Patients, practitioners and "pots": probing Chinese medicine in East Africa

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Introduction

The medical encounter has a long tradition of being analysed in terms of patient-practitioner relations, but in medical anthropology this frame has been critiqued as too narrow from the earliest days of the field's inception. One of the first monographs, which was on "medical pluralism" (Janzen 1978), emphasized that decisions regarding treatment were not merely taken by the patient in consultation with their practitioner. Rather, they involved a wide range of different people, a so-called "therapy-managing group". Janzen, who worked as a general practitioner in a dispensary, furthermore noted that his consultation with a patient was but one in a long series of visits to diviners and herbalists, conversations with friends and relatives, and participation in large meetings held by prophets and/or village elders.

Plurified practitioners

Janzen presents six case histories in separate chapters. As figure 17 in the appendix highlights, the sequence of medical authorities sought does not follow a particular pattern. Rather, it comes across as pretty random. Janzen intended this, no doubt, as a covert critique of the rather rigid formula of "hierarchies of resort" identified earlier by Romanucci-Schwartz (1969). He advanced a notion of medical pluralism that emphasized a multiplicity of choice, situational decision-making, and a probing attitude of experimentation. M.-J. Delvechhio and B. Good (1994) would later speak of a "subjunctive mode" in illness narratives and Susan Whyte (1997) of a pragmatist "trying out". The zigzag in Janzen's

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figure 17 has set the tone for how medical anthropologists have conceived of patients seeking health, which is that in the case of illness, everything is being tried out and probed, seemingly at random, even by otherwise most principled and rational people.

The concept of medical pluralism became prominent in debates that pitted "pragmatic" over "rational" choice. However, the concept lends itself also to another longstanding anthropological problem, that of the medical "culture" (Last 1981). Inquiry into the theme of medical pluralism can be used to counter the widespread idea that in the event of a crisis, which sickness is, "culture" provides its members with a routine set of normative behaviours and practices. Rather, we observe ever-changing re-configurations of patients, practitioners and what I will call "pots", arising out of play in a certain place. This play is effected by the attitudinal shift into which human beings are propelled in the event of a crisis: a subjunctive, playful and probing mood. Although in the face of suffering the word "play" seems inappropriate to our modern sensibilities and even if Janzen himself never reflected on the use of the term in this way, an anthropological concept of play may frame the therapeutic endeavour in a productive way, as it comments on configurations created by multiple actors' mutually attuned, yet testing attentiveness (Huizinga [1938] 1980; Turner 1982). Importantly, the "as if" attitude, which makes play possible among animals and humans alike (Bateson [1953] 1972), arises from the ability to recognise and adhere to certain – if only temporary – patterns of conduct. Not "everything goes", as the post-modernist would have it, there are so-called "internal dynamics", as Kapferer (2004) calls them, to those situations.

Multifaceted patients

Rhodes (1980) went a step further. Health-seeking was probing but patterned. The event in focus was that of a girl who suffered from an attack of *pissu* (madness) while preparing for her high school exams. Rhodes depicts the consultations that the main caretaker, the father, arranged for his daughter as mutually constitutive parts in an exploratory journey until, finally, the girl is sent to the psychiatric ward and successfully treated with anti-psychotic medication. What some biomedical professionals might call a "six-month delay", is on the basis of *post-hoc* interviews with the father and other carers put in a different light. The movement among healers constituted an integral part of the girl's recovery. The stars and planets (which prompted consultation of two astrologers), the demons and gods (warranting exorcism and, later, pilgrimage), the bodily juices and humours (and according medication, Ayurvedic and biomedical)

were all considered complementary to each other. The consultations undertaken outside the biomedical establishment were not merely "a waste of time", delaying the patient's access to badly "needed" treatment, but paved the way for making it successful and efficacious. Although the author does not make a point out of it, it goes without saying that the health seeking involved a probing attitude[1]. We note the testing, the "trying out", the "what if" attitude that is so characteristic of play. This probing exploration was not considered an entirely random or even mindless zigzag, but a patterned exploration that arose out of historically-given dynamics specific to the landscape populated by human and non-human actors in which the patient was emplaced.

Rhodes saw herself as attending to different "epistemologies", but she can be read to have implicated the "things" that mattered in Sri Lanka's medical landscapes: demons and gods, stars and humours, overwork and excessive happiness. In our own common parlance, on which materialist philosophies have left their mark, we would not call demons or overwork things, although they could be interpreted to qualify for what Bruno Latour (1988) called the *tertium quid* in nineteenth century medical debates[2]. Important here is merely that the search for therapy involved the navigation of a universe where different "things", with each their own internal dynamics, were conceived as a possible and powerful *tertium quid* affecting multiple, mutually interdependent levels of the patient's well-being.

