of the topics surrounded by discussions, negotiations and exchanges under the East-West rubric in public discourse and in both natural and social sciences. Its reception in the Western world has ranged from xenophobia to romanticism, from total rejection to admiration. However, while emphasizing differences between Western and Chinese medicine, rejecting either one of the two or trying to convince which one represents the "truth," it has often been forgotten that above all the differences there is a common goal – to heal illnesses.

Studies in sociology of health and illness, medical anthropology, history of sciences and medicine, cultural studies and other disciplines have shown that medicine can be perceived not only as a natural science but also as a cultural phenomenon situated in a particular cultural environment and sociohistorical context and possessing unique social and cultural features (e.g., Baer, Singer, & Susser, 2003; Foucault, 1994; Lupton, 2003; Taylor & Field, 2007).

Sociohistorical circumstances have determined that biomedicine has been seen as a normative and "true" one since the nineteenth century in many parts of the world, placing other medical systems on the complementary, alternative or folk (as opposite to science) level if not in the realm of magic or quackery. In the second half of the twentieth century, under the growing influence of postmodernism and poststructuralism, the situation yet started to change (Fox, 1993).

The cross-cultural perspective towards medicine provided by anthropologists and the history of medicine highly influenced by Foucault's writings have shown that "conventions of western medicine are no more 'scientific' or 'objective' than medical systems in other cultures or in other times" (Lupton, 2003, p.17). In terms of Chinese medicine, it is recognized now as:

> [A] coherent and independent system of thought and practice that has been developed over two millennia. Based on ancient texts, it is the result of a continuous process of critical thinking, as well as extensive clinical observation and testing. It represents a thorough formulation and reformulation of material by respected clinicians and theoreticians. It is also, however, rooted in the philosophy, logic, sensibility, and habits of a civilization entirely foreign to our own. (Kaptchuk, 2000, p. 2)

This turn of understanding in social theory and public discourse goes in step with the spread of Chinese medicine. Nowadays, the attributes *Western* and *Chinese* thus have not much to do with geographical location. Due to the development of modern science and unquestionable reliability of experiment-based knowledge, biomedicine has become a normative medicine all around the world. During the last few decades, Chinese medicine has also made a worldwide migration and it is "no longer confined to locations such as Shanghai, Seoul, or Singapore, it has become a vibrant component of health care from Sidney to Seattle to Stockholm" (Kaptchuk, 2000, p.1). In other words, Chinese medicine has trespassed borders of Chinese societies, making boundaries between global and local blur.

Following changing geographies of the two medical systems, globally recognized Western medicine is beginning to be questioned as being the only right way of healing. Chinese medicine provides alternative ways of conceptualizing health and illness. It is unquestionable thus that the

dialogue, negotiation, exchange, or as Breslau (2001) calls it, *meeting* between two medical-cultural systems is definitely taking place. Further questions thus follow: How does this meeting proceed? What processes are taking place? What kind of new agreements and compromises are reached? These are relevant questions nowadays, especially in medically pluralistic countries and societies.

Taiwan's society is one of those where both kinds of medicine have been widely practiced. Taiwan's medical pluralism is marked by a dual system. The dialogue between the two systems is very lively what makes it topical for studying (e.g., Chan, 2005; Chen, Shum, & Hsieh, 2002; Hsu, Hsieh, Huang, & Wang, 2007; Kleinman, 1980; Lew-Ting, 2005; Wu, 1982)

Early scholarship has shown that Chinese medicine, just as biomedicine, has its own logical structures and principles (e.g., Porkert, 1974). Nevertheless, this early scholarship left the impression that it is a closed system of practice and knowledge, totally different from that of biomedicine. Reacting to this problem, later studies, especially those in the field of history of sciences and cultural anthropology, have presented much more complicated social and cultural contexts surrounding Western and Chinese medicine separately and together (e.g., Hsu, 1999; Kleinman, 1980; Kuriyama, 1999; Unschuld, 1992, 2003).

Most recent works on Chinese medicine from the intercultural perspective emphasize the importance of historical, cultural and social contexts while conducting research in different parts of the world (Hinrichs, 1998). The largest part of the scholarship examining contemporary processes in Chinese medicine and its encounter with Western medicine and culture is found in the field of medical anthropology. There are studies exploring Westerners' motivation for engaging in Chinese medicine (Barnes, 2009), globalization of Chinese medicine (Hsu, 2001;

Zhan, 2001, 2009), perception of Chinese medicine in different cultural systems (Barnes, 2005; Ho, 2006).

However, little work in this area has examined the processes taking place in contemporary Chinese medicine from the prism of human communication. There is even less literature dealing with the professional identity of practitioners of Chinese medicine in the context of interaction with Western medicine. In order to fill this gap, I will draw on the multilayered concept of identity developed in communication theory of identity (CTI), which provides multiple perspectives and starting points for a scholarly inquiry. In this study, identity is seen as communicative, emergent, enacted, and relational. The communication process is an arena where people's self-perception and self-expression can be caught (Hecht, Warren, Jung, & Krieger, 2005). Moreover, the concept of positioning is employed as an analytical tool for capturing this communication process. In this study, identity emerging in the communication process is thus seen as one of the sites where the meeting between Chinese and Western medicine can be observed.

In sum, what gives a stimulus for the research is an increasing interaction and intensification of dialogue between Chinese medicine and its Western counterpart and the lack of literature on identity from human communication perspective in this area. The goal of this study is thus to comprehend what patterns and processes emerge during the meeting of the two medical systems in the context of globalization. To do so, I will inquire into the professional identity of practitioners of Chinese medicine and will explore what messages and meanings are brought with it when encountering Western medicine. First, I turn to the broader sociohistorical context and to the discourse on medicine and identity in social sciences and humanities, and next, using

qualitative tools of participant observation, the phenomenon in question is explored.

2. Literature Review

This chapter introduces the epistemological position, the contextual background, and the theoretical framework of this research. First, I will discuss the main trends and approaches towards Western and Chinese medicine in modern social sciences and humanities and define the epistemological basis which informs the methodology of this study. Second, I will provide an overview of the sociohistorical context by introducing the development of Chinese medicine in the twentieth century in China and Taiwan, respectively. Third, I will review recent studies of Chinese medicine situated under the context of globalization. Finally, I will explicate the theoretical framework and concepts employed in this research.

2.1 Setting the Context

2.1.1 Medicine as culture

Studies in social sciences have illustrated that medicine belongs not only to the realm of natural sciences. It is also a cultural and social system carrying its own artifacts, symbols and patterns, which can tell numerous stories about societies, cultures and people it is situated in. Over the past three decades, the status of biomedicine has witnessed a paradoxical situation. On the one hand, a well-established medical system has become one of the most important indicators of development in many countries; people's lives are increasingly dependent on biomedicine. On the other hand, globalization and familiarization with other medical systems "began to call into question the claims to 'truth' and political neutrality of biomedical knowledge (that which is founded upon scientific principles and understandings)" (Lupton, 2003, p. 5).

Changes of perception in public life and discourse go in step with changes in social sciences and humanities. Inquiries into medicine have been made from different fields, such as sociology, anthropology, history and cultural studies. Development and changes in conceptualization of medicine have been affected by main intellectual traditions and paradigms at large and have influenced all of these disciplines. In the beginning, theorizing about medicine in social sciences was merely based on positivist values and empiricism. Only under the impact of postructuralism, postmodernism, feminist studies and Foucauldian reassessment of medicine, have new perspectives of approaching medicine and society been introduced into social theory (Lupton, 2003; Scambler, 1987).

Social constructionism has become one of the most influential perspectives in social sciences and humanities. Although it gained importance in social theory in the mid-1960s when Berger and Luckmann (1967) published their influential book *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*, the linkage of social constructionism to medicine did not become prominent until the 1980s. This turn was largely influenced by Michel Foucault, who argued that nothing in history is given or natural, that all so-called *natural categories* are social constructs, articulated by discourse, and nothing can be taken for granted (Jones & Porter, 1995). In terms of medicine, Foucault (1994) raised a question of sociohistorical contextuality of medical knowledge, in this way rejecting the objectivity of contemporary biomedicine and exposing it as being discursively constructed.

The most valuable input for introducing medical knowledge from intercultural cultural perspective was done by anthropologists. As argued by Kleinmann (1980), “in the same sense in which we speak of religion or language or kinship as cultural systems, we can view medicine as a

cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions" (p. 24). Medical anthropologists' engagement with ethnic minorities and different cultures brought the perception of medicine as culture into humanities and social sciences. In this study, I follow social constructionism and see medicine as a discursively constructed cultural system.

1.1.2 Great divides

While helping to widen horizons of medical knowledge and introducing different health care systems into scholarship, medical anthropology at the same time has too often been trapped in the polarity of biomedicine (as a normative system of medical knowledge) and *other* knowledges (Zhan, 2001). The trinity of magic, religion, and science has been a very influential framework in anthropological inquiries into construction of knowledge, especially knowledge of *others* (e.g., Evan-Prichards, 1981; Malinowski, 1948; Nader, 1996). These three concepts have been widely used as major analytical categories in comparative studies (Tambiah, 1990). They played a critical role by demarcating boundaries of *other* knowledge measuring them against science (Zhan, 2001). As Good (1994) indicated, the main concern of anthropologists has been to show how they "make sense of cultural views of the world that are not in accord with contemporary natural sciences" (p. 10).

Turning to medical anthropology, Lupton (2003) and Leslie (2001) pointed out similar problems. For many years, biology was considered objective and universal, and culture – an external phenomenon. Different perspectives of illness, body, and healing were thus thought to be superstitions emerging out of sociocultural realm and being inferior to "real" biomedical illness

and healing practices as diagnosed by doctors and described in medical books. For example, Stoekle and Barsky (1981) wrote that "folk and primitive beliefs persist today, even in the attributions offered by the modern 'well-educated' patient, not only in those of the less educated, ethnic minorities" (as cited in Lupton, 2003, p. 16).

Ever since the 1960s, social constructionism and political economy approaches have encouraged the emergence of critical and interpretive medicine-related theorizing. However, the aforementioned processes have brought what Latour (1993) called the "great divides" between culture and nature, tradition and modernity, global/universal and local. In times of boundary blurring between disciplines, these divides have penetrated humanities, social sciences and intellectual thought at large.

Historical circumstances and modern sciences made an enormous impact on dividing the so-called *traditional* Chinese medicine and *modern* Western medicine. In the context described above, the word *modern* bears meanings of progress, advance and efficiency, alluding to technological advancements, efficiency of organization and moral improvement (Knauft, 2002, p.9). *Modern* is also often understood as universal and globally recognized. *Traditional*, by contrast, can refer to anything that is local, not Western nor modern, and varying from place to place. Although this approach has been successfully challenged by cultural studies under the context of globalization, it is still very strong in the realm of medicine. Nevertheless, according to Foucault (1994) and Latour (1993), even biomedicine cannot claim to be modern because the distinction between modernity and tradition is merely rhetorical.

1.1.3 Different globalization modes of Chinese medicine

In the era of the global economy, the world has become interconnected more tightly than ever before. Discussions about present political, economical, social, cultural and other processes cannot spare the frame of globalization. The interface between Chinese and Western medicine is taking place not only in Chinese societies but also all around the world. Recent intercultural studies tend to choose globalization as a general contextual frame. A similar development can be seen in the field of Chinese medicine.

By inquiring into the discourse of acupuncture in the United States, Ho (2006) explored conversations among practitioners of Chinese and Japanese acupuncture focusing on the concept of *qi* (氣). Acupuncturists expressed their dissatisfaction over the tendencies to evaluate traditional acupuncture by the standards of biomedicine. Ho's results thus show that the *qi*-related discourse among physicians advocates classical perception of the concept of *qi* and is a form of resistance to the scientific integration of Chinese medicine into the health system. The study suggests that there is a discursive tension between the two medical traditions.

Breslau (2001) explored the meeting between Chinese medicine and biomedicine in the Department of Psychiatry at Kobe University, Japan. He inquired into the stories of four Chinese physicians working in this psychiatry department. Their stories revealed that the tensions between biomedicine and Chinese medicine were overcome by using hybrid practices developed during the meeting between the two medical systems.

In Taiwan, Lew-Ting (2005) conducted a survey to explore patients' health-seeking strategies for choosing between biomedicine and non-biomedical healing techniques. The results

show that the main reason for choosing non-biomedical treatment is the antibiomedicine beliefs, mostly related to inefficiency and incompetence of *xiyi* (Western medicine). Nevertheless, biomedicine per se was not rejected by people who chose Chinese medicine. Instead, the phenomenon which can be called *integrative/hybrid medicine seeking* has been emerging in Taiwan.

