Alternatives to Oriental-ism

Orientations:

Beginning in the wake of the protests memorializing George Floyd, Breonna Taylor, and too many others in summer 2020, two movements began to address a related issue of racism within our own scholarly and professional field. At the grassroots level, Influential Point launched a petition and campaign requesting that the U.S. acupuncture and oriental medicine (AOM) community remove this racist word from our professional discourse. At the administrative level, Dr. David Lee, the Academic Vice President of Alhambra Medical University in California, initiated a campaign among his peers to "repeal and replace" the word "oriental," school by school, in school names and degree titles, with the goal of carrying this momentum forward into pressuring ACAOM and NCCAOM to do the same. Collectively, it would seem, the moment has come for making long-overdue, necessary change.

But after determining to not use this word, what other word should we use? And more importantly, how do we make that choice? How might we, the professionals impacted by the name and public face of our craft get a say in making it? If practitioners wish to have a voice in the decision about how we redefine the AOM profession to patients and our broader communities, step one is educating ourselves about the pros and cons of commonly proposed alternative names.

This list of terms, and breakdown of some of their more salient associated issues, is by no means exhaustive. This paper presents a starting point for opening an informed discussion based on something other than personal opinions. It is further my hope that it will help readers cultivate an appreciation for the many different filters through which different people can see the world, let alone a single word. For this reason, each term needs to be looked at from many possible perspectives. One person's opinion is not going to decide this for us. Nor should it.

I am a clinician, philologically trained translator of classical Chinese, and historian-in-training. This is to say that I have spent countless hours researching and thinking closely about exactly what a word means, or what is the best way to translate X concept into Y language, or for Z type of audience. At the most fundamental level, any alternative would be better than the deeply embarrassing, racist word that we currently use. That said, how we choose our marginally better word matters, too. It is an opportunity not only for learning and self-reflection about the word "oriental" that we seek to replace. It is also an opportunity to recognize some of the many ways in which our field is Orientalist - perpetuating a reified notion of an exotic, but ultimately undifferentiated or falsely uniform, "alternative" or "other-than" medical culture.

How much do we wish to engage in the work of examining Orientalism within our field - self and public perceptions - along with changing its presently Orientalist name?

To change the broader dynamics (removing Orientalism), rather than only the most visible external manifestation of those dynamics (removing only the word oriental), are two separate things. In my opinion, we should not neglect the former opportunity in our rush to correct the latter problem. The work of examining the Orientalism that permeates our field is important work because it can help us to clearly define and create a professional community. At present, the AOM field in the United States, with its crazy-quilt patchwork of organizations, state practice scopes, regulatory agendas, and heterogeneity of training, entirely lacks professional cohesion. Such fragmentation prevents us from standing united against threats to our scope of practice, such as dry-needling, let alone advocating more strongly for our potential role as first point of contact providers of

healthcare in a country desperately in need of primary care providers.

How might we use the process of reflecting on replacement terms as a kind of professional praxis, forcing us to confront the ways in which words matter because words connote as well as denote, delimit, and define?

The idea that the name or definition of something matters - that a name should accord well with the thing it names - is not a new or radical one. Rather, we know that Confucius himself advocated for the "Rectification of Names," warning against the confusion and social unmooring created by the drift between signs (names) and the things they signify. As we come together as a collective in exploring the full context of each possible term, we are also forced to open a conversation about what values undergird our selection strategy. Naming ourselves presents an opportunity to better define the dynamics of our profession as a whole, our individual positioning within these dynamics, and a collective re-envisioning of how we wish to define ourselves and our practice.

Positionality, privilege, and issues centering on identity politics:
All good dialogue needs ground rules - especially if they are to include rather than exclude.
We are fortunate enough to work in a relatively diverse field, but need to agree that:

1) Although our broader professional field is diverse, leadership within our field does not mirror this: most acupuncture school administrators, teachers, and practitioners with significant professional profile are largely cis-het white men who actually constitute a minority of licensed practitioners. Women, as well as Black, Asian, Latinx, and indigenous practitioners are painfully under-represented in leadership - and thus value-setting and decision-making - roles in our field. Various dynamics play into this but suffice it to say that when we ask for "centering diverse voices," part of that means amplifying the voices of those less likely to have their perspective and position heard.
2) We practice a medicine that originated in East Asia; East Asia is diverse, and diasporas are not a new phenomenon. Thus, we need to stay mindful of that facts that:
    a) Practitioners of East Asian descent have more of a stake in this discussion than non-Asian practitioners.
    b) Practitioners of East Asian descent are not a monolith. Chinese, Japanese, Korean, Taiwanese, Vietnamese, and other practitioners probably have different perspectives, much as immigrants versus American-born practitioners will likely have different perspectives.
    c) We work in a broader context where most of our patients are non-Asian; thus, whether or not we ourselves are of Asian descent, simply by practicing this medicine we act as grassroots ambassadors of East Asian cultural heritage within our communities. Respect is the bare minimum we should be approaching this process with.

In order to avoid a perpetuation of old legacies of cultural appropriation, it is vital that we center diverse Asian voices in this discussion. We further, in my biased opinion as an academic, need to look not only at regional dynamics within East Asia (now and historically), but also to understand our own history, the role the United States has and continues to play in geopolitics, and the prevalence of Orientalist thinking broadly within discussions of East Asian anything in the U.S.[1]

[1] If you doubt this, I can walk you through some examples of how even a "neutral" newspaper like the New York Times frequently engages in Orientalist bias when discussing Asian culture.