Pluripotent pots

Where Janzen highlighted that there was a multiplicity of medical authorities and Rhodes that patients had a plurality of different issues demanding for attentiveness, the pluripotent "pot" is here added as the third player in the medical encounter, thereby transposing the gaze from the patient-practitioner dyad onto that of an analytically relevant triad. By "pot" I mean the material aspects of the medical encounter, and I call it pluripotent to emphasize how situation-dependent different material aspects of the medical encounter are foregrounded.

"Material" and "materiality" are terms that are not easy to define, particularly as Chinese medical practitioners and East African patients probe the pots. Should we consider matter only that which is tangible? Yet vision is known to be crucial in giving tangible matter a form. And what about the taste of medicines that the tongue identifies through touch or their odours, identified by inhaled molecules touching the endodermis of the nose? Sound is generally experienced as disembodied, but what about the sound, say of the step of your loved ones or of a crying child?

And why should this sound direct your attention to a physical body but not the sound that you hear at night in the loft and might attribute to a ghost? And what, if this latter sound is heard, also by others, in bright daylight?

We will not solve the problem of what is material and makes a thing here. The above spectrum of the sensed applies to a wide range of the things sensed in medical practice: its material layout, the perceived substance of the medicines on offer, and other medical instruments that Chinese medical doctors bring into play. The "pot", multifunctional and pluripotent, and admittedly as yet rather vaguely defined, may provide an interesting analytical perspective for future research.

I am not the first to have drawn attention to things in the medical encounter. Mark Nichter (1980), more so than Rhodes, focused on things in the medical encounter (in the materialistic sense in which we commonly use the word "thing"). In the patient's perception, the practitioner's learning was not as salient as the equipment on display: the medicines, the medical apparatus, the practitioner's white coat, etc. Nichter discussed the taste and colour of the coating of capsules, pills and tablets, their packaging, their brands, and the place of manufacture of instruments like stethoscopes. These things mattered. They carried information for the patient about the practitioner's quality of medical provision, more so than did the physician's medical learning (as implied by Leslie 1976).

Nichter did not speak of a *tertium quid* as an independent actor, as Latour did. Rather, Nichter related to the medicine as the medic's paraphernalia, a thing that mediated the patient-practitioner relation. Anthropologists of pharmaceuticals have attended to these things primarily in terms of their – metonymic and metaphoric – meanings (van der Geest & Whyte 1989). As good social scientists, they limited their analysis to the socially meaningful and did not interfere with the natural scientists' claim to expertise of the material aspects of these things, however compartmentalised and specialised, if not esoteric, that expertise remains.

We owe it to actor network theory, ANT (e.g. Latour 2000) that the thinginess of things is today foregrounded as an issue deserving social scientific inquiry. Latour echoes here Whitehead's (1920: 30) "theories of the bifurcation of nature" who laments the dichotomy between research into questions posed by a reflective "sense awareness" of matter, on the one hand, and into the unreflectively or one-dimensionally sensed, i.e. sense-perceived matter, on the other. This gave rise, Latour contends, to social scientists studying disembodied social relations and natural scientists researching decontextualised things. Building on another debate from the early twentieth century concerning the affordance of an

object (developed in circles of Gestaltpsychology and phenomenology), where an intended (or unintended) use is considered constitutive, if not defining, of the thing, ANT makes the thing into an independent actor in a network of other actors, some human, some non-human.

However, as in most network analyses, which account for complexity by means of a quantifiable operationalised uniformity of the elements considered, actors are often reduced to a geometrical point and their interrelations to straight lines between them, presented on a sheet of paper or computer screen, reminiscent of John Locke's *tabula rasa*. Tentative and testing attitudes, multiple levels of probing, historically shaped propensities that propel people and pots in specific places into an interrelation that has "internal dynamics" and shades of agency arising out of such interdependent re-configurations do not belong among their main themes. Rather, agency is located in an actor's ego-centred intentionality. Moreover, by locating agency in the actor, rather than in the interaction, a Cartesian understanding of personhood and its mind-body dichotomy is perpetuated. Notwithstanding, applied to the problem discussed here, ANT has to be credited for recognising in medicine a thingy "pot", and not merely a medium through which patient and practitioner communicate, and for treating this *tertium quid* as an actor with distinctive affordances.

Annemarie Mol's (2002) study of how atherosclerosis is diagnosed and treated on three different floors of a hospital in the Netherlands, foregrounds the importance of the "pot" in the medical encounter. In her ethnography the medical equipment to which physicians and laboratory technicians attend defines the patient's diagnosis and treatment options. But the patient and practitioner in their multiple and partial interactions are barely discussed, and if, only in a rather normative and hypothetical way. Instead, medical technology is minutely explained. These medicine "pots" are no longer understood merely as a metonymic extension of the physician. The "pots" Mol describes define the practices that constitute the pathology[3].

Mol's entry into the field is that of a naïve philosopher. She accounts for what she sees, and she lets us know, in a separate text what issues of wider relevance come to mind through the phenomena, which she observes with great acuity[4]. Yet the medical cultures studied on the three hospital floors are surprisingly well-bounded, geographically and epistemically.

