



Centre for Research on  
Socio-Cultural Change

**CRESC Working Paper No. 129**

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CRESC, Open University, and National Tsing Hua University; August 2013

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# Making things differently: on ‘modes of international’

Wen-yuan Lin and John Law<sup>i</sup>

What does it mean to be international? What if the way things are international could have been different? Can we imagine other *modes of international*? These are our questions.

Let’s start by thinking counterfactually. Here’s one of the great ‘what-ifs’ of history. What if the Chinese had dominated the world from the fifteenth century onwards? This might have happened: indeed it almost did. In 1400 Ming dynastic China was in expansive mode. A huge expedition sailed from China in 1405. Its 317 vessels, and 28,000 crew members were commanded by Zheng He (zhèng hé, 鄭和). (Compare and contrast the ‘voyages of discovery’ by Christopher Columbus and Vasco da Gama – three vessels and four, respectively). Over the next thirty years there were six more expeditions to south-east Asia, to India, and to present-day Sri Lanka. A trilingual stone tablet – in Chinese, Tamil and Persian – was left at Galle in Sri Lanka. And the fleets went further too, to the Arabian Gulf, the Red Sea, and then to the Horn of Africa, to Mogadishu and south to Mombasa.<sup>ii</sup>

This was exploration on a grand scale. But then again, it wasn’t. The fleets were simply following trade routes well known to the Song Dynasty (960-1279CE) and the Three Kingdom periods (3<sup>rd</sup> century CE.) So Zheng He and his people knew where they were going. There are excellent charts that show this. And they knew what they were up to too. These expeditions were about trading, but they were also about diplomacy and extending Chinese influence. And, as a part of this, they were about sabre-rattling: there were plenty of armed men on that first expedition and Zheng He wasn’t afraid to use them. Pirates received short shrift, and he wasn’t above fighting the odd land war (Sri Lanka in 1410). And then it all came to a stop. After 1433CE there were no more expeditions.

So why wasn’t a Chinese version of international created in the fifteenth century? How come the marginal Spanish and the even more impoverished Portuguese instead set the gold standard for what it was to be international? There is no shortage of stories: imperial succession; the size of China; court intrigue; Confucianism; a general distaste for foreigners; a Mongolian invasion; a sense that the periphery of the world was unimportant. Those debates don’t really matter here, because we’re interested instead in what we might think of as different ‘*modes of international*’. We’re interested in how international has been *done* in the world since the Spanish and Portuguese expansion. Our argument is that this has happened in a very specific way. It implies particular ways of acting, fighting, and specific versions of the person, organisation, the body, and healing – and not least, of understanding itself. In particular, it clings to the idea that realities and truths are universal (that, so to speak, they’re already international). As a part of this it takes it for granted that there’s just one world, and its order and its structure are out there waiting to be revealed. So here’s the

counterfactual in which we are most interested: *what might a different mode of international look like?* No doubt there are all sorts of possibilities, but let us anticipate our conclusion. Even though we live in an international world whose parameters were established by the European expansion, it isn't that there aren't alternatives *so long as you know where to look for them and how to see them*. And (lets add) if you're also willing to be fuzzy around the edges about what it means to be 'international'. One of these is alive and well in Chinese medical practices.

To look for this alternative we're going to come home. Home is in the north of Taiwan. It's Hsinchu the 'Windy City'. We're going to visit a GP's surgery and consult with a doctor, we'll call her Dr Lee, who's doubly trained: as a biomedical doctor; and as a practitioner of Chinese medicine. But first an initial word of caution: all the books tell us that big categories are dangerous. We've done it already, but it's better not to talk about 'the West' or 'the Chinese', because neither are great monoliths. Indeed, they are endlessly heterogeneous. However, we're going to have to lose some subtlety in order to tell the story quickly, so we will need to say that there are two modes of international at work in this clinic. There's the one we first learned from the Portuguese and the Spanish that is 'Western'. We'll also say that this is *analytical*. And then there's a second that is 'Chinese' and is *correlative*. In what follows we're going to try to show that they're quite different. But now for the story.

