Introduction
Mercurial Assemblages and Analytical Bricolage

> Power is everywhere; not because it embraces everything, but because it comes from everywhere. … Power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society.
>
> —Michel Foucault, *The History of Sexuality*

Southeast Asia is a region with a tumultuous history and an impressive diversity of religions, languages, and cultural practices. Within the region, Singapore is one of the most densely populated cities (7, 615 people per square kilometer and a total population of 5.47 million as of 2014), as well as the only nation-state with an ethnic Chinese majority (76.2 percent).[1] In the three decades after separation from Malaysia in 1965, Singapore's gross domestic product skyrocketed, transforming the country "from third world to first," as founding father and first prime minister Lee Kuan Yew often remarked.[2] This rapid transformation was facilitated by the deliberate and transparent engineering of the environment, the society, and the economy that established Singapore's international reputation for austere governance. For these and other reasons, Singapore seems to stand apart from its neighbors, even amidst such regional diversity: it is the supposedly sterile metropolis (called the Switzerland of the East) and so-called economic miracle of Southeast Asia.

"Singapore is very clean and safe." "Singapore is a high-tech, Westernized city." "Singapore is 'Asia for beginners'." "Singapore is a 'fine' city."[3] Over the course of the research and writing that informs this book, I heard many such generalizations, assessments, and jokes.

Although these expressions oversimplify an incredibly complex and dynamic environment, perhaps there is a kernel of truth in each. In my experience, Singapore's visual cues often evoked European and American cities: towering concrete, steel, and glass buildings with climate-controlled interiors and maintained exteriors; tidy sidewalks and bus stops, traffic congestion, and a busy metro system; manicured parks and gardens, trimmed trees, and potted plants; people in suits and skirts bustling through the Central Business District; retired men playing cards over lager and women chatting over tea; giddy teens sporting the newest clothing fads, hairstyles, and technologies; and children in school uniforms laughing and running about in playgrounds and schoolyards. On the other hand, as the Singapore Tourism Board's 2004–10 campaign asserted, there are many aspects of life in this tropical island city-state that are uniquely Singapore.[4]

Aside from this tourism-oriented branding, the government has embraced the labeling of Singapore as the Biopolis of Asia in foreign scholarship and media (Clancey 2012), encouraging their reputation for the most "advanced" biomedical facilities and research in the region. The Economic Development Board (the state agency responsible for economic planning) describes Singapore's biopharmaceutical industry as "Asia's fastest-growing bio-cluster." As of 2017 the board's website boasts seven biomedical research institutes, five research consortia, more than fifty research and development companies, numerous investigational medicine units, clinical trials in public hospitals and specialty centers, and the joint government-corporate Agency for Science, Technology, and Research.[5] Singapore's Biopolis is not only the name of a technology park in which public and private interests are brought together to produce marketable products, but it also describes a singular, technotopian vision for the bio-economic development of Singapore and its perfectible body politic (Waldby 2009). At the nexus of (cautious) scientific entrepreneurialism and post–severe acute respiratory syndrome (SARS) biosecurity concerns, the Biopolis ecosystem strategically positions Singapore as a global hub for cosmopolitan science and medicine with a supposedly Asian orientation (Ong 2016). This heavily subsidized "bio-cluster" is marketed to attract international investors, transnational biopharmaceutical companies, highly qualified scientists, and biomedical professionals (both expatriate and local), and to project the image of a "modern," high-tech nation-state.

Meanwhile, subsidized healthcare services and screenings are provided for the general populace at more than 1,500 private clinics and eighteen government polyclinics, eight public hospitals (six of which are acute general hospitals), and six national specialty centers. In the 1980s and 1990s Singapore's acute hospitals and specialty centers were privatized—restructured as so-called private entities that were wholly owned by the government—while so-called public hospitals continue to be managed as not-for-profit organizations. In the 2010 National Health Survey, the Singapore Ministry of Health (MOH) reported that 74.6 percent of Singaporeans consulted private general or family practitioners, while 25.4 percent visited government polyclinics or military medical centers. Meanwhile, among Singaporeans aged forty to sixty-nine without prior medical diagnoses, 63.5 percent participated in diabetes screening, 61.2 percent had their cholesterol checked, and 70.8 percent were screened for hypertension, suggesting remarkable compliance with public health campaigns administered through the MOH and Health Promotions Board (HPB). Finally, 61.7 percent of Singaporeans aged eighteen to sixty-nine described their overall health as "very good" or "good," 36 percent regarded their health to be "moderate," and 2.3 percent reported it was "bad" (MOH 2010: 72–82). Along with declining rates of hypertension, high blood cholesterol, and behavioral risk factors like smoking and lack of exercise—and despite rising rates of obesity and diabetes—these statistics are used to highlight the successes (and potential areas for improvement) in Singapore's biomedical healthcare system.

Disregarding the widespread use of so-called alternative medicines and the creation of a statutory board under the auspices of the MOH to regulate the practice of Chinese medicine in 2001, these investments and figures have explicitly excluded what they refer to as traditional medicine.[6] Nonetheless, Singaporeans persist in using and practicing Chinese medicine. As Loh Chee Hong (2009) notes, a 2001 survey found that 67 percent of Singaporean respondents received Chinese medical care, while Loh's own study found that 84.3 percent of parents surveyed administered Chinese medical herbs to their children and 43.7 percent took them to receive acupuncture. Furthermore, since 2004 Singaporean hospitals have increasingly offered herbal and acupuncture therapies—albeit in separate wards—suggesting a gradual acknowledgment (of a sort) of

the role of Chinese medicine by both the state and biomedical institutions. This small, island nation-state off the tip of the Malaysian peninsula thus provides a fascinating opportunity to examine power, knowledge, and practice as negotiated with reference to the dynamic position, practice, and use of Chinese medicine and food.

Beginning with the observation that Chinese medical materials, practices, and processes are assembled in different ways within various sociopolitical conditions, this book will describe the plasticity and positioning of one such mercurial assemblage.[7] More precisely, I will examine the emerging practice, promotion, and use of Chinese food and medicine in Singapore in relation to post-colonial power dynamics, identity politics, sensorial experiences, and creative negotiations of convention. This research is theoretically and methodologically informed by critical medical anthropology, and includes a range of perspectives, including those of patients, caregivers, physicians, educators, legislators, shop owners, researchers, entrepreneurs, and students. This broad scope explores individual and collective agency vis-à-vis state agendas, and considers contemporary medical practice in relation to government policies favoring international investment, urban redevelopment, healthcare regulation, transnational flows and circulations, "multiracial" nationalism, and the management of history and heritage.

This multifaceted orientation situates patients' and physicians' practices within a dramatically changing physical and sociopolitical landscape, with particular attention to the political economy of health and the mutual entanglement of (medical) theory and practice with everyday life. In order to ground theory, observed practice, and embodied experience in a particular place and time, my analysis includes politicolegal representations, restrictions, and campaigns; day-to-day clinic operations; patients' bodily experiences; changes in the lived environment; and Chinese food and medical practices outside the clinic. This book therefore contributes to anthropological debates regarding the post-colonial intersection of knowledge, identity, and governmentality, and to transnational studies of Chinese medicine as a permeable, hybrid, and/or fluid practice.