By contrast, critical medical anthropologists, both the early Marxist authors (e.g. Vincent Navarro, Michael Taussig, Howard Waitzkin etc.) and those inspired by literary criticism from the late 1980s, relocate the micro-social problem of the patient-practitioner dyad into social institutional, political economic, socio-historical and conceptual-historical dynamics. Among their works belong the now classic ethnographies by Allan Young (1995) on PTSD as a sickness and Margaret Lock (1993) on menopause

as a local biology. Although these two critical medical anthropologists barely addressed the issue of medical pluralism, they have exploded the doctor-patient dyad, and the "pots" involved, in ways that can creatively be applied to revisiting research into medical pluralism.

Summary

In summary, the patient-practitioner dyad as analytic unit has always posed problems to medical anthropologists. Janzen's seminal study of medical pluralism highlighted that a doctor was not actually dealing with a single patient but also with a multiplicity of relatives and friends (the therapy managing group), as well as with multiple competing practitioners who had been consulted in the past, or would be in future. Rhodes (1980), based on comparable case materials, multiplied the facets of well-being that matter to a patient, and this allowed her to place patient, practitioners and "pots" in a therapeutic landscape where the specialists were not merely competing with each other, but considered mutually complementary. Taking exorcist measures, ensuring "good fortune" and the blessing of the gods, balancing out one's humoral make-up and getting one's brain chemistry right were depicted not merely as matters of belief, but as intrinsic to bodily aspects of well-being. Rhodes discussed both the epistemologies of the practitioners and the perceived physicalities that motivated the patient carer's actions but her focus was not on things and their affordances, let alone on their agency.

It is only with Latour's *tertium quid* and Mol's detailed description of hospital technology that things in the clinical encounter have been accorded an independent agency. These thingy aspects of the medical encounter, here called "pots", will be shown to come into play in as plural ways as the practitioners and on as multiple levels as the different facets of the patient's well-being. Pots, patients and practitioners are put into a triangular relation and rather than imbuing each with an ego-centred self-interest, agency ensues from their interaction. Nor is pragmatic "need" or "necessity" taken as guiding principle. Rather, the medical encounter appears to draw patients, practitioners and their pots into an "internal dynamics", as is any ritual or ritualised interaction, in a mood that is probing and in a world that is yet to be (culturally) renewed and re-constituted.

Fieldwork

My entry into the medical fields of East Africa is perhaps best approximated as that of a landscape ethnographer. Acutely aware of the

phenomenological axiom that one's perception critically depends on how one projects oneself into the world, I cannot attempt to write from a bird's eyes view about the medical landscapes of East Africa, as has been masterfully done in classical accounts of critical medical anthropology. Rather, like the naïve philosopher Mol in the hospital ward, my gaze is on the directly perceived phenomena. However, unlike the philosopher, it is impossible for me to restrict myself to documenting the phenomena as such, having been sensitised to perceiving traces of history of whatever appears to be a naturally given landscape[5].

Fieldwork extended over almost a decade from 2001-2008. It was undertaken in brief spells of about one month a year. It was multi-sited in that it was spent in different geographic locations where I lived in mid- to low-level inns and hotels and ate in down-market restaurants of popular neighbourhoods. Much information was gathered in informal conversations and semi-structured interviews, whenever possible in the home of the interviewee. There were also some individuals with whose family I was invited to stay; among them a Chinese medical doctor in Mombasa and a local psychiatric nurse on Pemba. This allowed me to conduct participant observation in their homes, and yielded insights of an entirely different quality than do interviews and informal chitchat.

Admittedly, the populations I studied were fairly small. As far as I could make out, the self-styled "Chinese medical" practitioners who ran a private practice in any one year barely numbered more than twenty in Tanzania, Kenya or Uganda, i.e. sixty in total. The great majority moved around different neighbourhoods of Dar es Salaam, Nairobi and Kampala, but others also set foot into more peripheral towns and cities: Arusha, Moshi, Dodoma, Mbeya, Tanga, Zanzibar town, Chake Chake, and others, in Tanzania; Mombasa, and apparently also Kisumu and Eldoret in Kenya (I gathered no reliable information on this in Uganda). Their clientele numbered in the hundreds and thousands. The first private practice was opened in the late 1980s in Kenya, and in the mid-1990s in Uganda and Tanzania respectively.

The populations I worked with were too mobile and also changed radically in constitution over the years, the practices they engaged in were extremely varied and my study of them too piecemeal to aim to account for East Africa like a hospital, with clearly bounded medical cultures on each floor. I soon realised that I was not studying a public health phenomenon but a theme that is easily relegated into the classic medical anthropology theme of "medical pluralism". I was witnessing the burgeoning of a social phenomenon in Africa, and what appeared like a social movement coming from China. But was it a social movement

at all? These few enterprising individuals, were they sufficiently streamlined, let alone aware of each other, to speak of a movement?

