

CONTEXTUALISING CHINESE MEDICINE IN SINGAPORE

MICROCOSM AND MACROCOSM

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Introduction

After the formation of the People's Republic of China (PRC) in 1949, Singaporean Chinese who chose to remain in Singapore were confronted with the challenge of carefully tending to both their cultural heritage and their emerging nation's future. Externally, the promotion of Chinese culture was discouraged by the anti-communist and anti-Chinese sentiments of neighbouring post-colonial governments, which arose in response to increasing Chinese nationalism in Southeast Asia (Kong 2003: 64). Internally, it waned after independence due to the state's necessary sensitivity toward non-Chinese Singaporeans, an issue at the heart of the race riots of the 1950s and 1960s. And yet, Singapore's long-standing ethnic Chinese majority have nonetheless maintained, adapted and to some extent reinvented a rich variety of Chinese cultural practices throughout the politically tumultuous twentieth century and into the twenty-first century.

Although recent economic and multicultural stability has allowed a tentative acknowledgment of the potential of Chinese medicine (without overt advocacy), the Singaporean government still exclusively supports and promotes biomedicine as a remedy for post-colonial ills and a 'sign of the modern' (Ferzacca 2002: 36). Nonetheless, Chinese medicine has tirelessly persisted in Singapore, alongside the public and private celebration of major Chinese festivals, the preparation and consumption of Chinese cuisine and many other tenacious elements of Chinese culture. Exploring the dynamic between agency and control, this research illuminates one way in which political processes have impacted the public expression of Chinese heritage and community, from the colonial era into the present.

In this article, I will examine how Singaporean Chinese medicine patients, explicitly as situated in a tropical climate, define and negotiate certain bodily states. After first briefly describing my field site and methodology and providing a few historical details, I will then move on to an ethnographic account of Chinese medical practice and perception in Singapore. Focussing on the ubiquitous notion of 'heat' (*re*), I will explore to what extent Singaporean Chinese medical patients' appreciation of immaterial substances/forces varies

from, or is consistent with, Chinese medical theory. Exploring links between Scheper-Hughes and Lock's (1987) 'three bodies' and Hsu's (1999, 2007) 'body ecologic', I will thus describe how Chinese medicine in Singapore provides a paradigm in which bodily experiences of 'heatiness'¹ are understood, sociality is redefined and healing facilitated.

Methodology and field site

Based on fieldwork conducted in Singapore between January 2006 and October 2007, this research depicts a local manifestation of the increasingly globalised and commoditised practice of Chinese medicine. It seeks to link patients' experiences and meanings to macro-processes such as government policies favouring international investment, political constructions of heritage and the global market for Chinese medicine spurred by the opening of the PRC. In trying to represent both macro- and micro-processes influencing the position, use, practice and perception of Chinese medicine in Singapore, my research took me all over the island and, on one occasion, to a nearby Indonesian island. I interviewed, observed and conversed with Singaporean Chinese patients of all ages, both in and outside of clinics. I interviewed practitioners, researchers and Ministry of Health officials; attended public health events and lectures; toured Chinese medical factories and research facilities; and conducted observations at a popular Chinese medicinal herb and food shop.

Most prominently, I was fortunate to conduct long-term participant observation with several full-time, highly esteemed Chinese medical practitioners. I say 'fortunate' not only out of gratitude for their generosity with time, information and introductions, but also because at present there are *relatively* few well-established full-time practitioners in Singapore. Three of these extraordinary individuals granted me their patient attention, and their patients' attention, over the course of the two years I stayed in Singapore. The first was Dr Li, a first-generation Singaporean woman who practices general medicine, and specialises in hypertension and diabetes at Thong Chai Medical Institute.² I observed and conversed with her and her patients for several months at Thong Chai, while she also operated a private practice.

The second physician was Professor Tan Chwee Heng, whose activities include running a private practice, lecturing and demonstrating at the prominent Singapore College of

¹ Although 'heaty' or 'heatiness' is certainly a translation of the Mandarin Chinese term *re* ("heat"), used in Singapore alongside various southern Chinese dialects, my use of the English reflects the actual words Singaporeans employed when speaking English with me.

² Hereafter, Thong Chai.

Traditional Chinese Medicine (SCTCM)³ and its charity clinic, Chunghwa Yiyuan,⁴ teaching *qigong*, and serving on the examinations committee of the TCM Practitioners Board. I interviewed him at his private clinic, conducted observations at Chunghwa for several months and then followed him to another charitable clinic in Geylang called Dazhong Yiyuan.⁵ Last, but far from least, was Dr Wang, a Taiwanese businessman who had come to Singapore to import and export cane, and decided to study Chinese medicine at SCTCM. In addition to countless hours of discussion, Dr Wang kindly permitted me to observe and speak with patients in his private clinic in Chinatown, to accompany and observe him on a Tzu Chi medical mission to Batam, Indonesia, and to observe him at Chunghwa, where he volunteers once per week.

With two field sites in the Chinatown area—with Dr Li at Thong Chai and at Dr Wang’s private clinic—I managed to acquire a good feeling for one of Singapore’s oldest neighbourhoods. Called *Niucheshui* (Mandarin: ‘oxcart water’), the area has always had a great deal of activity. During the early colonial days, ethnic Chinese would bring oxcarts from various *kampong* (villages) to collect water. Despite the apparent redundancy of a ‘Chinatown’ on an island with an ethnic Chinese majority—and the governmental Housing Development Board’s (HDB) ethnic integration policies—this area is still known to have a high concentration of Chinese, particularly newly arrived immigrants. It is also a colourful ‘uniquely Singapore’ site, towards which the Singapore Tourism Board funnels tourists. Chinatown thus provides a poignant example of the difference between the *idea* of Singapore—as a sanitized tourist package—and the experience of *living* in Singapore.

Two major roads run through the centre of Chinatown, with a strip of manicured grass, or simply concrete, between them. Several blocks deep on the gentrified New Bridge Road side consist of renovated colonial architecture, painted in pastel hues and heavily laden with cheap souvenir shops. The Eu Tong Seng Street⁶ side is dominated by large, boxy shopping complexes, HDB estates and smaller provision shops. To observe at Thong Chai, I would walk several blocks back from Eu Tong Seng, through old hawker centres (which are reputed to have the best food), under multiple floors of laundry hung from apartment windows and—

³ The acronym ‘TCM’ is used in governmental and administrative discourse in Singapore, but Singaporean practitioners and patients more often simply used the term *zhongyi*, its most direct English translation, ‘Chinese medicine’, or the specific name of a healing modality such as ‘acupuncture.’