In the following chapters I will argue that, contrary to modernist discourses, Chinese medicine in Singapore is not a static and bounded practice that can be neatly captured within either a traditional or a complementary and alternative medicine (CAM) framework. Rather,

it can be viewed in light of contemporary reformulations of identity and intersubjective expressions of heritage that are formed somewhat in tension with the "multiracial," nationalist narrative of the Singaporean state. In repositioning their practices, Chinese medical physicians creatively negotiate Singaporean governmentality and biopower, along with the experiential body of knowledge, epistemology, and cultural authority associated with Chinese medicine. Furthermore, Chinese medical patients in Singapore assess Chinese food and medicine by means of embodied experiences within a dynamic lived environment, developing multifaceted healthcare strategies that cannot be reduced to rational choices. Again, these strategies are crafted with respect—but not absolute adherence—to state and public health discourses, often reflecting a pragmatic utilization of both biomedicine and Chinese medicine. They are also adjusted to environmental, seasonal, and dietary fluctuations, as well as to familial and social relations. Hence, pluralism and synthesis, fluidity, and complex power relationships appear to characterize both the post-colonial sociopolitical milieu of Singapore, and the use or practice of Chinese medicine therein.

In this introduction I will suggest a framework of analysis that can attend to these (often competing) representations and interests. After a description of my research methods and field sites, and of some of the people who shared their time and expertise with me, I will introduce several disciplinary trends and concepts to which this book contributes. In particular, postcolonial/postmodern critiques of the grand narratives of modernity—as well as medical anthropology debates regarding medical pluralism and medical systems—have shed considerable light on the dynamic (re)positioning of Chinese medicine in contemporary Singapore. These discussions will provide the disciplinary and theoretical context in which my research and writing was conducted—a kind of wide-angled view in which I situate the more-specific focus on Chinese medicine presented in chapter 1. Finally, I will conclude this introduction with an overview of the book as a whole.

Methods, Settings, and Key Interlocutors

In the course of twenty-two months of fieldwork—between January 2006 and October 2007—I investigated a wide range of processes

and experiences relating to the emergent position, use, and practice of Chinese medicine in Singapore. I conducted observations, interviews, and site visits at locations all over the main island, the adjacent resort island of Sentosa and, on one occasion, the nearby Indonesian island of Batam. To gain perspective and respite from the dense metropolis I also traveled within the region whenever practical, scheduling multiple visits to Thailand and Indonesia, a daytrip to Johor Bahru, Malaysia, and an excursion to Cambodia.[8] The vast majority of my ethnographic data, however, was collected in clinics, shops, eateries, and neighborhoods on Singapore's main island. In order to properly set the scene for the discussions that follow, I will introduce a few of the key people with whom I interacted, and the primary places in which I observed. This will illustrate the breadth of my research activities and sketch the field in which I observed various interests (by no means exhaustively presented here) competing to define and control Chinese medicine in Singapore.

After a little over a year of Mandarin Chinese (Putonghua) instruction and study at the University of Oxford, I was able to follow some of the conversations held in Chinese medical clinics in Singapore.[9] Many consultations were conducted in southern Chinese dialects such as Cantonese, Hokkien, or Hakka (or, rarely, in Malay) owing to the fact that the majority of Singaporean Chinese families emigrated from southern China, rather than from the predominantly Mandarin-speaking north, during the colonial or post-colonial eras.[10] Hence, older Singaporean Chinese often spoke a southern Chinese dialect more fluently than Mandarin, and even the younger Singaporean Chinese I met often grew up hearing and/or speaking Chinese dialects at home. Furthermore, although Malay is the official national language of Singapore (a reflection of colonial and immediately post-colonial political unity with Malaysia), at the time of my fieldwork English was the language of education, commerce, and law. Even older Singaporean Chinese educated solely in Chinese (bilingual education was introduced in 1956) were usually able to speak some English, and most people with whom I spoke were more or less fluent in the language known as Singlish.

At the time of my fieldwork, Singlish was a lingua franca used by people of different nationalities, ethnicities, or dialect groups in Singapore.[11] This relatively straightforward translation of Chinese into English often retained Chinese grammar or word order, while

incorporating words and phrases from Malay, Mandarin, Hokkien, or other Chinese dialects as suited the speaker. For example, "What should we eat for dinner tonight," was simplified in Singlish's economical phrasing as, "Tonight eat what, *ah?*" Or, "Oh man! This movie is incredibly boring," became, "*Wah lau*, this movie damn *sian,*" using the Hokkien adjective *sian* to convey boredom, weariness, or emptiness.[12] To this American English speaker's ear, Singlish was markedly different from the more formal English spoken in board rooms, schools, and political speeches.

According to many Singaporeans with whom I spoke, Singlish was exemplified by taxi drivers and, in the case of Singaporean Chinese, was discouraged by the state in favor of what they considered proper English or Mandarin. For instance, the "Speak Good English" campaign was launched by Prime Minister Goh Chok Tong in 2000, similar to the "Speak Mandarin" campaign initiated by Prime Minister Lee Kuan Yew in 1979 to promote the use of Mandarin, rather than dialects, in the home.[13] While both campaigns have no doubt enjoyed some success, during my fieldwork Singlish was still prevalent. While younger generations of Singaporean Chinese were often fluent in Mandarin (due to compulsory education in their state-ascribed mother tongue), dialects were still widely used. Because it was often immediately (and correctly) assumed that I spoke English, the vast majority of people with whom I interacted insisted on speaking English or Singlish with me, even if I initiated a conversation in Mandarin.[14]

In the nearly two years that I lived in Singapore I had the opportunity and privilege to speak with people operating in a wide range of capacities and contexts.[15] Seeking insight into the intersections of regulatory activity, business and public health, I was fortunate to conduct a semistructured interview with the registrar of the Traditional Chinese Medicine Practitioners Board (TCMPB) and an informal discussion with an HPB dietician. I conducted five months of observations and informal interviews at the Toa Payoh branch of a popular Chinese medicinal herb and food shop called Hock Hua (or Fu Hua, in Mandarin), and was given tours of Chinese food and medicine factories and research facilities (Hock Hua, MediPearl, and Auric). These observations, augmented with informal discussions with Hock Hua's branch manager, were supplemented by several lengthy interviews with Dr Song, a Chinese medical physician with

Figure 0.1. Popular Chinese food and medicine shop, Hock Hua (Fu Hua) in Toa Payoh

a private practice who also consulted for Hock Hua. I also attended numerous public health events and lectures on topics as diverse as weight loss, Ayurvedic health and beauty products, the benefits of *dongchong xiacao* (cordyceps, *Cordyceps sinensis*), chronic pain management, arthritis, asthma, and many others to get a sense of the sources and content of health-related information disseminated to the public. To this end, I also paid particular attention to public health campaigns and commercial advertisements relating to health and the body (including ever-changing beauty product trends) that were posted in public spaces, distributed through the mail, and promulgated in the mass media.

Figure 0.2. Phytopharmaceutical research and development at MediPearl

I also investigated a range of academic and institutional perspectives on Chinese medical practice and products in Singapore. I arranged three interviews with Chinese medical students at the Singapore College of Traditional Chinese Medicine (SCTCM): a stand-alone discussion with one student, followed by two lengthy discussions with another pair of students, one of whom I later observed volunteering at a medical mission in Batam, Indonesia. These interviews were complemented by observations and interviews with Professor Tan Chwee Heng, who lectured and demonstrated acupuncture techniques to SCTCM students and recent graduates at Chung Hwa Yiyuan, the charity clinic on the first two

floors of the building occupied by SCTCM in Toa Payoh. Hoping to broaden my perspective on academic approaches to Chinese medicine in Singapore, I interviewed Professor K. C. Lun who, at the time, served as vice dean (academic) of Nanyang Technological University's School of Biological Sciences. After discussing Nanyang Technological University's new double-degree program for biomedical and Chinese medical sciences in some detail I attended one of their student recruiting events on Professor Lun's invitation. Finally, I arranged semistructured interviews with an environmental and occupational health researcher at the National University of Singapore who was working on cruciferous vegetables and herbs from the Chinese *materia medica,* and with a researcher and entrepreneur working on the popular Chinese fungus *lingzhi* (*Ganoderma lucidum,* also commonly referred to as Reishi mushroom).

