During my time shadowing a TCM physician in Beijing, a woman came in for what initially appeared to be a routine follow-up appointment. Pleasant small talk filled the room as she described how her insomnia and anxiety had greatly improved following Dr. W's previous prescription. As the appointment came to an end and the woman prepared to leave, however, she mentioned that she was worried about her father.

The conversation quickly shifted. Her father, she explained, was ninety years old and required constant care. He had a bad leg, struggled to sleep, had recently suffered a serious fall, and frequently argued with family members who insisted that he was ill. He refused to accept that anything was wrong. The previously lighthearted appointment became increasingly emotional as the woman repeatedly and almost helplessly asked Dr. W, "What do I do?"

Dr. W responded in more than one way. She listened to the woman's description of her father's symptoms and examined the CT scan from his recent fall, offering her medical assessment of his condition. At the same time, she comforted the woman, telling her that many children of aging parents came to her with similar concerns. Dr. W advised the woman to convince her father to stay with her as an inpatient so that his condition could be more closely assessed and treated. Before the appointment ended, Dr. W exchanged personal contact information with the woman and encouraged her to send a message if she had any questions or concerns.

The following week, the woman returned to Dr. W's office near the end of her father's inpatient stay. The two discussed what should happen next. The woman considered whether to send her father to a nursing home or hire a caregiver, but both options seemed to have significant drawbacks. Again, she expressed worry for her father and appeared exhausted herself. As Dr. W listened to her describe the possible futures that each option presented, she also reassured her that she was a good daughter. Together, they looked at nursing homes in the area. In the end, Dr. W extended her father's inpatient stay, both because she believed his health would benefit from continued treatment and because it would give the woman an opportunity to rest.

Within the span of a week, Dr. W had become central to this woman's well-being, even though the woman herself was not technically the patient receiving treatment. As a patient myself in the United States, I found Dr. W's role striking. Exchanging personal contact information, discussing the woman's family responsibilities at length, and helping her search for nursing homes felt to me like forms of involvement that crossed the professional boundaries I had come to associate with the physician-patient relationship. While these boundaries may serve important practical purposes, I have sometimes experienced and witnessed the distance they create with a patient. Physicians may successfully treat ailments, yet it can still feel that they are treating conditions rather than the person.

This tension has long concerned medical anthropologists. Arthur Kleinman, for example, has distinguished between disease as the biological disorder understood through biomedical knowledge and illness as the subjective experience of suffering. In critiques of biomedicine, this distinction raises the possibility that forms of suffering that cannot be easily measured or translated into objective pathology may become secondary to the treatment process (Kleinman,

1997). My observations do not suggest that all biomedical physicians practice in this way, nor do they support a simple opposition between "Western" medicine and TCM. Instead, my own experiences with physicians and conversations with practitioners have complicated any assumption that one medical system is inherently more humane or attentive than another.

This paper draws on ethnographic observations at TCM hospitals in Beijing to examine how care can extend beyond the treatment of physical disease. I argue that, in the clinical settings I observed, care was produced not only through the treatment of symptoms but also through attention to patients' subjective experiences, family relationships, everyday concerns, and the practical realities of sustaining treatment. At the same time, these forms of care were shaped by relationships, time, and the integration of different medical practices. Through an examination of patients' experiences of minor and preventative health concerns, physician-patient relationships, the integration of TCM and biomedicine, and the circulation of TCM beyond the hospital, this paper explores how medical care can extend beyond the boundaries of the clinical encounter.

Section 1: What counts as a medical problem?

In the hospital, the absence of an acute injury was not grounds for dismissal or an absence of good care. A patient's concern or discomfort was itself enough to warrant serious attention. I began to recognise this one afternoon in the orthopedic department of Hospital G. Earlier that afternoon, I had observed patients dealing with torn tendons, fractured legs, and scoliosis when a middle aged man entered the examination room with seemingly none of these conditions. His only complaint was that his knee felt uncomfortable when he was in air conditioning.