⁴ Hereafter, Chunghwa.

⁵ Hereafter, Dazhong.

⁶ Incidentally, named after the eldest son of the founder (and inheritor) of the transnational TCM company, Eu Yan Sang.

depending on the season—carefully around various offerings or ash remnants thereof on the ground.

Amidst the tailors, cheap trinket shops and overpriced restaurants on the New Bridge Road side was Dr Wang's private clinic—a newly remodelled and tastefully decorated clinic with a small reception area, two consultation rooms and two curtained beds in the back, on the ground floor of an old colonial shop house. In the first of what was to become many conversations with Dr Wang, he informed me that, because Chinese medicine does not enjoy the same status as 'Western medicine' in Singapore, the average salary is far less than in places like Taiwan.⁷ Given the fact that the median rent for a two-room HDB apartment is over S\$1,000 (£350) a month (HDB 2008), the S\$1,500-1,800 (£500-600) a month he reported (Dr Wang claimed to earn more than the average practitioner) is not likely to satisfy the financial needs of most Singaporeans (even if they are single), let alone their increasingly materialistic preferences. Popularly referred to as the 'Five C's,' the majority of Singaporeans associate material success with cash, a car, credit cards, a condominium and country club membership. The average salary quoted by Dr Wang could not begin to satisfy these prerequisites and does not, therefore, encourage many full-time practitioners. This is, as he put it, 'the Singapore way'. In order to understand why this increasingly popular practice does not command higher prestige or salary, we must consider both the legislative and historical position of Chinese medicine in Singapore.

Chinese medicine: regulation, colonialism and control

Singapore's Chinese medical community has long included herbalists, acupuncturists, Chinese food and medicine shopkeepers, bonesetters, reflexologists and physicians. Their treatments include raw and processed herbs to be taken orally or used as compresses, acupuncture, moxibustion, massage (*tui na*), cupping, bloodletting, scraping and *qigong*, to name just the most common. Although some physicians are known to make house calls, either independently or as part of a service (such as the 'Mobile Free Clinic' run by Dazhong), most operate in Chinese medical halls, institutes, dispensaries, and 'charity clinics'. Presently, some are locally qualified and registered professionals, while others—such as bonesetters at Chinese Buddhist temples—practice skills that did not originate in formal training and are not recognized by any formal institution (Sinha 1995: 214-15).

⁷ Maintaining ties in Taiwan and visiting several times a year keeps him apprised of the current affairs and economies of both countries.

Although both ends of the spectrum are considered to be healing professionals by the Chinese medical community and the general public, only the former are recognised by the state.

Despite the discouragement of Chinese medicine implied in a solely biomedical healthcare system, the persistence of Chinese healing modalities in Singapore has finally warranted more serious legislative attention. The regulation of Chinese medicine, under the meticulous management of the Ministry of Health (MOH), politically acknowledges only a portion of this varied community. The *practice* of Chinese medicine is regulated under the Traditional Chinese Medicine Practitioners Board (TCMPB), while Chinese *herbs*—plant, mineral or animal—are regulated by the Health Sciences Authority (HSA). The TCMPB consists of five to nine members, and must include an appointed ex-officio Registrar, at least one biomedical doctor and two registered TCM practitioners with at least ten years experience each. Based on the Singapore Medical Council, which regulates the practice of biomedicine in Singapore, its functions, registration processes and guidelines for conduct are thus founded on the biomedical model.

While certainly motivated and influenced by the ongoing regulation of Chinese medicine in the PRC, Singapore's strategy differs substantially in its clear biomedical bias. According to the TCMPB Registrar, the reason for this lies in Singapore's colonial history. In crafting a healthcare system, the state chose to perpetuate the biomedical model set in place by the colonial authorities, rather than develop one of the other 'traditional' medical practices. In order to properly contextualise Chinese medicine as one of the more prominent symbols of Chinese heritage in Singapore, I will briefly examine the state's strategies for crafting a specific notion of history and heritage.

Prior to colonisation, most of the Chinese in Southeast Asia travelled for trade-related purposes; very few stayed in Singapore for an extended period of time. After Singapore was established as a free port by the British East India Company in 1819, its tremendous economic success ushered in several waves of Chinese migrant labour. Migrating first from Malacca and Penang in contemporary Malaysia, and then from southern China, Chinese labourers and merchants constituted a numerical majority by 1849.⁸ Under the jurisdiction of the British East India Company, the public was left largely to its own devices. Once established as a crown colony, however, Singapore's colonial administration sought to secure a healthy labour pool. Thus, in the 1920s the first concerted efforts to manage public health were made, primarily through campaigns to increase awareness of disease prevention

⁸ This majority has been sustained, producing a 77% ethnic Chinese majority today.

measures. While biomedical services did become more widely available in the first half of the twentieth century, they were mostly intended for British expatriates and other westerners (Sinha 1995: 88, 107-9).

Meanwhile, southern Chinese migrants and their descendants were served primarily by Chinese medical practitioners who set up services through clan associations (*bang*), often offering their expertise free of charge. Chinese medicine was not seen as a threat—or even an issue that warranted attention—by the colonial authorities. Similarly, the Chinese nationalism promoted locally and by Chinese politicians visiting Southeast Asia was not perceived as problematic for colonial rule. Quite the contrary, China's interest in the welfare of overseas Chinese, and particularly the education of their children, lifted a burden that the colonial administration did not intend to bear. Thus, during the colonial era there was little impediment to the practice or use of Chinese medicine in Singapore.

A substantial shift occurred, however, after the PRC was established and Singaporean Chinese were urged to decide between Chinese nationalism (returning to China) and 'Malayan' nationalism (remaining in British Malaya, which included Singapore). Singaporean politicians and the public expected to remain part of Malaya due to the long-established political and economic unity between the two territories. Thus, once negotiations for self-government began after World War II, it became politically unwise to promote the cultural practices of any specific ethnicity. Further, for the majority of those who chose to remain, issues of cultural continuity were less immediately pressing in the 1950s and 1960s than the economic and social welfare of themselves and their children. In order to remain in power after Singapore was unexpectedly launched into 'Independence', the government was thus faced with the task of finding another way to bring together Singapore's various populations. It therefore sought to create a national identity that did not privilege the language, political agenda, culture or other needs of any single group over the others.