Initially, I understood my research to be on countervailing trends, countervailing the globalised flows of Coca Cola and blue jeans "from the West" "to the rest" of the world; I spoke of flows from East to South. When I started my studies in 2001, political scientists had not yet discovered the importance of what they later dubbed South-South relations. This happened a few years later, in an explosive way, such that China-Africa relations are now being studied not merely as a theme but within what aims to become a dynamic field of its own within Area Studies[6]. Today, no one would frame a study on the Chinese in Africa as a countervailing trend.

So should I frame my ethnography of Chinese medicine in East Africa as an event of cultural translation? My doctorate was initially to be about the Westernisation of Chinese medicine, so what about the Africanisation of Chinese medicine? Given my experience of finding it empirically difficult, if not theoretically impossible, to identify any essentially Western shaping of the varied Chinese medical theories and practices I observed in China, the thought of any identifiable Africanisation was instantly dismissed. Africa is a geographical term, denoting a continent, not a culture. Moreover, in East Africa, health care has undergone significant neoliberal reforms. The World Bank, rather than the WHO, seemed to have a say. Government matters, also in the neoliberal era (Ong 2006), surely, but it has been torn by ethnic, and other politicised tensions, by ongoing corruption, and by excessive dependence on ever-changing policies of NGOs. What was African about these political economic processes common to so many health fields of southern nation-states?

Or, were there ways in which this study could contribute to current debates on the interface of medical anthropology and migration studies (as done in Dilger *et al.* 2012) or on the worlding of Chinese medicine (as did Zhan 2009)? Now, that I have been asked to comment yet again on "medical pluralism", and setting myself anew to the task, I found myself grappling with the notions of "culture" (Last 1981) and "circularity" (Bibeau 1981), familiarity and exoticness, i.e. cultural proximity and constructed distance (Parkin 1968), in my reflections over a somewhat playful probing of Chinese medicine's "pots". These observations warrant an analysis that challenges the ego-centred sense of agency in some pragmatically-oriented and actor network analyses.

Pots, patients and practitioners

The medicine "pots" that Chinese medical practitioners generally make use of in their clinics in East Africa are so-called formula medicines,

zhongcheng yao (which biomedical professionals typically call "propriety medicines"). African health professionals vilified them as hybrids of Chinese herbal and Western chemical substances, but Chinese policy-makers celebrated them as a fast food kind of innovation. Their immense varieties and pervasiveness on the health market testifies to an intense industry of playful recombination and a hugely inventive "ethno-chemistry" (Hsu 2009a: table 1). Detailed documentation of the medications on display in several clinics showed that only a minority of kinds were in fact such contested hybrids, though some of them belonged among the most frequently demanded ones (e.g. certain slimming teas). This is said with a *caveat* as in most cases it was difficult to establish what the precise ingredients were. Some information on the packaging was intentionally misleading, in others it was numerically overwhelming, as in the case if medications for enhancing sexual performance where up to thirty substances might be mentioned on the packaging, from donkey's penis to licorice.

In Chinese medical clinics the cultural distance between patient and practitioner was an integral aspect of the medical encounter (Hsu 2009b). Precisely the exoticness of the "pots" made them potent and seductive. Risk and danger, as in the face of anything unknown, played into the probing of these powers. Regardless of whether they were to be ingested or externally applied, they were met with a certain apprehension – unsurprisingly, given how significant sexual intercourse is on social, intimate, and personal levels. The body that would be affected was not a Cartesian machine, as they related to it as resonating with deep-going feelings and emotions, lineage duties and responsibility, as well as a more general sense of integrity.

Men who tried out these medicine "pots", would they be forever hooked by these substances? Would sex ever be the same again once one had tried out these medications or would men loose interest in it altogether without them? On Pemba, a shopkeeper asked my Muslim host this question while we were looking in silence into the glistening heat on the road, waiting for the *dalla dalla* bus for well over an hour, thankful for the shelter he offered in the cool breeze that swept through his stall. What came across as an existential anxiety expressed also an ingrained worry about Pemba island's social and political sovereignty. What was the ulterior motive of these Chinese medical doctors? Doing business could be a pretext. The colonial experience of the Portuguese, Arab, German and British claim to doing commerce was lingering on. Were the Chinese eventually going to build a church and aim to convert Pemba's population to Christianity as did a few years earlier the Seventh Day Adventists in Pemba's capital, Chake Chake?

Time inscribed in space

In this context, it is interesting to note that the layout of one of the busiest clinics in East Africa allowed clients to go for both the anonymity of a commercial over-the-counter transaction as well as for the intimacy of a face-to-face medical consultation. This medical practice was located in a large air-conditioned hangar space and the consultation room was boxed off in a corner, just large enough to accommodate a desk and two chairs on either side. However stuffy and hot it was for the doctor in that tiny space, when he relocated his practice a few years later across the street he made sure that the spatial layout was much the same. He evidently understood that the tiny size and stuffy heat inside the consultation room mattered. Patients entering it would shut the door before they started speaking, in a lowered voice, as one does in intimate conversation.

