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Asian Medicine and COVID-19: Ethnologies, Histories, Reflections

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Everyone is waiting for a safe vaccine. A snake winds its way around a syringe as if it were the rod of Asclepius. Will a new drug render harmless the virus at the center of the picture, which has trapped the entire globe in a pandemic? On the left a biomedical doctor relies on antibodies hovering over him like a speech bubble. Stethoscope, ECG, and computer-assisted sequencing are his instruments. On

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the right is a traditional doctor. He tries to classify the new disease into classical interpretations of humoral theory, symbolized by the tree of physiology and pathology in Tibetan medicine above him. A Chinese doctor would perhaps recommend licorice root, red sage, or mandarin orange peel to recover from a mild course of disease. Everywhere the virus can infect us, but for all the difference in access and medical training, masks and protective clothing are mandatory for all.

"Hope," KATHARINA SABERNIG, 2020, https://www.knitted-anatomy.at/corona-extra/. Used with permission.

When we took it upon ourselves to edit this special issue about a year ago, practically everything about COVID-19 looked different from the way it does today. Asian countries were managing to keep the pandemic at bay, while Europe and the US were going through their worst medical catastrophe in living memory. In the hospital up the road from where one of us lives in London, hundreds of people were dying. Everyone she knows had friends or family who were either very sick or passed away.

Meanwhile, in Singapore, apart from a tremendous outbreak within migrant laborer camps, life was already beginning to come back to normal as the city came out of an early imposed "circuit breaker" stay-at-home period comparatively unscathed. Friends and colleagues in London found this gap mind-boggling. They were asking: but how do they do it? While some of the reasons behind the successes against COVID-19 in East Asia lie in the biomedically grounded institutions, knowledge, and practices that emerged in response to earlier SARS outbreaks, there are other aspects of the story that have yet to be told.

One part of the story is that narratives to do with older regional medical traditions have not been welcomed, or worse, actively suppressed in Anglophone media. Asian medicines have been deliberately misrepresented in high-level publications such as *Foreign Policy* and *Nature*, using nineteenth-century tropes of quackery, deception, and fraud. At the same time, the spread of conspiracy theory culture and internet misinformation has translated alternative, holistic affections for Asian medicine into antiscience sentiments that align with vaccine aversion and antiscientism.

Both of these positions, widespread through Anglophone and Europhone media, misconstrue Asian medicines and actively impair our ability, as a global community, to learn from, apply, and integrate the strategies they have to offer. They both suffer from a flattening out and dumbing down of Asian medicine, an epistemological deafness that fails to acknowledge that these traditions have robust, long-standing cultures of practice, experimentation, and verification, of institutional authority, of adjudication of efficacy within which they have developed responses to epidemics. They are not arbitrarily determined, neither on the whim of a state leader for economic or political gain, nor by the fantastic imagination of unseen manipulators of truth. They emerge from *longue durée* histories of epidemics, medicine, and cultures of care, and these rationales and approaches need to be carefully understood on their own terms in order to be implemented and integrated safely, authoritatively, and productively.

It was this crisis of representation, in the midst of the global health crisis, that motivated us to join forces and invite expert scholars in Asian medical traditions to refresh and deepen our understanding of these traditions. Last year we hosted a webinar series to get the conversation started, some speakers from which appear in this issue. You can watch these online on the IASTAM website, and use them for teaching, perhaps in combination with the articles here.[1] Meanwhile, the authors were busy producing their articles at a rapid pace, and the journal kindly supported us to fast-track the issue so it could be available for teaching, and as a timely commentary on the pandemic.

Our goal here is not to advocate for particular therapeutic interventions. That is a matter for clinical trials, medical bodies, government institutions, and individual practitioners to decide. Rather, our goal is to advocate for deeper listening—especially, to contribute toward an awareness of the cultural, epistemological, and institutional barriers in present-day health care: the false equations of epistemological difference with unprofessionalism, and the hubris of believing that the power of the scientific method to find *good* answers means that it provides the *only* answers. We understand the conversation about COVID-19 to be a long one, one that will not be limited to the present outbreak but extend to future global outbreaks of new health crises. We want to support the intellectual flexibility, nuance, and tone of dialogue that will allow healthcare workers from different paradigms to cooperate, learn from, and support each other in the common endeavor to protect our fellow humans from harm

1 International Association for the Study of Traditional Asian Medicine. See http://iastam.org/iastam-webinars/.

and disease. Such dialogue requires critical tools, and we believe that a good supply of those tools is available within the covers of this issue.