In addition to amassing field notes on everyday life in public places—hawker centers (public eateries), coffee shops, housing estates, public transit hubs, on board various modes of transportation (e.g., buses, taxis, and Mass Rapid Transit [MRT] trains), public health lectures, and exhibitions and so on—I conducted observations at three well-established Chinese medical charity clinics: Thong Chai Medical Institute in Outram (hereafter referred to as Thong Chai), Chung Hwa Yiyuan in Toa Payoh (hereafter, Chung Hwa), and Dazhong Yiyuan in Geylang (hereafter, Dazhong). I was also able to observe one of the physicians who volunteered at Chung Hwa practicing at his private clinic in Chinatown. These observations were supplemented by numerous discussions with the physicians with whom I worked, as well as interviews with two clinic administrators and a senior board member at Thong Chai. In order to understand institutional and clinical procedures I spent time in group consultation rooms under the auspices of one or more physicians and in waiting rooms as both an observer and, on occasion, as a patient. It was in the latter role that I felt most able to employ the anthropological method of participant observation. While I sat in multiple patient consulting rooms with my notebook and pens—a rather conspicuous fly on the wall—the slightest sniffle or appearance of ill health was usually noted by the attending physician. More frequently than not, they would insist on a diagnosis and treatment on the spot, requiring me to draw my observations inward and participate in the clinical reality I might have otherwise simply observed.

These participant observation sessions, alongside numerous interviews with physicians and patients (and sometimes their families and friends), constituted the core of my fieldwork. I interviewed, observed, and conversed with Chinese medicine patients of many ages both inside and outside the clinics mentioned above, eighteen of whom agreed to lengthy (one and a half- to three-hour) semi-structured interviews. I conducted the majority of these interviews in public places like cafes, hawker centers, or other air-conditioned environments; a few took place in interlocutors' homes. Because I met many of these people in clinics where I observed regularly, I was able to conduct formal or informal follow-ups in most cases. With five respondents, I was able to schedule an additional semistructured interview (or, if I was particularly lucky, more) for further in-depth discussion. Naturally, these formal interviews were dispersed through nearly two years of everyday observations, interactions, and discussions with friends, colleagues, neighbors, and strangers.

I became fairly well acquainted with two families in particular, interviewing and/or spending time with family members of multiple generations in each. First, a colleague and friend from the University of Oxford (an undergraduate at the time) who was also interested in Chinese medicine kindly introduced me to many of his family members. Often with the assistance of his mother (who generously facilitated meetings with Chinese medical professionals as well), he arranged for interviews with his grandfather and aunt, spent hours discussing Chinese medicine and heritage, arranged and/or attended various engagements, and answered seemingly endless questions about life and work in Singapore. I became acquainted with the second family when initially looking for housing because the head of the family, Tom, and his partner Adelle were housing agents. After spending quite some time at their multigenerational apartment and accompanying them on various family outings, I also came to know Tom's two young children (a boy and an adopted Indonesian girl), mother, and several siblings, as well as their Indonesian maid, whom they considered a family member. Although Tom's mother was the only family member I officially interviewed (Tom's sister translated, as their mother only spoke Teochew), Adelle's unsolicited updates, invitations to accompany her to shops and clinics, and kitchen demonstrations and discussions provided a rich example of health-care management in a middle-class Singaporean Chinese family.

Most prominently, I was fortunate to conduct long-term participant observation with several full-time, highly esteemed Chinese medical physicians. I say "fortunate" not only out of gratitude for their generosity with time, information, and introductions, but also because at the time of my fieldwork there were relatively few well-established, full-time, registered Chinese medical physicians in Singapore. The first was Dr Li, a first-generation Singaporean Chinese woman who practiced general medicine and specialized in hypertension and diabetes at Thong Chai, while also maintaining a private practice. I observed her work with hypertension and diabetes patients in the morning and general practice in the afternoon (with ten to twenty patients per shift at Thong Chai), once per week for two and a half months.[16] These observations were supplemented by several interviews with her and other physicians at the clinic, in addition to the aforementioned administrative interviews.

The second physician with whom I worked was Professor Tan Chwee Heng, a lecturer, demonstrator, and senior Chinese physician at SCTCM/Chung Hwa who also maintained a private practice and taught and practiced *qigong* (a self-cultivation practice involving meditative movement and breathing).[17] I interviewed him at his private clinic on several occasions, conducted observations and patient interviews during his Chung Hwa shifts for a little over five months, and then followed him to Dazhong in Geylang for a further eight months. These observations were (on average) once a week for two and a half hours, during which time he would typically see twenty to twenty-five patients. Outgoing and charismatic, Professor Tan was a reputable lecturer and physician, whose unwavering conviction in his innovative practices set him apart at SCTCM/Chung Hwa. He took great pride in his single-needle acupuncture technique, which he developed in pursuit of a master's degree in China.

Another senior physician at Chung Hwa with whom I worked was Dr Wang—a Taiwanese businessman who had come to Singapore to import and export cane, and then decided to study Chinese medicine at SCTCM. In addition to countless hours of discussion, Dr Wang kindly permitted me to observe and speak with patients in the afternoons at his private clinic in Chinatown twice a month for five months, to accompany and observe him on a medical mission to Batam, Indonesia, and to observe at Chung Hwa, where he volunteered once a week. On average, I worked with him two to three

times a month for six months; in the two and a half hours he volunteered, he typically saw between twenty and twenty-five patients.

Finally, as mentioned above, I also had several opportunities to speak with Dr Song—a Chinese medical physician who worked with the Chinese food and medicine chain Hock Hua. With degrees in both Chinese medicine and business, and a background in medical marketing, Dr Song consulted for Hock Hua on the import, processing, packaging, sale, and export of Chinese medicinal products. He also maintained a private practice and occasionally gave public lectures or media interviews on topics related to Chinese food and medicine. In his capacity as a physician, he negotiated the evolving regulation of clinical practice; as a consultant for Hock Hua, he also followed developments in manufacturing and import practice. Both tasks required a nuanced understanding of the changing social and political position of Chinese medicine in not only Singapore, but also Southeast and East Asia, Europe, and North America.

The socio-intellectual matrix in which my research and writing developed—constituted largely by formal anthropological training at the University of Montana, the University of California, Berkeley, and the University of Oxford—provided both methodological and analytical guidance for the research that informs this book. Having already described my fieldwork methods and activities, I will now outline several of the core disciplinary trends and tools that prepared me for this fieldwork, and then influenced my orientation to its analysis.

"Modern" Ventures and Postmodern Adventures

As described by Adam Kuper (1996), Katy Gardner and David Lewis (1996), Peter Pels (1997), and others, many mid twentieth-century anthropologists reflected on our discipline's establishment in the colonial era and the ways in which this context biased representations of the Other. In the 1920s and 1930s anthropologists had been called on to help in the economic and administrative development of the colonies. After World War II, the increasing emphasis on welfare, the "civilizing mission," and development in the colonies produced further opportunities for anthropological research (particularly in Africa), even as the colonial era was coming to a close (Kuper 1996: 99–103). However, in the post-colonial era (and

through postcolonial theory in particular), debates about the relevance and nature of anthropological knowledge challenged previous anthropologists' claims to scientific objectivity, by evaluating the socioeconomic and political conditions in which their ethnographies were produced.[18]

While I will return to this theme in the conclusion of this book, in this section I will discuss how it relates to the postmodern/poststructuralist challenge of naturalized categories and concepts like modernity. I will then explore how this critical stance was adopted in medical anthropology and investigations of the political economy of health (albeit not always under the banner of postmodernism). These significant intellectual and social transformations inspired many of my research questions and provided various lenses through which I analyzed my data; they played a significant role in how I chose to interact with the people and institutions with whom I worked. They were also integral to the frequent reflexive consideration (and sometimes suspension) of my own epistemological, sociopolitical, and cultural biases as I engaged both the familiar and the strange in post-colonial Singapore.