Jennings (2005) analyzed the role of Chinese medicine, as a cultural system, in Tanzania's pluralistic health system. He approached medicine from the perspective of culture stating that "health and healing are rooted in the social and cultural order" and that "Western biomedicine is not founded upon unarguable, unchallengeable scientific facts that fit easily within all cultures and societies across the world" (p.459). Jennings thus introduced Tanzanian health system as a site of cultural exchange between indigenous healing techniques, biomedicine, Ayurvedic[1] and Chinese medicine. He criticized against adopting the perspective of cultural imperialism in viewing the impact of the globalization on medicine, which suggests that local medical traditions be replaced with the universal biomedicine.

Instead, Jennings emphasized that the cultural exchange between Chinese medicine, biomedicine and local African healing techniques should be seen through the prism of *glocalization*. Glocalization, as proposed by Robertson (1992), refers to "the synthesis of the local and the global to create something that both reflects its constituent parts and functions as something distinctive" (as cited in Jennings, 2005, p. 467). Jennings thus rejected the approach that globalization is merely a binary process of developed vs. underdeveloped, rich vs. poor, strong vs. weak, for the case of Chinese medicine in Tanzania shows global flows between two

[1] Ayurvedic medicine is a traditional medical system originating from India.

developing regions. Jennings thus concluded that under the impact of globalization, not only Western cultural, economical and political notions have been traded around the world. Chinese medicine in Africa can be also seen as global. In addition, the flexible local (in this case, traditional Tanzanian) healing can be transformed without alienation to foreign and its own traditions at the same time.

Globalization (as cultural imperialism) and glocalization are usually understood as spreading of one culture to other, from global to local (e.g., Giddens, 1990; Robertson, 1995). A seemingly give-and-take relationship underlies these concepts. Therefore, the adaption of these conceptual frameworks becomes troublesome in the context of Taiwan's pluralistic health care system. In other words, the relationship between Western and Chinese medicine does not fit into the binary system of global-local. While the majority of the local population is ethnic Chinese, at the first sight, Chinese medicine appears as a local phenomenon. Nevertheless, it has been exported to the other parts of the world and thus can be seen as another global as well. Therefore, I argue that the global/local prism for looking at the relationship between Western and Chinese medicine is not adequate in the Taiwanese context.

Variations in medical pluralism from country to country have induced the need for developing new approaches towards globalization process in the medical arena. For example, the journal *Medical Anthropology* has dedicated a special issue to the topic "Globalizing Chinese Medicine."[2] In this issue, Linda Barnes, Elizabeth Hsu, and Mei Zhan discussed globalization of Chinese medicine from the bottom-up perspective.

Hsu (2009) explored the globalization processes of Chinese medicine and inquired into the

[2] See *Medical Anthropology*, Issue 2, Vol. 28, 2009.

debates of Chinese propriety medicines in East Africa in the context of political economy. Her research results show that, according to the Western biomedical criteria, Chinese propriety medicines are modern Western drugs. Despite this fact, practitioners of Chinese medicine consider them to be modernized form of traditional herbal remedy. The latter perception fits into the concept of "alternative modernity," which refers to "the understanding of modernity as a differentiated and variegated process" that accounts for "global political economy and regional histories in appreciation of culturally shaped subjective dispositions" (Knauf, as cited in Hsu, 2009, p.118). Hsu (2009) thus proposed to see the processes taking place in Chinese medicine from the perspective of alternative modernity.

In the same issue of *Medical Anthropology*, Barnes (2009) inquired into practitioners' motivations to be engaged in the practice of Chinese medicine in the United States and China, respectively. Barnes employed theories of agency and decision making to study how and why practitioners chose to engage in Chinese medicine. She also drew on the non-Eurocentric concept of *xin* (心 heart-mind) as an analitycal frame to enrich the discussion of agency and decision making.

Furthermore, Zhan (2009) examined how the meanings of Chinese medicine had shifted in the previous decades since Chinese medicine was commoditized and reinvented as a new type of preventive medicine fitting into the cosmopolitan, middle-class lifestyle. She pointed out that this was an outcome of the competition with biomedicine for both medical authority and patient-clientele under the global economy. Findings of this research show that practitioners and proponents of Chinese medicine "insist as much on continuity and antiquity, cosmopolitanism

and globalization" (Zhan, 2009, p. 169). Zhan developed an alternative perspective and concept for looking at the globalization of Chinese medicine. She proposed the term *worlding* which "indexes the constant making, unmaking, and remaking of the histories and routs through which knowledge travel and, in due course, take on new and sometimes unexpected meanings and forms" (Zhan, 2009, p. 172). Zhan suggested that the perspective of worlding of Chinese medicine allows escaping the binary mode of global/local, which is often inaccurate when describing processes taking place in the Chinese medicine:

> Choice of the word "worlding," then, is a conscious effort to distance from globalist assumptions of totality and transcendence. It is critical to bear in mind that globalization does not invariably produce free-floating nomads. Nor does it equally embrace all corners of the world. Difference […] is neither entrenched in the local nor easily transcended through the global. (p.172)

Zhan thus tried to avoid the global/local perspective by criticizing an overemphasis on the economic processes and underestimation of cultural logics in analyzing globalization of Chinese medicine.

The purpose of highlighting the aforementioned studies is to show that there are many points of departure for approaching the processes taking place in Chinese medicine under the contextual umbrella of globalization: Glocalization, hybridization, alternative modernity, integration, worlding, just to name a few. In addition, sometimes the meeting between the two medical systems under the processes of globalization produces tension, at other times it results in collaboration or integration. Although this study is placed in the context of globalization, I refrain from forehanded application of globalization modes developed in other societies to the context of

Taiwan's health care system in order to avoid a preconceived conceptual divide. I only adopt Zhan's (2009) approach of studying the relationship between Western and Chinese medicine as a relationship between the specific translocal systems which generates various new processes in the realm of medicine (including theory, practice and sociocultural aspects). Taking this approach as a departing point, I will explore the culture of Chinese medicine in its exclusive mutual interaction with biomedicine.

2.1.4 Chinese medicine meets Western medicine

The beginning of Western medicine can be traced to the 5th century BC. A few centuries later, a different medical system had been developed on the other side of the world, in China (Unschuld, 2003). Although both medical systems have their roots in much older healing techniques, here medicine is referred to as an independent system of knowledge and practice which was developed from long lasting observations and explorations of illness and the human body. It took two thousand years for both Chinese and Western medicine to evolve into complex formations encompassing "natural science and philosophy, ethics and religion, language and literature, society and economics, technology and handwork" (Unschuld, 1997, p. 11). Due to the lack of space and the different scope of this research, it is impossible to review the whole history. In addition, there is already a bunch of valuable literature from historical and comparative perspectives discussing the development of Chinese medicine and its encounters with Western counterpart (e.g., Hsu, 2001; Kaptchuk, 2000; Kuriyama, 2003; Li, 1998; Li, 2009; Qu, 2004; Unschuld, 1997; Unschuld, 2003). Here I will only provide a short overview of the development of Chinese medicine in the twentieth century in China and Taiwan as a sociohistorical

background of the phenomenon explored in this study.

The kind of Chinese medicine found today has been highly affected by sociohistorical circumstances and events since the turn of the twentieth century. At that time, inner upheavals, social unrest, political instability, and unsuccessful struggles against Japanese and European imperialist powers had greatly weakened China. The overall atmosphere in the country forced intellectuals to rethink traditional Chinese values, cultural principles and practices which had been considered universal and supreme (Spence, 1990). According to Fruehauf (2009), despite the fact that many aspects of society at that time were in the state of collapse,

> [T]he culture of traditional medicine was alive with the multihued color and texture of a 2,500 year-old art. There was the stimulating discourse between the newly founded fever school and the school of the neo-classicists, there were numerous scholar physicians publishing influential discourses, and there was the arcane realm of esoteric discipleship, alchemical experimentation, and the kaleidoscopic facets of folk wisdom that have always characterized the sensuous heart of the profession. (para.5)

The critique against "old" culture reached its apogee in 1910s-1920s during the New Culture Movement informed by European intellectual traditions. One of the most escalated topics in this modernization movement was *science*. Modern sciences were seen as a salvation bringing enlightenment, progress, and prosperity to China. New medicine (*xinyi*[3] 新醫) challenged traditional healing system which became estranged as old, unscientific and therefore inferior (Liu,

[3] In this study, I use Hanyu Pinyin Romanization system, except for Chinese proper nouns (mostly Chinese names and surnames or names of certain places) which have standardized international usage or refers to the identification of a person whose name is transcribed according to other Romanization systems. For example, Taipei is used instead of Taibei, Chiang Kai-shek instead of Jiang Jieshi (蔣介石), etc.

1995). This was the first (but not the last) big challenge for Chinese healing tradition which at that time lost its status of the only kind of medicine and became *jiuyi* (old medicine 舊醫), *guoyi* (national medicine 國醫), or *zhongyi* (Chinese medicine 中醫) (Liu, 1995).

Under these sociohistorical circumstances, harsh debates between the so-called modern Western medicine and traditional Chinese medicine[4] began. Reacting to this situation, some progressive practitioners and theoreticians of Chinese medicine tried to integrate some aspects of modern medicine. Now they are known as Integration School of Chinese and Western Medicine (*zhong xi yi huitong pai* 中西醫匯通派). The main representatives were Wang Qingren (1768-1831), Tang Zonghai (1851-1908), Zhang Xichun (1860-1933), and Zhang Shouyi (1873-1934). These early integrators advocated an ideal vision of integrating the two medical systems by adopting some elements from Western medicine into their own system in order to benefit its development. Although these integrators adopted some aspects of Western medicine, they insisted on keeping the holistic principle of Chinese medicine. This way, the representatives of Integration School remained "Chinese at heart" as the title of Zhang Xichun's collective writings suggests, "Chinese at heart but Western where appropriate" (as cited in Fruehauf, 2009, para.6).

More serious challenges for classical medicine were presented officially. Although contemporary scholarship shows that Chinese medicine has been neither a closed and coherent system unchanging for several millennia nor an antipode of modern Western science (Farquhar,

[4] Here *traditional Chinese medicine* refers to classical Chinese healing tradition as contrasted to *modern Western medicine*. It should not be confused with TCM (Traditional Chinese Medicine), which refers to Chinese medicine today and is broadly used in contemporary analyses of Chinese medicine. Because of this terminological ambiguity, in this study, we simply use *Chinese medicine*.

1987; Hsu, 2001; Sivin, 1981), statesmen and modernizers were not aware of this fact. During the first half of the twentieth century, Nationalist Party (*guomintang* 國民黨) government launched several campaigns against *jiuyi* (Zhan, 2001).

For example, in 1929, public health officials presented a radical proposal called *A Case for the Abolishment of Old Medicine to Thoroughly Eliminate Public Health Obstacles* (*feizhi jiuyi yi saochu yishi weisheng zhi zhangai an* 廢止舊醫以掃除醫事衛生之障礙案). The proposition suggested that "the theories of yin and yang, the five elemental phases, the six atmospheric influences, the zang-fu systems, and the acupuncture channels are all illusions that have no basis in reality" and warned that "old medicine is still conning the people with its charlatan, shamanic, and geomancing ways" (Wa, as cited in Fruehauf, 2009, para.9). It also included three major clauses: to restrict the practice of Chinese medicine, to ban its advertisements, and to prohibit the establishment of Chinese medicine schools.

The proposition passed the first legislative session of the Central Ministry of Public Health. However, it was not implemented due to the harsh public reaction and protests by thousands of doctors and patients. Despite the failure of the proposition, the anti-traditional sentiment of the document influenced the general mood in the realm of medicine during the first half of the twentieth century (Fruehauf, 2009; Li, 1998). It was followed by an introduction of administrative, curricular, and pedagogical styles of biomedicine into academies of Chinese medicine.

A similar attitude towards Chinese medicine was held by the founder of People's Republic of China (PRC), Mao Zedong, and his communist government. In order to establish model public

health villages, Mao instructed to root out "all shamanic beliefs and superstitions," grouping Chinese medicine doctors together with circus entertainers, snake oil salesmen and street hawkers in to the same category (Fruehauf, 2009, para.10). In 1954, after the establishment of the PRC, Mao, however, declared Chinese medicine to be a "treasure house" of the country emphasizing its uniqueness of being "native," "patriotic," and "among people." It became a tool for promoting the uniqueness of Chinese communism (Farquhar, 1987).