A history of colonial subjugation, a failed Malayan identity and the unrest promised by promoting Chinese culture in its place were all seen as antithetical to the ideal of a multicultural Singaporean national identity. Thus, history and heritage were carefully managed by the state, and actively promoting Chinese cultural practices such as Chinese medicine became politically untenable for over three decades. Since the late 1970s, however, Singapore's political relationships with its neighbours and the PRC have stabilised, fostering a growing recognition of the economic and moral value of Chinese language and culture. Perhaps in response to local sentiment, and certainly motivated by a growing regional interest

in the PRC's expanding economy, in the late 1990s the Singaporean government proposed 'to groom a Chinese cultural elite' (Lee 2003: 247). In turn, this has expanded the possibility of cultural growth and expression in Singapore, as well as enabled the government to draw practices such as Chinese medicine under more direct surveillance and control.

The body in context

Singapore's lack of natural resources and delicate political position at independence justified the careful crafting of a healthy population and environment, which, in turn, ensured a healthy economy. Given the 'backward' postcolonial conditions inherited by the state—overcrowding, rampant tuberculosis, poor sanitation and so on—one can see the state's impetus for creating the gleaming and sterilised façade that characterises Singapore's image of modernity today. The state still has its own agenda with regard to 'environmental health', which reflects public health and development strategies. But this biomedical management of bodies in space does not necessarily reflect the everyday experiences of many Singaporeans, navigating through health and illness in a tropical cityscape. In order to contextualise how Singaporean Chinese medical patients interpret the influence of immaterial substances/forces such as *re* ('heat') on their bodies, I will briefly examine the 'body ecologic' proposed by Chinese medicine before illustrating its variable application through ethnographic examples.

Notwithstanding the shifts between wet (monsoon) and dry seasons, Singapore's climate may seem hardly to change relative to more northerly parts of Asia like the PRC. As Dr Teo explained to me at Thong Chai, the practice of Chinese medicine in Singapore therefore differs from its practice in the context of the four distinct seasons in which it was developed. For instance, whereas the relatively colder climate of northern China encourages the use of herbs that produce heat to harmonise bodies exposed to heteropathic cold, if one were to apply the same strategy in Singapore, one could easily overheat patients and exacerbate their condition or produce a new one. Conversely, the experience that physicians acquire in Singapore cannot be used directly in Beijing. Although the theory remains the same, its application must be modified according to the environment.

This relative lack of seasonality therefore poses a slight problem for the practice of Chinese medicine in tropical Singapore; nonetheless, the underlying concepts and principles remain the same. In Chinese medical theory, life is predicated on the accumulation of *qi* from the cosmos and sustained by drawing vitality (other forms of *qi*) from the air and food throughout life, while death results from the dissipation of *qi*. Conceptions of the body and

health are therefore also framed in terms of *qi*, or ‘dynamic agents of change’ (Sivin 1987: 46-53). The constancy of change—its force and substance constituted by *qi*—is further elucidated by the general cyclical character of natural processes, which serves as the governing principle of the cosmos and all things within it. From the astrological level to the details of an individual life, repetitive patterns of transformation link microcosms to each other and to the larger macrocosm in a single cyclical pattern.

Aptly referred to in the *Annals of Lu Bu-wei* as ‘the Round Way’ (*yuan dao*), this microcosm–macrocosm relationship has been described by Hsu (1999) in terms of a ‘body ecologic’. Building on Scheper-Hughes and Lock’s (1987) ‘three bodies’ (the individual and social bodies, and the body politic), Hsu suggests the body ecologic as an additional framework. Generally speaking, Chinese medicine’s body ecologic refers to the resonance of macrocosm and microcosm—a notion that developed over the course of the last three centuries BCE, in which the cosmos, the state and the body are all part of the same complex, united by the ‘shared substrate’ of *qi* (Hsu 1999: 78-82).⁹ Working backwards in time from the systematised ‘scientific’ TCM theory constructed in the mid-twentieth century PRC, she outlines the manner in which embodied observations of the seasonality of illness eventually became codified as a disembodied universal theory of *wuxing* (‘five phases/agents’).

Hsu argues that the contemporary elevation of ‘The Theory of the Five Agents’ (wood, fire, earth, metal and water) in TCM theory developed out of a sixteenth- to seventeenth-century heuristic device for understanding ‘how apparent phenomena in the universe resonated with hidden ones inside the body-enveloped-by-skin’ (Hsu 2007: 98). Previously, however, its primary purpose was to advocate moderation, regularity and etiquette—in other words, a ‘distinctive lifestyle’—amongst an honour-seeking status group of the eighth century (Hsu 2007: 107-109). Taking the reader back to the Han dynasty (206 BCE to 220 CE), she demonstrates how observations of seasonal changes and wind direction were applied to the realm of medicine in terms of the seasonality of illness (Hsu 2007: 110-17). Finally, she explains how the legitimisation of medical practice such observations conferred was in turn influenced by the status granted to successful pre-Han prognosticators outside the medical context (Hsu 2007: 118-19). In charting these developments of Chinese medicine’s body ecologic, Hsu demonstrates how changing social conditions and historical events crafted a central contemporary conception of the body.

⁹ As a concept fundamental to Chinese medicine, this ‘shared substrate’ of *qi* was also discussed by Sivin (1987: 53-6) in the context of the constancy of change and by Farquhar (1994: 31-6) in her discussion of the ‘source-manifestation relationship’, among others.

Akin to the body politic, the body ecologic describes the body as ‘intricately intertwined with its environment, so body and environment cannot be dealt with as separate entities’ (Hsu 1999: 82). Hsu’s notion also overlaps with that of the social body, in which the body is seen as at least partially resulting from historical accident, including social, geographical and ecological factors, as also discussed in Zimmermann’s (1987) analysis of Ayurveda. Her approach thus avoids the sort of socio-cultural determinism promoted by scholars such as Unschuld (1985) and Ots (1994). However, although the body ecologic successfully bridges the body politic and the social body, the individual body is left underrepresented. If the body ecologic posits a relationship between observations of the natural environment and seasonal bodily processes, might not a similar relationship exist between the physical, *built* environment and contemporary body practices? In other words, if the moral values of a status-seeking elite group—emerging out of observed relationships between seasonal changes and illness—can be incorporated into a systematic understanding of the body in eighteenth-century China, what sort of influences on Singaporean bodily understandings might we find in the contemporary tropical cityscape? In the remainder of this article, I will examine how Singaporean Chinese medicine patients define and negotiate certain bodily states in order to demonstrate how this concept of a body ecologic can also integrate aspects of their own experiences, that is, of the individual body.