From my limited perspective, it felt strange that this man would come to the hospital with such a small concern. I automatically assumed this visit would be brief. The orthopedist, however appeared neither surprised nor dismissive. Instead, he diligently asked follow up questions and examined the man’s knee. He repeatedly tapped different places along knee, asking each time if the man felt pain. In the end, the orthopedist recommended that the patient keep warm, avoid excessive movement, and use herbal patches.

The care that this orthopedist extended to this man felt quite foreign to me. I found myself wondering why a seemingly minor discomfort warranted the same attentiveness I had observed being given to patients with fractured bones and torn tendons. My reaction revealed an assumption that I had brought with me into the hospital: that medical attention should correspond to the severity and visibility of a physical injury. Yet in this encounter, the absence of an acute or visibly serious condition did not mean that the patient's experience of discomfort was medically irrelevant.

In a conversation with a herbalist at Hospital G, he explained that listening carefully to patients was central to TCM partly because prevention was considered an important form of care. From his perspective, a patient's description of discomfort could itself provide important information about their health, even when there was no immediately visible injury. Rather than relying exclusively on laboratory tests and other physical measurements, he described TCM diagnosis as involving inspection, listening and smelling, inquiry, and palpation. For him, the patient's

subjective account was therefore not simply an addition to diagnosis but an important part of how a practitioner came to understand the patient's condition.

The herbalist pointed to the example of how cancer is frequently caught in the final stages. He argued that serious illnesses may develop before patients or physicians are able to identify clear signs of disease and that patients may experience more ambiguous forms of discomfort or fatigue before receiving a diagnosis. Whether or not these symptoms point to a particular disease, his example revealed an important logic within his understanding of TCM: discomfort does not have to reach the level of an acute medical crisis before it deserves attention.

In this sense, the diligent care I observed in the hospital was not reserved exclusively for patients experiencing severe or life-threatening diagnoses. It could also be extended to milder complaints, uncertainty, and discomfort. The patient did not necessarily need to arrive with a broken bone or a clearly identifiable pathology in order to be taken seriously. What mattered was that something in the patient's experience of their body had prompted concern.

2: Care as knowing the patient

Care was not demonstrated only through selecting the correct medicine. It also involved attention to the patient's subjective experience. In the clinic, this meant not only understanding what was medically wrong with a patient but also understanding who the patient was outside of their illness: their background, family, personality, and the ways they experienced treatment itself.

One way this occurred was through the familiarity that developed between Dr. W and her patients. As mentioned above, some of these interactions initially appeared to cross the boundaries that I had come to associate with physician-patient relationships in the United States. In my observations, conversations between doctor and patient often felt relaxed and colloquial, allowing patients' personalities to become part of the clinical encounter.

One interaction that particularly struck me occurred when a patient whom Dr. W had described as "full of personality" came in for an appointment. Before he had even arrived, Dr. W expressed that she was excited to see him. On that day, however, Dr. W was running behind schedule, and the patient had waited past his appointment time. As soon as he entered the room, he immediately asked what had taken so long, his annoyance clearly visible. Rather than responding with the professional formality I had come to expect in medical settings, Dr. W apologized while laughing. Throughout the rest of the appointment, the relaxed and familiar nature of their interaction allowed his personality to remain present. As they discussed his daily routine, the recent heat wave, and the new iPhone, the visit occasionally felt less like a formal medical encounter and more like two people catching up.

This level of familiarity was not unusual in Dr. W's practice. She frequently described herself as knowing not only individual patients but also their families. Family members often accompanied

one another to appointments, and Dr. W might treat several members of the same family. Over time, she learned about patients' professions, where they were from, and aspects of their family lives. This familiarity allowed her to understand patients as people whose medical decisions and experiences existed within relationships and everyday lives.