That said, arguments hinging purely on identity are often weak arguments. In part this is because modern identity constructions (example: Black vs. African vs. Senegalese vs. Muslim) are frequently rooted in imperialist, or nationalist, logics that only arose in the 19th-century. The categories themselves are problematic. For our purposes here, a more salient point is that overreliance on these categories can connect back to Orientalist thinking itself - the assumption that a whole big, complex, diverse geographic region or country within that region is a monolithic entity. Likewise, identity arguments can also sway listeners into tokenistic thinking - i.e. the idea that all members of a given group will think the same way. We would not assume that all white men think similarly about a single topic; breaking that down further we still would not assume that all white, college-educated men living in coastal metropolitan areas think similarly about a single topic.

Furthermore, to say "I am Y-identity and I find X word offensive" without elaborating on *why* is often opaque to those who do not share that identity. It shuts off discussion by locking people in and out of identity-based categories. Instead, following up one's opinion with why-reasoning opens up more space for mutual understanding and transformation, by forcing listeners to grapple with how/why their experience of a word differs from the speakers. We all have quite differing (present-continuous tense) experiences of the world, our medical practice, and perceptions of each of these terms.[2] For example, the statement "I am Y-identity, and because of PQR historical events, I find X word offensive," allows others to understand the why or reasoning behind an opinion.

FAQ:

1. **Why should I care? My voice doesn't matter here.**
   If we – if you – ignore this work, administrators who run acupuncture schools and national organizations will make the decision for us. You read that right: the same crowd who allowed a known racist term to publicly define our profession for decades are currently strategizing to winnow-down this list to the terms that best serve their agenda and ideas about the future of the profession. The agenda of a school or institution driven by pressing financial need of recruiting more students and future licensees does not necessarily overlap with the needs of licensed professionals actually practicing in and representing this field in the world on the daily. Practitioners vastly outnumber administrators, but unless we come together as a collective, we will lose our voice in this discussion - and who is better capable of defining ourselves than us?

2. **Modern East Asians born in Asia do not find this word problematic, so why should I?**
   Okay, well, are we in those countries? Clearly no. We are here, working with a public that is majority non-Asian. Whether or not an individual is offended by a word commonly - in this case, legally[3] - deemed offensive, our collective positionality demands we act to remove a word that in this context is patently offensive. This is also an example of "tokenism" in action.[4]

3. **Why can't we use "actor's categories" - the terms East Asian practitioners in East Asia use to describe their own medical traditions?**

[2] Intersectionality is a great analytic/tool for understanding differences of perspective, see Kimberlé Crenshaw: https://www.youtube.com/watch?v=akOe5-UsQ2o
[3] See H.R. 4238 (Meng Bill), 2016.
[4] i.e. some member of a marginalized group thought X, therefore all members of that group think X.

In East Asia at present there is not one single collectively agreed term.[5] Instead:

- China: “Chinese Medicine“ 中醫 or 中藥, or TCM
- South Korea: In 2010 or 2011 the name was changed from “Han Medicine” 漢醫學 to “Korean Medicine” 韓醫學.
- North Korea: Either “Choson Medicine” 朝鮮醫學 “Chinese Formula Medicine” 漢方醫學.
- Historical/pre-division Korea in the 20th century used “Eastern Medicine” 東醫.
- Japan: “Han Formula Medicine” 漢方医学
- Vietnam: Vietnamese Medicine or TVM.
- Taiwan: As of July 2020, a movement is afoot to rename as “Taiwanese Medicine”

[5] Special thanks to James Flowers, PhD, formerly Secretary-General of IASTAM and President of the Australian Acupuncture and Chinese Medicine Association, for sharing information about several of these terms with me.

Acupuncture 針灸**|** The most publicly recognizable term, but, a modality not a medical system.

At a purely surface level, we might see this as synecdoche - a part standing in for a whole. If we look back, however, into the 17th-19th centuries, we can actually find quite a long history of acupuncture (and/or moxibustion) being parted out from the dominant medical epistemology of East Asia and brought to the European and eventually American "West."

In a chapter of his dissertation dedicated to exploring the history of acupuncture in the United States, anthropologist Victor Kumar argues that after the practice was imported from Europe around 1820, there was significant medical interest in acupuncture as a "scientific" or "surgical" technique. A modality, in other words, that various members of the medical community either conceptualized within Western medical epistemology or used as a way to pull at the still rough fringes of that scientific paradigm.[6]

Kumar and Tyler Phan both trace rising anti-Chinese sentiment through the 1870s building into racist legislation and lynch mobs of the early 1880s, noting this as a pivot point where earlier public perceptions of acupuncture with "Chinoiserie" (the chic aesthetic of Chinese motifs and goods such as blue and white China) shifting into rejecting this in favor of rising xenophobia against Chinese (and other) immigrants.[7] Phan argues that after this turning point, acupuncture in the U.S. was mostly practiced within Chinese communities through the mid-20th century when lineage-style transmission into radical organizations such as the Black Panthers lent acupuncture counter-culture credibility. From here, it was taken up by white members of the counterculture and mainstreamed via a professionalization process that all too often shut Chinese practitioners out of legal practice.[8]