Bodily experiences of heat, cold, wind and rain

It was Tuesday morning, my day to observe Professor Tan at Chunghwa, situated in one of Singapore’s oldest HDB neighbourhoods, Toa Payoh. It was also July, and although I had only walked a block from the bus stop, I was sweating by the time I reached the top of the clinic’s wide stone steps. Even in the morning, the summer sun pierces hazy skies and bounces off Singapore’s utilitarian concrete and steel high-rise buildings, heating the island from above and below. On days like this it made sense to me why so many Singaporeans walk beneath umbrellas on sunny days. In addition to accommodating an aesthetic that favours pale skin, this portable shade provides slight relief from the heat when walking between buildings, crossing the street, etc. Amongst those who are compelled to walk outdoors, the ‘five foot ways’ beneath awnings commonly found in front of ground-level shop houses—introduced in the colonial era to shield pedestrians from the sun and rain—are noticeably popular.

Upon entering Chunghwa, I was greeted by the usual waft of air-conditioning and the surprised glances of several patients sitting in the crowded waiting area in the centre of the ground floor. As Singapore lies only one degree north of the equator, the summer can be unbearably hot by most people's standards. On most days, patients, students, physicians and staff enjoy air-conditioning throughout Chunghwa, as they would in most public buildings in Singapore. This is a luxury in many parts of the region, but viewed as necessity here—one of many indicators of Singapore's dramatic economic success relative to its neighbours. It is also common knowledge that the increased national productivity that resulted from the widespread use of air-conditioning in Singapore led ex-Prime Minister and founding father Lee Kuan Yew to declare it the greatest invention of the twentieth century.

This ubiquitous access to air-conditioning is taken for granted by most Singaporeans and, for many, has become an automatic mechanism for moderating the heat, particularly in the summer. In numerous discussions concerning where to meet with a Singaporean friend and colleague, he would suggest McDonalds—not because of the 'quality' of the food or the convenience of its numerous locations, but largely because of the air-conditioning. Walking to the Mass Rapid Transit (MRT) train from my second apartment in Sengkang on a weekend, I consistently observed noisy clusters of people around the few benches inside the Compass Point shopping mall (which houses the nearest MRT station). Although I did encounter a few, usually older people conversing at tables on the outside void decks (the open-sided ground floor) of HDB buildings, these areas were not air-conditioned. Thus, HDB void decks were often empty or under-represented during the day, whereas it was commonplace to find crowds of ten to twenty people chatting around shopping mall benches designed for three people.

This is not to say, however, that all Singaporeans responded to air-conditioning in the same manner, or experienced its effects on their bodies in a similar way. Kira, one of Dr Wang's patients, described to me why her mother is sensitive to air-conditioning, a sentiment I found especially common amongst older Singaporean Chinese women. Shortly after Kira was born, her mother went to close a window to stop the rain from coming in and caught a chill (described as *feng*, or 'wind'). This was in violation of Chinese postnatal confinement practices that traditionally shield the weakened mother's body from potentially harmful substances/forces like wind and rain; touching water is strictly forbidden unless specific Chinese herbs are first boiled in it. Kira's mother believes that the 'confinement wind' she

caught in this manner has remained with her ever since, making her susceptible to chills in the rain or under air-conditioning.

The aversion to rain and water is extremely common, not only in the context of confinement periods, but also in the everyday lives of Singaporeans. I cannot count the number of times I was informed—usually by text message—that someone I was meeting was going to be late because they were ‘caught in the rain’. This means that they did not want to walk to their preferred method of transport (even with an umbrella) until it stopped raining. Of course this can be partially explained by the discomfort associated with having wet clothes—even with an umbrella, it rains so hard during the monsoon season that one is drenched from above and below, as the rain bounces off the ground. But more often, Singaporeans would cite the potential risk of illness caused by being in the rain as a reason for avoiding it. The aversion also extended to the period immediately following rain, when sometimes visible vapours rising from the ground (especially in the morning or evening) were said to cause all manner of illnesses.

Kira’s story demonstrates a common acceptance, amongst Singaporean Chinese medical patients in particular, of the power of intangible, environmental forces to act upon individual bodies—sometimes with lifelong repercussions. Aside from the atmospheric pathogenic dangers implied here, there are numerous other themes in this short account that will reappear later in this discussion. While Kira prefers to stay under air-conditioning (she also requested we meet at a McDonalds to take advantage of the cooler environment), her mother cannot tolerate it. Not only are older people often said to be more sensitive to climatic changes and extremes, it is fully expected and accounted for that individual constitutions and life experiences will produce different reactions to hot and cold in both the environment and in foods or medicines consumed.

Returning, however, to the Tuesday in question at Chunghwa, the air-conditioning in Professor Tan’s room on the first floor was not working. Despite the heat, Professor Tan informed me, the clinic administrators instructed him not to open the windows so as to prevent mosquitoes from entering. Dengue fever, a potentially lethal disease carried by mosquitoes (‘mozzies’), is an intractable problem in Singapore that no amount of fogging or National Environment Agency (NEA) campaigns has been able to fully eradicate. I encountered many messages associated with this campaign—written in English, Chinese, Tamil and Malay—all over Singapore throughout my fieldwork. Billboards erected in small grassy spaces near HDB estates depicted a fleet of giant mozzies hovering above the city and

the fear-inducing directive: ‘When they strike, you can’t hide. Stop dengue. Act now!’ Spaces normally reserved for advertising on the heavily used MRT trains were frequently appropriated by the NEA with illustrated instructions on the mandatory daily ‘10-minute Mozzie Wipe-out.’¹⁰ Similar instructions were delivered by local celebrities in television advertisements and in flyers mass-mailed to residents’ homes warning, ‘If they breed, you will bleed.’

Failure to comply with these instructions, as revealed by surprise NEA spot-checks at one’s home that produced mozzie larvae, could (and often do) result in hefty fines. While many Singaporeans are undoubtedly compliant with government public health initiatives—eating ‘healthily’, exercising regularly, taking anti-mozzie measures and so on—the NEA’s anti-dengue campaigns are intentionally oriented towards the domestic (as opposed to natural or public) environment. One of many efforts to reach into the private space of Singaporeans, this campaign meets resistance not through public protest or debate, but through non-compliance. Many Singaporeans simply do not empty out the trays underneath their plants or cover the ends of their laundry poles (both of which can collect rain water and therefore provide the necessary conditions for mozzie breeding). Hence, the need for an ongoing and high-profile campaign that highlights danger and responsibility, and reproduces the controversial ‘climate of fear’ often (quietly) attributed to government propaganda.