We have much to learn from broadening the perspective on COVID-19: temporally, geographically, and culturally. It is not about superficial comparisons but more about paths of enquiry and styles of dialogue: What are the questions we as global citizens of the twenty-first century need to be asking ourselves in light of this earth-shaking experience? What lessons can we learn? What kinds of vocabulary and styles of conducting comparative discourse are destructive and harmful to further learning and mutual support? What valuable lessons are in danger of being ignored? What angles of the story are clearer to historians, anthropologists, and practitioners of Asian medicine? Can these angles help us make sense of diverse, often competing understandings of pandemics? Does a comparatively high level of historical awareness of pandemics among politicians and healthcare practitioners alter their responsiveness? How can pandemics inspire renewed and revised thinking about social justice?

One key issue is that Asian medical systems have been able to provide explanations for COVID-19 which biomedicine—at least for quite some time—could not. Also, for a very long time—and in many places on the planet, still to date and for long to come—these were the only explanations, or in any case, the only therapies available. Those explanations, derived therapies, and policy positions are delineated in the articles by Ochs and Garran, Flowers, Craig et al., and Tidwell and Gyamtso. The Asian understandings of COVID-19 described in these papers deal not only with physiological multiorgan aspects that in biomedical terms made little sense, but also with the mental and psychological aspects which are a central crucial element in the way Asian approaches address illnesses more generally.

While cultural variations in institution, infrastructure, and policy help to frame the "East Asian COVID Miracle" within a narrative of regionally nuanced biomedicine, the papers in this issue further frame the varied relationships between biomedicine and traditional medicine in different regions. In Singapore, for example, acupuncturists were forbidden to treat any patients at all during the most extreme "circuit breaker" period, with the first signs of easing restrictions being the return of customers to hairdressers and acupuncturists. No traditional medicine practitioner at all, however, is allowed to treat any COVID-19 patients, who must be processed through designated hospitals or community care facilities. Ochs and Garran portray a quite different picture in China, where the state has taken a strong-handed approach, mandating integration between biomedicine and traditional medicine, and the development of nationally recommended herbal recipes and protocols. Meanwhile, Flowers's study of the Korean COVID-19 response shows a biomedical neglect

of traditional medicine similar to Singapore's, except that traditional practitioners were simply ignored and left out of national interventions, though still allowed to practice privately. Contrary to the Chinese case, 20 percent of the population chose traditional style treatments and avoided biomedical treatment. This situation has allowed researchers to examine the effects of traditional medicine independent of biomedicine, producing data quite different in nature and in the degree of transparency. The lack of infrastructural support and homegrown organization and technology, however, has meant a dearth of large-scale published studies. This affords a quite different and arguably more transparent data set for Korean preference for traditional medicine. On the one hand it does not suffer from the influence of state interests which may filter the data coming from China, and on the other it shows effects of traditional medicine on its own, without any biomedical adjuvants. Further review of Korean case study data could potentially be a source for data on the efficacy of interventions. We learn from these two papers that the research data on traditional medicine is not neutral, as is also true for biomedical research; the studies must be considered within the regional epistemological politics within which the research has been produced.

Tidwell and Gyamtso explore avenues of making sense of COVID-19 within Tibetan medical nosology: its etiology, diagnosis, and treatment as understood through the *Four Medical Treatises* (a.k.a. the *Four Tantras* or *Gyushi*), and related commentaries. These nosological categories underpinning infectious disease provide the theoretical background to Tibetan preventive measures and therapeutic approaches explored in their paper, as well as in the paper by Craig et al. Tidwell and Gyamtso's paper also calls us to think deeply about the significance of the environmental aspect of this crisis, as well as some long-term avenues for further exploration. The current pandemic, they suggest "requires a particular reorientation of mind—a therapeutically relevant cultivation of awareness and care for the global community of beings in which one resides." This would be relevant, they propose, not only with regards to the current pandemic, but "even more so, protecting from its recurrence by reversing its socioecological causal conditions."

Another key aspect raised in this issue, which will require our ongoing civic and scholarly vigilance is the racism, or the "'Kung Flu'-ization of COVID-19," as put by Craig et al., endorsed by politicians and circulated through social media, which has fueled responses of ignorance and fear of the other, which all too often have been associated with epidemics and pandemics.