While early anthropological studies reinforced the idea that colonialism was an inevitable, evolutionary process of "civilization" (or, later, "modernization"), subsequent studies critiqued colonial domination and exploitation. The authoritative manner in which anthropologists generalized and catalogued the people with whom they worked was shown by critics like Talal Asad (1973) and Edward Said (1979) to distort the cultures and practices in question, while revealing broader power dynamics between subject (in this case, the anthropologist) and object (the people they objectified). Thus, in the mid- to late twentieth-century anthropologists began to reflexively consider the objectifying relations inherent in anthropological observations, and critiqued previous representations that depicted culture and practice in terms of static, reified, and discrete categories (Bourdieu [1980] 1990; Gardner and Lewis 1996; Schechner 2002).

Early, ahistorical anthropological analyses—and the reification of culture therein (the depiction of immaterial phenomena and relations as static, material things)—often reinforced a hierarchical, taxonomic arrangement of societies. This supposedly natural arrangement, which placed Western European (and, later, North

American) societies at the pinnacle of social evolution, justified ethnocentrism, imperialist expansion, racism, and early development discourses—ethnocentric and frequently exploitative practices widely criticized by the end of the colonial era. By contrast, later anthropologists (sometimes labeled postmodern or poststructuralist) critiqued grand narratives that sought to explain the world through an all-encompassing and Eurocentric paradigm (e.g., unilinear social evolution, modernity, Enlightenment, and so on), rather than attending to local experience and accounts of reality.

In lieu of these master narratives—founded on naturalized and supposedly absolute Truth—postmodern theorists emphasized the plurality and relativity, as expressed through a multiplicity of voices. According to Jürgen Habermas,

> The project of modernity, formulated in the eighteenth century by the Enlightenment *philosophes,* consists of a relentless development of the objectivating sciences, the universalistic bases of morality and law, and autonomous art in accordance with their internal logic. … Proponents of the Enlightenment … still held the extravagant expectation that the arts and sciences would further not only the control of the forces of nature but also the understanding of self and world, moral progress, justice in social institutions, and even human happiness. (Habermas 1992: 162–63)

In a similar vein, Steven Best and Douglas Kellner (2001) compare the values of modernity and postmodernity. The former was predicated on sociocultural and political domination, the notion of limitless growth and resources, and mastery of nature. Meanwhile, the latter proposed reverence for nature and all life, sustainability, and ecological balance while retaining modernity's emphasis on humanism, individuality, reason, rights, and so on. Postmodernism, then, could be understood (in the simplest of terms) as a broad cultural and intellectual rejection of the post-Enlightenment discourse of modernity. Such critique, however, is not the goal of theorists like Best and Kellner, who stress the need for sustained "critical reflection on the pathologies and illusions of the modern adventure and their continuation in the present" (Best and Kellner 2001: 11).[19]

During the last quarter of the twentieth century, postmodern and postcolonial critiques and deconstructions gained momentum in anthropology in general, and medical anthropology in particular. For instance, anthropologists illustrated the sociohistorical contingency of

naturalized concepts such as illness, sickness, and disease (Kleinman, Eisenberg, and Good 2006; Young 1982); knowledge and belief (Good 1994); race (Bibeau and Pedersen 2002); a singular, universal human body (Lock and Nguyen 2010; Scheper-Hughes and Lock 1987); and medicine defined as an activity isolated from other aspects of life and with exclusive reference to biomedicine. As I will describe later in this introduction, medical anthropologists also began to question the utility of the concept of medical pluralism, particularly where heterogeneous medical practices were arranged so that so-called modern biomedicine retained its air of superiority. Even when they used terms like "medical systems" and "medical pluralism," scholars like Charles Leslie (1976, 1992) challenged the reification of traditional medicine and the false dichotomy between tradition and modernity on which it was based. Similarly, historical and anthropological studies called into question the "traditional" designation in the twentieth- and twenty-first-century reinvention of classical Chinese medicine as "Traditional Chinese Medicine" (TCM).[20]

In contrast to their anthropological predecessors (who produced synchronic analyses theoretically classified as functionalist, structuralist, or structural-functionalist), postcolonial medical anthropologists increasingly viewed health, illness, healing, and embodied experience as embedded, or emerging, within particular political and economic conditions[21]. Early *clinical* (or applied) medical anthropology analyses often neglected sociohistorical context, focusing narrowly on the so-called problem of patient compliance and indigenous communities' resistance to biomedical interventions. Such studies were later interpreted as cultural translation projects that unreflexively served to disseminate and reinforce biomedical goals and standards at the expense of local practices. As a more politicized, decolonized anthropology developed, critical medical anthropologists began to acknowledge material and social determinants of health and illness, as well as the importance of political and economic context in their analyses. In the spirit of critical theory and reflexivity, many critical medical anthropologists turned the anthropological gaze toward the "once-sacrosanct terrain of biomedicine" (Morsy 1996: 32), and interpreted embodied experiences and health-related practices within a framework of power dynamics.

Nancy Scheper-Hughes's (1992) study of mothering, hunger, illness, and child mortality in Northeast Brazil provides an example of

this conceptual framework. Broadly speaking, Scheper-Hughes considers individual and collective experiences of the body "as socially represented in various symbolic and metaphorical idioms, and as subject to regulation, discipline, and control by larger political and economic processes" (Scheper-Hughes 1992: 175). This perspective integrates the three bodies heuristic she developed with Margaret Lock (Scheper-Hughes and Lock 1987): the individual body experiencing the world, the social body symbolizing nature and culture (following Douglas [1970]), and the body politic inscribed with power relations. Although I will focus on the body politic perhaps more heavily, this book will illustrate how all three analytical perspectives—and even a fourth, body ecologic, proposed by Elisabeth Hsu (1999, 2007)—can be intertwined in the observation of practice.[22]

Other powerful examples of the entwinement of political economy and suffering can be found in physician-scholar Paul Farmer's research, writing, and medical practice in Haiti and the United States. Farmer explains how the uneven distribution and outcome of infectious diseases (1999), as well as experiences of suffering and structural violence (2003), are embedded within larger social, political, and economic dynamics. According to Farmer, the underlying conditions that perpetuate structural violence—extreme and relative poverty, social inequality, regular acts of violence, and so on—prevent people from satisfying basic human needs (e.g., food and water). Because structural inequalities and human rights violations are not haphazard or accidental, Farmer considers them to be "symptoms of deeper pathologies of power" (Farmer 2003: 7). Hence, he asserts, the experiences of everyday people are intimately connected with national and transnational processes (e.g., social inequality and political economy) and discourses (e.g., human rights and social justice).

Similarly, numerous scholars have presented examples of the historical and contemporary entwinement of medical practices and political economy in Southeast Asia. For instance, Lenore Manderson (1990) describes inequalities in the distribution of medical resources, and the production of ill-health, in British Malaya (present day Singapore and Malaysia). Adopting an intentionally neutral stance on the impact of colonialism, Ing-Britt Trankell and Jan Ovesen's (2004) account of French colonial medicine in Cambodia mediates between accounts that glorify the achievements

of European doctors in the colonies and those that critique colonial medicine as a tool of empire. Ayo Wahlberg (2006) explains how the revival and strategic modernization of herbal medicine in Vietnam integrated it within the national public health delivery system—a biopoliticization that promoted public health and encouraged medical self-sufficiency in rural areas. Davisakd Puaksom (2007) describes how the Thai state used Pasteurian medicine and the notion of germs as a hegemonic instrument of national development. Finally, Claudia Merli (2010) interprets *sunat muu*—an annual, collective male circumcision ritual—as "a conquest of the state and biomedical power" (Merli 2010: 735) that is, in turn, appropriated by some local Malay-Muslim men in southern Thailand in asserting their identity vis-à-vis the Thai Buddhist nation-state. These examples further illustrate how issues of power, political economy, and sociohistorical context have come to the fore in anthropological analyses of health, illness, and healing.