Dr Lee is well-known, and she's popular. You may have to wait hours to see her, but it's worth it. So you go in through her store-front door. What do you see? It's not 'traditional', this practice. It's not in a dark room with herbs and dried fungi hanging from the ceiling. It's clean, it's light, and there's a Formica counter where you register once you've arrived. There's a small waiting room and there's a pharmacy – you can just see it down the corridor. And you know because you've been there before, that Dr Lee's got a small consulting room behind the pharmacy. You're going to have to wait, but take the time to look round the waiting room more carefully. Ignore the fish tank. Look at the display cabinet instead. It's filled with bottles. Look carefully and you'll see an array of traditional Chinese medication: ginseng, deer horn, shark cartilage and tortoise shell. These are just for looking at, not for use: endangered species are out of bounds.

Now look at the noticeboards. There are Ministry of Health licences and certificates. Dr Lee's qualified, and we learn she was trained at the Chinese Medical University. There's a certificate about the electronic patient record system. Why? That's a little unclear. Then we see the qualifications of the nurses pinned up too. They've got degrees in biomedicine. Now look at the other noticeboards. You can read about diabetes and osteoporosis. You can read about the quality control of so-called 'scientific Chinese medicine'. There's been a scandal recently, and the posters are there to reassure you that you will not be ingesting pesticides or heavy metals when you take your medicine. And then you can read about tests. What will the surgery test you for? You've seen the list before in other surgeries: allergies; possible

forms of cancer; sexually transmitted diseases. It's the same in many GP's surgeries round the world: diseases are international, more or less.

Though hang on a minute. There's a whole lot of social science that says this isn't right. This insists that the idea that things like diseases are international doesn't happen automatically. It tells us instead that it takes a lot of effort to *make* things international. Perhaps Vasco da Gama or Zheng He would have agreed. It's not trivial getting from A to B and holding together in one piece on the heaving seas.<sup>iii</sup> But let's bring the argument right home and up to date too. Let's talk about a particular 'medical thing.' So here's a question: is hypoglycaemia (that's a 'medical thing') a symptom from which everyone might suffer? Anywhere in the world? It sounds as if the answer should be yes. But it isn't, at least according to STS, though the argument sounds really strange if you were raised in the 'Western' mode of international. STS says that the answer is: no; not necessarily; and not everywhere. Hypoglycaemia *isn't* a universal condition. Yes, you may feel poorly. You may collapse, and indeed you may die. But do you actually get *hypoglycaemia*? And the answer is: no you don't, not necessarily. Instead, whether you do or whether you don't depends on *where* you are, *who* is looking at you, and probably on a bunch of *technologies* too.<sup>iv</sup>

Here's the argument. Hypoglycaemia is only possible in contexts created by biomedicine: if you're biomedically trained and you've got the right equipment. 'Blood sugar level 3.3 mmol/l? Quick, get some carbohydrates down her! Fast.' That's a version of hypoglycaemia in practice in biomedicine. But now we need an instant clarification. 'Biomedically trained' doesn't mean that you're necessarily a doctor. It means you've learned to think and act in a generally biomedical way; that you're caught up in a biomedical world. Perhaps you're a doctor, a nurse, a patient, a partner, a friend, a medical statistician, a coroner, or a passer-by, it doesn't really matter. All it needs is: someone who might say 'no, she's not drunk, she's got a hypo'; someone who gives her a glass of orange juice; someone who knows the real cause of the blurred speech; someone who knows that the person who's collapsing has Type 1 diabetes.

Strange though it may sound, here's what STS is saying. *Hypoglycaemia is only hypoglycaemia if it is done in biomedical practices.* And then we can add this. *Hypoglycaemia is only international if it is done in lots of biomedical places and practices in different parts of the world.* This means that it isn't a universal reality. STS is saying that it takes *effort* to turn bodies and their conditions into specific diseases, and then to make them international by making them transportable. And it adds that this is what biomedicine is all about: its fights against quackery; all those laboratories; the years of training; the clinics; the insurance policies; the technologies; and the treatments. It's about creating and practising disease conditions, pathologies and remedies, and doing this in different places. It's about creating practices that will hold steady across time and space. This means also that it's about creating *similar kinds of bodies* in different places too, in the clinics and the hospitals and the laboratories and the streets and the dwelling-places of the world. The