Nevertheless, this turn in Mao's policy did not equate the status of Chinese medicine to that of Western medicine. The former was forced to be standardized and modernized under the guidelines of the latter. Following Mao's revolutionary vision to integrate Chinese and Western medicine (*zhongxiyi jiehe* 中西醫結合), *zhongyi* was adopted to biomedical sciences, institutionalized and professionalized. It became a subject of national health and educational systems. Itinerant healers and literati doctors (*ruyi* 儒醫) were excluded from the official version of Chinese medicine as being "superstitious" and "unprofessional" practitioners (Zhan, 2001). This resulted in an emergence of what is presently called TCM (Traditional Chinese Medicine), a contemporary form of Chinese medicine.

In the first half of the 20th century, both governments, Nationalists and Chinese communists, used Chinese medicine as a mean for defining national identity. In addition, they tried to put classical medicine into the controlled existence replacing its original parameters with "objective" and "progressive" standards of modern sciences (Chan, 2005; Chen, Shum, & Hsieh, 2002; Farquhar, 1987; Fruehauf, 2009).

Heretofore, the historical overview has shown that there have been different kinds of

understanding of what integration of Chinese and Western medicine means, including scientification of Chinese medicine, complementary usage of Chinese medicine in biomedical health care system, and remaining *zhongyi* in the core but not rejecting the employment of biomedical tools if needed, etc.

2.1.5 Chinese medicine in Taiwan

After 1945, the Chinese Nationalist government continued its policy on Chinese medicine in Taiwan. Chinese medicine was allowed to coexist with Western medicine but at the same time it was pushed towards modernization and scientification. Under American influence after the Second World War, the practice of biomedicine has been the main stay of the healthcare system. The practice of Chinese medicine was officially recognized in 1956. *Chinese Medicine Education Act* passed in the same year provided a legal ground for establishing research and educational institutions of Chinese medicine. It aimed to overall modernization of Taiwan's health system. Although the act gave the same status to both medical systems, "the path [of Chinese medicine] to respectability and acceptability among the general public, academic and healthcare professionals has been arduous" (Chen, Shum, & Hsieh, 2002, p.303).

In terms of education, before the late 1960s, all Chinese medical practitioners acquired their education through apprenticeship and self-study. The development of institutionalized Chinese medical education has been led by College of Chinese Medicine (established in 1958 in Taichung, now China Medical University), which since 1966 has offered the formal professional training and the medical degree of Chinese medicine (Chi et al., 1996). Modernization of Chinese medicine and integration of Chinese and Western medicine have been the unwavering guiding

principles of the medical curriculum in China Medical College since its establishment. To date, Taiwan has five major institutions offering undergraduate and post-graduate programs and conducting different kinds of research projects (Chen, Shum, & Hsieh, 2002).

In terms of licensing, under the Western medicine-dominated health care system, the licensing system has also "contributed to the secondary role of Chinese medical practitioners in providing health care" (Chi et all, 1996, p. 1330). According to Chi et al. (1996), there are five types of Chinese medical practitioners in Taiwan: Chinese medicine physician (CMP), Chinese medicine pharmacist (CMPharm), Chinese medicine registered nurse (CMRN), Chinese medicine nurse (CMN), and Chinese medicine physician's aid (CMPA).

However, only the first two categories, CMP and CMPharm, are official titles. There are no separate examinations for CMRN, CMN and CMPA. CMN yet can take a licensure examination for Western medicine nurses thus becoming CMRN. Until 2010, there have been two systems of licensing CMP: Chinese Medicine Physician License Exam (CMPLE) and Chinese Medicine Physician Special License Qualifying Exam (CMPSLQE). The former exam can be taken only by physicians with medical degrees in Chinese medicine. The latter licensure system has been offered for physicians who have acquired their education in the traditional way of apprenticeship and self-study. The CMPSLQE includes two levels of examination: Qualifying Examination and Special License Examination. Only by passing both can one obtain the CMP license (Chi et al., 1996). However, the CMPSLQE will be suspended in 2011 (Qualifying Examination was held for the last time in 2008 and Special License Examination will be concluded in 2011) because, according to the Taiwan's Ministry of Examination, the CMPSLQE has had its historical meaning but does not correspond to modern professional standards:

> Considering that the traditional private training of the doctors of Chinese medicine did not fit well with the social demands for independently arrived professional assessment and official accreditation, the Special Examination for Doctors of Chinese Medicine has been set up as a provisional means to approve the credentials of doctors of Chinese medicine. The Examination has its historical function. However, as the formal education system has begun to offer structured Chinese medical instruction with results becoming steadily in tune with the social expectations and professional standards, the need for the Initial Qualifying and Special Examinations for Doctors of Chinese Medicine has decreased over time. (Ministry of Examination, 2005)

In sum, nowadays Taiwan is acknowledged as a medically plural society where both biomedicine and Chinese medicine are officially recognized healing practices. Western medicine yet dominates the orthodox establishment of health care system (Hsu et al., 2007; Kleinman, 1980; Lew-Ting, 2005). For example, in 2008, Taiwan had 3,160 clinics and 22 hospitals of Chinese medicine, compared unfavorably with 10,326 clinics and 493 hospitals of Western medicine (Department of Health of Republic of China, 2009). Nonetheless, even though the science-based Western medicine has a more predominant voice in the orthodox establishment, Chinese and folk medicine have still been widely practiced by local people (Wu, 1982; Chan, 2005). This situation thus results in the uniquely dual health care system.

The aim of this part of the literature review is to illustrate the sociohistorical background of present dialogue between Western and Chinese medicine which has been taking place since the nineteenth century. In fact, these discussions are still taking place nowadays.

Several statements must be made before continuing further with the literature review. First, I acknowledge the invaluable input of postmodernism and Foucauldian theory as major players in the paradigmatic changes in social sciences and intellectual history at large. The critique of objective knowledge and empiricism has provided a new perspective for understanding the world, including medicine, by allowing scholars to see it as a cultural phenomenon. Second, in this study, I make extensive references to the irreplaceable anthropological scholarship of Chinese medicine. However, I distance from the understanding of Western science and medicine as a universal, modern and progressive entity and Chinese medicine as a traditional and local system. Instead, I will follow social actors and their own understandings about traditional and modern, *xiyi* and *zhongyi*, and about the integration of both. Third, although this study is placed under the context of globalization, the literature review suggests that patterns and processes of globalization vary place to place. Therefore, I refrain from adopting any of the aforementioned perspectives towards globalization of Chinese medicine to Taiwan's context. I will engage in an exploratory and interpretive qualitative study in order to acquire an understanding of the phenomenon.

2.2 Discussing Identity

2.2.1 Conceptual confusion about identity

Although in the history of social sciences and humanities, the modern term *identity* accounts only several decades, its extensive and diverse usage in academic literature makes it an unclear and complicated concept. One can find *national identity*, *race identity*, *gender identity*, *online identity*, *illness identity* and others in anthropology, sociology, psychology, political sciences, cultural studies, communication studies, etc.

Conceptual diversity of identity as an analytical concept has its dual roots in the philosophical traditions of modernism and postmodernism. Modernism was an era of "untrammeled individualism" and the search for individual realization (Harvey, 1990, p. 19). It was also marked by the scientific enquiry focused on the *self*. Thus, modern identity is marked with a search for "real" and "true" self. In contrast, postmodernism introduced an idea that there is no ultimate truth and that people may have diverse perspectives of reality. A new perspective of "freely chosen and multiple identities of the modern self that accepts and affirms an unstable and rapidly mutating condition" (Kellner, 1992, p. 158) has emerged. Postmodernism thus created a new concept of complex, contextual and changing identities.

Intellectual thoughts of modernity and postmodernity have laid the foundation for essentialists' and constructivists' conceptualization of identity in social sciences. Although the essentialists' viewpoint and the search of the real identity had been harshly criticized by constructivists who have theorized about identities as multiple, constructed and changeable (Calhoun, 1994), both perspectives are still present in social scientific studies.

According to Brubaker and Cooper (2000), *identity* in the social sciences encompasses "not only great heterogeneity but also a strong antithesis" (p. 10). It becomes very controversial when taking into account "strong" and "weak" understandings of identity. The former one emphasizes fundamental or abiding sameness over time and across persons, while the latter takes a position rejecting notions of sameness. Brubaker and Cooper (2000) thus argued that *identity* is an ambiguous term and "too torn between 'strong' and 'weak' meanings, essentialist connotations and constructivist qualifiers, to serve well the demands of social analysis" (p.2). They stated that the only way out from this conceptual chaos is to retract the term from the academic vocabulary

overall because it embraces several, and even contradictory, meanings. They thus suggested using three different clusters of terms that are embedded in the word *identity*. Those terms are *identification* and *categorization*, *self-understanding* and *social location*, and *commonality*, *connectedness* or *groupness* (Brubaker & Cooper, 2000). [5]

I argue yet that Brubaker and Cooper (2000) not only have failed to manage the confusion they described, they followed the same path of those they had criticized. Using *categorization*, *self-understanding*, *groupness* and so on does not protect these concepts from being too strong or too weak, and the issue is still stuck between the constructivists' or essentialists' positions. Therefore, it is suggested that, instead of radically removing *identity* – the term that has been used for years in a broad range of disciplines – from scholarship, its meaning should be further clarified according to the context. The main problem of identity research is not whether identity is fluid, negotiated, constructed or originally embedded and persistent. The question is how it is approached.

2.2.2 Identity from the communication perspective

Other scholars have tried to solve the aforementioned conceptual problem of identity differently – by creating a more comprehensive concept. One of the theories trying to widen the understanding of identity is the communication theory of identity (CTI) developed by Michael L. Hecht and his colleagues (see, for example, Jung & Hecht, 2004; Hecht, Warren, Jung, & Krieger, 2005).

CTI emerged out of the research examining the effective intergroup communication and

[5] *Identification* and *categorization* refer to processes of how people define and characterize themselves vís-a-vís known others and situate themselves and others in social categories (such as race, ethnicity, social stratum, gender, etc.). *Self-understanding* and *social location* are dispositional terms referring to a person's sense of who he/she is, of his/her social location, and of how he/she is prepared to act. *Commonality*, *connectedness*, and *groupness* are the terms defining the sense of belonging to a certain group (Brubaker & Cooper, 2000).

has its metaphysical roots in three different cultural traditions. It attempts to "integrate holism from Asian and African conceptions, polarity from the Greeks, harmony from African views, collectivism from Asian ideas, and the individual orientation in the Greek perspective" (Hecht et al., p.257). CTI also has its origins in modernity and postmodernity incorporating the notion of identity located in the individual and the conceptualization of fluid, complex and changing identity, respectively. In addition, CTI has imported the notion of group-based identities and categorization from social identity theory (SIT)[6] and social roles and ascriptions from identity theory (IT)[7]. SIT derives and is closely related with the social cognition theory, and IT follows the tradition of symbolic interactionism. These two theories have set the agenda for theorizing about identity in many academic fields (Hecht, Warren, Jung, & Krieger, 2005). Nevertheless, CTI differs in the dimension of communication.

Although SIT and IT, as well as most of the other identity-related theories, recognize identity as communicated, expressed in the act of communication, they usually do not conceptualize *how* it is communicated. In contrast, CTI conceptualizes the act of communication as part of identity; social behavior is an aspect of self – the enacted identity. That is, "a person's sense of self emerges and is defined and redefined in social interaction" (Hecht et al., 2005, p.

[6] Social identity theory (STI) was developed by Henri Taijfel and John Turner in late 1970s. It is largely influenced by social cognition theory which analyzes how people store and process information. SIT's primary focus is on cognitive and motivational basis of intergroup differentiation and on identity formation as a product of social categorization. Social categories can be understood as parts of structured society, such as gender, ethnicity, religion, political affiliation, age group, etc. According to this theory, individual has several selves, or several social identities. In the different social contexts individuals think, feel, or act on the basis of his personal, family, or national level of self (Hogg, 1993; Turner, 1991).

[7] Identity theory (IT), one of the most influential theories in identity research, was developed by Sheldon Stryker in the 1970s. This theory conceptualizes identity in terms of role relationships. The self is seen consisting of many identities, each of which is based on a certain social role, such as a father, a teacher, a priest, etc. It also incorporates the meanings and expectations associated with a certain role and its performance (Stets & Burke, 2000).