Whatever we choose to call this artistic, social, and intellectual zeitgeist, post-colonial anthropology seems to be confronting a growing number of contradictions, competitive claims, and reformulations of theory and practice. As I will explore more fully in chapter 1, biomedical values and standards of evidence are frequently used in assessing Chinese medicine in Singapore and elsewhere, with little regard for the epistemological and ontological differences between the two medical practices. On one hand, such evaluations often marginalize or devalue Chinese medical drugs and other therapies. On the other hand, these values and standards are sometimes appropriated by Chinese medical physicians and entrepreneurs seeking to legitimize their practices and allay patient-consumer concerns about the safety and authenticity of their interventions. This is particularly apparent in integrated healthcare systems-cum-medical markets, where so-called traditional medicine is "modernized," or otherwise refashioned, through industrialized production processes and standardized clinical practices.

In consideration of these dynamics, I found inspiration—if not resolution—in a wide range of sometimes contradictory perspectives, perhaps in resonance with this ethos of ambiguity, negotiation, oscillation, and reinvention. This book will therefore draw on an assortment of complementary techniques and frameworks—including a critical, politico-economic orientation to medical anthropology,

postmodern skepticism of naturalized Truth, and postcolonial critique of modernity. Like analytical bricolage, these disciplinary trends and concepts provide an eclectic but coherent framework on which my analysis of the competing interests and uneven distribution of medical authority in Singapore will accrete.

Assessing Medical Pluralism and Systems

Despite the dubious distinction of being the only nonbiomedical practice under legislative scrutiny in Singapore, Chinese medicine continues to play a vital role in Singaporean daily healthcare strategies (both home based and clinical).[23] Indeed, at the time of my fieldwork it was the only "traditional" medical practice to be included in the healthcare system at all, yet from a politico-economic standpoint, it might still be viewed as a marginalized practice.[24] From the perspective of many members of the Chinese medical community, however, their ongoing efforts to reposition and professionalize their practice (discussed further in chapter 1) are dynamic negotiations rather than signs of a static and inherently subordinate position. Critical medical anthropologists have similarly highlighted the emergence of medical practices within dynamic sociohistorical, political, and economic processes, rather than judging them with reference to grand narratives, such as modernity, and exogenous standards and values.

There have been a number of terms proposed to describe the relationship between coexisting medical practices: "synthesis," "integration," "hybridity," "dominance," "subjugation," and "monism," to name a few. Despite the nuances in perspective that differentiate these terms, each suggests an orientation to medical pluralism in general, and to the power dynamics of and between medical practices in particular. Medical anthropologists have especially noted uneven power distributions in colonial or post-colonial contexts, in which individuals often engage both indigenous practices and inherited practices such as biomedicine. Where indigenous medical practices have been disempowered by means of the same, or similar, dynamics that facilitated colonial exploitation of local people, biomedical monism (or hegemony) is considered to be prominent characteristic of medical pluralism. Where biomedicine is the dominant medical practice and so-called traditional practices are then subsequently

introduced, reinvented, or popularized, the latter is often referred to as "complementary and alternative medicine" (CAM) in popular and/or political discourse. In this section I will discuss anthropological debates regarding medical pluralism and medicine in everyday life in order to sketch an analytical framework for subsequent discussions of the contemporary status of Chinese medicine vis-à-vis biomedicine in Singapore.

Charles Leslie's work on Asian medical systems, and medical pluralism, has been particularly formative in the discipline of medical anthropology. Working around the theme of medical revivalism, Leslie's (1976) edited volume, *Asian Medical Systems: A Comparative Study,* demonstrates variability in how medical pluralism is negotiated in a variety of settings. Rather than evaluating Asian medical practices from an epistemologically exterior point of view, Leslie advocates examining the underlying assumptions of cosmopolitan medicine (i.e., biomedicine) and the manner in which its privileged position subjugates other forms of medicine. Furthermore, he considers the term "modern medicine" to impose a false dichotomy of modernity and traditionalism onto cosmopolitan and Asian medicine respectively, and instead stresses that both are dynamic and open to innovation. Finally, Leslie stresses the exchanges and interplay between medical practices, highlighting the subtlety with which systems are interrelated.[25]

Similarly challenging the reification and analytical division of medical practices, Emiko Ohnuki-Tierney (1984) illustrates that medical practices do not remain neatly divided and isolated in medically plural societies but are instead mutually entrenched. Nor, she claims, do shifts in the dominant medical paradigm mean that prior concepts or practices are simply uprooted and replaced. Instead, she illustrates how Japanese health-related concepts and behaviors are consistent with historical cultural patterns but couched in biomedical terms. Similarly, Judith Farquhar (1987) observes that the notion of pluralistic medical systems is dependent on the division of reified practices, and that non-Euro-American scientific and philosophical discourses (e.g., Chinese medicine) are based on very different understandings of categories such as knowledge. Hence, she notes, the act of evaluating Chinese medicine set against biomedicine often entails an ethnocentric mode of description, based on naturalized constructions of subjects and epistemology in "Western" philosophy

(see also Rabinow 1996). According to Elisabeth Hsu (2008), one of the strengths of medical pluralism appears to be its ability to challenge biomedical monism with viable alternatives. However, she notes, it has also been critiqued from a Marxist perspective for creating a false consciousness of choice that reifies capitalist values, and by subsequent deconstructions of the notion that biomedicine is monolithic to begin with.

Meanwhile, Joseph Alter's (2005) introduction to *Asian Medicine and Globalization* observes that practices and concepts sometimes restricted to the domain of medicine are also linked with other areas of life—from philosophy and religion, to sports and war. He claims that defining medicine exclusively in terms of the logic of healing inhibits a more inclusive, health-oriented framework by reducing broader issues of health, healing, and the body to biomedically defined questions of efficacy and legitimacy. Hence, Alter argues, the politics of culture in which the category of Asian medicine is constructed—bound within certain discourses and power dynamics—restrict the definition of what constitutes medicine to Euro-American scientific terms. This orientation is further illustrated by other contributors to the volume. For instance, Martha Ann Selby (2005) describes how the Euro-American wellness industry transformed notions of women's health by repackaging and commodifying Ayurveda, which ultimately enabled them to sell abstract concepts such as purity, wellness, and so-called enlightenment. Similarly, Susan Brownell (2005) describes the impact of geopolitics on Chinese body perceptions and practices, manifest in the adoption of cosmetic surgery. Both authors demonstrate that the categorical boundary between medicine and beauty is, in reality, blurred by socioeconomic and political interests.

The entanglement of socioeconomic and political interests with medical practices is also illustrated in Steve Ferzacca's (2002) account of medical pluralism in post-colonial Indonesia and Soheir Morsy's (1988) analysis of Islamic medicine in Egypt. Ferzacca illustrates how development ideology was used by the Indonesian government (during Suharto's regime) to appropriate the concept of medical pluralism, which in turn served to control the population. He demonstrates how local and global power relations are intimately involved in the practice and perception of traditional medicine and discusses how the regulation and management of medicine served

development purposes, as well as ideologies of national identity and heritage. By contrast with developments in Indonesia (Ferzacca 2002), India (Alter 2005), or China (Taylor 2005)—where the revival of traditional medicine refashioned practice in accordance with political (and particularly nationalist) agendas—Egypt (like Singapore) developed a biomedical infrastructure that marginalized other medical practices. Morsy notes that while the Egyptian state subsequently moved to legitimize Islamic clinics, the state's equipment, orientation to healthcare, practices, and political associations were based on a biomedical model. Thus, Morsy asserts, the growing number and power of Islamic clinics in Egypt reflects the dynamics of international biomedical hegemony, rather than a revival of traditional medicine.