In addition to demonstrating the tenacity of public health campaigns, statements like, ‘Look around. Are you breeding danger?’¹¹ convey a sense of urgency and responsibility in a hostile environment. It is important to note that dengue fever in Singapore—labelled or understood as such by patients, caregivers or physicians—is almost exclusively treated within the domain of biomedicine. Nonetheless, given the prevalence of these messages it makes sense that, despite its status as a biomedically-defined and -treated disease, concerns about dengue are manifest even in Chinese medical clinics. Thus, Chunghwa administrators were doing their part to shield their patients from both the environment and some of its more dangerous agents (mozzies) by insisting that the windows remain closed.¹²

¹⁰ This includes: changing the water in vases, flower pot plates and any other household vessels every other day; turning over water storage containers (e.g. buckets), covering bamboo pole holders—used for hanging laundry outside the windows of most HDB estates; and clearing and adding insecticide to roof gutters every month.

¹¹ Slogan from a feedback form mailed out by the NEA in May 2006 that urged people to examine a series of pictures and then answer a few simple questions. Appealing to *kiasu* (Hokkien, ‘fear of losing’—often, losing the opportunity to get something free) Singaporeans, residents who submitted the form stood a chance to win one of several prizes.

¹² Although malaria is still a problem in other parts of the region, it does not seem to be in Singapore.

The clinic administrators' concern about mozzies notwithstanding, Professor Tan disregarded the instruction by opening *all* the windows, commenting with clear authority in Singlish: 'All the patients are, you know, fainted—who come and save them? Crazy lah!' Tan's blatant prioritising of patient comfort over clinic administrator or NEA preferences seemed to bolster his authority, perhaps by virtue of the audacity of his resistance. His comment sparked animated discussion in Mandarin, Singlish and several Chinese dialects amongst the five students and ten or so patients distributed about the room in various stages of consultation. It is perhaps a reflection of the different arenas in which Chinese medicine must operate in Singapore that, while the clinic administrators were responding to NEA formulations of illness causation (mozzies transmit dengue), Tan was concerned with the practical impact of 'heat' on his patients' bodies.

This emphasis on *immaterial* rather than *material* pathogenic substances is easily contextualised within Chinese medical theory. Although the politicised construction of 'TCM' in the mid-twentieth century PRC favoured theoretical aspects commensurate with biomedicine, Chinese medicine still maintains many non-materialist notions. The Chinese medical theory of *yinyang*, for example, provides an appropriate paradigm for interpreting *re* ('heat'). And yet, despite these clear correlations between the notion of heat in Singapore and *re* in theory, popular understandings and home-based practices do not always exactly match professional constructions. To illustrate this point, in the next section I will discuss several observations and accounts of the role of heat, 'heatiness' and Chinese medicine in everyday life in Singapore.

Practical and theoretical understandings of heat

The bodily experiences that Singaporeans ascribe to 'heatiness' are quite diverse, including (but not limited to) otherwise inexplicable headache, fatigue, giddiness, yellow build-up in the eye, mouth ulcers, sore throat and, of course, fever. Chinese medical physicians frequently deal with the symptoms of 'heatiness' in the course of their practice, sometimes naming the condition as such, at other times interpreting it in terms of a different treatment paradigm. But 'heatiness' is such a common element of daily life in Singapore—particularly throughout and immediately following the summer—that it is often managed outside the clinic entirely. Cooling soups, teas and desserts can be purchased premade in popular Chinese food and herb shops like Hock Hua, or can be made at home from easily accessible materials found in such shops or at Chinese medical halls and clinics. Grandparents and mothers

prepare these remedies for feverish children often in lieu of taking them to the clinic, blue-collar workers and businessmen alike drink *liang cha* (cooling tea) throughout the year, particularly in the summer, and regular diets are adjusted according to the changing climate.

However one experiences the tropical heat, it is an unavoidable reality that even the most pampered Singaporeans must encounter in going between air-conditioned buildings, one which is largely ignored in biomedical notions of health maintenance. Although symptoms of dehydration and heat stroke, for instance, are certainly interpreted within the biomedical paradigm, interventions are typically episodic rather than taking into account natural fluctuations or seasonality. We must therefore be careful not to conflate the Chinese medical notion of ‘heat’ (*re*) with bodily or environmental temperature as understood and measured by western science, for one can experience ‘heatiness’ without running a fever in the biomedical sense. Given the prevalence of the notion of balancing hot and cold foods in Singaporeans’ healthcare strategies, it is not surprising that they would, at times, prefer a medical practice that incorporates (rather than denigrates) their subjective experiences of heat and cold.

With regard to the clinical management of ‘heatiness’, as Farquhar notes in her examination of the ‘practical logic of the clinical encounter’ (Farquhar 1994: 61), the diagnostic and therapeutic process in Chinese medicine relies on observations by *both* patient *and* physician. In order to explore the practical application of Chinese medicine’s dynamic body of knowledge, Farquhar first relates a generalized account of the clinical encounter while warning us that a great deal of variation exists between clinics and between doctors (Farquhar 1994: 41-4). Here, she explains the concept of *kanbing* (‘looking at illness’) to describe the joint effort between patient and doctor in evaluating the illness. As she explains, each contributes their own perspective and experience, sharing authority over the ‘truth’ of the symptoms in a manner very different from the biomedical clinical encounter (Farquhar 1994: 45, 67).

Although there are several frameworks that could be applied to contextualise notions of heat and cold within Chinese medical theory, the notion of *yinyang* is perhaps the most direct. Used to explain the dynamic internal relationships of temporal and spatial phenomena (such as the cycles of the sun and seasons, or the bodily changes that manifest themselves as illness), *yin* and *yang* demarcate the significant aspects, and their subsequent relationships, of nearly any natural continuum. In other words, *yin* and *yang* form the abstract archetypical pattern upon which all physical situations and their underlying dyadic relationships are

understood. Although there is always *yin* within *yang* and *yang* within *yin* (as the two, in turn, transform into one another), *yin* qualities are characterised as passive, internal, dark, feminine and cool; *yang* qualities are active, external, light, masculine and hot. Individually, the *yin* and *yang* aspects of a phenomenon can only be defined relative to each other, to another phenomenon or to the phenomenon itself in another phase of development (Sivin 1987: 59-65).