argument is that it takes work to create the condition (Type 1 diabetes) that is caused by autoimmune destruction of the pancreatic cells that produce the insulin that allows the body to metabolise glucose, a lot of work, expertise, and kit. Things *can* be the same everywhere, but only if you put the effort in to making them so. Here's the problem. The 'Western' mode of international doesn't see this at all. It thinks of itself as a way of uncovering universal truths about a single reality: the diabetic body. This is why the STS argument sounds so weird in the first place.

Sorry about the digression, but back in Windy City this is going to become important. Just hold the thought, 'it's about creating similar kinds of bodies in different places', and sit down again in Dr Lee's waiting room. Actually you're lucky. Dr Lee is calling you already. You walk down the corridor past the pharmacy, and you go into her surgery. There she is. She's sitting at her desk in her white coat. She smiles. You sit across from her, and then your consultation starts. You roll up your sleeve. You lay the back of your right wrist on a firm foam pillow. Now Dr Lee presses the tips of her middle three fingers on your radial artery. She presses down very gently. She's feeling your pulsation. Then she does the same with your left wrist. She does it a couple more times. And then she picks up a little torch. She wants to look at your tongue. She doesn't tell you to 'say ah', you don't do that in Chinese, but she's looking at the top of your tongue and then at the bottom. Now she's putting the torch down and she's starting to ask you questions. 'How are you sleeping?' 'How's your appetite?' Not so good. 'What are you eating? How's your digestion?' You've been having difficulty getting to sleep, eating irregularly, and your poo is a bit liquid in the morning. 'How's your emotional life?' Hmm, not so good. You've been working too hard and getting irritable. You tell her you've got a pain in your shoulder, and you remind her that the backs of your legs have been hurting too.

Dr Lee is making notes. She's typing into the computer. There it is, beneath glass top of the desk, the keyboard's handy. Then she calls the nurse. 'Take his blood pressure please.' A nurse comes in with the haemadynamometer. She wraps the cuff round your upper arm and pumps it up. She waits as it deflates and then she says: '102 over 78.' Dr Lee types the figures in, and then she speaks:

'Your pulsation points to the root of your problem. It's always deep at the 'chi' position (chě, 尺) in both your wrists. But it's stronger on the left. You're constantly drawing energy to keep going .... '

Now she's moving her fingers between your wrists again, to and fro, comparing the pulsations. Then she speaks again:

'Your pulsation is string and deep (chén xián, 沈弦) as usual, but it's a bit faster and stronger.'

She's typing again: 'white, thin coating'. That's your tongue. Now she's talking about your legs. So what's the problem? Why do they hurt? When you told your biomedical doctor he sent you off for a scan and a blood test. He was looking for signs of tendon injury, arteriosclerosis, or neuropathy, but the tests came back negative. Dr Lee takes the results seriously because they help her to eliminate possibilities, but at the same time she isn't surprised. She thought that the problem was to do with the kidney meridian (shèn jīng, 腎經) all along. You've been working too hard, she says. The end of the autumn is the time to restore 'yang qi' (yáng qì, 陽氣) to the meridian. But you're not doing that. You're *extracting* it. This is bad news, but it explains why your legs hurt. They're close to the kidney meridian, and the fact that they hurt is telling her that there's not enough qi to warm your body.