The feelings this confined space evoked were comparable to those generated during a séance in a divination hut. I am not speaking of a cognitively comprehended culture-specific conceptual schema, or of the objective spatial layout of the clinic from a bird's eyes view, but of what people sensed and felt and non-verbalised experiential dimensions of the medical encounter otherwise (Hsu 2005). The bodily attentiveness that the people in a certain locality have developed for certain bodily sensations, as Sagli (2008) notes, makes possible the adoption of unfamiliar body routines that produce comparable sensations. The experiential perspective is key to understanding how local bodily routines and skills are modified to make possible any so-called technology transfer or cultural translation.

Whether or not an architectural space should be studied as an aspect of the "pot" in the medical encounter or its "place" is of no major concern here. The stuffy consultation box certainly gave the patient the feeling of being emplaced in a familiar setting, although the practitioner was not a diviner, but a Chinese medical doctor, and the "pots" on offer had most affinity with Western medicine, not least due to their packaging. This effected that the Chinese medical consultation, like a divination séance, would have the hallmark of both intimacy and a constructed uncertainty (Whyte 1997): verbal misunderstandings were frequent, some of them simply due to phonetic mis-hearings; practitioners wrote their medical notes typically in Chinese; medication was given in numbers, but these numbers were codes for the local support staff and hence unintelligible to the patient, as was the Chinese script. Needless to say, all these bodily routines helped construct the expected uncertainty that precedes a successful diagnosis (see also Parkin 1991).

There was a certain bodily routine to the encounter, which instantiated the internal dynamics of familiar forms of ritualised

conduct. The practitioners would start with asking for the name of the patient, then they asked for the age and sex. Practitioners in East Africa rarely took the pulse, nor did they ask to see the tongue and inspect its coating. Some regularly took the blood pressure instead, which involved corporeal proximity and touch, while some few others, as they told me in Chinese, avoided tactile contact whenever possible for fear of contagion. Some sent the patient next door to a room within their practice that a local chemist had rented to let them have a lab test (mostly for malaria, typhoid, or "sugar") or down the block to a practitioner, more often a Muslim than a Christian, whom they had befriended as he offered reliable ultrasound scans (e.g. of fibroids in the womb). Patients were discouraged from asking questions, and most had already been routinised into the frame of mind that in bureaucratised settings one does not ask questions, but provides laconic answers if prompted and otherwise remains still and passive[7]. There were internal dynamics to the Chinese medical encounter, which combined engaging in body routines known from consultations with local diviners and those that colonial and current government officers requested.

Patients and practitioners clearly were implicated into a cooperative process into which the availability of and desire for "pots" had enfolded them. Usually, the patient left the stuffy "divination box" within ten minutes, a paper in hand that he or she would present to the female shop assistants at the counter. These very elegantly dressed local women would assemble the different medications prescribed, explain to how to consume them and receive the payment.

On later occasions the patient would go directly to the counter and get another portion of the medication prescribed, bypassing the practitioner. Many practitioners welcomed this, being pressed for time and less interested in therapeutic conversation than in speeding up the commercial transactions. Vice versa, many patients seemed more interested in the Chinese "pots" and their ingestion than in engaging with the practitioners as people with humanity.

Injections for siphilis and the anthropology of substances

Indeed, as an "anthropology of substances" (Davies 2000) would suggest, medicine "pots" contain substances, and patients are keen to ingest, imbibe or otherwise absorb these substances. A Chinese medical doctor once allowed me to observe his treatment of a syphilis patient, who had come all the way to Zanzibar island from the continent. This doctor was proud about his newly invented technique, which attracted syphilis sufferers from far away. It involved injecting a fluid into the acupuncture

point *guanyuan* 關元 that is located three inches (*cun* 寸) below the navel. The treatment was over in five minutes. "What is so special about this?!", I asked. I had seen other Chinese medical practitioners in East Africa treat syphilis patients by needling the *guanyuan*, as it is known to enhance one's most essential life forces and bolster the *jing* 精 (semen). He retorted that I had seen others needle the *guanyuan* point with acupuncture needles; he, however, injected a fluid, a medicine, a substance. "And I will not tell you what it is as this is my secret". He knew it was unlawful for a Chinese practitioner to use purified substances like antibiotics. But at the time I already knew that for the treatment of syphilis, Chinese medical practitioners would give a combined treatment: penicillin injections and sometimes an acupuncture needling session of about ten to twenty minutes. This doctor's hybrid method was ingenious in that it collapsed the two techniques into one. It also had distinctive sensorial effects: there was a brief phase of very acute pain (injections hurt more than fine needles) in the lower abdomen, a rather intimate part[8]. Furthermore, it shortened the time of the treatment.