Other scholars have addressed the limitations of medical pluralism and the rationale for investing in what is described as traditional medicine by investigating the ways in which plural medical markets developed and are maintained in the first place. Craig Janes (2002), for instance, cites Cant and Sharma's (2003) new medical pluralism—a reconceptualization of the concept in consideration of economics-driven global health policy. Assuming competition in a capitalist market fosters the structural (if not intellectual) decline of biomedical domination, Janes posits "a therapeutic pluralism structured along market, rather than cultural, or even political, lines" (Janes 2002: 285). Here, he explains, the definition of medicine and medical efficacy is conflated with efficacy in the market; measured in terms of cost, health care is moved into the private sector where higher prices reduce public access to care.[26]

Vineeta Sinha (1995) also critiques the concept of medical pluralism in Singapore, which she claims was appropriated as a political concession to "native" healing practices. This tacit acknowledgment established the coexistence of "discrete, bounded 'systems' of healing" through the circumscription of medical practices, the assumption of multiplicity, and the assertion of difference (Sinha 1995: 13). Sinha observes that not only do such constructions seem to privilege theoretical and textual sources above lay or informal healing strategies, but they also restrict the field of observation to formal medical practices and settings. By contrast, she explains, the "use of ordinary household, kitchen and garden articles for the everyday management of common medical ailments" (Sinha 1995:

240) not only challenges the notion of expertise by exploring home-made wisdom,[27] but also demonstrates that food and medicine are not necessarily mutually exclusive categories.

The importance of home-based remedies and the conflation of the categories food and medicine—a challenge to a neatly circumscribed domain of medicine in addition to the tidy division of discrete systems in medically plural societies—is by no means unique to Singapore. For example, Hareya Fassil (2005) describes home-based medicinal plant use and lay traditional knowledge in Ethiopia, seeking to broaden discussion of Ethiopian traditional medicine beyond the formalized knowledge of professional practitioners. Alfred Maroyi (2012) explores the ethnomedical, dietary, and ornamental uses of garden plants—both indigenous and introduced—in Zimbabwe, suggesting that further botanical studies are necessary to protect the public from accidental plant poisoning. Furthermore, in the context of a traveling study abroad program for which I taught in 2014, representatives of the Hanoi Medical College in Vietnam described the Vietnamese healthcare system, the establishment of traditional Vietnamese medicine, and the government's promotion of household medicinal gardens to our group of intrepid young explorers. In conjunction with broader initiatives to collect herbal materials and knowledge in rural Vietnam, we learned, both urban and rural Vietnamese communities have long been encouraged to grow particular plants for primary healthcare and dietary purposes.[28]

Sinha, Fassil, Maroyi, administrators at the Hanoi Medical College, and others have noted that traditional health practices—including lay or home-based remedies—hold great promise in the provision of affordable healthcare:

> Indeed, it appears that there is considerable traditional health knowledge in the public domain. The fact that traditional health knowledge is so pervasive, and the use of local medicinal plants so widespread, has staggering public health implications which simply cannot be ignored by those concerned with development and the promotion of public health and natural resources management (Fassil 2005: 47).

Accordingly, the preparation of home-based remedies and the observance of dietary proscriptions and prescriptions—practices that have been adjusted and adapted in form and composition over time—are essential to primary healthcare in many places, including Singapore.

Furthermore, food and medicine are interrelated concepts in Chinese medical theory and practice (both within and outside the People's Republic of China [PRC]), and diet is a vital component of health as conceived by Singaporean patients, physicians, and public health officers alike. Hence, this book employs the broader definition of medicine suggested by Alter, Sinha, Fassil, and others. Beyond clinical interventions, I will consider home-based remedies, aspects of the natural and built environment, and social interaction and heritage in the larger processes of health maintenance and healing.

Context and Conclusions: An Outline

With the increased attention to power relations in postcolonial anthropology, interaction between fluid practices—within and between societies—was often phrased in terms of competing interests, such as the tensions between biomedicine and traditional medicine (or CAM), or between formal and informal health sectors. While acknowledging how these boundaries might be produced or contested locally, many medical anthropologists have been careful to minimize the imposition of their own divisions of reality onto the practices and fields they observe. Hence, the implicit privileging of biomedical epistemology and practice that was present in early anthropological studies gradually gave way to critical consideration of how the power dynamics in medically plural societies encouraged this privileging to begin with. Despite the critiques of medical pluralism as an analytical concept, however, patients, medical professionals, and politicians around the world use and assess what they perceive to be distinct healthcare options. The manner in which these practices are assembled, disassembled, reassembled, evaluated, circumscribed, brought together, or differentiated in a given field of practice or social context therefore remains an important question.

In Singapore's tightly controlled sociopolitical and physical environment, the post-colonial state developed public health agendas and legitimized specific medical practices in accordance with a particular art of government (Foucault 1991). In addition to providing state-subsidized medical insurance and healthcare infrastructure, as well as enacting more recent legislation that finally drew Chinese medicine into its jurisdiction, the MOH has invested in public

health education and surveillance campaigns. These efforts must be contextualized within a historical propensity to privilege the needs of economic development strategies over social welfare, to be discussed further in chapters 2 and 3. In particular, the post-colonial state took whatever measures were necessary to allay the fears of potential foreign investors, corporations, and talent. Thus, a tightly regimented and docile body politic was crafted to ensure a stable sociopolitical climate and labor pool that would be conducive to the dynamic economic visions of the state.[29]

Bearing this sociopolitical landscape in mind, this book will consider the meanings, junctures, and disjunctures associated with the supposed resurgence of Chinese medicine—an "icon of Chinese culture" in Singapore (Quah 2003: 1997). While this study was intentionally designed to examine the practice and use of Chinese medicine outside the PRC, it was also primarily oriented toward Singaporeans with ancestral or more-immediate familial ties to China. In the course of my fieldwork, the majority of people with whom I spoke asserted their Singaporean identity—more or less content with the lifestyle and opportunities provided in Singapore, they professed no desire to permanently return to China. Nonetheless, many Singaporean Chinese still maintained connections with their ancestral homeland and, through these connections or family traditions, preserved or reinvented elements of their Chinese heritage and identity. As Stella Quah notes, the use of Chinese medicine formed an essential part of how many Singaporean Chinese actively related to this "cultural inheritance" (Quah 2003: 2003).

For many Singaporean Chinese patients and physicians, then, Chinese medicine was more traditional than the biomedical healthcare system with which they also engaged; at the same time, however, both biomedicine and Chinese medicine in Singapore were often depicted as "modern" or modernized. This stands in contrast with the government's economic evaluation (or neoliberal valuation) of Chinese medicine as CAM. As I will describe in chapter 1, the dynamic position of Chinese medicine in medically plural Singapore was often negotiated with explicit reference to biomedical standards and political discourses of CAM. While a CAM-based framework aligns nicely with World Health Organization (WHO) categories and nationalist boundaries of medicine, I will argue, it cannot account for the way in which Chinese medical professionals

have professionalized, "upgraded," and (re)invented their practice over space and time. Nor does it consider the complex relationship between the popularity of Chinese medicine and the contested cultural heritage of Singapore's ethnic Chinese majority. Hence, I suggest we consider a broader sociohistorical and transnational context in which the contemporary assemblage of Chinese medicine in Singapore continues to emerge and transform.