Yet knowing the patient as a person was only one aspect of care. It was also important to understand the patient's experience of treatment itself. One particularly clear example was the bitterness of herbal medicine. Herbal medicines can be difficult for patients to tolerate because of their taste. From a purely clinical perspective, I initially assumed that bitterness might be treated as something patients simply had to endure if the medicine was effective. However, this was not how Dr. W approached it. She frequently asked patients how well they tolerated the bitterness of their medicine. When patients complained, she might change the prescription to a pill form or alter the herbal mixture to make it less bitter.

I observed one particularly revealing example when a man accompanied his mother to her regular appointment with Dr. W. Near the end of the visit, Dr. W asked the man how he himself was feeling. He admitted that he had recently experienced some discomfort but said that he was unwilling to drink herbal medicine because he disliked its bitterness. After asking more about his symptoms, Dr. W recommended that he receive treatment. Rather than insisting that he simply tolerate the herbal medicine, however, she suggested that he try medication in pill form instead. A patient who had initially been uninterested in treatment because of his aversion to herbal medicine was therefore able to consider treatment in a form that was more acceptable to him.

The significance of this interaction was not simply that Dr. W offered different medications. Rather, she treated the patient's experience of the medicine as relevant to the treatment itself. Even when bitterness did not pose a significant medical risk, she recognized that a treatment could only be effective if a patient was actually willing and able to continue it. This was particularly common with children, who could be especially resistant to bitter medicine, but Dr. W also adjusted prescriptions for adult patients who simply disliked the taste. The "correct" treatment was therefore not determined only by what could theoretically treat a condition but also by what a particular patient could realistically tolerate.

This relationship between being understood and being able to tolerate treatment appeared again in another encounter. A woman came to see Dr. W with her daughter after previously visiting a physician practicing Western medicine. According to the woman, the physician had recommended surgery, but she did not want to proceed. Money was one concern, but she was also uncomfortable with the interaction itself. She felt that the surgeon had moved too quickly toward the operation and had not sufficiently talked with or examined her. As a result, she did not feel that he understood her.

During the visit, the woman's daughter explained that she had also struggled to understand aspects of what the previous physician had told her. She asked Dr. W to look at the chart and explain it again. Dr. W did so, explaining the patient's condition through the framework of Chinese medicine. The daughter indicated that she understood more clearly after the

explanation. Dr. W suggested that physicians can sometimes be rushed and that medical language can be difficult for patients and families to understand.

This encounter made visible another dimension of care: it is not enough for a physician to understand a patient if the patient cannot understand the physician in return. The clinical encounter involves an exchange of knowledge. Patients must be able to ask questions, express uncertainty, and understand the treatment options available to them. The woman's reluctance to undergo surgery was shaped not only by financial concerns but also by her feeling that she had not been adequately included in or understood through the process that led to the recommendation.

The encounters I observed therefore suggested that care involved more than the successful delivery of medicine. It required knowing the patient as a person, recognizing how the patient experienced treatment, and creating opportunities for patients and families to understand what was happening to them. None of these forms of care are exclusive to TCM, nor were they necessarily present in every interaction I observed. However, in this clinic, they repeatedly appeared as important parts of the relationship through which treatment became possible. The physician was not simply responsible for identifying a condition and selecting a treatment. She also had to negotiate how that treatment would enter into the patient's life.

3: Integration and the possibilities of care

One of the characteristics that appeared inseparable from the practice of contemporary TCM in the hospitals I observed was its integration with Western biomedicine. The TCM physicians I observed did not practice within an isolated system of medical knowledge. Their work frequently involved interpreting laboratory results, considering biomedical diagnoses, prescribing or discussing Western medications, and referring patients to biomedical hospitals when necessary. At the same time, they practiced TCM alongside these forms of knowledge rather than treating Chinese and Western medicine as mutually exclusive.

Dr. W herself was careful to describe the limits of her biomedical expertise. While her medical training and clinical experience allowed her to work with aspects of Western medicine, she told me that a physician specializing exclusively in biomedicine would have greater expertise in practicing it. This distinction was important. Integration did not mean that TCM practitioners considered themselves equally specialized in every form of medicine. Rather, it allowed practitioners to move between different forms of medical knowledge while recognizing their respective limitations.