The ingestion of medicines and their injection by syringes facilitate the absorption of substances into the body, as does the widespread method in Africa of making razor blade cuttings, which also are meant to hurt briefly as medicines are rubbed into the blood stream. Warnier (2007) describes how the spit of the Fon king is sprayed over his assembled community who seeks to absorb his blessings in front of his palace; I imagine how each and everyone in the crowd feels the barely perceptible prickling on the skin that cooling water droplets effect. Taylor (1988) emphasizes, in a similar vein, that well-being derives from an experience of being connected through substances, when he emphasizes the exchange of fluids. Other Africanists, however, stress the absorption of substances as a mode of emplacing people into a locality.

Geissler and Prince (2010: 189) highlight that among the Luo in Kisumu the daily herbal baths for fortifying toddlers involve herbs that grow on the ancestral lands of the paternal grand-mother. The children who are washed with these substances and absorb them through the skin hence become consubstantial with their ancestral lands. This strengthens their lineage identity, and ultimately also their health and well-being. Likewise, Kelly (2014) noted in the forests of Oku of northern Cameroon that the ingestion and absorption of herbal medications connects the patient to the ancestors, who typically dwell in the region of the roots of the plant, underground. This culture-specific relation to the ground and earth in Oku, in turn, resonates well with observations in other places where earths are sacred.

Fayers-Kerr (2013) describes among agro-pastoralist Mursi/Mun in the Lower Omo valley "body painting" that involves what appears to us as a

smearing of colourful clays onto one's skin. Why should this be healthful? One could try to argue in terms of the clay's pharmacology on the patient's physiology; many antibiotics are produced by soil fungi and have been extracted from soils. A more culturally attuned explanation notes that procedures of emplacement are meant to strengthen one's lineage identity and thereby one's health. By making themselves consubstantial with the specific hues of clay from the sacred lineage clay pit they emplace themselves into the lands of their ancestors. These procedures are said to involve an "eating" of the clay, a word that is best understood, in a so-called "physiognomic", practical and immediately recognizable way (Morris 2012: 25), as gesturing towards a consumption and absorption of the clay.

In other words, one "eats" the clay to become consubstantial with one's ancestral lands. An auspicious dream might prompt a young man to smear his favourite cow and himself with clay. More recently, tourists offering money for photography may prompt a young man or woman to deploy clay for body decoration (e.g. Turton 2004; Silvester 2009). Those encounters between tourists and Mursi may be tinged by mutual curiosity, but more so are marked by a very distinctive mood of irony, where the Mursi deploy their land's substance but resist giving away the ways of and to their ancestors.

The clientele in Chinese medical clinics generally did not like the thought of being needled but had no objection to ingesting medicines. This certainly facilitated the dispensing of Chinese formula medicines. Difference and distance can also awaken curiosity. Patients were partly drawn into Chinese medical clinics because they were curious about things Chinese. The attitude to the Chinese medicine "pot" thus seemed to reverberate with the hesitations one has to one's (potential) affine and the other sex more generally. However strange and exotic the Chinese medicine "pots" were, they were things that through their consumption could be appropriated and made one's own. Interestingly, Chinese "pots" were sought out frequently precisely for "eating" in this sense.

However, the play with clay initiated by a monetary economy in the encounter between the culturally distant Mursi and tourists did not appear to be about emplacement, or if so, only in a hyper-ironic way. Likewise, as the familiar was mixed with the foreign in Chinese medical clinics, it sometimes transgressed the limits of what was felt to be acceptable for a self-respecting person. For instance, having a medical test done, which involved the taking of and tinkering with one's bodily substances (e.g. presenting one's urine to the laboratory assistant or having blood drawn), was generally not a problem for young men, but although elderly women and teenage girls were familiar with these biomedical procedures, some broke off the consultation at this point[9].

Hyper-ironic twists

Apart from the above formula medicine "pots" on offer in almost all Chinese medical clinics, other sorts of "pots" implicated patients and practitioners into other, more configuration-specific procedures, such as wound dressing, gynaecological surgery and acupuncture treatment. To be sure, the majority of Chinese medical practitioners dispensed formula medicines but some few perfected themselves additionally in the application of specific skills in response to the clientele that sought them out.

Dr Wu (all names are pseudonyms) was trained as a biomedical doctor, but after moving to Kenya in the late 1990s could only hope to practice in the grey zone of legality by advertising himself as a Chinese medical practitioner. He felt he knew sufficient Chinese medicine as biomedical training includes a minimum of two semesters of compulsory courses on acupuncture and the archived *materia medica*. The practice he opened in the early 2000s was located next to a Chinese textile shop in one of Nairobi's shopping centres on the outskirts of the city, catering to upper middle class clients who owned large mansions and cars. His consultation room looked more like an academic's office than a medical practice. All surfaces in were covered with magazines and books, the drawers being filled with medicines alongside electronic devices and stacks of paper. He had many friends who came to see him, mostly Chinese. Some of them needed some medication, others just enjoyed his conversation and company. By 2006, when I last visited him, Dr Wu had made so many friends that he gradually glided into a second hand car selling business, given that there is great mobility among the Chinese expatriates, and almost all really enjoyed driving.