Even as Kumar's research focuses specifically upon acupuncture, he counters Roberta Bivins's 2007 argument that acupuncture is a successful synecdoche for the whole of Chinese Medicine [sic]. Synthesizing the work of numerous recent historians, he asserts that acupuncture was never the dominant mode of practice among Chinese physicians. Rather, literati medical practitioners preferred herbal formulas, leaving practices involving bodily contact (massage, *guasha*, cupping, and moxibustion, in addition to acupuncture - most of the current modalities within our scope) to various folk healers. In many ways this mirrors the division between barber-surgery and medicine in Early Modern Europe.[9]

For those familiar with Arthur Kleinman's "three sectors" model of healthcare in 1970s Taiwan, and its revision by Christopher Cullen to better fit the pre-modern medical landscape, this raises the

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[6] Kumar, chapter 2. Cf. Pomata and Hanson, and Cook, for pre-19th century western interest in acupuncture.
[7] Phan, chapter 2. For a fun general read on the massive demand for and popularity of Chinese goods in the West during the Early Modern period, see Timothy Brook, *Vermeer's Hat: The Seventeenth Century and the Dawn of the Global World,* Bloomsbury, 2008.
[8] Phan, chapter 3.
[9] Kumar, 103, as well as the source he quotes for this, Andrews 2014. From my own experience surveying printed medical case histories published in 16th-century China, such as the "Case records of famous physicians" (*Mingyi leian* 名醫類案), confirms the preference for herbal therapies among literate practitioners. Tan Yunxian's very late 15th-century "Miscellaneous records of a female physician" (*Nuyi zayan* 女醫雜言) is thus remarkable to me not only for being a rare glimpse women's social conditions and a specifically female physician's path into and practice of medicine, but also because Tan records utilizing moxibustion in a relatively high number (12 out of 31) of her cases. Not once did Tan mention acupuncture. See Wilcox, 18.

important question of what, specifically, are the practices we seek to name here?[10] Are they purely, as any adherent of the inherent "Chinese-ness" of this medicine might argue, practices derived from the pre-modern professional (*ruyi* 儒醫) sector that were systematized and codified into professional practice in the early- and middle-20th century? Or, given how little used acupuncture was, does the supremacy of this particular modality itself point to folk and potentially popular involvement?[11]

Takeaways |

- historically the word has been utilized by people in the West in a culturally appropriative manner (taking the thing/modality but ignoring its context), calling into question its (apparent) cultural neutrality
- the term "acupuncture" on its own fails to convey an epistemological basis
- using this particular modality to stand in for the whole of East Asian medicine, at any time prior to its popularization in the 20th century, opens up other issues with the history and practice of the medicine we currently seek to define/name

[10] Kleinman's "three sectors" analysis distinguishes professional, folk, and popular medical domains. Because professionalization in Chinese medicine did not really begin until the early-20th century, Cullen modified this analytic for the pre-modern period by equating "professional" with "literati" (*ruyi* 儒醫) physicians. Both Kleinman and Cullen's models build from the concept of a "medical marketplace." This posits that, unlike health systems today, for much of history individuals had access to, and chose between, a wide variety of medical practitioners and services. For a really fun illustration of this, see Roy Porter, "The Patient's View: Doing Medical History from Below," 1985. For a nearly equally fun portrait of the medieval "religio-medical marketplace" in China, see Salguero.

[11] Vivian Lo's analysis of a 7th-century acu-moxa chart found preserved at Dunhuang is a tantalizing window into the possible usage of moxibustion by non-"professional" gentry households.

Asian 亞洲 **|** Describes an actual region, but so broadly cast that many other regional medical traditions are folded into it.

The biggest downside to this term is that it covers such a geographically large, culturally diverse region: not only East Asia, but South Asia and potentially the Middle East.[12] "Asian Medicine," as defined by the editor of the journal of the same name as well as its organizational sponsor, includes not only the practices of acupuncture and herbal medicine we currently seek to rename, but also Ayurvedic, Thai, Tibetan, and Unani Medicines.[13] These are distinct epistemological frameworks, with fairly distinct textual traditions.[14]

How might this word work to perpetuate the Orientalism our patients often carry into our clinics, expecting East Asian medical practitioners to also know something about chakra-alignment, Ayurvedic theory, etc.?

How does this word sit with East Asian-Asians? I have gotten some private messages from people sharing with me that because it encompasses so many cultural groups, they feel no personal connection of self-identification in this word. For how many is this true for?

Takeaway | Is this word itself - one so wide-ranging that it covers at least four distinct (but technically many, many more) cultural zones - merely another P.C. way of saying oriental?

[12] The Association for Asian Studies, https://www.asianstudies.org/, covers all of these places, as do some academic departments of "Asian Languages and Civilizations."
[13] Link to ASME brill.com/asme, IASTAM http://iastam.org/
[14] I deliberately used a weasel word here because trade has been happening as long as there have been surplus goods and the ability to move them, and ideas and texts circulated in addition to goods along these pathways. The earliest and most convenient example I can offer of this is "Buddhist Medicine," which entered China along with Buddhist sutras and translation projects in the 3rd - 6th centuries. Cf. Pierce Salguero.