260). It is also important to note that "the mutual interaction between an individual and society is reflected in identity… [I]dentity can be regarded as a pivotal point interrelating individual with society" (Hecht et al., 2005, p.260). In other words, communication is seen as a process constructing or reconstructing identity which is relational and discursive.

CTI posits that identity consists of four layers (Jung & Hecht, 2004; Hecht et al., 2005). The *personal layer* refers to the individual as a locus of identity. It appears as self-concepts and self-images (e.g., "I am a tolerant person"). The *relational layer* is where relationship is the locus of identity. Relational identity has several levels. For example, individuals may develop and shape their identities through internalizing how others view them; individuals also identify themselves through their relationships with others in terms of social roles (i.e., a spouse, a friend, a boss, a doctor, etc.). The *communal layer* refers to a group as a place where identity exists; members of a group establish common group identities, share same characteristics and collective memories which form a content of the group's identity. The *enactment layer* refers to communication as a locus of identity. Identity is enacted in social behavior and symbols; self is seen as a performance, as expressed.

These four layers are perspectives to a whole, integrated identity. They are interpenetrated in a number of ways. In some situations, the layers are complementary. In other situations, they may contradict each other. Nevertheless, even if the layers contradict each other, they coexist and compose a complex identity. Hecht and his colleagues (Jung & Hecht, 2004, 2008; Hecht et al., 2005) proposed that the four layers can be seen as functioning independently for analytical purposes. However, a concurrent analysis of two, three or all four would enrich the research (Jung & Hecht, 2004).

Jung and Hecht (2004, 2008) analyzed interconnection of personal-enacted and personal-relational identity layers. The researches were conducted in the communities of university students (Jung & Hecht, 2004) and Korean immigrants (Jung & Hecht, 2008). Research results indicated that discrepancies between identity layers are significantly related with communication outcomes, such as communication satisfaction, different levels of depression, feeling understood, conversational appropriateness, etc.

Wadsworth, Hecht and Jung (2008) discussed personal-enacted and personal-relational identity interpenetration among international students in the United States and how this interpenetration was related to educational satisfaction. Acculturation and perceived discrimination were found to be important factors to the formation of discrepancies, or identity gaps, between or among the layers.

CTI offers a theoretical basis for this research, in which identity is seen as enacted, relational and consisting of multiple but interconnected elements. I adopt CTI's perspective that communicative acts are a part of identity, not only a medium for identity expression. This study yet does not aim to introduce the overall picture of identity of an individual. Here I will focus on the professional identity of Chinese medical practitioners (which directs to the relational layer) and its enactment during the medical practice. Nevertheless, if any elements of personal and group identity appear to be salient and influencing professional identity, they will also be taken into consideration.

Professional identity informs practice and influences behavior in a workplace and is tightly related to social roles. Banton (1965) suggested that "a person's role is a pattern of social behavior that appears appropriate to the expectations of others and to the demands of the situation"

(as cited in Hecht et al., 2005, p.260). Thus roles form identity. Identity is built in opposition to and in relation to others (Charon, 1992). In medicine, for example, professional identity may include teamwork, relationships with patients and colleagues, communication, moral, ethical and clinical decision making, and engagement with professional development (Griffin, 2008; Jones & Green, 2006). The role *doctor* also prescribes an expected behavior attached to the position (Lynch, 2007). In other words, being a Chinese medical practitioner defines a certain identity based on a social role with particular values, duties and responsibilities, and determines a particular behavior.

However, the identification in terms of social role merely highlights what the relationship with surrounding society people have in a consistent form (for example, duties, obligations, responsibilities, rewards, expectations, etc.) (Davies & Harre, 1990). It does not reflect *how* identity is constructed and negotiated. In the next section, I will introduce the concept of *positioning* which provides an analytical tool for understanding identity not only in terms of structure but also in terms of processes.

2.2.3 Positioning and identity construction

The research under structural-functionist tradition has concentrated on social roles and identity as fixed components of complex structures which define social behavior. Scholars representing symbolic interactionism tradition have paid more attention to the way identity emerges in social interaction (Lynch, 2007). Positioning theory originated in discussion of limitations of social role. Davies and Harre (1990) argued that relationships defined merely by social roles, such as

mother-son, teacher-student, doctor-patient, etc., are relatively static categories and fail to represent how these relationships are actually experienced and enacted by their participants.

Shotter (1996, as cited in Linehan & McCarthy, 2000) suggested that there are many different ways in which people can relate themselves to their surroundings. Positioning theory, developed by Harre and his colleagues (Davies & Harre, 1990, 1999; Harre & Van Langenhove, 1991), focuses specifically on how people relate themselves to their surroundings. According to Davies and Harre (1999), "an individual emerges through the process of social interaction not as relatively fixed end product but as one of who is constituted and re-constituted through the various discursive practices in which they participate" (p. 35). In social interactions, individuals position themselves in relation to the surrounding social context. According to Davies and Harre (1999), positioning thus is:

> [T]he discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced storylines. There can be interactive positioning in what one person says positions another. And there can be reflexive positioning in which one positions oneself. (p. 37)

It is worth noting that people position themselves not merely through conversations. In positioning theory, the understanding of discursive practice includes language-like sign systems (Linehan & McCarthy, 2000). Social acts through which people position themselves consist of conversations, institutional practices and societal rhetoric (Harre & Van Langenhove, 1991). This requires "a focus on an ongoing discursive process … which is influenced by the history of interactants and the kind of storylines that the community has produced and through which selves are enacted" (Linehan & McCarthy, 2000).

Hsu and Lin (2006) employed the concept of positioning for analyzing interpretation of SARS in Taiwan's printed media. Their study indicated that Chinese and Western medical experts used different positioning strategies to interpret SARS. Nonetheless, both Chinese and Western medical representatives employed scientific evidences to defend their positions. It was also found that the content and dynamics of positioning were influenced by Taiwanese policy towards Chinese medicine and folk practices as well as by long-term self perception of practitioners.

In another study, Hsu and Wang (2007) analyzed positioning in the controversy related to aristolochid acid. The analysis of dynamics of positioning and power struggle between Chinese and Western medicine revealed multiple identities of Chinese and Western medical practitioners/experts. It was found that positioning was an important tool in creating or re-creating group identity as reflected in the news discourse.

The concept of positioning offers a dynamic model of identity construction where social actors identify themselves in a particular context through active positioning in relation/opposition to elements in their discursive sociocultural context (Linehan & McCarthy, 2000). Nevertheless, social actors do not necessarily build a unified identity during these processes. Their positions, and thus identification, may change with the discursive shift and the emergence of new storylines (Davies & Harre, 1990). This concurs with the CTI's perspective of multiple layers of identity which may either enhance or contradict each other (Jung & Hecht, 2004).

However, just as the majority of identity-related approaches, Davies and Harre's conceptualization continues to see identity as being created and negotiated *through* social interactions and communication. Here I adopt CTI's approach that identity is not only

communicated and expressed in the social relationships; more than that, social behavior is seen as a part of identity. The way Chinese medical practitioners act and communicate is thus also perceived as a part of their professional identity.

Based on CTI's communicative approach towards identity and employing positioning as an analytical tool, this study aims to understand how Chinese medical practitioners construct and negotiate their professional identity, be it perceived or enacted, within their discursive practices related to Western medicine. The answer to this question will contribute to a better understanding of some patterns and processes taking place in the meeting of Western and Chinese medicine in Taiwan's health care system.

3. Method

The perspective on identity as enacted and emergent points to the realm of communication. In this study, processes of communication are seen as a site where identity can be grasped. Accordingly, I examined communication processes taking place in the meeting between Chinese and Western medicine through a case study of a selected Chinese medical clinic. I employed participant observation and in-depth interviews to study the culture of the clinic. This chapter explicates the methodology of the research.

3.1 Introducing the Case: Yusheng Chinese Medical Clinic

Yusheng Chinese Medical Clinic (育生中醫診所) was chosen for this case study following logics deviant, or extreme, case sampling. According to Patton (2002), deviant case sampling is used for selecting cases that exemplify characteristics of interest and are information rich because "they are unusual or special in some way" (p. 231), for example, outstanding successes or notable failures, exotic events, crises, etc. Yusheng Clinic is considered as exemplifying characteristics of interest. The main criterion was a noticeable meeting between Chinese and Western medicine taking place in this clinic.

Yusheng Clinic was established by Dr. Chen-Yu Lee (李政育) in 1977. Lee graduated from National Chengchi University as journalism major in 1973. While pursuing studies in the university, he individually studied Chinese medicine. In 1978, Lee obtained his license of Chinese Medicine Physician. Apart from the position of a senior doctor and a director of Yusheng Clinic, Lee is an honorary chairman of Taiwan's Neurological Association of Integrated

Chinese and Western Medicine. He has also been a visiting professor and a research fellow in several schools in Taiwan and China. Along with the medical practice and involvement in educational activities and research projects, Lee publicizes his medical writings. His works often introduce diseases and their treatment from integrated Chinese-Western medical perspective.[8] Lee's involvement in the integration of Chinese-Western medicine is also represented by Taiwan's media (see, for example, Wan, 2008; Zhang, 2008; Li, 2010).

On the one hand, Lee is known as an innovative Chinese medical practitioner (Altschuler, 2005). On the other hand, he is recognized as a representative of traditional transmission of knowledge and practice (Zeng, 2003).[9] Having acquired his skills by self-study and apprenticeship, Lee promotes this form of knowledge transmission by accepting and tutoring students in the clinic.[10] Therefore, it is expected that the medical theory of Chinese-Western medicine integration advocated by Lee has been transmitted to his students and co-workers, emergent in daily medical practice and might be related to the professional identity construction. The intriguing questions yet arise here: Why is there a need to integrate Chinese and Western medicine? What is meant by *integration of Chinese and Western medicine* in Yusheng Clinic? How does it manifest in the daily practice? How is this integration reflected in professional self-identification of the Chinese medical practitioners?

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[8] For example, *Theory and Practice of Chinese-Western Medical Exchange*, *Practical Geriatrics of Chinese and Western Medicine*, *Series of Chinese and Western Medicine Consultation: Insomnia*, *Neuropathy: Integrated Chinese-Western Medical Therapy*, to name just a few.

[9] According to Hsu (1999), traditional transmission of knowledge and practice is based on "the personalities of mentor and follower and their choice to maintain personal relationship of mutual trust within which the follower acquires medical knowledge and practice" (p. 2).

[10] Since 1982, the number of students has reached almost ninety.

It is important to note though that this case study does not aim to represent Taiwan's Chinese medical circle at large. However, it does not lose relevance because generalizations of results are theory-based (Yin, 1994). In addition, the medical theory and practice advocated by Lee is not limited to one person or one clinic. It is disseminated through publications, media and educational activities. Accordingly, I suggest that findings of this research will reveal not only processes and patterns in one particular clinic; they can also be seen as representing one of the ways of coexistence of the two medical systems in Taiwan.

Presently, the clinic has ten full-time employees[11] and several students of Chinese medicine.[12] Participants of this study were limited to employees and students who are directly involved in patient consultation and treatment (diagnostics, medicine prescription, acupuncture, etc.) and have been working/studying in the clinic for at least three years. In addition to the senior doctor Chen-Yu Lee, three other persons meet these criteria: Lin (physician's aid), Thomas (student), and Mike (student)[13]. Table 1 provides more detailed introduction of the research participants.

[11] The staff of Yusheng Clininc includes one licensed Chinese medicine physician, one physician's aid, one manager, one accountant, two stock managers responsible for ordering and processing raw herbs and other medicines, and five staff members responsible for compounding prescriptions.

[12] The number of students and their schedule of coming to the clinic are not fixed. During the research period, I met five of them.

[13] I use pseudonyms for protecting participant's privacy. Dr. Chen-Yu Lee's name is used unchanged with his permission.

Table 1.

Profile of Research Participants

Name	Gender	Age	Nationality	Position	Education	Years in Yusheng Clinic
Lee	Male	58	Taiwan (ROC)	Chinese Medicine Physician	Apprenticeship and self-study	33
Lin	Male	45	Taiwan (ROC)	Chinese Medicine Physician's Aid	Apprenticeship and self-study	22
Mike	Male	28	USA	Student	Apprenticeship and self-study, Master Degree in Chinese Medicine at Liaoning Chinese Medical University (PRC)	5
Thomas	Male	39	France	Student	Apprenticeship and self-study	11

3.2 Data Collection and Analysis

Data were collected by employing methods of participant observation and interviewing. According to Berger (2000), observation gives a contextual knowledge and helps to find out what people do; interviewing helps getting insights into people's motivations of certain behaviors. The former one embraces *present*, *actions*, *context*, and *seeing*; the latter – *past* and *present*, *attitudes*, *motivations*, and *hearing* and *probing* (p. 113). Two different methods of data collection provide an opportunity to compare and to triangulate the results and thus to increase the credibility of the

study (Patton, 1990).