In chapter 2 I will outline a few key historical trajectories for this analysis, describing how Singaporean history and heritage were managed by the post-colonial state. In particular, I will argue that the political management of "race," history, and national identity directly impacted practices associated with Chinese heritage, such as Chinese medicine. After a tumultuous history of migration and colonial identity politics, the Singaporean state sought to promote "racial harmony," social and political consensus, and a productive population, using a logic of smallness that highlighted Singapore's lack of natural resources, internal social divisiveness, and insecurity with respect to other nations. Through careful and overt social engineering, the state crafted a unified, yet ranked, "multiracial" national identity and an ex post facto desire for independence. While these nationalist efforts—based more or less on the European forms of political economy inherited from the British—were certainly successful, individuals, groups, and neighborhoods nonetheless generated a very different sense of community in their own ways. Hence, I conclude, collective or intersubjective expressions of heritage were still possible through annual or sporadic community events, and many Singaporeans continued to practice and/or use Chinese medicine, despite its political marginalization.

In chapter 3 I will use Michel Foucault's notions of governmentality (1991) and biopower ([1976] 1990) to analyze the development of Singapore's healthcare system, the recent regulation of Chinese medicine, and the operation of Chinese medical institutions. Delving deeper into Singaporean biopower, I will describe how this technology of power is evident both in regulatory divisions and legislation (biopolitics) and in day-to-day, disciplined clinic operations (anatomo-politics). However, I will argue, not all physicians practiced Chinese medicine in the same way. Furthermore, we must account for practices that (even in institutional settings) appeal to forms of authority derived from other sources, as I will illustrate with

reference to particular physicians' practices and the notion of *jingyan* (experience). In addition to biopower, then, in this chapter I will describe key facets of the *emergent* (as opposed to static or exclusively historical) experiential archive that legitimizes and informs Chinese medical physicians in Singapore.

Whereas chapters 2 and 3 focus on the historical, legislative, and conventional aspects of Chinese medical practice (as well as contravening practices), in chapters 4, 5, and 6 I situate Chinese medicine within everyday life by discussing patients' sensorial experiences, embodied knowledge, the lived environment, lifestyle, and home-based remedies, as well as the conjunction of food and medicine. I will begin, in chapter 4, by illustrating how patients' perception and use of Chinese medicine is closely tied to embodied experience. By exploring bodily and then verbal articulations I will illustrate patients' (and caregivers') active engagement in the clinical encounter, demonstrating how their healthcare strategies cannot be reduced to mere rational choices. The ethnographic examples presented in chapter 4 will therefore explore the relationships between bodily sensations, embodied and intersubjective experiences, and treatment selections and evaluations. This will be followed, in chapter 5, by an ethnographic elaboration of Elisabeth Hsu's (1999, 2007) notion of body ecologic—an interpretive framework within which aspects of seasonality, the lived environment, and associated healthcare strategies can be explored.

Whether in Singaporean clinics, homes, or public spaces, various representations of the relationship between (individual and collective) bodies and the physical environment competed for authority. Whereas the public health discourses of the state suggested that a potentially dangerous environment needed to be kept at bay by the detailed management of domestic spaces, bodies, and things (evident, for example, in antidengue campaigns), Chinese medical physicians relied on different metaphors and conceptualizations of the body ecologic. I will therefore describe how many Singaporeans negotiated their health within a dramatically transformed landscape, particularly in terms of experiences of heat and cold as well as seasonal and dietary fluctuations. I will argue that despite variation between patients (as well as between patients and physicians), the regulation of internal and external heat and cold was remarkably common in Singaporean Chinese healthcare strategies.

Furthermore, while these concepts and strategies were theoretically and materially related to Chinese medicine, they were not always described by patients in such terms.

In chapter 6, I move even further beyond the clinic walls in order to consider common dietary practices in Singapore in relation to the healthy lifestyles promoted by the state, and Chinese medical concepts in turn. I will describe how various fields (including gastronomy, medicine, public health, and social or family relations) intersect in homes, Chinese medicine and food shops, hawker centers, and public spaces. Here, I return to Singaporean governmentality and self-care techniques—this time with reference to dietary prescriptions and proscriptions, and healthy lifestyle campaigns, to which the public has undoubtedly been responsive in many respects. This framework does not, however, sufficiently explain all aspects of Singaporeans' food-related practices, particularly those linked with a deeper sense of tradition and heritage than that provided by the state. As a simultaneous evocation of and deviation from their cultural heritage, Singaporean Chinese gastronomic and dietary practices can therefore also be viewed as avenues for the creative negotiation of authority, heritage, identity, and health.

Finally, in chapter 7 I will return to the main themes of the book in order to reflect on how the history of anthropological research and writing, and the mid twentieth-century crisis of representation in particular, guided my research and findings. I conclude that the plurality and plasticity of Chinese medicine in Singapore are salient features that resist its circumscription within a static, delimited medical domain. Hence, I emphasize its dynamic embedment within everyday life, alongside other practices associated with Chinese cultural heritage (including language, festival and religious observances, food, and so on). In light of Singapore's tumultuous sociopolitical history, complex identity politics, plural healthcare fields, and constantly changing urban landscape, the adaptive persistence of Chinese medicine in Singapore can also shed light on the intersection of post-colonial agency, knowledge, and power. Despite the apparent strength of the Singaporean state, governmentality and biopower provide only one vantage from which to view the mercurial assemblage of Chinese food and medicine. By broadening the analysis to include physicians' creative practices and patients' embodied experiences, as well as dietary/culinary and medical practices outside

of the clinic, we can begin to explore the larger tensions and processes in which Chinese medicine is embroiled.

Notes

1. National Population and Talent Division (Prime Minister's Office), Singapore Department of Statistics, Ministry of Home Affairs, and Immigration and Checkpoints Authority. 2014: *2014 Population in Brief*, Singapore: National Population and Talent Division.
2. This is, in fact, the title of one of Lee Kuan Yew's memoirs (Lee 2000). As will be described further in chapter 2, Lee helped negotiate Singapore and Malaysia's sovereignty at the end of the colonial period, becoming Singapore's first prime minister in 1965—a position he maintained for thirty years. Lee passed away in March 2015, at the age of 91.
3. The word "fine" is a tongue-in-cheek allusion to the myriad fines imposed by the government—from trespassing to spitting or urinating in public.
4. In March 2010 the Singapore Tourism Board shifted to a new advertising campaign and online presence called "YourSingapore" (http://www.yoursingapore.com/en.html).
5. As reported on the Economic Development Board website: https://www.edb.gov.sg/content/edb/en/industries/industries/pharma-biotech.html.
6. According to Vineeta Sinha (1995), "traditional medicine" in Singapore—as defined in state, professional, and popular discourses—includes Chinese medicine (sometimes used interchangeably with traditional Chinese medicine, or TCM), Indian medicine and Malay medicine. To date, only Chinese medicine is regulated by the state.
7. This description of the local manifestation of a transnational practice owes much to Stephen Collier and Aihwa Ong's notion of global assemblages—the new material, collective, and discursive relationships defined by specific territorializations of global forms (Collier and Ong 2005: 3–5, 9–14).
8. Subsequent to the fieldwork that informs this book, I returned to Southeast Asia four times: I visited Singapore and Indonesia for six weeks in 2008 (during which I conducted a few post-fieldwork interviews and site visits), I spent six weeks in Vietnam under the auspices of a traveling study abroad program for which I taught in 2014, I presented at a conference and conducted preliminary postdoctoral research in Singapore in 2015, and I traveled in Thailand for three weeks in 2016.
9. Unless otherwise specified, all Chinese terms in this book will be given in Mandarin Chinese, with pinyin Romanization.
10. The Mandarin term *fangyan* (regional speech) is used to describe all spoken Chinese variants. However, debate persists over whether the often mutually unintelligible regional speech groups of southern China are dialects of Mandarin or, in fact, distinct languages. While the more neutral neologism "topolect" might therefore be a prudent alternative, I

use the term "dialect" in deference to how these differences are usually described in Singapore and in Singaporean (English-language) literature.