As one herbalist at Hospital G explained to me, "we don't reject anything; everything used to heal is good." This statement captured an approach to treatment that I repeatedly observed. The question was not necessarily whether a treatment belonged to TCM or Western medicine. Instead, practitioners considered what combination of resources might be useful for a particular patient's condition.

One afternoon, a woman came to Dr. W's office carrying a stack of laboratory results. She had initially received the tests through a nearby biomedical hospital because they were required by her workplace. According to the woman, the physician who reviewed her results told her that there were no alarming findings, although some minor imbalances were present. The physician did not recommend a specific biomedical intervention at that time. When the woman mentioned that she regularly visited Dr. W, the physician reportedly told her that TCM seemed to have worked well for her and suggested that she bring her laboratory results to her TCM physician for further discussion.

During the appointment, Dr. W considered both the laboratory results and the woman's subjective experience. She looked at the quantitative information in the tests while also asking questions about the woman's energy levels, sleep, and stress. Based on these conversations, she recommended dietary changes and added herbs to the woman's prescription. The appointment did not involve choosing between a "scientific" biomedical approach and an alternative TCM approach. Instead, different forms of information were brought together within the same clinical encounter.

This integration appeared particularly significant in situations where patients continued to experience discomfort despite the limits of available biomedical treatment. One patient was an eighty-six-year-old man who frequently visited Dr. W. When I first observed his appointments, I did not know that he had cancer. His cancer was rarely the focus of the visits I observed. Instead, he was treated for constipation, insomnia, difficulty eating, and anxiety. Dr. W later explained that he was receiving care for his cancer at a nearby biomedical hospital. However, according to her, there were limits to the treatment options available to him, and chemotherapy was not considered appropriate for him because of his age.

For this patient, TCM did not replace his cancer treatment. Rather, it addressed aspects of his everyday life that remained relevant even when the primary disease could not be eliminated. His appointments focused on sleep, appetite, constipation, and anxiety—conditions that shaped how he experienced daily life while living with cancer. Integration therefore did not necessarily mean that one medical system succeeded where another had failed. Instead, different forms of care could operate simultaneously while addressing different aspects of the patient's experience.

The relationship also operated in the opposite direction. TCM practitioners did not treat Chinese medicine as sufficient for every condition. I observed many instances in which Dr. W identified situations in which biomedical care was necessary. One woman, for example, came to the hospital after completing laboratory tests required by her workplace. When Dr. W reviewed the results, she found that the woman's blood sugar was elevated. The woman explained that her blood sugar had been high for some time but that she had not made significant lifestyle changes to control it.

Dr. W explained that because the elevation was relatively mild, they could initially attempt to address the problem through Chinese medicine and lifestyle changes. However, she also made clear that if this approach was not effective, the patient would need to begin Western

medication. In other cases, Dr. W told me that she encouraged patients to continue their biomedical treatment or referred them to biomedical hospitals when their condition required resources unavailable at the TCM hospital.

These encounters demonstrated that integration was not governed by a simple formula in which certain diseases belonged permanently to TCM and others to Western medicine. Instead, decisions changed according to the patient, the severity and nature of their condition, the resources available, and the treatments that practitioners believed would be most useful. As Dr. W explained, there were times when TCM could supplement biomedical treatment, times when it could play a more central role, and times when Western medicine was necessary.

Integration, then, expanded the possibilities of care not because either TCM or biomedicine could solve every medical problem. Rather, the ability to move between medical systems allowed practitioners to recognize the limitations of each. A patient did not necessarily reach a therapeutic "dead end" when one form of treatment was insufficient. Other approaches could be considered, supplemented, or combined. In the clinical settings I observed, the question was not which medical system was universally superior. It was how different forms of medical knowledge could be brought together in an attempt to respond to the particular needs of a patient.