Step back from this. We've got computers here; we've got biomedical tests; we've got biomedical technologies; and we know already that Dr Lee and her nurses are trained in biomedicine. So we're in an international world, biomedical style. Neuropathy and blood pressures, these have travelled from Europe or North America and now they've been carried to a clinic in Hsinchu. This is the biomedical body on the march, and if you look at history you can tell a story that pushes this home, and it's all about domination. Taiwan was first named 'Formosa', mapped and made international, Western-style, by the Portuguese in the 1540s. Then between 1620s and 1660s the Dutch and the Spanish occupied parts of northern and southern Taiwan respectively. Much later Taiwan became a Japanese colony – from 1895 to 1945. Indeed it was a 'model colony', but this applied to health care too. Chinese medicine? The modernisers among the Japanese said that this wasn't scientific, it wasn't properly regulated, it wasn't effective, sometimes it was dangerous, and it made no kind of biomedical sense. Meridians? Could you point to them in the anatomical body? The answer is no, you couldn't. Or qi? What on earth was that? So the history tells us that for fifty years Chinese medicine was pushed to the periphery. It was suppressed, persecuted and outlawed.<sup>v</sup> And the result? By the time Japanese left in 1945 there wasn't much of it left, while all the time the biomedical body was on the march. It had been installed in the clinics and the hospitals and in the daily health-care practices of Taiwan and practised in those places, indeed just like Type I diabetes and its penumbra of blood sugar levels and hypoglycaemias. Chinese medicine pretty much stayed marginal after the Japanese left, but it wasn't quite squeezed out. It had hung on in there in 'folk practices' and 'back street clinics', and after 1945, very slowly, and very partially, it started to inch back in from the cold, such that in due course it became possible to train as a Chinese medical practitioner. Indeed it became possible to put Chinese medicine and biomedicine together. You could practise Chinese medicine, and the Chinese Medical College (which later became the Chinese Medical University) was founded in 1958, but the college supposed to revive Chinese medicine gradually started to include biomedical diplomas and departments too, so (we said this already) Dr Lee was a product of that double training. In short, there was a pushback, although even now more than 96% of Taiwan's health care budget goes on biomedicine.

So that's the story, told historically. It's a story about making biomedical things like bodies international on a grand scale. It's about the movement of those things. It's a story about a small pushback from Chinese medicine, emphasis on the 'small'. It's also another version of how international has been done in a 'Western' and analytical way since the Spanish and Portuguese expansion set its parameters. This is a specific mode of international with its particular ways of knowing, healing and self-understanding in which realities and truths are taken to be universal: were always *already* international. That's how it works.

So what is Dr Lee up to? The answer is given in her training. She's putting biomedicine (the haemodynamometer and all that) *together with* Chinese medicine. So she's not uninterested in the causal pathways of biomedicine. She's happy enough to take test results from the biomedical laboratory. 'Ah, good,' she's thinking, 'we're not looking at neuropathy.' And she's perfectly happy with the idea that there is a biomechanical body with its own specific anatomy. But there's something else going on too, or something different, because what she's doing doesn't fit with biomedicine's understanding of itself. This is because when Dr Lee gets to work, its realities and truths are no longer the only realities and truths. Suddenly they are lying down with kidney meridians and seasonal imbalances in yang qi. So how should we think about this? In the end the answer is going to lead us to another and quite different mode of international, one that is *correlative* – a term we are borrowing this term from sinology, where it has a specific meaning.<sup>vi</sup> It's going to take us on a difficult journey to a place where things look and are quite different, because we're going to have to give up on biomedicine's understanding of itself and the habits embedded in the *analytical* mode of international we've inherited from the Spanish and the Portuguese. To see what this might mean, let's make a short historical detour.

There's a surviving classic text in Chinese medicine called *The Yellow Emperor's Inner Canon* (huáng dì nèi jīng, 黃帝內經).<sup>vii</sup> Did the Yellow Emperor really exist? At least as a single historical figure the answer is probably not. Most likely we're back in Chinese origin myths about proper rulers, proper states, proper statehood, and proper forms of culture, but if he did exist after all then we're talking around 2500 BCE. However, the *Inner Canon* was compiled much later in the Han period (206BCE-24CE). It tells us about yin and yang (yīn yang, 陰陽) and how they relate, and it collects together a bunch of theoretical principles about pathology and physiology in terms of seven emotions and six evils (qī qíng liù xié, 七情六邪), twelve meridians (jīng luò, 經絡), and five zang (zàng, 臟) and six fu (fǔ, 腑) visceral systems. In practice it's an attempt to assemble the knowledge and practices of a whole series of partially connected medical traditions, including the five schools of ancient medical practice from the Warring States Period (475 to 221 BCE), and the five phases (wǔ xíng, 五行) theory that was added and adapted during the Qin Dynasty (221 to 206 BCE) and the Han period. Indeed, archaeological and textual evidence suggests that there have been different theories about meridians, and that the *Inner Canon* is just one of them. But for now the historical details don't matter. What's important is that the *Inner Canon* is *syncretic*. It's a