11. Mandarin was also occasionally used as a common language between members of different dialect groups, particularly among older Chinese Singaporeans and/or recent emigrants from the People's Republic of China (PRC).
12. In this context, *ah* and *wah lau* are exclamatory expressions (from the southern Chinese dialects Hokkien and/or Teochew) with no direct English translation.
13. Goh Chok Tong succeeded Lee Kuan Yew as Singapore's second prime minister in 1990, until Lee Kuan Yew's son Lee Hsien Loong took office in 2004. At the time of my research, Lee Hsien Loong was still prime minister.
14. This tendency was so prevalent that I was compelled to enroll in a Mandarin Chinese class offered by the Singapore Chamber of Commerce, and even joined a weekly elementary students' Mandarin tutoring group (to somewhat comedic effect), in order to maintain my language competency.
15. With the exception of scholars, people speaking in an official capacity, and Professor Tan (who specifically requested I use his name), the names in this book are pseudonyms.
16. Despite my attempts to explain my research, which led me to conclude I had obtained the necessary permissions to observe in this manner, after two and a half months I was asked to stop observing inside Thong Chai's consultation rooms. Although I was invited to spend time in the waiting areas, I decided to concentrate my efforts elsewhere.
17. In this book I use "Dr" for biomedical physicians, Chinese medical physicians, and individuals with a PhD. The title of Professor is used for individuals bearing that title, regardless of their educational background (e.g., Professor Tan had neither an MD nor a PhD but adopted the title of "Professor" nonetheless because he lectured at the Singapore College of TCM).
18. Throughout this book I will adopt Joanne Sharp's (2009) distinction between post-colonialism and postcolonialism (sans hyphen): whereas the former refers to a period of time after colonialization (and has been critiqued for overemphasizing a conclusive temporal break), the latter refers to an anticolonial stance that acknowledges contemporary continuities with the colonial project (e.g., colonization of the mind). Hence, like postmodernism, postcolonialism analyzes and critiques the dominance of "Western" knowledge and practice by highlighting a multiplicity of voices, styles of knowing, and ways of being.
19. Timotheus Velmeulen and Robin van den Akker (2010) and others have questioned or rejected the term "postmodern" as a descriptor of our contemporary ethos by citing the (inconsistent) persistence of modernist themes and practices. Similarly, Paul Rabinow uses the term "meta-modern" to describe the persistence of what is often referred

to as modernity in our supposedly postmodern world. In his view, configurations of knowledge and power, as well as metanarratives that postmodernists sought to deconstruct, were still present in turn-of-the-century discourses of techno-science and transnational capitalism (cited in Haraway 1997: 42).

20. The abbreviation TCM is used in governmental and administrative discourses in Singapore, but Singaporean Chinese medical physicians and patients more often simply used the term *zhongyi*, its most direct English translation of Chinese medicine, or the name of a specific healing modality (e.g., acupuncture). I will refer to TCM in Singapore only in those contexts where the abbreviation is actually used or implied.
21. The last decade of the twentieth century was marked by recurring (and largely unresolved) debates over the parameters of postmodernism and poststructuralism. Whether advanced under the title of postcolonialism, postmodernism, post-postmodernism, or another intellectual movement, many of the concepts and approaches associated with postmodernism were influential in the development of medical anthropology. While it is not my intention to label the scholars cited in this section as postmodernists or poststructuralists, I hope to illustrate how some of these techniques and perspectives were taken up in medical anthropology.
22. These approaches are heuristic devices for thinking about the body outside biomedical (Cartesian) discourse. As such, they represent different models, or angles, from which to view bodily practice. I do not propose them as absolute definitions or descriptions of reality but, instead, as intersecting, interpretive facets.
23. Several quantitative studies have also attested to this continued popularity (see, e.g., Lee 2006; Loh 2009).
24. Considered in light of Singapore's self-fashioning as the hub of a knowledge-based effervescent ecosystem with a disproportionate attention to the biopharmaceutical industry, the rationale for regulating Chinese medicine might be considered a neoliberal exception (Ong 2006). Alternatively, this legislative circumscription could be interpreted as a presenting a cost-effective solution for addressing the primary healthcare needs of Singapore's majority ethnic Chinese population (Clancey 2012).
25. While Leslie's observations have been positively received within the social sciences, it is worthwhile to note that the modern/traditional dichotomy (as well as the similarly critiqued Western/Eastern medicine distinction) endures in a wide range of discourses—from development and humanitarian aid efforts, to public health and nationalist discourses. Furthermore, as noted by Ulrich Beck and Natan Sznaider (2006), "cosmopolitanism" is a contested term—particularly in light of twenty-first-century trans-disciplinary and transnational challenges. In this book I use the term "biomedicine"—not because it is free of controversy (nonbiomedical practices also involve *bio*logical processes and effects, after all) but because it is a commonly understood referent for particular epistemological, theoretical, practical, and material lineages of medicine.

26. As one of many examples worldwide, this (neoliberal) privatizing and economizing of medicine was certainly a vital factor in the development of Singapore's healthcare system (Quah 1989). However, I contend that earlier (post-colonial) political economy of health and population management agendas, power dynamics, and personal negotiations of identity and heritage must also be considered when examining medical pluralism in Singapore.
27. From these experiences, Sinha insists that we expand our notion of expertise to include areas of the medical domain otherwise omitted. However, in doing so she does not account for the differences in the socialization of knowledge that creates a distinction between expertise and wisdom in the first place. See, for instance, Elisabeth Hsu's (2000) article on *shen* (spirit) for a brief account of the difference between theoretical knowledge and active knowledge, attained from lived experience.
28. Despite the perceived value (and potential savings) of these endeavors, it is important to note that while medicinal gardens might appeal to public health administrators, they do not always result in everyday applications, particularly in fast-paced, urban environments. I had the opportunity to discuss this promotion of medicinal gardens with Ayo Wahlberg—an anthropologist with substantial experience studying Vietnamese traditional medicine—at an academic workshop in Singapore (September 2015). Despite the government's promotion of medicinal gardens, he informed me, most of the urban Vietnamese people with whom he worked obtained their herbs from retailers or wholesalers, who sourced their materials from rural Vietnam or other countries. In his presentation at the workshop, Wahlberg discussed how urban residents' removal from the immediate vicinity of the source of herbs fostered an increasing distrust of the supply chain (and, potentially, the herbs thereby circulated)—an issue that also emerged in my fieldwork with regards to the sourcing of food and herbs from the PRC.
29. These feats of social engineering were designed, in part, to attract international investment and serve the entrepôt functions that had made Singapore so successful in the colonial era (Grice and Drakakis-Smith 1985). After the 1997–98 financial crisis in Asia, the state envisioned a New Singapore centered on information technology and a burgeoning biopharmaceutical industry, seeking to foster an effervescent ecosystem with Singapore as the hub of a transnational knowledge-based economy (Ong 2006).
30. "Upgrading" is a term used by the Singaporean state, and in popular discourse, to refer to the near-constant urban redevelopment process that I will describe further in chapters 2 and 5. Whether or not Chinese medical practices in Singapore have been upgraded or not is a matter of perspective.