In that very year, incidentally, on each of the few times I dropped in, a different tall Somali man with a gaping wound on legs or feet was lying on a plank bed in the backroom, while the doctor was handling cotton wool and disinfectant, tongues and scissors. The silence of concentration was protracted as he skilfully worked on the wounds, cleaning them, cutting off skin pieces, dressing them. The young well-grown men had no job prospects but some pushed themselves very hard, training as athletes for long distance running (ca 20-40 kms daily), in the hope of being selected into a sports team, one day, by an international trainer. They were not part of Kenyan civil society and had no access to Kenyan medical care but Dr Wu had become known among the refugee community for his hygiene and skill in dressing wounds. It involved re-enlivening some of his favourite repertoire, he said, having specialised in minor surgery during his student years in China. The Traditional Chinese Medicine doctor thus

made use of "pots" classified as biomedical, but since he was treating marginalised non-Kenyans, he was not denounced. Rather, his bodily routines and skilled handling of wounds with his very favourite types of "pots" assisted both his clients and himself in their different efforts of emplacing themselves into a foreign country, regardless of the cultural distance contained in their habits, geographic provenance and languages.

Dr Wei who worked in another suburb, likewise, engaged in minor surgery for people living at the margins of society, in this case prostitutes who needed an abortion or suffered from STDs. Dr Wei was in her late fifties, and had decades of clinical experience. She performed abortions as one does in China, with only a local anaesthetic. Once, when I dropped by, one could hear screaming from one of the back rooms of her practice, where she had her living quarters. The screaming was intense but not protracted. When Dr Wei opened the door to her practice, about twenty minutes later, she still wore her rubber gloves and disappeared into an adjacent room in which was the sterilisation unit she had shown me on another occasion; it was from the hospital in Northeastern China where she had worked before going into early retirement. In TCM (the form of Chinese medicine as promoted in the People's Republic of China), women's medicine, *fuke* 婦科, had always included Western medical procedures, to around 90%, she explained. This was because the traditional department of women, *fuke*, had been merged with the traditional teachings on birthing, *chanke* 產科, and the latter's almost exclusive reliance on incantations and other superstitions (*mixin* 迷信), Dr Wei said, had been replaced by training students in biomedical birthing techniques. She was insistent that she was a TCM professional and her wall was covered with photocopies of certificates to prove it.

Finally, there was Dr Wang, who had stationed herself in yet another suburb and advertised herself as an acupuncturist. She had been a Western medical laboratory technician in China. She had no training in Chinese herbal medicine but claimed to have attended evening classes in acupuncture. She came to Kenya as a refugee, fleeing out of Burundi. She too catered to people on the margins: white expatriate men and women. It is these expatriates who underline that Chinese medics cater to the affluent middle classes in urban Africa, Europe and North America. They are right but, as shown above, only partially.

Discussion

Accounting for culture through a landscape ethnographer's limited and always awkwardly positioned perspective puts patients, practitioners and pots in a triangular configuration specific to a certain place. Medical

encounters were my starting point, and since they have been conceptualised as rituals or, at least, as ritualised processes, I was sensitised to a certain way of looking. Following Bruce Kapferer's (2004) exposition on the relevance of discussing rituals as events, with their own "internal dynamics" (a term he uses in contradistinction to Victor Turner's "ritual process"), I aimed to convey for each of these events their potential and actual historical consequences rather than depict them as tokens of a normative ritual type.

Anthropologists of religion have always drawn attention to what they called ritual "paraphernalia", a term that implicitly locates the agency in the ritual specialist who "brings along" these things. However, by emphasizing the probing if not playfully experimental attitudes patients and practitioners adopt in ritual settings, and the ways in which they acquire, use and dispense of the medicine "pots", I hope to have hinted at an analytic space that allows the thinginess of these things come into play in ways particular to the situation. In some of the above examples the therapeutic endeavour was oriented towards effecting an emplacement in the medical landscape. In other cases we observed hyper-ironic twists. Incidentally, the latter situation was marked by an acutely aggressive monetary economy and hyper-inequality. Might it be that the bizarreness of the situation propelled the actors into a sort of play that enacted disavowal and disguise? I have in mind the ironic twists surrounding the treatment of refugees, prostitutes and expatriates in Nairobi and the tourists among the Mursi implicated into procedures of an othering that could be interpreted as a way of contrastively mimicking emplacement.