In this research, the observation helped me to gain primary insights on routine activities of the participants in the research setting and allowed me to collect data from real-time situations, as suggested by Schensul, Schensul and LeCompte (1999). The fieldwork took place in two one-week periods in November, 2009 (see Appendix A). During the first period, I was only observing (without asking any questions related to the research topic) for finding out how and in what kind of natural situations the practitioners engage into discourses/actions related to Western medicine. In-between observations, I summarized these discourses/actions in order to grasp the most emergent ones. During the second observation period, I engaged into conversations and informal interviews in order to find out practitioners' motivations for certain behaviors. For example, during the first period, I observed that it was common to refer to biomedical diagnostic tests when consulting patients. During the second observation period, I then asked the practitioners of their reasons for employing these tests.

Social interaction also incorporates material evidences since artifacts can be also interpreted as a form of discourse constructing social relationships and identities (Hodder, 1994). Thus, artifacts were also included in the analysis when they appeared relevant to the research topic.

In addition to being a valuable technique of data collection, participant observation provides the context for developing interview guidelines (De Walt & De Walt, 2002). During the observation time, due to the time constraints and busy practitioners' schedules, sometimes it was hard to attain comprehensive answers. To complement this, I conducted unstructured in-depth interviews (see Appendix B). The main goal of the interviews was to get a deeper understanding

of how practitioners define their main duties, responsibilities, challenges, etc., how they relate/separate themselves from Western medicine, and how they perceive and practically implement the so-called *integration of Chinese and Western medicine*. In short, interviews provided in-depth understanding and background for interpreting the practitioners' behaviors and discourses, as suggested by Lindlof (1999).

The method of participant observation is not without obstacles. For most of the researchers going into the field, the first problem is getting access to a social group to be studied (Shaffir & Stebbins, 2001). Before starting the participant observation, I was a student of Chinese medicine for five months (once or twice a week) in Yusheng Clinic.[14] This allowed me to conduct the research escaping an outsider's status, which usually negatively affects observer's immersion into community (Schensul, Shensul, & LaCompte, 1999).

The other obstacle usually encountered by observers is the use of different languages (Schensul, Shensul, & LaCompte, 1999). Mandarin Chinese, Taiwanese Hokkien and English are the three languages spoken in Yusheng Clinic. Communication with patients is usually in Mandarin Chinese and Taiwanese Hokkien. Foreign students communicate among themselves in English. English is also the most common language used with foreign patients. I possess good skills in Mandarin Chinese and English. Before starting the research, my main concerns were related to Taiwanese Hokkien because I have no knowledge of this dialect. Luckily, the practitioners communicated with patients in Mandarin Chinese in my presence at most times.

According to Hammersley and Wilkinson (2007), before organizing and analyzing the data,

[14] As a student in Yusheng Clinic, I learned to recognize medical herbs, assisted with processing of raw herbs and compounding of prescriptions, helped to change moxa or to remove acupuncture needles, etc. Some of these activities were also carried out during my participant observation.

the researcher has to decide whether a full transcription is necessary. I reduced the collected data to the context of the meeting between Western and Chinese medicine, taking into consideration every remark, dialogue, conversation, action, or the use of an artifact which fits into the research questions. In terms of the interviews, I made full transcriptions. In the next stage, I approached the data inductively, looking for the most salient themes in the field records and interviews, respectively. The themes were developed using *cutting and sorting* technique which "involves identifying quotes and expressions that seem somehow important and then arranging the quotes/expressions into piles of things that go together" (Ryan & Bernard, 2007, p.94). In addition, this technique allowed analyzing both textual and nontextual sources (Ryan & Bernard, 2007).

3.3 Stance of a Researcher and Ethical Concerns

As suggested by Kawulich (2005), "the degree to which the researcher involves himself/herself in participation in the culture under study makes a difference in the quality and amount of data he/she will be able to collect" (par.21). Gold (1958, as cited in Lindloff, 1995) developed a typology of researcher's roles which is still widely used in qualitative research. The typology includes four roles: *Complete observer*, *participant-as-observer*, *observer-as-participant*, and *complete participant*. Each role encompasses certain actions, obligations and rights. At the same time, it "has a situated character: adjustment of the self to specific people in specific situations" (Lindlof, 1995, p. 140). My role as a researcher in this study was highly predetermined by situational factors and the culture of Yusheng Clinic. A short introduction of my stance thus follows as it is closely related to the ethical decisions.

The status of complete observer is hidden. Just like a complete participant, a complete observer is not recognized as a researcher in social relationships. The main difference between two is that the latter one has no meaningful contacts with the human subjects (Lindlof, 1995). In Yusheng Clinic, the role of complete observer was not allowed by the circumstances as it was impossible to observe the setting without being noticed. In addition, this role possesses the highest degree of subjectivity as the data collected are based only on an observer's perspective (Lindlof, 1995).

For an observer-as-participant, observing is the main purpose of the research agenda; members of the observed culture are aware of the ongoing research but the researcher is not engaged in an intimate, prolonged study of the culture. Taking a role of observer-as-participant usually allows for making conclusions about communicative actions but it falls short of explaining meanings behind these actions, crucial to interpretive social sciences (Lindlof, 1995). However, the aim of this research is not only to describe the enactment of identity but also to explain the causes of certain types of enactment. Therefore, the tools available for a complete observer and an observer-as-participant are not sufficient for implementing the objectives of this research.

My status of a student in Yusheng Clinic predetermined my role of a participant-as-observer during the fieldwork. Accordingly, "the responsibilities that go with 'real' participation in the group are not full and binding"; normal rules do not apply for a researcher (Lindlof, 1995, p. 145). During the observations, I assisted in the acupuncture area or at the prescription compounding table. However, I could take field notes when needed, freely moved in the research setting or shifted from one activity to another. This would not be possible for a

complete participant that is a fully functioning member of the observed culture and his/her acting as a researcher is unknown by others in the field. In addition, complete participation usually interferes with ethical issues as human subjects are not aware of the research interests.

Kawulich (2005) suggested that the primary consideration in any research is to conduct the research in an ethical manner. First of all, a researcher needs to let the community know about an ongoing research and the purpose of observations. Moreover, DeWalt and De Walt (1998) suggested that one should constantly introduce oneself as a researcher. To do so, they further advised researchers to make some notes and records on the spot, raising and reinforcing participants' awareness of the ongoing observation. In this study, I informed the clinic personnel about the research in advance and repeatedly reminded them during the participant observations. Moreover, I took field notes directly on site, making the participants aware of my research without contravening their expectations. In addition, the informed consent of participating in the research was acquired from all employees and students in the clinic.

One of the most ambiguous ethical issues in this research concerns patients which were not informed about the ongoing research. Nevertheless, Lindlof (1995) suggested that ethical correctness can be situational and that in some situations,[15] it is ethically acceptable not to reveal the researcher's status. My choice for concealing the researcher's status from the patients had several reasons. First, the patients were not the subjects of inquiry. My focus was on the behaviors and discourses of the practitioners. Second, I took into consideration that my presence as a researcher might have interfered with patients' disclosure of private information about their

[15] The situations include the following: the social sensitive group is studied; it is awkward to proffer informed consent forms; the people are not the main subjects of the research; the research set is a public place; or the subject is anonymous to the researcher (Lindlof, 1995).

illnesses and, accordingly, would have affected the treatment. Third, when patients had questions about my presence in the clinic, they usually asked the practitioners and other employees which were introducing as one of the students. I thus considered it awkward to introduce myself as a researcher in these situations. In a word, I believe that the choice of concealing the researcher status did not infringe patients' rights.

De Walt and De Walt (1998) further suggested that the researcher should share the research results with the observed community for reinforcing accuracy of the findings. I discussed the findings with the participants from time to time during or after my participant observations. Furthermore, I also delivered one copy of the final write-up to Yusheng Clinic.

4. Results

4.1 Primary Observations

Yusheng Chinese Medical Clinic is situated in the central area of Taipei city. Its space occupies two floors of the twelve-storey building. The very first thing one learns about the clinic is a strong scent of herbs that can be smelled even in the arcade area outside the building. The scent floats from the lower floor of the clinic where crude medicines[16] are stored and processed using centuries-old methods of soaking, cutting, grinding, frying, etc. This is also where herbal compounds are brewed and turned into broth taken by the patients.[17] The upper floor has areas of reception, consultation, prescription compounding, acupuncture, etc. I spent most of my observation time in the consultation and acupuncture areas. In-depth interviews took place in the meeting room (see Figure 1 for the setting layout).

The reception area is the first place one gets in when entering the clinic. Just behind the registration desk, there is a long and narrow prescription compounding table and a wooden shelf with many drawers, labeled by names of different Chinese medicines. On the left side of the entrance, there is a consultation area with a big desk in the middle. Behind the consultation desk, one can easily notice a wooden board with an inscription which reads: Literati Doctor Chen-Yu Lee (儒醫李政育) (see Figure 2).

[16] A crude drug is unrefined medication in its raw or natural form derived from organic or inorganic material such as plant, animal, bacteria, organs or whole organisms.

[17] In contrast, nowadays most of the Chinese medical clinics in Taiwan use processed powders (科學中藥). However, there are some controversies about these concentrated powders. See http://zh.wikipedia.org/wiki/%E7%A7%91%E5%AD%B8%E4%B8%AD%E8%97%A5

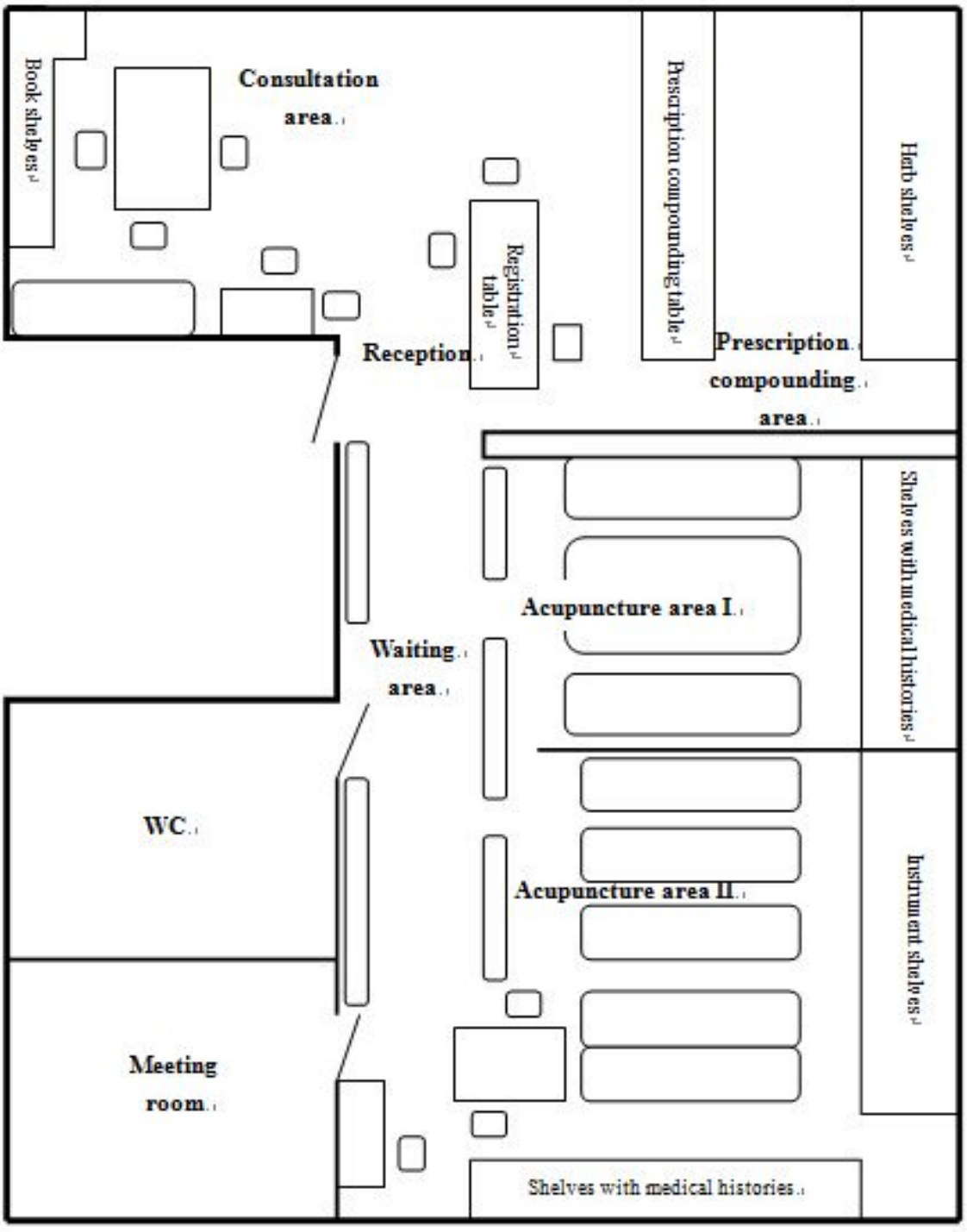

Figure 1. Layout of the research setting.