Chinese, or "TCM" 中醫藥**|** Publicly recognizable and frequently used, but sidelines non-Chinese contributions.

Undoubtedly, some permutation of "Chinese medicine" or "TCM" is the common term through which the public typically most easily understands our practice. Scholars - even scholars who themselves are of non-Chinese Asian descent, such as Tyler Phan - use the term "Chinese medicine" to describe it.[15] Rather than calling that good enough here, why might that give us pause?

To get there we need first to distinguish "Chinese medicine" from "TCM," and second to comprehend some disciplinary norms in scholarly writing on East Asian medicines, broadly.

TCM is a very specific packaging of East Asian medicine. It first coalesced between 1900-1930 as "national medicine" (*guoyi* 國醫). This occurred because traditional practitioners along with their practice were directly threatened by a well-positioned, vocal, but very small coterie of modern "Western" medical doctors.[16] This small group and their agenda of "modernizing" medicine by banning traditional medical practices were favored by many prominent elite reformers - including the author Lu Xun, and Chiang Kai-shek, who became the leader of the Nationalist (*Kuomintang* 國民黨) government by the late 1920s. Reasons for this privileging of the few promoting modern medicine were complex; suffice it to say that reformers advocating social change in China themselves deployed the "sick man of East Asia" trope (common in Western media writings on China in the late 19th century). This trope reformers to advance the idea that, along with other "backward" elements of traditional Chinese culture, traditional medicine had failed to heal the national body, contributing to China's ills. This direct assault (via both popular press and also attempts at legislation) on their practice led traditional practitioners from various lineages to come together as a profession for the first time. Location facilitated this, as they were gathered together in growing cities such as Shanghai, as did practical expediency: traditional practitioners vastly outnumbered modern practitioners at the time, and through uniting around the new label of "national medicine," they were eventually able to ally themselves with the needs of the emerging nation-state.[17]

"National medicine" was further synthesized (or "scientized") into TCM in the early years of the People's Republic. Again, this owed less to the basis of the medicine itself, and more to demographic, economic, and political exigencies. This medicine, now called TCM, was then exported by the People's Republic of China in the '80s/'90s through Chinese Foreign Languages Press publications such as *Chinese Acupuncture and Moxibustion*.[18]

TCM is far, however, from the only form of East Asian medicine currently practiced - both in East Asia and the West, because this recent wave was not the only time texts and ideas from East Asian medical practice were exported. (We've lived in a globalized world for a long time.) In the U.S. there are schools and practitioners branding themselves as "Daoist," "Five Element," "Classical Chinese," "Japanese," and "Korean." Diversity of method and practice is good - historically Chinese medicine was incredibly rich and heterogeneous.[19] Yes, our licensing exam and regulatory bodies center TCM, but if in this decision we center it we would be centering not only the "Chinese-ness" of our

[15] Phan actually specifies "American Chinese Medicine," distinguishing it from the more plural practices within China itself and other East Asian countries.
[16] Western is in quotes here because these physicians were largely trained in Meiji-era Japanese medical schools.
[17] See Andrews, Barnes, Lei, Rogaski, and Scheid.
[18] Taylor, and Lei.
[19] Scheid calls this "plurality and synthesis" and I am all about it.

medicine, but a single historically contingent iteration of it - one which, given the diversity we find within modes of practice domestically in this U.S. today, deserves to be challenged.

TCM, like "Chinese," works to reify a diverse modern practice by centering China's historical role in originating the medical epistemology of texts like *Huangdi neijing*. It would be simple to understand engagement with these ideas as central to all of the medical traditions under discussion, but the work of historians and anthropologists is increasingly problematizing that, instead demonstrating medical plurality, centuries of historical physicians writing and contesting ideas about how best to interpret those "classical" theories, and even evidence that many patients likely consulted with or were treated by a broad spectrum of healing professionals and laypeople, whose knowledge was derived from empirical, as opposed to theoretical, foundations. Centering a single historical origin of complex and multi-sited medical practices is an act of reification, full stop, working to obscure the contributions of peoples and traditions engaged with, but distinct from, the influential literary medical culture of China.

While not as overtly racist as the current term we're seeking to replace, "TCM" is racist (and teleological) in a more subtle way - by conflating plural East Asian medical traditions into the single category of "Chinese," and this one step further still into the sole category of "TCM." If you met Korean, Japanese, Taiwanese, and mainland Chinese people hanging out together somewhere and referred to them all as "Chinese" - or worse still, Beijingers - either because you couldn't tell the difference between them or you thought that a close enough descriptor, this would be racist, yes? How is labeling all of the medical practices, texts, etcetera from these culturally, linguistically, and geographically distinct places any different?[20]

Deep breath. Let's quickly turn back to what scholars are using, and why, yes?