While heat is generally associated with *yang* and cold with *yin*, none of these terms can be described as absolutes or universally experienced bodily states. Thus, the subjective experience and specific manifestation of *yinyang* (or cold/heat balance) in a patient's body at a given place and time must be considered very seriously in the diagnostic and treatment process. Using this angle of analysis, the experience of 'heatiness' in Singaporean summers can result from either excess *yang* or deficient *yin*, relative to both an individual's internal constitution and fluctuations, and his or her shifting relationship with a dynamic environment. Even amongst patients familiar with the biomedical diagnosis and treatment associated with severe symptoms of 'heatiness', Chinese medicine is thus often the first port of call. It must be noted that the vast majority of patients with whom I worked also use biomedicine in conjunction with (or even in preference to) acupuncture or herbal treatments. However, when it comes to the daily maintenance of bodily states in the environment, Chinese medicine provides an appropriate framework for managing patients' seasonal experiences, even amongst patients that concomitantly use biomedicine. In particular, such patients tend to prevent or treat 'heatiness' by means of home-made remedies, seeking assistance from a Chinese medical practitioner only in severe cases.

One such patient, named Margaret, sees Professor Tan on a very regular basis, has an excellent command of English and was quite interested in sharing her health-management strategy with me. At 77 years old, Margaret has a clear complexion, bright eyes, a tidy appearance and a generally good memory. However, she reports that she has high blood pressure, heart problems, diabetes and high cholesterol and is 'sick in the liver'. Every three months she sees her biomedical General Practitioner (GP) to get medication for her diabetes, blood pressure, cholesterol and heart condition. Every couple of days she gives herself a blood-sugar test for her diabetes, and every six months she has an overall check-up. Additionally, Margaret visits Tan up to twice per week for single-needle acupuncture. She treats her arthritis with 'medicated oils' and by avoiding direct exposure to air-conditioning (which she considers 'damp'), takes a variety of over-the-counter supplements and

prescription medications, makes herbal soups and other home-based remedies and carefully minds her diet. As she does not have insurance, this is all paid for out of her own pocket; even her heart surgery was partially paid by her savings and partially by her daughter's MediSave account. 'I'm a really expensive woman', she tells me; 'I spend a lot of money on my life'.

The healthcare strategy over which she has the most direct control, and a frequent topic of our conversations, is the preparation of herbal remedies and the regulation of her diet. Some of the advice on the latter—such as diabetes-related restrictions—comes from her GP or biomedically oriented literature.¹³ However, much of her daily activity—particularly the careful management of 'heaty' and 'cooling' foods—is not based on biomedical notions of health and the body. Further, Margaret worries alongside countless other patients with whom I interacted that the side-effects (most often giddiness and gastric pain) of the medication are indications that they are actually harming her. On the other hand, she explains, Chinese medicine doesn't affect the body as strongly as 'English medicine'. With faith in Chinese medicine's ability to improve health in a 'slow way', every week she prepares cooling teas (*liang cha*) and herbal soups from herbs purchased at a Chinese medical hall near her home for herself, her husband and any children or grandchildren that are around. The specific combinations she chooses depend on the weather: for cool weather she prepares warming foods, and in hot weather she prepares cooling foods.

Lena, a Malaysian Chinese currently living as a Permanent Resident with her husband, mother and mother-in-law in Singapore, reported remarkably similar opinions about the side-effects of biomedicine compared with the gradual effects of Chinese medicine. She reminded me, however, that some Chinese herbs are stronger than others—while certain herbs are safe to combine and consume as one sees fit, others require supervision and advice from a physician. To get a remedy for a specific ailment, she advised, one must consult a physician. For more general ailments, one can use standard combinations, packaged for use as homemade remedies or bought in bulk as individual ingredients based on these packages. Individuals may then tailor these 'general well-being soups' according to the health requirements of oneself or family members, recommendations of friends and/or one's taste:

So you have to combine the Chinese herbs, but unless she [Lena's mother-in-law] knows what she's combining, she wouldn't dare. Or she'll follow what her friends combine, then she'll

¹³ She frequently orders health-related books from *Reader's Digest*.

come: ‘Oh, this is what I was told to combine’, and we’ll combine. After the first, if it’s not right for us, we feel—‘Oh’. The next day we all feel very heaty, or something, and then we know it’s probably not right for us, and we have to stop drinking.

Like the vast majority of Singaporeans with whom I interacted, these individuals are sensitive to subtle changes in both the environment and their own internal balance of heat and cold. The commonsense knowledge collected through individuals sharing their bodily experiences helps to modify and refine certain standard formulae beyond the reaches of the clinical environment. This style of home-based remedies presents an extremely common strategy for moderating the relationship between Singaporeans’ bodies and their climate. To some extent they incorporate both individual and social understandings of the body, and represent a break from the body politic. They are grounded in Chinese medicine’s general ‘body ecologic’, and yet are specifically tailored to the Singaporean environment and seasonal experiences of illness. Despite the obvious linkages to Chinese medical theory and practice, however, it is inaccurate to say that patient perceptions exactly match those of Chinese medicine practitioners, as will be explored further shortly.

Home-based remedies, although often purchased and prepared without the assistance or advice of a Chinese medical physician, derive from the intersection of Chinese *materia medica* and various culinary traditions (particularly the Cantonese style of making soups). Whether prepared at home from raw herbs or purchased in bottles from stores like Hock Hua, they differ from the herbal prescriptions given by registered physicians, being produced and packaged for mass consumption, rather than tailored for the specific balance of an individual body in its environment, as described above. As such, they blur the already ambiguous line between ‘food’ and ‘medicine’ in Chinese (or overseas Chinese) culture.

On the other hand, lifestyle and diet are indeed a part of Chinese medical practice. In so far as they are inclined or required to provide dietary advice to their patients, several of the physicians with whom I worked did include proscriptions on certain foods. As Dr Teo at Thong Chai explained to me one day:

[Sometimes] when we prescribe the medicine, the patient got heatiness (internal heatiness) so we prescribe a medicine to get rid of the heatiness. At the same time we ask the patient, ‘no chilli’ or ‘less chilli’—those can produce heatiness. [Also] some fruits or oily [foods], in Chinese theory you have to ask the patient to reduce it, or cut down or get rid of it...because some of the patients, they got a habit to take chilli. You ask them to stop chilli—‘no!’ So [we

say] ‘less’. Actually, in Chinese theory, different people got different—we call it *tizhi*—constitution. Some patients, they can take heatiness OK. Some patients, they cannot take heatiness—they take just a little bit and soon they have to take cold. So there is the *yang*, there’s the *yin* and—there’s one more—the *yinyang* balance one: they take cold [foods or] they take heatiness, OK...