The flexibility and adaptability inherent to the Asian medical systems described here have allowed the interpretations and ensuing therapies in the many months—and among the vast populations of Tibetan-, Japanese-,

Korean-, and Chinese-speaking peoples—when and where nothing else was available, or indeed forthcoming. Craig and her team also document other aspects of how the Sowa Rigpa doctor, Dr. Kunchog, treating his patients in New York at the height of the pandemic, was able to provide explanations and care where biomedical doctors could not. The doctor-patient interactions described in many of the papers here, involve not only the physiological aspect, but also the mental health and emotional health aspects, central, of course, to Asian medical systems at large. Hence, for example, Craig and her team describe how the Tibetan physician they had documented was mindful of treating not only those who have contracted COVID-19 directly, but also those suffering from other profound health effects of the pandemic: depression, anxiety, insomnia, as well as musculoskeletal problems that have arisen from being confined to small living quarters and not getting exercise.

On the other side of the bed, as it were, Lim shares the huge emotional toll placed upon frontline medical staff on an isolation ward at the National University Hospital, Singapore. The piece, written as part of a medical humanities class at Lee Kong Chian School of Medicine, is a reminder that the long-term effects of COVID-19, which as a global society we will need to address for a long time to come, would, or at least should, involve care of the psychosocial-mental aspects, not only of people recovering from long COVID, but also of medical staff, many of whom carry physical and mental scars of traumatic pandemic experience.

Past experience and past memories have important bearings on how pandemics are managed, by societies as well as individuals, as historians of pandemics at large have repeatedly shown throughout this year. The initial responses of health practitioners, public health bodies, and governments had to rely—in varying degrees—on previous experience. These differed, of course, by culture and geography. As Timothy Brook has pointed out lately, collective memories of pandemics differ significantly between Europe and Asia.[2] In order to understand how and why we as a global society can understand and approach pandemics in a more global way, we need to understand, probe, and somehow join up these collective memories. Powerful memories of epidemics and pandemics—whether through lived experience or through cultural reification—apparently led to quicker, effective responses. Taiwan's experience with SARS in 2003, for example, allowed it to react swiftly and efficiently to keep COVID-19 outside its borders, establishing a highly sophisticated screening operation. Singapore's situation was different in that breakouts in

2 Brook 2020.

migrant worker dorms catapulted otherwise extremely low infection rates by orders of magnitude.

Both the Korean and Chinese traditional doctors discussed above drew on the *longue durée* history of epidemic medicine in their regions, a vision much longer than the biomedical view which is foreshortened to 2003. A number of papers in this issue afford us fresh perspectives on those histories. Are there lessons to be learned from Asian past experiences and memories more generally? The historical papers in this special issue provide much food for thought on this angle. Looking beyond human-to-human transmission toward the animal world, Di Lu gathers a wide array of references to animals and transmissible disease in imperial China. He presents a novel case within the history of Chinese medicine, drawing on a wide variety of sources to argue that while interspecies or zoonotic transmission did not become a formal object of Chinese medical theory, it was apparent to practical observers of animals and humans living in close proximity, particularly cattle. The notion of *du* 毒 (meaning poison, toxicity, or also "potency" when in reference to a drug), was applied not only to "plague poisons" among humans, but also sometimes livestock, and that *du* or disease could be transmitted through eating infected meat. The warnings of high-profile physicians against the eating of wild animals speak to false notions in current media that Chinese medicine is unequivocally concerned with the consumption of endangered and wild species. The variety of sources in Di Lu's paper prompts us to reflect that different medical notions circulated, in China, as elsewhere, within different community discourses: folk, official, medical, and religious, to name a few in this paper. We also see infrastructural considerations about the spread of disease in the observations of butchers contracting disease from animals. Readers should note that the Song dynasty emergence of the five plague demons (*wuwen shizhe* 五瘟使者) mentioned in the paper occurred during a period where widespread epidemics also precipitated the rise of scholarly pharmacology and official state medicine, leading to a radical reconceptualization of pharmacological theory. This timing points to the mutual imbrication of religion and medicine, and the innovations that newly widespread disease provoked across multiple fields of knowledge.

Looking at pandemics from a range of cultural and historical perspectives also brings to the fore wider epistemic shifts which may have occurred as a result of epidemic outbreaks, discussed here by Alberts with regards to treating smallpox in seventeenth-century Siam. These included rethinking some social norms, an increased emphasis on prophylaxis, both in personal and societal levels, a greater openness to foreign ideas, and increased processes of

experimentation, by medical experts and laypeople alike, which ultimately led to important medical developments—such as vaccination. Alberts's article—as several other contributions in this special issue do—makes the important point of the intercultural investigations which large-scale epidemics and pandemics bring about: her material exemplifies how, faced with crisis, we see a greater openness to experimentation which departs from medical certainties and social norms, an openness to learn from other cultures, facilitated simply by the fact that those "others" were doing better—the same "How do they do it?" question with which we began.