Historians and Sinologists, including famous scholars like Nathan Sivin and Paul Unschuld, largely use the term "Chinese Medicine." They do, primarily I think, because China is their specialty. Learning Chinese as a second or third language is hard; learning multiple Asian languages to a level of reading fluency is even harder. Academic departments have only recently begun experimenting with interdisciplinarity, and cross-cultural, or even regionally based research is still hard to pull off

[20] In a draft of this document released to our professional leadership in mid-July, one acupuncture school director took me to task for this "argument" (although I believe it is more correctly an analogy appended to an argument as a closing example), stating that it rests on "the logical fallacy of false equivalence." Obviously these two things (medicines and individual people) are different. Any two halves of any analogy are different - this is one of the problems inherent in analogical thinking. That said, while an analogy does not make an argument, it does have the benefit of (potentially) bringing to light certain salient themes that may be present, but otherwise difficult to identify, within a more complex argument. Was this analogy well-chosen? Lacking even half the confidence of a mediocre white man, I can never be 100% certain - of this or anything. I did, however, run this by my small committee of writing mentors (all PhDs trained at top universities), and none thought it problematic. So, I leave it to you, reader, to make your own decision here about the appropriateness of this analogy, and also about the dynamics inherent in a professional administrator (someone literally paid to, amongst other things, serve the profession) punching-down at a graduate student (someone doing this work for free in scant spare time), in the process missing the forest for a single tree, probably erroneously, and how gender or other dynamics may or may not play into such faulty engagement. Again, for those who weren't listening the first time, white men like this are trying to select a replacement term to define our profession behind closed doors before they ever seek actual input from the actual community of licensed professionals who will be impacted by it. I am not the only smart member of our community. If any meaningful dialectic around this term shift is going to occur, I need the practitioner community to get in on it.

for very real pragmatic reasons.[21]

Furthermore, the discipline of history (I speak to what I know) has only in the past generation or so undertaken something we call the "cultural turn." This essentially means that we no longer like to bore our audiences with histories of institutions, and many of us are deeply wary of mapping modern biases onto the past. Specifically, categories like the nation state are increasingly problematized as teleological (mapping the biases and assumptions of the present back onto the past).[22] This is because these categories in many places did not arise until the 19th century.

Sivin's student Benjamin Elman was at the forefront of a call to study medicine and science not only of China, but of regional connections between China and the greater East Asian sphere. Another Sivin student, Hilary Smith, mapped how the same disease term, "foot qi" (*jiaoqi* 腳氣) took on different meanings in different times and places, including medieval and later periods in China, and Meiji-era Japan (1867-1912). Sare Aricanli, a student of Elman, studied plurality within the Chinese empire itself by exploring medical pluralism within the Qing Dynasty (1644-1911) court, which patronized Han literati physicians, Jesuit missionaries, and Manchu *caban* (traditional practitioners who worked on both humans and horses). All of these projects in some way destabilize modern nation-state categories, either through demonstrating regional travel of goods and ideas, or problematizing the false notion of homogeneity within a delimited boundary.[23]

What even is "China," historically speaking?[24] An expanding and contracting group of different minority peoples occupying incredibly geographically diverse territories intercut by shifting river courses and many large mountain chains. The graphs long used to denote "Chinese medicine" outside of China (*Han yi* 漢醫) - describe not China, the middle kingdom (*Zhongguo* 中國), but the Han Dynasty (206 BCE- 220AD), from which the present-day Han majority of China take their name. In Japanese and Korean contexts, however, this word registers more temporally than ethnically.

Anthropologists who have conducted research in the United States would seem more useful for our purposes, but most adopt the language of their informants without strongly interrogating it. Wu, Zhan, Pritzker, and Phan all use some variant of "Chinese medicine" in their work, if not perpetuating the mistakes of their informants by conflating this with "TCM." Critical of such practices, Phan further localizes his description to "American Chinese medicine," much as Kumar does with "American Acupuncture."

And lastly, a brief note on the term "Sino": Joshua Hannum is the primary proponent of this term, so if interested please contact him for his thoughts. My take is that, by its very definition it is simply a high-falutin, five-dollar way of saying China with a word derived from Latin. Because of this, all of the problems inherent in the term "Chinese medicine" apply to it, which is why I have included it here.

Takeaway | At best, "Chinese Medicine" obscures, and at worst, its use entirely marginalizes Korean, Japanese, Vietnamese, and Taiwanese historical contributions and present-day lineages of

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[21] Lines of funding for graduate students and professors alike are often tied to specific purposes, most often using modern nation states as a guide.
[22] Prasenjit Duara, *Rescuing History from the Nation: Questioning Narratives of Modern China.*
[23] If you're curious about this, but rather than wanting nitty-gritty information about ethnicity (constructions of Manchu and Han identity in the Qing), or the Qing Dynasty's own colonialist ambitions, I strongly recommend Aricanli's article in *Current History/Asia-Pacific Perspectives.*
[24] http://afe.easia.columbia.edu/china/geog/M_Hist.htm

practice in the U.S. as in Asia.
Eastern | A meta-geographic, politically correct way of saying "oriental" (keeps the same assumptions).

Much like its predecessor, this word maintains the old "East/West" binary, in language that also is more "meta-geographic" than it is actually geographic. Yes, the globe has an eastern and a western hemisphere, that is a geographic fact. But, when these terms enter discourse they associate with ideas and preconceptions that do not always align well, if at all, with geographic reality. National Geographic's website states that Asia, Africa, and Europe are all part of the eastern hemisphere - but who among us considers Europe an "eastern" country?[25] In common usage, these terms are not aligned with any geographic fact but rooted in other considerations, thus, they function as meta-geographic signals.

But what considerations are our common usages rooted in, and what are they signals of?