On the right side of the entrance, one can see an oblong space partitioned into two acupuncture areas with three and five acupuncture couches in each respectively. Long shelves placed along the walls of the acupuncture area contain patients' medical histories, acupuncture and moxibustion tools, and medicines for external injuries.

The clinic opens at 10 a.m. from Tuesday to Saturday. During my participant observations, the routine clinic activities took place as follows: Patients were referred to the registration desk first. The assisting personnel looked for or established their medical histories which were handed to the senior doctor Lee in the consultation area. Nevertheless, during the busy hours, patients were examined by the physician's aid Lin or by the students, Thomas and Mike, before consulting the senior doctor. After examinations, medical histories were sent to the prescription compounding table. Patients then proceeded to the acupuncture area. If no acupuncture was prescribed, patients would wait while medicines were prepared.

Figure 2. Picture of a wooden board with the inscription of Dr. Lee's name and title.

At a glance, Yusheng Clinic may look like a very traditional Chinese medical clinic where the senior doctor carries a classical title *ruyi* (儒醫, literati doctor),[18] where natural crude medicines are used for the treatment (see Figure 3), and where patients' records and prescription formulas are kept in a handwritten form.[19]

Figure 3. Picture of herbal compounds.

[18] *Ruyi* (儒醫, literati doctor) is one of the most classical titles of a Chinese medicine doctor.

[19] In contrast, many Chinese medical clinics employ computer programs for making prescriptions and keeping patients' records.

However, a closer look at the surroundings and practices enabled me to capture more features characterizing Yusheng Clinic. For example, in the center of acupuncture area, there is a glass closet with Chen-Yu Lee's publications. Some of them are written in the context of integration of Chinese-Western medicine. Furthermore, during consultations, the practitioners tended to use biomedical terminology to communicate with patients and often times referred to biomedical diagnostic tests brought by the patients. Moreover, on the bookshelves of the clinic, one could find not only Chinese medical books but also anatomy atlases, pharmaceutical handbooks, biomedical dictionaries and encyclopedias. In addition, Western medicine-based sources were often employed by the practitioners to explain diagnosis. These observations thus raised intriguing questions: Why do the Chinese medical practitioners need to refer to biomedical tests and books? Why do they use biomedical terminology so extensively?

I observed that Western medicine-related discursive practices occurred mostly in the following contexts: professional obligations, issue of confidence, and discourse related to medical theory. These contexts have been chosen as the primary analytical categories. The following discussions highlight how the practitioners positioned and identified themselves with regard to Western medicine.

4.2 Professional Obligations

4.2.1 Correct diagnosis

During the participant observations, I noticed that the practitioners of Yusheng Clinic not only

employed Chinese medical diagnostic techniques,[20] but also referred to biomedical diagnostic tests, such as blood tests, urine tests, x-ray images, MRI scans, etc. For example, during a consultation observed on November 10, 2009, a female patient P3[21] was first examined by Lin, a senior physician's aid. Lin began examination by asking (*wen zhen* 問診), then he followed by referring to biomedical test results brought by the patient. The senior doctor Lee examined P3 in the same order. First, the patient was asked to describe her symptoms and daily routines. Hereafter, Lee referred to the check-up results and asked an assistant to make a copy to be attached to the patient's medical history. Finally, Lee took the pulse (*ba mai* 把脈) and prescribed a compound formula (participant observation, November 10, 2009). In fact, on the same day of my fieldwork, the practitioners referred to biomedical tests in eight of nineteen consultations. In addition, on November 14 and 24, 2009, two patients without having blood tests were asked to go for a check-up and bring their test results during next visits.

All practitioners provided similar answers when being asked about the need to employ biomedical tests in the practice of Chinese medicine. The professional obligation of making a correct diagnosis was named as the main reason for adopting biomedical diagnostic tools. For example, during the interview on December 15, 2009, Lin put it:

> Western medicine is easy to use, especially laboratory tests. However, our understanding of human body from the perspective of molecular biology is still in its early stage of

[20] Traditionally, there are four main diagnostic methods in Chinese medicine, called *Four Examinations* (*si zhen* 四診), which consist of looking (*wang zhen* 望診), listening/smelling (*wen zhen* 聞診), asking (*wen zhen* 問診), and touching (*qie zhen* 切診). The most widely used technique of *qie zhen* is taking the pulse (*ba mai* 把脈) (Kaptchuk, 2000).

[21] I coded the patients in the sequential order.

development. Thus, we can employ Chinese medical methods to fill the gap. Both Chinese and Western diagnostic methods represent the progress of human civilization. We all can make a good use of them without dividing into Chinese and Western…. The most important is to make a correct diagnosis. (Personal interview, December, 15, 2009)

On the one hand, Lin's explanation shows that the development of both Chinese and Western medicine is seen as a representation of the progress of human civilization. On the other hand, Chinese medical system is perceived as more sophisticated and mature than the Western one. Biomedicine is positioned as being unable to provide a comprehensive understanding of human body functioning. The advantages of biomedical diagnostic tools are yet recognized for their convenience.

The diagnostics-related discourse and practice indicate the pragmatic nature of integration of Chinese and Western medicine in the practice of Yusheng Clinic. Such pragmatism seems to have its roots in the perception of professional obligations. Making a correct diagnosis has been a normative obligation ascribed to a physician in many societies (Lynch, 2007). Lin's statement that "the most important is to make a correct diagnosis" echoes this notion. The driving force for the integration of biomedical diagnostics thus derives from the internalized social role.

In sum, although the practitioners positioned Chinese medicine as superior to biomedicine in terms of understanding the functioning of human body, using laboratory tests along with Chinese medical diagnostic techniques was found an integral part of the medical practice in Yusheng Clinic. Western medical diagnostics were defined as a tool helping to achieve one of the most important goals in a physician's job, that is, a correct diagnosis. This suggests that the perceived social role is enhanced in the practice by employing several possible means for implementing

professional duties. In other words, the relational identity seems to be complementary with the enactment layer in the context of diagnostics.

4.2.2 Effective communication with patients

Another reason for using biomedical test results has to do with the physician-patient communication. When being asked the same question why biomedical check-up results are employed in the Chinese medical practice, Thomas answered:

> Biomedical tests are for confirming, maybe for making patients more confident …. If you just tell them, "Ok, I will give you this formula and everything will be fine," they'll still think it's not enough. They still want to know where the exact problem is in terms of scientific Western standards. When I say *scientific Western*, I put it together because Chinese medicine, of course, is also scientific but, for many people, science is related only to Western medicine. (Personal interview, December 16, 2009)

Apart from being practically convenient, biomedical diagnostic tests thus become a strategic mean for effective communication with patients. Thomas claimed that Chinese medicine is as much scientific as Western medicine. However, he also perceived it is common to attribute the term *scientific* merely to Western medicine. The disparity between the practitioner's identification of Chinese medicine and his perception of how the society views Chinese medicine is obvious. Under these circumstances, the practitioners learn to adapt their medical practice to the societal context.

In addition, I observed that all four participants used both Chinese medical and biomedical terms when communicating with patients. Most of the times, diagnoses were introduced using

biomedical terms first and then followed by explanations from the Chinese medical perspective. Sometimes the latter ones were simply absent. For example, after the examination of a female patient P20, Dr. Lee indicated that she had Meniere's disease, or vertigo. Then he took *Harrison's Principles of Internal Medicine*, a biomedical textbook, and let P20 read about this disease. Only then did Lee add, "In Chinese medicine, it is called *zu tai yin tan jue tou teng* (足太陰痰厥頭痛)." Thereafter, he handed to P20 his own article *Vestibular Vertigo Treatment in Chinese Medicine* (耳性眩中醫療法), which introduces the disease from both Chinese and Western medical perspectives (participant observation, November 11, 2009).

When asked about the biomedical terminology, all four practitioners emphasized that it is not important what kind of terms are used. Clear explanations and patients' comfort were named as top priorities in their communication with patients. As Thomas said, "Both [terminologies] are fine. I mean, as long as diagnosis is correct. The point of the explanation is to make a patient understand" (personal interview, November 11, 2009). The four practitioners also acknowledged the fact that people in Taiwan are more familiar with biomedical terminology. Lin indicated that "the most important is to make lay people understand…. If a patient has high blood pressure, we say 'high blood pressure.' Why do we use the term 'high blood pressure?' Because it is often introduced on TV" (personal interview, December 15, 2009). Mike explained further:

> We have to work with Western medicine for a lot of reasons. Well, for one, to make patients feel comfortable. Because they are so familiar with Western medicine just as it is presented in the media.… But it depends also on a patient. So, I mean, you need to be able to explain it to the patient in the way they would feel understanding and comfortable about what you're

saying. (Personal interview, December 17, 2009)

Along with the biomedical terminology, the practitioners employed additional materials for explaining diagnoses, such as anatomical charts or medical books. For example, in the consultation area, one can find a big nervous system diagram rather than acupuncture point chart as expected in a Chinese medical clinic (see Figure 4). Thus, artifacts that can be originally ascribed to Western medicine are also used in Yusheng Clinic for providing clear explanations and improving communication with patients.

Figure 4. Picture of the spinal nervous system chart.

Previous studies (see Hsu & Wang, 2005; Hsu et al., 2007) indicated that Western medicine has the predominant voice in Taiwanese media. The practitioners in Yusheng Clinic were aware of this situation. They adapted themselves to the situation by integrating biomedical terminology into the Chinese medical practice. The aforementioned discussion regarding communication with patients uncovered a new factor influencing professional identity construction. The employment of biomedical terminology seems to be imposed by social circumstances. Nevertheless, it is also perceived as a way of implementing one of the professional obligations – effective communication with patients.

In the context of diagnostics and communication with patients, practitioners' professional ideal of being a good physician rather than a *Chinese* medicine physician was emphasized. For example, during a break between consultations, Lee asserted, "The patient is one and the same. The medicine is not separable into Western and Chinese. The difference lies only in terminology" (participant observation, November 25, 2009). Mike echoed Lee's notion, "There is no Western and no Chinese medicine; there is only one medicine. We have to think what is the best for the patients" (personal interview, December, 17, 2009). Thomas also expressed similar opinion, "The most important is not to make difference between Western and Chinese medicine, but to be a good doctor and to do your job properly." He also added, "Being a good doctor means being with the patient, being with people" (personal interview, December 16, 2009).

One may ask: Can employment of biomedical diagnostic results be seen as a part of the practitioners' enacted identity? Or is it merely a strategic tool for adopting themselves in Taiwan's health care system dominated by Western medicine? Based on the discussion above, I argue that the integration of biomedical diagnostics and terminology into the medical practice of

Yusheng Clinic is more than simply an adaptation or surviving strategy in Taiwan's health care system. Although such integration might have been informed by situatedness in the society which is more familiar with Western medicine, it is also rooted in the internalized image of being a good physician. The internalized professional obligations justify and warrant the introduction of biomedical diagnostics and terminology into the practice and thus create new features in professional self enactment of the Chinese medical practitioners.

In sum, the usage of biomedical diagnostics and terminology became inseparable attribute of the medical practice in Yusheng Clinic. The practitioners of Yusheng Clinic tried to attenuate the tension between Chinese and Western medicine, as induced by the latter's hierarchically superior status, by appealing to physicians' professional obligations. However, as Harre and Van Langehove (1991) pointed out, when the content of a position is defined merely in terms of rights, duties and obligations, positioning process is usually unstable. The following discussion highlights how positioning of Western medicine alters when it comes to the context of treatment.