In many respects, Singaporean Chinese medicine patients frame bodily experiences in similar terms, regardless of their compliance with physicians’ advice. Singaporeans certainly do not experience ‘heat’ (external or internal) in a uniform fashion, or necessarily agree on which foods are ‘heaty’ and which are ‘cooling’ (Wu 1979). Nonetheless, I did encounter a great deal of consistency—not only between patients, but also between patients and Chinese medical physicians—with regard to certain kinds of food. For instance, chilli and durian (a sweet, creamy and extremely stinky fruit) are almost universally considered to be ‘heaty’, while chrysanthemum and mangosteen are considered ‘cooling’. It is no accident that durian and mangosteen are usually eaten together, to counteract the tendency of the former to overheat the body in Singapore’s hot climate.

Furthermore, there are some Chinese medical concepts that are clearly mirrored (albeit with less detail and context) in patients’ home-based healthcare reasoning and treatment strategies. In preparing Chinese herbal soups, for instance, Lena recognised a marked distinction between her own constitution, her mothers’ and her mother-in-law’s, particularly in relation to heat. As her mother-in-law ‘can take more heaty stuff’ than others in the household, she informed me, she must be careful in preparing even general well-being soups. Thus, the different bodily responses within her household to the same substance (in this case, the Chinese herb *danggui*, *Angelica sinensis*) are understood in terms of different constitutions. As her mother-in-law’s constitution is relatively cool, she can take *danggui* to ‘perk up’. If Rena takes it, however, her already ‘heaty’ constitution will stimulate the opposite effect: the weariness often associated with ‘heatiness’. This is obviously quite consistent with Chinese medical theory as described by Dr Teo.

Nonetheless, a difference still seems to exist between professional and lay understandings of the balance of heat and cold. For instance, the correlation between *yinyang* and cold/heat rarely entered into my conversations with patients about ‘heatiness’, or the strategies they employed to prevent or dispel it. Instead, a simple correlation between either consuming too much ‘heaty’ food or spending too much time in a hot environment was usually invoked as an explanatory mechanism. Treatments (or preventive methods) were similarly simple and,

except in extreme cases or in association with other health problems being managed by a physician, largely conducted without direct professional supervision.

Thus, while certain remedies and popular dietary advice are often associated with Chinese medicine, the manner in which patients relate to concepts of seasonality, heat and cold differs somewhat from standardised Chinese medical theory. Nonetheless, the ‘body ecologic’ being constructed here is undoubtedly more in line with Chinese medical theory than with biomedicine. Although patients’ notions of ‘heatiness’ do not always exactly match their Chinese medical genesis, their subjective experiences are nonetheless validated and incorporated within Chinese medical treatments. By contrast, not only is subjectivity often degraded in biomedicine’s overt preference for ‘objectivity’, but the very bodily experience of ‘heatiness’ does not *exist* within the biomedical paradigm.

I have suggested that, if we are to understand why Chinese medicine provides a more appropriate framework for interpreting bodily experiences of ‘heatiness’ in Singapore than biomedicine, we must situate patients within a larger environment—both natural/climatic and therapeutic/clinical. The ‘atmospheric’ influences in Professor Tan’s practice were by no means limited to heat alone. Although I cannot possibly summarise every influence at work in even this one setting, let alone in Singaporean Chinese medical clinics in general, in what follows I shall highlight the influence of social interaction and sensory stimuli in particular. Moving beyond the clinic walls, I will then conclude this paper by initiating discussion on the influence of the (politically generated) sanitized cityscape on both individual and social bodies.

Healing social and individual bodies

Singapore is a highly manicured island with clearly defined geographical boundaries.¹⁴ If it were not for a sizeable nature reserve located in the centre of the island and smaller, rapidly diminishing pockets of undeveloped land (in inconvenient locations), one might easily forget that the island used to be covered in jungle. But even these ‘natural’ zones are monitored and controlled, permitted to exist under the careful management of the National Parks Board (previously a statutory board, now privately owned). Under the watchful eye of ex-Prime Minister Lee Kuan Yew (currently ‘Minister Mentor’), a garden approach to sustainable development was implemented with the intention of attracting foreign investors and softening the urban landscape for Singaporeans. With the demolition of the *kampongs* (villages) of the

¹⁴ Actually, the nation state comprises a small cluster of islands, but for the purposes of this discussion only the main island (which sustains the overwhelming majority of the population) will be considered.

colonial era and relocations of people into dense urban clusters under the HDB, everyday interactions of Singaporeans with their physical environment were increasingly defined in terms of concrete and steel. A number of parks, tree-lined boulevards, nature reserves and ‘park connectors’ (green pathways between parks) were thus planned and implemented to produce a ‘garden city’.

Singaporeans therefore encounter even the natural environment in a very controlled manner, while the vast majority of their time is spent in an orderly urban cityscape. The biomedical healthcare system, with its associated imagery of modernity, found concrete (in both senses of this word) manifestation in early development efforts such as improved infrastructure, efficient public transportation, public health and sanitation measures, and careful city planning. The island—with its veins (streets) and arteries (expressways), clearly defined but permeable skin (borders) and interconnected organs (beehive-like ‘towns’ scattered throughout the island)—is carefully managed by the government in the same manner, and for the same purposes, as the docile social body that was crafted to attract international investment. The health of the population is tied to the health of the urban environment, which in turn ensures the health of the economy and the continued survival of the nation.

Cityscape terminology can also be appropriated medically, as I regularly discovered in my observations with Professor Tan. After speaking with a patient, examining their tongue and quietly taking their pulse for a few moments, he would, on occasion, suddenly look up, nod confidently and simply say, ‘Traffic jam’. Regardless of the language Tan used in conversation with his patients (Mandarin, Hokkien, Teochew, Cantonese, a bit of Malay and English, depending on the patient), he used this English term quite frequently, either in explanation or as this sort of diagnostic declaration. In concert with other physicians with whom I spoke, Tan frequently commented that Singaporean patients do not always understand Chinese medical theory (or even terminology). In order to explain how his needling technique affects their bodies, he therefore employs the metaphor of *qi* as traffic in the city: in an ideal state, it flows smoothly and regularly, while stagnations or other problems are ‘traffic jams’. Acupuncture, then, relieves the congestion and helps the traffic resume its proper flow.