First and foremost, categorization into "eastern" and "western" is a form of binary thinking. How opposed are these two things? How distinct? Historians and archeologists know that global exchanges happened along the Silk Road as early as the Han Dynasty (206 BCE - 220 AD), flourishing during the Tang (618-907) and Yuan (1279-1368), all prior to the "first global age" of the sixteenth-century. How might focusing on points of intersection, or cross-cultural exchange, as a recent generation of historians is really beginning to do, help us destabilize the inherent binary opposition of these terms?[26]

What do we gain from using words that are literally just English translations of the old Latin "Oriental" and "Occidental," other than perpetuation of the same racist system of Orientalism that underlay the old name? Switching to the word "eastern" superficially removes the word oriental while doing nothing to address the Orientalist underpinnings of our study and practice of this medicine.

Takeaway | Do we want the easy path of replacement, or do we want to challenge the paradigm itself along with the word?

[25] https://www.nationalgeographic.org/encyclopedia/hemisphere/
[26] The first major wave of European and English language scholarship on China was largely based on ideas of China as a monolith of "tradition," only changing substantively in the 19th century with Western engagement via the opium trade and wars. This is considered the "impact-response" model of history, popularized by John Fairbank under the post-WWII rise of area studies. Subsequent generations of scholars have complicated our historical knowledge to a point where I am fairly confident no living historian of China would agree with that older view. Instead, recent historians (including Sare Aricanli, Li Chen, Kwangmin Kim, Steven Miles, Matthew Mosca, Jonathan Schlesinger, amongst many others) have followed in Evelyn Rawski's scholarly footsteps, examining the ways interaction between cultures shaped the Qing empire, and others (Paul Buell and Eugene Anderson, Pierce Salguero, Marta Hanson and Gianna Pomata, amongst a far longer list than I can offer here) have all written on instances of knowledge or material goods transfer across the boundaries of empire or culture in other periods.

East Asian 東亞**|** Describes an actual region strongly associated with our medical practice but carries imperialist baggage of its own.

Unlike many others, this one describes an actual region, and it does so without overly broad strokes. It has the virtue of being one of the more common terms in vogue in social science and humanities circles at present.[27]

It has two potential deficits:

1) It marginalizes the contributions of Vietnamese and other physicians of Southeast Asia working within the same general episteme (medical paradigm)
2) Negative associations held by an older generation of Asian practitioners against the term as not a neutral regional descriptor, but rather as one closely associated with past traumas. These include Western media portrayals of China as the "sick man of East Asia," and also Japanese self-legitimation of their imperialist ambitions throughout the region with the establishment of the "Greater East Asian Co-Prosperity Sphere."[28] This argument traces back to a letter written in September 2018 by a group of anonymous practitioners from the organization currently known as the Washington Eastern Asian Medical Association (WEAMA). The purpose of the letter was to air these complaints as a way of promoting their preferred replacement term, "Chinese Medicine." I think there are many things here to unpack, so let me start with the clearest, or most objective, and work my way out:
    a) Late-19th and early-20th century Japanese imperialist aggressions in East Asia were numerous, frequently brutal, and should not be trivialized.[29]
    b) Although Western media certainly did use the "Sick Man of East Asia" stereotype in popular writings on China, it was also used by Chinese authors in Chinese publications. Further, it is my opinion that while this phrase certainly does have a heavy history in its deployment by imperialist powers (European and Japanese) in partitioning and effectively colonizing parts of former Qing territory, the offensive half of this phrase is not the regional descriptor but rather the "sick man" trope itself.[30]
    c) Authors of this letter argued for the essential Chinese-ness of the medicine, claiming a historic ownership over it that should extend to the name. In making such a claim, they conflate the long history of Chinese Medicine with its modern standardization

[27] See the journal *East Asian Science, Technology, and Medicine,* for starters, and its sponsoring organization the International Society for the History of East Asian Science Technology and Medicine. http://www.eastm.org/index.php/journal

[28] "...in 2016, President Barack Obama signed legislation striking the word 'Oriental' from federal law; and Washington State prohibits the 'Oriental' word in legislation and government document [sic]. Similarly, although East Asian (東亞) is not inherently negative, it is associated with a time period when Asians had a subordinate status referred to 'Sick Man of East Asia' (東亞病夫) and 'Great East Asia Co-prosperity' (大東亞共荣). 'Oriental' and 'East Asian' are like the word 'negro', they conjure up an era associated with historical discrimination against China and some other Asian countries so that it is probably better to skip these pejorative and disparaging words, Oriental and East Asian when used to rename WEAMA." Excerpt from a letter written to the WEAMA Board and Membership Committee, September 27, 2018, from various licensees in their jurisdiction.

[29] Many modern histories of East Asia cover this. Of these, the most relevant for our current discussion of medicine include Ruth Rogaski's "Vampires in Plagueland" in *Health and Hygiene in Chinese East Asia*, and *Hygienic Modernity*, Sean Hsiang-Lin Lei's *Neither Donkey Nor Horse,* and James Flowers, "Koreans Building a New World: Eastern Medicine Renaissance in the Context of Japanese Rule, 1910-1945."