Taking up the theme of religion and medicine, Capitanio describes Buddhist concepts of epidemic in medieval China, the earlier notion of *yi* 疫 and the later notion of *wen* 瘟. The primary etiology of these plagues was thought to be karmic retribution, which could take form as punishment by plague demons, such as the aforementioned five plague demons. This framework explained the unequal distribution of disease within a "disease theodicy," or rationale for why bad things happened to good people, an explanatory framework which stabilized the anomie of an otherwise unpredictable world.[3] The host of rituals used primarily focus on incantation, but also involve talismans and other material magic as an embodied response to the latent karmic forces which generated the disease, operating on invisible forces within a framework of stable universal laws. These semiotic, social, and embodied ritual practices would have allowed practitioners and observers to performatively inhabit that stabilized cosmic framework in a corporeal way, situating their bodies within a rational cosmology that kept anxieties and instability at bay and produced choices, actions, and rationales. From an etic, or scholarly, perspective we can interpret these rituals as meaning-making events, part of a universal human response to disease and anxiety, with the potential to improve chances of survival, as placebo studies, or "meaning-response" studies, have shown.[4] We also see narratives of monks and state officials coming into conflict, and plagues emerging as a result of offenses against Buddhist prelates' sensibilities. The notion that epidemics were due to moral failures of state actors draws on even older native Chinese tropes where the moral culpability of the emperor could result in epidemics, but also rings true today.[5] Capitanio's paper highlights how these older tropes were subject to renegotiation through novel forms of contestation between religious and state authority, and how epidemics formed sites for the production of the new forms.

3 Stanley-Baker 2021.
4 Moerman 2002.
5 Schafer 1951.

Triplett's study of plague demon iconography extends the view to Buddhist phenomena in Japan in the first half of the second millennium. Foregrounding the visuality of Buddhist icons, Triplett harkens more generally at the artistic expressions which epidemics inspire. She argues that by stabilizing a visible object in the imagination, illustrations and iconography bring focus to the mind and the possibility of a stable relation to the otherwise invisible disease. Building on her observations, we note here that the directional rituals so prominent at the time, at city gates and invoking the four directions, further spatialized the relationship to disease and other potential harms. These afforded a geographic and regional relationship to disease outbreak, stabilizing practitioners' sense of space and the need to protect from unpredictable regional vectors of infection. Those who possessed the power to "see" these ghostly pathogens, whether through innate gift or ritual technology, also thereby possessed the power to control and dispel them. We may consider that this broader human need to visualize and spatialize also stimulated the widespread use of modern-day geographical infographics, such as the John Hopkins map.

The text introduced and translated by McGrath provides an illuminating example of a text with historical, medical, and religious significance. A section from the *Vase of Ambrosia*, a Tibetan tantric text written in response to the outbreak of bubonic plague in Tibet in the thirteenth century, contributes another important piece in the emerging picture of bubonic plague as a pan-Eurasian epidemic in the thirteenth and fourteenth centuries. Moreover, this text is a reminder of how these different aspects have been—and are—entangled and intertwined.

As we write this introduction, in May 2021, the reality of COVID-19 has shifted significantly from what it was a year ago. The rollout of vaccinations in the US, UK, and Europe have been a game changer. And on the face of it, those same people, who were asking "How do they do it?", are less interested now. But the *longue durée* of some of those same questions must not be forgotten. More broadly, we are beginning to see a more open approach, which is evident in publications, such as *Nature*, where in March 2021, Hetan Shah, the British Academy's chief executive, argued that in our attempts to recover from COVID-19, we need to go beyond the STEM (science, technology, engineering, and mathematics) disciplines, and take into account "human behaviour, motivations and culture," stressing also that "policymakers were overly focused on evidence from randomized control trials, rather than the observational, qualitative evidence that social sciences are steeped in" and that "had governments been set up to listen to the advice of historians, they could have helped us to think about what worked in past pandemics."[6]

6 Shah 2021.

Helen Tilley has pointed out that COVID-19 has provided a focus on how "homegrown" medical cultures can espouse a trust in forms of practice and experience that challenge more dominant techniques of scientific proof, opening the door to more dynamic forms of "polyglot therapeutics," and unsettling sharp boundaries of what has previously been labeled "effective" and "ineffective."[7] Crises, and an inability to respond to them, invite such an opening of doors and minds. This much we have learned from past pandemics. Now that the door has been opened, we can also observe what gets in and what does not, who sits at the doorway and why. It's going to be interesting, and this special issue is just the beginning.

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7 Tilley 2020.