collection of different thoughts, approaches, practices and forms of intervention. Even more important, its syncretism sets a pattern that has characterised Chinese medicine throughout its entire extended history, because subsequent classics have also been hybrid classifications. They've taken the form of collections of medical records (yī àn, 醫案) and reinterpretations of classic texts. Indeed, most recently (note this) they have more or less happily taken up and absorbed facts emerging from biomedicine. So here's the bottom line. The qi body and the theory of meridians have been *heterogeneous* from the beginning. From a Western point of view they don't look coherent, but heterogeneity or hybridity have never been a problem and biomedicine is just the most recent addition.

Here's something else: they've been *diverse* too. This is because different practitioners have always worked in different ways. More importantly, they have always taken it for granted that this was the *right* thing to do and indeed probably *necessary* too. Why? Because those who have practised Chinese medicine have always taken it for granted that the qi body is one that is relational and contextual. They have assumed that diagnosis and intervention need to include what in Western terms we would think of as (Chinese versions of) bodies, diet, symptoms, emotions, social relations (including practitioner-patient relations), the passage of the seasons, location, the daily round, and stage of life. All of these are both irretrievably contextual and irretrievably variable from one place to the next, or indeed, from one consultation to the next. At the risk of oversimplification, we might say that in the Chinese scheme of things there is no fixed knowledge and there are no fixed causal relations. Everything varies.

Now we have moved back to the realm of self-understanding. Remember we said that the self-understanding of biomedicine takes it for granted that in theory realities and truths and (let's add) causal mechanisms are universal. In theory (the practice is different) there's just one world and one set of (okay, very complex and only partly known) mechanisms out there.<sup>viii</sup> Well none of this applies to Chinese medicine. It knows that it is hybrid; it knows that there aren't fixed mechanisms; it knows that everything is contextual. That's how it understands itself. It includes whatever it finds syncretically which means that it's also diverse, because the same size doesn't fit all.

This detour into history makes it easier to see why Dr Lee works in the way she does.<sup>ix</sup> If *The Inner Canon* tells us that qi flows in the meridians with daily life, and ebbs and flows with the seasons, then this is why she asks you questions about your diet, your emotions, your sleep, and your bodily functions. It is why she makes sense of your problem by thinking about the interrelations between the liver, the spleen, and the kidney meridians. But it is also why she doesn't find it difficult to absorb parts of biomedicine too. We see this again when she starts to think about treatment. So what does she say? The answer is: all sorts of things. You should eat carefully. You should go for an hour's walk every day. You should make sure you're in bed before eleven. And then she prescribes a modified version of Wendan decoction (wēn



dǎn tang, 澁膽湯). What she wants to do is to warm your body. She wants to increase your yang qi. So she is talking about yin and yang propensities, the dynamics of the five phases, and how qi and xue (blood) are out of balance between the visceral systems of zang and fu in the meridians. And then, playing between biomedical and Chinese medical concepts, she also reminds you that your liver fire is not real fire, and that the liver in Chinese medicine is akin to the neurological system in biomedicine. Maybe you don't recognise this (perhaps you are too much a child of biomedicine), but she is being utterly thorough in a particular Chinese mode. She is systematically exploring correlations by drawing on some of the endlessly rich resources for thinking about patterns of relations within Chinese medicine. She's working *correlatively*. Though there's a moment when all this becomes clear, which is when she turns to her computer to record her diagnosis. Looking over her shoulder you discover that she's not writing about qi or meridians. Instead she's using the WHO's International Classification of Diseases (ICD). '30742, 5649, 7291', that's what she types, and then the ICD diagnostic entries flash up on the screen. 'Persistent disorder of initiating or maintaining sleep'. 'Unspecified functional disorder of intestine'. And 'myalgia and myositis, unspecified'. Finally the certificate about the electronic patient record system in the waiting room makes sense. The National Health Insurance scheme will only pay Dr Lee if she uses the ICD. She has no choice, she has to do this. But as she does so she's further weaving biomedicine and Chinese medicine together, and she's not doing this reductively. She's not attached to the bag and baggage of a single body with a single set of (complex) causal relations. Instead she's working *functionally* and *syncretically*. Indeed she's being *knowingly* syncretic. It's no problem laying bits of biomedicine alongside qi or the meridians. This has nothing to do with causes. She's trying to find ways of understanding how they are correlated together in the particular circumstances to hand. And to understand the pattern of those correlations, she's drawing on the corpus of Chinese medicine. The latter is an almost indefinitely rich resource for thinking about patterns. This is what it is to think correlatively rather than analytically.