4: TCM as a culture

Something that struck me outside of the hospitals themselves was how deeply TCM appeared to be embedded in everyday life. While the hospitals I observed represented formal institutions of Chinese medicine, many of the people I spoke with described encountering TCM knowledge long before entering a TCM clinic. Medical practices and concepts circulated through families, communities, food, and local environments. In this sense, TCM did not exist only as a specialized body of knowledge practiced by trained physicians. Certain forms of medical knowledge also appeared as part of everyday cultural practice. One woman I interviewed described growing up in an ethnic minority region where medical facilities were less developed and people frequently relied on locally available remedies:

“Growing up in an ethnic minority area, medical facilities weren't very advanced, so people relied on folk remedies. For instance, if you felt unwell, they would hard-boil an egg, peel it, wrap it in a cloth, and roll it over your skin. They claimed it could roll out bad *qi* from your body. It was quite interesting. Also, my mother used to do cupping often… You take a bamboo cylinder, light a fire inside to create a vacuum, and place it on the back so it suctions. That's called cupping. …Whenever she felt unwell, she'd do cupping. Bamboo tubes were easy to come by, making it very convenient.”

She also described how her grandfather would go into the mountains to collect tree bark to make a remedy for her childhood toothaches. Although she admitted that she was unsure whether it had actually helped, she emphasized that these practices were widely accepted

within her family and community. She also described her mother using cupping and guasha when she felt unwell.
Her account demonstrated that healing practices were connected to the materials and environments available to people. Bamboo, plants, food, and other locally accessible resources could become part of everyday practices of care. These practices were not necessarily confined to trained physicians or hospitals but could be carried out within families and homes.
This does not mean that professional medical knowledge was unnecessary, nor does it suggest that individuals should attempt to treat serious illnesses without medical guidance. Indeed, the boundary between what can be addressed at home and what requires professional attention is itself an important question. However, the accounts I encountered revealed a distinction between having access to medical care and having access to some forms of medical knowledge. People did not necessarily need to enter a hospital in order to encounter ideas about balance, qi, heat, dampness, or the medicinal properties of particular foods.
Another woman described how her own knowledge of TCM accumulated gradually through social relationships:

“First [my TCM knowledge comes] from parents; second, from various advertisements that mention them; and third, from people around me…You might know a little bit as a child from what your parents told you. Then as you grow up and encounter the outside world, you learn more through TV or other channels.”

She gave examples of learning from friends and colleagues about ideas such as "internal dampness" and foods that might be used to address it. People discussed adding barley to porridge, drinking red bean and barley water, or consuming mung bean soup during the summer. Medical knowledge, in these cases, was not simply transmitted from physician to patient. It moved laterally through conversations between parents and children, friends, colleagues, and acquaintances.

This circulation of knowledge was particularly important to my understanding of how TCM extended beyond the hospital. A person could rarely visit a TCM clinic and still possess a vocabulary through which to interpret bodily experiences. They might understand discomfort through concepts such as heat, dampness, or qi, or respond to these experiences through changes in food and everyday practices. TCM therefore appeared not only as a formal medical system but also as a cultural framework through which people could interpret and respond to their bodies.

Of course, no medical system is entirely separate from its cultural context, and biomedical knowledge also circulates outside hospitals. Yet the particular relationship I observed between TCM, food, family knowledge, local resources, and everyday conversation made this relationship especially visible. The boundaries between medicine and everyday life could become difficult to distinguish. Health practices could take place in a hospital, but they could also take place in kitchens, workplaces, conversations with family members, and through knowledge passed down across generations.

The significance of this observation is not that TCM eliminates the need for professional medical expertise. Rather, it suggests that access to health knowledge does not have to be limited entirely to professional institutions. Certain forms of knowledge can be shared, adapted, and practiced socially. In this sense, care can extend beyond the formal relationship between physician and patient. It can also exist within the cultural and social relationships through which people learn to recognize, interpret, and respond to their own bodies.