I took the medical encounter as entry point into a new social field. I saw patients, practitioners and pots that probingly come together in a specific place. The anthropology of ritual has always attended to social temporalities, spatial layout and thingy paraphernalia and might hence bring to ANT and globalisation studies a sensitivity for and awareness of rhythm and internal dynamics of given configurations through which people and things move and are transformed. ANT, in turn, can bring to the anthropology of ritual the insight that paraphernalia are more than what the ritual specialists "carry with them", as an extension of their selves. Rather than relating to these paraphernalia merely as metonymic extensions of the ritual specialist's power, they have affordances that implicate them in an internally dynamic way into the generation of situation-specific agency.

My final comment concerns the dynamics that led to the invention of a much-sought "pot" for syphilis patients. Here acupuncture needling that typically causes a gently tingling attentiveness was transformed into a *Blitz* injection of substances. Naturally, one could impute agency into this newly

invented "pot", but a more dynamic feel for the situation is conveyed, if one sees the "pot" as emergent from the configuration that gave rise to it. "Culture" and "cultural change" is here not so much a concept that hinges on the reproduction of sameness, closeness and familiarity, but on a mode of responsiveness to otherness that arises out of a probing attitude particular to the configuration of people and pots in a specific place.

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Notes

1. Trawick (1987) made this point most forcefully in a critique of Robin Horton's claim that traditional knowledge systems are closed systems, while modern science is an open one.

2. The *tertium quid*, the third thing that really mattered, was the microbe. Following *The Pasteurization of France* (Latour 1988), the *tertium quid* became the main causal agent for disease in so-called "germ theory" that later was to become the prototype for all biomedical theories of disease.

3. Mol claims to attend to three different ontologies rather than three epistemologies. An anthropologist working with contested knowledges will however find this claim rather spurious. If people consider gods and humours in their daily practice, it is supposedly a matter of how one knows what one knows (epistemology), but in the case of practices defined by high-tech detectors and computer programmes, it is a matter of being (ontology). Such an understanding of ontology comes across as a radical form of epistemology.

4. Her text is highly original in that it combines objective description with subjective philosophising, in that the main text reads like a scientific report of minutely recorded observations and the footnotes contain associative thinking.

5. The theoretical literatures I draw on are, in particular, Merleau-Ponty ([1945] 1962); Bourdieu (1984); Ingold (2000); Spirn (1998) on landscape.

6. Consider, for instance, the web-based network of Yoon Park: chinese-in-africaafricans-in-china@googlegroups.com.

7. On the colonized body as an object for scientific inquiry, see Vaughan (1991); Langwick (2006).

8. In Chinese this method is classified as an innovation in acupuncture and called *shuizhen* 水針 (water/liquid injection). It usually involves the injection of a Chinese medical decoction into what biomedicine recognises as the interstitial fluids of the connective tissue.

9. Whether or not this reflected a gender-specific attitude with which one deals with valued bodily substances is difficult to know as neither the patients nor the Chinese

medical practitioners suggested that these women's sense of propriety was related to an anthropology of substances.

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Abstract

The medical encounter has a long tradition of being analysed in terms of patient-practitioner relations but in medical anthropology this frame has been critiqued as too narrow from the earliest days of the field's inception. Early work on "medical pluralism" emphasized that decisions regarding treatment choice involved not only patient and practitioners but a wide range of different people and a multiplicity of medical authorities, and that patients presented with a plurality of different problems demanding medical attention. This article adds to this scenario the pluripotent "pot" as third player, or tertium quid (Latour 1988), thereby transposing the anthropologist's gaze from the patient-practitioner dyad onto an analytically relevant triad. By "pot" I mean the material aspects of the medical encounter. Yet rather than imbuing the pots themselves with agency, I call them "pluripotent" to highlight that through engaging their otherness and difference, pots can bring situation-specific dynamics into play.

Key words: East Africa, Chinese medicine, pluripotent objects, medical pluralism.

Riassunto

*L'incontro medico ha una lunga tradizione di analisi in termini di relazione operatore/paziente, benché l'antropologia medica, fin dai suoi esordi, abbai criticato questo approccio come troppo angusto. I primi lavori sul "pluralismo medico" hanno enfatizzato come le decisioni rispetto alla cura coinvolgessero non solo il paziente e l'operatore ma una più ampia gamma di individui e molteplici autorità mediche, e che i pazienti riferivano di una pluralità di problemi quando richiedevano l'attenzione degli operatori. Questo articolo aggiunge a tale scenario il pluripotente "*pot*" come terzo attore, o* tertium quid *(Latour 1988), trasponendo così lo sguardo dell'antropologo dalla diade paziente/operatore a una triade analiticamente rilevante. Con "*pot*" l'autore fa riferimento agli aspetti materiali dell'incontro medico. Tuttavia, piuttosto che permeare i "*pots*" stessi di una* agency*, l'autore li definisce pluripotenti, sottolineando così come, coinvolgendo la loro alterità e differenza, essi possano mettere in gioco dinamiche specificamente situate.*

Parole chiave: East Africa, medicina cinese, oggetti pluripotenti, pluralismo medico.