[30] Cf. Marta Hanson's forthcoming article in *Current History* revisiting this trope in a discussion contrasting East Asian and U.S. responses to Covid-19, titled "Sick Uncle Sam."

under the PRC, "TCM," then confounding this by equating TCM with all diaspora practices of what they themselves continue to describe as "East Asian medicine."[31]

d) If we refer back to current terms used in East Asia (page 4), we see a creep towards nationalistic nomenclature. According to the historian and practitioner James Flowers, who has been involved with the East Asian side of these terminological debates for two decades now, current WHO nomenclature also similarly reflects nationalist, or geopolitical concerns. Given the PRC's present tendency to engage in regional aggressions against other sovereign nations, and their very real current leveraging of "Chinese medicine" as soft-power on a global stage, I want us to be alert to the fact that these popular lines of thinking, spread by Chinese state-controlled media, will likely also arise in our present discussion of these topics.[32]

Takeaways | I am still at a bit of a loss on this one. Doubtless you've noted that I continue to use the term; this is not because I am untroubled by its potentially imperialist connotations, but, beyond my mere need to use something, my academic training has socialized me to use it because that is the current term used by historians, anthropologists, political scientists, sociologists, etc. I'm not saying that it's the right choice for everyone, but as someone committed to engaging in cross-disciplinary dialogue, making myself readily intelligible to colleagues outside of my immediate fields is important to me, thus, this remains the choice I am more comfortable with than not.

[31] "It is well known that TCM originated from China; it is the broad part of what's considered East Asian Medicine including various forms of herbal medicine, acupuncture, massage (*Tui na*), exercise (*qigong*), and dietary therapy."

[32] In media and online forum discussions of current events in China, including the Hong Kong protests and Xinjiang, I've noted a strong tendency towards "whataboutism" - a deflection away from issues at hand through leveraging past examples of bad historical action by Western countries. How much is a call back to the (many, painfully real) injustices suffered by the Chinese people and state at the hands of British, French, and Japanese soldiers from the mid-19th to early-20th centuries a rhetorical red herring - not from looking at the power of Chinese nationalism today, but from the ways in which that nationalism permeates popular rhetoric around what is, and is not, Chinese?

Integrative | Insurance and regulatory language already use this term. Many pros and cons, but the biggest is that (at least in isolation) it fails to acknowledge the cultural and historical roots of our medicine.

Other words under discussion attempt (with varying degrees of success) to acknowledge the cultural and historical roots of our medical practice. This word does not. In my opinion to ignore two millennia of work by East Asian writers and practitioners in crafting and refining a culturally derived medical epistemology[33] is an egregious act of cultural appropriation. This is made still worse by the fact that we heavily leverage those historical roots in advertising the merits of our practice to patients, even as most of our training programs pay scant attention to teaching from primary sources. Beyond these two strikes, there is a still more damning third: it threatens to destabilize the medical epistemology under discussion in its entirety.

How? Integrative, in its very framing, suggests the union of two separate entities. As practitioners of a binary coded medicine (*yin* and *yang*), many of us can easily hang with the idea of harmony in opposition, dynamic and evolving balance. However, the reality of integrative practice rarely sees East Asian medicine and Biomedicine engaged on equal footing. Acupuncturists who wish to work in integrated care settings must be medical bilinguals, speaking only the language of Biomedicine to insurers, Biomedical care providers, and patients. This is not true integration, but assimilation. It is rejigging the organizing foundations of East Asian medicine (its epistemology), sawing off its discordant edges, and sanding them down to fit into the dominant episteme without conflict, damage, alteration, or adaptation of that dominant worldview.

Rather than challenging the Biomedical paradigm, "integrative" stresses our willingness to dive into, and maybe happily swim around as a small but neglected fish within, and maybe one day drown in that paradigm - turning what was once an entire, magnificent and complex medical system, into another mere modality, and us into technicians of that modality. Is this the future we envision for ourselves?

Obviously, there are visible short-term benefits to not making waves within the dominant medical epistemology.[34] But how well will these short-term benefits register in the long term? How have other campaigns of social accommodation fared for minority groups of the past?[35]

Takeaways | The pros and cons of this term are both very strong. For this reason, I think it is impossible to discuss the term properly without engaging in a number of related questions: how do we, practitioners, wish to define ourselves and our profession? With whom do we want to be in conversation, and in what ways?

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[33] Every epistemology is culturally derived; for more information about why we need to study medical thought and practice as one fragment of its larger cultural manifold, see Nathan Sivin, 2005.

[34] As it suits neither my project nor specialty, I leave it to other minds than my own to elaborate these benefits.

[35] I have in mind the distinct strategies of accommodation versus systemic challenge espoused by Black intellectuals advocating racial uplift at the turn of the 20th-century, such as Booker T. Washington and W.E.B. DuBois, or even the different strategies taken by Asian immigrant groups in 20th century California - self-segregation of ethnic enclaves like Chinatown, versus the self-assimilation, sped by the trauma of their wartime internment, of Japanese-Americans living in the Western United States.

Traditional | "Traditional" hearkens to the past without acknowledging specific cultural debt. It foregrounds another false binary: modern and traditional, presumably with biomedicine mapping neatly onto modern. Because of this implicit contrast between past and present, "traditional" then becomes what is not modern, i.e. an old/dead/bygone thing rather than a modern/living thing. In doing so, "traditional" freezes our medicine in the past, inadvertently collapsing present perceptions of continuity and change within that past, thereby negating our practice as one that is both modern and evolving in its own right. In doing so it clearly echoes back to Orientalist framing, in which "oriental" was traditional and "Occidental" was modern. To me, this word is a superficial replacement that does not engage core problems with the original word.