4.2.3 Optimal treatment

Along with the correct diagnosis and appropriate communication with the patients, the effective treatment was named as one of the main obligations of a good physician. Nevertheless, the discourse with Western medicine in the context of treatment had a different tone and uncovered new features of practitioners' identity.

The practitioners of Yusheng Clinic perceived Chinese medical treatment as being more patient-centered. This was reflected in their criticisms against some normative biomedical standards. For example, during the consultation of an elderly patient P9 with high blood pressure,

Lee asserted that it is normal for elderly people to have higher blood pressure. He also added, "You cannot use the same standards for those who are eighteen years old and those who are your age. Many Western medicine doctors treat all patients as if they were eighteen years old by using the same standards" (participant observation, November 10, 2009). Thomas expressed similar criticism, "The patients you have here in Taiwan are completely different from those that you have in China, in France, or in the States. But Western medicine standards and drugs are pretty much the same everywhere" (participant observation, November, 21, 2009). The above opinions indicate that the practitioners perceived Chinese medicine as being more flexible and more patient-centered.

The practitioners of Yusheng Clinic also emphasized that, unlike biomedical drugs, natural Chinese medicines have less or no side effects and at the same time they can reduce side effects caused by Western ones. I observed that the practitioners would often ask their patients whether they took any biomedical pharmaceuticals. Some patients would bring their prescriptions given by Western medical doctors. Dr. Lee would examine side effects and explain them to the patients. Accordingly, he would change his own prescriptions in order to reduce side effects. In some cases, Lee would suggest cutting Western medicines off immediately or by gradually reducing the dosage.

During my observations, I also discovered that the practitioners would emphasize the absence of proper biomedical treatment for curing many diseases. For example, during the consultation of a diabetic patient P35, Lee said, "Western medicine does not have drugs to cure [diabetes]. The best it can do is to observe" (participant observation, November 14, 2009). In fact, this statement was repeatedly made when consulting patients with some immune system diseases,

psychosomatic disorders, nervous system dysfunctions, eye problems, etc. This shows that Western medicine is positioned differently in the treatment-related discursive practices. It was described as harmful and less advanced.

In addition, Western medicine's failure to provide an effective treatment was contrasted with Chinese medical treatment. During one conversation, Lee stated, "Most of the patients come here because Western medical treatments fail" (participant observation, November 26, 2009). In contrast, Chinese medical treatment was highly praised. As Mike put it:

> We can treat almost anything with Chinese medicine. Before I've studied Chinese medicine, I was under the impression that Chinese medicine is very good at treating more chronic or systemic diseases, and kind of end-stage diseases where Western medicine had given up. And that's true, of course. But now what I believe is that Chinese medicine is good for treating everything. I mean, acute diseases, traumas, any type of them. (Personal interview, December 17, 2009)

Judged from the above, Chinese medical treatment is clearly opposed to the Western one as being more effective and more patient-centered. The practitioners expressed confidence, pride, and competency about their treatment. Beliefs about the ability to cure a much broader range of diseases, harmlessness, and adoptability were found to be the main aspects underlying the perceived treatment superiority. In this context, the importance of being a *Chinese* medicine physician acts in concert with the role of a *good* physician.

In many societies, including Taiwan, Chinese medicine is usually labeled as complementary to biomedical treatment (Hsu & Lin, 2005). In contrast, the practitioners of Yusheng Clinic perceive it as substantive and independent. The analysis has shown that the practitioners

positioned Chinese medical treatment as superior to biomedical one. Such superiority manifested itself in criticisms against the inflexibility of biomedical standards, side effects, and the absence or failure of biomedical treatment. Accordingly, the belief that Chinese medicine can provide a better treatment is reflected in the practice: Only natural medicines are used in the Yusheng Clinic.

The practitioners' internalization of professional duties and obligations (namely, clear diagnosis, effective communication with patients, and optimal treatment) defined their medical practice. In other words, practitioners' perception of their social role was enhanced in the enactment layer by integrating Western medicine in diagnostics and terminology and by rejecting it in the realm of treatment.

4.3 Issue of Confidence

The aforementioned discussion shows that the practitioners of Yusheng Clinic tended to be highly confident about Chinese medical treatment. However, their perception of how the local society assesses Chinese medicine seemed to be different from their own beliefs. Several episodes below exemplify this issue.

On November 14, 2009, a middle-aged female patient P38 brought six different kinds of drugs prescribed by a Western medical doctor. Most of them were for treating high blood pressure. Dr. Lee examined each of them, copied the names to P38's medical history and indicated that these drugs have many side effects. Hereafter, he took two books from the shelf, *Handbook of Drug Therapy* and *Handbook of Common Drugs*, and let P38 read about the side

effects. P38 admitted that she felt many of them (participant observation, November 14, 2009). Such a scenario affirms previous observations about the anti-biomedical position taken by the practitioners in terms of Western pharmaceuticals. However, at the same time it raises an intriguing question about the role of biomedical handbooks in the Chinese medical practice.

The situation discussed above was not exclusive in Yusheng Clinic. The practitioners often referred to medical publications, pharmaceutical handbooks, or articles from newspapers in their communication with patients. For example, Dr. Lee would give a copy of the article *Do not Control Blood Pressure in the Aged Too Strictly* (*United Daily,* April 5, 2008) to every elderly patient complaining of high blood pressure. The article introduces medical research findings, showing that higher blood pressure for the elderly is a norm rather than a disorder and that lowering blood pressure too much may cause adverse effects (participant observation, November 9-10, 12-13, December 2, 4-5, 2009).

It is important to note that most of those books and articles can be regarded as so-called scientifically-based sources. This suggests that the employment of written sources functioned as a tool for warranting medical decisions, establishing trust and confidence among patients and increasing status credibility. This interpretation was confirmed by Mike when being asked about the challenges in his practice of Chinese medicine:

> Sometimes it's hard to get patients' confidence…. If we suggest, "Maybe this course of treatment is better," the patient may feel like, "Hm. The other doctor said this. So, who's right?" So, how can they know who to trust? Uh… so how can you get their confidence? I mean, so you can show some research data or some previous cases or similar cases, something like that. (Personal interview, December 17, 2009)

An attempt to reinforce status credibility can be also related to the use of some artifacts in Yusheng Clinic. For example, a newspaper clipping, representing Lee's successful collaboration with Western medical doctors for treating paralysis, was pasted on the door of the main entrance. The red, handwritten remark under the article reads, "Dr. Lee's successful clinical case was published in the front-page news of *China Times*" (see Figure 5). In addition, many other newspaper clippings introducing Yusheng Clinic or citing Lee (see Figure 6), as well as Lee's certificates and licenses (see Figure 7), are hanging on the walls of the clinic.

*Figure 5***.** Picture of the newspaper clipping introducing a successful Lee's case of paralysis treatment.

Figure 6. Picture of newspaper clippings pasted by the entrance of Yusheng Clinic.

Figure 7. Picture of Dr. Lee's certificates.

According to Harre (1993), achieving certain characteristics and reputation (e.g., authority, sympathy, professionalism, etc.) requires time. However, society driven by practical purposes requires that certain people would have certain characteristics directly and immediately. The solution to this problem is usually found in the use of uniforms, regalia, and other symbolic objects for framing and determining the person using these things. In Yusheng Clinic, the artifacts, such as medical research findings, biomedical handbooks, newspaper clippings, etc., are extensively used for acquiring trust and confidence among patients. This constant need to reinforce credibility has to do with the hierarchically inferior status of Chinese medicine in

Taiwan's health care system.

The sociohistorical situatedness appeared to be an important issue related to the formation of positioning strategies and professional identity. The perception of being under Western medicine's dominance was salient among the practitioners of Yusheng Clinic. The physician's aid Lin expressed dissatisfaction and grievance that Chinese medicine is still unrecognized in the orthodox system:

> Taiwan's health care system has been created on the basis of Western medicine. Even nowadays, for example, National Taiwan University Hospital system does not recognize Chinese medicine. They think that Chinese medicine is not scientific. Therefore, they do not encourage patients to search for Chinese medical treatment…. They cannot deny the effectiveness of Chinese medicine but at the same time they cannot tolerate its existence. That's why the conflict still exists.... If we talk about practical convergence of the Western and Chinese medical systems, it is not very possible. It is often the question of power, dominance and profit. But if everybody takes a patient-centered perspective, one day these conflicts could be reduced to minimum. (Personal interview, December, 15, 2009)

The unequal power distribution in the health care system was perceived as one of the greatest obstacles for smooth collaboration between the two medical traditions. Lin positioned National Taiwan University Hospital (and supposedly all other hospitals with similar attitude in the orthodox establishment) as intolerant and authoritarian. The perception that Chinese medicine is positioned as not scientific appeared once again. I argue thus that the constant need to warrant medical decisions for patients is related to the perceived situatedness in the society where Western medicine possesses authority in the orthodox establishment (Chan, 2005) and the

predominant voice in the mainstream media (Hsu et al., 2007). This causes Chinese medical practitioners to find a way of accommodating themselves to the above-mentioned circumstances. Such an accommodation is achieved through the employment of some biomedical elements, which make the Chinese medical practice in Yusheng Clinic look more "scientific" from the perspective of evidence-based science.

In short, an integration of Western medical elements into the practice of Yusheng Clinic was found to have a twofold application: First, it was perceived as benefiting the implementation of professional objectives; second, it worked as an adjustment to the existing social circumstances and as a strategic technique for gaining confidence and trust among patients. I argue that the practitioners' perception of how society views Chinese medicine forced them to negotiate their professional identity, especially in the enactment layer.

4.4 One Patient vs. Two Medical Systems

In this section, I continue with a discussion on professional ideology and medical theory, which, along with sociohistorical situatedness, appeared to be the most salient factors in influencing the practitioners' discursive tone with Western medicine.

As mentioned above, the practitioners of Yusheng Clinic emphasized that from the patient's perspective it is irrelevant to dichotomize Chinese and Western medicine. They were repeatedly neglecting boundaries between the two medical traditions. For example, "There are no such things as Western or Chinese medicine. The main thing is whether you understand this or not" (Lee, personal interview, December 18, 2009); "There is no Chinese medicine and there is no

Western medicine. It's just medicine" (Mike, personal interview, December 17, 2009); "There is nothing Western or Chinese here. It's just how your body is. And from medical perspective your body is neither Western nor Eastern" (Thomas, personal interview, December 16, 2009). Thus, the professional ideology carried by the practitioners of Yusheng Clinic rejected the division of medicine into Western and Chinese. In this context, they emphasized professional duties and obligations. This is also where identity of being a good physician was prioritized by the practitioners.

Nonetheless, when the discourse turned to the context of medical theory, the way the practitioners positioned themselves took a different direction. All four participants pointed out the essential differences between Western and Chinese medicine. As Thomas indicated:

> The biggest difference in modern times is whether you are going to use pills, which are actually extracts from the herbs with other chemicals added inside, or natural herbs. But if you want to use natural herbs, you have to know why you're using them. You have to know the Chinese medical system…. You have to keep in mind that you're doing Chinese medicine and, even if you use biomedical testing, your diagnosis and treatment have to follow the Chinese medical way of thinking. (Personal interview, December 16, 2009)

In other words, according to Thomas, the largest differences reside in the thought system (Western vs. Chinese medical way of thinking), medical theory (You have to know the Chinese medical system) and treatment options (pills vs. natural herbs). The importance of following the logics of Chinese medical theory, as raised by Thomas, was also echoed by other practitioners and perceived as the essential requirement for a Chinese medical physician. In addition, it was also discovered that the practitioners were critical about modernization and scientification of

Chinese medicine advocated by official Chinese medical authorities and educational institutions in Taiwan.

Finally, when asked how they perceive *integration of Western and Chinese medicine*, which was so often pointed out in Yusheng Clinic, the practitioners raised the importance of communication and linkages between the two medical systems rather than their convergence into one system. As Lee stated, "Chinese medicine and Western medicine carry different perspectives. The most important thing is to create links between the two" (personal interview, December 18, 2009). Mike echoed this statement, "Chinese medicine is pretty complicated, I mean. The systems don't really fit together perfectly. I think it's pretty hard to make a system. So, in my mind, everyone should do his own job but it's good to communicate" (personal interview, December 17, 2009).