So now we have what we want to say in place. If we set it up as a binary then we've got the analytical on the one hand and the correlative on the other. In the correlative there are no big reductions or general explanations. It's site specific, and it shifts and it moves as contexts change. It's a grammar or a syntax for sensing and interpreting the endless possibilities in the weave of things, qi and all the rest of it. It is a set of metaphors for coming up with a story-line that makes sense of the pattern of things as they are in a place. Compare and contrast this with the analytical of the biomedical. This sees symptoms, and it goes looking for causes. It's into mechanisms. (Think of hypoglycaemia again.) That's the theory, even if biomedicine in practice often has more to do with tinkering than with causes.<sup>x</sup> Nevertheless that's how it likes to imagine itself. It works in a world, a single world, of mechanisms; and it lives in the hope – quite often the reality – that if we can understand those mechanisms then we'll be able to intervene and cure or manage the disease. Sit down, chew on the glucagon tablets, drink an orange juice, keep quiet, and hopefully you'll come round in a few

minutes. And then, alongside this, there is the commitment to universality: that since things are pretty much the same everywhere, all we need to do is to transport what we know about those things because our knowledge will work in other places too. Biomedicine in Taiwan under the Japanese? Of course. There's your analytical mode of international. If it can overcome prejudice like attachments to Chinese medicine it will work in the farthest corners of the globe. There's only room for one reality because there is only one reality. End of story.

So that's the binary: analytical versus correlative. Let's underscore our earlier warning. The division is too simple, and it's a whole lot more complicated in practice. But if we stick with it then we learn something interesting about different modes of international. In the world of analysis Chinese medicine gets squeezed: biomedicine is dominatory. But in the world of correlativity, or at least in the version we're seeing in Dr Lee's practice, things look quite different. The biomedical doesn't dominate here. *It's just being added*. It's being absorbed into the great, lumpy, heterogeneous weave of possible correlations that makes up Chinese medicine. And now we're back to our opening question: what does it mean to be international? We've seen that it takes hard work to make things transportable and hold them steady. This is a tough way of doing international, but it's pretty successful even so, and biomedicine's very good at it. Along with imperialism, colonialism, and European gun-boat diplomacy in various shape and forms. And massacres. And opium wars. And Japanese imperialism. And economic domination. And technological subordination. And colonisation by 'Western' ideas, such that a Taiwanese university campus looks very like one in Michigan with the same kinds of departments and concerns: journal publication, rankings, the Science Citation Index, and all the rest. But the making of similarities like this has been going on since Vasco da Gama in the Western mode of international. Yes, it comes in various guises, as modernisation, or Westernisation, or globalisation, or development, or even civilisation. But it's been done on a massive scale since the sixteenth century. And it has always been *analytical and dominatory*.

So think again about Zheng He's voyages, the world of 'what-if'. What if the Chinese had expanded to fill the world instead of the Spanish and Portuguese? What might such a world have looked like? What form might a correlative international have taken? Now we have been in Dr Lee's clinic the ghost of an answer begins to take shape. We have four thoughts on this.