While this metaphor is certainly tailored to contemporary Singaporeans, it also has predecessors in Chinese medical theory—particularly as pertains to the notion of *jingluo* (also romanised as *ching-lo*), or the tracts and channels that link acupuncture points on the body.

Lu and Needham describe this network of twelve primary channels (*zhen jing*), additional channels, junctions and short branches as ‘a complicated reticulate system, resembling at first sight to modern eyes a map of the underground railway system in a great city’ (1980: 15). However, they also note that the typical metaphor evoked in Chinese medical texts like the *Ling Shu* involves networks of water:

There is no doubt that in the ching-lo system we have to deal with a very ancient conception of a traffic nexus with a network of trunk and secondary channels and their smaller branches. From the beginning these were thought of in terms analogous to those of hydraulic engineering, involving rivers, tributaries, derivate canals, reservoirs, lakes, etc.... (Lu and Needham 1980: 22-3)

Thus, while the water traffic metaphor was developed in the environmental context of ancient China, Tan’s automobile traffic metaphor is particularly appropriate in contemporary Singapore, since it represents a reconceptualisation of *jingluo* within a modernised cityscape.

Orderly city life was also reflected in the bodily practices of Singaporeans outside the clinical context. While public austerity is certainly consistent with Chinese cultural codes of conduct, such as the Confucian avoidance of immoderate emotional expression (Lin 1981: 101-2), there are also a few aspects that are ‘uniquely Singapore’ (to misappropriate the Singapore Tourism Board’s catchphrase). Graffiti—like facial piercings, torn clothing or neon-dyed hair—is not common in Singapore, although all of these do indeed exist (particularly outside the gentrified tourist areas). Public expressions of resistance are limited not only by law—public protests are prohibited, and ‘free speech’ is restricted to the acoustically challenged ‘Speaker’s Corner’¹⁵—but also by self-surveillance. In so far as the government has created a clean and efficient image of Singapore in the international eye, so too do the vast majority of Singaporeans maintain a tidy and productive image of themselves in the local public eye. With limited resources—both in terms of space and in the constant ‘lack of natural resources’ political rhetoric—competition between *kiasu* (Hokkien: ‘fear of losing’, see also footnote 12) Singaporeans was often quite fierce. Although often friendly after becoming better acquainted, the majority of Singaporeans I encountered as strangers, even on our shared housing estate, were remarkably sombre.

¹⁵ At the corner of a very busy intersection in the Chinatown area, ‘Speaker’s Corner’ is considered something of a joke amongst Singaporeans, as any opinion expressed in the location during daylight would be easily drowned by the sound of traffic. Sound amplification devices are, of course, prohibited.

Upon arrival at Chunghwa, many of Professor Tan's patients still bore these hallmark characteristics of the (public) social body: serious expressions, arms crossed, backs turned or gazes avoided. Within the consultation room, however, regular patients knew each other and interacted in a friendly and mutually helpful manner. Patients typically sat in chairs that migrated around the room as people came and went, waited for consultation with Tan, stretched various body parts and socialised with each other. In addition to the intended physical adjustments provided in this environment, therefore, a distinct sense of community was also being created. This sense of community followed Tan to Dazhong in Geylang. The volume of chatter from the waiting room (which I affectionately labelled 'the henhouse')—usually in various dialects between older, female patients—earned frequent notations in my field notes.

In the course of participant observation at both Chunghwa and Dazhong, I was therefore able to observe how the 'clinical encounter' that Professor Tan manages also facilitates *social encounters*. In so far as it is the physician's prerogative to arrange patients as he or she sees fit (i.e. one at a time, or in groups), Tan intentionally influenced the therapeutic environment and social relations therein simultaneously. Although patients arrived quietly and seriously—expressions blank, as one would expect to find on passers-by on the sidewalk—they often left with a lighter air, even graced with the occasional smile. While the experience of symptomatic relief that many reported and/or displayed (via increased mobility, facial expressions and so on) was undoubtedly a factor, I noticed an affective change even amongst those who did not report their symptoms being relieved.

In order to explore what else might contribute to this shift in affect, I suggest, in concert with Desjarlais (1996), that other (non-quantifiable) aspects of the healing environment must be considered. This perspective is not only an engaging orientation emerging in medical anthropology, but is also more aligned with the Chinese medical epistemology and ontology operating in Professor Tan's practice. In Tan's consultation room the senses are certainly evoked: the touch of pulse diagnostics and pinch of needling; the light from fluorescent bulbs and the open windows; the white jacket and tie of physicians; the sound of laughter and chatter from other patients. Through this evocation Tan, like the Yolmo shamans of north-central Nepal, renews his patients' 'presence', or 'participation in the world' (Desjarlais 1996: 159). Following Desjarlais, we might therefore view these atmospheric characteristics as providing a space not only for individual healing, or the backdrop for doctor–patient relations, but also for social affirmation.

Through ethnographic examples, I have explored a few facets of patients' relationships with their natural and built environment. Resonating with humoral notions and associated body praxis found in many parts of the world, the vast majority of Singaporeans with whom I worked were mindful of both dietary excesses and slight fluctuations in climate. Although patient adaptations of the hot/cold idiom clearly derive more from Chinese medicine than from biomedicine, climactic differences between the PRC and Singapore complicate a direct transfer of Chinese medical practice into the tropics. While we must take into account how local practitioners creatively apply even standardised TCM treatments and advice, we must also consider how patients' perceptions of these concepts differ further. Finally, we must remember that Singaporean Chinese medical patients interact not only with their natural environment, but also with the sprawling city in which they live. In so doing, they come into more direct contact with the built environment of the state and its associated constructions of modernity and aesthetics.

After an extended stay in Singapore—investigating alleyways, wet markets, coffee shops, pool halls and marginalised neighbourhoods—a *private* sphere was revealed that suggests a cityscape that deviates from the idyllic tourist package. Similarly, after participant observation in Chinese medical settings, a very different individual and social body was revealed, engaged passively, but *critically*, with the body politic. In conclusion, I propose that, while Singaporean Chinese medical patients' bodily experiences are undoubtedly interpreted within the Chinese medical body ecologic (particularly with regard to 'heatiness'), there are other influences at work as well. The production and management of a healing environment holds the hostile terrain (as implied by both Chinese medical concerns with environmental pathogens and NEA dengue campaigns) at bay, moderates patients' relations with that environment and demarcates a space in which social 'presence' can be (re)affirmed. Resituating patients in a sense of community that is often lacking in the wider society, the Chinese medical clinical encounter in Singapore therefore heals both individual and social bodies.

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