In terms of medical theory, the practitioners clearly separated Chinese and Western medicine but advocated the linkage, exchange and communication between the two. This is also reflected in Lee's medical writings which introduce diseases from both Chinese and Western medical perspectives. Similarly, in these articles, the so-called integration is implemented by trying to elaborate the linkages between Chinese and Western medical terminology and by employing biomedical diagnostic tests. In terms of treatment, the natural, traditional Chinese medical treatment is applied.

Nevertheless, in certain cases, the relationship between Chinese and Western medicine was defined in terms of partnership. For example, as Mike put it, "There are a lot of cancer patients that they still need to take chemotherapy. There are a lot of different disorders when it's still helpful to have Western medicine. So, I mean, working together is a good way" (participant

observation, November 26, 2009).

The position of a partner and communicator was related to some personal characteristics ascribed to a good Chinese medical physician. The practitioners emphasized a need of recognizing the advantages of Western medicine and not hesitating to adopt it to their own practice. Exchanges were seen as inducing the progress. In other words, open-mindedness, adaptability and innovativeness were perceived as important characteristics for fulfilling the professional obligations optimally.

In sum, the way the practitioners of Yusheng Clinic positioned themselves with regard to Western medicine was selective and switched by context. In terms of the professional ideology, they discursively eliminated the dichotomy between the two medical traditions. By contrast, in the discourse of medical theory, the identity of being a *Chinese* medical practitioner was more salient. Chinese and Western medicines were perceived as being two separate systems. The practitioners assigned themselves the position of communicators and partners. Therefore, the relationship between Chinese and Western medicine in Yusheng Clinic can be described as *huitong* (匯通, exchange and communication) rather than *jiehe* (結合, integration).

5. Discussion and Conclusions

To recapture the major findings of this research, in this chapter, I will summarize how the practitioners of Yusheng Clinic positioned and identified themselves in the discursive practices with Western medicine. Furthermore, I will highlight the main shifts of positions and the emergence of different identity features in different contexts. Moreover, I will provide my interpretation of the patterns and processes emerging during the meeting between Chinese and Western medicine in Yusheng Clinic and propose a new perspective for looking at this meeting in the global context. Finally, I will reassess limitations of this study and suggest future research directions.

The practitioners of Yusheng Clinic took different standpoints in their discursive practices related to Western medicine in different contexts. I discovered three main contexts determining the positional shifts: professional ideology, medical theory, and sociohistorical situatedness.

The study results have revealed that professional obligations ascribed to a physician in many societies also form the basis of the practitioners' professional identity in Yusheng Clinic. The practitioners asserted that the most important duties and responsibilities in their work are these: correct diagnosis, effective communication with patients, and ability to choose an optimal treatment. Furthermore, being a good physician was related to the elimination of division of medicine into Western and Chinese. Both were seen as two different options for implementing same professional goals. At the first glance, following professional objectives and ideology, the practitioners resisted the dichotomization of medicine into Western and Chinese. However, this professional ideology based on normative obligations falls short of representing the

comprehensive picture of professional identity. A closer examination has shown that processes of identity formation and negotiation are more complex.

Turning to the context of thought system and medical theory, the way the practitioners positioned themselves took a different direction. In this context, Western medicine was clearly defined as the "other" medical system. Chinese medicine was perceived as more sophisticated and developed. Chinese medical "way of thinking" was raised as an important maxim for a Chinese medical practitioner. Generally, in the context of medical theory, Western medicine was separated but not rejected. It was placed more or less on the equal footing. The practitioners took the role of mediators and partners in the relationship of the two knowledge and practice systems and emphasized the need for more linkages between them.

The positioning process can be either deliberate or not intentional. Individuals can position themselves or others. They can also resist being positioned. In the context of sociohistorical situatedness, the practitioners of Yusheng Clinic perceived that Chinese medicine was seen as non-scientific in the orthodox establishment of Taiwan's health care system and in Taiwanese society. The perceived status inferiority forced the practitioners to look for additional ways of establishing credibility among patients. This was done by introducing some elements (terminology, biomedical handbooks, etc.), which act in concert with evidence-based science, in their daily medical practice and communication with patients. As will be discussed below, such a resistance to being positioned was also one of the active factors in constructing professional identity, especially in the enactment of professional self. I follow the discussion by highlighting how the three different ways of positioning were reflected in the construction and re-construction of the practitioners' identity.

Position shifts in the discursive interaction with Western medicine had repercussions in the medical practice. According to the practitioners of Yusheng Clinic, biomedical diagnostics and terminology contributed to the fulfillment of their professional goal – correct diagnosis and effective communication with patients. The professional ideal of being a good physician brought the two medical systems together in terms of diagnostics and terminology. The integration of some biomedical elements functioned as an enhancement of professional practice. The perceived professional self-image of being a good physician, communicator, innovator, etc. was extended into the enactment layer.

However, in terms of treatment, the ideal of being a good *Chinese* medicine physician was more salient. The Chinese medical treatment, as provided in Yusheng Clinic, was perceived to be superior to the biomedical one. The latter was positioned as underdeveloped, inflexible, and possessing many side effects. Through positioning Western medical treatment this way, the practitioners unveiled their own beliefs about Chinese medical treatment as more sophisticated, harmless, flexible, and individual patient oriented.

The practitioners of Yusheng Clinic expressed strong confidence about Chinese medicine during the interviews. Nonetheless, it was less apparent in their communication with the patients. The strong confidence in Chinese medical treatment, adherence to Chinese medical knowledge system and beliefs in Chinese medicine being scientific in its own way were underrepresented in the daily practice. Thus, the daily practice appears to be problematized by a clash between professional self-image and yet having to meet the performance requirements determined by the society. This is where discrepancies between being and doing, between perceived professional self and enacted professional self occurred.

In sum, I would define the professional identity of Yusheng Clinic practitioners by using the expression *Chinese at heart, Western where appropriate*[22] (*zhong can xi lu* 中參西錄[23]). On the one hand, the practitioners emphasized the adherence to Chinese medical theory, thought system and treatment, thus remaining "Chinese at heart." On the other hand, the instrumental adaptation of some biomedical elements into the practice was also welcomed "where appropriate."

I would like to summarize the discussion on processes and patterns taking place during the meeting of the two medical systems in Yusheng Clinic by returning to the context of globalization within which I place this study. At a glance, Western medicine in Taiwan, just as in the other parts of the world, is recognized as dictating normative standards for all other medical systems. By taking this perspective, it is easy to define biomedicine as universal. Accordingly, Chinese medicine should be seen as local. Nevertheless, the example of Yusheng Clinic shows that the relationship between Chinese and Western medicine is more complex and includes more directions of discursive and practical exchanges between the two than merely a two-way cultural flow between universal and local. Therefore, from the social actors' perspective, the processes taking place between Chinese and Western medicine do not fit into the bipolar models of globalization.

In this study, I follow the notion that there are no absolute universal or local matters. There is the world with various places and contexts where unique patterns and processes emerge. The

[22] As mentioned in the literature review, it represents one of the possible ways of Chinese and Western medicine integration, as was advocated by Zhang Xichun, one of the early integrators of Western and Chinese medicine, in the beginning of twentieth century (Fruehauf, 2009).

[23] Translated by Heiner Fruehauf (2009).

culture of Chinese medicine is not an exception. Therefore, I suggest seeing globalization of medicine by escaping bipolarity of global/universal vs. local. Recently, some scholars introduced the yin-yang mode of thinking for understanding globalization (see Gunaratne, 2005, 2009; Wang, 2009). Although emerging in the field of media studies, this call is aimed at social sciences at large (Gunaratne, 2009).

Yin-yang is the philosophical construct originating from the Chinese naturalistic thought system and Daoism. Yin and yang, two complementary opposites, are labels used to describe "how things function in relation to each other and to the universe" and "continuous process of natural change" (Kaptchuk, 2000, p.p. 7-8). Yin-yang theory represents a worldview in which everything is seen having both yin and yang aspects which constantly interact. At the same time, all things are seen as parts of the whole. Looking from the yin-yang worldview, globalization is perceived not as a process created by the tension between the two dichotomous forces (local vs. global, fragmentation vs. unification, etc.), but as a constantly changing state of being and becoming produced by "contrastive but mutually inclusive dynamic forces" (Wang, 2009, p. 136). The relationship between yin and yang does not have a finite form.

Accordingly, the relationship between Western and Chinese medicine emerging from the practitioners' professional identity can be seen as a constantly changeable outcome of many forces which are induced by myriads of elements, both human and non-human, such as social actors (practitioners, patients, colleagues, etc.), cultural and ideological aspects (cultural-medical theories, professional obligations, etc.), power relations (superiority of Western medicine vs. inferiority of Chinese medicine in the official establishment), historical situatedness,

psychological aspects (self-images, stereotypes, perceptions, etc.), material artifacts (medicines, books, setting, etc.), and so on.

The interaction of forces induced by these elements creates the professional identity which is neither homogenous nor stable. However, namely with this kind of identity could the Chinese medical practitioners make sense of their practice and establish themselves in the pluralistic yet Western medicine-dominated health care system. Furthermore, following yin-yang perspective, there might be more than one form of interaction between forces and their outcomes (Wang, 2009). As discussed above, in some situations, the interaction between Western and Chinese medicine was perceived in terms of partnership; in other situations, they were unified or clearly separated. But at the end, all these forces and their outcomes represent the whole in which the two medical-cultural systems coexist in Yusheng Clinic. Like yin and yang, they exist in opposition but at the same time they create, control and transform each other.

Finally, the discussion on strengths and limitations of this study and recommendations for future research follows. The communicative perspective of looking at identity enabled to see the complex picture of Chinese medical practitioners' professional identity. Moreover, the utilization of positioning as an analytical tool allowed capturing various factors involved in the professional identity construction and negation. Nevertheless, if identity is seen as a network of constantly changing connections, it must be kept in mind that this picture of practitioners' professional identity is not exhaustive; it may change in time and within different contexts and situations. One of the limitations of this study is relatively short period of observations. I suggest that new situations, positions, relationships, and other factors involved into identity creation and re-creation might be capture through the longer exposure to the culture of Yusheng Clinic.

In addition, different contextual perspectives could also be taken into consideration for revealing more explicit picture of the practitioners' identity. For example, Chinese medical education and knowledge transmission could be one of the possible research contexts for exploring formation of professional identity. While this study discussed mostly enacted identity and its links to relational identity, further studies could pay more attention to individual and communal factors affecting professional identity.

Moreover, the research results were inducted by finding repetitive themes in the social behavior and discourse of the Chinese medical practitioners. I suggest that the analysis of language, employed in the positioning process, would enhance these results. Therefore, future researches could engage in the analysis from linguistic communication perspective.

Furthermore, along with deepening knowledge in professional identity research, broadening understanding of the interaction between Chinese and Western medicine is the other possible research direction. The present study explored this interaction only through the culture of one Chinese medical clinic. Further researches may consider exploring more Chinese medical clinics for gaining a broader understanding of the phenomenon. The comparative perspective could also generate interesting insights. In addition, the interaction between the two medical systems can be observed in Western medical circles.

In short, this study accumulates some knowledge about the undergoing processes between Chinese and Western medicine in Taiwan's medically pluralistic society. In addition, it attests the advantage of positioning concept for capturing the complex picture of Chinese medical practitioners' identity. Finally, this study addresses globalization-related theories and calls upon further discussions on the relevance of yin-yang perspective in the interpretation of the

relationship between Chinese and Western medicine in the contemporary world.

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Appendix A

Schedule of Participant Observation (2009)

Period 1	Nov. 09 Mon.	Nov. 10 Tue.	Nov. 11 Wed.	Nov. 12 Thu.	Nov. 13 Fri.	Nov. 14 Sat.	Nov. 15 Sun.
10:00-12:00		∗	∗	∗		∗	
12:00-18:00		∗	∗	∗	∗	∗	
18:00-21:00		∗		∗		∗	

Period 2	Nov. 30 Mon.	Dec. 01 Tue.	Dec. 02 Wed.	Dec. 03 Thu.	Dec. 04 Fri.	Dec. 05 Sat.	Dec. 06 Sun.
10:00-12:00		∗	∗	∗		∗	
12:00-18:00		∗	∗	∗	∗	∗	
18:00-21:00		∗		∗		∗	

Note. Time of participant observation corresponds working hours of the Yusheng Chinese Medical Clinic.

Appendix B

Schedule of In-depth Interviews

Participant's Name	**Interview Date**	**Interview Duration**
Lin	December 15, 2009	41 min
Thomas	December 16, 2009	45 min
Mike	December 17, 2009	36 min
Lee	December 18, 2009	55 min