First, *things* would look different. Dr Lee does so much for *you*, but she is doing almost nothing to your *diseases*. Instead she's looking for symptoms and circumstances. She's worrying about correlations. And she's trying to patch the clues she sees, bodily, emotional, and contextual, into correlative patterns and figuring out its imbalances. She is telling you that the patterns might be better balanced if you lived in a slightly different way, and then she's prescribing a decoction that might be added to the pattern and help to shift it. So where's the *disease* in all this? The answer is that it's not clear that she's working on a

disease at all – even when she’s working with the ICD. Instead she’s dealing with the complexity of symptoms. There’s no idea of a magic bullet that can go everywhere and work in all contexts. All of this suggests that as things moved from place to place in a correlative mode of international they wouldn’t hold their shape. More strongly, the extent to which it would make sense to talk of ‘things’ at all is quite unclear. Propensities, relations, patterns, flows, and knowledges or forms of expertise for sensing and working upon these – this is how a correlative international would frame the places it joined together. But things themselves? Perhaps they would still be there, but they would turn into shape-shifters. They’d respond to patterns and propensities. Indeed, *they’d look more like symptoms than objects.*<sup>xi</sup>

Second, the *relations between places* would change. Chinese medicine is syncretic in each location, but also *between locations*. Yes, you attend to the flows and meridians and the visceral systems and to the balances and movements of yin and yang but these work differently each time round. It’s not even that these principles are *applied* differently. Rather it is that they don’t count as analytical principles at all. Instead they are sensibilities that draw contextually on an endlessly rich set of metaphors for knowing correlativity. Everything shifts from place to place, and time to time, and this explains why Chinese medicine was mostly traditionally taught in apprenticeships rather than medical schools. It also explains why practitioners don’t (simply) pass exams but gather a following. Finally it explains why Chinese medical practice is diverse and distributed and has (as it were) been ‘correctly’ practised in endlessly many ways. Places cannot be reduced to one another. They aren’t abstract, spatially coordinated, locations, sites to which universal truths naturally apply. Instead specific things-in-place make the particular propensities and patterns of that place. It is almost as if *different places are in different worlds*. And this implies a corollary. Centres and peripheries in a correlative mode of international would look quite unlike those of the analytical international bequeathed to us by the Spanish and the Portuguese.

Third, the mode of *doing* international – what it actually *takes* – would look different too. It would be more supple or subtle than its analytical counterpart. Think, again, of the relations between biomedicine and Chinese medicine. As we saw, the former almost entirely displaced the latter in Taiwan. In an analytical mode of international there’s just one right way of doing things because there’s just one version of reality. It’s powerful, it’s focused and, to use a religious metaphor, it’s monotheistic. This contrasts with the dispersal of Chinese medicine. But now we need to add that there is also a kind of practised *ease* to the conduct of the latter. This is because a practitioner like Dr Lee isn’t trying to press everything into an analytical framework. Instead she is drawing on sensibilities educated by the vast metaphorical resources in Chinese medicine for knowing and recognising relational patternings, and *she is gently working on those patterns* to improve the imbalances that she detects. She works with propensities to make small manoeuvres at strategic points. She shapes things by following and working with things as they flow and return. And then she is

inviting you to work with her strategy. The *Dao De-Jing* of Lao-zi (lǎo zi, 老子) tells us that it is better to ‘do-nothing’ (wú wéi, 無為). ‘The softest thing in the world /Rides roughshod over the strongest. /No-thing enters no-space. /This teaches me the benefit of no-action.’<sup>xii</sup> This is what it would be to do or to act in a correlative mode of international. It would be flexible, it would be subtle, it would ‘work with’, and it would be minimalist. To be sure, its critics would say that it was manipulative.

Finally, what of *international itself*? The answer is that it would dissolve. The notion of ‘international’ implies nations, territorial patches, borders, and differences; insides and outsides; lines drawn between places; and the creation of connections between those places. As we have implied above, it also implies *a single space within which all this takes place*. The United States is here on the map, China and Taiwan are over there. They can trade. Let’s hope they’re not going to fight a war. But here’s the problem. All of this is *analytical*. There’s one world, and then there are nations within that world. That is how we get to ‘inter-national’. But this doesn’t work for correlativity. Think of Chinese medicine. The extent to which it lives in a single world and – importantly – *imagines* that it lives in a single world is very limited. That practice over there? It’s in a different place, and the things that make that place are also irreducibly different. Yes, we might learn from looking somewhere else in a correlative world. We might find that we share the *Inner Canon* and the subsequent medical classics. We might apprentice ourselves in a different place and do things differently. But the world is irreducible variably, composed, as the Chinese put it, of the ten thousand things (wàn wù, 萬物). There’s no larger context – spatial or otherwise – in which we or our nations could be lined up to join the ranks of ‘the international’.