Traditional medicine, unqualified, does not exclusively refer to our practice. Countless different "traditional medicines" have existed throughout time, and many of these are still actively practiced today: Ayurveda. Thai massage. Hmong spirit healing. Shamanism in all its own varied forms.

Because traditional is the obverse of modern, however, modernist thinkers rarely differentiate the diversity of traditional medical systems. Tour the comments section of a skeptic blog like "Science-based medicine," or nearly any reddit post mentioning East Asian medicine in any way, and you will inevitably find comparisons to "witchcraft," "homeopathy," and other practices rooted in superstition. Indeed, in my academic career most (but not all) of my mainland-born and raised Chinese academic friends have at some point and in some way or another admitted to me that to them, Chinese medicine is a kind of folk superstition (*mixin* 迷信), and not something they themselves would use (only their parents).[36] Thus, although treading a bit on the line of stereotype, I think it safe to say that by and large, "traditional" in both eastern and western contexts largely only reflects badly on the "backwardness" of the thing under consideration.

Why is this? I think to understand "traditional" we first need to explore what is "modern" - and how, when, and why concepts of modernity as progress took hold.

Most of us probably link "modern" with technological progress - steam engines, automobiles, telephone lines, wi-fi. But intellectuals before these inventions took hold had a different litmus for defining "modern" - educational standards, social reforms, the all-too-sadly-still-to-this-present-day-elusive gender parity, and most importantly for our current discussion, medical practice. In China, in particular, reform-minded intellectuals advocating for these (then) radical social changes were deeply disparaging of "traditional medicine," and themselves deployed the "China as the sick man of East Asia" trope.[37] This happened both literally, in writings suggesting that traditional medicine perpetuated the weakness of the body politic, and more figuratively in recreating the image of the "traditional Chinese woman" into one of frailty whose very body was thought to embody China's own national frailty, through the dual image of her bound feet (preventing her from free movement and work) and her illiteracy (preventing her from "mothering the nation" through producing strong sons).[38] Ruth Rogaski's groundbreaking work explores the concept of "hygienic modernity," i.e. how "modern medicine" (biomedicine) worked to reinforce nationalist power structures through public health and infrastructure campaigns.[39] Sean Hsiang-lin Lei extended this in his chapter on the western-trained physician Wu Lien-teh, who came to Manchuria in 1910 to study and control an outbreak of pneumonic plague there. Wu's work and suggestions for

[36] This is a decidedly "modernist" orientation. See Salguero, "Metamodernist Approach," 2020.
[37] Lu Xun, one of the most famous Chinese writers of the early-20th century, was also a famous detractor of traditional medicine.
[38] See Dorothy Ko's brilliant book *Cinderella's Sisters: A Revisionist History of Footbinding,* as well as Nicole Barnes' *Intimate Communities*.
[39] Rogaski, *Hygienic Modernity*

quarantine had the effect of pitting practitioners and advocates of traditional medicine against his newly imported Western medical notions of germ theory (the theory itself, not even actual treatments).[40] At stake then and there was the (then quite weak) Qing dynasty's territorial control over resource-rich Manchuria. Medicine, in the late-19th and early-20th centuries, was a tool of empire.

Medicine continued to be a tool of empire under the People's Republic, which out of economic necessity was forced to abandon Mao's initial desire to (like Chiang Kai-shek before him) reject traditional medicine for the more modern biomedical paradigm. Instead, Kim Taylor describes how "traditional" medicine underwent "scientization" over the course of the 1950s, in effect modernizing an old practice.[41] Given that it is this specific branch of East Asian medical theory (TCM) that has been codified (through licensing exams and other standards) in the U.S., how traditional is what we practice, versus how modern?

In summary, I think the label "traditional" plays into an inescapable (even if ultimately artificial) binary that does not serve us well. It does nothing to change, challenge, contest, or even converse with the "modern" paradigm of biomedicine. And in reinforcing an "us/them" binary, I think it allows for a lot of magical thinking that is not part of either medical paradigm to float in under the radar: from chakras to healing crystals to essential oils, anything can be traditional. This allows practitioners of "traditional medicine" (defined in its opposition to "modern") to continue flouting other tenets of that biomedical paradigm.

At what point does allowing every other "alternative" practice and idea under the sun to fold into our own practice itself become Orientalism? And at what point does rigid definition of what is or is not part of a historically diverse, pluralistic medical practice become the construction of a reified fantasy past, as well as a form of gatekeeping? And how do all of these factors then sit with the mandate of professionalization (standardized practice via licensing exams and ACAOM approved school curricula) we have just to survive in the overall modernist worldview of the United States in 2020?

Takeaway | It is my opinion that in defining our profession through the selection of a replacement term, we also need to define our scope of practice more clearly. Not just in what we are allowed to do by external regulators, but also in what we, as a professional community, deem acceptable and unacceptable ways of presenting medical knowledge to the public.

[40] Lei, *Neither Donkey Nor Horse*
[41] Taylor, *Medicine in Communist China*

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