Making things international. In this chapter we’ve played with the hypothesis that there are many modes of international. One of these, the analytical, seems to be everywhere, and it occupies most of the space and most of the talk. But we’ve gone looking for alternatives and we think that we’ve found one. It is alive and well in a GP’s surgery in Hsinchu, and it is correlative. If we are right, this tells us that other internationals are possible. What would the world would have been if the Chinese not withdrawn from the Western Ocean in 1433? The answer is that we will never know.

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## Endnotes

<sup>i</sup> We would like to thank Ping-yi Chu, Judith Farquhar, Daiwie Fu, Casper Bruun Jensen, Sean Hsiang-lin Lei, Shang-jen Li, Annemarie Mol, Kuo-li Pi and Hugh Raffles for dialogue, friendship and support. We are also grateful to the Taiwanese National Science Council for its generous financial support.

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<sup>ii</sup> Levathes, Louise (1996), *When China Ruled the Seas: The Treasure Fleet of the Dragon Throne, 1405–1433*, Oxford: Oxford University Press.

<sup>iii</sup> Latour makes this argument by talking of immutable mobiles, and it is explored by Law for the case of Portuguese imperialism. See Bruno Latour, (1987), *Science in Action: How to Follow Scientists and Engineers Through Society*, Milton Keynes: Open University Press; and John Law (1986), 'On the Methods of Long Distance Control: Vessels, Navigation and the Portuguese Route to India', pages 234-263 in John Law (ed.), *Power, Action and Belief: a new Sociology of Knowledge? Sociological Review Monograph*, 32, London: Routledge and Kegan Paul.

<sup>iv</sup> For further discussion of hypoglycaemia, see Annemarie Mol and John Law (2004), 'Embodied Action, Enacted Bodies. The Example of Hypoglycaemia', *The Body and Society*, 10: (2-3), 43-62, also available at <http://www.heterogeneities.net/publications/MolLaw2004EmbodiedAction.pdf>.

<sup>v</sup> Lo, Ming-cheng Miriam (2002), *Doctors Within Borders: Profession, Ethnicity, and Modernity in Colonial Taiwan*, Berkeley: University of California Press.

<sup>vi</sup> Hall, David L., and Roger T. Ames (1995), *Anticipating China: Thinking Through the Narratives of Chinese and Western Culture*, Albany: State University of New York.

<sup>vii</sup> *The Yellow Emperor's Classic of Internal Medicine*, (2002) translated by Ilza Veith, Berkeley: University of California Press.

<sup>viii</sup> It is indeed important to note that the practice is different. See, for instance, Annemarie Mol (2002), *The Body Multiple: Ontology in Medical Practice*, Durham, N. Ca., and London: Duke University Press.

<sup>ix</sup> Our account draws on a large body of work about contemporary Chinese medical practice, and in particular on Judith Farquhar and Qicheng Zhang (2012), *Ten Thousand Things: Nurturing Life in Contemporary Beijing*, New York: Zone Books, and Volker Scheid, (2002), *Chinese Medicine in Contemporary China: Plurality and Synthesis*, Durham, North Carolina, and London: Duke University Press.

<sup>x</sup> Annemarie Mol, Ingunn Moser, and Jeannette Pols (eds) (2010), *Care in Practice: on Tinkering in Clinics, Homes and Farms*, Bielefeld: Transcript Publishers.

<sup>xi</sup> It may be that the western analytical mode misunderstands itself and is also fluid. Annemarie Mol and John Law (1994), 'Regions, Networks and Fluids: Anaemia and Social Topology', *Social Studies of Science*, 24, 641-671.

<sup>xii</sup> Lao Tzu (2007), *Tao Te Ching*, London and Boston: Shambhala.